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Compassionate Care Delivery for Elderly Patients: Nurses' Perception

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Abstract **Background:** Compassion is evident in literature within science and the humanities. It has an evolutionary basis, marking a point in human development when we could think about others' feelings. As a consequence, humans were able to care for those in need and exhibit concern for them. This shows the relational aspect of compassion, which necessitates an understanding of and connection with another. **Aim**: This study aims to measure nurses' perception of compassionate care in Beni-Suef city. **Sample:** A descriptive cross-sectional design for 140 nurses. **Setting:** Beni-Suef University Hospital, General Hospital, as well as Continuing/Long-term care and Home Health Care (HHC) services. **Results**: 90.0% of the nurses were having a positive compassion attitude related to hospital leadership. Statistically significant relations between nurses' compassionate care attitude and many of their characteristics, however, nurses' compassionate care attitude was positive among highly qualified married young-aged males from urban nurses who have sufficient income. A statistically significant relationships were found between nurses' compassionate care practice and their gender (p=0.006), residence (p=0.003), and nursing qualification (p<0.001). **Conclusion:** Nurses in the study settings have a generally positive attitude towards compassionate care. However, their practice of compassionate care and related self-confidence seems to be low. These are influenced by nurses' age, qualification, experience years, residence, and income. **Recommendations:** In-service training programs should be applied on a wide scale for nurses to improve their practice and self-confidence related to compassion care.

Keywords: *compassionate care, elderly patients, nurses' perception*

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1. Introduction

Compassion is considered to be the basis for ethical codes in nursing and is one of the five values required by professional nurses in the ***American Nurses Association's*** Code of Ethics for Nurses ***(2015)***, to uphold the inherent dignity of each person; nurses should practice with compassion and respect. [1] Compassion is perceived to be a fundamental aspect of caring and described as the "capacity to bear witness to, suffer with, and hold dear within our heart the sorrow and beauties of the world". Compassion may be nursing's most vital and precious asset. [2,3]

The concept of compassion is derived from the Buddhist traditions and is defined as sensitivity to the suffering of self and others with a commitment to engage with suffering and prevent it. However, the origins of compassion are thought to be both innate and learned. Compassion may be part of a natural frame of mind that instinctively is present during patient care, whereas, other people may slowly build up compassion through life experience, clinical practice, and the reality that everyone is susceptible to uncertain situations like the patients. Thus, compassion can be innate and also partially cultivated. In both instances, the showing of compassion to another person often flows very naturally and can be seen to be quick and easy to incorporate into healthcare. [4,5,6]

In the Oxford English Dictionary, compassion is defined as (1) Suffering together with another, participation in suffering; fellow - feeling, empathy; (2) The feeling of emotion when a person is moved by the suffering or distress of another; (3) Sorrowful emotion, sorrow, grief. Compassion entails a deep awareness of and strong willingness to try to relieve others' suffering, an active empathic presence from others, and an understanding and appreciation of a person's unique way of being in the world. [2]

Many different definitions of compassion have been highlighted in the nursing literature. Due to its subjective nature, defining and understanding the true meaning of compassion remains elusive and complex. Compassion

has been varyingly referred to as a feeling; an emotion or sentiment; an attitude; an altruistic expression; and a moral virtue. Evidence suggests that compassion requires a variety of skills, including noticing, engaging, connecting, and showing humanity and humility. [7,8,9]

For healthcare professionals, compassion is more about relational interpersonal practice. There is evidence that being cared for by compassionate clinicians increases and speeds up recovery. In addition, when clinicians feel themselves be compassionately treated by their organization and each other, they are more robust, creative, and more open The role of compassion in contemporary healthcare systems is increasingly important for both practice and policy: it is a social phenomenon that 'shapes and is shaped by conditions of inequality and coercion' extending to the notions of social justice and solidarity. [10,11,12,13]

Sympathy, empathy, and compassion are closely related terms. They are often used interchangeably within healthcare policy, delivery, and research in describing some of the human qualities that patients desire in their healthcare providers *Sympathy* has been defined in the healthcare literature as an emotional reaction of pity toward the misfortune of another, especially those who are perceived as suffering unfairly. In contrast, *empathy* has been defined as an ability to understand and accurately acknowledge the feelings of another, leading to an attuned response from the observer (Figure 1). [14,15,16]

In general, researchers identify two types of empathy: cognitive empathy (detached acknowledgment and understanding of a distressing situation based on a sense of duty) and affective empathy, which while containing each of the elements of cognitive empathy, extends to an acknowledgment and understanding of a person's situation by "feeling with" the person as shown in Figure 1. [17]

STRATEGIES TO BOOST COMPASSIONATE CARE

Compassion is evident in literature within science and the humanities. It has an evolutionary basis, marking a point in human development when we could think about others' feelings. As a consequence, humans were able to care for those in need and exhibit concern for them. This shows the relational aspect of compassion, which necessitates an understanding of and connection with another. [18]

A framework has been developed to help HCPs and managers contemplate how to reduce patient suffering, called Compassionate Connected Care. It consists of 4 components: *Clinical* (e.g. basing care on up-to-date evidence), *operational* (e.g. good coordination of care), *cultural* (e.g. not being driven by targets and data collection), and *behavioral* (e.g. respectful interactions, providing complete and understandable information). [19]

The compassionate care flow model (Figure 2) recognizes how compassionate care is provided within healthcare settings along a continuum and can be affected by a complex range of interpersonal and organizational factors. These influenced professional compassion, which appeared to energize the compassionate care flow and was driven by an innate desire to help others within work-related goals and expectations. The model shows that although compassion is commonly related to an individual, when applied to healthcare it is social, given and received in a specific setting, and shaped by being part of a professional community. [18]

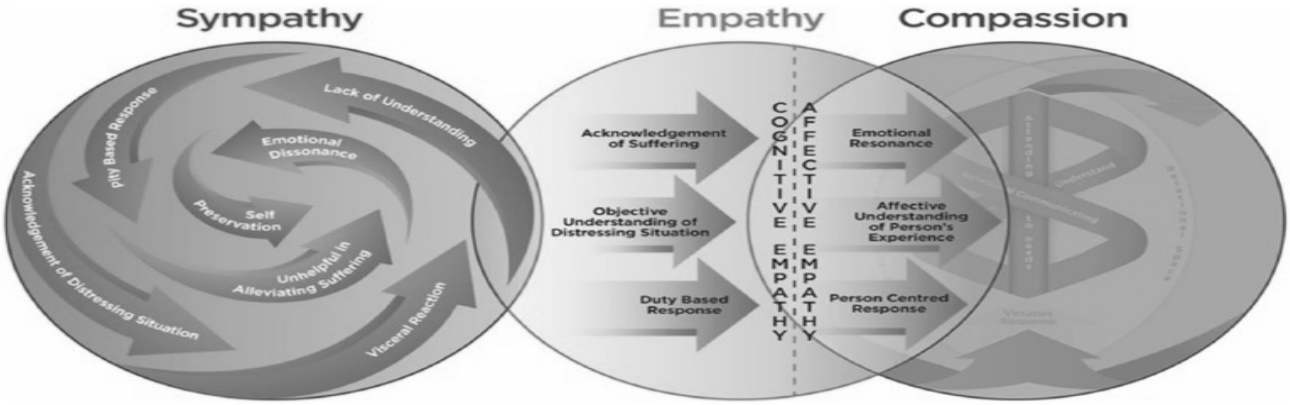

Figure 1. Sympathy, empathy, and compassion [14]

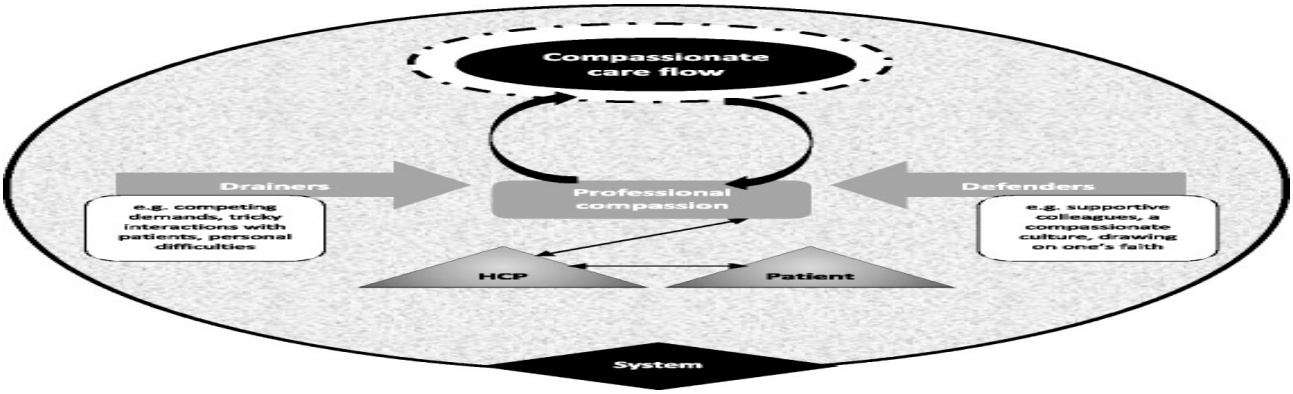

Figure 2. Compassionate care flow [18]

NURSES' PERSPECTIVES OF COMPASSION

Nurses and all healthcare professionals witness suffering daily within the working environment. When discussing healthcare professionals' reactions to suffering, although there may be a wish to remain detached from the situation and care for patients from a distance, the profession requires them to be engaged and provide compassionate care to patients and as such, they must be involved and respond appropriately to the patient that is suffering. Although this is the aim that all healthcare professionals should aspire to attain, unfortunately, many patients feel they are being left to suffer in silence and that the healthcare setting itself is causing the patients to suffer more than the medical problem. [20,21]

Van der Cingel (2011) examined compassion in the care of older adults with a chronic disorder and the nurses' who cared for them and identified the subjectivity of suffering. This need to acknowledge that suffering is subjective was explained by one of the nurses in her response to suffering 'One suffers when one says he suffers'. The study established that the suffering endured by most patients with a chronic disease was not that of pain or breathing difficulties, it was the everyday issues that concerned them, including the loss of possibilities and the thought of being a burden on people. This then highlights that suffering impacts peoples' personhood. When nurses identify with patients and the suffering experienced, they respond with compassion. [22]

Nevertheless, it is, clearly, impossible to think that nurses can always relieve a patient's suffering; however, they can facilitate patients in finding meaning to their suffering by incorporating compassion whilst caring for them. When health care providers understand a patient's view, they can better assist a suffering patient. This can be achieved by witnessing the patient's suffering and providing support that acknowledges the patient's suffering by listening and creating a supporting, healing environment. [23]

A study discerned the challenging emotions encountered when experiencing the suffering of patients. Emotions that were felt included: 'heavy', 'demanding', 'tough', energy consuming', physically and emotionally draining, and 'exhausting'. Nurses also expressed the feeling of frustration and distress when caring for a patient who was unlikely to recover from their illness; as it was felt that the suffering could not be relieved. [24]

1.1. Significance of the Study

The context for healthcare and support is continuously changing with people's life expectancy increasing, which results in a greater number of older adults requiring support. More elderly are now living in communal establishments. To provide them with the best possible compassionate care, there is a need to assess current practice in the older adult care setting, whilst taking into consideration the needs of the healthcare professionals carrying out this care. Meanwhile, it seems from media reports that current healthcare professionals are no longer compassionate in their care of patients as shown by the rise of complaints by patients and family members of poor standards of care. Since there is little work done on compassionate care in the Egyptian cultural context, studying this phenomenon could provide a deep understanding of compassionate care from the perception of Egyptian nurses.

1.2. Aims of the Study

This study aims to measure nurses' perception of compassionate care in Beni-Suef city.

1.3. Research Objectives

1. Assess nurses' practices regarding providing compassionate care to elderly patients.
2. Assess nurses' attitudes toward providing compassionate care to elderly patients.
3. Assess nurses' confidence in compassionate care?
4. Find out the relation between nurses' compassionate care and their characteristics

1.4. Research Questions

1. What about nurses' practices regarding providing compassionate care to elderly patients?
2. What about nurses' attitude toward providing compassionate care to elderly patients?
3. What about nurses' confidence in compassionate care?
4. Is there a relation between nurses' compassionate care and their characteristics?

2. Subjects and Methods

2.1. Research Design

A descriptive cross-sectional design was used in conducting the study.

2.2. Setting

This research was conducted at Beni-Suef University Hospital, General Hospital, as well as Continuing/Long-term care and Home Health Care (HHC) services.

2.3. Sampling

Sample type: convenience sample.

Sample size: 140 nurses being employed in the current health care facility for at least one year were eligible for inclusion in the study sample.

Sample technique: The required sample size was estimated based on an expected high perception rate of 50% or higher among nurses with 4% standard error, and 95% level of confidence, taking into account the finite population correction and an expected non-response rate of approximately 15%. Accordingly, and through the use of the Open-Epi software package.

2.4. Tools of Data Collection

2.4.1. Tool (1): A Structured Interviewing Questionnaire Sheet Included Two Parts

Part 1: Included data related to socio-demographic characteristics and job characteristics of nurses: such as

age, gender, residence, nursing qualification, marital status, years of experience, training courses attended, as well as the work department.

Part 2: Included Compassionate Care Scale: This was adapted and translated by the researcher based on Kemper et al (2006). [25] It was translated into Arabic using the translate-back-translate technique to preserve its validity. The scale consists of three sections as follows:

1. Compassionate care attitude: This included 15 statements categorized into attitudes related to:

a) Nurse role (5 items) such as "the nurse-patient ratio in my unit helps in the provision of compassionate care;"

b) Hospital leadership role (5 items) such as "The hospital leaders are role models in the provision of compassionate care;"

c) Individual (5 items) such as "compassionate care provision is not affected by age, sex, or nationality."

Scoring: Each statement's response was on a 4-point-Likert scale ranging from "strongly agree" to "strongly disagree." These were scored respectively from 4 to 1. The negatively stated items were inversely scored so that a higher score indicates a more positive attitude. The scores of each section and the total scale were summed up and divided by the corresponding numbers of items. These were converted into percent scores. A score of 60% or more was considered as a positive attitude, whereas a lower score was considered as a negative attitude.

2. Compassionate care practice: This consisted of three statements as follows:

a) Self-training to be calm;

b) Trust own intuition;

c) Use non-drug therapies to help a patient feel better.

Scoring: For each statement, the nurse had to provide a percentage ranging from zero to 100%. The scores of each statement and of the total scale were considered adequate practice if 60% or more, and inadequate if <60%.

3. Self-confidence in compassionate care:

This consisted of 7 statements measuring nurse's confidence in the provision of compassionate care, such as "Keep peaceful and focused when moving or in noise" and "Can describe major risks of mind-body therapies for patients."

Scoring: The response to each statement was on a numeric scale ranging from 0 = no confidence to 10 = total confidence. The scores of the seven statements were summed up and converted into a percent score, and a higher percentage reflected more self-confidence. The nurse confidence was considered high if the percent score was 60% or more, and low if <60%.

2.4.3. Tools Validity and Reliability

The scales used in this study have proved validity and reliability. [26,27] Moreover, they were translated using a translate-back-translate process to preserve their validity as recommended by Sireci et al. (2006). [28] The prepared tools were presented to a panel of experts from nursing faculty members in the community and geriatric nursing for final review. The tools were modified according to their minor suggestions. The reliability was achieved by Cronbach's Alpha coefficient test which revealed moderate to high reliability of each tool. The reliability of the scales was assessed by testing their internal consistency. They mostly demonstrated good levels of reliability as shown below.

Scales	Number of Items	Cronbach's Alpha
Nurse:		
Compassionate care attitude	15	0.42
Compassionate care practice	3	0.80
Compassionate care confidence	7	0.66

2.4.3. Pilot Study

The applicability of the study tools was tested through a pilot study that was carried out on 10% (14 nurses) to ensure clarity, and understandability of the tool. Based on the results of the pilot study, modifications and omissions of some details were done and then the final forms were developed, so the pilot study was excluded from the study sample.

2.4.4. Administrative Issue

Official permissions were obtained from the directors of the mentioned hospitals, as well as from the nursing managers as authorized personnel in the study settings. This was achieved through official letters addressed from the Dean of the Faculty of Nursing, Beni-Suef University, explaining the aim of the study and its procedures.

2.4.5. Ethical Issue

Before embarking on study conduction, approval was obtained from the scientific research and ethics committee of the Faculty of Nursing, Beni-Suef University. Oral informed consents were obtained from each nurse after a full explanation of the aim of the study and the data collection procedure. They were informed that they can refuse participation or withdraw at any stage of the data collection. They were also reassured that any information collected would be strictly confidential and only used for research purposes.

2.4.6. Fieldwork

The execution of the study was through three phases namely assessment, implementation, and evaluation. This lasted for 6 months from the beginning of July 2019 till the end of December 2019.

2.4.7. Statistical Analysis

Data entry and statistical analysis were done using SPSS 20.0 statistical software package. Data were presented using descriptive statistics in the form of frequencies and percentages for qualitative variables, means, standard deviations, medians, and interquartile ranges for quantitative variables. Qualitative categorical variables were compared using the chi-square test. Whenever the expected values in one or more of the cells in a 2x2 table was less than 5, Fisher's exact test was used instead. In larger than 2x2 cross-table, no test could be applied whenever the expected value in 10% or more of the cells was less than 5. Spearman rank correlation was used for the assessment of the inter-relationships among quantitative variables and ranked ones. To identify the independent predictors of compassionate care scores, multiple linear regression analysis was used and analysis

of variance for the full regression models was done. Statistical significance was considered at a p-value <0.05.

3. Results

The sample of nurses consisted of 140 staff nurses whose age ranged between 20 and 60 years, median 28.5 years, mostly females (63.6%) as presented in Figure 3. More than two-thirds of them were diploma degree nurses (68.6%), married (70.7%), from rural areas (77.1%), and having sufficient income (82.9%). Their medians' experience was 5.0 years.

Concerning the work departments, Figure 4 shows that slightly more than one-fourth of the nurses (27.9%) were from surgical departments. On the other hand, only 7.1% were working in special units such as dialysis, cardiac catheter, etc.

Figure 5 demonstrates that slightly less than two-thirds of the nurses in the study sample had previously attended training courses in critical care and IV catheter. Meanwhile, the majority of them attended training in infection control (81.4%).

Figure 6 indicates that a great majority of the nurses were having a positive compassion attitude related to hospital leadership (90.0%). Conversely, only 58.5% of them were having a high compassionate attitude related to nurse role. In total, the majority were having positive compassionate attitude (82.9%).

Regarding compassionate practice, Figure 7 illustrates lower percentages. Thus, the adequate compassionate practice ranged between 35.7% for the use of non-drug therapies to help a patient feel better and 68.6% for self-training to be calm. Overall, 51.4% of the nurses were having adequate compassionate practice.

Figure 8 displays that approximately two-fifths (59.3%) of the nurses in the study sample were having high total confidence in compassionate care.

Table 1 points to no statistically significant relations between nurses' compassionate care attitude and many of their characteristics, however, nurses' compassionate care attitude was positive among highly qualified married young-aged males from urban nurses who have sufficient income, p>0.05.

Similarly, as presented in Table 2, nurses' compassionate care attitude was positive among nurses who work at emergency units and have 5-10 years of experience, and who attended neither infection control nor critical care courses. However, no statistically significant relationship could be revealed between nurses' compassionate care attitude and any of their work characteristics.

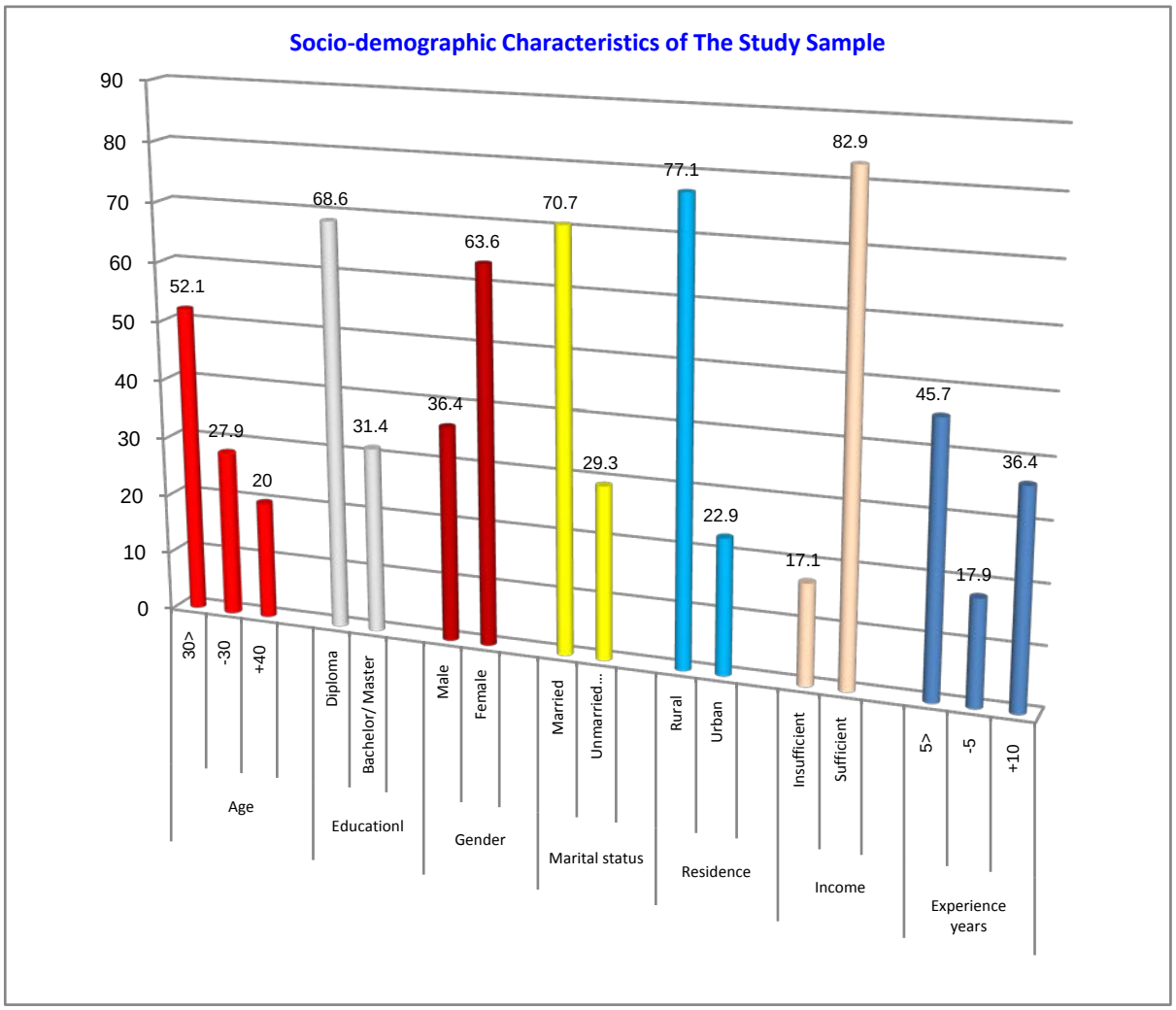

Figure 3. Socio-demographic characteristics of nurses in the study sample

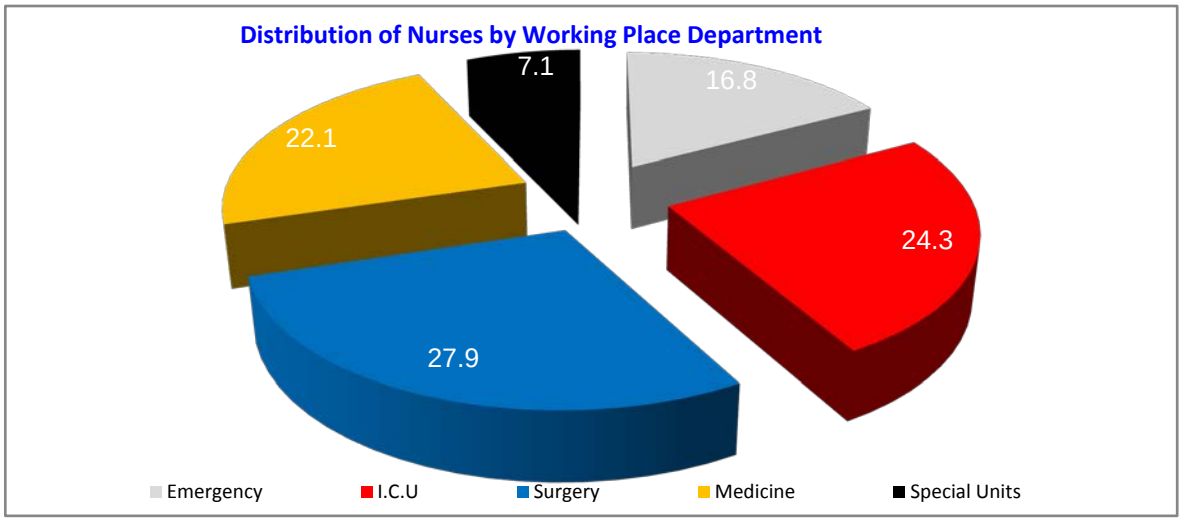

Figure 4. Distribution of nurses in the study sample by work department

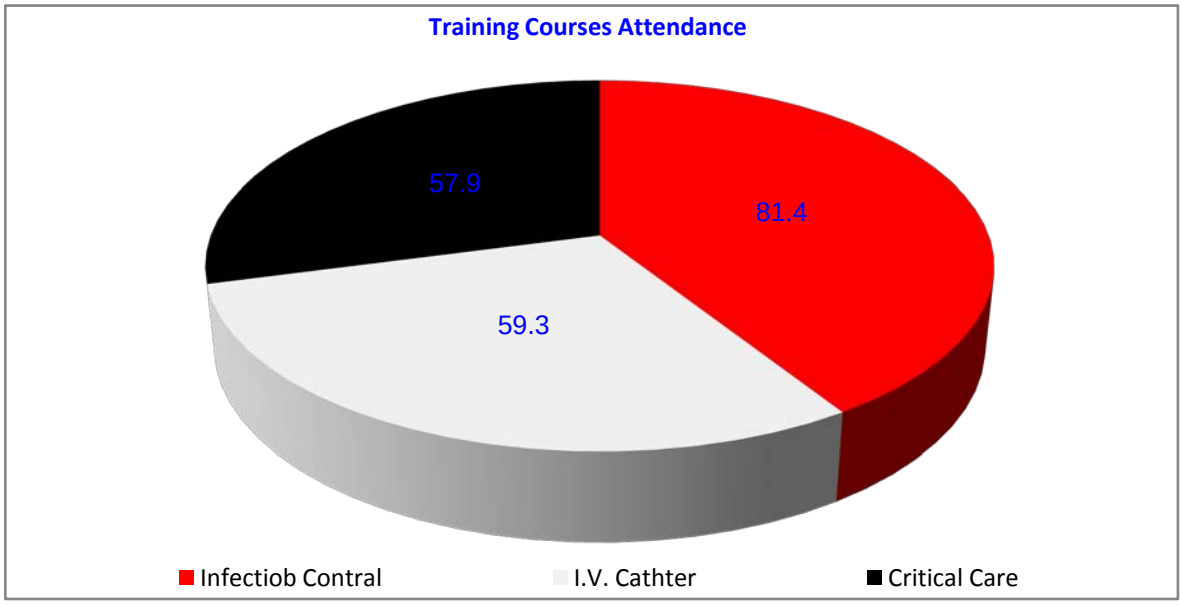

Figure 5. Attendance of training courses as reported by nurses in the study sample

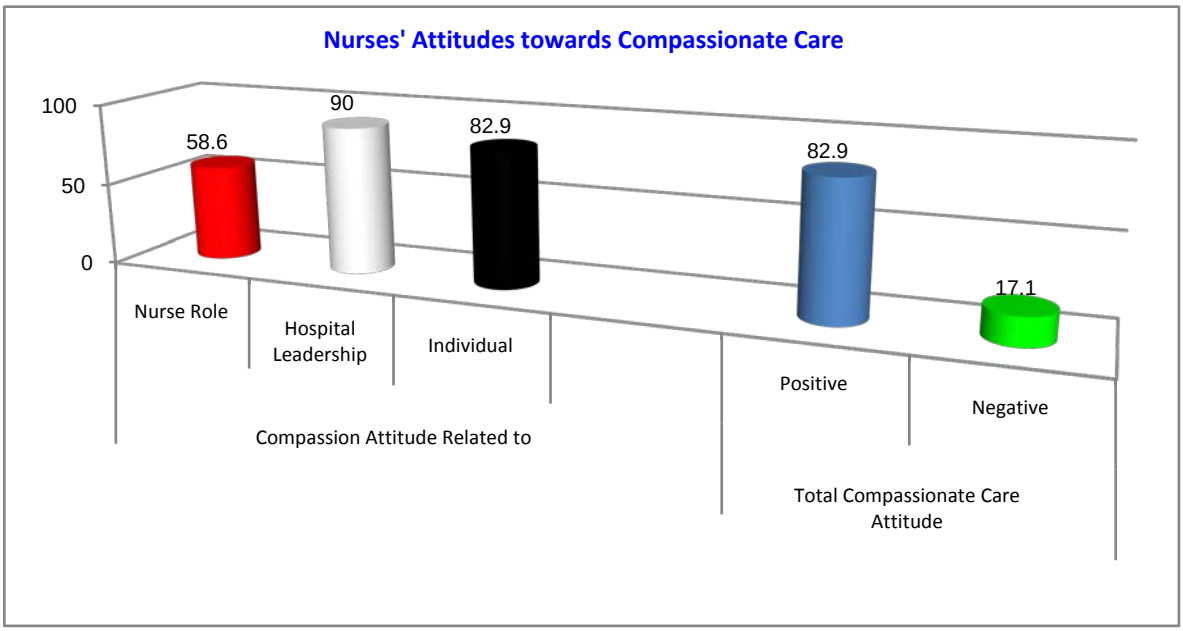

Figure 6. Attitudes towards compassionate care among nurses in the study sample

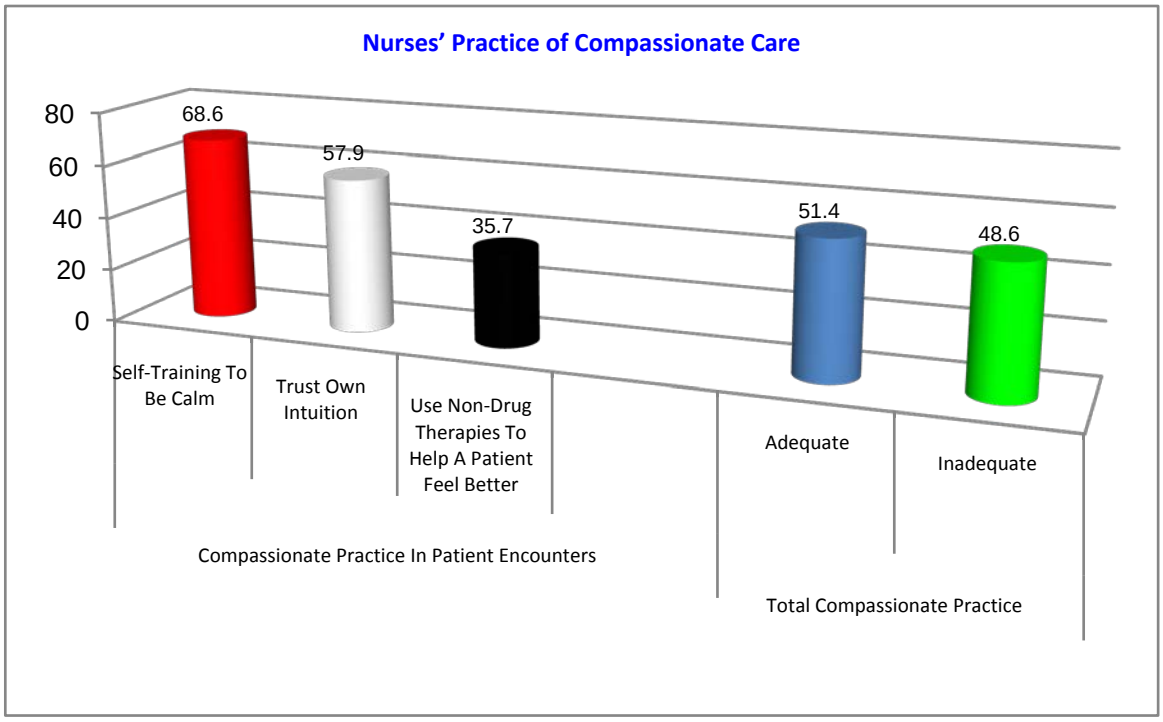

Figure 7. Practice of compassionate care among nurses in the study sample

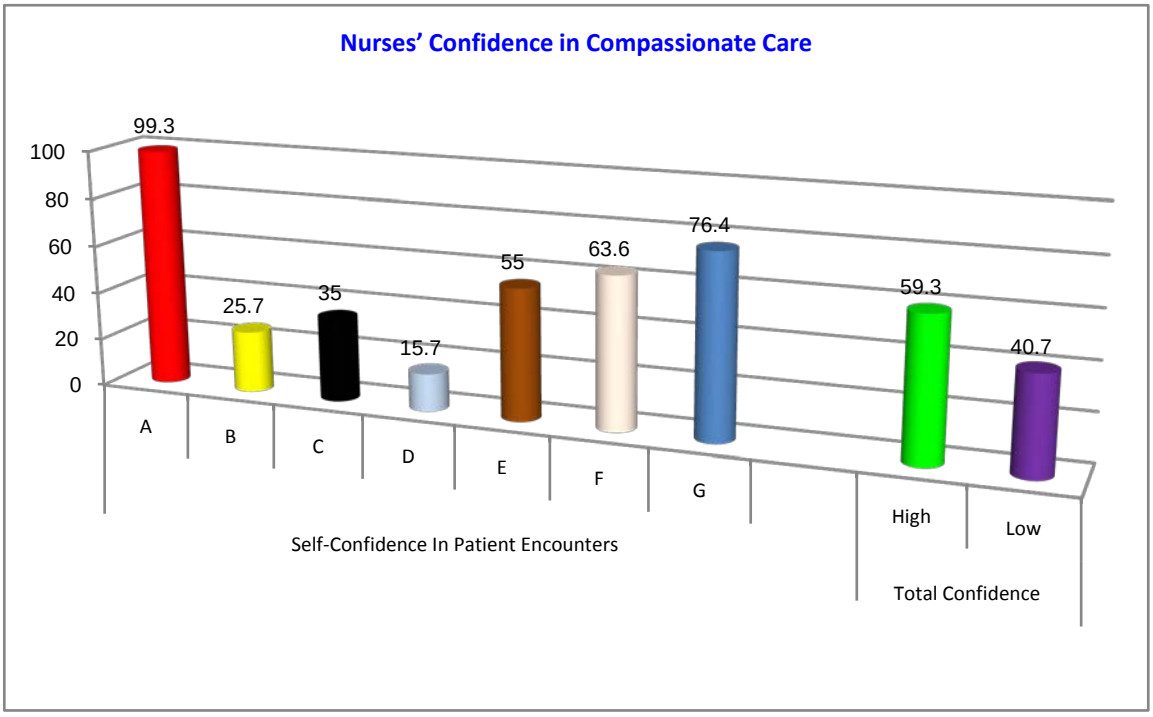

Figure 8. Confidence in compassionate care among nurses in the study sample (A. Keep peaceful and focused in a quiet environment; B. Keep peaceful and focused when moving or in noise; C. Practice non-verbal, non-pharmacological approaches to calming and reassuring patients; D. Confident in being calm, peaceful, and focused before and during patient encounters; E. Can describe major risks of mind-body therapies for patients; F. Can describe major risks and benefits of mind-body therapies for self and other clinicians; G. Can extend kindness, peace, and compassion to patients, colleagues, and self)

As illustrated in Table 3, statistically significant relationships were found between nurses' compassionate care practice and their gender (p=0.006), residence (p=0.003), and nursing qualification (p<0.001). The practice of compassionate care was more adequate among male nurses, those from rural areas, and having bachelor/master degree.

Table 4 demonstrates a statistically significant relationship between nurses' compassionate care practice and their work department (p=0.02), and experience years (p=0.04). It can be noticed that the practice of compassionate care was lowest among the nurses in surgery departments while it was adequate among those with ten or more experience years. Moreover, no statistically significant relationship could be revealed between nurses' compassionate care attitude and attendances either infection control or critical care courses.

Table 1. Relationship between nurses' attitude towards compassionate care and their personal characteristics

Items	Compassionate care attitude				X^2 test	p-value
	positive		Negative			
	No.	**%**	**No.**	**%**		
Age						
<30	64	87.7	9	12.3	--	--
30-	31	79.5	8	20.5		
40+	21	75.0	7	25.0		
Gender						
Male	45	88.2	6	11.8	1.63	0.20
Female	71	79.8	18	20.2		
Residence						
Rural	88	81.5	20	18.5	0.63	0.43
Urban	28	87.5	4	12.5		
Nursing qualification						
Diploma	77	80.2	19	19.8	1.51	0.22
Bachelor/ Master	39	88.6	5	11.4		
Marital status						
Married	84	84.8	15	15.2	0.94	0.33
Unmarried	32	78.0	9	22.0		
Income						
Insufficient	18	75.0	6	25.0	Fisher	0.25
Sufficient	98	84.5	18	15.5		

(--) Test result not valid.

Table 2. Relationship between nurses' attitude towards compassionate care and their work departments, experience, and training

Items	Compassionate care attitude				X^2 test	p-value
	positive		Negative			
	No.	**%**	**No.**	**%**		
Department						
Surgery	32	82.1	7	17.9	2.93	0.57
Medicine	25	80.6	6	19.4		
Special units (dialysis, catheter, etc.)	7	70.0	3	30.0		
Emergency	24	92.3	2	7.7		
ICU	28	82.4	6	17.6		
Experience years						
<5	54	84.4	10	15.6	3.04	0.22
5-	23	92.0	2	8.0		
10+	39	76.5	12	23.5		
Courses in infection control						
No	23	88.5	3	11.5	Fisher	0.57
Yes	93	81.6	21	18.4		
Courses in critical care						
No	51	86.4	8	13.6	0.92	0.34
Yes	65	80.2	16	19.8		

Table 3. Relationship between nurses' practice of compassionate care and their characteristics

Items	Compassionate care Practice				X^2 test	p-value
	Adequate		Inadequate			
	No.	%	No.	%		
Age						
<30	42	57.5	31	42.5	3.86	0.15
30-	20	51.3	19	48.7		
40+	10	35.7	18	64.3		
Gender						
Male	34	66.7	17	33.3	7.46	0.006*
Female	38	42.7	51	57.3		
Residence:						
Rural	63	58.3	45	41.7	9.02	0.003*
Urban	9	28.1	23	71.9		
Nursing qualification						
Diploma	39	40.6	57	59.4	14.27	<0.001*
Bachelor/ Master	33	75.0	11	25.0		
Marital status						
Married	54	54.5	45	45.5	1.31	0.25
Unmarried	18	43.9	23	56.1		
Income						
Insufficient	14	58.3	10	41.7	0.55	0.46
Sufficient	58	50.0	58	50.0		

(*) Statistically significant at p<0.05.

Table 4. Relationship between nurses' practice of compassionate care and their work departments, experience, and training

Items	Compassionate care practice				X^2 test	p-value
	Adequate		Inadequate			
	No.	%	No.	%		
Department						
Surgery	11	28.2	28	71.8	12.21	0.02*
Medicine	18	58.1	13	41.9		
Special units (dialysis, catheter, etc.)	7	70.0	3	30.0		
Emergency	15	57.7	11	42.3		
ICU	21	61.8	13	38.2		
Experience years						
<5	38	59.4	26	40.6	6.45	0.04*
5-	15	60.0	10	40.0		
10+	19	37.3	32	62.7		
Courses in infection control						
No	15	57.7	11	42.3	0.50	0.48
Yes	57	50.0	57	50.0		
Courses in critical care						
No	29	49.2	30	50.8	0.21	0.65
Yes	43	53.1	38	46.9		

(*) Statistically significant at p<0.05.

Table 5. Relationship between nurses' confidence in compassionate care and their personal characteristics

Items	Compassionate care confidence				X^2 test	p-value
	High		Low			
	No.	%	No.	%		
Age						
<30	54	74.0	19	26.0	20.29	<0.001*
30-	22	56.4	17	43.6		
40+	7	25.0	21	75.0		
Gender						
Male	34	66.7	17	33.3	1.81	0.18
Female	49	55.1	40	44.9		
Residence						
Rural	66	61.1	42	38.9	0.65	0.42
Urban	17	53.1	15	46.9		
Nursing qualification						
Diploma	49	51.0	47	49.0	8.60	0.003*
Bachelor/ Master	34	77.3	10	22.7		
Marital status						
Married	59	59.6	40	40.4	0.01	0.91
Unmarried	24	58.5	17	41.5		
Income						
Insufficient	15	62.5	9	37.5	0.12	0.72
Sufficient	68	58.6	48	41.4		

(*) Statistically significant at p<0.05.

Table 6. Relationship between nurses' confidence in compassionate care and their work departments, experience, and training

Describe	Compassionate care confidence				X^2 test	p-value
	High		Low			
	No.	%	No.	%		
Department						
Surgery	16	41.0	23	59.0	9.26	0.055
Medicine	18	58.1	13	41.9		
Special units (dialysis, catheter, etc.)	6	60.0	4	40.0		
Emergency	19	73.1	7	26.9		
ICU	24	70.6	10	29.4		
Experience years						
<5	46	71.9	18	28.1	13.50	0.001*
5-	17	68.0	8	32.0		
10+	20	39.2	31	60.8		
Courses in infection control						
No	15	57.7	11	42.3	0.03	0.85
Yes	68	59.6	46	40.4		
Courses in critical care						
No	30	50.8	29	49.2	3.01	0.08
Yes	53	65.4	28	34.6		

(*) Statistically significant at p<0.05.

Concerning compassionate care confidence, Table 5 points to a statistically significant relationship with nurses' age ($p<0.001$), and nursing qualification ($p=0.003$). As the table presents, the confidence in compassionate care decreased with increasing age and was higher among the nurses having bachelor/master degrees.

Table 6 shows that the only statistically significant relationship between nurses' compassionate care confidence and their work characteristics was with their experience years ($p=0.001$). The compassionate care confidence was higher among the nurses with less than 5 experience years.

4. Discussion

Compassionate care is one of the core values of the nursing profession since its founding by Florence Nightingale. Today, it is evident in codes of ethics, standards of care, and health policy documents that guide nursing practice Compassionate care is an international priority of healthcare professionals. [29,30,31]

The nurses in the present study sample were mostly females, in younger age groups, diploma degree nurses, with less than ten-year experience. More than two-thirds were married, and living in rural areas. Yet, the ranges of their age and experience years were very wide, so that the sample includes a wide spectrum of these two characteristics that would certainly influence their view and practice of compassionate care.

According to the results of the present study, a majority of the nurses had a positive compassionate attitude. Their compassionate care attitude was highest regarding hospital leadership. This reflects their belief in the importance of the hospital administration in fostering the practice of compassionate care in its premises. This would be through its support of the delivery of compassionate care and set it as a priority in patient's care, and also through the provision of role models by managers.

In accordance with the current study finding, ***Zamanzadeh et al. (2018)*** in Iran reported that the participating organizations seem to not support the nursing staff in providing compassionate care. [32] Additionally, a study conducted by ***Quinn (2017)*** in a study in England emphasized the role of leadership in the provision of compassionate care. [33] Furthermore, ***Ledoux et al., (2018)*** in a study in Canada concluded that nurses are often blamed for the lack of provision of compassionate care but the work environment reasons and related barriers underlying such deficiency are mostly not considered. [34]

On the other hand, the present study nurses' attitude towards compassionate care was lowest regarding the nurse role. According to the results of the current study, more than two-thirds of the study sample had a secondary level of nursing education. This is in agreement with the findings of Farag M. (2012) who found 3 types of nursing education relating to three types of nurses in Egypt today. The first level is carried out within high schools for nursing education akin to a sort of vocational education that takes place in lieu of high school (referred to as secondary level school in Egypt). The second level is carried out within a technical institute of nursing education (two years of after high school nursing education). The third or highest level is attained via a University college of nursing (students are trained over four years plus a one-year internship within a post-secondary school education or technical institute of nursing). [35]

The health sector in Egypt suffers from a severe shortage of qualified nurses (nurses with at least technical institute, or 2 years of post-high-school nursing education). The shortage has implications both for the quality of health care as well as the efficiency of the production of health services. The majority of nurses in Egypt (approximately 90%) are high school level nurses reflecting an inadequate/insufficient quality of nursing education not only internationally but even by the region's local standard. The current approach by the Ministry of Health and Population is to upgrade the standard of quality of nursing education in Egypt to eliminate high school level nursing education in the future; this seems to be the right approach. [36]

As mentioned above, most of the study nurses their attitude towards compassionate care was lowest regarding the nurse role. This low response reflects their concerns about the barriers that hinder nurses to deliver proper compassionate care such as the workload and nurse-patient ratio, as well as the limited time due to the high workload. It could also be related to the emotional distress they may experience when providing compassionate care. Nonetheless, the attitude towards compassionate care should originate from the person him/herself regardless of any barriers as shown in a study on Canadian nurses. [37] In this respect, ***Lown (2015)*** highlighted that compassionate nursing care is an individual choice whereby nurses attempt to provide care that they consider morally right. [38] Moreover, ***Fotaki (2015)*** added that people do have the option to behave compassionately or not. [12]

Concerning the factors influencing nurses' compassionate care attitude, the present study results showed that only the marital status had a significant effect on it. Thus, the multivariate analysis identified the unmarried status as the only significant negative predictor of the compassionate care attitude score, indicating a tendency to more positive attitude among the married nurses. This might be explained by the experience of more close family relations with spouses and children that might increase the sense of compassion.

The present study has also assessed nurses' compassionate care practice. The findings demonstrated that only around a half of them were having adequate compassionate practice. This low adequacy of practice might be attributed to the lack of training in compassionate care. In contradiction with this, a systematic review concluded that the delivery of compassionate care is recently more facilitated by the increasing use of digital technology in nursing care. [39]

According to the current study results, the least adequate area of nurses' compassionate practice was related to their use of non-drug therapies to help a patient feel better. This might be explained by their lack of knowledge of non-pharmacological approaches like relaxation exercises, meditations, and other related therapies. In this regard, a recent study in the United States demonstrated that the majority of elderly patients,

as well as health care providers, found that the non-pharmacological approaches as compassionate care tools improved patients' satisfaction. [40]

On the other hand, around two-thirds of the nurses in the present study reported adequate practice in self-training to be calm. This might be acquired through their long experience with the provision of care to patients. They might have learned that anger and a nervous response would have negative outcomes on the patients and their families, as well as on themselves. In agreement with this, previous research has concluded that compassion is a core component in human nature, and thus compassionate care can be developed and nurtured throughout a person's lifetime. [41,42]

Regarding the factors influencing nurses' compassionate care practice, the bivariate analyses revealed that male nurses and those residing in rural areas had significantly more adequate practice. However, in the multivariate analysis, nurse's gender had no significant influence, but the rural residence persisted as a positive predictor of the score of compassionate practice. The finding might be attributed to the more close relationships in the rural community leading to a more intense sense of compassion among them. A similar finding was reported by ***Ruiz-Fernández et al. (2020)*** in a study of compassion satisfaction among nurses in Spain. Their results demonstrated that urban residence was a negative predictor of their compassion. [43]

Nurses' age and experience were also factors having a significant impact on their compassionate care practice in the current study. Thus, the scores of compassionate care practice had significant negative correlations with nurses' age and experience. Meanwhile, only age persisted in the multivariate analysis as a significant negative predictor of the score of compassionate care practice. This might be attributed to the increasing low tolerance to stressors with increasing age, thus leading to less adequate compassionate care. The finding is in congruence with ***Kolthoff and Hickman (2017)*** whose study in the United States demonstrated that nurses' compassionate care had an inverse relationship with their age. [44]

The present study has also demonstrated that the nurses having a bachelor/master degree in nursing had significantly more adequate compassionate practice. Moreover, nurses' score of compassionate care practice had significant positive correlations with their qualification, and in the multivariate analysis, a higher qualification was identified as a positive predictor of this score. This might be attributed to the higher emphasis given to this subject in the curricula of these higher degrees. The result is in line with previous studies that reported a positive impact of a higher level of education on nurses' confidence in compassionate care. [45,46] Moreover, a systematic review provided strong evidence of education on nurses' compassionate care. [47]

It was also noticed that the practice of compassionate care was lowest among the nurses in surgery departments, although the influence of this factor was not confirmed in multivariate analysis. This difference might be explained by that the time of contact between the nurse and the patients. In surgical patients, this contact time is usually shorter in comparison with those in medical departments where more prolonged contact and less acuity of patient condition may lead to more close relationships and more compassionate care. In agreement with this, a study in Scotland revealed that nursing students perceived a lower possibility of compassion in acute situations. [48]

Concerning nurses' confidence in compassionate care, the present study results showed that approximately two-thirds of them were having high confidence. This is a relatively low percentage reflecting their inability to keep peaceful and focused in dealing with patients and their families, and to use non-pharmacological approaches such as mind-body therapies to calm and reassure them. This is again certainly due to their lack of knowledge and deficient training in compassionate care. Hence, ***Babaei and Taleghani (2019)*** in their study in Iran recommended more emphasis on training nurses in compassionate care to improve their related attitudes and practice. [24]

As for the factors affecting nurses' confidence in compassionate care practice, the results of the current study revealed that this confidence significantly decreased with increasing age and experience, and was higher among those having bachelor/master degrees. Moreover, the scores of compassionate care confidence had significant positive correlations with nurses' qualifications and negative correlations with their age and experience. These findings were confirmed in multivariate analysis. The same explanations provided before regarding the effect of age and nursing qualification on compassionate care practice also apply to nurses' confidence in compassionate care. In agreement with this, a study in Spain demonstrated that nurses' emotional and compassionate skills increased with their age ***(Giménez-Espert et al., 2019)***. [49]

5. Conclusion

The study findings lead to the conclusion that the nurses in the study settings have a generally positive attitude towards compassionate care. However, their practice of compassionate care and related self-confidence seems to be low among them. These are influenced by nurses' age, qualification, experience years, residence, and income.

6. Recommendations

1. In-service training programs should be applied on a wide scale for nurses to improve their practice and self-confidence related to compassion care.
2. The subject of compassionate care should be given more consideration in undergraduate and postgraduate nursing curricula.
3. Further research is suggested to evaluate the long-term effect of in-service training programs on nurses' practice of compassionate care and their related self-confidence.
4. The impact of such training interventions on elderly patients' opinions about compassionate care should also be investigated.

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