**TITLE:** Teaching Compassionate Care to Nursing Students in a Digital Learning and Teaching Environment

**ABSTRACT**

**Background:** Healthcare that is technically excellent, but without compassion, fails to meet the expectations of patients. Ample evidence about teaching compassion to nursing students in classrooms exists; however, few studies report online teaching.

**Aim:** This study explored final year nursing students’ perceptions of compassion and practising compassion before and after studying an online compassion module.

**Methods:** An exploratory, descriptive qualitative approach guided data collection and analysis. Students responded to open-ended questions before and after studying the module.

**Findings:** Themes derived from the analysis: *being present*, *acting to relieve suffering*, *getting the basics right*, *going forward*. Being present for patients was evident in statements such as placing yourself in their shoes, taking time to listen carefully and doing things that mattered (e.g., using touch to convey compassion). Acting compassionately depends on communicating to understand the suffering of others and what matters. Being resilient involved getting the basics right (e.g., positive self-care and lifestyle practices, cultivating supportive networks, setting boundaries). Going forward included being mindful to act compassionately as new registered nurses and supporting colleagues.

**Conclusions**: This study provided new insights into how students’ new knowledge translated into compassionate action. Students described the positive impact of small acts of compassion from one nurse to another that enhanced teamwork and resilience. Recognising the critical role of compassion to patient and family outcomes, provider wellbeing, and organisational culture, these findings could be used by nurse leaders and educators to develop evidence-informed curricula to foster the practice of compassion which all nurses aspire to provide.

Keywords: compassion; nursing; digital education; resilience; culture; compassion literacy

**Summary of Relevance**

**Problem or Issue**

Healthcare without compassion fails to meet patients’ expectations.

There is scant evidence about teaching compassion online to nursing students.

**What is already known**

Compassion literacy and resilience may act as protective mechanisms.

Compassion is essential for quality care and improving well-being and resilience in clinicians.

Touch can express compassion and may relieve suffering.

Organisational factors foster or hinder compassionate care.

**What this paper adds**

Compassionate care can be taught online.

Compassion education is a precursor to practising compassion toward patients, relatives, colleagues, and oneself.

1. INTRODUCTION

Compassionate care is a public expectation; it matters to patients, and is foundational to what it means to be a nurse (Bray et al., 2014; von Dietze & Orb, 2000). Compassionate care ‘requires understanding of another’s pain or suffering, with commitment to doing something to relieve this’ (Lown et al., 2017). Patients and their families say the manner in which they are listened to and cared for matters just as much as healthcare quality (Bray et al., 2014; Lown et al., 2011). As Haslam (2015, p. 1) clarifies: ‘compassion is not an optional extra, but far too frequently it is seen as being much less important than other aspects of care’. Globally, however, there is an increasing concern that healthcare systems continue to fail to meet the core needs and expectations of patients (Bray et al., 2014; Aiken et al., 2014; Lown et al., 2011). Patients report that ‘care may be technically excellent but depersonalized, and will fail to address the uniquely human aspects of the healthcare experience’ (Lown, 2014, p. 7). The core needs and expectations of patients are to receive compassionate care. Compassion is: ‘recognizing the concerns, distress and suffering of patients and their families and taking action to relieve them. It is based on active listening, respect, empathy, strong communication and interpersonal skills, and knowledge and understanding of the patient’s life context and preferences. At its core, it means treating patients as people, not just the illness’ (Rosen, 2015).

International research has linked poor patient outcomes with austerity measures and identified compassion as a missing component of healthcare (Bray et al., 2014; Francis, 2013; van der Cingel, 2014). These issues have prompted debates about what constitutes core nursing values and whether virtues (such as compassion) can be taught in undergraduate nursing programs.

2. BACKGROUND

Compassion is not a new concept. In his debates with Protagoras, Socrates (in the *Meno*) argued that a moral virtue such as compassion could not be taught and that it was a ‘gift of the gods’. In contrast, Protagoras said compassion could be modelled and learned in certain contexts and systems (Pence, 1983; Plato, 1961). Protagoras’s view suggests compassion can be taught, nurtured, suppressed or hindered within social relationships, cultures, and systems (Pence, 1983).

The terms compassion, empathy and sympathy have been used interchangeably, however, ‘patients distinguish and experience them uniquely’ (Sinclair et al., 2016, p. 1). Compassion is defined as ‘a virtuous response that seeks to address the suffering and needs of a person through relational understanding and action’ (Sinclair et al., 2016, p. 6). Compassion is more than seeing (sympathy) and acknowledging (empathy) suffering of others (von Dietze & Orb, 2000). Taking action to relieve suffering is what distinguishes compassion from other concepts (Richardson et al., 2015; Sinclair et al., 2016; von Dietze & Orb, 2000). Notably, patients can recount experiences in which they felt communication and compassion was present or absent in their health care (Bramley & Matiti, 2014). Compassion can be expressed through small, meaningful gestures (Adamson & Dewar, 2011).

However, adverse work environments, unmanageable workloads and incivility may impede nurses’ ability to provide compassionate care and predispose nurses to compassion fatigue (Christiansen et al., 2015; Coetzee & Klopper, 2010; Ledoux, 2015). Moreover, organisational, team and individual factors operate to enable or hinder ‘caring cultures in which compassionate care can flourish’ (Christiansen et al., 2015, p. 837). Recent evidence calls for compassion literacy to ‘understand compassion, identify the barriers that impact upon the delivery of compassionate care, and develop strategies to address such barriers effectively’ (Burridge et al., 2017, p. 90). Compassion literacy and resilience could act as protective mechanisms for nurses working in adverse environments. The ‘fuel’ to build resilience arises from self-compassion, self-care, and supportive networks (McAllister & McKinnon, 2009). Moreover, evidence regarding the latest social neuroscience of compassion argues compassion training could have a buffering effect against burnout (Lown, 2016).This salient evidence supports the urgent call to teach compassion to undergraduate nursing students.

There is ample evidence about classroom teaching of compassion in undergraduate nursing curricula (Adam & Taylor, 2013; Adamson & Dewar, 2011; Bray et al., 2014). However, there is scant evidence about teaching compassion in digital learning environments. Digital learning is an umbrella term to define teaching practices where technology is used to support the learning process. It includes online, blended and mobile learning practices.

3. STUDY METHODS

3.1 Study purpose

This qualitative study was designed to investigate nursing students’ understanding of compassion and their practices of compassion towards patients, colleagues and themselves before and after studying an online compassion module. Little is known about teaching compassion online to nursing students.

3.2 Study design

An exploratory, descriptive, qualitative design was considered suitable for the purpose of this study (Sandelowski, 2010). The study protocol comprised an online knowledge intervention (i.e., compassion module) and pre- and post-intervention qualitative questions that has been published elsewhere (Hofmeyer et al., 2016). The online self-directed compassion module was a component in a compulsory course in the final year of a three year Bachelor of Nursing program at an Australian University. The 5,000 word online module took 4-6 hours to complete. The compassion module was written using a question and answer format in eight sections that addressed the concept of compassion; practising compassion in healthcare; practising compassion toward patients, colleagues and oneself; leading with compassion; cultivating self-care and resilience. Each section concluded with reflective questions and key readings. Students then discussed their reflections in tutorials or in the online discussion forum with other students and their tutor, depending on their enrolment mode.

Data were collected using pre- and post-intervention qualitative open-ended questions administered via SurveyMonkey®. Text boxes were used to collect respondents’ written responses. This qualitative method is useful to access geographically distant respondents (Braun & Clarke, 2013). Thirty-three per cent of students enrolled in the course lived throughout Australia, while the remainder lived locally. Thus, this data collection method was ideal for the study.

3.3 Sampling and Data Collection

Purposive sampling was used to recruit respondents from a final year cohort of 362 undergraduate nursing students who studied the compulsory course that contained the online compassion module. Students received an email invitation and information letter outlining the study, consent process, and the link to questions in SurveyMonkey®. In September 2015, n = 17 respondents typed their responses to five open-ended pre-intervention questions. During late October and November 2015, n = 25 respondents provided responses to 12 open-ended post-intervention questions (see Table 1). In qualitative research the richness of the data is critical rather than response rates (Lincoln & Guba, 1985). Seven demographic questions were asked at both time points and the respondent demographic data reflected the wider student population. Responses submitted implied consent to participate and became the transcripts.

3.4 Ethics Statement

Approval was obtained from the University’s institutional research ethics committee to conduct the study (Application ID 034507).

3.5 Data Analysis

The researchers undertook analysis of the data to ensure its trustworthiness, reach consensus, and verify coherence throughout the data analysis and reporting process (Lincoln & Guba, 1985). All researchers had qualitative expertise. The reflexive process was documented by the chief investigator as an audit trail of decision-making throughout the study. Transcripts were analysed using Braun and Clark’s (2013) six-stage method of thematic analysis. The researchers had access to read the transcripts to become familiar with the data. An analytical process of coding was undertaken to capture the conceptual reading of the data and to identify relevant data extracts. Similarities in the data were the basis of constructing themes. The researchers identified themes in each transcript to understand the respondents’ meanings and analyse similar and different patterns. Emergent findings were checked, compared and validated, and agreement reached by the researchers to enhance trustworthiness. Key phrases were identified and categorised into preliminary themes (Braun & Clark, 2013). The researchers engaged in this recursive process in team meetings, telephone calls and email. Preliminary themes were re-ordered until major themes and sub-themes were established. Verbatim extracts was used to illustrate themes in the writing-up. Presentation of findings at several international nursing conferences confirmed resonance and credibility with relevant audiences (Lincoln & Guba, 1985). The students had graduated, so an email invitation was sent from the university alumni office to invite further participation, but no individuals made contact.

4. FINDINGS

Four major themes derived from the analysis describe how compassion is understood and practised: being present; acting to relieve suffering; getting the basics right; and going forward. In the following sections, quotations by the respondents are presented in inverted commas from the pre- [1] and post- [2] data to illustrate themes. The number after the slash (‘/’) signifies the respondent.

4.1 Being Present

Putting yourself in their shoes

Prior to studying the module, respondents used words such as pity, sympathy, empathy and being kind to describe their understanding of compassion. Their understanding focused on patients. One said compassion meant ‘placing yourself in their shoes’ [1/11]. Compassion was also explained as having the ability to empathise with others and the intention to make a situation better for someone who is suffering. Three respondents described compassion as feeling pity for patients. Post-intervention, respondents described deeper understandings of compassion, greater richness in complete sentences, and being compassionate toward family and colleagues.

Taking time to listen carefully

Several respondents referred to compassion as the ability to connect with a person, listen carefully to what they are saying, take account of their wishes, and respond to their needs. Post-intervention, one respondent said, ‘compassion means emotional intelligence, [being] able to express kindness and respect’ [2/13]. Another described compassion as being ‘able to stop and respect each individual that you care for in the midst of the busyness of nursing care’ [2/16].

4.2 Acting to relieve suffering

The smallest actions can convey compassion

After studying the module, respondents said compassion was essential to nursing practice because it could have a positive impact on patients by reducing their emotional and physical pain. One described practising compassion as ‘Ensuring I always put myself in another’s position, without passing judgement’[1/3]. Another described stopping in a busy workday to foster person-centred care and explained *why* their example of listening and spending time with a patient illustrated compassion:

‘A teenage girl with cystic fibrosis did not want to take her morning medications despite understanding the importance of the therapy. She appeared more angry and frustrated than usual so I put down the medication and sat down. She started talking about her illness and feelings. We discussed what she wanted. Then I consulted the team. It was only small changes such as medication timing and intervention routines, but she responded well and was more positive. *Because* for me, compassion is not just being able to empathise with a person, it should also drive actions and behaviours with that person’[2/4]

Another respondent described how she facilitated person-centred care through inclusive decision-making: ‘I asked the resident’s preference about a better way to manage the wound *because* thinking from the resident’s point of view is the way to provide holistic care’ [2/16].

Doing things that really matter

One respondent said, ‘compassion means a lot to me now because doing things that really matters [sic] to a patient to help alleviate their suffering is a way of showing care’[2/14]. Others provided examples and explained *why* it illustrated their practice of compassion. Many said they held a patient’s hand or touched a shoulder *because* physical touch reassures patients. One discussed ‘showing gentleness and using touch to reassure patients who are confused or disorientated *because* their circumstances are beyond their control’ [1/9]. Post-intervention, compassion towards relatives was highlighted:

‘When families do not visit they can be judged quite harshly by those who do not understand dementia. It’s important to show compassion toward the family of dementia clients *because* dementia is a horrible disease and clients cannot even say their own name or engage in normal family activities’ [2/17].

Moreover, a respondent explained *why* her nursing action was compassionate:

‘Finding my resident crying on my medication round after her family had left, I sat with her, held her hand and we chatted about why she was upset. She had cancer but was more worried about how her family was taking the news than for herself. She didn’t know how to tell her family that she didn’t want any treatment. This is a good example *because* I did not keep going with my drug round so I could finish on time. By spending 20 minutes with her I found out how to help. She agreed to have a family meeting to tell her family of her wishes. She felt relieved someone was there to help and that she was not alone in what she was going through’ [2/5].

Acting to help colleagues thrive

Post-intervention, several examples showed respondents understood that acting to support a colleague’s wellbeing improves their ability to care for patients and potentially fosters compassionate and resilient team cultures. For example, one respondent described ‘seeing a new nurse struggling to get through their work and offering assistance to be supportive’ [2/4]. Another described showing ‘consideration towards a colleague—a family member had died so I took over the palliative patient she was assigned *because* I did not want her to be in a distressing situation’ [2/6].

4.3 Getting the basics right

Being resilient to achieve goals

After studying the module, respondents said that being resilient increased their job satisfaction, achieving work goals, and intentions to remain in nursing. As one said ‘the capability of caring for others is only sustainable with personal resilience’ [2/2]. Many respondents worked in challenging clinical environments and believed that nursing is a tough job emotionally and physically and that being resilient helps nurses to thrive. As one explained, ‘Nurses have a lot to bear. They are dealing with death and dying on a regular basis. They have high workloads and often understaffed. Nurses need to have resilience so they do not burn out from compassion fatigue or [become] worn down by systemic failures’ [2/19]. Another stated, ‘being resilient means you don’t break while doing those extra tasks no matter how impossible it may seem when the job pushes you to your limits as a person’ [2/1]. Resilience was also linked to being prepared to care for others (i.e., other nurses), preventing burnout, and being able to remain in the profession.

Positive lifestyle choices

Most respondents talked about practical, positive strategies to foster self-care and build resilience so they are better prepared to care for others. The importance of getting the basics right was emphasised (e.g., a healthy balanced diet, sufficient sleep, regular exercise, a calm mind, positive attitude) to maintain physical and mental health. Many said they engaged in positive lifestyle practices (e.g., meditation, massage, music, aromatherapy, goal setting and hobbies). One said ‘I try to keep active and practise meditation and positive affirmations. When I leave my workplace my work life stays behind, I have achieved the best I can during my shift’[2/4]. Several discussed taking time out for themselves and the importance of solitude. As one respondent said, nurses need to ‘find time do something [they] enjoy or spend time in nature by themselves’.

Boundaries and support networks

Setting boundaries was a strategy for clarity and safety. A few noted ‘personal boundaries are important so we are not manipulated by others’ [2/19] and to ‘separate work/home life’ [2/23]. Cultivating supportive social connections and networks was also a strategy for coping and gaining perspective on work experiences. Some described the importance of ‘friendships, family relationships, networks, and de-briefing with co-workers to diffuse emotions and get support’ [2/5, 2/13]. A few differentiated between routine debriefing with co-workers and family and recognising when it was necessary to seek professional support (i.e., from a psychologist) to manage work-related issues.

4.4 Going forward

New insights

Many respondents said the new insights gained from studying the compassion module would influence their practice and self-care as new registered nurses. One noted ‘compassion needs to go hand in hand with providing safe, evidence-based practice’ [2/10]. Several said they now understood connections between resilience and fatigue and the importance of being compassionate to patients, families, colleagues and themselves. Others said they gained new insights into the factors that fostered and hindered compassion in organisations and being treated compassionately by colleagues and managers did matter to them. Some respondents said the module challenged them to think differently about their professional practice as new registered nurses. Others said they did not realise that self-compassion was vital to being prepared to practise compassion. One respondent stated, ‘don’t be so hard on yourself, give yourself a second chance’ [2/11]. Another said she learned ‘not to conform to the idea that compassion needs to be earned by patients; that regardless of the influence of colleagues, I shall not withdraw compassion from the care I give to my patients’ [2/3].

Being mindful

Most respondents reported greater awareness that would influence their practice as new registered nurses. One respondent said she would be ‘more mindful of self-compassion as a new nurse’ [2/2]. Respondents also said they would be more alert to the wellbeing of other nurses on the team and the existence of organisational factors that fostered or hindered compassionate care. One said, ‘despite being very aware of compassion and resilience, it is necessary to continually remind myself of basic self-care practices to continue to be compassionate’ [2/2]. Several respondents said they now understood they had a responsibility as new registered nurses to show compassion to colleagues and analyse situations so that they could recognise fatigue developing in themselves or colleagues.

5. DISCUSSION

There is ample evidence about teaching compassion to nursing students in classrooms (Adam & Taylor, 2013; Adamson & Dewar, 2011; Bauer-Wu & Fontaine, 2015; Bray et al., 2014). However, there is an increasing global demand for higher education to incorporate flexible, online education. Few, if any, studies have explored the extent to which compassion can be taught in a digital learning and teaching environment.

In this study, four major themes derived from the analysis identify and describe a shift in how students translated their understandings into compassionate practice toward patients, colleagues and themselves before and after studying an online compassion module, namely: being present; acting to relieve suffering; getting the basics right; and going forward.

Whilst these findings demonstrate the translation of students’ perceptions and theoretical understandings (pre-intervention) into deeper understanding and insight into real world clinical practice (post-intervention), it is evident that many were also challenged to consider and in some cases reframe their own attitudes, values and beliefs.

Respondents’ perceptions of compassion centred on ‘being present’ as expressed by listening and empathising with patients who were suffering. Before studying the module, respondents used multiple terms to describe their understandings of compassion, including pity, empathy, sympathy, kindness and caring. Others viewed compassion as feeling pity towards others. However, compassion is not analogous with empathy, sympathy or pity and this conceptual confusion has been echoed in the literature until recently (Richardson et al., 2015; von Dietze & Orb, 2000). Definitional clarity matters in nursing curricula to ensure nurses are clear about what compassion is and what it is not.

Despite some conceptual confusion about the definition of compassion, the examples provided by respondents were compassionate and consistent with the definition by Sinclair *et* *al.* (2016). Some described being present with patients as ‘putting yourself in their shoes’ and taking time to listen to patients to understand what mattered and how to act compassionately. These perceptions are supported by the literature (Adam & Taylor, 2013; Adamson & Dewar, 2011; Bramley & Matiti, 2014). After studying the compassion module, most respondents had a more nuanced view of the practice of compassion, as shown through their powerful exemplars and rationale for acting with compassion towards patients, relatives and colleagues.

Respondents’ understood that the smallest action (e.g., talking with patients to understand what really matters) could relieve suffering and convey compassion. These findings further confirm the importance of developing communication skills in undergraduate education (Adamson & Dewar, 2011; Bramley & Matiti, 2014). Listening is key to identifying what matters to patients and what actions could relieve their suffering. Potential barriers to practising compassion included the pressure to complete routine tasks on time (i.e., medication administration) and being reprimanded for lateness. Such barriers hindered some respondents from pausing to listen to distressed patients, even though they knew the action would be perceived as compassionate. These findings are consistent with previous studies that confirmed organisational barriers can hinder the practice of compassion towards patients and exacerbate frustration and moral distress of clinical nurses (Aiken et al., 2014; Christiansen et al., 2015).

Pre-intervention, most respondents only discussed compassionate care for patients. However, respondents gained greater awareness about compassionate practice in the module, so a significant finding of this study was examples of acting compassionately to help colleagues thrive. Their small compassionate actions enabled colleagues to provide better care for patients. These findings build on the literature about the importance of fostering a compassionate culture to support nurses’ satisfaction in practising compassion towards team members, patients and families (Christiansen et al., 2015).

Enhanced awareness of the importance of self-care and potential positive impacts on patient care were clearly articulated after studying the compassion module. Many respondents talked about adopting self-care strategies such as positive lifestyle practices, cultivating supportive networks, setting personal boundaries, and accessing professional counselling when necessary to make sense of stressful experiences. Positive lifestyle practices included exercise, healthy eating, taking time out and sufficient sleep. Some respondents understood that self-compassion and self-care are critical factors in being resilient in workplaces. Fostering strategies to build resilience could also positively affect compassion satisfaction and increase nurses’ skills to challenge organisational norms that act as barriers to compassionate practice (such as time pressure to complete tasks). These findings further develop the discourse to promote mindfulness and self-care (Bauer-Wu & Fontaine, 2015; Bray et al., 2014; Christiansen et al., 2015) and are applicable to education and practice environments.

Respondents confirmed new understandings about the importance of practising self-care in the coming year when they would be new registered nurses. Some said they now realised taking time to rejuvenate was not selfish, but essential to their resilience and capacity to care for others (Mills et al., 2015). Others said they would be more alert to fatigue in themselves and colleagues. A few respondents said they now understood compassion must be present in workplace cultures to provide safe, evidence-based care. Others said they understood that patients were more likely to receive compassionate care if nurses worked in compassionate cultures and were supported by managers in their self-care practices. However, despite the variation in responses it was apparent that there was a recognition that self-care and compassionate care were fostered in positive workplace cultures and this in turn translated into more positive experiences. The importance of workplace cultures supporting nurses’ wellbeing and resilience, particularly new registered nurses, is established (Christiansen et al., 2015; Horsburgh & Ross, 2013).

5.1 Limitations

Data collection was conducted at one higher education institution. Relevant insights into students’ understandings about compassionate practice and resilience were generated; however, it is possible the study attracted respondents with a pre-existing interest in compassion.

6. CONCLUSION

This study has shown that nursing students can learn about compassion and self-care practices to cultivate resilience, and foster their ability as new registered nurses to provide compassionate care for patients and promote compassionate team cultures. This study provided new insights into how students’ new knowledge translated into compassionate action. The ability to act compassionately is predicated upon effective communication to uncover and understand the experience of another and what matters to them. Compassion is then acting upon that knowledge in a way that matters to the person to relieve their anxiety and suffering. The significance of practising compassion towards colleagues and adopting self-care practices and work-related strategies to sustain resilience as new registered nurses was highlighted. The inclusion of compassion and self-care training in undergraduate nursing education is justifiable, given the growing body of evidence supporting the vital contribution of compassionate care to patient outcomes and provider well-being. The findings could be used by nurse leaders and educators to develop empirically supported online curricula and compassionate workplace cultures that foster the practice of compassion and resilience for current and future generations of nurses. To what extent new registered nurses practise self-care and compassion in clinical practice requires further investigation.

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**Table 1: Qualitative Questions**

|  |  |
| --- | --- |
| Pre-intervention | Post-intervention |
| What does compassion mean to you?  What does practising compassion mean to you?  Can you give an example of you acting compassionately towards a client or patient?  Why do you think this is a good example? | What does compassion mean to you now?  What does practising compassion mean to you now?  Can you give an example of you acting compassionately towards a client or patient?  Why do you think this is a good example?  Can you give an example of you acting compassionately towards a colleague at work?  Why do you think this is a good example?  Why do you think it is important to be resilient as a nurse?  What can you do to take better care of yourself? Please give an example.  What important idea have you learnt in the compassion module?  How will this knowledge influence your practice as a new registered nurse? |

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