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Nurses' ratings of compassionate nursing leadership during the Covid-19 pandemic—A descriptive cross-sectional study

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Abstract

Aim: The aim of this study is to investigate how intensive and emergency nurses rated the adequacy of compassionate leadership during the early stages of the Covid-19 pandemic.

Background: The pandemic has resulted in nurses' increased stress and need for compassion from leaders. Compassionate leadership is here defined as a number of leadership practices based on altruistic values and emotional intelligence.

Method: This is a quantitative descriptive cross-sectional study based on a questionnaire for 50 intensive and emergency care nurses in a central hospital in Finland.

Results: The pandemic had increased nurses' need for compassion, but their needs for support had not been met and their strengths and competence appreciated sufficiently. They agreed that compassionate leadership could be developed through experience and personal development rather than through education.

Conclusion: Compassionate leadership is a process that involves a number of leadership practices based on altruistic values and emotional intelligence and benefits from recognition and use of employee strengths. Leaders and employees could benefit from simulation-based learning, work supervision and discussion led by external facilitators.

Implications for Nursing Management: Compassionate leadership involves approachability, genuine presence and listening, which could be developed through work-based learning combined with reflection.

KEYWORDS
compassionate leadership, competence, empathy, leadership, nursing staff

1 | BACKGROUND

This study deals with nurses' experiences of the adequacy of compassionate leadership during the early stages of the SARS Co-V-2 (Covid-19) pandemic. Stress and compassion fatigue are generally high among health professionals (Wallace et al., 2020), and nurses' work is especially stressful in complex and busy environments, such as intensive and emergency care (Highfield, 2019). The COVID-19 pandemic, with its high volumes of critically ill patients and limited resources, stressed health systems (Smith et al., 2020) and negatively affected nurses' well-being, caring behaviours and work performance (Labrague & Santos, 2020). Studies across the world have confirmed elevated stress levels, anxiety and burnout for professionals working with COVID-19 patients in the nursing profession. The 19 pandemic has also been a major disruptor of nurse retention (ICN, 2021). In intensive and emergency care, emotional stress is caused by

witnessing suffering combined with the perceived inability to alleviate the suffering (Alharbi et al., 2019, 2020). Prolonged stress may affect decision-making and performance (Kang et al., 2020) and indirectly jeopardize patient safety (ICN, 2021). A significant number of nurses might leave their profession as a result of the pandemic (ICN, 2021). In Finland, where this study was conducted, a prospective cohort study revealed the increased COVID-19 incidence rates to be associated with psychological distress and sleeping problems. Individual variation explained much of the psychological distress (Laukkala et al., 2021).

As a response to the increased stress levels during the COVID-19 pandemic, it has been suggested that cultivating compassion at the workplace can foster resilience and self-compassion and help professionals to cope with suffering and death (Ruiz-Fernandez et al., 2021; While, 2021). This study uses the term compassion to refer to awareness of another person's suffering, feeling for it and motivation to act to share or alleviate suffering. Compassion contains the elements of understanding the universality of human suffering and tolerating uncomfortable feelings (Goetz & Simon-Thomas, 2017; Strauss et al., 2016). Compassion is inherently reciprocal. Common barriers to compassion in health care settings include overload, time pressure, and complex and uncertain clinical situations (de Zulueta, 2016).

Although compassion is conceptually similar to empathy, compassion is a distinctive emotion (Goetz & Simon-Thomas, 2017). Empathy involves the aspects of affective and cognitive empathy. Affective empathy emphasizes emotional responses to feelings and emotions of other individuals, whereas cognitive empathy refers to the ability to understand and know other people's perspectives, affections and beliefs (Rohani et al., 2018). According to some research, the difference between empathy and compassion lies in the latter having an active component, that is, active behaviour (Muller et al., 2014). According to de Zulueta (2016), compassion is a broader concept and, unlike emotional empathy, involves distress tolerance.

Compassionate leadership is a relatively new construct. For the purposes of this study, we define it as a number of leadership practices based on altruistic values and emotional intelligence. As in many other recent leadership models and theories (see, e.g., Carragher & Gormley, 2017), compassionate leadership is regarded as a dynamic process or a social construct and as something that can be learnt through education, personal growth and professional development.

Experts in human resources development (Shuck et al., 2019) have suggested a model containing six behaviours that characterize compassionate leadership. The model can be applied to everyday routines as a way of being, as a natural part of who a person is. Shuck et al. agree with what is proposed by servant (Eva et al., 2018) and transformational leadership (Anderson & Sun, 2015) in that compassion is accessible to everyone and does not have to depend on traditional leader–follower roles. The six compassionate leader behaviours include integrity (transparency and keeping one's word); accountability (feedback in relation to high standards); presence (ability to focus one's attention and listen); empathy (understanding other individuals' perspectives, thoughts and feelings, and taking action); authenticity (openness and expressions of vulnerability) and dignity (respecting the worth of all human beings). Shuck et al. (2019) also proposed a Compassionate Leader Behavior Index based on these six behaviours. They see compassion as a potential solution for creating healthier organisations.

Other researchers, who have recently advocated compassion as a key attribute in health care leadership, include de Zulueta (2016), who in her integrative literature review reported a growing recognition of the importance of compassion to patient outcomes. In her words, a compassionate health care system is one in which "patients and staff would be listened to, supported, and cared for" (de Zulueta, 2016, p. 2). Compassionate leadership can flourish, if individuals' intrinsic motivation and staff engagement are nurtured, positive adaptive responses to challenges that are sought democratically, and a culture of learning from mistakes is fostered. Similar to Schuck, de Zulueta (2016) advocates a dynamic process of shared or distributed leadership, which could involve altruistic focusing on service, people and the needs of others (as in servant leadership) and having self-organizing multidisciplinary teams assume responsibility for daily decision-making. De Zulueta (2016) sees hierarchy and the market model of health care as detrimental to compassion.

Similarly, OToole et al. (2021) argue for compassionate care, instead of addressing leadership and care only in terms of clinical "safety" and "efficiency." Ali and Terry (2017) contend that compassionate leadership involves both cognitive and affective elements, leading with the head and heart. Ou et al. (2015) and West and Chowla (2017) emphasize listening, understanding and supporting staff as part of compassionate leadership. They suggest dialogue, negotiation and humility to help reach compassionate action in stressful times.

A significant question concerns the culture specificity of compassion. According to an extensive study (Papadopoulos et al., 2021), nurse and midwifery managers across 17 countries defined compassion universally in terms of humanness. Still, culture (e.g., collectivist vs. individualistic culture) influenced individuals' understanding of compassion, and attention should be given to both patients' and professionals' cultural backgrounds and for the development of transcultural models and practices (Papadopoulos et al., 2021).

Other practices and solutions suggested for the mitigation of stress in the nursing profession through compassionate leadership include the recognition of distress-prone individuals (Laukkala et al., 2021); mutual support between colleagues; frequent debriefs (Hendin et al., 2020); good work-life balance (Horesh & Brown, 2020); mindfulness (Ruiz-Fernandez et al., 2021) and collaboration with multiple stakeholders in the community to develop creative solutions (Alharbi et al., 2020). Vogel and Flint (2021) have developed the Compassion in the Workplace Model, to be used as a tool by leaders in the assessment and development of compassion (Vogel & Flint, 2021).

Last, emotional intelligence is discussed briefly, as the concept has been linked with effective leadership (Carragher & Gormley, 2017). Emotional intelligence can be considered an ability, a trait or a combination of the two, but there is no universally agreed definition (Carragher & Gormley, 2017). This article relies on the definition of Salovey and Mayer, who refer to emotional intelligence

as an ability to recognize, use, understand and manage one's and other individuals' emotions to guide one's thinking and to regulate behaviour (Mayer et al., 2004). Some researchers (e.g., Akerjordet & Severinsson, 2010) have pointed out that having emotional intelligence might not necessarily result in ethically sound behaviour. Therefore, compassionate leadership is best discussed in terms of altruistic values and concrete practices, in agreement with Shuck et al. (2019).

The purpose of this study was to investigate how intensive and emergency care nursing staff rated the adequacy of compassionate leadership they experienced during the early stages of the Covid-19 pandemic. Their experiences could then be used to inform compassionate leadership in hospitals and other health care organisations.

2 | METHODS

This is a quantitative descriptive cross-sectional study. A self-administered online questionnaire was used to collect data from 50 intensive and emergency care nurses in March and April 2020.

2.1 | The instrument

As no suitable instrument was available, a questionnaire based on a systematic literature review was used for this study. The following online resources were used in the literature search: (1) Ebsco academic Search Elite, "compassionate leadership" 2011–2022, peer reviewed, 44 results; (2) EBSCOhost CINAHL, "compassionate leadership" OR compassion AND leadership OR nursing management, 2011–2022, research articles, 10 results; and (3) EBSCOhost E-mail Result, CINAHL, Emotional Intelligence AND Leadership OR Nursing Management, 2011–2022, research articles, 37 results. Out of the 91 studies, 68 articles were included in the review based on their abstracts. The concepts used in this paper were operationalized based on the review, whose results will be presented in another paper.

The questionnaire was pre-tested with four nurses (Burns & Grove, 2020), who found it be unambiguous and easy to understand. They agreed that the questionnaire was realistic and measured relevant concepts. The analysis was conducted using SPSS 25 for Statistics.

2.2 | Setting

The setting was a central hospital, which served a population of 190,000 in Finland (population 5.5 million). The number of nurses per capita is high in Finland: 14.6/1,000, the second highest in the European Union compared to the average of 8.4 (State of Health in the EU Finland Country Health Profile, 2017). The mortality associated with Covid-19 is low; the current rates from February 2022 are 410 deaths per million population, compared to 2,868 in the United States and 2,342 in the United Kingdom (Worldometers, 2022).

The hospital had 361 beds, including 22 emergency care, 6 intensive care and 18 high dependency beds. In 2020, the number of high dependency patients was 1,516 and that of intensive care patients 359.The average number of visits at the emergency department was 120 per day.

At the time of data collection, the hospital was not particularly stressed; it had treated under 10 Covid-19 patients (four in intensive care). The nurses worked 38 h per week. There were no Covid-19 related deaths early in 2020. Less than five nurses had contracted Covid-19, and none of them had died. Vaccines became available to nursing staff later, in August and September 2020.

There had been no need to cancel elective surgeries, but surgical nurses were being trained to care for intensive care patients. The two negative pressure rooms of the infectious diseases unit had been reserved for Covid patients, and four more rooms had been converted to negative pressure rooms. The hospital was preparing to convert the infectious diseases unit into a pandemic unit, but this occurred much later, in December 2021. The scarcity of nursing staff had been a problem even before the Corona pandemic.

2.3 | Ethics and reliability

The choice of the topic was ethically justified, because the current COVID-19 pandemic has been found to result in stress and nurses' increased need for compassion from the leaders. The study produces new knowledge about nurses' experiences of compassionate leadership in acute nursing. Permission to conduct research was obtained from the Administrative Nurse Leader at the Central Hospital. The Hospital District requires no further ethical approval, if no patients or family members are involved. Participation was voluntary. Ethical guidelines published by the TENK National Board on Research Integrity (2012) were observed carefully. Given the sensitive nature of the topic, the participants' anonymity was protected, and there was no comparison between the results from the two departments.

The low response rate (26%) may decrease reliability, although it can be considered moderate for an electronic survey (Baruch & Holtom, 2008). The low rate may be explained by the short response time (3 weeks), several simultaneous surveys and by the challenges brought on by the pandemic. The manuscript was blinded for submission, and reviewer identities were concealed from the authors.

2.4 | Data collection

The authors contacted all nurses at the hospital's intensive care and emergency departments via e-mail through the Hospital Press Officer. The study did not use sample size calculation, because the hospital district is relatively small and we wanted to involve all nursing staff in intensive and emergency care.

An online survey tool (Webropol) was used to collect the data in October–November 2020. The respondents accessed the link through e-mail and responded anonymously. The questionnaire contained

three background questions (gender, department and nursing experience) and 21 Likert-type items (Table 1). The term immediate supervisor in the questionnaire refers to ward managers or assistant ward managers. The expression "work community" is commonly used in Finland to refer to those staff members at the workplace experienced as colleagues and managers.

2.5 | Data analysis

SPSS 25 for Statistics was used to analyse the data. The results are presented using frequency distributions and percentages under the following headings: Compassionate Leadership during the Covid-19 Pandemic; Support Received in Acute and Challenging Situations;

TABLE 1 Results of compassionate leadership scale

	Fully Agree (1)	Somewhat Agree (2)	Cannot say (3)	Somewhat Disagree (4)	Fully Disagree (5)	Mean
Kyllä vaan, 1–5. Ja 1. täysin samaa mieltä, 2 = melko samaa mieltä, 3 = ei samaa, eikä eri mieltä, 4 = melko eri mieltä ja 5 = täysin eri mieltä.						
Compassionate leadership during the Covid-19 pandemic						
The Covid-19 pandemic increased the need for compassion in my work community	22%	44%	22%	12%	0%	2.00
I have received support from my immediate supervisor during the Covid-19 pandemic	6%	20%	18%	36%	20%	3.44
The supervisor of the work community supports everybody equally	4%	14%	22%	38%	22%	3.60
Support received in acute and challenging situations						
The supervisor encourages employees in acute situations	6%	8%	28%	34%	26%	3.66
The supervisor supports employees in acute and challenging situations	4%	12%	24%	34%	26%	3.66
The supervisor is able to encourage employees in acute situations	4%	19%	22%	36%	28%	3.66
The supervisor understands employees' insecurity in acute situations	6%	10%	26%	38%	20%	3.56
Leader empathy and approachability						
Empathy is important in working life	76%	18%	4%	2%	0%	1.34
Empathy is visible in the work of the supervisor	6%	8%	18%	44%	24%	3.72
The supervisor of the work community allows the expression of negative emotions	4%	26%	18%	32%	29%	3.38
My immediate supervisor is easy to approach	16%	28%	6%	36%	14%	3.50
Appreciation of competence and strengths						
Everybody's competence is appreciated in my work community	8%	16%	30%	30%	16%	2.50
The supervisor of the work community appreciates everybody's competence	8%	16%	30%	30%	16%	2.50
In the work community, everybody's development is equally supported	2%	30%	12%	40%	16%	3.38
The supervisor recognizes the strengths of the work community members	4%	29%	24%	40%	12%	3.36
The supervisor makes use of work community members' strengths to reach the common objective	6%	18%	24%	36%	16%	3.38
The team recognizes members' strengths required to reach the common objective	12%	54%	20%	12%	2%	2.38
The team makes use of members' strengths to reach the common objective	14%	52%	12%	18%	4%	2.46
Development of compassionate leadership						
Compassionate leadership is reached through experience	26%	54%	8%	8%	4%	2.10
Compassionate leadership is reached through personal development	32%	48%	16%	2%	2%	1.94
Compassionate leadership can be developed through education	44%	12%	18%	24%	2%	2.60

Leader Empathy and Approachability; Appreciation of Competence and Strengths; and Development of Compassionate Leadership.

The Strengthening the Reporting of Observational Studies (Strobe) checklist for reports of observational studies was used (von Elm et al., 2007).

3 | RESULTS

The target group contacted was nurses ($N = 192$) from intensive care and emergency departments, March and April 2020. The response rate was 26% ($n = 50$). Most respondents were female (42 women and 7 men). The majority (57%) were experienced nurses ($n = 14$ > 30 years; 16% = 30–21 years; 27% = 20–11 years). Only 12% had less than 2 years of experience.

3.1 | Compassionate leadership during the Covid-19 pandemic

As noted in Tables 1, 66% of the participants (22% strongly; 44% moderately) believed that the Covid-19 pandemic had created a greater need for compassionate leadership, and more than half of them (56%) believed they had not experienced it. A majority (60%) believed that support had not been equally provided to all.

3.2 | Support received in acute and challenging situations

In further questions, nurses were requested to rate the understanding, encouragement and support received from their supervisors. A majority of the participants had not felt understood (58%), encouraged (64%) or supported (60%) in acute or challenging work situations.

3.3 | Leader empathy and approachability

Almost all respondents (94%) agreed that empathy was important in working life. However, according to most respondents, empathy had not been visible in the work of ward managers (68%), and the managers had not allowed the expression of negative emotions (61%). The results were slightly more positive for the approachability of the ward managers; 50% of the nurses agreed that their supervisors had been easy to approach.

3.4 | Appreciation of competence and strengths

Almost half of the nurses (46%) felt that their supervisors had not appreciated the competence of all employees. Many participants (30%) neither agreed nor disagreed. More than half of the respondents (56%) found that staff members at their workplace had not been equally supported in their development. Similar results were obtained for the experienced appreciation of employee strengths. More than half (52%) of the nurses found that their supervisors had not recognized or made use of staff members' strengths to reach the common objective.

In contrast, the nurses rated their team's ability to recognize its members' strengths positively: Most respondents (66%) agreed that team members had recognized and made use of their strengths to reach the common objective.

3.5 | Development of compassionate leadership

Finally, the majority of the nurses agreed that compassionate leadership could be developed through experience, personal development and education. The ratings were higher for experience and personal development (80%), compared with education (56%).

4 | DISCUSSION

Conducted with 50 intensive and emergency care nurses in Finland, the study showed that even in its early stage, the Covid-19 pandemic increased nurses' need for compassionate leadership. Although the situation was relatively stable at the time of the study, it can be assumed that nurses were stressed and concerned about their coping. The study revealed inadequate support, encouragement and understanding from the nurse leaders. Alarmingly, half the participants found it difficult to approach their leaders. Instead, the nurses seemed to rely on their team's support. The great majority of the nurses agreed that compassionate leadership could be developed through experience or personal development, whereas slightly over half of them believed in the effectiveness of education. We can only speculate on the reasons for the participants' lack of faith in education. They may think that life and work experience makes the best leaders, not trusting education to foster self-awareness and reflection in a way that results in better leadership.

Compassionate leadership is not easily achieved. Nurse leaders work in fear-laden, safety critical environments, trying to balance between task orientation (executing the defined goals) and relationship orientation (attending to emotional and ethical concerns). In addition, not only does leadership shape the organisational culture but vice versa (de Zulueta, 2016). The leaders in this study may have been overwhelmed with the situation and the pandemic-driven shift to remote work and thus less capable of supporting their staff (cf. Selander et al., 2021).

Some practical implications can be drawn from this study for leaders interested in developing compassionate leadership. They include focusing on encouraging, constructive communication, listening carefully to nurses' vulnerabilities and providing space for the expression of negative emotions. These actions call for approachability and genuine presence (cf. Markey et al., 2021). Leadership attributes can be developed through work-based learning, accompanied by structured reflection on work practices. However, also, the

employees' role in this process needs to be considered. Ideally, reciprocal support is provided between leaders and staff. If we take the idea one step further and accept the aim of shared leadership, the creation of a compassionate, collaborative culture implies collective education in leadership skills (de Zulueta, 2016).

Simulation-based learning could be an effective and inexpensive way of promoting compassion and emotional intelligence within organisations. Work supervision sessions with external facilitators could foster open dialogue on stress and coping and enhance nurses' personal development by encouraging them to express themselves and to make the most of their strengths. Further methods that can contribute to a compassionate environment include Schartz Center Rounds® (staff discussing challenging emotional issues), appreciate inquiry, appreciative storytelling and meditation to enhance staff wellbeing and empathy (de Zulueta, 2016). As suggested by Papadopoulos et al. (2021), the effect of cultural diversity should be considered when planning educational interventions (Papadopoulos et al., 2021).

This study has a number of limitations. The fact that this study was conducted in a single central hospital can be considered a limitation. Although the results can indicate important observations, they cannot be widely generalized. As no suitable instrument existed, a questionnaire based on a systematic literature review was developed and pre-tested with four nurses. The validity of the instrument can be improved by testing it further in another setting. Qualitative research on the topic is required.

5 | CONCLUSION

Compassionate leadership is a process that involves a number of leadership practices based on altruistic values and emotional intelligence and benefits from recognition and use of employee strengths. These leadership attributes can be learnt through formal and informal education, personal growth and professional development. Leaders and employees could benefit from work-based training and reflection on compassion. We suggest simulation-based learning, work supervision and discussion led by external facilitators.

6 | IMPLICATIONS FOR NURSING MANAGEMENT

Exceptional circumstances increase stress in acute nursing settings and call for support for staff coping to ensure high quality care and patient safety. Both leaders and employees could benefit from work-based training and reflection on compassion and emotional intelligence through simulation-based learning and work supervision sessions led by external facilitators. Compassionate leadership involves approachability, genuine presence and listening. It can enhance personal development by encouraging nurses to express themselves and to make the most of their strengths. Encouraging and compassionate leadership can help prepare for exceptional circumstances and improve staff commitment, nurse retention and wellbeing at work.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

ETHICS STATEMENT

Permission to conduct research was obtained from the Administrative Nurse Leader at the Central Hospital. The Hospital District requires no further ethical approval, if no patients or family members are involved. Participation was voluntary. Ethical guidelines published by the TENK National Board on Research Integrity (2012) were observed carefully. Given the sensitive nature of the topic, the participants' anonymity was protected, and there was no comparison between the results from the two departments.

DATA AVAILABILITY STATEMENT

Data are available only in Finnish language.

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