Mixed Method- How Do Medical-Surgical Nurses Provide Compassionate Care to Patients in the Face of Adversity?

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MIXED METHOD – HOW DO MEDICAL-SURGICAL NURSES PROVIDE COMPASSIONATE CARE TO PATIENTS IN THE FACE OF ADVERSITY?

A Dissertation Submitted to Molloy College
The Barbara H. Hagan School of Nursing & Health Sciences
PhD in Nursing

In Partial Fulfillment
of the Requirements for the Degree

Doctor of Philosophy

by
DIANE D. KRET
Elizabeth Cotter, Dissertation Chairperson

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The dissertation committee of the Barbara H. Hagan School of Nursing & Health Sciences has examined the dissertation titled

MIXED METHOD – HOW DO MEDICAL-SURGICAL NURSES PROVIDE COMPASSIONATE CARE TO PATIENTS IN THE FACE OF ADVERSITY?

Presented by Diane Domino Kret

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ABSTRACT

Compassion is a quality that is the very essence of nursing. Nurses, as professionals, seek to alleviate suffering. It is through providing compassionate, connected care that nurses can relieve their patients’ suffering. In the midst of adversity such as taking care of ill and dying patients, especially in the Covid-19 pandemic, nurses have been challenged with providing compassionate care despite the increased toll that this may have on them. There is evidence that exposure to these events can cause compassion fatigue and burnout. When these signs of compassion fatigue or compassion burnout are not addressed, nurses have decreased job satisfaction and are at risk of leaving the profession altogether. Despite this dichotomy in the research, compassionate care is still being delivered to patients regardless of the population that they care for or adverse events that they face. The research shows that compassionate care has been provided during adversity that focused on dying patients, traumas, critically ill, and emergency room patients, but there was limited research on compassionate care delivered to medical-surgical patients.

The purpose of this mixed-method study was to understand the process of how medical-surgical nurses provide compassionate care despite the adversity they face. The explanatory sequential design was used as the mixed method, in which there were two phases. A quantitative instrument was used as a self-assessment of compassion competence that an intensity-purposeful sample of medical-surgical nurses from the Academy of Medical Surgical Nurses completed. The quantitative findings suggest that regardless of working nights, the increased number of patients, higher percentage of direct patient care, and working mandatory overtime, the medical-surgical nurses still assessed themselves with high compassion competence. To further explore and encourage reflection on compassionate care, a smaller sample of medical-surgical nurses
who completed the Compassion Competence Scale were interviewed to describe their process of providing compassionate care despite the adversity they faced. Three categories were explored: adversity, why medical-surgical nurses provide compassionate care, and how medical-surgical nurses provide compassionate care. From these categories, an overarching category of altruism was identified. Quantitative and qualitative methods were used to triangulate results. Findings from the quantitative analyses were concurrent with the findings from the qualitative analyses. With the exception of one item from the Compassion Competence Scale, the instrument items upheld the prominent categories discovered in the qualitative data. Applying the grounded theory of altruism and supporting data from this mixed-method study provides nurses and nurse leaders valuable information to encourage the retention of nurses, reminding them of the importance of compassionate care in their practice and the badge of honor that nurses wear every day.

*Keywords*: compassion, caring, compassionate care, compassion fatigue, compassion burnout, traumatic events, adversity
DEDICATION

To my beautiful sister, Dionne, God rest her soul. I know she is looking down on me with her gorgeous smile, glowing with pride. This is for you, Ate.

Ate D

You have been my beautiful light all my life.
Gently guiding me, sometimes not so gentle, throughout my life
You tried to protect me from so much, ready to fight anyone who hurt me.
Protecting everyone, even until the very end, so we wouldn’t worry.
Selfless, kind, intelligent, beautiful.
Your smile would light up the room and touch the hearts of so many people.
You gave your spirit and love to so many and was still able to give so much more love to
Kev, Meghan, Tony, Sean, Mom, Dad, me, our family, and friends.
Your encouraging words always gave me the wisdom and strength
I needed to move forward and succeed.
You gave me and your patients hope for a better tomorrow and baby miracles to happen.
My sister, my friend, my warrior, my angel, my inspiration.
You took care of me and protected me all my life.
Then with this terrible battle against the beast, the roles were reversed.
I had to take care of you, protect you, encourage you, especially when you got scared.
You never knew your full potential, your worth, how strong you were,
But you knew at the very end.
As you took your last breaths, locked in an embrace,
Heads leaning against each other, looking into each other’s eyes.
I helped you reach the gates of heaven, so you didn’t have pain, fear, or anxiety anymore.
It is an honor being your sister and I will wear this medal of honor, always.
Fill me with your beautiful light to continue to live.
To help your beautiful daughter and little man live to their full potential.
To help our family and friends pick up the broken pieces, patch them up and continue living.
Help me to remember the amazing memories.
To keep your spirit and love alive,
To help all of us remember your warmth, your kindness, your love, your smile.
You will forever be in my heart, keeping me strong,
My Ate.

By: Diane Domine Kret
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CHAPTER 1: INTRODUCTION, PROBLEM STATEMENT & SIGNIFICANCE OF PROBLEM

Compassion is a quality that is the very essence of nursing. Nurses, as professionals, seek to alleviate suffering. It is through providing compassionate, connected care that nurses can relieve their patients’ suffering. Within the definition of nursing by the American Nurses Association (2021b), the responsibilities of nursing are to help protect, promote, and maximize health, prevent injury and illness, lessen suffering through the appropriate use of the nursing process to care for patients in all settings.

When nurses care for an increasingly complex patient population, such as taking care of ill and dying patients, especially in the Covid-19 pandemic, nurses are challenged with providing compassionate care. When there was continuous exposure to stress and neglect of their own self-care, compassion fatigue occurred. Beginning signs of compassion fatigue are decreased desire to work and care for patients, poor attendance, or verbal attacks on coworkers. When these signs of compassion fatigue are not addressed, nurses have decreased job satisfaction and are at risk of leaving the profession altogether. The Schwartz Center for Compassionate Healthcare (2017) found that there has been a decrease in compassionate care among healthcare providers, including nurses. Although evidence suggests that compassion is dropping, research shows that some nurses allow their innate compassion to show in the care they provide, despite the presence of adversity (Beaune et al., 2017; Berg et al., 2016). Despite this dichotomy in the research, compassionate care is still being delivered to patients regardless of the population that they care for or the adversity they face. The compassionate care that nurses provide in time of crisis, such as during the recent Covid-19 pandemic, was courageous but challenging and emotionally draining for nurses in the studies reviewed. The nurses had to not only serve as caretakers but
also as surrogate family members. Exploring the research, compassionate care was provided
during times of adversity that focused on patients who were dying, had experienced some
traumas, were critically ill, or were in the emergency room (Beaune et al., 2017; Berg et al.,
2016). The research is limited in compassionate care delivered in the medical-surgical setting
(Kret, 2011; Tehranineshat et al., 2019).

**Researcher’s Perspective**

The abstract term *compassion* has been of interest to this researcher from a previous
study that was conducted (Kret, 2011). Having experienced many professional roles as a
medical-surgical nurse, nurse educator, and now nursing director of professional practice
development and education, the ability to provide compassionate care has always been this
researcher’s interest. As a medical-surgical nurse with competing priorities and management of
care, compassion still needs to be at the forefront of care. As a nurse educator, this researcher
supports the need for nurses to be educated about the importance of incorporating compassion in
the everyday care that they provide, along with initiatives and new policies and procedures. As a
nursing director of professional practice development and education, the researcher supports the
need for nurse educators to be guided to incorporate compassion in the education that they
provide to orientees and nurses alike and to educate nurses on how to be compassionate. This
researcher is a nurse by profession and seeks the truth in the words of her participants. Illness
and suffering are human experiences. It takes compassionate care to alleviate this suffering, and
it is the art of nursing to discover ways to continue to provide this care. Nursing and
compassionate care are the core of the researcher’s being and cannot be separated from this
study, so the researcher will not bracket for this study.
Problem Statement

Compassion is seen as a quality that is inherent in nursing and can improve the patients’ experience in the healthcare setting. Dempsey et al. (2014) discussed how implementing the strategies within the Compassionate Connected Care Framework can improve the patient experience. Compassion is providing care that alleviates the suffering of an individual. It takes special, talented, creative people to cope with the many challenges of nursing, while still providing compassionate care. Nursing is an art because nurses utilize their personal experience, education, imagination, and a part of themselves to create a unique style of nursing to help reduce patient suffering. When nurses give so much of themselves, providing compassionate care without being aware of the signs and symptoms of compassion fatigue and reversing them, compassion can quickly become a detriment to nurses. They may display signs of job dissatisfaction, physical and mental decline, and feelings of hopelessness. Providing compassionate care during stressful conditions can lead to compassion fatigue or burnout (Hamilton, 2018; Perregrini, 2019). If nurses do not manage compassion fatigue, they may leave the profession altogether, contributing to the global nursing shortage. The demand for nurses will increase in 2022 because 500,000 nurses are projected to retire. To replace these retired nurses and avoid a nursing shortage, 11 million nurses are needed (American Nurses Association, 2021). A nursing shortage could cause dire effects, since healthcare is already struggling globally due to rising costs, an aging population with more complex disease processes, and the need to treat patients efficiently (Haryanto, 2019).

Medical-surgical nurses make up the largest nursing specialty in the United States and therefore care for the largest number of patients (Academy of Medical-Surgical Nurses [AMSN], 2021). The consequences that may arise due to compassion fatigue are nursing turnover, not
receiving reimbursements due to not meeting quality indicators, and nurses getting hurt. These could all contribute to the nursing shortage and cost institutions a huge financial burden (Sorenson et al., 2017). According to the survey by Nursing Solutions (2021), “The average cost of turnover for a bedside RN is $40,038 and ranges from $28,400 to $51,700 resulting in the average hospital losing $3.6m–$6.5m/yr. Each percent change in RN turnover will cost/save the average hospital an additional $270,800/yr.” (p. 1). To prevent the consequences of compassion fatigue or burnout, it was important to gain insight on how compassionate care can endure although nurses are being faced with adversity.

**Purpose of the Study**

The purpose of this study was to understand the process of how medical-surgical nurses provided compassionate care despite the adversity they faced. Different challenges, such as a pandemic, can either prevent or enhance nurses’ ability to provide compassionate care. It was important to understand the choices that nurses made and what enabled them to continue to provide compassionate care, despite being faced with adversity.

The aim of this study was to develop clinical practice recommendations regarding the provision of compassionate care. To achieve this aim, the researcher took the following steps: (a) surveyed medical-surgical nurses and determined their Compassion Competence Score, (b) interviewed volunteers from the survey sample population, and (c) integrated data and determined mutually supported findings from the analyses.

**Significance of the Study**

Compassionate connected care is a framework that is shown to improve healthcare quality and patient outcomes. Positive outcomes using compassionate connected care are satisfaction and development for the healthcare team, individual, and organization. Other
positive outcomes are care of self, dignity, self-compassion, therapeutic patient-physician relationship, holistic care, and patient satisfaction. When compassion and collaboration occur among the healthcare team and with the patient and family as the center, the patient and family report satisfaction with care delivery from the entire team (Pfaff & Markaki, 2017).

Compassion and collaboration between the patient/family and the healthcare team are key components ensuring that high-quality care is provided to patients. The connection that patients and families gain from compassion and collaboration provided by the healthcare team help them feel involved in their own care. The relationships that are formed build trust in the care delivery and in the process. With this team approach, care delivery is more efficient and the needs of the patient/family are met, which will lead to positive patient outcomes and ultimately patient satisfaction. As essential members of the healthcare team, nurses should provide compassionate care to their patients. Nurses facilitate collaboration among the healthcare team and maintain the connection with patients and families. Despite adversity that nurses face, their responsibilities are to continue to provide compassionate care and stay connected to their patients. Compassion is the additional component that means the difference between high-quality care and mediocre to poor-quality care (Pfaff & Markaki, 2017).

**Relevance to Nursing**

Compassion is the very essence of nursing. With the adversity that nurses face, it could be buried among the priorities and tasks that they need to address. It was important to understand the process of how nurses continued to provide compassionate care in the face of adversity. Supporting nurses’ ability to provide compassionate care to their patients is essential to provide quality care to their patients, which includes developing relationships with their patients. These relationships allow collaboration to occur, efficiency of care, and the needs of the patient to be
met (Pfaff & Markaki, 2017). Providing compassionate care does require balance. The nurses need to find a balance among their work life, family life, and self-care. If nurses do not pay attention to self-care, compassion fatigue or burnout may occur (Kohli & Padmakumari, 2020). Understanding this balancing act of providing compassionate care can provide a roadmap of how to navigate through adversity. This roadmap can be used as a guide to educate nurses to improve their practice or help new nurses enter their professions prepared.

**Research Questions**

This study used a mixed-method approach to answer the following questions.

**Quantitative Research Questions**

The quantitative strand of this study was guided by the following questions:

- What is the level of compassion that medical-surgical nurses had in their self-assessment of compassion competence?
- Does employment in a magnet facility compared to a non-magnet facility increase Compassion Competence Scale (CCS) scores for medical-surgical nurses?
  - Hypothesis – Working at a magnet-recognized facility is associated with high CCS.
- In medical-surgical nurses, what is the relationship between education level and CCS?
  - Hypothesis – As education level increases, the CCS will increase.
- In medical-surgical nurses, what is the relationship between holding an advanced certification and CCS?
  - Hypothesis – Holding an advanced certification is associated with high CCS.
- In medical-surgical nurses, what is the relationship of current nurse/patient ratio and CCS?
Hypothesis – The higher nurse-to-patient ratio, the lower the CCS scores.

- In medical-surgical nurses, what is the relationship of mandatory overtime and CCS?
  - Hypothesis – Being required to work unplanned or mandatory overtime is associated with low CCS.

- In medical-surgical nurses, what is the relationship of the shift worked and CCS?
  - Hypothesis – Nurses that work the day shift will be more compassionate than those that work the night shift.

- In medical-surgical nurses, what is the relationship between the percentage of direct patient care and CCS?
  - Hypothesis – The higher the percentage of direct patient care, the lower the CCS scores.

**Qualitative Research Question**

The qualitative strand of this study was guided by the following question:

- What is the process of medical-surgical nurses that provide compassionate care in the face of adversity?

**Mixed-Method Questions**

- Do the quantitative items uphold prominent concepts discovered in the qualitative data?
  
  Which specific examples from the qualitative data (interviews) provide the best insight into the quantitative results?

- To what extent does the qualitative data contribute to an enhance interpretation and understanding of the relationships discovered among the quantitative variables?
Definitions

**Adversity:** Stressors or types of trauma that test human beings’ coping mechanisms and resilience (Jirek & Saunders, 2018).

**Caring:** “Caring is when the one caring connects with and embraces the spirit of the other through authentic, full attention in the here and now, and conveys a concern for the inner life and personal meaning of another” (Sitzman & Watson, 2014, p. 17).

**Compassion:** “Compassion is that of sympathy for someone who is suffering and the desire to alleviate that suffering” (Johnson, 2015, p. 339).

**Compassionate Care:** “A deep feeling of connectedness with the experience of human suffering that requires a personal knowing of the suffering of others” (Peters, 2006, p. 38).

**Compassion Competence:** “First, nurses who have respect for and can empathize with patients based on their professional nursing knowledge. Second, nurses who can connect and communicate with patients emotionally and with sensitivity and insight, based on their experience and knowledge. Third, nurses who put constant effort into self-development” (Lee & Seomun, 2015, pp. 77-78).

**Compassion Burnout:** “Burnout is characterized as running on empty; nurses have given all with the feeling of nothing is being accomplished, which results in emotional exhaustion” (Henson, 2020, p. 79).

**Compassion Fatigue:** “A state of exhaustion and dysfunction…As a result of prolonged compassion stress” (Figley, 2015, p. 253).

**Compassion Satisfaction:** “Compassion satisfaction is defined as the pleasure that comes from the feeling that work is done well and that it contributes to the work environment and to the greater good” (Wijdenes et al., 2019, p. 19).
**Empathy:** “Empathy is feeling; compassion is action” (Konrath et al., 2011, p. 180).

**Medical-Surgical Nursing:** “The single largest nursing specialty in the United States and beyond. Medical-surgical nurses provide care to adults with a variety of medical issues or who are preparing for/recovering from surgery…Medical-surgical nursing is practiced in several settings across the health care industry, including hospitals, outpatient settings, in homes, via telemedicine and other non-traditional settings” (AMSN, 2021, p. 1).

**Secondary Traumatic Stress:** Post-Traumatic Stress Disorder (PTSD)-like symptoms because of providing care or alleviating suffering of patients that experienced trauma (Sorenson et al., 2017).

**Stressful or Traumatic Events:** “Some experiences (that) are very difficult to forget even with the passing of time” (Loesin et al., 2009, p. 26).

**Sympathy:** “Sympathetic understanding on the other hand, involves a process in which the helper loses his own separate identity and takes on the patient’s feelings and circumstances as if he were in his place” (Kalisch, 1973, p. 1548).

**Research Plan**

This research study followed a mixed-method approach using an explanatory sequential design (Creswell & Clark, 2018c). The first phase of this design started with the implementation of the Compassion Competence Scale (CCS) to a sample of 103 medical-surgical nurses, followed by the collection and analysis of these results. The second phase of this design obtained 27 participants, which was a subset of the 103 medical-surgical nurses to interview. The data from the interviews were collected and analyzed to explain the results from the quantitative phase of the design. The aim of this study was to produce a process from the collected data. In this study, the researcher investigated how medical-surgical nurses continue to provide
compassionate care in the face of adversity. A context-substantive theory was developed with this social compassionate interaction faced with adversity (Creswell & Clark, 2018c).

**Chapter Summary**

This chapter introduced compassion and how it can be compromised. The purpose, significance, relevance to nursing, and researcher’s perspective were explained. Compassion, related terms to compassion, and other terms were defined. These definitions gave the study a better understanding of the definitions related to compassion. The definitions also served to differentiate related terms, such as empathy, compassion, sympathy, and caring. Also mentioned were the related terms to compassion such as compassion fatigue, compassion burnout, and compassion satisfaction. This chapter provided an operational definition of compassion competence to provide a direction on how it was used in the study. Definitions of medical-surgical nursing, adversity, and stressful or traumatic events were provided to provide further clarity.
CHAPTER 2: LITERATURE REVIEW

Chapter 2 provides a synthesis and critical evaluation of the literature that addresses providing compassion, measuring compassion, being fatigued by compassion, having compassion during adversity, and incurring negative consequences of compassion fatigue or burnout on nurses. These elements allowed the researcher to further explore the essence of compassionate care and the process that these nurses followed to continue to provide compassionate care. This succinct review enabled the researcher to avoid assumptions based on related studies and allowed the findings to emerge from the participants’ interviews.

Providing Compassion

The common attributes found in the literature were caring, attentiveness, empathy, good communication, connection, and the development of a trusting relationship (Devik et al., 2020; Kret, 2011; Straughair et al., 2019; Tehranineshat et al., 2019). These studies gave rich descriptions of compassion through the eyes of patients, caretakers, nurses, and other healthcare workers, in different practice areas of medical-surgical, palliative homecare, and critical care, taking place in different countries, including the United States, the United Kingdom, Iran, and Norway.

Devik et al. (2020), Kret (2011), Price (2013), Straughair et al. (2019), and Tehranineshat et al. (2019) discussed how different individuals experienced different aspects of compassion in the nursing care they received. In Kret’s (2011) study, medical-surgical patients rated the care they received by their nurse; their prevailing themes were caring and attentiveness. Straughair et al. (2019) conducted a grounded theory study in the UK that studied volunteers and nurse instructors’ perceptions of compassionate nursing care and how it connects the humanization that occurs with nursing care. Straughair et al.’s (2019) overarching theme of “humanizing for
compassion” included the categories of “conditions for compassion,” “self-propensity for compassion,” “attributes for compassion,” and “socializing for compassion” (p. 1533). The attributes for compassion were kindness, attentiveness, gentle approach, effective communication, reassurance, the making of connections, and being observant. Tehranineshat et al. (2019) conducted a phenomenological study in Iran that studied nurses, patients, and family caregivers from the emergency department, medical-surgical units, burn unit, and critical care units, which drew out the themes of “effective interaction,” “professionalism,” and “continuous comprehensive care” (p. 1711). Effective interactions included kindness, effective communication, and trust gained by being attentive to patients’ needs. In Price’s (2013) ethnographic study conducted in the UK, the researcher explored the ability of doctors, physiotherapists, and nurses to provide care using technology, such as electronic documentation and machinery used to monitor patients, in a critical care unit. Price’s (2013) overaching theme was the “crafting process” that had the subthemes of “vigilance,” “focus of attention,” “being present,” and “expectations” (p. 282). In the study by Devik et al. (2020), they used a hermeneutic approach studying nurses’ compassionate experiences when providing home care to palliative patients. The overarching theme in Devik et al. (2020) was “valuing caring interactions as positive, negative, or neutral” (p. 197), which included how compassion was experienced through the awareness of patients’ needs, attention to the patients’ feelings, and engagement with their patients. Caring, being attentive, developing a trusting relationship with the patient, and viewing patients holistically were all highlighted to gain an understanding of how to best provide compassionate care (Devik et al., 2020; Kret, 2011; Price, 2013; Straughair et al., 2019; Tehranineshat et al., 2019). Caring and being kind to their patients build a connection or rapport with their patients that lead to trusting relationships. Attentiveness to their patients gave nurses
the information they need to provide care specific to all their patients’ needs.

While some nurses have a predisposition to be compassionate, others can be taught to be compassionate. Straughair et al. (2019) found that nurses have the disposition to be compassionate because it is their nature. In the category “socializing for compassion” (p. 1532), which were external factors that affect compassion, participants felt that education and exposure to compassion even at a young age were important to nurture compassionate adults. This compassion education can be continued in formal training in universities and hospitals given by the nurse role-models, nurse instructors, nurse educators, and preceptors. External factors that can affect nurses’ ability to provide compassionate care to their patients are role models, training, high ratios, hospital-process improvement initiatives, electronic medical record documentation, the timely achievement of tasks, and the institution’s culture (Price, 2013; Straughair et al., 2019). Despite some of the negative external factors that affect compassion, it remains an important attribute in healthcare. Although it is inherent in many healthcare workers, compassion can be taught through role-modeling and formal training to ensure that compassionate care ensues in universities and in different healthcare settings.

**Measuring Compassion**

Common themes tied to compassion were (a) empathy, (b) caring, and (c) communication. Compassion instruments measured the compassion of nurses and physicians through the perceptions of patients, their family, female cancer survivors, medical-surgical patients, correctional physicians, and resident physicians. The compassion instruments measured compassion in varied ways, based on who rated the compassion of their healthcare providers. There were studies in which patients measured compassion in nurses (Burnell & Agan, 2013; Kret, 2011); another in which patients, their family, and healthcare staff measured compassion in
nurses (Dewar, 2011); and other studies in which patients measured compassion in their physicians (Fogarty et al., 1999; Sabapathi et al., 2019). There were also self-assessments of compassion in physicians that were measured (Dhawan et al., 2007; Roberts et al., 2011) and self-assessments of compassion competence in nurses that were measured in the study by Leo and Seomun (2015). Overall, patients perceived their healthcare providers as compassionate. Physicians who worked in correctional facilities displayed empathy and compassion similar to other physicians but had less curiosity of their patients’ feelings and emotional resonance than their physician counterparts (Dhawan et al., 2007). Physicians who have experienced illness were more likely to be more compassionate than physicians who have not experienced illness (Roberts et al., 2011). Reviewing how compassion was measured in these instruments gave insight on various aspects of compassion.

Empathy was identified as a key component of compassion because it is necessary for nurses or other healthcare workers to recognize and understand the suffering or distress of patients (Lee & Seomun, 2015; Papadoupoulos & Ali, 2016; Sabapathi et al., 2019). Papadoupoulos and Ali (2016) completed an integrative review of studies that measured compassion in nurses and physicians. Sabapathi et al. (2019) conducted a cross-sectional study in three emergency departments in the United States that validated an instrument that measured emergency department physicians’ compassion assessed by their patients. Lee and Seomun (2015) conducted a study that developed and validated the CCS, which was a self-assessment of nurses’ compassion. Empathy was a prevalent theme that allowed nurses and physicians to gain a better understanding their patients. There were items within the instruments that specifically measured empathy. Sabapathi et al. (2019) asked the patients, “During this emergency department visit, how often do you feel your clinician cared about your emotional or
psychological well-being?” (p. 2). Within the subdomain of the CCS of insight (Lee & Seomun, 2015), empathy was seen in the item, “I can empathize well with patients’ difficulty” (p. 81). In one of the studies in Papadoupoulos and Ali (2016), correctional physicians were asked to rate their agreement of the statement “When I am upset at patient, I usually try to ‘put myself in his or her shoes’ for a while” (Dhawan et al., 2007, p. 260). Once suffering is identified, the act of alleviating suffering followed.

Caring was an underlying theme included in the instruments and items related to relieving or addressing the needs of their patients (Lee & Seomun, 2015; Papadoupoulos & Ali, 2016; Sabapathi et al., 2019). In two studies in Papadoupoulos and Ali (2016), patients were asked to rate if their healthcare provider was caring or uncaring (Fogarty et al., 1999; Kret, 2011). In another study in Papadoupoulos and Ali (2016), there was a subscale named “caring attributes” within the Compassionate Care Assessment Tool that included items such as consideration of patients’ needs, encouragement of patients, and appreciation of the patient’s family (Burnell & Agan, 2013, p. 181). Within the subdomain of the CCS of insight (Lee & Seomun, 2015), caring was seen in the item “I offer customized care to patients by taking their characteristics into consideration” (p. 81). Caring was also seen when the patients were asked, “During this emergency department visit, how often do you feel your clinician showed you care and compassion” (Sabapathi et al., 2019, p. 2). Caring or compassionate care were responses to empathy and provided the patients with individualized care based on their needs.

Another important component of compassion found was therapeutic communication. Being approachable, developing rapport, gaining trust, treating patients with respect, and understanding patients were ways in which nurses connect to their patients. Although not specifically stated within the instrument, communication was implied in the item when the
patient was asked, “During this emergency department visit, how often do you feel your clinician was able to gain your trust?” (Sabapathi et al., 2019, p. 2). With these components of therapeutic communication, nurses can gain their patients’ trust, develop relationships with their patients, and provide better care to their patients (Lee & Seomun, 2015; Papadoupoulos & Ali, 2016; Sabapathi et al., 2019). Other themes that emerged from the review of compassion instruments were competence, professionalism, attentiveness, and patient involvement (Papadoupoulos & Ali, 2016).

In the instruments reviewed, empathy, caring, and communication were prevailing themes that emerged. All the instruments discussed gave insight on how compassion can be measured and the different perspectives by the patients, families, and physicians. Patients perceived their healthcare providers as compassionate caretakers either through their actions or interventions that were implemented. Physicians generally assessed themselves as empathetic and compassionate to their patients, but those who experienced illness were more inclined to be more compassionate than those who did not experience illnesses because they had a personal experience being patients themselves. Through therapeutic communication, healthcare providers made connections with their patients, became empathetic to their needs, and provided caring acts to address those needs.

**Compassion During Adversity**

Nurses continue to be compassionate despite being faced with adversity. Despite adversity or adverse events that they encounter, nurses continue to provide compassionate care because it is their higher calling and they grow in this provision of care. *Traumatic or adverse events* are defined as “some experiences (that) are very difficult to forget even with the passing of time” (Locsin et al., 2009, p. 27). Examples of adverse events are caring for Covid-19 patients
Caring for patients with novel diseases when the prognosis is poor, transmission is high, and little is known about treatment are all sources of adversity for nurses (Alharbi et al., 2020; Locsin et al., 2009; Pariseault et al., 2022). Pariseault et al. (2022) conducted a qualitative study that interviewed 17 RNs from various settings and used Watson’s theory of human caring as a framework. This study revealed that due to constraints of social isolation and the use of personal protective equipment (PPE) caring for Covid-19 patients, nurses felt that good communication was essential in the assurance of quality care and good patient outcomes. Alharbi et al. (2020) conducted a literature review in Australia that discussed the potential to develop compassion fatigue among critical care nurses that cared for Covid-19 patients. A phenomenological study by Locsin et al. (2009) discussed nurses caring for patients dying of the Ebola hemorrhagic fever. Nurses in the studies by Alharbi et al. (2020) and Locsin et al. (2009) feared bringing these contagious diseases to their families. Because of this fear, both sets of nurses self-isolated themselves to protect their loved ones. Despite the risks of contracting these diseases and spreading it to their families, these nurses continued to selflessly care for their patients. Like the self-sacrifice of nurses that cared for Ebola patients, nurses that cared for Covid-19 patients also made a commitment to care for these patients, by not only being their nurses but also being surrogate family members when visitors were not allowed in patients’ rooms. There was a similarity in the knowledge and protection theme during the Covid-19 crisis: Once more knowledge was gained on how to better care for their patients and there were more resources such as PPE, nurses and other healthcare workers felt better supported to care for their patients.
Due to the intensive nursing care that was required of both diseases, nurses were at risk of suffering from compassion fatigue or burnout.

Studies gave varying insights on how nurses dealt with patients who experienced quite different adverse events, one with an incredibly positive outlook and the other with a less positive outlook on the situation (Beaune et al., 2017; McCall, 2020). A phenomenological study was conducted in Ontario, Canada, interviewing 24 pediatric healthcare professionals (8 nurses, 9 social workers, and 7 physicians) describing their experiences and coping mechanism when caring for dying patients, and the themes that emerged from the interviews were related to personal growth (Beaune et al., 2017). From the construct of personal growth, themes that emerged were “new or altered life perspectives, enhanced personal resources, and benevolence” (p. 301), and positive outcomes of resilience and job satisfaction occurred as a result. McCall (2020) interviewed seven emergency nurses in Tennessee who cared for pediatric patients involved in a shooting. The theme that emerged was self-care in the prevention of secondary trauma, which can lead to compassion fatigue. McCall (2020) found that nurses remained focused on caring for these victims and that maintaining their competence helped decreased their stress levels. There was difficulty noted with closure and not knowing what happened to the children after they treated them, resulting in flashbacks if similar events occurred in the news. Being faced with adversity, nurses turned to their social support and practiced self-care to prevent secondary trauma and experienced personal growth.

Adversity can present in different ways, such as caring for Covid-19 patients, Ebola patients, dying patients, and pediatric patients affected by a shooting. Nurses continue to provide compassionate despite risks of contracting a contagious disease or risk of experiencing secondary trauma. With the provisions of social support and reinforcement of self-care, nurses can continue
to provide compassionate care and experience personal growth in the process.

**Compassion Fatigue**

When there is an increased demand for compassion and warning signs are ignored, compassion fatigue or burnout can ensue. There have been several examinations of compassion fatigue using concept analysis, a meta-synthesis of compassion fatigue integrating nine qualitative studies (Henson, 2020; Nolte et al., 2017; Sorenson et al., 2017), and studies that measured compassion fatigue in trauma (Berg et al., 2016; Wijdenes et al., 2019). There were many commonalities found in the concept analyses and meta-synthesis related to compassion fatigue. The common defining attributes to compassion fatigue from these concept analyses are a decline in caring or empathy toward patients, emotional exhaustion, and sudden onset of symptoms. The common antecedents to compassion fatigue are continuous exposure to the suffering of others, compassion/empathy toward people that are suffering, and job-related stress. The common consequences of compassion fatigue besides the physical, emotional, and behavioral symptoms are inability to form a trusting relationship with patients, poor quality care, and nursing turnover (Henson, 2020; Nolte et al., 2017; Peters, 2018; Sorenson et al., 2017). Common physical symptoms of compassion fatigue include fatigue, exhaustion, body aches/pains, and sleeplessness, whereas common emotional symptoms are helplessness, hopelessness, apathy, and decreased sense of purpose (Henson, 2020; Nolte et al., 2017; Sorenson, 2017). Through their concept analyses and meta-synthesis of compassion fatigue, all the authors felt that by promoting education on the signs and symptoms of compassion fatigue and implementing prevention strategies, nurses and other healthcare professionals can combat compassion fatigue and promote self-compassion and self-care (Henson, 2020; Nolte et al., 2017; Peters, 2018; Sorenson et al., 2017).
Berg et al. (2016) and Wijdenes et al. (2019) measured compassion fatigue risk in trauma centers. These studies showed that exposure to compassion stress was high among nurses in areas of trauma, which include emergency department and critical care units. Berg et al. (2016) studied compassion fatigue and burnout syndrome among trauma team members in Kansas, using a mixed-method approach. A focused group of 12 participants were chosen from a trauma team in a Midwestern level 1 trauma center. Wijdenes et al. (2019) measured compassion fatigue at a large urban trauma center in a Southwestern hospital in the United States and used the Professional Quality of Life Scale-5 to measure compassion fatigue risk in nurses. The sample included 315 nurses. Trauma nurses are exposed to high compassion stress and have moderate to high scores of secondary traumatic stress disorder. Also found was a need to have more adequate coping techniques such as debriefing, going to the chapel, taking a bath, blowing bubbles, and self-isolating to decrease their compassion fatigue scores (Berg et al., 2016; Wijdenes et al., 2019).

High exposure to adverse events could cause compassion fatigue in nurses. Caring for Ebola patients suffering hemorrhagic fever, Covid-19 patients, victims of a shooting, dying patients, or trauma patients are all examples of adverse events that nurses face. There are positive outcomes that occur if compassion fatigue or burnout are managed such as resilience and job satisfaction (Beaune et al., 2017). It also comes with negative outcomes such as not effectively decreasing their compassion fatigue and burnout levels and continuing to have flashbacks of these events when similar situations occur in the news (McCall, 2020). Acknowledging and addressing the signs and symptoms of compassion fatigue can prevent it from changing to compassion burnout and allow nurses to continue to provide compassionate care.
Negative consequences of compassion fatigue

There are several negative consequences of compassion fatigue and compassion burnout (Dyrbye et al., 2020; Gensimore et al., 2020; Haizlip et al., 2020; Lee et al., 2017; Razo et al., 2021; Roomaney et al., 2017). Negative outcomes from compassion fatigue and burnout are career choice regret, nurse turnover, and depersonalization (Dyrbye et al., 2020; Lee et al., 2017; Razo et al., 2021; Roomaney et al., 2017). There are constructs or scenarios that can reverse or decrease compassion fatigue, such as a positive nurse practice environment and mattering (Gensimone et al., 2020): “Mattering is a construct from social psychology that describes the feeling that one makes a difference in the lives others and has significance in one’s community” (Haizip et al., 2020, p. 267).

In a study by Dyrbye et al. (2020), a sample of 6,933 ANA nurses were given surveys on compassion burnout and career choice regret. The results of the study showed that career regret increased significantly as severity of emotional exhaustion and depersonalization worsened. There was evidence that reducing compassion burnout can reduce career choice regret and reduce nurses’ intent to leave the profession. Razo et al. (2021) was the first to measure nurses’ intent to leave related to the perceived level of the Covid-19 pandemic impact and found that 31% of nurses had intent to leave, with nurses older than 60 most likely to have intent to leave at 8.4%. Pandemic impact was perceived to be higher in clinical nurses who had the intent to leave the profession. Also, Lee et al. (2017) conducted a prospective study that examined Taiwanese \( N = 1,283 \) nurses’ intention to leave after one year of practice. The nurses completed a demographic form, the Chinese version of the Quality of Nursing Work Life Scale, and an intention to leave questionnaire. More than half the sample (56.1%) had intention to leave the nursing profession. The results from the scale indicated that nurses not having autonomy and
respect in their practice were large factors causing nurse turnover. Both studies indicated that awareness of well-being of nursing staff and the rest of healthcare team, a work environment that has enough resources, and adequate staffing are all important factors that need to be addressed to keep the numbers of intent to leave low to prevent nurses from leaving the profession (Lee et al., 2017; Razo et al., 2021).

Predictors of compassion burnout were studied by Roomaney et al. (2017). The components of compassion burnout that were targeted were emotional exhaustion, depersonalization, and personal accomplishment in South African nurses caring for HIV patients. It was convenience sample of 109 participants from a large tertiary hospital. There were positive association of the factors of depersonalization and emotional exhaustion to compassion burnout. When these HIV patients ceased care, not receiving their anti-retroviral medication and follow-up care led to dire outcomes for these patients. The stigma associated with caring for HIV/AIDs and the stress of death and dying in this population were not only occupational hazards but also were negatively associated with personal accomplishment and caused depersonalization with patients (Roomaney et al., 2017).

Positive traits that can reverse the effects of compassion fatigue and burnout were discussed (Gensimore et al., 2020; Haizlip et al., 2020). Gensimore et al. (2020) used a descriptive design to study the effect of nurse practice environment on the retention and quality of care through examining compassion burnout and work characteristics, including resilience. Five hundred and seven nurses were surveyed, and responses were applied to a series of instruments that measured social capital, ability to make decisions freely, workload, compassion burnout, and resilience. As defined by Gensimore et al. (2020), “Social capital examines the relationships between and among staff and the collective values and mutual trust between
members of an organization” (p. 547). Having positive work characteristics and work environment improved patient outcomes and decreased compassion burnout. Protective factors against compassion burnout associated with social capital were a good working environment, trusting relationship among nursing colleagues, and value sharing. Social capital also showed that it was protective against a below-average resilience score. Resilience affected practice environment and perception of organization support. When nurses had a higher resilience score, nurses had a positive perception of management/organization support, which led to improved retention. Valuable information on the effect of positive work characteristics, including resilience and social capital, was gained in combatting compassion burnout. The study by Haizlip et al. (2020) used a cross-sectional survey design that combined several validated instruments with two additional open-ended questions that asked what was meaningful about work and to describe a time when work mattered. Mattering and its effect on compassion burnout and engagement were studied. Haizlip et al. (2020), defined mattering as “a psychosocial construct that describes an individual’s perception that he or she makes a difference in the lives of others and is significant in the world” (p. 268). From a sample of 324 RNs in Virginia, nurses reported moderately high levels of mattering, meaning of work, and good social support from peers, which also showed high levels of engagement and commitment to the job. Mattering is an important construct and predictor of compassion burnout and engagement. If nurses do not feel that they matter in their profession, compassion burnout may increase and engagement will decrease.

Understanding and addressing the negative consequences of compassion fatigue or burnout are important to reverse negative consequences. Increased workload, understaffing, increased hours of unplanned or mandatory overtime, poor work environment, depersonalization,
increased emotional exhaustion, perception of decreased personal accomplishment, and not having autonomy or respect were all factors that increased compassion fatigue or burnout, which would also increase nursing turnover. Having positive work characteristics, such as resilience and a positive work environment in which social capital or social support is abundant may reverse the effects of compassion fatigue or burnout, which would improve patient outcomes.

**Summary**

In the review of the literature, the common attributes of compassion are caring, attentiveness, developing a trusting connection or relationship with the patient, and viewing patients holistically. The concepts of *compassion fatigue* and *compassion burnout* were further analyzed through concept analyses and concept meta-analysis. Compassion instruments were reviewed and narrowed down to one instrument that this researcher selected. In this study, the quantitative instrument by Lee and Seomun (2015), the CCS, was used as self-assessment of compassion in medical-surgical nurses. Compassion despite adversity such as caring for Covid-19 patients, trauma patients, victims of gun violence, and dying pediatric patients were discussed. Even when faced with adversity, nurses could still be resilient, have job satisfaction, and experience personal growth. From the review of literature, the only studies that measured compassion in medical-surgical nurses was a mixed-method study by Kret (2011) and a qualitative study by Tehranineshat et al. (2019). Also presented in the review of the literature were the many negative consequences of compassion fatigue and burnout such as career choice regret, intent to leave, and decreased patient engagement (Dyrbye et al., 2020; Gensimore et al., 2020; Haizlip et al., 2020; Lee et al., 2017; Razo et al., 2021; Roomaney et al., 2017). Understanding the predictors of compassion fatigue or burnout and ways to reverse them could give insight on how nurses can continue to provide compassionate care.
CHAPTER 3: METHOD

The purpose of this chapter is to provide an explanation of the method used in this study. A description of the mixed-method method is described, followed by the philosophical underpinnings of the use of the mixed-method design. The sampling plan and how the researcher obtained the targeted population are discussed. The quantitative and qualitative strands of this mixed study are presented, along with the design description, data collection, trustworthiness, instrumentation, and method of analysis for each strand. This chapter concludes with ethical considerations.

Method

This study used a mixed-method design using a quantitative instrument, followed by interviews to further clarify the meaning of the results from the quantitative instrument results. Mixed-method research integrates quantitative and qualitative techniques that contributed to an enhanced interpretation of the data. Qualitative data informed quantitative data. Using a mixed-method approach offers new insight into research because it uses the strengths of quantitative and qualitative research when combined. Compassion is an abstract concept that has been studied with quantitative and qualitative methods. Due to this complexity of the concept of compassion, the research was more complete by combining the two methods. The mixed-method approach used in this study was the explanatory sequential design. In the explanatory sequential design, there are two phases. In the first phase, significant quantitative data were obtained, and in the second phase, qualitative data were collected (Creswell & Clark, 2018b). In the first phase, the quantitative instrument used was the CCS. Permission to utilize the CCS was granted by the author (Appendix B). In the participation selection variant of explanatory sequential design, details or characteristics found in the large group collected by CCS were extracted and used to
select a smaller purposeful sample. Although there were significant data collected from the CCS, there was greater emphasis on the qualitative data collection. In this design, the qualitative data informed the quantitative data (Polit & Beck, 2017a). The researcher examined the connection between these two groups and triangulated the results of descriptive statistics from the quantitative strand to the rich descriptions of what it means to be a compassionate nurse provided by the medical-surgical nurses (see Figure 1).

The qualitative strand of this mixed-method study was grounded theory, which was generated to provide prediction and explanation of a behavior of phenomenon being studied—in this case, compassionate care. The development of this theory was grounded in the data that were collected. The main method of data collection and analysis in grounded theory was comparative analysis. Within comparative analysis, the researcher concurrently collected data and generated conceptual categories that were constantly compared, and differences were extracted. Each interview evolved to further inform the theory that was being developed. The goal of grounded theory is to predict, explain, interpret, and apply to empirical scenarios (Glaser & Strauss, 1967).

The purpose of this qualitative inquiry was to describe and explain the process of how nurses continue to provide compassionate care despite being faced with adversity. The findings informed the researcher of the process of providing compassionate care when faced with any situation. To have a deeper understanding of the phenomenon under study, the experience of the nurse providing compassionate care in the face of adversity was examined through an interview process.

![Figure 1: Explanatory Mixed-Method Process](image)


**Philosophical Assumptions**

The paradigm for mixed methodology is pragmatism, which is the study of multiple realities (or approaches) to draw a conclusion or study phenomena. It combines deductive and inductive reasoning in which the focus of the method is to answer the research question. The philosophical assumptions within mixed-method studies includes ontology, epistemology, axiology, and methodology. The philosophical underpinning of mixed method begins with post-positivism, which explains the quantitative approach. In the quantitative approach, researchers use instruments to determine cause and effect, relationships, and testing of theories. Qualitative approaches use constructivism in which understanding is formed by interviewing participants to obtain their subjective worldview. Social constructivism is also incorporated to understand the meaning of phenomena formed by participants’ views and their environment. The ontological assumption explores what is real in the world. In the quantitative approach, the ontological assumption is that the instrument being used provides reality of concrete numbers to the phenomena being measured. In the qualitative approach, the ontological assumption states there are multiple realities and truths that are discovered by interviewing participants on specific phenomena. The epistemological assumption studies the relationship between the researcher and the participants of the research. In the quantitative approach, the researcher is apart from the participants. In the qualitative approach, the researcher has personal contact with the participants through interviewing them in their environments. By understanding the context from where participants live and work, data can be collected on how they interact with their environment, giving more information and a different perspective. The axiological assumption studies the role of values. In the quantitative approach, unless there is a specific instrument that measures specific values, values may not be included in the quantitative approach. In the axiological
assumption, qualitative methods are value laden, in which values and biases are part of the study and cannot be separated. The methodological assumption studies the research process. In the quantitative approach, deductive process is used by collecting data from the instrument measuring phenomena. The research process in the qualitative approach is an inductive process in which the researcher collects data from the interviews and generates patterns and themes from the data (Creswell & Clark, 2018d).

A mixed-method study incorporates research design, methods, and philosophical or theoretical approaches. The researcher in mixed methods accomplished the following:
1. Answered research questions and hypotheses utilizing quantitative and qualitative data collection and analysis;
2. Consolidated both quantitative and qualitative data and results;
3. Provided structure to research design and plan on how research was conducted; and
4. Embedded theory and philosophy within the research design. (Creswell & Clark, 2018e)

**Sampling Plan**

**Purposeful sampling**

The primary purpose of this study was to understand the process of providing compassionate care despite the adverse events that nurses encounter. The first step in sampling was to determine what would be the best source to obtain this information. The researcher chose intensity purposeful sampling to select participants that would be a rich source of data for this study. Intensity sampling is used to choose cases that offer powerful examples of the phenomenon (Polit & Beck, 2017b). Since medical-surgical nurses are the largest population of nurses, the intensity purposeful sample chosen for this study was the medical-surgical nurses that are members of the AMSN. The AMSN is the only specialty organization designed for medical-
surgical nurses that support nurses through the spectrum of nursing school to obtaining certification. The three main values listed on their website are compassion, commitment, and connection (AMSN, 2021). Based on these values and AMSN’s commitment to quality patient care, AMSN fit the criteria for the intensity purposeful sample. The aim was to enroll participants who were willing and able to provide insight on providing compassionate care when faced with adversity.

**Inclusion Criteria and Exclusion**

The inclusion criteria for this study included participants who were English speaking, members of the AMSN, and nurses who completed the surveys. The exclusion criteria included participants who were not members of the AMSN.

**Recruitment**

Permission to send out the survey and recruit members through the organization was obtained from the editor of the AMSN (Appendix C). The survey information included an introductory letter (Appendix D) explaining the purpose of the study that was posted on the AMSN website twice a month (at the beginning of the month and at mid-month) to encourage members to complete the survey. Notification of the survey information was listed on the AMSN website, on the AMSN “Clinical Practice Digest” postings of discussion to AMSN members, AMSN social media sites, and AMSN monthly e-news. At the end of the survey information, a link to the demographic questionnaire (Appendix E) and the CCS was accessible. Consent was implied by nurses when they clicked on the link and completed the CCS instrument and demographics via Google Forms (Appendix F). The survey was open for about four months, from October 25, 2021, through February 17, 2022, during which 103 responses were collected. The final question on the survey queried, “Are you willing to participate in a 30–60-minute
interview using a video conference medium (i.e., Google Meet) about providing compassionate care; followed by a 30-minute follow-up interview via phone or video conference to clarify items from previous interview?” If the participant responded “yes,” they were prompted to include their email address. Ninety-five of the 103 participants expressed an interest to be interviewed and included their emails. A total of 49 participants were notified via email with an invitation to interview and a consent form (Appendix G), along with an explanation of the purpose of the qualitative portion of the study. Forty-nine participants were invited because they were noted to have high CCS scores. Twenty-four participants responded to the invitation via email to set up interviews according to their availability. These 24 participants were contacted, and interviews were scheduled based on their availability. Interviews continued until all 24 were obtained to confirm the theory being developed. An additional 3 interviews were obtained because they had lowest CCS scores to satisfy maximum variation sampling (Creswell & Clark, 2018e). Participants were given a gratuity of a $25 Amazon gift card to participate in the interview.

**Quantitative Strand**

**Quantitative Research Questions**

The quantitative strand of this study was guided by the following questions and hypotheses:

- What is the level of compassion that medical-surgical nurses had in their self-assessment of compassion competence?

- In medical-surgical nurses, what is the relationship of working a Magnet-recognized facility and the CCS score?
  - Hypothesis – Working at a Magnet-recognized facility is associated with high CCS.
In medical-surgical nurses, what is the relationship of education level and CCS?
  o Hypothesis – As education level increases, the CCS will increase.

In medical-surgical nurses, what is the relationship of holding an advanced certification and CCS?
  o Hypothesis – Holding an advanced certification is associated with high CCS.

In medical-surgical nurses, what is the relationship of current nurse/patient ratio and CCS?
  o Hypothesis – The higher the nurse-to-patient ratio, the lower the CCS scores.

In medical-surgical nurses, what is the relationship of mandatory overtime and CCS?
  o Hypothesis – Required to work unplanned or mandatory overtime is associated with low CCS.

In medical-surgical nurses, what is the relationship of the shift worked and CCS?
  o Hypothesis – Nurses that work the day shift will be more compassionate than those that work the night shift.

In medical-surgical nurses, what is the relationship in the percentage of direct patient care and CCS?
  o Hypothesis – The higher the percentage of direct patient care, the lower the CCS scores.

**Study Design**

The quantitative strand of this study used a descriptive-correlational one-group design with a bivariate analysis of the relationship between the results of the CCS (Lee & Seomun, 2015) and demographics. It showed the relationship of working in a Magnet facility, educational level, advanced certification, nurse-to-patient ratio, if recently required to work mandatory overtime,
Instruments

Demographic Data Sheet

A demographic data sheet was completed by each participant. The data included age, gender, ethnicity, percentage of direct patient care, care provided to Covid-19 patients, marital status/partnered, children, day/night shift, educational information, working at a Magnet facility, advanced certification such as medical-surgical certification, current nurse/patient ratio, and if they were recently required to work unplanned or mandatory overtime.

Compassion Competence Scale

Lee and Seomun (2015) developed and validated an instrument that measured nurses’ compassion competence called the CCS. To elucidate the components of compassion, the authors did a concept analysis of compassion competence in nurses. A 17-item instrument was developed to assess for compassion competence. The three themes that emerged from the concept analysis of compassion competence were communication, sensitivity, and insight. “Sensitivity, refers to the ability to recognize – through careful observation – and reaction to changes in patients’ emotions” (p. 80). This sensitivity is based on the concept of empathy and having a deep understanding of what the patient is going through. Among the CCS and other measures, the correlation analysis of the convergent validity showed that there was a strong correlation between emotional intelligence and competence. This translates to the fact that behavior and clinical skills are linked. Nurses’ compassion was included in the framework of the nurses’ competence; therefore, the instrument can be used as a resource for assessment and education of incoming nurses. The reliability of the instrument was > .90, but the test-retest reliability was limited because the response rate was only 20%. Another limitation was that this instrument was
developed and validated in Korea, so the findings may not be generalizable to nurses in another country.

The CCS by Lee and Seomun (2015) is a 17-item instrument using a 5-point Likert scale ranging from 1 = *strongly disagree*, 2 = *disagree*, 3 = *neutral*, 4 = *agree*, and 5 = *strongly agree*. The questions focus on three main factors of compassion: communication, sensitivity, and insight. The Cronbach’s alpha of the CCS is .90. Each question’s total score is calculated by using a range of 1 to 5. Each question has a score, and a total score is calculated at the end of the CCS (Lee & Seomun, 2015). The scores can range from a minimum of 17, up to a maximum score of 85. The higher the participant’s score, the higher their CCS (Kim & Lee, 2020). Most of the participants (87.4%) had high CCS scores while the others had low scores (12.6%).

Kim and Lee (2020) further validated the CCS instrument by relating the CCS scores with having missed opportunities of providing compassionate care, work life, and general quality of life. This study was a secondary analysis from a previous study of a larger sample in Korea. This study had a sample of 1,556 nurses. This study found that the CCS had a high internal consistency reliability and a Cronbach’s alpha of .82. Relationships of the variables were analyzed using Pearson’s correlations. The effects of the CCS scores to missed nursing care, compassion satisfaction, compassion burnout, secondary traumatic stress, and general quality of life were analyzed using multivariate linear regression. This study showed that compassion competence was a significant predictor associated with missing nursing care and compassion burnout. The authors showed that having a high compassion competence decreased missed nursing care and compassion burnout, while it increased quality of life and compassion satisfaction. With these results, it further supported the researcher’s intent to study the nurses’ compassion competence scores and the relationship of their perspectives on their process of
providing compassionate care. This was also the first time the CCS was conducted with medical-surgical nurses in the United States.

**Quantitative Data Analysis**

To provide exploration of the research questions, the survey data were analyzed using SPSS version 24 for descriptive and correlational methods. The descriptive analysis explored the data distribution and provided association among variables. The correlation analysis examined the strength and statistical significance of the relationships between study variables (demographics) (see Table 1). The average of all the CCS scores were extracted from the sample and were analyzed to see how those scores related to the demographic data. Data from surveys from those participating in the interviews were analyzed separately.

Table 1

**List of Variables and Measurement Instruments**

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<thead>
<tr>
<th>Variable</th>
<th>Type of Variable</th>
<th>Measurement Instrument</th>
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<tbody>
<tr>
<td>Compassion competence</td>
<td>Dependent and Descriptive</td>
<td>CCS</td>
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<tr>
<td>Age</td>
<td>Descriptive</td>
<td>Demographics</td>
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<td>Gender</td>
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<tr>
<td>Children</td>
<td>Descriptive</td>
<td>Demographics</td>
</tr>
<tr>
<td>Percentage of direct patient care</td>
<td>Independent</td>
<td>Demographics</td>
</tr>
<tr>
<td>Day/night shift</td>
<td>Independent</td>
<td>Demographics</td>
</tr>
<tr>
<td>Highest education level</td>
<td>Independent</td>
<td>Demographics</td>
</tr>
</tbody>
</table>
To ensure sufficient data for analyses and to examine relationships between variables, five observations per variable were used (Wood & Ross-Kerr, 2011). In this study, the CCS and seven other variables of the demographic data (working in a Magnet facility, educational level, holding an advanced certification, nurse-to-patient ratio, if recently required to work mandatory overtime, shift worked, and percentage of direct patient care) were used. All demographic data were not analyzed but served the purpose to describe the sample and generalize back to the population of AMSN. In applying the five observations per variable, 40 observations would be needed to ensure sufficient data analysis. After having the CCS open for about four months, the researcher received 103, which assured sufficient data for analyses.

Qualitative Strand

Qualitative Research Questions

- What is the process in which medical-surgical nurses provide compassionate care in the face of adversity?
- Are they able to provide compassionate care in their day-to-day practice? Objective: confirm compassionate care is still being provided.
- How do medical-surgical nurses describe compassionate care in their practice? Objective: to understand how they provide compassionate care.
• What are the challenges that may have impacted their compassionate care practice?
  Objective: have them state specific barriers or challenges they face providing compassionate care.

• How do medical-surgical nurses describe the environment that is needed to allow for them to provide the best compassionate care? Objective: have them state what would enhance their ability to provide compassionate care.

Mixed-Method Questions

• Do the quantitative items uphold prominent concepts discovered in the qualitative data? Which specific examples from the qualitative data (interviews) provide the best insight into the quantitative results?

• To what extent does the qualitative data contribute to an enhanced interpretation and understanding of the relationships discovered among the quantitative variables?

Study Design

The qualitative strand of this study used grounded theory, as it was most appropriate to answer the study questions. The researcher identified the challenge of providing compassionate care to patients as a social problem. Nurses are challenged with providing compassionate care, especially when faced with adversity. Being in constant exposure to adversity, they are in danger of developing compassion fatigue (Hamilton, 2018; Perregrini, 2019). Compassion fatigue, if not addressed, can lead to a drop in compassion and may contribute to the nursing shortage with nurses leaving the profession. Grounded theory was chosen for this study because the researcher sought to understand the process in which medical-surgical nurses provide compassionate care despite the adversity they faced. The core or underlying basic psychosocial problem that the researcher sought in the data collection was how nurses continue to provide compassionate
care—how do they do what they do, providing compassionate care. Creswell and Poth (2018b) stated, “Grounded theory research focuses on a process or an action that has distinct steps or phases that occur over time. Thus, grounded theory study has ‘movement’ or some action that the researcher is attempting to explain” (p. 83). The grounded theory procedure that was followed was the constant comparative method.

In the constant comparative method, the initial data collection described compassion and how it was provided by medical-surgical nurses. It was the researcher’s assumption that medical-surgical nurses provided compassionate care, and this assumption was supported based on their survey results. After these results were obtained, the researcher wanted to know how medical-surgical nurses continue to provide compassionate care. Consistent with constant comparative analysis, data were collected and sequentially analyzed. Thus, interviews were conducted and then progressively analyzed. As more participants were interviewed, transcribed, and coded, the researcher continually analyzed the data to extract concepts and constructs that emerged from the data. During the coding, theoretical sampling was used to strengthen the theory being developed. Three participants who had CCS scores lower than the initial 24 interviewees were also interviewed. During this process joint coding occurred, while analyzing data at the same time, and developing a theory throughout the process (Glaser & Strauss, 1967).

To further guide the interview and interview development, appreciative inquiry was used as a model of questioning in four stages. Appreciative inquiry is a way of asking questions using a positive approach. Cooperider and Whitney (2001) stated that appreciative inquiry “involves systematic discovery of what gives ‘life’ to a living system when it is most alive…Appreciative inquiry involves, in a central way, the art and practice of asking questions that strengthen a system’s capacity to apprehend, anticipate, and heighten positive potential” (p. 3). There are four
stages of appreciative inquiry or the 4 Ds: Discovery, Dream, Design, and Destiny/Deliver (see Figure 2). In the discovery stage, the question was aimed at understanding the basis of the positive behavior. In the dream stage, the inquiry was aimed at understanding the vision and purpose of this positive behavior/action. In the design stage, the inquiry was aimed at creating the perfect environment to nurture this positive behavior. In the final stage, destiny, the inquiry was aimed to explore how this positive behavior/action was implemented (Cooperider & Whitney, 2001).

Figure 2
The Appreciative Inquiry 4-D Cycle


**Interview Question and Probes Guided by Appreciative Inquiry**

**Main Interview Question (RQ9)**

I am interested in finding out how you, as a medical surgical nurse, are able to provide
compassionate care despite the adversity you may face in the workplace.

**Additional Questions**

- Describe *compassionate care* in your own practice.
- Do you feel providing compassionate care is important to your practice?
- What challenges might you encounter in attempting to provide compassionate care?
- Looking at your patient encounters in the past year, tell me about a time that you might have served as an exemplar for delivering compassionate care.
- Describe the perfect environment that is needed for you to provide the best compassionate care.
- Describe how leadership helps you provide a compassionate care environment.
- What recommendations do you have to create the perfect compassionate environment while providing patient care?

**Data Collection and Analysis**

**Procedure**

The researcher chose medical-surgical nurses from the participant sample that completed the CCS and agreed to participate in the interview process. Of the sample, 95 of the 103 CCS participants expressed interest in being interviewed. A total of 49 participants were notified via email, and a consent form was sent to these interested participants, along with an explanation of the qualitative portion of the study. Forty-nine participants were invited because they all had high CCS scores. Twenty-four participants responded to the invitation via email to set up interviews according to their availability. Using the Glasser and Strauss (1967) approach, the research question directed the researcher to identify the adversity nurses faced when providing compassionate care and to discover the process of how they did it. Data were compiled from the
phenomenon of compassionate care and explained the processes occurring within the phenomenon. Twenty-four participants were initially interviewed because they had high CCS scores. Concepts emerged from the simultaneous data analysis. Theoretical sampling then continued, and the researcher interviewed an additional three participants who had low CCS scores to implement maximum variation sampling and to trim the grounded theory further. It is a grounded theory strategy of selecting additional participants to further elaborate on the developing theory to illustrate all its intricacies and assure an adequate presentation of the theory (Creswell & Clark, 2018e). After completing the last three interviews, the researcher felt saturation was reached and no new information was generated. All the interview participants met inclusion criteria, and no one was excluded. After 27 interviews were completed, $25 Amazon gift cards were given to the participants.

Informed Consent

Prior to participating in the interview portion of the research study, participants completed an informed consent that provided an explanation and purpose of the study. The consent was voluntary and indicated that participants are free to withdraw from the study anytime and that the study is conducted over video conference call (i.e., Google Meet) and recorded. Privacy and confidentiality were maintained during the data collection and was stated in consent. After the participant reviewed the consent form, the form was signed by the participant to indicate understanding of the study. The consent form was sent via Google Forms, which allowed participants to type in their name.

Potential Risks

There were no anticipated risks to participate in this study. If emotional distress did occur, participants were assured that questioning would be paused and stopped if the participants
felt they could not continue or could withdraw from study without penalty. None of the participants expressed distress, required the interview to be paused, or requested to withdraw.

**Potential Benefits**

Participants were informed that the data collected from the study may reveal a grounded theory on the process of how compassionate care was delivered by medical-surgical nurses in the face of adversity. It was also discussed that the data analysis may lead to educational opportunities on how educators or leaders can better prepare medical-surgical nurses to provide compassionate care during times of crisis or unforeseen challenges.

**Participant Interviews**

Participant interviews were conducted via a video conference medium, Google Meet, in a private area, at an agreed upon time and were recorded. They were semi-structured interviews that lasted 30 minutes, with one lasting up to 45 minutes when the participant chose. Twenty-seven participants were interviewed until enough categories emerged and saturation was reached, which was on February 17, 2022. The researcher conducted interviews with participants one at a time. An interview guide (Appendix H) of semi-structured questions with open-ended questions allowed participants to expand on their own experiences and explore topics meaningful to them. The purpose of the interview guide was to assist the researcher in keeping the questions standardized and keeping the researcher focused on the phenomenon being studied.

The interviews were recorded with a digital recorder and transcribed verbatim by a transcriptionist service called rev.com, which was reliable, private, and safe. The data collection included verbal and nonverbal data, with the use of memos and field notes.

**Memo**

During the interview, the researcher wrote memos that link codes to the data that led to
theory development. The operational and theoretical process organized the researcher’s thoughts during data collection and provided an audit trail. Operational memos provided decision making and problem solving in adjusting the interview process. Theoretical memos provided ongoing progress of theory development (Creswell & Poth, 2018a).

Field Notes

Following the interview, field notes were recorded to represent the researcher’s reaction to the interview. The memos and field notes provided additional information to provide insight on emerging theory and any adjustments that needed to be made to the interview process.

Field Memo Sheet

Upon completion of each interview, the researcher completed the field memo sheet (Appendix I). This was used by the researcher concurrently with the analyzed data to add richness to the data collected. This memo sheet identified issues or themes that were significant during the interview. Any salient, interesting, and illuminating information were noted as well. It also provided direction on any changes to the interview process.

Follow-Up Contact

All 27 interview participants were offered follow-up contact and were requested to review the findings. They were contacted via email and were asked if the categories or concepts found in analysis were consistent with what they said in the interview; this served as member checking. Only 2 out of 27 interview participants responded. This provided the participants the opportunity to correct information and add new information if needed and ensured trustworthiness of the data. The follow-up contacts assured accuracy of interviews and data analysis. They both agreed to themes that were generated, and no new information was given.
Analysis

The interviews were recorded and then transcribed by rev.com, an online secure data-transcribing service. The interview data were identified by participant pseudonyms to protect their identity. NVivo was used to organize the data for analysis to seek emerging categories, concepts, and constructs. Because the grounded theory approach was being used, constant comparison was used throughout data collection and data analysis to create categories, which was open coding. These categories were constantly reviewed to determine similarities and differences of these categories. As data collection continued, inquiry became more and more focused on emerging theoretical themes. Then these categories were interconnected, creating axial coding. As these categories were further connected, selective coding was created. Finally, at the end of constant comparative analysis, a theoretical framework was created (Creswell & Poth, 2018a).

NVivo

The researcher conducted data coding using NVivo 12® computer software program that was used in qualitative and mixed-method design to organize and manage qualitative data. It helped the researcher analyze unstructured data, including interviews, field notes, and open-ended survey responses. Utilizing NVivo “nodes,” the researcher isolated and categorized similar participant responses for easier data management. The identified nodes were then restructured into smaller nodes or grouped together when there was a commonality.

Mixed-Method Analysis

Quantitative and qualitative data were compared by quantifying the qualitative data. This procedure is referred to as quantitizing (Creswell & Clark, 2011). To analyze the mixed data, the method of quantitizing was used in which a frequency table of the number of times words or
themes show up was used. The method of qualitizing was a method of analysis used in which interview responses were grouped with the CCS scores. From these combined methods, the researcher created a matrix in which concepts and categories identified through in-depth interviews were analyzed according to subgroups defined by participants’ scores on CCS (Creswell & Clark, 2018a).

**Strategies to Enhance Scientific Rigor and Trustworthiness**

Within qualitative research, criteria to assure rigor and trustworthiness include credibility, dependability, confirmability, transferability, and authenticity. Authenticity was assured throughout the data collection and analysis process through auditability and reliability in the rigor of the study. Credibility is the truth from the data and interpretation of that data. Dependability is how data remain constant regardless of time or condition (Lincoln & Guba, 1985). Credibility, dependability, and confirmability were demonstrated by the accurate transcription of the interview and member checking to ensure that the concepts and categories that emerged matched the participants’ thought process. Transferability is the possibility of the findings to be applied to another setting or group (Lincoln & Guba, 1985). Transferability was achieved through providing adequate descriptions and emerging categories and concepts that formed a grounded theory that can be applied to another set of nurses.

**Human Subject Considerations/Ethics**

The Collaborative Institutional Training Initiative training (a basic course in the protection of human subjects) was completed by the researcher prior to IRB approval. Molloy College IRB approval (Appendix A) was obtained after approval of the research proposal by the dissertation committee. This was the first step in protecting the participants of the study because the purpose of IRB is to protect human subjects/participants from harm. The researcher in the
introductory letter, prior to completing the CCS, explained the study in detail to the participants and stated that there are no risks in participating in the study. When the participants completed the CCS, consent was implied. Privacy was maintained, and pseudonyms were used to de-identify the participants. For participants who were interviewed, an informed consent was obtained. Only the researcher was able to identify participants for follow-up contact. Trustworthiness and rigor of the study were maintained. Pseudonyms will be used in any future publications. The storage of the data collection is in a password-protected laptop according to Molloy College’s IRB policy. Confidentiality was maintained throughout data collection.

**Chapter Summary**

The purpose of this mixed-method grounded theory study was to understand the process in which medical-surgical nurses provide compassionate care in the face of adversity. After obtaining IRB approval, obtaining a sample of medical-surgical nurses who completed the CCS, and obtaining consent, private interviews with participants were conducted. Data were collected in semi-structured interviews, using appreciative inquiry as a model. Nurses were interviewed via secure video conference software and were recorded to assure accuracy. Constant comparison was used during data collection and data analysis to create and compare categories and concepts. This study’s aim was to generate a theory on the process of how medical-surgical nurses provide compassionate care even in the face of adversity. Generating this theory has the potential to assist nurse educators or nurse leaders in implementing educational programs that focus on compassionate care in nursing orientation or in the hospitals.
CHAPTER 4: FINDINGS

In this chapter, sources of data and findings from the quantitative and qualitative strands are presented. All sources of data were presented in tables for quantitative, qualitative, and combined to triangulate the results. The qualitative strand informed the quantitative data.

Sources of data

Quantitative data were pulled from demographic data and the CCS (see Table 2). Qualitative data were represented from the individual interviews and follow-up contacts. Triangulated results were then combined from mutually supported data and offered a complete and valid analysis of the central phenomena of compassionate care provided in the face of adversity.

Table 2

Data Sources and Sample

<table>
<thead>
<tr>
<th>Data Sources</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quantitative</td>
<td></td>
</tr>
<tr>
<td>Demographic Data and CCS</td>
<td>N = 103</td>
</tr>
<tr>
<td>Qualitative</td>
<td></td>
</tr>
<tr>
<td>Individual Interview</td>
<td>n = 27</td>
</tr>
</tbody>
</table>

Quantitative Participant Demographics

Participants’ demographics are presented as a narrative and tables (see Table 3). Demographic information is important to determine if the sample was representative of the target population, which were the AMSN nurses (Dillman et al., 2014). This information was combined with quantitative and qualitative results for meaningful interpretation. All participants varied in age, ranging from 21 to 70 years. Most of the medical-surgical nurse sample was between the ages of 21 and 30 years old (43.7%). More than half of the sample was female (55.3%). The
most represented ethnic groups were African American or Black (49.5%) and White or European American (28.2%). A little more than half of the participants were married/partnered (54.4%) compared to single (45.6%). Most of the sample were parents (66%) compared to the sample that were not (34%). The majority of sample worked the day shift (65%) compared to the night shift (35%). The highest educational level varied with bachelor’s degree being the highest percentage at 52.4%, master’s degree at 28.2%, and associate’s degree at 10.7%. Much of the sample had an advanced certification (82.5%). A high percentage of the sample were employed by a Magnet facility (78.6%). The percentage of nurses providing direct patient care was high, with 85.5% spending over half their work time providing hands-on care. There was a high percentage caring for Covid-19 patients (86.4%) and those who worked mandatory overtime (75.7%).

Table 3
Participant Characteristics: Frequency and Percentage

<table>
<thead>
<tr>
<th>Characteristics (N = 103)</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21–30 years</td>
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<td>43.7</td>
</tr>
<tr>
<td>31–40 years</td>
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<td>25.2</td>
</tr>
<tr>
<td>41–50 years</td>
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<td>15.5</td>
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<tr>
<td>51–60 years</td>
<td>14</td>
<td>13.6</td>
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<tr>
<td>61–70 years</td>
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<td>1.9</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
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<td>3.9</td>
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<tr>
<td>African American or Black</td>
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<td>49.5</td>
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<tr>
<td>White or European American</td>
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<td>27.5</td>
</tr>
<tr>
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<td>13.6</td>
</tr>
<tr>
<td>Asian or Asian American</td>
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<td>5.8</td>
</tr>
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<td>Native Hawaiian or Other Pacific Islander</td>
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<td>1</td>
</tr>
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<td>Arab or Middle Eastern</td>
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<td>1</td>
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<tr>
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<td>---------</td>
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<td>Married/Partnered</td>
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<td>34</td>
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<table>
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<td>4</td>
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<td>7.8</td>
</tr>
<tr>
<td>5</td>
<td>2</td>
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</tr>
<tr>
<td>Nights</td>
<td>36</td>
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<th>Highest Level of Education</th>
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<td>Bachelor’s</td>
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<td>Master’s</td>
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<tr>
<td>Associate’s</td>
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<td>10.7</td>
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<td>6</td>
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<tr>
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<table>
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<th>Percentage of Time involved in Direct Patient Care</th>
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</tr>
<tr>
<td>51-75%</td>
<td>35</td>
<td>34</td>
</tr>
<tr>
<td>25-50%</td>
<td>12</td>
<td>11.7</td>
</tr>
<tr>
<td>&lt;25%</td>
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<tr>
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<tr>
<td>No</td>
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<td>17.5</td>
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<table>
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<th>Number of Patients Assigned</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3</td>
<td>2.9</td>
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<tr>
<td>2</td>
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</tr>
<tr>
<td>9</td>
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</tr>
<tr>
<td>10</td>
<td>9</td>
<td>8.7</td>
</tr>
<tr>
<td>&gt;10</td>
<td>17</td>
<td>16.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Caring for Covid-19 patients</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
This was a varied population that reflected a picture of medical-surgical nursing in the United States related to age, ethnicity, marital status, number of children, and caring for Covid-19 patients. It was a well-educated group having a bachelor’s degree or higher; most of them had an advanced certification, most of them provided direct patient care (51%-100%), most were female, and most worked mandatory overtime. This was a fair representation of medical-surgical nurses, but it was only a snapshot of participants who agreed to participate in the study.

Quantitative Findings

The quantitative findings are reported in a question-and-answer format. The first research question is exploratory and has been answered using descriptive statistics. Research questions 2 through 8 examines the relationship between the descriptive data and the CCS and has been answered using inferential statistics and multiple linear regression analyses.

Descriptive Statistics

Descriptive statistics, mean, and standard deviation were computed to provide summaries about the sample in relation to the CCS. The descriptive statistics were the basis of the quantitative analysis and was combined with the qualitative analysis to triangulate the data. Table 4 illustrates measures of central tendency for the CCS and its subscales. Reliability was determined with Cronbach’s alpha (Table 5).

Inferential Statistics

Quantitative research questions 2 through 8 were examined using Pearson product-moment correlations and multiple linear regression analyses. Assumptions for analyses were
met. Pearson product-moment correlation coefficients were computed to examine relationships among the variables (Table 6). Regression analysis identified significant predictors of compassionate care (Table 7).

**Quantitative Research Question 1**

RQ1: What is the level of compassion that medical-surgical nurses have in their self-assessment of compassion competence?

Table 4

**CCS Mean and Standard Deviation (N = 103)**

<table>
<thead>
<tr>
<th>CCS Mean and Standard Deviation (N = 103)</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassion Competence Scale</td>
<td>76.6</td>
<td>9.13</td>
<td>17-85</td>
</tr>
<tr>
<td>Communication subscale</td>
<td>36.1</td>
<td>4.19</td>
<td>8-40</td>
</tr>
<tr>
<td>Sensitivity subscale</td>
<td>22.6</td>
<td>2.78</td>
<td>5-25</td>
</tr>
<tr>
<td>Insight subscale</td>
<td>17.9</td>
<td>2.65</td>
<td>4-20</td>
</tr>
</tbody>
</table>

**Reliability of Compassion Competence Scale**

The participant’s CCS was determined using the 17-item CCS. The minimum score was 17, with a max score of 85. Also shown is that the CCS is divided into three subscales of communication, sensitivity, and insight and the breakdown of the sample into those subscales. The Communication subscale had a minimum = 12, maximum = 40, mean = 36.1, and $SD = 4.19$. The Sensitivity subscale had a minimum = 6, maximum = 25, mean = 22.6, and $SD = 2.78$. The Insight subscale had a minimum = 4, maximum = 20, mean = 17.9, and $SD = 2.65$. Most of the participants had high CCS scores (close to 85) of 87.4% and low scores (close to 17) of 12.6%.

Table 5

**Reliability of CCS**
The Cronbach’s alpha of the CCS = .951, which means that it is a highly reliable instrument (N = 103).

Quantitative questions 2 through 8 were examined using Pearson’s correlation analysis. Table 6 aids in presenting the data. Here are quantitative research questions 2 through 8:

RQ2. In medical-surgical nurses, what is the relationship of working a Magnet-recognized facility and the CCS score?
RQ3. In medical-surgical nurses, what is the relationship of education level and CCS?
RQ4. In medical-surgical nurses, what is the relationship of holding an advanced certification and CCS?
RQ5. In medical-surgical nurses, what is the relationship of current nurse/patient ratio and CCS?
RQ6. In medical-surgical nurses, what is the relationship of mandatory overtime and CCS?
RQ7. In medical-surgical nurses, what is the relationship of the shift worked and CCS?
RQ8. In medical-surgical nurses, what is the relationship of the percentage of direct patient care and CCS?

The findings of the data analysis using Pearson’s correlation was presented and discussed.

Table 6

<table>
<thead>
<tr>
<th>Select Demographic Data</th>
<th>Pearson’s Correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Magnet Facility</td>
<td>.105</td>
</tr>
<tr>
<td>Highest Education Level</td>
<td>.042</td>
</tr>
</tbody>
</table>
Quantitative Research Question 2

RQ2: In medical-surgical nurses, what is the relationship of working a Magnet-recognized facility and the CCS score?

Pearson Product-Moment Correlation Analysis

As illustrated in Table 6, a Pearson correlation coefficient was computed to assess the relationship between the sum of CCS scores and working at a Magnet facility. No statistically significant correlation between CCS scores and working in a Magnet facility was noted for this sample ($r = .105, N = 103, p = .145$). This suggests that this sample’s employment by a Magnet facility did not have a significant impact on CCS.

Quantitative Research Question 3

RQ3: In medical-surgical nurses, what is the relationship of education level and CCS?

Pearson Product-Moment Correlation Analysis

As illustrated in Table 6, a Pearson correlation coefficient was computed to assess the relationship between the sum of CCS scores and highest educational level. No statistically significant correlation between CCS scores and the highest education level was noted for this sample ($r = .042, N = 103, p = .337$). This suggests that this sample’s education level did not have a significant impact on CCS.
Quantitative Research Question 4

RQ4: In medical-surgical nurses, what is the relationship of holding an advanced certification and CCS?

Pearson Product-Moment Correlation Analysis

As illustrated in Table 6, a Pearson correlation coefficient was computed to assess the relationship between the sum of CCS scores and having an advanced certification. No statistically significant correlation between CCS scores and advanced certification was noted for this sample ($r = .133, N = 103, p = .091$). This suggests that this sample’s advanced certificate status did not have a significant impact on CCS.

Quantitative Research Question 5

RQ5: In medical-surgical nurses, what is the relationship of current nurse/patient ratio and CCS?

Pearson Product-Moment Correlation Analysis

As illustrated in Table 6, a Pearson correlation coefficient was computed to assess the relationship between the sum of CCS scores and the nurse/patient ratio. A statistically significant moderate positive correlation between CCS and the quantity of patients cared for during one shift was noted for this sample ($r = .357, N = 103, p = .000$). This suggests that as the number of patients cared for during a shift increased for this sample, the sum of the CCS also increased.

Quantitative Research Question 6

RQ6: In medical-surgical nurses, what is the relationship of mandatory overtime and CCS?

Pearson Product-Moment Correlation Analysis

As illustrated in Table 6, a Pearson correlation coefficient was computed to assess the relationship between the sum of CCS scores and working unplanned or mandatory overtime. A statistically significant weak positive correlation between CCS and working unplanned or
mandatory overtime was noted for this sample ($r = .279$, $N = 103$, $p = .002$). This suggests that working mandatory overtime contributed to slightly higher CCS for this sample.

**Quantitative Research Question 7**

RQ7: In medical-surgical nurses, what is the relationship of the shift worked and CCS?

*Pearson Product-Moment Correlation Analysis*

As illustrated in Table 6, a Pearson correlation coefficient was computed to assess the relationship between the sum of CCS scores and shift worked. Night shift was coded as 0 because this researcher anticipated day shift was going to be the most of the sample. A statistically significant weak negative correlation between CCS and shift worked was noted for this sample ($r = -.163$, $N = 103$, $p = .05$). This suggests that working the night shift contributed to slightly higher CCS for this sample.

**Quantitative Research Question 8**

RQ8: In medical-surgical nurses, what is the relationship of the percentage of direct patient care and CCS?

*Pearson Product-Moment Correlation Analysis*

As illustrated in Table 6, a Pearson correlation coefficient was computed to assess the relationship between the sum of CCS scores and the percentage of direct patient care. A statistically significant weak positive correlation between the sum of CCS and percentage of direct patient care was noted for this sample ($r = .206$, $N = 103$, $p = .018$). This suggests that as the time spent performing direct patient care increased for this sample, the sum of the CCS also slightly increased.

**Multiple Linear Regression Analyses**

Regression analyses identified significant predictors of how nurses assess their own
compassion competence ($F[7,95] = 3.614; p = .002; see Table 7). The Number of Patients Cared for in a Shift (95% CI, -1.46, 8.485, $p = .009$) was a statistically significant predictor, and Mandatory Overtime (95% CI, .264, 1.794, $p = .058$) was trending toward significance.

Advanced certification, direct care, Magnet facility, highest level of education, and shift were not significant predictors of nurses' reported CCS. There was a positive relationship among the significant predictors and the frequency of which nurses assessed their CCS. The $R$ value represented a moderate degree of correlation ($R = .459, p = .002$). The Adj. $R^2$ represents how much the dependent variable, the CCS, can be explained by the independent variables (Adj. $R^2 = .152$). For this sample, 15% of the variability in CSS was explained by the model. Even though the model explained only 15%, this finding indicates there are other factors that influenced the nurses' compassion competence.

Table 7

Summary of Regression Analyses

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>SE(B)</th>
<th>β</th>
<th>$t$</th>
<th>$p$</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>LL</td>
</tr>
<tr>
<td>Shift</td>
<td>-3.135</td>
<td>1.871</td>
<td>-.165</td>
<td>-1.676</td>
<td>.097</td>
<td>-6.849, 0.579</td>
</tr>
<tr>
<td>Highest Education Level</td>
<td>-0.263</td>
<td>1.056</td>
<td>-.024</td>
<td>-0.249</td>
<td>.804</td>
<td>-6.849, 0.579</td>
</tr>
<tr>
<td>Magnet Facility</td>
<td>-4.973</td>
<td>2.706</td>
<td>-.224</td>
<td>-1.838</td>
<td>.069</td>
<td>-2.359, 1.834</td>
</tr>
<tr>
<td>% of Work Time Performing Direct Patient Care</td>
<td>0.909</td>
<td>1.167</td>
<td>.080</td>
<td>0.779</td>
<td>.438</td>
<td>-10.34, 0.399</td>
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<tr>
<td>Advanced Certification</td>
<td>3.512</td>
<td>2.505</td>
<td>.147</td>
<td>1.402</td>
<td>.164</td>
<td>-1.407, 3.226</td>
</tr>
<tr>
<td># of Patients Cared for in a Shift</td>
<td>1.029</td>
<td>0.385</td>
<td>.318</td>
<td>2.669</td>
<td>.009</td>
<td>-1.460, 8.485</td>
</tr>
<tr>
<td>Mandatory Overtime</td>
<td>4.453</td>
<td>2.319</td>
<td>.210</td>
<td>1.920</td>
<td>.058</td>
<td>0.264, 1.794</td>
</tr>
</tbody>
</table>

$R = .459; \text{ Adj } R^2 = .152; F(7,95) = 3.614; p = .002$. 


Summary of Quantitative Findings

The following is a list of major findings discovered through quantitative analyses of the CCS and demographic data.

1. The CCS has a Cronbach’s alpha = .951 for this study, which shows that it is a highly reliable instrument to measure compassion competence.

2. Most of this sample rated themselves with high compassion competence (87.4%).

3. Although most of the sample worked at Magnet hospitals (78.6%), the significant correlation between the sum of CCS scores and working in a Magnet facility was not noted for this sample ($r = .105, N = 103, p = .145$).

4. Most of the sample either had a bachelor’s degree (52.4%) or master’s degree (28.2%), significant correlation between sum CCS scores and advanced certification was not noted for this sample ($r = .133, N = 103, p = .091$).

5. Although most of the sample had advanced certifications (82.5%), significant correlation between the sum of CCS scores and advanced certification was not noted for this sample ($r = .133, N = 103, p = .091$).

6. As the number of patients the medical-surgical nurses cared for during a shift increased, the sum of the CCS increased.

7. As the medical-surgical nurses increase the mandatory overtime they worked, the sum of CCS increased.

8. The sum of the CCS scores were slightly higher among medical-surgical nurses working the night shift.

9. As the nurses increased the percentage of direct patient care, the sum of the CCS increased.
10. Regression analyses identified that the number of Patients Cared for in a Shift (95% CI, -1.46, 8.485, \( p = .009 \)) was a statistically significant predictor and Mandatory Overtime (95% CI, .264, 1.794, \( p = .058 \)) was trending toward significance in predicting how nurses assess their own compassion competence.

Quantitative data were used to measure compassion competence in medical-surgical nurses and the relationship to the demographic data. The findings discovered through quantitative analyses were combined with the qualitative analyses for methodological triangulation and are discussed in detail in Chapter 5.

**Qualitative Findings**

Ninety-five individuals volunteered to interview, of which 24 were interviewed. These participants were interviewed via Google video conferencing. Maximum variation sampling was implemented in which participants were chosen from opposite criteria. The researcher used this approach to maximize differences in the study to reflect different perspectives (Creswell & Poth, 2018a). The first 24 participants were noted to have high CCS scores. Three more participants with low CCS were added to implement maximum variation sampling and further trim down the grounded theory. The interviews were conducted from December 2021 to February 2022.

**Qualitative Participant Demographics**

The demographic characteristics of CCS participants in the qualitative strand of the study \( (n = 27) \) with comparison to the entire study sample or the quantitative data \( (N = 103) \) are presented in a summary format (see Table 8). The demographic data of the qualitative participants are discussed. All participants work at magnet hospitals, have advanced certifications, and all worked mandatory overtime. From the sample, 26 of 27 participants had cared for Covid-19 patients. This subsample may have possible bias, as they were self-selected to
be participants of the interview process.

Table 8

Comparing Quantitative and Qualitative Characteristics

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>f(%) quantitative (N = 103)</th>
<th>f(%) qualitative (n = 27)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work at Magnet hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>81 (78.6)</td>
<td>27 (100)</td>
</tr>
<tr>
<td>No</td>
<td>22 (21.4)</td>
<td>0</td>
</tr>
<tr>
<td>Advanced Certification</td>
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<td></td>
</tr>
<tr>
<td>Yes</td>
<td>85 (82.5)</td>
<td>27 (100)</td>
</tr>
<tr>
<td>No</td>
<td>18 (17.5)</td>
<td>0</td>
</tr>
<tr>
<td>Mandatory Overtime</td>
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<td></td>
</tr>
<tr>
<td>Yes</td>
<td>78 (75.7)</td>
<td>27 (100)</td>
</tr>
<tr>
<td>No</td>
<td>25 (24.3)</td>
<td>0</td>
</tr>
<tr>
<td>Caring for Covid-19 patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>89 (86.4)</td>
<td>26 (96.2)</td>
</tr>
<tr>
<td>No</td>
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<td>1 (3.7)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21–30 years</td>
<td>45 (43.7)</td>
<td>10 (37)</td>
</tr>
<tr>
<td>31–40 years</td>
<td>26 (25.2)</td>
<td>10 (37)</td>
</tr>
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<td>41–50 years</td>
<td>16 (15.5)</td>
<td>4 (14.8)</td>
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<td>51–60 years</td>
<td>14 (13.6)</td>
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<td>61–70 years</td>
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</tr>
<tr>
<td>Gender</td>
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<tr>
<td>Female</td>
<td>57 (55.3)</td>
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</tr>
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<td>Male</td>
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<td>Non-Binary</td>
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<td>2 (7.4)</td>
</tr>
<tr>
<td>Ethnicity</td>
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<td>African American or Black</td>
<td>51 (49.5)</td>
<td>16 (59.2)</td>
</tr>
<tr>
<td>White or European American</td>
<td>28 (27.5)</td>
<td>4 (14.8)</td>
</tr>
<tr>
<td>Hispanic or Latina/e/o/x</td>
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<td>5 (18.5)</td>
</tr>
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<td>Asian or Asian American</td>
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<td>1 (3.7)</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander</td>
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<td>1 (3.7)</td>
</tr>
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<td>American Indian, Alaska Native, Indigenous, or First Nations</td>
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<td>0</td>
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<tr>
<td>Arab or Middle Eastern</td>
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<td>Marital Status</td>
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<tr>
<td>Married/Partnered</td>
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<td>17 (63)</td>
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<td>Single</td>
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<td>No. of children</td>
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<td>0</td>
<td>32 (31.1)</td>
<td>8 (29.6)</td>
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<td>1</td>
<td>23 (22.3)</td>
<td>4 (14.8)</td>
</tr>
<tr>
<td>2</td>
<td>35 (34.3)</td>
<td>9 (33.3)</td>
</tr>
<tr>
<td>Days</td>
<td>3</td>
<td>13 (12.6)</td>
</tr>
<tr>
<td>------</td>
<td>---</td>
<td>-----------</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>8 (7.8)</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>2 (1.9)</td>
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**Shift**

<table>
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<th>Days</th>
<th>Nights</th>
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</thead>
<tbody>
<tr>
<td>Days</td>
<td>67 (65)</td>
</tr>
<tr>
<td>Nights</td>
<td>36 (35)</td>
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</tbody>
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**Highest Level of Education**

<table>
<thead>
<tr>
<th>Degree Level</th>
<th>Bachelor’s</th>
<th>Master’s</th>
<th>Associate’s</th>
<th>Doctoral</th>
<th>Diploma</th>
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<tbody>
<tr>
<td></td>
<td>54 (52.4)</td>
<td>29 (28.2)</td>
<td>11 (10.7)</td>
<td>6 (5.8)</td>
<td>3 (2.9)</td>
</tr>
<tr>
<td></td>
<td>14 (51.9)</td>
<td>9 (33.3)</td>
<td>4 (14.8)</td>
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**No. of Patients typically cared for**

<table>
<thead>
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<th>4 (3.9)</th>
<th>1 (3.7)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>4</td>
<td>13 (12.6)</td>
<td>5 (18.5)</td>
</tr>
<tr>
<td></td>
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<td>17 (16.5)</td>
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<td></td>
<td>10</td>
<td>9 (8.7)</td>
<td>5 (18.5)</td>
</tr>
<tr>
<td></td>
<td>&gt;10</td>
<td>17 (16.5)</td>
<td>5 (18.5)</td>
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</tbody>
</table>

**Percentage of Direct Patient Care**

<table>
<thead>
<tr>
<th>Percentage</th>
<th>76-100%</th>
<th>51-75%</th>
<th>25-50%</th>
<th>&lt;25%</th>
</tr>
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<td>53 (51.5)</td>
<td>35 (34)</td>
<td>12 (11.7)</td>
<td>3 (2.9)</td>
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<tr>
<td></td>
<td>13 (48.1)</td>
<td>9 (33.3)</td>
<td>4 (14.8)</td>
<td>1 (3.7)</td>
</tr>
</tbody>
</table>

**Qualitative Participant Portraits**

The following biographical summaries are provided to present an overview of each qualitative participant. Each portrait provides the participants’ age, gender, ethnicity, years working as a medical-surgical nurse, percentage of direct care with patients, provided care to Covid-19 patients, marital status/partnered, children, day/night shift, educational information, working at a Magnet facility, hold advanced certification such as medical-surgical certification, current nurse/patient ratio, if recently required to work unplanned or mandatory overtime, and their perspective of providing compassionate care. The study participants’ actual names have been replaced with pseudonyms to maintain anonymity.
Derrick

Derrick participated in an individual interview but refused to use the video camera option of Google Meet. His age range is 31–40 years old. He is Native Hawaiian or Pacific Islander male, single, with two children. He has an associate’s degree, spends 51–75% of time in direct patient care, works on the day shift, and takes care of three patients at a time. He said he always tries to make a connection with his patients. He stated,

how you can be able to make your patient feel comfortable with you, feel like you really care about the patient, you really care about her condition and then the patient will feel comfortable around you and then will enhance you in delivering this kind of compassionate care.

He feels that compassionate care changes over time, but it is possible to learn new ways to provide care by learning the patients’ needs and therefore improve the care provided. The adversity he faces is the high patient-to-nurse ratio. He feels that he is not able to spend adequate time with each patient, thus reducing the compassionate care he can provide. He feels that the perfect compassionate environment would be that the patients have more privacy and that there is support from the family to help transition the patient from the hospital to the patient’s home.

Junior

Junior participated in an individual interview but refused to use the video camera option of Google Meet. His age range is 31–40 years old. He is an African American or Black male, married/partnered with two children. He has a bachelor’s degree, spends 51–75% of his time in direct patient care, works on the day shift, and takes care of five patients at a time. He said he tries to provide compassionate care through listening, getting to know patients through their personal interests and experiences, being sympathetic toward his patients, and alleviating their
suffering. He stated, “That is having that sympathetic awareness of your patient distress. Then you combine your desire to alleviate it—the distress.” The adversity that he faces is the difficulty connecting with patients while social distancing and wearing PPE. He is not able to be close to the patient and show his facial expressions with his patients. His idea of a perfect compassionate environment is where everyone has the collective responsibility of being compassionate and they support one another to provide that care.

**Nelly**

Nelly participated in an individual interview but refused to use the video camera option of Google Meet. Her age range is 41–50 years old. She is an African American or Black female, married/partnered with three children. She has a master’s degree, spends 76–100% of time in direct patient care, works on the day shift, and takes care of eight patients at a time. She said she provides compassionate care through having sympathy and developing bonds with her patients through good communication and building trust. The adversity she faces is that not all her patients are respectful of different cultures. She stated, “Having effective communication, being kind, feeling of integration, building trust and communication skills. Then again, there is professionality.”

**Teddy**

Teddy participated in an individual interview but refused to use the video camera option of Google Meet. His age range is 21–30 years old. He is an African American or Black male, married/partnered with two children. He has an associate’s degree, spends 76–100% of time in direct patient care, works on the night shift, and takes care of nine patients at a time. He gave seven points on how to provide compassionate care: (a) being empathetic, (b) getting to know your patients, (c) giving someone to talk to, (d) being a good listener, (e) providing emotional
support, (f) positive body language toward patients, and (g) taking time to explain things to his patients. The adversity that he faces is the disrespect he sometimes receives from patients. To overcome this adversity, he tries to be empathetic and understand what the patient is going through. He stated,

I tend to be less emotional. So, I try and understand that this person is going through a lot of pain; maybe that's why she's behaving that way, tend to be that way. So, I give the patient some time to cool down and see the value of my support.

Becky

Becky participated in an individual interview but refused to use the video camera option of Google Meet. Her age range is 31–40 years old. She is an African American or Black female, married/partnered with no children. She has a bachelor’s degree, spends 51–75% of time in direct patient care, works on the day shift, and takes care of four patients at a time. She uses her personal experience to improve her compassionate care and provides holistic care to her patients. She stated,

In my practice, compassionate care is the part of being with the patient, giving the patient quality care and being with the patient the maximum time you can be with them…And taking care of them, and not holistically, and not like physically only, or maybe emotionally only. So you take care of them, like realistically, both physically, emotionally, psychologically, socially.

The adversity that she faces includes not enough staffing, equipment, or time to properly taking care of her patients.

Bobby

Bobby participated in an individual interview but refused to use the video camera option
of Google Meet. His age range is 21–30 years old. He is an African American or Black single male with no children. He has a bachelor’s degree, spends 25–50% of time in direct patient care, works on the day shift, and takes care of five patients at a time. He provides compassionate care by giving his patients hope and good communication. He stated,

You tell the patient that everything will be alright—if everything will go on well, nothing will happen to him or her. If they go through the surgery, they just will recover and they will have all the support that they need during the hard time that they are facing.

The adversity he faces is the fear that he may suffer from the same illness or situation and that providing compassionate care is emotionally draining.

Sarah

Sarah participated in an individual interview but refused to use the video camera option of Google Meet. Her age range is 31–40 years old. She is an African American or Black female, married/partnered with two children. She has a bachelor’s degree, spends 51–75% of time in direct patient care, works on the day shift, and takes care of ten patients at a time. She provides compassionate care by using her past experiences to help relieve patients’ suffering, by treating each of her patients as individuals, and providing quality care over quantity. She stated,

It's all about how the personal experiences that help you to relate things. Maybe you've experienced something before, and so, these are having you more familiar with it. Those things are the ones that help me to provide compassionate care, despite the adversity, and improvising, because you can't let the patient suffer. You can improvise something that can save them.

The adversity that she faces are insufficient resources and staffing. She feels providing compassionate care is important because it provides holistic care to the patient and helps improve
the health of society and the nation in general.

**Kevin**

Kevin participated in an individual interview but refused to use the video camera option of Google Meet. His age range is 21–30 years old. He is a White or European-American male, married/partnered with one child. He has a bachelor’s degree, spends 51–75% of time in direct patient care, works on the night shift, and takes care of eight patients at a time. He provides compassionate care by being empathetic to patients, listening, using body language appropriately, and remaining positive. He stated,

I try and be empathic to these patients that come with serious conditions, because most of them, they're emotionally unstable because they don't really understand the type of sociology of this, so I try and explain to them. For some people, I try and be positive so that they can think about their recovery.

The adversity he faces is compassion fatigue while providing care to his patients. He feels that nurses should provide quality care and not worry about quantity. He feels he could provide better compassionate care if leadership could hire more staff and ensure there are enough resources for the nurses.

**Leonard**

Leonard participated in an individual interview but refused to use the video camera option of Google Meet. His age range is 51–60 years old. He is an Asian single male with four children. He has a master’s degree, spends 76–100% of time in direct patient care, works on the day shift, and takes care of >10 patients at a time. He provides compassionate care by putting himself in his patients’ shoes. He stated, “To be empathetic to the patients and kind of getting into their shoes and, yeah, trying to solve the issues while you are feeling what they’re feeling.”
Some of the adversity he faces are insufficient resources and staff. He feels leadership facilitates compassionate care by attaining the resources that the staff need.

**Coleen**

Coleen participated in an individual interview but refused to use the video camera option of Google Meet. Her age range is 51–60 years old. She is an African American or Black female, married/partnered with three children. She has a master’s degree, spends 51–75% of time in direct patient care, works on the day shift, and takes care of eight patients at a time. She provides compassionate care by getting emotionally attached to her patients, listening to her patients, being empathetic, and trying to understand her patients. She stated,

> Compassionate care is the care that it involves basically the empathy and the treating of the patient individually and giving them quality care and ensuring that they’re growing physically, emotionally, and socially.

She feels that providing compassionate care is important because it helps them feel and do better. They have quality care, not quantity. The adversity that she faces is the lack of resources, not enough time spent with the patient because of the volume of patients that needs to be cared for, and getting too close her patients and feeling hurt when they hurt. She feels that leadership can help support providing compassionate care by getting the resources that the staff need to deliver care.

**Alice**

Alice participated in an individual interview but refused to use the video camera option of Google Meet. Her age range is 51–60 years old. She is a Hispanic or Latina/e/o/x female, single with four children. She has a master’s degree, spends 76–100% of time in direct patient care, works on the night shift, and takes care of >10 patients at a time. She said she provides
compassionate care by gaining her patients’ trust, being empathetic, and developing a rapport with her patients. Adversity that she faces are that there is not enough time to provide compassionate care with the volume of patients that she cares for. She stated,

And the persons, the people that involved, they didn't schedule another nurse to come for the shift. And so I did the shift by myself and I really did it. And by the time I was finished, I was so tired. I was so worn out….and so I felt, but after I felt like I did something good because I helped those patients.

She also finds it stressful that when providing compassionate care, it is physically and emotionally draining. Her recommendation would be for staff to be educated on compassionate care.

**Jack**

Jack participated in an individual interview but refused to use the video camera option of Google Meet. His age range is 21–30 years old. He is an African American or Black male, married/partnered with one child. He has a bachelor’s degree, has an advanced certification, and works at a Magnet hospital. He spends 51–75% of time in direct patient care, works on the day shift, and takes care of eight patients at a time. He provides compassionate care by showing personal interest in patients, being empathetic, understanding them, and gaining their trust. He stated,

I try to be empathetic to the patients, try to understand them so that you can be able to pass message...helpful message for them. For example, trying to explain the procedure before it is done.

The adversity he faces is that sometimes patients refuse care because they do not understand or do not trust the care being provided. His recommendation is for administration to help provide
enough staff and resources to help facilitate compassionate care being delivered to their patients.

**Carrie**

Carrie participated in an individual interview but refused to use the video camera option of Google Meet. Her age range is 21–30 years old. She is an African American or Black single female with one child. She has an associate’s degree, spends 51–75% of time in direct patient care, works on the day shift, and takes care of 10 patients at a time. She provides compassionate care to her patients by having personal interest in her patients and acknowledging their feelings. She stated,

I practice school manners to the patient. I also show some personal interest to the patient. That is, whatever it is that they're telling me, I listen to it very keenly and show some interest. I always try to like acknowledge their feelings, try to reason with them, try to understand whatever it is that they're feeling and also show that I actually see further with their situation.

The adversity that she faces is that she encounters violence from her patients because they do not understand her and her purpose. She feels that a perfect compassionate environment would be where the patient had mutual respect of the nurses, cooperation from all patients, and fewer interruptions while providing care.

**Oscar**

Oscar participated in an individual interview but refused to use the video camera option of Google Meet. His age range is 21–30 years old. He is an African American or Black male, married/partnered with two children. He has a bachelor’s degree, spends 76–100% of time in direct patient care, works on the day shift, and takes care of >10 patients at a time. He provides compassionate care by putting himself in his patients’ shoes and participates in teamwork to get
the work done. He stated, “Most of the time, I try and put myself in people’s shoes and understand their feelings from their perspective.” The adversity he faces is short staffing. He feels that compassionate care is about doing to others like you would want to have done to yourself. He feels leadership plays a major role in uniting staff to work as a team.

**Barry**

Barry participated in an individual interview but refused to use the video camera option of Google Meet. His age range is 21–30 years old. He is an African American or Black male, married/partnered with two children. He has a bachelor’s degree, spends 76–100% of time in direct patient care, works on the day shift, and takes care of eight patients at a time. He said he provides compassionate care by trying to understand the feelings and needs of the patients by putting himself in their shoes. He stated, “I may try and understand the feelings of the patient while doing so; it might help them to get better relief. This is because you support the emotional needs.” He felt that compassionate care is important because it reduces cost due to the shorter stay in the hospital. The adversity he faces is being emotionally and physically drained from the compassionate care being delivered. He felt leadership is key to unify the department and help meet the objectives of the institution. His recommendation was to provide year-round compassionate care training.

**Josie**

Josie participated in an individual interview. She chose to use the video camera via Google Meet. Her age range is 21–30 years old. She is a White or European-American, single female without children. She has a master’s degree, spends 76–100% of time in direct patient care, works on the day shift, and takes care of four patients at a time. She has been a medical-surgical nurse for four years. She said she feels that providing compassionate care to Covid-19
patients is very different than providing compassionate care to patients who do not have Covid-19. She continues to provide compassionate care to her patients because she feels it is a “badge of honor” that nurses carry and is proud to provide this compassionate care. Her idea of nursing as a badge of honor influenced the development of the grounded theory from this study. She stated,

    There was this like almost…a badge of honor, like bestowed upon us of like, ‘You are the ones that are going to take care of these people while we figure out what this disease is and how to treat it, and we trust you enough to be the only people going to the room.

Betty

Betty participated in an individual interview but refused to use the video camera option of Google Meet. Her age range is 31–40 years old. She is a Hispanic or Latina/e/o/x single female with no children. She has a master’s degree, spends 76–100% of time in direct patient care, works on the night shift, and takes care of >10 patients at a time. She said she provides compassionate care by respecting her patients for their ideas and for who they are, acknowledging their feelings, and showing personal interest toward them. She stated, “I respect their ideas; I respect whatever it is that they want to do…and even if sometimes they tell me that I am not agreeing with…” She feels compassion is important in her practice because it helps the patients relieve their suffering through the knowledge that someone cares about them beside their family or loved ones. The adversity she faces is the fear of getting infectious diseases and that patients can be harsh and not accepting of compassionate care being provided. Her recommendation is to provide seminars on compassionate care.

Samantha

Samantha participated in an individual interview but refused to use the video camera
option of Google Meet. Her age range is 41–50 years old. She is a Hispanic or Latina/o/x married female with three children. She has a master’s degree, spends 76–100% of time in direct patient care, works on the night shift, and takes care of 10 patients at a time. She feels that nursing is a calling and that nurses should go the extra mile to care for their patients. She stated,

When you get into nursing, you just get the...with the calling, with the urge to help others, and that's what drives you to do some things or to step on extra mile and help the patients.

She said she provides compassionate care by stepping into her patients’ shoes. The adversity that she faces is that she feels that her patients have no trust in the care that is provided and the emotional distress that she feels when she gets too close to her patients.

Kristen

Kristen participated in an individual interview. She chose to use the video camera via Google Meet. Her age range is 31–40 years old. She is White or European-American, single female without children. She has a master’s degree, spends <25% of time in direct patient care, works on the day shift, and takes care of four patients at a time. She provides compassionate care by listening to her patients and finding out personal facts about her patients to give them joy. The adversity she faces is not enough staffing. She sees how hard her nurses work and does her best to keep them motivated by celebrating the small moments the nurses provided compassionate care. By celebrating these moments, the nurses become role models for each other and continue to promote compassionate care on their unit. Her statement about her dedication to nursing reminded the researcher the reason why nursing was so important:

And I think the reason I got into nursing was because of the compassion. I didn't get into it for the money, God forbid, because I've always said there's no amount of money that's going to make me want to provide postmortem care or clean up C. diff. There's no money
out there that's going to make me do that. It's because I care about the patient and the family. So if I don't have compassion, then what am I doing here?

**Jacqueline**

Jackie participated in an individual interview but refused to use the video camera option of Google Meet. Her age range is 41–50 years old. She is an African American or Black married female with four children. She has a bachelor’s degree, spends 51–75% of time in direct patient care, works on the night shift, and takes care of >10 patients at a time. She feels that providing compassionate care is not about quantity but quality. She stated,

> what I basically do is that, I just give the patients my best, according to my training and according to the quality of what they should get and especially for hospice patients, because we aim increasing the quality and not the quantity of life.

The adversity she faces are being attached to her patients, the emotional overload that she feels providing compassionate care, and the patients do not appreciate the care being delivered. Her recommendation is to provide compassionate care to all staff, including the providers, so that everyone is aware of compassionate care and its benefits.

**Janice**

Janice participated in an individual interview but refused to use the video camera option of Google Meet. Her age range is 21–30 years old. She is an African American or Black single female with no children. She has a bachelor’s degree, spends 76–100% of time in direct patient care, works on the night shift, and takes care of 10 patients at a time. She provides compassionate care by having good manners, putting herself in her patients’ shoes, being attentive, trying to understand her patients, and giving them hope. She stated,
I give my patient my full attention by being attentive to them. That is when we are talking. When they're telling me something, I maintain appropriate eye contact. I also try as much as possible to be generally kind to my patient by, first of all, trying to understand their problems and putting myself, of course, in their shoes.

The adversity she faces is the fear of catching infectious diseases from her patients. She feels that the best environment to deliver compassionate care is where the staffing ratio is appropriate and when administration supports their staff providing this care by helping to attain the resources they need.

**Matty**

Matty participated in an individual interview but refused to use the video camera option of Google Meet. Matty’s age range is 31–40 years old. This participant is a Hispanic or Latina/e/o/x non-binary, married with two children. Matty has a bachelor’s degree, spends 51–75% of time in direct patient care, works on the day shift, and takes care of 10 patients at a time. Matty provides compassionate care by providing hope, being friendly, being approachable, and showing personal interest by being attentive and listening to the patients:

I always spend some time to talk to my patients, of course in a friendly way. I try to install some hope in them and encourage them not to give up, but to keep fighting. I also make sure I'm very friendly to the patient so that they can be...I can be approachable in case they have an issue.

Adversity this participant faced are the shortage of nurses and violence from patients.

**Helen**

Helen participated in an individual interview but refused to use the video camera option of Google Meet. This participant’s age range is 21–30 years old. This participant is single,
Hispanic or Latina/e/o/x non-binary with no children. Helen has a bachelor’s degree, spends 25–50% of time in direct patient care, works on the night shift, and takes care of five patients at a time. This participant provides compassionate care by showing kindness and respect for the patients and by being empathetic to the patients. Helen shows that active listening occurs by repeating what the patients say. This participant is also very attentive and shows personal interest in the patients. Helen provides hope to patients as well and stated, 

the way I see my patient, I see it makes the patient feel as much as they have their family and their friends out there, they also feel that they have support and they have someone inside the hospital who can actually understand them. So, it makes them feel like as much as they have someone outside there, they also have someone inside here who can listen to them, which is very good and very essential for their recovery.

The adversity that this participant faces are violence from the patients, shortage of staff, mandatory overtime and long working hours, and exposure to infectious diseases. This participant felt that leadership should recognize the nurses for all the hard work they do.

**Eliza**

Eliza participated in an individual interview. She chose to use the video camera via Google Meet. Her age range is 31–40 years old. She is a White or European-American, single female without children. She has a master’s degree, spends 76–100% of time in direct patient care, works on the day shift, and takes care of four patients at a time. She said she provides compassionate care by trying to spend as much time with her patients to make connections with them. The adversity she faces is that she has limited time with her patients due to short staffing or how acutely ill her patients are. She feels that she cannot do everything she wants to do for her patients. When she has limited time, she would sacrifice documenting until after the report is
given so she can spend the extra time with her patients. She feels providing compassionate care is important because nurses serve as their patient’s advocate, especially in the medical-surgical specialty. As she stated,

Sometimes I feel like med-surg is not the most glamorous specialty. A lot of the patients who are cared for in a med-surg area have been there before and will be there again. Maybe you're sometimes treated somewhat dismissively. Potentially, you're facing sort of like upstream barriers that contribute to them being in the hospital more frequently. And so I think it's still important to provide compassion to those patients just as much, if not more, than in any other setting.

The last three participants were added to trim the grounded theory further. They were specifically picked from the larger sample because they rated themselves lower in the CCS. The researcher wanted to see if there was a difference in their responses compared to the participants that scored higher in the CCS. The researcher discovered there were no differences in their responses. They actually echoed the categories and concepts of their counterparts.

**Joe**

Joe participated in an individual interview. He agreed to using the video camera via Google Meet. His age range is 21–30 years old. He is an African American or Black married male with no children. He has a bachelor’s degree, spends 25–50% of time in direct patient care, works on the day shift, and takes care of two patients at a time. He said he continues to provide compassionate care because he loves what he does as a nurse. He stated, “It’s a little challenging, like any other job. So I need to dedicate myself and believe in what I’m doing. I love what I’m doing, no matter how hard it is.” The adversity he faces are that patients are not accepting of the compassionate care and can be very rude. Other difficulties are that social distancing and
wearing PPE make it difficult to connect and communicate with his patients.

Paul

Paul participated in an individual interview. He agreed to using the video camera via Google Meet. His age range is 31–40 years old. He is an African American or Black married male with two children. He has a bachelor’s degree, spends 76–100% of time in direct patient care, works on the day shift, and takes care of nine patients at a time. He has not cared for Covid-19 patients. He has six years of medical-surgical experience. He said he provides compassionate care to his patients by gaining their trust and making a connection with his patients by putting himself in their shoes. He provides emotional support to his patients and provides care that makes his patients feel special by going above and beyond. He stated,

Other times, you need to talk to them, show them some sort of psychological assistance…I have a friend, a psychologist, and there's this boy I was made to take care of last two weeks. And he went through some sort of psychological trauma. He was traumatized. So, I had to bring in my friend, my psychologist friend, to come talk with him. And then it turns out to be that this young dude was actually suffering from fatigue and he needed someone to confide with; he needed someone to talk to. He needed someone to open up his self to. So, that was where I came in with my friend, and we were able to get him talk some things over with.

The adversity that he faces is compassion fatigue. He feels leadership could help him provide compassionate care by “bridging the gap” of what patients express to the nurses about what their needs are and leadership obtaining the resources the nurses need to provide compassionate care.

Joshua

Joshua participated in an individual interview but refused to use the video camera option
of Google Meet. His age range is 31–40 years old. He is an African American or Black married male with one child. He has an associate’s degree, spends 25–50% of time in direct patient care, works on the day shift, and takes care of six patients at a time. He provides compassionate care to his patients by having good manners, maintaining professionalism, acknowledging the feelings of his patients, having a personal interest in his patients, and providing emotional support to his patients. He stated,

…delivering care with empathy and just respect and dignity. Those are the things that I just look at them mostly when I'm giving the compassionate care to the patient. Because we have to take care of your emotional needs and concentrate on the emotional care of the patients.

The adversity he faces is his patients’ ignorance of the purpose of the compassionate care that he provides. He feels that leadership can support his compassionate care by maintaining the moral and values of compassionate care through role modeling.

**Follow-Up Data Collection**

Member-checking was achieved through contacting the participants via email. The participants were given the opportunity to review the grounded theory of altruism diagram (see Figure 3) that was created to display the categories that emerged from the qualitative data. Two out of the 27 responded and agreed to the categories that emerged from the data.

**Overview: Grounded Theory of Altruism**

The purpose of a grounded theory was to provide prediction and explanation of how medical-surgical nurses provide compassionate care in the face of adversity. Facing adversity while providing compassionate care was identified as the basic social physiological problem. There were two main constructs of why and how medical-surgical nurses provide compassionate
care and their related causal, contextual, and intervening. Figure 3 illustrates the Grounded Theory of Altruism. Table 9 presents the categories and concepts of the Grounded Theory of Altruism.

Figure 3. Diagram of Grounded Theory Altruism
Table 9

Categories and Concepts of the Grounded Theory of Altruism

| Category 1: Adversity                | Concept 1: Not enough staffing |
|                                    | Concept 2: Not enough time to provide compassionate care |
|                                    | Concept 3: Not accepting of compassionate care from patients |
|                                    | Concept 4: Fear of catching infectious disease |
|                                    | Concept 5: Not enough resources |
| Category 2: Why medical-surgical nurses provide compassionate care | Concept 1: Moral responsibility |
|                                    | Concept 2: Badge of honor |
|                                    | Concept 3: Fills them up |
| Category 3: How medical-surgical nurses provide compassionate care | Concept 1: Steps into patients’ shoes (Empathy) |
|                                    | Concept 2: Gain trust |
|                                    | Concept 3: Provide hope |
|                                    | Concept 4: Respect |
|                                    | Concept 5: Going above and beyond |
|                                    | Concept 6: Comfort care |

<table>
<thead>
<tr>
<th>Category 4. Altruism</th>
<th>The category generated the core category of “altruism”</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Concept 1: Selflessness</td>
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<tr>
<td></td>
<td>Concept 2: No matter the cost to themselves</td>
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Basic Psychosocial Problem: Facing Adversity While Providing Compassionate Care

Facing adversity while providing compassionate care was discovered to be the basic psychosocial problem. All the medical-surgical nurses encountered adversity while providing compassionate care to their patients. The top three examples of adversity were not enough staffing, not enough time to provide compassionate care, and patients not accepting of compassionate care provided. Other examples of adversity were the risk of catching an infectious disease and lack of or limited resources. See Table 10 for Categories and examples of each category. Caring for a high ratio of patients made it difficult for them to provide the best care that they could give to all of their patients.

As stated by Coleen,
Sometimes you might decide since your few nurses attending to many patients, you feel like you have that one patient that you're taking care of. Like, you know, because you can't just go concentrating on all of them. So you might sometimes choose just one and concentrate on him or her. And sometimes there may be some might feel somehow left out.

Here was another statement about “not enough staffing” by Derrick:

Sometimes you're overwhelmed with the number of patients that you're supposed to take care of, and that actually reduces the contact of how I am supposed to be able to be with those patients, with each one of them. That reduces the compassionate care that I'm supposed to deliver to them.

There is conflict seen as the medical-surgical nurses provide care for these patients. As stated by Eliza:

If it's a day where the nurse-to-patient ratio is higher and as a result you don't have as much time for patient or maybe one patient is more acutely ill, or is needing more time spent with them because of procedures or whatever it is. Then the time that I can offer to the other patients might not be as much as otherwise would be.

With the “not enough time” to provide compassionate care example of adversity, the medical-surgical nurses felt that they were so busy that they could not spend enough time with their patients. As described by Eliza,

There have been shifts that have just been so busy that I just don't feel like I have time to do everything that I would want to do. I think that's probably the number-one challenge. It's just not always feeling like I left the shift doing every single thing that I would want to do for the patients because time is sometimes limited.
Here is another example of “not enough time” by Kristen:

I think there are time challenges and time pressures that definitely make it harder to provide the compassionate care that I would want to give. I think it's still there, but it's just harder right now.

Participants also felt that they found it difficult to provide compassionate care when their patients did not accept or refused the care that was provided to them especially because these nurses only had the best intentions for them. As stated by Jacqueline,

When you're attempting to do compassionate care, some patients may refuse. It's not 100% guaranteed that this might work. But when you provide compassionate care, you will try your best to be empathic, but really, some patients make you feel as though... you may feel really depressed or stressed that some patients don't give you trust. So it's really hard to do compassionate care because it's not 100% that all patients will understand you or give you trust.

There is conflict of the attempt to provide compassionate care when meeting resistance from the patient. As illustrated in the next statement by Josie,

….because I think a lot of people go into nursing, because they have that passion to bring science and compassion together to treat a common goal. When you have those two battling each other, it just makes for a horrible, horrible environment, and you're just in almost this whirlpool of like, ‘Okay, I want to so badly care for you, but you don't respect me or my profession right now, and you don't trust what I'm doing.’ I'm like in this moral gray area of like, “How do I get past this to still show you care when you care nothing about what I'm doing, don't think that I'm caring for you properly?”

Medical-surgical nurses also fear catching infectious disease while providing compassionate
care. Betty stated,

Some of the difficulties that I face is exposure to some of the infectious disease. You come into contact with these diseases daily; some of these patients, they have infectious diseases. But then still, you don't want to show them that you are afraid of them or something; you don't want to show them that you don't want to stay with them. Because of course, you're also afraid of the disease, but then that as a challenge—that has actually been my greatest challenge.

Medical-surgical nurses are challenged with providing compassionate care due to “limited resources.” As stated by Sarah,

Sometimes you might want to do something the ideal way, but you know the resources are not there that allow you to do that. And so, you have to do them in another way. Maybe you have to improvise or do something else, and that might bring down the quality of care.

Although these medical-surgical nurses were faced with the adversity of limited resources, they embraced the challenges and found the why and the how of providing compassionate care.

**Categories of the Grounded Theory of Altruism**

This study identified four categories:

1. Facing adversity while providing compassionate care;
2. Why medical-surgical nurses provide compassionate care;
3. How medical-surgical nurses provide compassionate care;
4. Altruism, which also led to the core category of altruism.

The why is the reason these medical-surgical nurses continued to provide compassionate care. The concepts within the category “why medical-surgical nurses provide compassionate care” are
as follows: (a) moral responsibility, (b) badge of honor, and (c) fills them up. The “how” provides information on the process of providing compassionate care. The concepts within the category “how medical-surgical nurses provide compassionate care” are as follows: (a) step into the patients’ shoes, (b) gain trust, (c) instill hope, (d) show respect, (e) going above and beyond, and (f) comfort care (see Table 10 for Categories of Grounded Theory of Altruism and Examples).

**Category 2: Why Medical-Surgical Nurses Provide Compassionate Care**

The first concept or reason medical-surgical nurses provide compassionate care is that they feel providing compassionate care is their moral responsibility or “the right thing to do.” As described in the following quote by Becky,

> In my practice, compassionate care is the part of being with the patient, giving the patient quality care and being with the patient the maximum time you can be with them...And taking care of them, and not holistically, and not like physically only, or maybe emotionally only. So you take care of them, like realistically, both physically, emotionally, psychologically, socially.

Medical-surgical nurses want to help their patients heal and feel better. Betty stated,

> I think it's really helping the patient. For example, when you show them that you understand whatever it is that they're going through, at times, as much as it may not heal them, it eases their pain. At least it makes them aware that they have someone inside the hospital, not only outside, not only their relatives, or that kind of thing. It makes them feel that they also have someone here on daily basis, in the hospital.

This is also stated by Coleen:

> Being compassionate is definitely important because it's important to the patients, mostly
because they get to be better, they get to do better. Even for the palliative patients, they get to at least to have quality life…and not quantity…so they get to get what's best and they live happily despite their disease…at least they're holistically well.

The second concept within “why medical-surgical nurses provide compassionate care” category is “badge of honor.” The medical-surgical nurses feel that they wear this “badge of honor” by providing compassionate care to their patients. They feel that they are entrusted with this great honor of being a nurse and are proud to be in this profession. As beautifully stated by Josie,

There was this like almost…a badge of honor, like bestowed upon us of like, ‘You are the ones that are going to take care of these people while we figure out what this disease is and how to treat it, and we trust you enough to be the only people going to the room…there was that like almost this badge of responsibility and trust that we are able to do this all on our own.

The following quote further describes the pride nurses have in this profession, as stated by Josie:

At the beginning, we got the respect that the profession had been begging for years, right? The healthcare and all the stuff, we just were getting recognized for the work that we've been doing this whole time. It just was an opportunity for nursing to finally shine.

Here was another quote that further illustrates “badge of honor” by Kristen:

And I think the reason I got into nursing was because of the compassion. I didn't get into it for the money, God forbid, because I've always said there's no amount of money that's going to make me want to provide postmortem care or clean up C. diff. There's no money out there that's going to make me do that. It's because I care about the patient and the family. So if I don't have compassion, then what am I doing here?

From these statements, it is evident that these medical-surgical nurses take pride in the work they
The final concept within “why medical-surgical nurses provide compassionate care” category is “fills them up.” Medical-surgical nurses provide compassionate care because they receive fulfillment from this noble profession, as illustrated by Jack:

There's something special about nurses of just being so full for knowing that you're taking care of your patient fully. There was a patient that I felt...I didn't feel drained after caring for her. I didn't feel drained going above and beyond for her, because I knew that that was what she needed. And so, it was really refreshing to have that back. I think that was something that I really miss a lot of the time with a lot of my patients is doing what I want to do to go above and beyond for my and feeling so emotionally full, like your bucket is full.

Medical-surgical nurses have compassion satisfaction when they provide care to their patients. As stated by Carrie, “Of course, it made me feel great. It also made me feel like I'm useful. Like I'm doing whatever it is that I'm meant to do.” Also illustrating this point was Derrick,

I really felt good; I really felt like actually, in as much as you can be able to help more patients than nurses, you can actually be able to achieve the care that you really want to be able to your patients.

Here was a final example of “fills them up” by Helen: “It really made me feel resourceful. It made me feel that I was doing whatever it is that I’m supposed to be doing.” When these medical-surgical nurses felt they made a difference for the patients, they felt fulfilled and reminded of the reason why they went into nursing.

Category 3: How Medical-Surgical Nurses Provide Compassionate Care

The first concept of how medical-surgical nurses provide compassionate care is “steps
into patients’ shoes” (empathy). The medical-surgical nurses felt that they had a better understanding of what their patients’ needs were by being empathic toward their patients. This is depicted in the quote by Barry: “For example, I may try and listen carefully to what the patient is saying and try and be empathetic towards their feeling. It's trying to put myself in their shoes.”

Empathy was also illustrated by Bobby:

First you have to understand the patient, talk to him or her, what he likes or what he doesn't like. You see, with that, you will create an environment that is for the patient, knowing what he or she likes, knowing what the patient wants to be done.

Also illustrating this point was Coleen:

The compassionate care—I may say—I work with the patient to ensure that I feel what they feel and I consider their emotions and their emotional health and what they think and how they're emotionally growing.

Another explanation of empathy was stated by Junior: “That is having that sympathetic awareness of your patient distress. Then you combine your desire to alleviate it—the distress.”

Here was a final example of “steps into patients’ shoes” by Derrick:

…how you can be able to make your patients feel comfortable with you, feel like you really care about the patient; you really care about her condition and then the patient will feel comfortable around you and then will enhance you in delivering this kind of compassionate care.

The medical-surgical nurses have a better understanding of their patients by stepping into their patients’ shoes.

The second concept of how medical-surgical nurses provide compassionate care is “gain trust.” Medical-surgical nurses would provide compassionate care by gaining their patients’
trust—by being attentive and make connections with their patients. One way they would accomplish this is through active listening. This is illustrated by the following example from Junior:

And I think one of the key things that I have really been loving is being active listener. So I try my best to listen to my patients and try to also pick those unspoken cues. A patient explains some things how they feel, but there are a lot of things that they don't say. So through my listening skills, I'm able to understand how they feel from the unspoken feeling, from unspoken emotions they express.

Another example of active listening skills was by Helen:

For example, I always make eye contact when talking to them; I always listen to them. And also, I always repeat what the patient says to confirm that I've understood whatever they are saying.

Another way the medical-surgical nurses display their attentiveness is having personal interest in their patients and connecting with them with that information. This is illustrated by the following statement by Kristen:

So one of my goals that I always tell my nurses—and the nurses I work with—is make it your goal to walk away each day knowing one personal fact about a patient. And not something medical—just something, whether they have a dog. Make sure you've seen the picture of a dog if that's what is something that brings them joy. I'll pull out my phone and show them my new puppy, that kind of a thing. I guess I really connect with people as far as animals go. Or just I work with an older population, so, “Show me your grandkids”—something like that.

Personal interest in their patients was also described in the following quote by Alice:
I try to show personal interest in these patients. For example, I try and create light conversations with the patients. That is to gain trust and rapport so that when I'm offering these services, they gain trust. When I decided to... when, for example, a doctor decides to tell them to do a certain surgery, most of the time, these patients they come to me and ask for advice.

These statements describe how medical-surgical nurses pay attention to details of their patients to make connections with their patients and gain their trust.

The third concept in how medical-surgical nurses provide compassionate care is “instill hope.” Medical-surgical nurses provide compassionate care by encouraging them and providing hope. As stated by Bobby,

You tell the patient that everything will be alright. If everything will go on well, nothing will happen to him or her. If they go through the surgery, they just will recover, and they will have all the support that they need during the hard time that they are facing...I give counseling and talk to the patient and relatives about the condition, give them hope, that maybe there's hope, and everything will go on well.

Another example of “instill hope” was from Betty:

I really used to encourage her. I really used to listen to her stories and whatever it is that she wanted to tell me. I used to encourage her—that she’ll get better. The situation is not bad after all.

Another example of “instill hope” was from Derrick:

Actually, their response is so positive and they really help you in that care because they're getting information that's so positive and that really helps a lot in delivering compassionate care.
The final example of “instill hope” was from Helen:

At least you can see that you are giving them some sort of hope. It also makes the...at times I see it...the way I see my patient, they also feel that they have support and they have someone inside the hospital who can actually understand them. … which is very good and very essential for their recovery.

As described by these statements, medical-surgical nurses provide compassionate care to their patients by ensuring to their patients that everything is going to work out, instilling the hope they need to heal and get better.

The fourth concept in how medical-surgical nurses provide compassionate care is “show respect.” Medical-surgical nurses provide compassionate care by showing respect to their patients. As stated by Betty,

And some of the ways that I provide the compassionate care, for example, is showing respect to the patient. I show them that I respect them, I respect their ideas, I respect whatever it is that they want to do. And even if sometimes they tell me that I am not agreeing with, I show them that, first of all, I respect what they're saying.

Also explaining this point was Matty:

I really show respect to my patient. I really listen to whatever it is that they have to say.

And I always, as much as possible, I always try and respect their opinions and be attentive to whatever it is that they're telling me.

Mutual respect is also important in providing compassionate care. As stated by Josie,

… but the two parties having respect for each other. Me respecting the patient's desires, wishes, beliefs, and being able to meet them where they're at for those and letting me know what they need and how I can do that, and reciprocally, the patient trusting me to
take care of those needs.

Also describing mutual respect was Josie:

….but just that mutual understanding of like, you trust me enough with your literal life right now, and I want to be able to care for you. I just need that respect back, that you trust me with that.

Maintaining respect for their patients allow medical-surgical nurses to have a good rapport and develop good working relationships with their patients.

The fifth concept in *how medical-surgical nurses provide compassionate care* is “going above and beyond.” Sometimes, medical-surgical nurses need to go above and beyond for their patients. As illustrated by Coleen,

And the persons, the people that involved, they didn't schedule another nurse to come for the shift. And so I did the shift by myself and I really did it. And by the time I was finished, I was so tired. I was so worn out….and so I felt, but after I felt like I did something good because I helped those patients.

Also describing this point was Eliza:

I'm particularly interested in individuals who are living with dementia. So any time I'm caring for someone with dementia, I really try to go out of my way to ensure that we're avoiding situations where restraints might be utilized. So just really making sure I'm doing things to help with circadian rhythm and comfort and routine and familiarity. So I think probably when I have patients like that, I probably spend more time with them than with my other patients, because I feel like the presentation warrants having that additional contact as much as possible.

Here was the final example of “going above and beyond” by Paul:
Other times, you need to talk to them, show them some sort of psychological assistance… I have a friend, a psychologist, and there's this boy I was made to take care of last two weeks. And he went through some sort of psychological trauma. He was traumatized. So, I had to bring in my friend, my psychologist friend, to come talk with him. And then it turns out to be that this young dude was actually suffering from fatigue and he needed someone to confide with, he needed someone to talk to. He needed someone to open up his self to. So, that was where I came in with my friend, and we able to get him talk some things over with.

The medical-surgical nurses go above and beyond because they feel it is just part of providing compassionate care.

The sixth concept in how medical-surgical nurses provide compassionate care is “comfort care.” Medical-surgical nurses provide their patients with comfort care to help them in ways that they may not be able to help themselves. As stated by Eliza,

Focus on things like comfort, warmth and pain management. You know, those things sometimes are not the most... they're not hard to accomplish, but they make a big difference for the patients… I think it's very rewarding to feel like I've safely and intentionally brought that patient through that shift without incident. That they didn't have a situation that caused them to feel agitated or to escalate. That they were able to maybe receive the appropriate amount of mealtime assistance if that's what they need. So I feel good knowing that maybe they've consumed as much as they possibly wanted to consume because they had the time and support needed to be able to do that.

**Category 4: Altruism**

A fourth category is altruism. It is also an overarching theme that led to the core concept
of altruism. The concepts related to this are (a) selflessness and (b) no matter the cost to themselves. The first concept of selflessness is that the medical-surgical nurses are selfless when they provide compassionate care to their patients. Selflessness was stated by Josie,

I think that specifically in med-surg nursing, and then I guess, even more specifically, in COVID nursing as of the last almost two years here, compassionate nursing went from being able to provide emotional and physical support in addition to your medical care, to being the sole purpose person responsible for emotional, mental, spiritual, and physical well-being for that person for upwards of three weeks, because at most places at my particular institution, nursing is one of the few people that still go into the room with the patient.

Here was another great example of selflessness by Josie:

And I think nursing is so self-sacrificing historically. And I think that there's a lot of reasons why nursing is self-sacrificing...probably a lot to do with how female centered it is. And how self-sacrificing in our culture—like in Western culture, a lot of women are in a caring role where you just give and give to your family or you give and give to your friends and you'll be fine. You got it. But you have to give and you have to be the emotional center for everyone. And I think that translates almost directly into nursing because it's a caring profession.

Another example of selflessness was from Eliza:

Sometimes I feel like med-surg is not the most glamorous specialty. A lot of the patients who are cared for in a med-surg area have been there before and will be there again. Maybe you're sometimes treated somewhat dismissively. Potentially you're facing sort of like upstream barriers that contribute to them being in the hospital more frequently. And
so I think it's still important to provide compassion to those patients just as much if not more than in any other setting.

The second concept in altruism — no matter the cost is “no matter the cost to themselves.” The medical-surgical nurses provided compassionate care despite the compassion fatigue they experienced. As stated by Junior,

Of course, I really felt bad. You understand, one of the things that help us become connected to our careers is that compassionate care and that feeling of taking and sharing experiences with your patients and being open, and it makes us feel some more bad…it makes us feel like we are not giving our best. Of course, at times you have to first take care of your health before, now for example, someone else's health.

Another quote explained the same point by Josie:

I think that's at the sacrifice of a lot of our own mental health and personal health, because then we come home, and I know most of my coworkers do as well, but we just sleep when we're off, or lounge around or whatever, like we just are so emotionally drained that it takes our three days off to recover back to what feels like a normal emotional level; then we go back to work and burn all of that.

When medical-surgical nurses do not replenish themselves, they may suffer from compassion fatigue and, if not addressed, this may progress to compassion burnout.

Table 10

*Grounded Theory of Altruism and Examples*

<table>
<thead>
<tr>
<th>Core problem: Facing adversity when providing compassionate care</th>
<th>Examples</th>
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<tbody>
<tr>
<td>Category 1: Adversity</td>
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<tr>
<td>Concept 1: Not enough staffing</td>
<td>Coleen: “Sometimes, you might decide since you’re few nurses attending to many patients, you feel like you have that one patient that you're taking care of. Like, you know, because you can't just go concentrating on all of them. So you might sometimes choose just one and concentrate on him or her. And sometimes there may be some might feel somehow left out.”</td>
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<td>--------------------------------</td>
<td>Eliza: “If it's a day where the nurse-to-patient ratio is higher and as a result you don't have as much time for patient or maybe one patient is more acutely ill or is needing more time spent with them because of procedures or whatever it is, then the time that I can offer to the other patients might not be as much as otherwise would be.”</td>
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<tr>
<td>Concept 2: Not enough time to provide compassionate care</td>
<td>Eliza: “There have been shifts that have just been so busy that I just don't feel like I have time to do everything that I would want to do. I think that's probably the number-one challenge. It's just not always feeling like I left the shift doing every single thing that I would want to do for the patients because time is sometimes limited.”</td>
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<td>Kristen: “I think there are time challenges and time pressures that definitely make it harder to provide the compassionate care that I would want to give. I think it's still there, but it's just harder right now.”</td>
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<td>Concept 3: Not accepting of compassionate care</td>
<td>Josie: “...because I think a lot of people go into nursing, because they have that passion to bring science and compassion together to treat a common goal. When you have those two battling each other, it just makes for a horrible, horrible environment, and you're just in almost this whirlpool of like, ‘Okay, I want to so badly care for you, but you don't respect me or my profession right now, and you don't trust what I'm doing.’ I'm like in this moral gray area of like, ‘How do I get past this to still show you care when you care nothing about what I'm doing, don't think that I'm caring for you properly?’”</td>
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<td>Jack: “When you're attempting to do compassionate care, some patients may refuse. It's not 100% guaranteed that this might work. But when you provide compassionate care, you will try your best to be empathic, but really, some patients make you feel as though... you may feel really depressed or stressed that some patients don't give you trust. So it's really hard to do compassionate care because it's not 100% that all patients will understand you or give you trust.”</td>
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<td>Concept 4: Fear of catching an infectious disease</td>
<td>Betty: “Some of the difficulties that I face is exposure to some of the infectious disease. You come into contact with these diseases daily, some of these patients, they have infectious diseases. But then still, you don't want to show them that you are afraid of them or something, you don't want to show them that you don't want to stay with them. Because of course, you're also afraid of the disease, but then that as a challenge, that has actually been my greatest challenge.”</td>
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<td>Concept 5: Not enough resources</td>
<td>Sarah: “Sometimes you might want to do something the ideal way, but you know the resources are not there that allow you to do that. And so, you have to do them in another way. Maybe you have to improvise or do something else, and that might bring down the quality of care.”</td>
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<td>Category 2: Why medical-surgical nurses provide compassionate care</td>
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Concept 1: Moral Responsibility
Becky: “In my practice, compassionate care is the part of being with the patient, giving the patient quality care and being with the patient the maximum time you can be with them. Yeah. And taking care of them, and not holistically, and not like physically only, or maybe emotionally only. So you take care of them, like realistically, both physically, emotionally, psychologically, socially.”

Betty: I think it's really helping the patient. For example, when you show them that you understand whatever it is that they're going through, at times, as much as it may not heal them, it eases their pain. At least it makes them aware that they have someone inside the hospital, not only outside, not only their relatives, or that kind of thing. It makes them feel that they also have someone here on daily basis, in the hospital.”

Coleen: “Being compassionate is definitely important because it's important to the patients, mostly because they get to be better, they get to do better. Even for the palliative patients, they get to at least to have quality life… and not quantity… so they get to get what's best and they live happily despite their disease… at least they're holistically well.”

Concept 2: Badge of Honor
Josie: “There was this like almost… a badge of honor, like bestowed upon us of like, ‘You are the ones that are going to take care of these people while we figure out what this disease is and how to treat it, and we trust you enough to be the only people going to the room.’”

Josie: “There was that like almost this badge of responsibility and trust that we are able to do this all on our own.”

Josie: “At the beginning, we got the respect that the profession had been begging for years, right? The healthcare and all the stuff, we just were getting recognized for the work that we've been doing this whole time. It just was an opportunity for nursing to finally shine.”

Kristen: “And I think the reason I got into nursing was because of the compassion. I didn't get into it for the money, God forbid, because I've always said there's no amount of money that's going to make me want to provide postmortem care or clean up C. diff. There's no money out there that's going to make me do that. It's because I care about the patient and the family. So if I don't have compassion, then what am I doing here?”

Concept 3: Fills Them Up
Jack: “There's something special about nurses of just being so full for knowing that you're taking care of your patient fully. That was a patient that I felt... I didn't feel drained after caring for her. I didn't feel drained going above and beyond for her, because I knew that was what she needed. And so, it was really refreshing to have that back. I think that was something that I really miss a lot of the time with a lot of my patients is doing what I want to do and go above and beyond for my... and feeling so emotionally full, like your bucket is full.”

Carrie: “Of course, it made me feel great. It also made me feel like I'm useful. Like I'm doing whatever it is that I'm meant to do.”

Derrick: “I really felt good, I really felt like actually, in as much as you can be able to help more patients than nurses, you can actually be able to achieve the care that you really want to be able to your patients.”

Helen: “It really made me feel resourceful. It made me feel that I was doing whatever it is that I'm supposed to be doing.”

Category 3: How medical-surgical nurses provide compassionate care
### Concept 1: Steps into Patients’ Shoes

<table>
<thead>
<tr>
<th>Barry</th>
<th>“For example, I may try and listen carefully to what the patient is saying, and try and be empathetic toward their feeling. It's trying to put myself in their shoes.”</th>
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<td>Bobby</td>
<td>“First, you have to understand the patient, talk to him or her, what he likes or what he doesn't like. You see, with that, you will create an environment that is for the patient, knowing what he or she likes, knowing what the patient wants to be done.”</td>
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<td>Junior</td>
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### Concept 2: Gain Trust

**Subcategory: Attentiveness - Listening**

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<tr>
<th>Junior</th>
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<td>Helen</td>
<td>“For example, I always make eye contact when talking to them; I always listen to them. And also I always repeat what the patient says to confirm that I've understood whatever they are saying.”</td>
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<td>Joe</td>
<td>“I show emotional support during difficult times and during patients’ treatment and recovery. I make sure that the bond between me and my patient is solidified. I become an active listener to my patients. We discuss their health issues…”</td>
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**Subcategory: Attentiveness - Personal Interest**

| Kristen | “So one of my goals that I always tell my nurses and the nurses I work with is make it your goal to walk away each day knowing one personal fact about a patient. And not something medical; just something, whether they have a dog. Make sure you've seen the picture of a dog if that's what is something that brings them joy. I'll pull out my phone and show them my new puppy, that kind of a thing. I guess I really connect with people as far as animals go. Or just I work with an older population, so ‘Show me your grandkids,’ something like that.” |
Alice: “I try to show personal interest in these patients. For example, I try and create light conversations with the patients. That is to gain trust and rapport so that when I'm offering these services, they gain trust. When I decided to...when for example, a doctor decides to tell them to do a certain surgery, most of the time, these patients they come to me and ask for advice.”

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<td>Matty: “I really show respect to my patient. I really listen to whatever it is that they have to say. And I always, as much as possible, I always try and respect their opinions and be attentive to whatever it is that that they're telling me.”</td>
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Eliza: “I'm particularly interested in individuals who are living with dementia. So any time I'm caring for someone with dementia, I really try to go out of my way to ensure that we're avoiding situations where restraints might be utilized. So just really making sure I'm doing things to help with circadian rhythm and comfort and routine and familiarity. So I think probably when I have patients like that, I probably spend more time with them than with my other patients, because I feel like the presentation warrants having that additional contact as much as possible.”

Paul: “Other times you need to talk to them, show them some sort of psychological assistance….I have a friend, a psychologist, and there's this boy I was made to take care of last two weeks. And he went through some sort of psychological trauma. He was traumatized. So, I had to bring in my friend, my psychologist friend, to come talk with him. And then it turns out to be that this young dude was actually suffering from fatigue and he needed someone to confide with, he needed someone to talk to. He needed someone to open up his self to. So, that was where I came in with my friend, and we were able to get him talk some things over with.”

Concept 6: Comfort Care
Eliza: “Focus on things like comfort, warmth, and pain management. You know, those things sometimes are not the most... they're not hard to accomplish, but they make a big difference for the patients.”

Eliza: “I think it's very rewarding to feel like I've safely and intentionally brought that patient through that shift without incident. That they didn't have a situation that caused them to feel agitated or to escalate. That they were able to maybe receive the appropriate amount of mealtime assistance if that's what they need. So I feel good knowing that maybe they've consumed as much as they possibly wanted to consume because they had the time and support needed to be able to do that.”

Category 4: Altruism
Concept 1: Selflessness
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Josie: “And I think nursing is so self-sacrificing historically. And I think that there's a lot of reasons why nursing is self-sacrificing...probably a lot to do with how female centered it is. And how self-sacrificing in our culture, like in Western culture, a lot of women are in a caring role where you just give and give to your family or you give and give to your friends and you'll be fine. You got it. But you have to give and you have to be the emotional center for everyone. And I think that translates almost directly into nursing because it's a caring profession.”

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**Summary: The Grounded Theory of Altruism**

The collection of categories was discovered through comparative analysis of the data derived from individual interviews, field notes, and memos. The participants spoke about compassionate care in their practice and the adversity that they faced through semi-structured interviews. In doing so, they described the process of how they provided compassionate care in the face adversity. The following four categories emerged and are representative of what the data signified.

1. **Adversity**

   To get a better understanding of what adversity medical-surgical nurses faced, the researcher asked each of the participants what they faced. Through their responses, they defined *adversity* as not enough staffing, not enough time to providing compassionate care, fear of catching an infectious disease, not accepting of compassionate care, and limited resources. Despite this adversity, the participants found the why and how to continue to provide compassionate care to their patients.

2. **Why Medical-Surgical Nurses Provide Compassionate Care**
Responses that led to the emergence of this category, *why medical-surgical nurses provide compassionate care*, represented the reason why these nurses got up every day to continue to provide compassionate care. These medical-surgical nurses felt that providing compassionate care was their moral responsibility and a “badge of honor” that they could wear proudly. They continued to provide compassionate care because it “filled them up” or gave them fulfillment and purpose.

3. How Medical-Surgical Nurses Provide Compassionate Care

Responses that led to the emergence of this category, *how medical-surgical nurses provide compassionate care*, represented the process of how these nurses provided compassionate care. They provided this care and explained through the concepts: step beyond, and comfort care.

4. Core Category: Altruism

Altruism represented the overarching category and process of providing compassionate care in the face of adversity. Despite the adversity that the medical-surgical nurses faced, they met adversity head on and continued to provide compassionate care, no matter the cost to themselves. They would give themselves to their patients selflessly to make connections, step into their shoes, and go above and beyond to alleviate suffering and heal their patients. These nurses felt that they had a moral responsibility and wore this “badge of honor” of being a nurse proudly. With this enormous responsibility came the risk of these medical-surgical nurses developing compassion fatigue when they did not take care of themselves.
Mixed-Method Findings

The mixed-method approach used in this study was the explanatory sequential design in which there are two phases. In the first phase, significant quantitative data were obtained using the CCS. In the second phase, qualitative data were collected through interviews from a smaller purposeful sample. Although there were significant data collected from the CCS, there was greater emphasis on the qualitative data collection. In this design, the qualitative data informed the quantitative data. The researcher examined the connection between these two groups and triangulated the results of descriptive statistics from the quantitative strand to the rich descriptions of what it means to be a compassionate nurse provided by the medical-surgical nurses. Independent findings of the quantitative and qualitative strands have been combined and analyzed in this section to answer the mixed-method questions:

1. (RQ 10) Do the quantitative items uphold prominent concepts discovered in the qualitative data? Which specific examples from the qualitative data (interviews) provide the best insight into the quantitative results?

2. (RQ 11) To what extent does the qualitative data contribute to an enhanced interpretation and understanding of the relationships discovered among the quantitative variables?

Quantitative and qualitative data were compared by quantifying the qualitative data. This procedure is referred to quantitizing (Creswell & Clark, 2011). The qualitative data were quantitized to determine the frequency of words pertaining to compassion and compassion-related categories (communication, sensitivity, and insight) appeared in the qualitative data. Quantizing the data further shows the relationship between the quantitative data and qualitative data (see Table 11). In this integrated analysis, quantitative and qualitative analysis results were merged to expand understanding of the findings (Creswell & Clark, 2018a). Products of
descriptive and correlation statistics used to analyze compassion competence and the prominent categories discovered in comparative analysis of individual interviews were combined to create a matrix and hierarchical categorization of merged findings.

Table 11

Cross-Tabulation of Quantitative and Qualitative Data

Frequency Table of Compassion, Communication, Sensitivity, Insight, and Related Concepts

<table>
<thead>
<tr>
<th>Category</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compass</td>
<td>347</td>
</tr>
<tr>
<td>Gain Trust (Total)</td>
<td>72</td>
</tr>
<tr>
<td>Gain Trust (Understanding)</td>
<td>35</td>
</tr>
<tr>
<td>Gain Trust (Personal Interest)</td>
<td>12</td>
</tr>
<tr>
<td>Gain Trust (Listening)</td>
<td>17</td>
</tr>
<tr>
<td>Gain Trust (Good communication)</td>
<td>3</td>
</tr>
<tr>
<td>Gain Trust (Education)</td>
<td>6</td>
</tr>
<tr>
<td>Instill Hope</td>
<td>18</td>
</tr>
<tr>
<td>Sensitivity</td>
<td>16</td>
</tr>
<tr>
<td>Gain Trust (Attentiveness)</td>
<td>7</td>
</tr>
<tr>
<td>Gain Trust (Acknowledge Feelings)</td>
<td>4</td>
</tr>
<tr>
<td>Show Respect</td>
<td>9</td>
</tr>
<tr>
<td>Insight</td>
<td>82</td>
</tr>
<tr>
<td>Step into Patients’ Shoes (Empathy)</td>
<td>47</td>
</tr>
<tr>
<td>Moral Responsibility</td>
<td>22</td>
</tr>
<tr>
<td>Going Above Beyond</td>
<td>7</td>
</tr>
<tr>
<td>Comfort Care</td>
<td>6</td>
</tr>
</tbody>
</table>

Note. Compassion was the common category that was seen throughout all the interviews. The categories of Communication, Sensitivity, and Insight were the sub-categories of the CCS. The italicized categories were categories that emerged from the Grounded Theory of Altruism, and the other concepts are related sub-categories from the Grounded Theory of Altruism.

RQ 10: Do the quantitative items uphold prominent concepts discovered in the qualitative data?

Which cases provide the best insight into the quantitative results? Overall, the answer is yes, as presented in Tables 12–14 and is explained further as narrative. A cross-tabulation analysis was performed to compare quantitative variables and qualitative concepts. A matrix of quantitative items and qualitative concepts drawn from the grounded theory of altruism was developed.
Tables 12–14 aided in presenting and interpreting the data in a meaningful way.

**Table 12**

**Integrated Quantitative and Qualitative Data — Subscale of Communication**

<table>
<thead>
<tr>
<th>Subscale in CCS</th>
<th>Corresponding CCS Item with the following statements</th>
<th>Corresponding Concepts from Grounded Theory of Altruism</th>
<th>Corresponding subcategory of Grounded Theory of Altruism</th>
<th>Qualitative Exemplar Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can express compassion toward patients through communication with them.</td>
<td>I can express compassion toward patients through communication with them.</td>
<td>4 – Agree</td>
<td>Instill Hope</td>
<td>Bobby: “You tell the patient that everything will be alright. If everything will go on well, nothing will happen to him or her. If they go through the surgery, they just will recover, and they will have all the support that they need during the hard time that they are facing.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 – Strongly Agree</td>
<td></td>
<td>Helen: “... the way I see my patient, I see it makes the patient feel as much as they have their family and their friends out there, they also feel that they have support, and they have someone inside the hospital who can actually understand them… which is very good and very essential for their recovery.”</td>
</tr>
<tr>
<td>I am aware of how to communicate with patients to encourage them.</td>
<td>I am aware of how to communicate with patients to encourage them.</td>
<td>5 – Strongly Agree</td>
<td>Show Respect</td>
<td>Betty: “And some of the ways that I provide the compassionate care, for example, is showing respect to the patient. I show them that I respect them, I respect their ideas, I respect whatever it is that they want to do. And even if sometimes they tell me that I am not agreeing with…”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 – Strongly Agree</td>
<td></td>
<td>Matty: “I really listen to whatever it is that they have to say. And I always, as much as possible, I always try and respect their opinions and be attentive to whatever it is that they're telling me.”</td>
</tr>
<tr>
<td>In conversation, I have a sense of humor to induce a good mood in my patients.</td>
<td>In conversation, I have a sense of humor to induce a good mood in my patients.</td>
<td>5 – Strongly Agree</td>
<td></td>
<td>Jack: “we decide to provide compassionate care by providing good words. The process is. So, we show our words for interest, like, try and provide conversation with the patients.”</td>
</tr>
<tr>
<td>Patients express their concerns and difficulties about diseases to me.</td>
<td>Patients express their concerns and difficulties about diseases to me.</td>
<td>1 – Strongly Disagree</td>
<td>Attentiveness - Listening</td>
<td>Joe: “I show emotional support during difficult times and during patients' treatment and recovery. I make sure that the bond between me and my patient is solidified. I become an active listener to my patients. We discuss their health issues…”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 – Strongly Agree</td>
<td></td>
<td>Colen: “And I tend to listen to them and get to understand them, get to understand their problems, what they're thinking…”</td>
</tr>
<tr>
<td>I try to support patients through nursing to help them overcome their problems.</td>
<td>I try to support patients through nursing to help them overcome their problems.</td>
<td>5 – Strongly Agree</td>
<td>Attentiveness - Personal Interest</td>
<td>Paul: “It's actually is a very good option to follow the patient, determine where to start from, whether to start from medication or to start from the psychological/hospital fee.”</td>
</tr>
<tr>
<td>When communicating with patients, I respond to them with proper nonverbal presentation.</td>
<td>When communicating with patients, I respond to them with proper nonverbal presentation.</td>
<td>4 – Agree</td>
<td>Attentiveness - Listening</td>
<td>Junior: So I try my best to listen to my patients and I'm trying to also pick those unspoken on some that is at times, a patient explains some things how they feel, but there are a lot of things that they don't say. So through my listening skills, I'm unable to understand how they feel from the unspoken feeling, from unspoken emotions they express.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 – Strongly Agree</td>
<td></td>
<td>Kevin: “I try and listen to them, through body language, and try to make eye contact with them”</td>
</tr>
<tr>
<td>I participate in education to develop interpersonal relationships skills with patients, colleagues, etc.</td>
<td>I participate in education to develop interpersonal relationships skills with patients, colleagues, etc.</td>
<td>5 – Strongly Agree</td>
<td>Attentiveness - Education</td>
<td>Alice: “There was this diabetic patient who was advised to have his leg amputated. I decided to sit with him. I offered him psychological counseling, and then I took my time with him. I talked to him and finally, the next day he decided to go ahead with the surgery.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 – Strongly Agree</td>
<td></td>
<td>Barry: “There was this boy that had taken poison, OPP. So when I first hit poisoning, so I sat him and asked him what was the problem. And he refused at first. So every day I used to go and talk to him every day, creating light...until I gained his trust. And he told me that his parents were really mistreating him. So I talked with the parents and the family talked with each other and they...”</td>
</tr>
</tbody>
</table>
I can provide the required emotional support to patients appropriately.

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Corresponding CCS Item with the following statements</th>
<th>Corresponding Concepts from Grounded Theory of Altruism</th>
<th>Corresponding subcategory of Grounded Theory of Altruism</th>
<th>Qualitative Exemplar Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitivity</td>
<td>I am careful of my speech and behaviors so as to avoid hurting my patients’ feelings.</td>
<td>Show Respect</td>
<td>Attentiveness</td>
<td>Jacqueline: “I show them that I respect them, and I do things that communicate respect to them. I talk to them nicely.”</td>
</tr>
<tr>
<td></td>
<td>I always pay attention to what the patients say.</td>
<td>Gain Trust</td>
<td>Attentiveness</td>
<td>Junior: “... to share that compassionate feeling that with someone who share the same thing with you, because some patient you try your best to listen to them, provide that emotional support, using a good, a positive voice, body language”</td>
</tr>
<tr>
<td></td>
<td>I promptly respond to patients when they ask for attention.</td>
<td>Gain Trust</td>
<td>Attentiveness</td>
<td>Helen: “When one of the patients wants to talk to me, I really make sure that I'm very attentive and I show the patient that I'm really interested in whatever it is they want to say. I also provide the patients with an opportunity to share their thoughts and feelings.”</td>
</tr>
<tr>
<td></td>
<td>I am tolerant of others’ opinion.</td>
<td>Show Respect</td>
<td></td>
<td>Betty: “And some of the ways that I provide the compassionate care, for example, is showing respect to the patient. I show them that I respect them, I respect their ideas, I respect whatever it is that they want to do. And even if, sometimes they tell me that I am not agreeing with, I show them that, first of all, I respect what they’re saying.”</td>
</tr>
<tr>
<td></td>
<td>I am well aware of changes in my patients’ emotional condition.</td>
<td>Gain Trust</td>
<td></td>
<td>Joe: “I had to take my time, think on how to approach the guy, because people have different personalities. So, all you do, you just decide on how to do it. So, I made my small researches. The next day when I had to take care of the guy, I was prepared...”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Barry: “For example, I may try and understand the feelings of the patient while doing so, it might help them to get better relief. This is because you support the emotional needs.”</td>
</tr>
</tbody>
</table>
Paul: “It goes a long way in the sense that you have to show some sort of connection, some sort of relationship connection with, with your patient. And it's quite demanding on a job to say to the least, because it's about the showing some emotional support, which can less... Lessen the depression and stretching the patients to be able to survive. So if that really, really is the case, then it can really overemphasize the need to show love and compassion to the patient.

Table 14

Integrated Quantitative and Qualitative Data—Subscale of Insight

<table>
<thead>
<tr>
<th>Subscale in CCS</th>
<th>Corresponding CCS Item with the following statements</th>
<th>Corresponding CCS Score</th>
<th>Corresponding Concepts from Grounded Theory of Altruism</th>
<th>Corresponding subcategory of Grounded Theory of Altruism</th>
<th>Qualitative Exemplar Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insight</td>
<td>I am intuitive about patients because of my diverse clinical experience.</td>
<td>4 – Agree</td>
<td>Badge of Honor</td>
<td>Attentiveness</td>
<td>Josie: “I think that specifically in med-surg nursing, and then I guess, even more specifically in COVID nursing as of the last almost two years here, compassionate nursing went from being able to provide emotional and physical support in addition to your medical care, to being the sole purpose person responsible for emotional, mental, spiritual, and physical well-being for that person for upwards of three weeks, because at most places at my particular institution, nursing is one of the few people that still go into the room with the patient.”</td>
</tr>
<tr>
<td></td>
<td>I offer customized care to patients by taking their characteristics into consideration.</td>
<td>3 – Neutral</td>
<td>Gain Trust</td>
<td>Attentiveness</td>
<td>Kristen: “I think the biggest thing is just setting aside the time to listen to patients whenever possible. Because even just if it can only be a couple of minutes, just hearing their story will let them know that you do care. And you try not to tell them that they're one of six patients or whatnot and you have somewhere else you have to be. But at the same time, you need to kind of get your point across that, “Okay. I would love to hear your entire story, but I just can't right now.” And then I'll try and come back a little bit later.”</td>
</tr>
<tr>
<td></td>
<td>I look after patients without being influenced by personally challenging situations.</td>
<td>5 – Strongly Agree</td>
<td>Compassion fatigue prevention (did not make it into grounded theory)</td>
<td>Attentiveness</td>
<td>Eliza: “But because of that I don't leave my shifts feeling as close of a relationship with the patients as I did when I worked on the day shift. So I do notice that difference, but I try to spend as much time with them as appropriate. I try to do things like make sure that when I'm speaking to the patient, that I'm looking at them and, use touch as appropriate.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 – Strongly Agree</td>
<td></td>
<td></td>
<td>Junior: “Like talking, going an extra step of getting them to know from their background, family background, their experiences of life. That is understanding the patient experiences from his own range.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 – Strongly Agree</td>
<td></td>
<td></td>
<td>Kristen: “So one of my goals that I always tell my nurses... and the nurses I work with is make it your goal to walk away each day knowing one personal fact about a patient... and not something medical, just something, whether they have a dog. Make sure you've seen the picture of a dog if that's what is something that brings them joy.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 – Strongly Agree</td>
<td></td>
<td></td>
<td>Betty: “I think we should also empower self-care among the nurses, make sure that the nurses are taking care of themselves—that is emotionally. Because of course you can't give what you don't have. If you don't have love within you, you can't really love someone else, if you don't have that in you. That is how I feel; we can do it better.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 – Strongly Agree</td>
<td></td>
<td></td>
<td>Jacqueline: “Most of the time, I try to do an activity that I can distract myself with. And I try to make sure that, I don't know, the things in the hospital, I leave them in the hospital so that they cannot affect my daily activities back at home with my family and all that.”</td>
</tr>
</tbody>
</table>
I can empathize well with difficulty.

5 - Strongly Agree

4 - Agree

5 - Strongly Agree

4 - Agree

4 - Agree

Step into Patients' Shoes (Empathy)

Burry: “For example, I may try and listen carefully to what the patient is saying and try and be empathetic toward their feeling. It's trying to put myself in their shoes.”

Bobby: “First, you have to understand the patient, talk to him or her, what he likes or what he doesn't like. You see, with that, you will create an environment that is for the patient, knowing what he or she likes, knowing what the patient wants to be done.”

Carrie: “...always try to like acknowledge their feelings, try to reason with them, try to understand whatever it is that they're feeling and also show that I actually see further with their situation.”

Derrick: “Compassionate care is that care that is...How can I put it? It's close to the patient. The patient really feels that you are really part of the disease process.”

Derrick: “You have to be with them emotionally to help the patient in accepting the condition, accepting how the management goes along, being with the patient and being empathetic with the patient alone, emotionally, how the patient is being trained emotionally in their pain and everything.”

Note. The anchors of Agree and Strongly Agree were added to these tables to show the example of exemplars combining the categories of the CCS and categories found in the Grounded Theory of Altruism. Neutral and Strongly Disagree (not shown in Tables 12–14) gave cumulative scores of low CCS scores, which gave the researcher an opportunity to use maximum variation sampling, comparing responses of participants with high CCS and low CCS scores.

Overall, the CCS instrument variables uphold the prominent concepts discovered in the qualitative data. The only item from the CCS, with the subscale of insight that does not coincide with the qualitative concepts, was “I look after patients without being influenced by personally challenging situations.” There was an example of a supporting statement from the qualitative data by Betty:

I think we should also empower self-care among the nurses, make sure that the nurses are taking care of themselves—that is emotionally. Because of course you can't give what you don't have. If you don't have love within you, you can't really love someone else, if you don't have that in you. That is how I feel; we can do it better.

Compassion fatigue prevention was one of the categories discovered in the data analysis but was not a prominent category in the grounded theory of altruism.

The prominent concepts that emerged from the data also represent specific items from the CCS instrument. The concepts of badge of honor, instill hope, show respect, gain trust, and step into
the patients’ shoes (Empathy) are all represented in Tables 12–14. The item from the CCS that upholds the prominent concept of badge of honor is “I am intuitive with my diverse clinical experience.” Josie shared an example that connects and shows her clinical experience:

I think that specifically in med-surg nursing, and then I guess, even more specifically in COVID nursing as of the last almost two years here, compassionate nursing went from being able to provide emotional and physical support in addition to your medical care, to being the sole purpose person responsible for emotional, mental, spiritual, and physical well-being for that person for upwards of three weeks, because at most places at my particular institution, nursing is one of the few people that still go into the room with the patient.

The item from the CCS that upholds the prominent concept of instill hope is “I can express compassionate towards patients through communication with them” As stated by Bobby,

You tell the patient that everything will be all right. If everything will go on well, nothing will happen to him or her. If they go through the surgery, they just will recover, and they will have all the support that they need during the hard times that they are facing.

There were three items from the CCS that uphold the prominent concept of show respect. One of the items is, “I am aware of how to communicate with patients to encourage them.” As stated by Betty,

And some of the ways that I provide the compassionate care, for example, is showing respect to the patient. I show them that I respect them, I respect their ideas, I respect whatever it is that they want to do. And even if sometimes they tell me that I am not agreeing with…

There are 12 items from the CCS that upholds the prominent concept of gain trust. One of the
items from the CCS is “Patients express their concerns and difficulties about diseases to me.” An example of this was stated by Joe:

I show emotional support during difficult times and during patients’ treatment and recovery. I make sure that the bond between me and my patient is solidified. I become an active listener to my patients. We discuss their health issues...

The item from the CCS that upholds the prominent concept of “steps into patients’ shoes” is “I can empathize well with patients’ difficulties.” One of the examples by Carrie was,

…always try to like acknowledge their feelings, try to reason with them, try to understand whatever it is that they're feeling and also show that I actually see further with their situation.

RQ 11: To what extent does the qualitative data contribute to an enhanced interpretation and understanding of the relationships discovered among the quantitative variables?

The data support that medical-surgical nurses rated themselves higher in the CCS during the night, the more direct patient care they gave, the more patients that they had, and working mandatory overtime. The correlation of having a high CCS or high compassion competence with mandatory overtime was interesting because it is contrary to what was found in another study. In a study by Kim et al. (2021), it was found that long working hours and increased direct patient care increased the likelihood of severe compassion burnout. The first group of qualitative participants \( n = 24 \) rated themselves with a higher CCS score of 73 and above. When the additional three interviews were obtained from those who rated themselves with a lower CCS (22, 59, 60), the same categories and concepts were identified as their higher scoring counterparts. This was also reflected in Tables 12–14. This integration of the data supports the fact that medical-surgical nurses provide compassionate care due to their altruistic nature of
providing this care, no matter the cost to themselves.

**Summary of Mixed-Methods Findings**

The mixed-method analysis was comprised of combining quantitative and qualitative data for meaningful interpretation. Together, the quantitative and qualitative answered the mixed-methods research questions: Do the quantitative items uphold the prominent concepts discovered in the qualitative data? To what extent do the qualitative data contribute an enhanced interpretation and understanding of the relationships discovered among the quantitative items? Findings from the quantitative analyses were concurrent with the findings from the qualitative analyses. Overall, with exception of one item from the CCS, “I look after patients without being influenced by personally challenging situations,” the instrument items upheld the prominent themes discovered in the qualitative data. The instrument measure of compassion competence for the qualitative participants revealed that the qualitative sample \( n = 27 \) had mostly high CCS scores \( 24/27 \) and the last 3 who were interviewed had low CCS scores \( 3/27 \). The most prominent categories from the grounded theory of altruism were badge of honor, instill hope, show respect, and step into patients’ shoes. Each of these concepts was directly connected to most of the items on the CCS, with a corresponding statement from the qualitative interviews. The matrix Tables 12–14 showed the relationship among the CCS items, the prominent concepts, the score the interview participant scored for each item, and the corresponding statement from the qualitative data. The integration of the quantitative and qualitative data showed that regardless of the CCS score, medical-surgical nurses continued to provide compassionate care through their altruistic nature, no matter the cost. Chapter 5 provides a discussion of the findings from the quantitative, qualitative, and mixed-method analyses.
CHAPTER 5: DISCUSSION

The purpose of this chapter is to discuss the findings of the study by integrating the problem statement, purpose, and relevant literature. After a summary of the study, the triangulated results are discussed, along with the application of the theoretical framework. Implications to nursing practice, limitations, and recommendations for future research are presented.

Summary of the Study

Through the integration of the Human Caring Theory by Watson (1988), this explanatory sequential mixed-method study sought to explore and describe the process in which medical-surgical nurses provided compassionate care in the face of adversity. In the explanatory sequential design, there are two phases. In the first phase, the quantitative instrument used was the CCS. The data suggested that the sum of the CCS increased as the number of patients the medical-surgical nurses cared for during a shift increased, as the medical-surgical nurses working mandatory overtime increased, and as the nurses increased the percentage of direct patient care. The data also suggested that the sum of the CCS scores were slightly higher among medical-surgical nurses working the night shift.

In the participation selection variant of explanatory sequential design, details or characteristics found in the large group that was collected by CCS were extracted and used to select a smaller purposeful sample. Twenty-four interview participants were chosen from the 103 medical-surgical nurses who participated in the quantitative strand. These participants had high CCS scores. For comparison and for maximum variation sampling, three additional interviews were conducted from those who scored lower in the CCS to further trim the grounded theory being developed. The grounded theory of altruism provided an explanation of how medical-
surgical nurses provided compassionate care in the face of adversity. Facing adversity while providing compassionate care was identified as the basic social physiological process. The core concept of the theory was altruism. There were two major constructs of why and how medical-surgical nurses provide compassionate care, and their related causal, contextual, and intervening conditions were discovered.

Independent findings of the quantitative and qualitative strands were combined to triangulate the results. Overall, the CCS instrument variables upheld the prominent concepts discovered in the qualitative data. The only item from the CCS, with the subscale of insight that did not coincide with the qualitative concepts, was “I look after patients without being influenced by personally challenging situations.” The prominent concepts from the grounded theory that were connected to the items of the CCS were the concepts of badge of honor, instill hope, show respect, gain trust, and step into patients’ shoes (empathy). The integration of the quantitative and qualitative data showed that regardless of the CCS score, medical-surgical nurses continued to provide compassionate care through their altruistic nature, no matter the cost.

Discussion of Findings

Compassion is an abstract concept that has been studied with quantitative and qualitative methods. Mixed-method research integrates quantitative and qualitative techniques that contributes to an enhanced interpretation of the data. Due to the complexity of the concept of compassion, research was more complete by combining the two methods. The mixed-method approach used in this study was the explanatory sequential design. Although there were significant data collected from the CCS, there was greater emphasis on the qualitative data collection. In this design, the qualitative data informed the quantitative data (Polit & Beck, 2017a). The researcher examined the connection between these two groups and triangulated the
results of descriptive statistics from the quantitative strand to the rich descriptions of what it means to be a compassionate nurse provided by the medical-surgical nurses.

In the first phase of this explanatory sequential design, quantitative data were collected using the CCS. The medical-surgical nurses’ compassion competence was determined using the 17-item CCS. The instrument provided a self-assessment of participants’ compassion competence, including the 3 subscales of communication, sensitivity, and insight. The minimum score was 17, with a max score of 85. The closer the participant’s score was to 85, the higher their CCS score was. Most of the participants had high CCS scores (87.4%) while 12.6% had low scores. Pearson’s correlation was used to find relationships among demographic data and CCS scores. There were correlations found among shift, number of patients, percentage of direct patient care, and mandatory overtime with the CCS scores. The quantitative data suggest that regardless of working nights, the increased number of patients, higher percentage of direct patient care, and working mandatory overtime, the medical-surgical nurses still assessed themselves with high compassion competence. The correlation of having a high CCS or high compassion competence with mandatory overtime and higher percentage of direct patient care were interesting because it is contrary to what was found in another study. Kim et al. (2021) found that long working hours and increased direct patient care increased the likelihood of severe compassion burnout. Perhaps this sample of AMSN nurses had a good balance of self-care that enhanced their self-efficacy and allowed them to continue maintaining their high compassion competence. When new graduates and nursing students were exposed to the challenges of the Covid-19 pandemic, they remained in the profession and had self-efficacy despite being exposed to the stress of the job through self-care practices (Mannino et al., 2021). Other self-care practices that can reduce stress, compassion fatigue, or burnout can be the use of “serenity
lounge” (p. 40) or lounge where nurses can de-stress in a massage chair and listen to serene music during their lunch break (Pagador et al., 2022); or they can participate in Schwartz Center Rounds in which healthcare providers have discussions on difficult topics during their daily routine. Healthcare providers who have participated in the rounds reported improved collaboration, communication, decreased stress and compassion fatigue, and increased compassion and desire to decrease the suffering of their patients (Whitehead et al., 2022). Other examples of self-care programs that provide support to healthcare professionals are the development of a formal support system like the Peer Support Network and providing compassion training like the GRACE program that offers strategies to decrease compassion fatigue (Victorson et al., 2021), which are discussed further in this section.

In the second phase of this explanatory sequential design, qualitative data were collected through semi-structured individual interviews. To further guide the interview process, appreciative inquiry was used as a model of questioning, using the four Ds: Discovery, Dream, Design, and Destiny/Deliver (Cooperider & Whitney, 2020). Using the interview format provided the researcher a positive perspective on how the medical-surgical nurse provided compassionate care to their patients facing adversity.

Facing adversity while providing compassionate care was the basic social-psychological process discovered. All the medical-surgical nurses encountered adversity while providing compassionate care to their patients. The top three examples in this study of adversity were not enough staffing, not enough time to provide compassionate care, and patients not accepting of compassionate care provided. Other examples of adversity were the fear of catching an infectious disease and the lack of resources. In a recent study by Abuatiq and Borchardt (2021), the occupational stresses or adversity that nurses faced during the Covid-19 pandemic in a tertiary
acute facility were: “wearing a face mask at all times in a hospital, unpredictable staffing and scheduling, not enough staff to adequately cover the unit, feeling helpless in case a patient fails to improve and being assigned a Covid-19 patient” (p. 600). This adversity was echoed in the words of the participants in this study. With the concept of not enough staffing, the medical-surgical nurses caring for a high ratio of patients made it difficult for them to provide the best care that they could give to all of their patients. With not enough time to provide compassionate care as an example of adversity, the medical-surgical nurses felt they were so busy that they could not spend enough time with their patients. There was conflict of the attempt to provide compassionate care when meeting resistance from the patients who were not accepting of the compassionate care provided. Some nurses also feared catching an infectious disease when providing compassionate care. When nurses have the perception that they are protected from infectious disease, they are less likely to have severe compassion burnout (Kim et al., 2021).

Medical-surgical nurses were challenged in providing compassionate care with limited resources. Although these medical-surgical nurses were faced with adversity, they took on these challenges and found the why and the how of providing compassionate care.

This study identified two main categories within the grounded theory of altruism: (a) why medical-surgical nurses provide compassionate care and (b) how medical-surgical nurses provide compassionate care. The why is the reason these medical-surgical nurses continued to provide compassionate care. The concepts within the category of why medical-surgical nurses provide compassionate care are (a) moral responsibility, (b) badge of honor, and (c) fills them up.

The first reason nurses provided compassionate care is that they felt providing compassionate care is their “moral responsibility” or that they needed to provide compassionate
care because it was “the right thing to do.” The second concept within *why medical-surgical nurses provide compassionate care* category is “badge of honor.” They felt that they wear this “badge of honor” by providing compassionate care to their patients. They felt that they are trusted with this great honor of being a nurse and are proud to be in this profession. The third concept within *why medical-surgical nurses provide compassionate care* category is “fills them up.” They have compassion satisfaction or “fills them up” when they provide care to their patients. These medical-surgical nurses felt that when they made a difference for the patients, they felt fulfilled, which reminded them of the reason why they went into nursing.

The how provides information on the process of providing compassionate care. The concepts within the category of *how medical-surgical nurses provide compassionate care* are (a) step into the patients’ shoes, (b) gain trust, (c) instill hope, (d) show respect, (e) going above and beyond, and (f) comfort care. The first concept of *how medical-surgical nurses provide compassionate care* is “steps into patients’ shoes” (empathy). The medical-surgical nurses felt that they had a better understanding of their patients’ needs by being empathic toward their patients. The second concept of *how medical-surgical nurses provide compassionate care* is “gain trust.” They provided compassionate care by gaining their patients’ trust. They gained their patients’ trust by being attentive and made connections with their patients. Through active listening, the nurses showed their attentiveness, made connections with their patients, showed that they care, and individualized their patients’ care through collaboration with the patients and families. How patients perceive this simple act of listening made the difference in the compassionate care that nurses deliver because the patients felt that they formed a partnership with their nurse (Loos, 2021). Ensuring that good communication is maintained through innovative techniques, despite challenges with PPE or social distancing, can further strengthen
patient and family involvement in the patients’ plan of care and maintain compassionate care that
patients need (Pariseault, 2022). The third concept in *how medical-surgical nurses provide
compassionate care* is “instill hope.” They provide compassionate care by encouraging them and
providing hope. The fourth concept in *how medical-surgical nurses provide compassionate care*
is “show respect.” They provide compassionate care by showing respect to their patients. The
fifth concept in *how medical-surgical nurses provide compassionate care* is “going above and
beyond.” Sometimes, these need to go above and beyond for their patients. The sixth concept in
*how medical-surgical nurses provide compassionate care* is “comfort care.” Nurses provided
their patients with comfort care because the patients may not be able to help themselves.

These categories or constructs have an overarching theme of altruism, and concepts
related to this are (a) selflessness and (b) no matter the cost to themselves. The first concept of
selflessness is that nurses are selfless when they provide compassionate care to their patients.
The second concept is *no matter the cost to themselves*.

The nurses provided compassionate care despite the compassion fatigue they
experienced. Independent findings of the quantitative and qualitative strands have been
combined to triangulate the results. Overall, the CCS instrument variables uphold the prominent
concepts discovered in the qualitative data. The only item from the CCS, with the subscale of
insight that does not coincide with the qualitative concepts, is “I look after patients without being
influenced by personally challenging situations.” The prominent concepts from the grounded
theory connected to the items of the CCS were the concepts of *badge of honor, instill hope, show
respect, gain trust, and step into patients’ shoes* (empathy).

The item from the CCS that upholds the prominent concept *badge of honor* is “I am
intuitive with my diverse clinical experience.” The item from the CCS that upholds the
prominent concept of instill hope is “I can express compassionate towards patients through
communication with them.” There were three items from the CCS that uphold the prominent
concept of show respect. One of the items is, “I am aware of how to communicate with patients
to encourage them.” There are 12 items from the CCS that upholds the prominent concept of
gain trust. One of the items from the CCS is “Patients express their concerns and difficulties
about diseases to me.” The item from the CCS that upholds the prominent concept of steps into
patients’ shoes is “I can empathize well with patients’ difficulties.”

In the application of the five observations per variable, 40 observations were needed to
ensure sufficient data analysis. After having the CCS open for about four months, the researcher
received 103 potential participants, obtaining more than enough observations for sufficient data
analysis. The data support that the medical-surgical nurses rated themselves higher in the CCS if
working the night shift, the more direct patient care they gave, the more patients that they had,
and working mandatory overtime; this all seems opposite of studies previously reviewed. The
previous studies showed that the more patients nurses had and the more mandatory overtime they
worked, the more nurses had compassion fatigue and a greater intent to leave the profession
(Dyrbye, 2020; Lee et al., 2017; Razo et al., 2021). Most of interview participants rated
themselves with a higher CCS score. When the additional three interviews were obtained from
those who rated themselves with lower CCS scores (sum CCS = 22, 59, 60), the same categories
and concepts were echoed from their higher scoring counterparts. This integration of the data
supported the fact that medical-surgical nurses provide compassionate care due to their altruistic
nature of providing this care, no matter the cost to themselves.

Not all the data collected from these interviews were drawn to create the grounded theory
of altruism but did give insight into how nurses would want to design the perfect environment to
provide compassionate care and how leadership could support this vision. Although a perfect environment does not exist, having a healthy work environment is attainable. The medical-surgical nurses from this study felt that the environment to provide compassionate care they needed was one that had adequate staffing, supplies, privacy for their patients, and good teamwork. As stated by Josie about staffing, “just having the staff on the floor to be able to go into a room for 20 minutes and sit down and talk to a patient, just little things like that.” Leonard made a statement about supplies: “It makes everything successful because we give them what they don't have and help them provide the care that they should be providing to the patient.” Another medical-surgical nurse Derrick talked about privacy, you can be able to now go separately to those patients and then you can be able to talk to them separately, so that one patient can't be able to know what exactly you're speaking with the other one.

Teamwork helps with workflow, as stated by Oscar:

I think the ability of all nurses to unite as a one group to do all the work, all the nursing work, is very important. It is more of cooperation…it's really important. Rather than letting all the work be done as an individual.

Another interesting topic brought up in the design stage of appreciative inquiry was compassion training. The medical-surgical nurses felt that leadership should provide compassion training to nurses and the rest of the interdisciplinary team so that compassion can be ingrained in the entire team’s practice. One example was provided by Betty:

…hospital should be coming up with workshops and seminars to teach the nurses more on compassionate care. And the seminars and workshops should be strictly for compassionate care; nothing else should be discussed there…just teaching the nurses how
they can provide that care better and better, how we can better our services there.

Here was another example by Derrick:

I think other ways we're able to have the teaching, we educate each other, we have people who are specialists in teaching this compassionate care, who can keep on training us, so we can have things like seminars and we can be able to learn. That will be able to enhance our provision and enhancing how we can be able to provide compassionate care.

One example of compassion training was the GRACE program that was delivered to eight units in a mid-sized Southwestern hospital (Victorson et al., 2021). The GRACE training included helping the participants improve healthcare providers’ (mostly nurses) well-being by decreasing stress, providing support for compassionate care, and the recognition and promotion of compassionate care moments. This study showed that after these medical units received GRACE training, there was significant improvement in patient satisfaction scores compared to units that did not receive the training. The study by Victorson et al. (2021) showed that compassion training can alleviate compassion fatigue signs and symptoms and improve patient satisfaction scores, which support these nurses’ ideas of providing education to nurses and other healthcare professionals.

A healthy work environment can affect nurses’ intent to leave. Common reasons for nurses’ intent to leave are poor work environment, which includes decreased staff, lack of resources, and poor social capital (relationships between and among staff and leadership). When leadership attains adequate resources, such as supplies and staff, promotes congruent social capital, and supports and acknowledges the staff with their efforts of providing compassionate care, it nurtures a healthy work environment (Gensimore et al., 2020; Razo et al., 2021; Taylor-Clark et al., 2022). This was seen in the statements by the medical-surgical nurses in this study.
As stated by Helen regarding leadership support, “leadership can really help or the way that they help is by looking into the needs of the nurses and trying to solve their problems so that the nurses can deliver care even more effectively.” Jacqueline also talked about leadership support: “They should also be compassionate so that the nurses can follow their examples since they are, of course, they're our leaders. I think they should serve as our role models.” As stated by Helen about recognition:

And also I think the leaders should motivate the nurses by recognizing the nurses that perform very well in providing compassionate care. That will motivate the nurses to strive and provide the best compassionate care that they can.

Leadership support and collaboration with their staff promotes a healthy work environment, increases retention, and increases job satisfaction among nurses. Other strategies that leadership can implement are increased frequency of communication and transparency (Kim et al., 2021; Turnipseed & VandeWaa, 2022), supporting camaraderie among staff members, being present, being role models of compassion, and implementing crisis management skills being faced with adversity (Turnipseed & VandeWaa, 2022). This leadership support will also nurture the altruistic nature of their nurses and allow them to continue providing compassionate care.

The last topic that did not make it into the grounded theory of altruism was compassion fatigue and burnout prevention. Many of the nurses knew that the compassionate care they provide may lead to compassion fatigue if they did not practice self-care. They must be aware of when they need a break or pause from the care they provide. As stated by Josie:

Sometimes that requires us eight hours into our shift to be like, ‘Alright, I can't answer this guy's light next. I need just someone else to answer his light. I need one more
break... I think one of the biggest things I've learned during all of this is that if I don't have things to fill me up outside of work, then I can't take care of anyone else.

Participants also stated the importance of self-care, as stated by Betty:

I think we should also empower self-care among the nurses, make sure that the nurses are taking care of themselves—that is emotionally. Because of course you can't give what you don't have. If you don't have love within you, you can't really love someone else, if you don't have that in you. That is how I feel; we can do it better.

Some of the participants would do a hobby, exercise, or gain support from co-workers or family and friends. A program that developed a support system within the healthcare system is a study by Wahl et al. (2018). In this study, 20 nurses from a Midwestern trauma center went through Peer Support Network training to help alleviate compassion fatigue in their colleagues. There were statistically and nonstatistical improvement in compassion fatigue noted with staff that had the support from the training.

Also seen in compassion fatigue prevention is the concept of resilience. As stated by Josie,

And so I think that a lot of nurses didn't realize that they weren't filling themselves up appropriately, caring for themselves appropriately. The word resilience has been thrown around like a hot cake during COVID, but really not knowing how to be resilient, not knowing how to actually perform self-care...like self-care isn't just doing a face mask every once in a while. Self-care is internal and external and really making sure that you are caring for yourself or that you're having people around you that know how to fill you up so that you can give that compassionate care to the people that need it at your work. But the time to learn that isn't during a pandemic; it's before that. And so that you can use those skills and those tools to be able to push through that resiliency during the time of
stress.

Kim et al. (2021) studied severe burnout and poor mental health among healthcare professionals during the Covid-19 pandemic and found that resilience was an important factor. In that study, one-third of the participants reported severe compassion burnout, and having high resilience lowered the likelihood of participants developing stress and depression. Compassion fatigue prevention can provide nurses what they need to replenish themselves so they can continue to provide compassionate care.

**Integration of Theoretical Framework**

Watson’s (1998) theory of human caring can be integrated with this study based on Watson’s concept of *caritas*. As stated by Sitzman and Watson (2017), “*Caritas* is a Latin word that means to cherish, appreciate, and give special or loving attention with charity, compassion, and generosity of spirit” (p. 26). Watson’s first five Caritas can be found within the grounded theory of altruism that was developed. The overarching theme of the grounded theory of altruism is consistent with the first caritas process of “embrace altruistic values and practice loving kindness with self and others” (Sitzman & Watson, 2017, p. 26). An example of this was provided by Josie in her own words:

> compassionate nursing went from being able to provide emotional and physical support in addition to your medical care, to being the sole purpose person responsible for emotional, mental, spiritual, and physical well-being…

The second caritas process of “be authentically present, instill faith and hope, and honor others” (Sitzman & Watson, 2017, p. 29) coincides with the concept of *instill hope* within the category of “how medical-surgical nurses provide compassionate care.” One example of *instill hope* by Bobby was,
You tell the patient that everything will be all right. If everything will go on well, nothing will happen to him or her. If they go through the surgery, they just will recover, and they will have all the support that they need during the hard time that they are facing.

The third caritas process of “be sensitive to self and others by nurturing individual beliefs and practices” (Sitzman & Watson, 2017, p. 31) coincides with the concept of show respect within the category of “how medical-surgical nurses provide compassionate care.” As illustrated by Matty: “I really listen to whatever it is that they have to say. And I always, as much as possible, I always try and respect their opinions and be attentive to whatever it is that they're telling me.” The fourth caritas process of “develop helping-trusting-caring relationship” (Sitzman & Watson, 2017, p. 34) and the fifth caritas process of “promote and accept positive and negative feelings as you authentically listen to another's story” (Sitzman & Watson, 2017, p. 37) coincide with the concept of step into the patients’ shoes within the category of “how medical-surgical nurses provide compassionate care.” An example of “steps into patients’ shoes” by Derrick was how you can be able to make your patients feel comfortable with you, feel like you really care about the patient; you really care about her condition and then the patient will feel comfortable around you and then will enhance you in delivering this kind of compassionate care.

The essence of Watson’s (2008) theory of human caring is felt throughout this mixed-method grounded theory of compassionate care and is echoed in the voices of these medical-surgical nurses (see Figure 4).
Limitations

There were a few limitations to the study. One limitation was that participants were not asked the years of experience of nursing practice, which would have added another interesting dimension. Another limitation was that the researcher did not ask all the participants the location of where they practiced. AMSN is a national organization, so it would have been interesting to know if there was a difference in how they practiced in different locations in the United States.
There was a limitation to the CCS because it was self-report/self-assessment of compassion competence in which most nurses would rate themselves with high compassion. Another limitation was that it was not clear once approval was attained on how the CCS and demographic questions were going to be distributed to members of the AMSN. The survey was sent out as a notification twice a month to AMSN to the link of a webpage twice a month. If the CCS and demographics were sent out to individual members via email, there would have been a higher return of surveys to the researcher. There were risks in security, with the researcher using email as correspondence. The researcher had to be vigilant to not have participants that did not answer the CCS first because there were some attempts of people trying to obtain the $25 gift card without going through the AMSN properly and start this mixed-method study process. There was a limitation with participants volunteering to be interviewed in which they self-selected themselves as compassionate nurses. Another limitation was that all the interviews were conducted via Google Meet. There was something that got lost in interviews when not done in person. Only 4 out of 27 interview participants opted to use the video option in Google Meet and the researcher was only able to observe these participants’ facial expressions and body language while interviewing them. Although using Google Meet as a medium to conduct interviews was convenient, internet connections from the interview participants were not always good. The researcher was also surprised that even with the trend of more video conferences, some participants had difficulty getting onto Google Meet and the researcher had to walk some participants through the process.

**Recommendations for Future Research**

The data collected from the interview participants from the design phase of the appreciative inquiry used in this study can be helpful in providing insight into how
compassionate care can be supported and enhanced. The participants felt that leadership support and good communication were vital in helping them get adequate staffing, resources, problem-solve, serve as role-models, and give them recognition and motivation to continue to provide compassionate care. They also felt that compassionate care training for nurses and other members of the interdisciplinary team was important to change the culture of the institution. The participants felt that this training can bring awareness of enhancing care rendered through compassion and how it improves patient outcomes. Perhaps future studies can utilize appreciative inquiry to further develop the design of providing the perfect compassionate environment and developing specific compassion training for nurses and other health care professionals to further support a compassionate care environment.

Implications to Nursing Practice

The aim of this study was to develop clinical practice recommendations regarding the provision of compassionate care. Since compassion is the essence of nursing, it needs to be nurtured, especially in the face of adversity. The adversity that nurses face every day gets more complex. This study gave specific examples of what the participants faced and how they found creative ways to continue providing compassionate care. Although not included in the grounded theory of altruism, compassion fatigue prevention was discussed in the qualitative data and in the integrated mixed-method data. With the risk of nurses developing compassion fatigue or burnout, nurses need to identify compassion fatigue or burnout symptoms and implement self-care to replenish themselves and continue to be effective healthcare providers. Understanding the grounded theory of altruism provided the process of providing compassionate care and shed insight into how nurses can continue to provide quality care to their patients. Applying the grounded theory of altruism and supporting data from this mixed-method study provides nurses
and nurse leaders valuable information to encourage the retention of nurses, reminding them of the importance of compassionate care in their practice and the badge of honor that nurses wear every day.
REFERENCES


for Nursing.


APPENDICES

Appendix A: IRB Approval

From: Patricia Eckardt <no-reply@irbnet.org>
Date: Fri, Oct 1, 2021, 11:05 AM
Subject: IRBNet Board Action
To: Diane Kret <diane.kret@gmail.com>, Elizabeth Cotter <ecotter@molloy.edu>

Please note that Molloy College IRB has taken the following action on IRBNet:

Project Title: [1778195-1] MIXED METHOD – GROUNDED THEORY STUDY - HOW DO MEDICAL-SURGICAL NURSES PROVIDE COMPASSIONATE CARE TO PATIENTS IN THE FACE OF ADVERSITY?
Principal Investigator: Diane Kret, MSN

Submission Type: New Project
Date Submitted: September 23, 2021

Action: APPROVED
Effective Date: October 1, 2021
Review Type: Exempt Review

Should you have any questions you may contact Patricia Eckardt at peckardt@molloy.edu.

Thank you,
The IRBNet Support Team

www.irbnet.org
Appendix B: Permission to use Compassion Competence Scale

Dear Youngjin Lee,
Thank you for your response and granting permission. I will absolutely share the outcome after the completion of my study.
Sincerely,
Diane Kret

On Wed, Apr 29, 2020, 3:45 AM 이영진 <yjlee531@ajou.ac.kr> wrote:
Dear Diane Kret,

Thank you for your interest in our survey instrument. We are giving you permission to use it in your research. We would like you to let us know about the outcome of the research and acknowledge us in your research.
If you have any questions, please let us know.

Sincerely,
Youngjin Lee

Youngjin Lee
Assistant professor, Ajou University College of Nursing,
164, World cup-ro, Yeongtong-gu. Suwon 16499, KOREA
T. +82-31-219-7011
E-mail. yjlee531@ajou.ac.kr

2020년 4월 29일 (수) 오전 11:18, 서문경애(GyeongAe Seomun) <seomun@korea.ac.kr>님이 작성: 전달

--------- Forwarded message --------
보낸사람: dkret1@lions.molloy.edu <dkret1@lions.molloy.edu>
Date: 2020년 4월 29일 (수) 오전 9:47
Subject: RE: permission to use instrument
To: seomun@korea.ac.kr <seomun@korea.ac.kr>

Dear Dr. Seomun,

I am a PhD student in Molloy College and I am currently in the beginning stages of writing my dissertation on compassion. I would like to have medical-surgical nurses evaluate their own compassion,
using your instrument. I was writing to you to ask permission to use your instrument.

Thank you for your time and consideration,

Diane Kret MSN, RN, NPD-BC, CMSRN, ACNS-BC
Good afternoon, Diane,

Thank you for your email. Your study has been approved to be listed on the amsn.org website.

The general process for inviting AMSN members to participate in your research is as follows:

Complete the application. (done)
Your application will be reviewed by AMSN staff and the AMSN Research Team. (Please allow up to 10 business days for review) (done)
If needed, an AMSN staff person will contact you for further information/clarification, then your new materials will be reviewed again by the Research team. (N/A)
Upon approval, you will receive an email from AMSN staff. (This email)

We will then schedule your survey information to be posted to the AMSN website on this page. (Request attached)
Requests for survey postings to amsn.org are posted two times per month (around the 1st of the month and mid-month). The posting will remain on the website through the date indicated on your application.

Notification of your survey information listed on our website will be announced, on or around the date indicated on your application, on the AMSN member community, "HUB", AMSN social media sites, and AMSN monthly enews.

I will submit the request for your research study to be added to the AMSN website for the week of 10/25. I attached the info that will be posted.

Please let me know if you have any questions.

Have a good weekend,

Donna
Appendix D: Introductory Letter to Study Participants

Dear Participant,

My name is Diane Kret and I am a student at Molloy College pursuing my PhD in Nursing. I have close to 20 years’ experience as a Medical-Surgical Nurse. My research study is a mixed method, grounded theory study entitled: How do medical-surgical nurses provide compassionate care in the face of adversity? The first part of my study are to complete demographic questions and to measure your own compassion competence using an 18-item instrument. The questions focus on 3 main factors of compassion: communication, sensitivity, and insight. It should take about 10 – 15 minutes to complete. The risks of filling out this survey are minimal since it is anonymous and includes only the inconvenience of time to answer the questions of the survey. This study may benefit you and others because this information will add to the body of knowledge to nursing. The second part of this study is an interview (if you are interested in participating) exploring how medical-surgical nurses’ providing compassionate care.

Taking part in this study is voluntary and you can choose not to participate in this survey. If you wish to participate in the survey, please click the survey link. By clicking the survey link, you are acknowledging that you have read the information in this email, you agree to volunteer, and you are physically present in the United States.

Thank you in advance for supporting a fellow medical-surgical nurse.

Sincerely,

Diane D. Kret PhD(c), RN, NPD-RN, CMSRN, ACNS-BC
Barbara H. Hagan School of Nursing and Health Sciences
Molloy College
Rockville Centre, NY
Appendix E: Demographic Survey

Age: 21-30 ____ 31-40 ____ 41-50 ____ 51-60 ____ 61-70 ____ 71 & over ____

Gender: Male ____ Female ____ Non-binary: ______

Ethnicity: Select all that apply:
African American or Black; American Indian, Alaska Native, Indigenous, or First Nations; Arab or Middle Eastern; Asian or Asian American; Hispanic or Latina/o/x; Native Hawaiian or Other Pacific Islander; White or European American

Marital Status: Single ____ Married/Partnered ______

Children: No ____ Yes ____ How many? ____

Shift: Day ____ Night ______

Educational Level: Diploma ____ Associate Degree ____ Bachelor's Degree ____ Master’s Degree ____ Doctoral Degree ______

Work in a Magnet Facility: Yes ____ No ____

On average, what percentage of your work time involves direct patient care
<25% ____ 25-50% ____ 51-75% ____ 76-100% ____

Did you take care of Covid-19 patients?
Yes ____ No ____

Advanced certification (i.e., medical-surgical certification): Yes ____ No ____

On average how many patients do you care for during one shift? 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, >10

Recently required to work unplanned or mandatory overtime: Yes ____ No ____
Appendix F: Demographics & Compassion Competence Scale created in Google Forms

Compassion Competence Scale and Demographics

Dear Participant,

My name is Diane Kret and I am a student at Molloy College pursuing my PhD in nursing. I have close to 20 years’ experience as a Medical-Surgical Nurse. My research study is a mixed method, grounded theory study entitled: How do medical-surgical nurses provide compassionate care in the face of adversity? The first part of my study is to measure compassion competence using an 18-item instrument that is a self-assessment of Compassion Competence. The questions focus on 3 main factors of compassion: communication, sensitize and insight. It should take about 10 – 15 minutes to complete. The risks of filling out this survey are minimal since it is anonymous and includes only the inconvenience of time to answer the questions of the survey. This study may benefit you and others because this information will add to the body of knowledge to nursing. The second part of this study is an interview (if you are interested in participating) exploring how medical-surgical nurses’ providing compassionate care.

Taking part in this study is voluntary and you can choose not to participate in this survey. If you wish to participate in the survey, please click the survey link. By clicking the survey link, you are acknowledging that you have read the information in this email, you agree to volunteer, and you are physically present in the United States.

Thank you in advance for supporting a fellow medical-surgical nurse.

Sincerely,
Diane D. Kret PhD(c), RN, NPD-RN, CMSRN, ACNS-BC
Barbara H. Hagan School of Nursing and Health Sciences
Molloy College
Rockville Centre, NY
Age
- 21 - 30
- 31 - 40
- 41 - 50
- 51 - 60
- 61 - 70
- 71 or older

Gender *
- Male
- Female
- Non-binary

Ethnicity - Select All That Apply: *
- African-American or Black
- America-Indian, Alaska-Native, Indigenous, or First Nations
- Arab or Middle-Eastern
- Asian or Asian American
- Hispanic or Latina/o/x
- Native Hawaiian or Other Pacific Islander
- White or European American
- Other...
Marital Status *
- Single
- Married/Partnered

Children *
- No
- Yes

Children
Description (optional)

How many children? *
Short answer text

Shift *
- Day
- Night

Highest Educational Level *
- Diploma
- Associate Degree
- Bachelor's Degree
- Master's Degree
- Doctoral Degree
Currently Work in Magnet recognized facility? *
- Yes
- No

On average, what percentage of your work time involves direct patient care? *
- <25%
- 25-50%
- 51-75%
- 76-100%

Do you have an advanced certification (i.e. Medical-Surgical Certification)? *
- Yes
- No

On average how many patients do you care for during one shift? *
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- >10
Did you care for Covid-19 patients? *
- Yes
- No

Were you ever required to work unplanned or mandatory overtime? *
- Yes
- No

I can express my compassion towards patients through communication with them. *
- 1 - Strongly Disagree
- 2 - Disagree
- 3 - Neutral
- 4 - Agree
- 5 - Strongly Agree

I am aware of how to communicate with patients to encourage them. *
- 1 - Strongly Disagree
- 2 - Disagree
- 3 - Neutral
- 4 - Agree
- 5 - Strongly Agree
In conversation, I have a sense of humor to induce a good mood in patients.

- 1 - Strongly Disagree
- 2 - Disagree
- 3 - Neutral
- 4 - Agree
- 5 - Strongly Agree

Patients express their concerns and difficulties about diseases to me.

- 1 - Strongly Disagree
- 2 - Disagree
- 3 - Neutral
- 4 - Agree
- 5 - Strongly Agree

I try to support patients through nursing to help them overcome their problems.

- 1 - Strongly Disagree
- 2 - Disagree
- 3 - Neutral
- 4 - Agree
- 5 - Strongly Agree

When communicating with patients, I respond to them with proper nonverbal presentation.

- 1 - Strongly Disagree
- 2 - Disagree
- 3 - Neutral
- 4 - Agree
- 5 - Strongly Agree
I participate in education to develop interpersonal relationship skills with patients, colleagues, etc.

- 1 - Strongly Disagree
- 2 - Disagree
- 3 - Neutral
- 4 - Agree
- 5 - Strongly Agree

I can provide the required emotional support to patients appropriately.

- 1 - Strongly Disagree
- 2 - Disagree
- 3 - Neutral
- 4 - Agree
- 5 - Strongly Agree

I am careful in my speech and behaviors so as to avoid hurting my patient’s feelings.

- 1 - Strongly Disagree
- 2 - Disagree
- 3 - Neutral
- 4 - Agree
- 5 - Strongly Agree
I always pay attention to what patients say. *

- 1 - Strongly Disagree
- 2 - Disagree
- 3 - Neutral
- 4 - Agree
- 5 - Strongly Agree

I promptly respond to patients when they ask for attention. *

- 1 - Strongly Disagree
- 2 - Disagree
- 3 - Neutral
- 4 - Agree
- 5 - Strongly Agree

I am tolerant of others’ opinion. *

- 1 - Strongly Disagree
- 2 - Disagree
- 3 - Neutral
- 4 - Agree
- 5 - Strongly Agree

I am well aware of changes in patients’ emotional condition. *

- 1 - Strongly Disagree
- 2 - Disagree
- 3 - Neutral
- 4 - Agree
- 5 - Strongly Agree
I am intuitive about patients because of my diverse clinical experience.*

- 1 - Strongly Disagree
- 2 - Disagree
- 3 - Neutral
- 4 - Agree
- 5 - Strongly Agree

I offer customized care to patients by taking their characteristics into consideration.*

- 1 - Strongly Disagree
- 2 - Disagree
- 3 - Neutral
- 4 - Agree
- 5 - Strongly Agree

I look after patients without being influenced by personally challenging situations.*

- 1 - Strongly Disagree
- 2 - Disagree
- 3 - Neutral
- 4 - Agree
- 5 - Strongly Agree

I empathize well with patients’ difficulties.*

- 1 - Strongly Disagree
- 2 - Disagree
- 3 - Neutral
- 4 - Agree
- 5 - Strongly Agree

Are you willing to participate in a 30 – 60 minute interview using a video conference medium (i.e. zoom call) about providing compassionate care, followed by a 10-minute follow-up interview via phone or video conference to clarify items from previous interview? (You will receive a $25 Amazon gift card for participating.)

- No
- Yes
# Interest in Participating in Interview

**Description (optional)**

<table>
<thead>
<tr>
<th>Please provide your email to be contacted by researcher.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short answer text</td>
</tr>
</tbody>
</table>
Appendix G: Informed Consent

Molloy College
Barbara H. Hagan School of Nursing and Health Sciences
1000 Hempstead Avenue
Rockville Centre, NY 11570
516-323-3000

MIXED METHOD – HOW DO MEDICAL-SURGICAL NURSES PROVIDE COMPASSIONATE CARE IN THE FACE OF ADVERSITY?

This study is being conducted by: Diane D. Kret Doctoral student in the Barbara H. Hagan School of Nursing and the Faculty advisor is Dr. Elizabeth Cotter.

Key Information about this study:

This consent form is designed to inform you about the study you are being asked to participate in. Here you will find a brief summary about the study; however, you can find more detailed information later on in the form.

- Researcher will ask participants questions. Participants will be chosen because they rated themselves with a compassion competence score and volunteered to participate in the interview. Participation in study is voluntary.
- Inclusion criteria: able to read, speak, and understand English, member of the Academy Medical-Surgical Nurses, those that volunteer to participate in the study
- Exclusion criteria: non-English speaking nurses; not a member of the AMSN
- Risks: There are no anticipated risks to participate in this study. If emotional distress would occur, participants will be assured that questioning would be paused and will be stopped if the participants feel they could not continue or could withdraw from study without penalty.
- Benefits: There are not direct benefits.
- Time commitment: 30-minute interview and until participate chooses with email correspondence. Follow-up interview 30-minutes and until participate chooses to review researcher’s findings and to verify what was said.
- Privacy will be maintained and pseudonyms to be used to identify participants.
- Compensation: $20 Amazon gift card will be given to the participants.
Data will be collected and analyzed from interviews until categories emerge and no new themes arise. ENVIVO, a computer program will be used to assist with data analysis. Themes will be extracted from analysis.

Why am I being asked to take part in this study?
The purpose of the study is to understand the process of how medical-surgical nurses provide compassionate care despite difficult situations/challenges they face. Participants will be chosen because their high Compassion Competence score and assumption that they provide compassionate care to their patients.

What will I be asked to do?
After signing the consent form, you will then be asked to schedule an interview (approximately 30-60 min.) at your convenience with this investigator. The interview will be voice recorded and I will take written notes.

Where is the study going to take place, and how long will it take?
The study will take place via a video conference call with a 30-60-minute commitment for the interview. The researcher will contact participants via email to have the participants verify and validate that interview was transferred to written document correctly by a follow-up 30-minute interview via phone or video conference.

What are the risks and discomforts?
It is not possible to identify all potential risks in research; however, reasonable safeguards have been taken to minimize known risks. If an uncomfortable memory triggers emotional distress, questioning will be paused and will be stopped if you wish. You may withdraw from the study at anytime. Although every reasonable effort will be taken, breach of the protections in place to maintain confidentiality cannot be guaranteed. We will minimize any risks of confidentiality breach by coding written data on interviews and using pseudonyms (not your real name or the real name of patients or locations). This way, while information will not be anonymous, it will be coded decreasing risk to your data confidentiality.

What are the expected benefits of this research?
Individual Benefits: No direct benefit is known, other than sharing experience of providing compassionate care and to develop a compassion theory to be transferrable to other scenarios or settings.

Do I have to take part in this study?
Your participation in this research is voluntary. If you decide to participate in the study, you may change your mind and stop participating at any time without penalty or loss of benefits to which you are already entitled.

Will it cost me anything to participate? There are no costs to participating in this study.

What are the alternatives to being in this study? Instead of being in this research, you may
choose to not participate.

**Who will have access to my information?**

You will be identified only by a pseudonym (another name for yourself). Your personal information and signed consent will be kept confidential. Your real name will not be reported in any publication or presentation of the study.

Only the group data obtained as a result of your participation in this study will be made public. Personal identifiers such as addresses, workplace, or health care providers will not be used in any publication. Email communication will be kept confidential and deleted after read and transcribed to secure computer study files without any of your personal identifiers.

**How will my information be used?**

All the study participants’ information will be analyzed as a group and summarized into a written document for the purpose of sharing the research analysis with health professionals and the academic (college and university) community.

Any future publications related to this research may then help to inform the nursing profession of how medical surgical nurses provide compassionate care. Your information collected as part of this research will not be used or distributed for future research studies.

To ensure that this research activity is being conducted properly, Molloy College’s Institutional Review Board (IRB), whose members are responsible for the protection of human subjects’ rights for all Molloy-approved research protocols, have the right to review study records, but confidentiality will be maintained as allowed by law.

**Can my participation in the study end early?**

If you suffer from any emotional distress or have personal reasons to withdraw, participant can withdraw from study at any time.

**What if I have questions?**

Before you decide whether you’d like to participate in this study, please ask any questions that come to mind now. Later, if you have questions about the study, you can contact Diane Kret at or dkret1@lions.molloy.edu, 516-376-2917; or my Doctoral Dissertation Chairperson, Dr. Elizabeth Cotter at ecotter@molloy.edu, 516-323-3000

**What are my rights as a research participant?**

You have rights as a research participant. All research with human participants is reviewed by a committee called the Institutional Review Board (IRB), which works to protect your rights and welfare.
If you have questions about your rights, an unresolved question, a concern or complaint about this research you may contact the IRB contact the Molloy IRB office at irb@molloy.edu or call 516 323 3000.

Documentation of Informed Consent*:

You are freely making a decision whether to be in this research study. Signing this form means that
1. you have read and understood this consent form
2. you have had your questions answered, and
3. after sufficient time to make your choice, you have decided to be in the study.

You will be given a copy of this consent form to keep.

____________________________________________________  ______________________
Your signature                                      Date

____________________________________________________  ______________________
Your printed name                                    Date

____________________________________________________  ______________________
Signature of researcher explaining study             Date

____________________________________________________
Printed name of researcher explaining study
Appendix H: Interview Guide

A Mixed Method-Ground Theory of How Nurses Provide Compassionate Care in the Face of Adversity

Open-ended script:

Hello, my name is Diane Kret. I am a doctoral student at Molloy College working on completion of my dissertation exploring the phenomenon of How Nurses Provide Compassionate Care in the Face of Adversity. Thank you for taking the time to meet with me to participate in my study. I will be recording our conversation with a digital recorder that will be transcribed verbatim at a later date. I am looking forward to hearing and understanding your experience.

In the event the participant requires further prompting, the below questions with probes can be used by the researcher to obtain additional information. Using grounded theory methodology, the questions may need to be adjusted from one interview to the next to gain a rich, in-depth understanding of the phenomenon.

Interview Question and Probes Guided by Appreciative Inquiry

Main Interview Question

I am interested in finding out if you, as a medical surgical nurse, are able to provide compassionate care and if so, how do you do that despite the adversity you may face.

Probes

2. Describe compassionate care in your own practice?

3. Do feel being compassionate care is important to your practice?

4. What difficulties might you encounter in attempting to provide compassionate care?
5. Looking at your patient encounters in the past year, tell me about a time that you might have served as an exemplar for delivering compassionate care.

6. Describe the perfect environment that is needed for you to provide the best compassionate care?

7. Describe how leadership helps you provide a compassionate care environment?

8. What are recommendations you have to create the perfect compassionate environment while providing patient care?
Appendix I: Field Memo Sheet

FIELD MEMO

<table>
<thead>
<tr>
<th>ID of Contact: _________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone Number: ____________________</td>
</tr>
<tr>
<td>Interview Number: _____________________</td>
</tr>
<tr>
<td>Date of Interview: ____________________</td>
</tr>
<tr>
<td>Time of Interview: ____________________</td>
</tr>
</tbody>
</table>

What were the main issues/themes that struck the researcher with this contact?

_____________________________________________________________

Summarize the information the researcher got (or needs to get) on each of target questions for this contact:

<table>
<thead>
<tr>
<th>Question # ____ :</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information/Salient Points :</td>
</tr>
</tbody>
</table>

___________________________________________________________

Themes/Codes :

___________________________________________________________

Anything else that struck researcher as salient, interesting, illuminating, or important in this contact?

________________________________________________________________

What new questions does the researcher have in considering the next contact with this participant (or other participants) if indicated?

________________________________________________________________