Compassion in the emergency department. Part 3: enabling and supporting the delivery of compassionate care

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Abstract

In the final part of this three-part series David Hunter and colleagues analyse the factors that enable and support delivery of compassionate care in emergency departments (EDs). Part one reported findings from doctoral level research that explored nursing students' experiences of compassionate care in EDs, while part two considered the barriers to this identified by the students. This article highlights and celebrates the ways in which emergency nurses provide compassionate care despite the challenges they face.

compassionate care, emergency department, emergency nurse, exploratory-descriptive qualitative research, student experience

Introduction

This article focuses on some of the findings of a qualitative research study which explored 15 nursing students' experiences of compassionate care in emergency departments (EDs) [note to sub. Please add refs to first 2 articles, and add to reference list]. One element of the study asked the student participants to consider factors that enabled them to provide compassionate care in acute, busy clinical environments. They identified five enablers which are discussed below, experiences in resuscitation, dealing with death and its consequences, supportive learning environment, benefit of team work and influence of role models. Direct quotations are included to illustrate the students' thoughts.

Experiences in resuscitation

As highlighted in part two [sub please add ref], the physicality of EDs can have a detrimental effect on nurses' ability to provide compassionate care. However, it became apparent in this study that the opposite is also true when students described their experiences in resuscitation areas. Seven participants described their experiences in resuscitation in relation to the way it enabled them to provide compassionate care, including one who experienced the failed resuscitation of a child. Two main elements emerged from their descriptions, the one-to-one nature of nursing patients in this part of an ED, and the additional time available for nurses to spend with patients and their relatives. One participant said: 'You do have more time or if you're in resus. You've got that one to one, you can stand for five minutes and sit and tell somebody "it's going to be all right, you are in the right place, things are going the right way" (Donna).

The participants suggested that the higher nurse to patient ratio in resuscitation areas, which is often one to one, gives them greater opportunities to provide compassionate care. This finding is significantly different from their other descriptions about staffing, particularly in relation to how being short staffed is a barrier to compassionate care. From an operational viewpoint, the need for safe staffing in EDs is complex due to the varied patient groups, staff mix, and multiple patient destinations when they leave (Izady and Worthington 2012).

In addition, the students suggested that being in the resuscitation area gave them more time to spend with patients, which again varies from their discussions about time as a barrier to compassionate care. The participants said that in the resuscitation area they had more time to communicate with and offer reassurance to patients, which reaffirms the finding that communication is a vital part of compassionate care. The students described how communication not only involves the nurses and doctors caring for the patients, but also patients' relatives, and suggested there was time to offer detailed explanations about diagnoses and prognoses, and for patients and relatives to ask questions.

Finally, the participants commented that being in the resuscitation area gave them greater opportunity to provide compassionate care by ensuring patients' comfort by 'doing the little things', as discussed in part one [sub please add reference]. There appears to be a lack of discussion about nursing students' experiences of ED resuscitation areas in the literature.

Dealing with death and its consequences

Although challenging, the experience of dealing with death and its consequences described by the participants were overwhelmingly positive in terms of providing compassionate care. They highlighted how these events shaped their understanding of compassionate care and how this would influence their future nursing practice. Poultney et al (2014) recognised that nursing students are exposed to death, dying and bereaved relatives from the start of their preregistration studies and therefore require guidance to enable them to cope. Equally, Scott (2013) recognised that emergency nurses can find it challenging to support grieving relatives. One participant said: 'There was a couple of times when people had come in with cardiac arrests and things and they (the staff) had comforted the family and they

had a quiet room and things, you know, I think that is showing, kind of, compassion with concern and, you know, sitting down and making sure they're ok, even offering them a cup of tea and just the way they interact with the, you know, just to show that they cared' (Robert).

Dolan (2013) highlighted that sudden death can have a significant effect on ED workload and that dealing with the suddenly bereaved can be difficult for staff, regardless of their experience. Hogan et al (2016) support this, but also found that nurses can provide compassionate care both for dying patients and their families, while Walker and Deacon (2016) identified that nurses are individually driven to provide person-centred care, including dignity, compassion and respect, to the bereaved. A quantitative survey by Hallgrimsdottir (2004) identified that both Scottish and Icelandic emergency nurses considered caring for bereaved relatives difficult and that staff shortages, lack of facilities and lack of appropriate supportive literature and contacts made this more challenging.

The student participants linked the provision of compassionate care to bereaved family members with other discussions about what compassionate care is, for example 'doing the little things', and their communication skills. This is mirrored by Walker and Deacon (2016) who claim communication is central to the care of the recently bereaved as nurses endeavour to support families to understand the situation through giving and receiving information. It is also recognised that families highly value gestures such as being offered a cup of tea or simply being asked if anything can be done to help (Brysiewicz 2008). In addition, bereaved families find comfort simply from nurses' presence, or in any acts of kindness, comfort or emotional support they provide (Scott 2013, Shapcott 2015).

The literature on this topic highlights good practice in relation to the care of the bereaved in EDs, but there is a contrasting view. In an English ethnographic study by Bailey et al (2011) patients who required palliative care were often placed in physical spaces in EDs that were separate from other patients, and as a result they received lower quality care. Bailey et al (2011) found that emergency staff were keen to transfer palliative patients to wards, as EDs were not regarded as appropriate settings for end-of-life care. A more recent Australian study by Decker et al (2015) drew similar conclusions and found that emergency nurses believed moving these patients to a ward was in their best interests as they would receive better quality end-of-life care. This phenomenon was not discussed by the students in this study.

Dolan (2013) stated 'the unexpected end of one person's life is the beginning of someone else's grief' and emergency nurses can make the last memory of a loved one a lasting memory of compassion and support. The students in this study provided positive examples of involvement in high quality, compassionate care when dealing with bereaved relatives, and suggested that these experiences would influence their practice in similar situations later in their careers, regardless of clinical setting.

Supportive learning environment

The participants described the EDs as supportive learning environments, which supports previous research (Henderson et al 2009, Hunter 2010). Henderson et al (2009) found that the quality of everyday interactions with clinical staff had a direct effect on the quality of students' clinical experience and subsequent learning, while Brown et al (2008) suggested that nursing students require the freedom to learn, explore roles and develop competencies in supportive, enabling environments, in which members of the established teams recognise the vulnerabilities associated with being a student.

The participants in this study described formal and informal learning opportunities in the EDs, and that they felt secure enough to ask questions without worrying about reprisals if their question was perceived as silly. They perceived this supportive learning environment as expression of compassion from staff towards students: 'They're very open for you to ask questions, they are very willing to share their knowledge. That was… so for me that was really, that was good… So having it as a teaching area where the consultants are teaching the doctors and as a student I was able to tag on and listen to what was being explained and why things are happening, that was excellent' (Ann).

Benefit of team work

In addition to a supportive learning environment the students described how being part of the team helped them develop their skills in compassionate care. They witnessed positive examples of emergency teams working together and their interactions with patients and families: 'They worked really closely as part of a team. They supported each other, you know, and they did try their best to deliver good care' (Robert). This was found in previous research, in which students reported that despite initial apprehension about their allocation to an ED they quickly integrated into the team (Hunter 2010).

It is important that students integrate into ED teams as Kilner and Sheppard (2010) indicated that teamwork and communication are vital in this clinical area, and contribute to patient safety and reduced clinical errors. Groves (2014) suggested that peer support and trust are required for effective team working, and that a shared ambition of continuous learning, and fostering a culture in which nurses and extension nursing students can actively participate, maximising their roles and responsibilities within the team, can help build that sense of trust. Fry et al (2013) identified that teamwork, especially teaching and supporting junior team members, supports professional socialisation and the ability to provide compassionate care.

This study, and previous work (Hunter 2010), suggest that the spirit of teamwork as described by Groves (2014) and Fry et al (2013) is present in EDs. This is a positive finding as Santen and Hemphill's (2011) study of medical students' experiences in American ED revealed examples of unprofessional communication and lack of teamwork, although cultural and professional differences must be acknowledged. One participants in this study said: 'I noticed a difference in emergency department. The doctors and nurses have a really good relationship. There is not a hierarchy as such, it's more they, kind of, work together, feed off each other, and I think, em, I think they set a good example of how to, kind of, speak to people and talk to them and treat them' (Ellie).

The participants also witnessed compassion within the wider multidisciplinary team, not only from the team to patients and families but also to each other, for example offering reassurance that a team member had provided the best care that they could, or when staff experienced a challenging personal issue. Griffin (2008) described how emergency nurses in the past were told to 'toughen up', but rejects this in favour of encouraging them to support one another to process and cope with the emotions associated with working in this clinical setting. Person et al (2013) also identified mutual support as important, and found that junior team members had to go through 'a rite of passage' before being accepted (Person et al 2013). The student participants in this study did not articulate the same perception. Peer support, debriefing and reflection following a traumatic event, such as a patient death, can help staff consolidate their feelings and achieve a sense of closure (Hogan et al 2016). The participants recognised that this multidisciplinary compassion extended beyond the healthcare team to include administrative and support staff, and external agencies such as the police.

Influence of role models

Participants gave examples of the positive and negative role models they had encountered in the ED. Additionally, when exposed to a negative role model experience they recognised this and transformed it into a positive learning point. This is supported by Keeling and Templeman (2013) who identified that when students were exposed to the behaviours of registered nurses they considered either positive or negative role models this influenced their professional development. Walker et al (2014) found that good role models supported learning and helped nursing students create their own professional identity, while poor role models had a negative effect on learning in clinical practice, morale and perception of nursing (Walker et al 2014, Vinales 2015).

One participant commented: 'There is an awful lot of nice people there that really do… that are quite inspiring when you see them just doing something really nice and I think you know what, we should all be like that… there was

an awful lot of good care that I witnessed there that I thought was really inspirational. And I would like to be like that' (Rachel).

Straughair (2012) highlighted that role models are in the best position to demonstrate to nursing students, through their own commitment, that compassion is a core behaviour of professional nursing. Firth-Cozens and Cornwell (2009) also advocated that registered nurses should act as role models for the delivery of compassionate care to emphasise its importance to nursing students and less experienced staff. According to Vinales (2015), while negative role models may have a detrimental effect on nursing students, they might also have a similar effect on the nursing profession as a whole and on patients. Although not explored in this study, Baldwin et al (2014) noted the influence of positive role models in education on nursing students' development of professional behaviour, which could include compassionate care. It could be argued therefore that nursing faculty have a responsibility to demonstrate compassionate care in their interactions with students, in the same way as colleagues in clinical practice interact with patients (Edinburgh Napier University and NHS Lothian 2012). Indeed, Ross et al (2014) suggested that university personal tutors can influence students' development of caring behaviours.

Most of the participants in this study witnessed positive role models in the ED which influenced the development of their compassionate care skills.

Implications for practice

This study contributes to nursing practice by giving examples of positive and negative nursing care, and reinforces the claim that EDs can be positive learning environments for nursing students. However, it has also highlighted a range of barriers that can affect the delivery of compassionate care negatively. Nurses working in EDs can reflect on their clinical practice in relation to patient groups at risk of receiving less compassionate care than others. Educational needs identified by this reflection can be addressed to improve patient care.

Conclusion

Participants in this study described the beneficial aspects of being in EDs, which they regard as supportive learning environments in which learning is encouraged, team work/dynamics are strong, and where they witnessed staff showing compassion to one another. Additionally, the students recognised the significance of role models on their own development of compassionate care. Although the students were positive about their overall experience of providing compassionate care in EDs many of the positive aspects occurred in resuscitation areas, often when managing critically ill or injured patients, those who had died and their loved ones. Many, but not all, of the barriers to compassionate care discussed in part two [sub please add ref] appear to have less effect in resuscitation areas. Discussions about positive role models and support mechanisms were often linked to the students' time in these areas. It is possible that the students perceived that patients in resuscitation are more deserving of compassionate care, because of their conditions, than those discussed in part one as 'challenging' [sub please add ref]. There is little literature on the experiences of nursing students in ED resuscitation areas, and is an area worthy of further study.

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