Nurses' Perception of Elderly Patient Compassionate Care Delivery in Beni_Suef city

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ABSTRACT

Background: Although compassionate care especially for elderly patients is increasingly addressed in nursing, little work was done in the Egyptian cultural context. **Aim of the study:** to measure nurses' perception of compassionate care delivery in Beni_Suef city. **Subjects and methods:** This descriptive cross-sectional study was carried-out in Beni_Suef University Hospital, General Hospital, as well as Continuing/Long-term care and Home Health Care (HHC) services on 140 nurses in the settings. Data were collected using a self-administered questionnaire including the compassionate care scale assessing nurse's compassionate care attitude, practice, and self-confidence. The fieldwork lasted from January to June 2019. **Results:** Nurses' age ranged between 20 and 65 years, mostly females (63.6%), with diploma degree nurses (68.6%). The majority had high compassionate attitude (82.9%), but only 51.4% had having adequate compassionate practice and 59.3% had high confidence in compassionate care. The compassionate care confidence and practice scores had significant positive correlations with qualification, and negative correlations with age and experience. **Conclusion and recommendations:** The nurses' attitude towards compassionate care is high, whereas their practice of compassionate care and related self-confidence are low. The study recommends in-service specialized training programs for nurses. The subject of compassionate care should be given more consideration in nursing curricula. Further research is suggested to evaluate the long-term effect of such programs on nurses' practice of compassionate care and related self-confidence.

Keywords: Compassionate care, elderly, nurses, attitude, practice, self-confidence

INTRODUCTION

Compassion is a feeling or sympathetic attitude towards others' distress that stimulates a desire to help them ***(Sinclair et al., 2016)***. It could be innate in nature as a trait or acquired through practice ***(Baker et al., 2018)***. In health care, compassion fosters caregivers' desire to assist patients and to focus on their uniqueness as humans. Such compassion is of major benefits for the patients as well as the care providers. For patients, it enhances their trust, with subsequent more satisfaction, relief of symptoms, more speedy recovery, and better quality of life. For the caregivers, compassion has a positive impact on their

job satisfaction and retention ***(Tehranineshat et al., 2019)***.

Compassionate care is a core value in nursing throughout the history of this profession and all over the world ***(Mills et al., 2015)***. It is sometimes used as a synonymous for nursing care given its empathetic nature ***(McCaffrey and McConnell, 2015)***. Thus, the nursing ethical codes are mostly based on compassion and compassionate care ***(American Nurses Association, 2015; Tehranineshat et al., 2018)***. It s thus fundamental and valuable asset for nurses ***(Hemberg and Wiklund Gustin, 2020)***.

Conversely, the lack of compassion care could have negative impacts on patients, with more distress and suffering, leading to poor patient outcomes, dissatisfaction with the quality of care, and blame of nursing ***(Papadopoulos and Ali, 2016)***. In fact, if the care providers are not compassionate with their patients, they would not be capable of address their problems and concerns as well as of their families ***(Lown, 2014; Babaei and Taleghani, 2019)***.

Although compassionate care is increasingly addressed in nursing as a desirable attributed in care settings, nurses are faced with many challenges hindering its practice ***(Robinson et al., 2020)***. This is often attributed to the shortage of resources including time and manpower ***(Arespacochaga and Shin, 2019)***. Another challenge is the cultural context in which the compassionate care is to be delivered, since the significance of compassion may vary according to culture ***(Sims et al., 2020)***. Hence, facilitating the provision of compassionate care in daily nursing practice is a challenging matter that needs more investigation ***(Zamanzadeh et al., 2018)***.

Significance of the study

The context for healthcare and support is continuously changing. 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.

AIM OF THE STUDY

The aim of this study was to measure nurses' perception of compassionate care in Beni Suef city and its relation to their characteristics.

SUBJECTS AND METHODS

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

Setting: The study was carried-out in Beni-Suef University Hospital, General Hospital, as well as Continuing/Long-term care and Home Health Care (HHC) services.

Subjects: All nurses in the above mentioned settings who fulfilled the inclusion criterion of being employed in the current facility for at least one year were eligible for selection in the study sample. 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, the required sample size turned to be 140 nurses. Nurses were recruited by convenience sampling according to the eligibility criterion.

Data collection tools: A self-administered questionnaire sheet was developed by the researcher based on related literature. It included a section for the nurse demographic and job characteristics and a compassionate care scale. This was adapted and translated by the researcher based on ***Kemper et al (2006)***. The scale consists of three sections.

- *Compassionate care attitude* included 15 statements categorized into attitudes related to nurse role (5 items), hospital leadership role (5 items), and individual (5 items). For 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 of the total scale were summed-up and divided by the corresponding numbers of items and converted into percent scores. A score of 60% or more was considered as positive attitude, whereas a lower score was considered as negative attitude.
- *Compassionate care practice*: *consisted* of three *statements* assessing self-training to be calm, trusting own intuition, and using non-drug therapies to help a patient feel better. 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%.
- *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." For 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%.

Validity and reliability of the tool: The scale used in this study have proved validity and reliability ***(Burnell and Agan, 2013; Grimani, 2017)***. Moreover, it translated using a translate-back-translate process to preserve their validity as recommended by ***Sireci et al. (2006)***. The prepared tool was also presented to a panel of experts from nursing faculty members in community and geriatric nursing for final review. The tool modified according to their suggestions,

which were minor. The reliability of the scales were assessed through testing their internal consistency. They mostly demonstrated good levels of reliability for practice and confidence, Cronbach's Alpha 0.80 and 0.66 respectively.

Pilot study: This was carried out on samples representing about 10% of the main sample size to assess the clarity and legibility of the tools, as well as evaluating the suitability of the setting. It also served to determine the approximate time needed for the data collection. The pilot sample was included in the main study sample as no changes were needed in the data collection tool.

Fieldwork: The researcher visited each of the study settings, met with the nursing director, and arranged a schedule for data collection. Then, the eligible nurses were recruited after giving their oral consent. They were handed the data collection form and instructed in filling it. The researcher was present all time for any clarification, collected the filled forms, and checked for their completion. The fieldwork lasted from January to June 2019.

Ethical considerations: Official permissions were obtained from the directors of the mentioned hospitals. The study protocol was approved by the scientific research and ethics committee of the Faculty of Nursing, Beni-Suef University. Oral informed consents were obtained from each nurse after 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 in research purposes.

Statistical analysis: Data entry and statistical analysis were done using SPSS 20.0 statistical software package. Spearman rank correlation was used for assessment of the inter-relationships among quantitative variables and ranked ones. In order to identify the independent predictors of the 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 p-value <0.05.

RESULTS

The sample of nurses consisted of 140 staff nurses whose age ranged between 20 and 65 years, median 28.5 years, mostly females (63.6%) as presented in Table 1. 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. 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.

As Table 2 indicates, a great majority of the nurses were having high compassion attitude related to hospital leadership (90.0%). Conversely, only 58.5% of them were having high compassionate attitude related to nurse role. In total, the majority were having high compassionate attitude (82.9%).

Regarding compassionate practice, Table 3 illustrates lower percentages. Thus, the adequate compassionate

practice ranged between 35.7% for the use 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.

As regards nurses' confidence in compassionate care, Table 4 indicates a very wide variation. Thus, almost all of them (99.3%) were having high self-confidence in keeping peaceful and focused in quiet environment. On the other extreme, only 15.7% of them had high confidence in being calm, peaceful, and focused before and during patient encounters. In total, approximately three-fifth (59.3%) of the nurses in the study sample were having high confidence in compassionate care.

As illustrated in Table 5, statistically significant moderate positive correlations were identified among nurses' scores of compassionate care attitude, practice, and confidence. The strongest of the correlations was between the scores of confidence and practice (r=0.642). Nurses' scores of compassionate care confidence and practice had statistically significant weak positive correlations with their qualification, and negative correlations with their age and experience. Meanwhile, their attitude had no significant correlations with any of their characteristics.

In multivariate analysis (Table 6), the unmarried status of the nurse was the only statistically significant independent negative predictor of the compassionate care attitude score. However, it explained only 3% of the variation in this score. Meanwhile, nurse age and urban residence were the statistically significant independent negative predictors of the compassionate care practice score, whereas the higher nursing qualification was a positive predictor. These factors explain 18% of the variation in the practice score. Moreover, nurse age was a statistically significant independent negative predictor of the compassionate care confidence score. On the other hand, a higher nursing qualification and longer experience were positive predictors. These factors explain 13% of the variation in the confidence score.

DISCUSSION

Compassion is a universal concept with differing perception, understanding, and meaning in various cultures and races ***(Singh et al., 2020)***. The aim of this study was to measure nurses' perception of compassionate care in Beni Suef city. The findings indicate generally high and positive attitudes but low practice and self-confidence regarding compassionate care among these nurses.

According to the present study results, a majority of the nurses had high compassionate attitude, especially regarding hospital leadership. This reflects their belief in the importance of the hospital administration in fostering the practice of compassionate care in its premises through setting it as a priority in patient care, and through the provision of more support and managers' role model. In congruence with this, ***Quinn (2017)*** in a study in England emphasized the role of leadership in the provision of compassionate care. Additionally, a study by ***Zamanzadeh et al. (2018)*** in Iran reported that the participating organizations seem to not support the nursing staff in providing compassionate care. Furthermore, ***Ledoux et al., (2018)***

in a study in Canada concluded that nurses are often blamed for lack of provision of compassionate care but the work environment reasons and related barriers are mostly not considered.

On the other hand, the present study nurses' attitude towards compassionate care was lowest regarding nurse role. This reflects their concerns about the barriers that hinder their delivery of proper compassionate care such as the workload and nurse patient ratio, with limited time. 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 ***(Singh et al., 2018)***.

In this respect, ***Lown (2015)*** highlighted that compassionate nursing care is a personal choice whereby nurses attempt to provide care that they consider morally right. Moreover, ***Fotaki (2015)*** added that people do have the option to behave compassionately or not.

Concerning the factors influencing nurses' compassionate care attitude, the present study results showed that only the marital status had a significant effect on it, and the unmarried status was identified 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 spouse 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 might be attributed to the lack of related training. 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 ***(Kemp et al., 2020)***. According to our results, the least adequate area of nurses' compassionate practice that of their use non-drug therapies to help patient feel better. This might be explained by their lack of knowledge of such non-pharmacological approaches like relaxation exercises, meditation, and other related therapies. In this regard, a recent study in the United States demonstrated that the majority of health care providers found that non-pharmacological approaches as compassionate care tools improved patients' satisfaction ***(Lichen et al., 2020)***.

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 have been acquired through their long experience with provision of care. They might have learned that anger and 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 ***(Greenberg and Turksma, 2015; Chaloner and Healthc, 2019)***.

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 multivariate analysis, gender had no significant influence, but the rural residence persisted as a positive predictor. This result might be attributed to the more close relationships in 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 among nurses in Spain, where urban residence was a negative predictor of their compassion.

Nurses' age and experience were also factors having significant impact on their compassionate care practice in the current study, with significant negative correlations. Meanwhile, only age persisted in the multivariate analysis as a significant negative predictor of the score of 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 demonstrated that nurses' compassionate care had an inverse relationship with their age.

The present study has also demonstrated that the nurses having a bachelor/ master degree in nursing had significantly more adequate compassionate practice, 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 ***(Bray et al., 2014; Henderson and Jones, 2017)***.

Moreover, a systematic review provided a strong evidence of the impact of education on nurses' compassionate care ***(Coffey et al., 2019)***.

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.

As for the confidence in compassionate care practice, the results of the current study revealed that it significantly decreased with increasing age and experience, and was higher among those having bachelor/ master degree. Moreover, the scores of compassionate care confidence had significant positive correlations with nurses' qualification, and negative correlations with their age and experience, and this was confirmed in multivariate analysis. The same explanations provided before regarding the effect of age and nursing qualification

on compassionate care practice also apply for 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)***.

Conclusion and recommendations

In conclusion, the nurses in the study settings have generally positive attitude towards compassionate care. However, their practice of compassionate care and related self-confidence seem to be low among them. The study recommends in-service specialized training programs for nurses, with more focus on older age nurses and those with lower level of nursing qualification. The subject of compassionate care should be given more consideration in nursing curricula. 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.

REFERENCES

American Nurses Association (2015): Code of ethics for nurses with interpretive statements. Retrieved on Feb. 20, 2020 at: https:// www. nursing world. org/practice-policy/ nursing-excellence/ethics/

Babaei S, and Taleghani F. (2019): Compassionate Care Challenges and Barriers in Clinical Nurses: A Qualitative Study. Iran J Nurs Midwifery Res.;24(3):213-219. doi: 10. 4103 /ijnmr.IJNMR_100_18

Baker L.R., Martimianakis M.A.T., and Nasirzadeh Y. (2018): Compassionate Care in the Age of Evidence-Based Practice: A Critical Discourse Analysis in the Context of Chronic Pain Care. Acad Med.; 93(12): 1841- 1849. doi: 10. 1097/ ACM. 000000000 0002373

Bray L., O'Brien M.R., Kirton J., Zubairu K., and Christiansen A. (2014): 'The role of professional education in developing compassionate practitioners: A mixed methods study exploring the perceptions xof health professionals and pre-registration students', Nurse Education Today; 34(3):480-486.

Chaloner R.S.J., and Healthc M. (2019): Providing Compassionate Care for Every Kind of Person. 2019 Jul- Aug; 64(4):205-208. doi: 10. 1097/ JHM-D-19-00100

Coffey A., Saab M.M., and Landers M. (2019): The impact of compassionate care education on nurses: A mixed-method systematic review. J Adv Nurs.; 75(11):2340-2351. doi:10. 1111/jan.14088

Fotaki M. (2015): Why and how is compassion necessary to provide good quality healthcare?. Int J Health Policy Manag.;4(4):199-201. Published 2015 Mar 16. doi:10. 15171/ijhpm.2015.66

Giménez-Espert M.D.C., Valero-Moreno S., and Prado-Gascó V.J. (2019): Evaluation of emotional skills in nursing using regression and QCA models: A transversal study. Nurse Educ Today.;74:31-37.doi: 10. 1016/ j. nedt. 2018. 11.019

Greenberg M.T., and Turksma C. (2015): Understanding and watering

the seeds of compassion. Res Hum Dev; 12: 280– 7.

Grimani K. (2017): Measuring Compassionate Care: Reliability and Validity of the Greek Version of a Compassionate Care Assessment Tool. Journal of Correctional Health Care. 2017;23(3):353-364. doi: 10. 1177/ 1078345817716436

Hemberg J., and Wiklund Gustin L. (2020): Caring from the heart as belonging-The basis for mediating compassion. Nurs Open.;7(2):660-668. Published 2020 Jan 10. doi:10. 1002/nop2.438

Henderson A., and Jones J. (2017): Developing and Maintaining Compassionate Care in Nursing. 2012 RCN Publishing Company Ltd. PMID: 29094531. DOI: 10.77 48/ns. 2017. e10895.

Kemper K., Larrimore D., Dozier J., and Woods C. (2006): Impact of a medical school elective in cultivating compassion through touch therapies. Complement Health Pract Rev; 11:47-56

Kemp J., Zhang T., and Inglis F. (2020): Delivery of Compassionate Mental Health Care in a Digital Technology-Driven Age: Scoping Review. J Med Internet Res.; 22(3):e16263. doi:10.21 96/16263

Kolthoff K.L., and Hickman S.E. (2017): Compassion fatigue among nurses working with olde. Geriatric Nursing 38 (2017) 106e109. 2016 Elsevier Inc. All rights reserved.

Ledoux K., Forchuk C., Higgins C., and Rudnick A. (2018): The effect of organizational and personal variables on the ability to practice compassionately. Appl Nurs Res.; 41: 15- 20. doi: 10. 1016/ j. apnr. 2018. 03.001

Lichen I.M., Berning M.J., and Bower S.M. (2020): Non-pharmacologic interventions improve comfort and experience among older adults in the Emergency Department [published online ahead of print, 2020 May 4]. Am J Emerg Med.;S0735-6757 (20) 30322- 3. doi: 10. 1016/ j. ajem. 2020. 04. 089

Lown B.A. (2014): Toward more compassionate healthcare systems Comment on "Enabling compassionate healthcare: perils, prospects and perspectives". Int J Health Policy Manag; 2: 199.

Lown B.A. (2015): Compassion is a necessity and an individual and collective responsibility: comment on why and how is compassion necessary to provide good quality healthcare? Int J Health Policy Manag; 4: 613. Crossref PubMed Web of Science®Google Scholar.

McCaffrey G., and McConnell S. (2015): Compassion: a critical review of peer-reviewed nursing literature. J Clin Nurs; 24(19–20): 3006– 3015.

Mills J., Wand T., and Fraser J.A. (2015): On self-compassion and self-care in nursing: selfish or essential for compassionate care? Int J Nurs Stud; 52(4): 791–793.

Papadopoulos I., and Ali S. (2016): Measuring compassion in nurses and other healthcare professionals: an

integrative review. Nurse Educ Pract; 16: 133–9.

Quinn B. (2017): Role of nursing leadership in providing compass-ionate care. Nurs Stand.; 32 (16-19): 53-63. doi: 10. 7748/ ns. 2017. e11035

Ruiz-Fernández M.D., Pérez-García E., Ortega-Galán Á.M. (2020): Quality of Life in Nursing Professionals: Burnout, Fatigue, and Compassion Satisfaction. Int J Environ Res Public Health.;17(4):1253. doi:10.3390/ijerph17041253

Sims S., Leamy M., Levenson R., Brearley S., Ross F., and Harris R. (2020): The delivery of compassionate nursing care in a tick-box culture: Qualitative perspectives from a realist evaluation of intentional rounding [published online ahead of print, 2020 Mar 20]. Int J Nurs Stud.;107:103580. doi:10.1016/j.ijnurstu.2020.103580

Sinclair S., Norris J., McConnell S.J. M., Chochinov H., Hack T.F.M., Hagen N., McClement S.A., and Bouchal S.R. (2016): Compassion: a scoping review of the healthcare literature. BioMed Central Pallative Care;15 (6) 3-16

Singh P., Raffin-Bouchal S., Mc Clement S., Hack F. T., Kelli Stajduhar NA. Hagen, A., Chochinov H. M, and Sinclair S. (2018): Healthcare Providers' Perspectives on Perceived Barriers and Facilitators of Compassion: Results From a Grounded Theory Study. 2018 May; 27(9-10): 2083-2097. doi: 10.1111/jocn.14357.

Singh P., King-Shier K., and Sinclair S. (2020): South Asian Patients' Perceptions and Experiences of Compassion in Healthcare; 25 (4): 606- 624. doi: 10. 1080/ 13557858. 2020. 1722068.

Sireci S.G., Wang Y., Harter J., and Ehrlich E.J. (2006): Evaluating guidelines for test adaptations: A methodological analysis of translation quality. Journal of Cross-Cultural Psychology; 37:557–567.

Tehranineshat B., Rakhshan M., Torabizadeh C., and Fararouei M. (2019): Compassionate Care in Healthcare Systems: A Systematic Review. J Natl Med Assoc.; 111(5): 546- 554. doi: 10. 1016/ j. jnma. 2019. 04. 002

Tehranineshat B., Rakhshan M., Torabizadeh C., and Fararouei M. (2018): Nurses', patients' and family caregivers' perceptions of compassionate nursing care. Nursing Ethics; 26: 1707–1720. 10. 1177/ 09697330 18777884

Zamanzadeh V., Valizadeh L., Rahmani A., van der Cingel M., Ghafourifard M. (2018): Factors facilitating nurses to deliver compassionate care: a qualitative study. Scand J Caring Sci.;32(1):92-97. doi: 10. 1111/ scs. 12434.

Table (1): Socio-demographic characteristics of nurses in the study sample (n=140)

	Frequency	Percent
Age:		
<30	73	52.1
30-	39	27.9
40+	28	20.0
Range	20.0-65.0	
Mean±SD	31.3±9.5	
Median	28.5	
Gender:		
Male	51	36.4
Female	89	63.6
Nursing qualification:		
Diploma	96	68.6
Bachelor/ Master	44	31.4
Marital status:		
Married	99	70.7
Unmarried (single/divorced/widow)	41	29.3
Residence:		
Rural	108	77.1
Urban	32	22.9
Income:		
Insufficient	24	17.1
Sufficient	116	82.9
Experience years:		
<5	64	45.7
5-	25	17.9
10+	51	36.4
Range	0.0-43.0	
Mean±SD	8.2±7.9	
Median	5.0	
Department:		
Surgery	39	27.9
Medicine	31	22.1
Special units (dialysis, catheter, etc.)	10	7.1
Emergency	26	18.6
ICU	34	24.3

Table (2): Attitudes towards compassionate care among nurses in the study sample (n=140)

High (60%+) compassion attitude related to:	**Frequency**	**Percent**
Nurse role	82	58.6
Hospital leadership	126	90.0
Individual	116	82.9
Total compassionate care attitude:		
High	116	82.9
Low	24	17.1

Table (3): Practice of compassionate care among nurses in the study sample (n=140)

Adequate (60%+) compassionate practice in patient encounters:	**Frequency**	**Percent**
Self-training to be calm	96	68.6
Trust own intuition	81	57.9
Use non-drug therapies to help a patient feel better	50	35.7
Total compassionate practice:		
Adequate	72	51.4
Inadequate	68	48.6

Table (4): Confidence in compassionate care among nurses in the study sample (n=140)

High (60%+) self-confidence in patient encounters:	**Frequency**	**Percent**
Keep peaceful and focused in quiet environment	139	99.3
Keep peaceful and focused when moving or in noise	36	25.7
Practice non-verbal, non-pharmacological approaches to calming and reassuring patients	49	35.0
Confident in being calm, peaceful, and focused before and during patient encounters	22	15.7
Can describe major risks of mind-body therapies for patients	77	55.0
Can describe major risks and benefits of mind-body therapies for self and other clinicians	89	63.6
Can extend kindness, peace, and compassion to patients, colleagues, and self	107	76.4
Total confidence:		
High	83	59.3
Low	57	40.7

Table (5): Correlation matrix of nurses' scores of compassionate care dimensions and with their characteristics

Compassionate care	Spearman's rank correlation coefficient		
	Attitude	**Practice**	**Confidence**
Attitude			
Practice	.417**		
Confidence	.414**	.642**	
Characteristics:			
Age	-.003	-.215*	-.246**
Qualification	.157	.274**	.230**
Income	.028	-.102	-.071
Experience	.030	-.250**	-.179*

(*) Statistically significant at p<0.05 *(**) Statistically significant at p<0.01*

Table (6): Best fitting multiple linear regression model for nurses' scores of compassionate care attitude, practice, and confidence

	Unstandardized Coefficients		**Standardized Coefficients**	**t-test**	**p-value**	**95% Confidence Interval for B**	
	B	**Std. Error**				**Lower**	**Upper**
Compassionate care attitude scores							
Constant	76.81	1.38		55.753	<0.001	74.09	79.54
Unmarried	-2.39	1.01	-0.20	2.376	0.019	-4.38	-0.40
r-square=0.03 Model ANOVA: F=5.47, p=0.02 Variables entered and excluded: age, gender, qualification, experience, residence, income							
Compassionate care practice scores							
Constant	83.13	7.47		11.126	<0.001	68.35	97.90
Age	-0.41	0.16	-0.21	2.594	0.011	-0.72	-0.10
Urban residence	-8.30	3.56	-0.19	2.333	0.021	-15.33	-1.26
Qualification	13.30	3.16	0.33	4.214	<0.001	7.06	19.54
r-square=0.18 Model ANOVA: F=9.66, p<0.001 Variables entered and excluded: gender, experience, marital status, income							
Compassionate care confidence scores							
Constant	82.24	3.68		22.330	<0.001	74.96	89.52
Age	-0.50	0.15	-0.51	3.296	0.001	-0.81	-0.20
Qualification	4.83	1.64	0.24	2.942	0.004	1.58	8.07
Experience	0.43	0.18	0.36	2.333	0.021	0.07	0.80
r-square=0.13 Model ANOVA: F=6.76, p<0.001 Variables entered and excluded: gender, marital status, residence, income							