

An exploration of the '6Cs' as a set of values for nursing practice

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Abstract

In 2012, after several high profile cases of poor quality care in England and concerns about a lack of compassion and a need to refocus on values, the Department of Health (DH) in England published a new strategy for nursing, midwifery and care staff: 'Compassion in practice'. The strategy included the 6Cs (care, compassion, courage, communication, competence and commitment) and in the follow-on framework, produced by NHS England in 2016, the 6Cs are included again. This article explains the background to the 6Cs and highlights the other values frameworks that nurses and midwives must work within too. Nursing theorists have studied caring extensively and the earlier set of 6Cs, produced by a Canadian nurse, Sister Simone Roach, is explained within this article. The meaning of the DH's 6Cs is then explored in detail with reference to previous research and nursing theory.

Key words

Care, Nursing, Compassion, Values, 6Cs,

Introduction

Values are generally defined as beliefs or principles that influence behaviour (Baillie and Black, 2014). For example, Rassin (2008) suggested that values represent '*basic convictions of what is right, good or desirable, and motivate both social and professional behaviour*' (p.614). Following several reports that revealed poor care quality, with an apparent lack of compassion, the Department of Health (DH) (2012a) in England introduced the '6Cs' as values for practice within a new nursing strategy (Cummings and Bennett 2012). In 2016, the 6Cs were included within the new framework for nursing (NHS England, 2016). This article sets out the background to the 6Cs, considers other sets of values relevant to nursing practice and theories of caring, and then explores the meaning of the DH's 6Cs in detail.

Background to the 6Cs

In 2012, following a consultation exercise with over 9,000 nurses, midwives, care staff and patients, the DH published 'Compassion in Practice: Nursing, Midwifery and Care staff: our Vision and Strategy' (Cummings and Bennett 2012). The document included the '6Cs' (care, compassion, courage, communication, competence and commitment), identified as 'our fundamental values'. Cummings and Bennett (2012) identified the need to improve the culture of care, citing high profile failures of care in England: mid-Staffordshire NHS Foundation Trust (Francis, 2013) and Winterbourne View Hospital (DH 2012). These reports particularly highlighted a lack of compassion and dignity for older people in hospital, and for people with learning disabilities. Cummings and Bennett (2012) aimed to embed the 6Cs in all nursing, midwifery and care-giving settings throughout England's NHS and social care. As the 6Cs apply to non-registered care staff, as well as registered nurses and midwives, and to staff working in any settings, the 6Cs could be a unifying set of values for nursing staff across England.

In a review entitled 'Compassion in Practice: two years on', NHS England (2014) reported that other professions were now embracing the 6Cs: '6Cs are for everyone'. England's Chief Nursing Officer, Jane Cummings, asserted that the strategy had changed the culture of care and the culture of how people work (NHS England 2014a). In 2015-16, a further extensive consultation and review led to a new framework for nurses, midwives and care staff entitled

'Leading change, adding value' (NHS England 2016), which followed on from the previous strategy. NHS England (2016) reported that the consultation revealed substantial support for the previous strategy's 6Cs, which were therefore included in the new framework and referred to as 'the foundation of our value base' (p7). The 6Cs should not be seen in isolation as 'Leading change, adding value' also includes 10 commitments to support actions of nurses, midwives and care staff. The framework is also aligned with the Five Year Forward View's triple aim of better outcomes, better experiences for people and better use of resources, through tackling gaps in health and well-being, care and quality, and funding and efficiency (NHS England, 2014).

Other values frameworks for nurses

As well as the 6Cs, nurses are expected to adhere to various other values frameworks, which have both similarities and differences. As healthcare is devolved, each UK country has a separate set of values. In England, the NHS Constitution, first published in 2011, set out core NHS values as being: Respect and dignity, Commitment to quality of care, Compassion, Improving lives, Working together for patients, and Everyone counts; these values apply to all NHS staff. NHS Scotland (2013) identifies similar core values with: Care and compassion; Dignity and respect; and Quality and teamwork. The core values also include: openness, honesty and responsibility (DH, 2015). NHS Wales (2016) states three values: Caring for each other; Working together; and Always improving. In Northern Ireland, stated values for health and social care are: empowerment, involvement, respect, partnership, learning, continuity, equity and equality (Department of Health, Social Services and Public Safety, 2017). Notably all four sets of values include working together (or a similar concept such as teamwork or partnership), revealing an NHS consensus about the importance of teamwork for effective healthcare. In the report from the mid-Staffordshire inquiry, Sir Robert Francis urged that the NHS Constitution values should be adopted interprofessionally (Francis, 2013), highlighting that NHS staff must remember that they are part of one large team with one objective: *'the proper care and treatment of their patients'* (p.1401).

Nurses and midwives must also work within the NMC Code, which sets out 'values and principles' within four themes (4Ps): Prioritise people; Practise effectively; Preserve safety; Promote professionalism and trust (NMC 2015). There are some common elements between the 6Cs and the 4Ps and Bradshaw (2016) questioned why there is no cross-reference between the DH's 6Cs and the NMC's Code values. However, as noted earlier, the 6Cs are expressed within an English policy document whilst the NMC Code applies across the UK. It is perhaps more surprising that there is no cross reference between the NHS Constitution values and the 6Cs, as these both originated from the English government.

In addition to the 6Cs, the NHS values, and the NMC Code for registered nurses across the UK, nurses must also work within their employing organisation's values, which are usually developed through consultation with their staff and local populations. The organisation's values apply to all staff, clinical or non-clinical, as all staff impact on quality of care and patient experience. Whilst the 6Cs encompass values that organisations often include too, the actual words used might differ. For example, an organisation might include 'kindness', which is linked with compassion in the 6Cs. Healthcare providers often include values that are about how the organisation works as a whole, for example, 'inclusivity' would reflect an organisation's commitment to ensuring services are accessible to their local population.

The 6Cs and caring theories

Internationally, over several decades, many nursing theorists have recognised the interrelated nature of nursing and caring. For example, Jean Watson from the United States of America (US) asserts that 'the practice of caring is central to nursing' (Watson 1979) while in Canada,

Sister Simone Roach (2002) identified caring both as a natural attribute of being human and as the core of nursing. From Iceland, and based on a study of caring and uncaring nurse-patient encounters, Sigríð Halldórsdóttir (1991) described her view of professional caring as being: 'compassionate competence, genuine concern for the patient as a person, undivided attention when the nurse is with the patient, and cheerfulness' (p.44).

The 6Cs bear resemblance to Roach's (1992, 2002) theory, which was published in 'Caring: the human mode of being'. However, 'Compassion in practice' (Cummings and Bennett, 2012) includes no reference to Roach's work (Baillie, 2015; Bradshaw, 2016). Sister Simone Roach (1922-2016) was a nun and a Canadian nurse theorist who led the development of the first code of ethics for the Canadian Nurses' Association (Villeneuve, 2016). In 1992, she identified 5Cs of caring (compassion, competence, commitment, confidence and conscience), and added a sixth C (comportment) in a second edition in 2002. Roach's theories were developed from lengthy scholarship and her books articulate her theory of human caring with critical discussion and application to practice. Roach started with the question: 'What is the nurse doing when she or he is caring?' The attributes that emerged were then organised under the original 5Cs, described as a broad framework with 'categories of human behaviour within which professional caring is to be understood' (Roach, 2002, p.66). There have been adaptations of Roach's theory, for example, from Australia, Pusari (1998) reported on the application of Roach's original 5Cs for end of life care, with additional 'Cs' added: communication, culture and courage; the DH's (2012a) 6Cs includes two of these additions (communication and courage). Bradshaw's (2016) analysis of the 6Cs in 'Compassion in practice' (DH, 2012a) refers to Simone Roach's work as 'the hidden presence of Simone Roach's model of caring' and argues that Roach's work should be referenced and discussed within the DH strategy (now framework).

Exploring the 6Cs

Box 1 presents the definitions of the 6Cs that are provided in 'Compassion in practice' (DH 2012a) are given below and will be explored in more detail.

Care

'Care is our core business and that of our organisations, and the care we deliver helps the individual person and improves the health of the whole community. Caring defines us and our work. People receiving care expect it to be right for them, consistently, throughout every stage of their life'. (Cummings and Bennett, 2012: 13)

Both 'care' and 'caring' are widely used in discussions about nursing and both terms are included in the DH (2012a) definition of care. The DH (2012a) presents 'care' as a separate 'value' in the 6Cs but arguably, nurses cannot provide effective care without compassion, competence, communication, courage and commitment. The DH (2012a) definition highlights that nurses provide care to individuals and communities and to people of all age groups and that the care should meet each individual's needs on a consistent basis. An individualised approach to care should include consideration of biological, psychological, social and spiritual needs (Matiti and Baillie, 2012), with holistic nursing care being about caring for the person as a whole, rather than in fragmented parts (McEvoy and Duffy, 2008). A concept analysis that drew on an extensive review of literature about nurses, nursing, care, caring and nursing care led to the following comprehensive operational definition of nursing care:

'Nursing care is a skilled, safe, high quality, holistic, ethical, collaborative, individualised, interpersonal caring process that is planned and designed based on best evidence available, and results in positive patient outcomes, optimisation of health, palliation of symptoms, or a peaceful death' (Dalpezzo 2009, p.261).

This definition is useful for providing a deeper understanding of what care means in nursing practice and both the process and outcomes of nursing care.

Compassion

'Compassion is how care is given through relationships based on empathy, respect and dignity - it can also be described as intelligent kindness, and is central to how people perceive their care'. (Cummings and Bennett, 2012: 13)

In her seminal work, Sister Simone Roach (2002) argued that compassion is needed more than ever to humanise the ever-increasing 'cold and impersonal technology' used within healthcare. However, she also eloquently wrote that compassion is not enough:

'while competence without compassion can be brutal and inhumane, compassion without competence may be no more than a meaningless, if not harmful, intrusion into the life of a person or persons needing help' (p.54).

The implications are that we need to ensure that our actions must be skilful and informed by best evidence when we show compassion and offer help to people.

Of the 6Cs, compassion appears most prominent as it is included in the title of the original strategy document (DH, 2012a). There is no one accepted definition of compassion, though many make reference to recognising suffering and taking action to relieve suffering, a perspective linked to the original Latin meaning ('with suffering'). For example, Goetz et al. (2010) defines compassion as 'The feeling that arises in witnessing another's suffering and that motivates a subsequent desire to help' (p351). The DH (2012a) provides a different perspective, however, emphasising relationships and including empathy, sympathy and dignity. Bramley and Matiti (2014) highlight that words such as empathy, sympathy and caring are often used interchangeably with compassion, although the meanings of each differ.

Schanz (2007) conducted a concept analysis of compassion, and argued for its uniqueness: 'only compassion impels and empowers people to not only acknowledge, but also act toward alleviating or removing another's suffering or pain' (p.51). She noted that a nurse cannot show compassion if they do not recognise a person's suffering, highlighting the need for empathy and for competent assessment skills, for example, to identify pain when people have communication difficulties. In a study of compassion within the relationship between nurses and older people with a chronic disease, van der Cingel (2011) highlighted the interpersonal and complexity of compassion, identifying seven dimensions: attentiveness, listening, confronting, involvement, helping, presence and understanding. Bramley and Matiti (2014) studied compassion from the perspectives of acute medical ward patients who frequently referred to care and caring, while discussing their experiences of compassion, often using the words interchangeably. Highlighting the relationship between compassion and empathy, participants felt it important that nurses understood how it was to be 'in their shoes' believing this led to compassionate behaviour. All participants viewed communication as a key factor in compassion.

Competence

'Competence means all those in caring roles must have the ability to understand an individual's health and social needs and the expertise, clinical and technical knowledge to deliver effective care and treatments based on research and evidence'. (Cummings and Bennett, 2012: 13)

Competence is a commonly used term in nursing and is frequently interpreted as being about a skilled performance (Garside and Nhemachena, 2013; Bing-Jonsson et al., 2015). Similarly, in Benner's (1984) seminal work 'Novice to expert', competent nurses were able to carry out conscious and deliberate planning and prioritise and manage their work, but without the flexibility and speed of proficient nurses. Sister Simone Roach's definition of competence is more holistic however: 'the knowledge, judgment, skills, energy, experience and motivation to respond adequately to the demands of one's professional responsibilities' (Roach, 2002, p.54). Yanhua and Watson (2011) too argued for competence being considered a holistic construct. Cowan et al. (2007) identified competence as encompassing skills, knowledge and attitudes, a view echoed in the NMC's (2010) 'Standards for pre-registration nursing education'. However, in 'Compassion in practice', the DH (2012a) definition of competence emphasises skilled performance based on best evidence, but omits an attitudinal element to competence.

Bing-Jonsson et al. (2015) considered competence to encompass knowledge, skills and personal attributes but also recognises contextual aspects of competence, including political, technical and structural factors. If a skilled, evidence based performance is not accompanied by an appropriate attitude, such as respect and a non-discriminatory approach, the care experience is likely to be undignified. In a study of competencies required to care for older people, the wide range identified included communication (Bing-Jonsson et al., 2015), which is another of the 6Cs. Competence should also include cultural competence, with nurses providing care in a culturally appropriate manner for each person and their family.

Communication

'Communication is central to successful caring relationships and to effective team working. Listening is as important as what we say and do and essential for "no decision about me without me". Communication is the key to a good workplace with benefits for those in our care and staff alike'. (Cummings and Bennett, 2012: 13)

Effective communication in healthcare and nursing practice is essential and there is a well-established evidence base for how to communicate effectively, using verbal and non-verbal skills. Communication is integral to other values in the 6Cs, for example, how nurses deliver care, convey compassion and achieve competence. Indeed, Nyatanga (2014) argues that in palliative care, communication is the 'glue that makes the other Cs possible' (p.463) as otherwise, care will be perceived negatively. Many people accessing healthcare have communication difficulties, which could be due to physical and mental health issues, or a learning disability, for example. A person's ability to communicate can be affected by fear and anxiety too. Nurses must develop the skills to communicate effectively with patients and families in a wide range of situations, for example: when explaining medication, conveying unwelcome news, providing comfort, carrying out an assessment, and during discharge planning. The DH (2012a) definition highlights the importance of good communication for teamwork and for involving people in their care.

Courage

'Courage enables us to do the right thing for the people we care for, to speak up when we have concerns and to have the personal strength and vision to innovate and to embrace new ways of working'. (Cummings and Bennett, 2012: 13)

Courage has been recognised as a valuable human character trait since at least Aristotle's time (384-322 BC). Aristotle considered courage to be a moral virtue; he defined courage as the ability to respond appropriately to fear (Lindh et al., 2010). Courage is important in nursing practice, for example, in relation to safeguarding people who are vulnerable, raising

concerns about standards of care or challenging accepted practices, and to implement change. The NHS Constitution expects all NHS staff to raise concerns (DH, 2015) and it is a professional requirement for nurses to raise concerns about people who may be at risk (NMC, 2015). Sellman (2011) argued that within today's healthcare system, where nurses must deliver safe and competent care within constrained resources, nurses need to be courageous and remain firm to their values.

Lindh et al. (2010) analysed courage and nursing practice and argued for the need to foster courage in nurses so they can act ethically and creatively, make changes, face challenges and motivate others through role modelling. In a different perspective of the need for courage, Thorup et al. (2011) identified that nurses need the courage to help patients face their own suffering and vulnerability and to argue for and provide professional care. They argued that vulnerability and suffering shape nurses' courage in relation to care, seeing courage as the unifier. One nurse in their study gave the example of staying with a patient who is struggling to breathe: 'for a patient in that situation, it's really important that the people around them can bear to stay there and be present with the patient' (p.432). Without the courage to stay with a patient who is suffering, nurses may distance themselves from the patient (Thorup et al., 2011), which could lead to a lack of compassion. The nurses in Thorup et al.'s (2011) study also discussed the courage needed to challenge colleagues about ethics in care: initiating the discussion and 'daring to stick their neck out' (p.432). They believed this courage developed over time.

Commitment

'A commitment to our patients and populations is a cornerstone of what we do. We need to build on our commitment to improve the care and experience of our patients, to take action to make this vision and strategy a reality for all and meet the health, care and support challenges ahead'. (Cummings and Bennett, 2012: 13)

The explanation of commitment refers to showing a commitment to care quality and improving care and patient experience. Similarly, the NHS Constitution (DH, 2015) includes commitment to quality of care as an NHS value. Sister Simone Roach's definition of commitment in her 6Cs takes a different stance, with a focus on fulfilling responsibilities: 'a complex affective response characterised by a convergence between one's desires and one's obligations, and by a deliberate choice to act in accordance with them' (Roach, 2002, p.62). Henderson et al. (2007) found that nurses who responded to patients' needs in a timely manner were perceived as caring; patients were dissatisfied when nurses apparently forgot patients and their needs, perceiving a lack of commitment. In a study of caring for patients dying in ITU, Boharni et al. (2014) identified commitment to care as a dominant theme within interviews with nurses who were caring for patients who were dying.

Conclusion

The 6Cs should not be viewed in isolation as other values frameworks, including professional and organisational, must also be embraced. It is unclear as to why a further set of values was considered necessary for nursing, midwifery and care staff in England, when there were already identified NHS values, which could have been extended to other parts of health and social care. However, the 6Cs have become well established as a value basis for nursing, midwifery and care staff in England, resonating with many within these professions and beyond. The values identified in the 6Cs are certainly relevant and as a profession, we can learn from the large body of theoretical work and previous research on care and ethics that explores these values in greater depth.

Key points

- Following several high profile reports of poor quality care in England, concerns surfaced about a lack of compassion and a need to refocus on nursing values.
- In 2012, the Department of Health (DH) in England published '*Compassion in Practice: Nursing, Midwifery and Care Staff: our Vision and Strategy*', which included the '6Cs' (care, compassion, courage, communication, competence and commitment), referred to as 'our fundamental values'.
- The 6Cs were included in the follow-up framework '*Leading change, Adding Value*', published by NHS England in 2016.
- Nurses must also work in accordance with other sets of values: NHS values, professional values and their organisational values.
- Nursing theorists have studied caring in nursing over several decades and a similar set of 6Cs of caring were previously published by a Canadian nurse theorist, Sister Simone Roach.
- The Department of Health's 6Cs have been well received across the nursing profession and beyond and are relevant to nursing practice, though benefit from more in-depth exploration, with learning from nursing theory and research.

CPD reflective questions

- Why do you think the Department of Health published the 6Cs for nurses, midwives and care staff?
- How do the 6Cs (care, compassion, courage, communication, competence and commitment) relate to your daily practice? Identify an example from your practice for each of the 6Cs
- What are your organisation's stated values and how do these relate to the 6Cs?

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