Chapter 1  Setting out the context for the Study

1.1 Introduction

This thesis reports on an illuminative evaluation of the response to the National Dignity in Care campaign, within an acute healthcare Trust in England. This first chapter identifies the definition of dignity used within the National Dignity in Care campaign launched by The Department of Health in England in 2006, as well as consideration of how dignity is situated within professional codes of conduct, and nursing standards within professional bodies. The nature of concerns raised through published reports on dignity in care is identified followed by a comprehensive review of healthcare policies and guidance related to dignity. A detailed description of the National Dignity in Care campaign along with a review of work undertaken to inform the campaign is given. Finally, the context of the acute healthcare Trust where the evaluation study took place is considered along with how the Dignity in Care campaign was translated within this Trust and the priority areas identified by the Trust to improve aspects of care related to dignity.

1.2 Definition of Dignity used within the Dignity in Care Campaign

The definition used for the National Dignity in Care campaign was:

“a state, quality or manner worthy of esteem or respect; and (by extension) self-respect. Dignity in care, therefore, means the kind of care, in any setting, which supports and promotes, and does not undermine, a person’s self-respect regardless of any difference” (Social Care Institute for Excellence, [SCIE], 2006, p. 6).

This has been derived from a dictionary definition as opposed to studies undertaken in this area; however it does capture the inherent worth of an individual as a key feature of dignity, the subjective nature of dignity, as well as emphasising that the person being the recipient of care is treated respectfully and without discrimination. The Dignity in Care campaign initially set out to focus on older people as there had been serious concerns about the quality of care for older people (Help the Aged, 1999; Health Advisory Service, [HAS], 2000; Department of Health [DH], 2001a). However, in August 2007 the Dignity in Care campaign was extended to include mental health service users. It is also acknowledged that older people over the age of 65 will occupy at least two thirds of hospital beds at any one time (DH, 2000a) and that there is significant frailty associated with illness in old age that affects a person’s ability to care for
themselves (Bridges, Flatley & Meyer, 2010). Prior to, and following, the launch of the National Dignity in Care campaign there had been an increasing level of attention given to the area of dignity in care. Before reviewing the concerns identified, and the healthcare policy agenda related to dignity it is first important to have a clear understanding of the role and responsibility of nurses in relation to dignity. This next section considers how dignity is situated within codes of conduct and professional bodies.

1.3 Dignity within the Professional Codes of Nursing

Human dignity has been identified as an essential value of professional nursing (Jacelon, 2004). Nurses and other healthcare professionals are often exhorted to respect the dignity of patients and clients. Within the United Kingdom (UK) the Nursing and Midwifery Council (NMC) has put dignity as a central value within its code and the starting point for the standards of conduct, performance and ethical values of nurses and midwives (NMC, 2008). Responsibility includes, that each nurse should be:

“personally accountable for ensuring that you promote and protect the interests and dignity of patients and clients irrespective of gender, age, race, ability, sexuality, economic status, lifestyle, culture and religious or political beliefs” (NMC, 2004, p. 5).

In addition the NMC produced National Guidance on the Care of Older People (NMC, 2009) setting out principles to enable nurses to think through the issues and enable them to apply professional expertise and judgement in the best interests of older people in their care. This also refers to a number of aspects of dignity including: respect, privacy and safeguarding of vulnerable adults. In addition the International Council of Nursing (ICN) code – states that:

“Inherent in nursing is respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect” (ICN, 2006, p. 1).

Furthermore the Royal College of Nursing (RCN) in the UK has identified dignity as a defining characteristic of nursing:

“nursing is based on ethical values which respect the dignity, autonomy and uniqueness of human beings” (RCN, 2003, p. 3).

However, whilst these codes promote the ethical values to guide and inform nurses in their practice, a European wide qualitative study (Tadd et al, 2006) identified that nurses had a poor understanding of their professional codes, did not recognise their practical value and tended to rely on personal values and experiences. This questions the value and importance attached to
professional codes if they are not recognised by nurses. It also suggests the need for personal ethical values to be embedded in a framework of common professional practice.

It is also of interest that whilst dignity is explicitly referred to in professional codes, a recent meta-narrative review of seminal nursing texts, on the fundamentals of care (Kitson, Conroy, Wengstrom, Profetto-McGrath, & Robertson-Malt, 2010) identified that whilst concepts and practices related to eating and drinking as well as toileting were consistently represented, the concepts of dignity, comfort and pain management showed much less consistent presentation in nursing texts. It is suggested that these concepts seemed to have emerged as discrete elements of fundamentals of care over the past ten years or so and, in particular, linked to government responses to patient safety and public concern. This next section examines some of the key reports that have identified serious concerns related to dignity in care.

1.4 Concerns reported on Dignity in Care

This section presents a sample of key reports, from a range of key sources, over the past fifteen years that have highlighted serious concerns related to the dignity of older people in hospitals.

In 1997 The Observer, a British newspaper, profiled a campaign entitled ‘Dignity on the Ward’ following widespread concerns around a lack of dignity and basic care in NHS hospitals. Such was the public’s reaction at the time, that the then Health Minister Frank Dobson convened an independent inquiry into the care of older people on acute wards in general hospitals, undertaken by the Health Advisory Service (HAS, 2000) with key areas of concern identified in Box 1.1.

<table>
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<tr>
<th>Box 1.1 Main deficiencies in care identified by the Health Advisory Service Report on Dignity in Acute Hospital Wards 2000</th>
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<tr>
<td>• Delays in admission</td>
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<td>• Poor physical environment, lack of basic equipment and supplies</td>
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<td>• Non availability of, and poor quality food and drink</td>
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<td>• Lack of attention to feeding and nutrition, insufficient assistance and poor communication during these aspects of care</td>
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<td>• Limited privacy and dignity, especially on mixed sex wards</td>
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<td>• Failure to negotiate the boundaries of care, mutual expectations unclear</td>
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<td>• Continued difficulties around discharge exacerbated by poor communication between professionals, lack of information to patients and insufficient or inadequate community services</td>
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<td>• Pressured staff demonstrating poor attitudes and communication skills</td>
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<tr>
<td>• Occasional difficulties in staff-patient interactions</td>
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<td>• Staff shortages and over reliance upon junior staff, too few specialist therapists</td>
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At the same time, a Standing Nursing and Midwifery Advisory Committee (DH, 2001a) undertook a review that also found major deficits in the standard of nursing care and identified: a lack of clinical leadership; management and role modelling; inadequate training for nurses working with older people; and deficiencies in the physical environment and resources. As a result of this review the Government embarked on a series of reforms in the NHS to improve quality and respond to the HAS 2000 report, which will be discussed later in a review of healthcare policies and guidance related to dignity, section 1.5.

The Healthcare Commission and its more recent successor, the Care Quality Commission, is a statutory body that has a responsibility to safeguard patients, promote rights of access to healthcare and promote improvement in healthcare services. In 2006, a joint review of older people’s services was carried out by the Healthcare Commission (HCC), the Commission for Social Care, and the Audit Commission entitled ‘Living well in later life’ (HCC, 2006). This report highlighted dignity and respect for older people as a major area of concern, with specific examples of poor practice: single sex bays that in fact accommodated both men and women, with significant concerns around privacy related to mixed sex accommodation and toileting facilities; patients being moved frequently to release beds; and meals being taken away uneaten with no help offered to eat them. The patchy implementation of policies and best practice to support patient nutritional needs were also raised in a further report by the Healthcare Commission’s ‘Caring for Dignity: A national report on dignity in care for older people while in hospital’ (HCC, 2007). This focussed on four core standards that were part of the framework that all healthcare Trusts were expected to meet, which included: minimum standards for all patients in relation to being treated with dignity and respect, access to meals, information on treatment and care, as well as privacy and confidentiality, see table 1.1.

### Table 1.1 Healthcare Commission Core standards related to treating patients with dignity and respect

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<thead>
<tr>
<th>Core Standard</th>
<th>Aspect of Dignity identified within Core Standard</th>
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<tr>
<td>13a</td>
<td>Healthcare organisation having systems in place to ensure that staff treat patients, their relatives and carers with dignity and respect</td>
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<tr>
<td>15b</td>
<td>That patient’s individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day</td>
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<tr>
<td>16</td>
<td>That accessible information is available to patients and the public on the services and on the care and treatment they receive</td>
</tr>
<tr>
<td>20b</td>
<td>That environments promote effective care and optimise health outcomes by being supportive of the patient’s privacy and confidentiality</td>
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In addition, the Parliamentary Joint Committee on Human Rights (JCHR, 2007) reporting on the human rights of older people in healthcare identified dignity as being central to the fulfilment of human rights and addressed a number of similar concerns which included: malnutrition and
dehydration, and a lack of privacy in mixed sex wards. In addition other serious concerns were identified as: abuse and rough treatment; insufficient attention paid to confidentiality; neglect; carelessness; poor hygiene; and a fear of complaining.

More recently, three reports have again highlighted serious concerns relating to quality of care and dignity within acute hospitals: the Mid Staffordshire NHS Foundation Trust Inquiry (2010), the Parliamentary and Health Service Ombudsman (2011), and the Care Quality Commission [CQC] (2011). The Mid Staffordshire NHS Foundation Trust Inquiry (2010) noted specific concerns relating to dignity of: incontinent patients left in degrading conditions; patients left inadequately dressed in full view of passers-by; patients moved and handled in unsympathetic and unskilled ways, (causing pain and distress); failures to refer to patients by name, or by their preferred name; and rudeness or hostility. The Parliamentary and Health Service Ombudsman (2011) reported on ten investigations into the care of older people in the NHS where failings were identified in the most basic standards of care of: clean and comfortable surroundings; assistance with eating if needed; drinking water available; and the ability to call someone who will respond. Whilst many of these aspects of care have been previously identified, a particular theme within this report was poor communication and thoughtless action. In 2011, the Care Quality Commission, a new health and social care regulator for England, set out to ensure better care for everyone in hospital, in a care home and at home published its first report into dignity and nutrition for older people in Hospital (CQC, 2011). This report identified recurring concerns around dignity and respect that included patients not involved in their own care: failure to explain and discuss their treatment; patients not being told what would happen to them; without prior consent being sought or concerns addressed and; staff addressing patient’s relatives rather than the patient. Concerns also included: staff not treating people in a respectful way (e.g., spooning food into people’s mouths from above without engaging with them); discussing patient’s personal information in open areas and; staff speaking to patients in a condescending or dismissive way, with an example of a patient saying that staff talked to him as if he was ‘daft’.

1.4.1 Concerns raised by Voluntary Bodies on Dignity

Whilst statutory bodies have raised concerns about dignity in acute hospitals, the voluntary sector has also highlighted concerns and advocated improvements in dignity in care. Help the Aged’s campaign entitled Dignity on the Ward first raised concerns following observations, interviews and focus groups in 24 acute hospitals in England.  Their report identified that
standards of care depended on: adequate staffing; leadership; and coordination of different services (Davies, Laker, & Ellis, 1999; Help the Aged, 1999). Since then Help the Aged and Age Concern, prior to their merger to become Age UK, individually promoted campaigns and published reports on aspects of dignity. One of these reports entitled ‘Hungry to be Heard’ (Age Concern, 2006) again reported on the malnutrition of patients in hospital wards due to a lack of care. A further two reports revisiting ‘Dignity in Care’ and ‘The Challenge of Upholding Dignity’ identified key areas for which improvements were needed, in: eating and drinking; privacy; personal hygiene; communication; autonomy; pain relief, personal care; end of life care; and social inclusion (Help the Aged, 2007; Levenson, 2007; Help the Aged, 2008a).

In summary, over the past ten years reports have focussed on the dignity of older people in acute hospitals that has identified recurring themes of serious concerns related to a number of basic care needs not being met including: lack of privacy, unmet nutritional needs, inadequate communication, and a lack of respect to the point that it breached human rights. Organisational and system failures have also been identified that have related to a lack of leadership as well inadequate resources and training. The next two sections will review the policy context with a particular focus on dignity, including strategies, guidance and the National Dignity in Care campaign.

### 1.5 Healthcare Policies and Guidance related to Dignity

As set out in section 1.4 serious concerns have continued to be highlighted about the quality of care and dignity within hospitals over the past ten to fifteen years. However it can be seen that during this period a significant number of policies, strategies and guidance have been developed by the Department of Health to both respond to these concerns and reform the way healthcare is provided and commissioned. Table 1.3 lists the key policies and guidance in chronological order.

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<tr>
<th>Policy/Guidance</th>
<th>Comment</th>
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<tr>
<td>The Patient’s Charter (1991)</td>
<td>Identified rights and standards for patients accessing NHS services, that included respect for privacy, dignity, religious and cultural beliefs as one of nine charter standards</td>
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<tr>
<td>NHS Plan (DH 2000b)</td>
<td>Dignity was identified within one of the ten core principles of the NHS and as a commitment to improve standards in the care of older people.</td>
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<tr>
<td>Caring for Older People: A Nursing Priority (DH 2001a)</td>
<td>Report by the Standing Nursing and Midwifery Advisory Committee (SNMAC) following a review of standards of nursing care that identified: a lack of leadership, inadequate training, and deficiencies in the physical environment and resources</td>
</tr>
<tr>
<td>Policy/Guidance</td>
<td>Comment</td>
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| The National Service Framework (NSF) for Older People (DH, 2001b) set out eight key standards | Standard 1 – Ageism  
Standard 2 – Person centred care and the single assessment process  
Standard 3– Intermediate Care  
Standard 4 – General Hospital Care  
Standard 5 – Stroke services  
Standard 6 – Falls  
Standard 7 – Mental Health  
Standard 8 – Health Promotion  
Supplementary standard to 8 – Medicines management |
| Essence of Care (DH, 2001c, 2003a, 2006c, 2007b, 2010a)                          | 1. Bowel, bladder and continence care  
2. Care environment  
3. Communication  
4. Food and Drink  
5. Personal Hygiene  
6. Prevention and management of pain  
7. Prevention and management of pressure ulcers  
8. Promoting of health and well being  
9. Record Keeping  
10. Respect and Dignity  
11. Safety  
12. Self care |
| The role of modern matrons (DH,2003b)                                           | Guidance on ten key responsibilities of modern matrons. Includes: Making sure patients are treated with respect. |
| Standards for Better Health (DH, 2004)                                           | Core standards C13a, C15b, C16 & C20b specifically focussed on 1) staff treating patients and carers with dignity and respect, 2) that patients dietary needs are met, 3) accessible information on treatments and 4) environments promote privacy and confidentiality. |
| A New Ambition for Old Age (DH, 2006b)                                          | Refocus of the NSF for Older people with a key theme dedicated to Dignity as well as the first of the ten programmes on Dignity in Care that included: Nutrition and physical environment; Skills competence and leadership in the workforce and; Assuring quality. |
| Privacy and Dignity (DH, 2007a)                                                 | A report by the Chief Nursing Officer defining mixed sex accommodation and setting out responsibilities to eliminate mixed sex accommodation |
| High Quality Care for All (DH, 2008a) NHS Next Stage Review Final Report        | ‘High quality care should be as safe and effective as possible, with patients treated with compassion, dignity and respect. As well as clinical quality and safety, quality means care that is personal to each individual.’ p. 17. |
| Confidence in Caring (DH, 2008b)                                                | The confidence in caring framework for best practice was the result of a project to explore ‘caring’ and identify how dignity and caring could be improved |
| NHS Constitution (DH,2009a)                                                     | The NHS Constitution emphasises care and compassion and was the first time that patients had the right to be treated with respect, dignity and compassion within the NHS. |
| Eradicating Mixed Sex Accommodation (EMSA) (DH, 2009b)                          | This report identified those Trusts that were not performing in relation to targets around mixed sex accommodation. Action plans were required by Primary Care Trusts and Strategic Health Authorities to eradicate mixed sex accommodation. |
| Front line care –Prime Minister’s Commission report on the Future of Nursing & Midwifery in England (DH, 2010b) | Identified seven themes with twenty recommendations on the future of nursing. The first theme ‘compassionate care’ identified that truly compassionate care is skilled, competent, value-based care that respects individual dignity. |
| Tens of thousands of patients still placed in mixed sex accommodation. (DH 2010c) | Department of Health Press Release 16th August 2010 published data on those healthcare Trusts where there were ‘breaches’ of mixed sex accommodation as a name and shame driver along with increased accountability to deliver single sex accommodation. |
Given the wide range of policy initiatives and guidance related to dignity a number of key areas have been identified: 1. Inclusion and endorsement of dignity within national strategies for all healthcare services; 2. Where dignity has been identified as a particular focus within strategies in the care of older people; 3. Guidance for nursing and care delivery; and 4. The particular focus on seeking to address mixed sex accommodation within policies and guidance.

1.5.1 Inclusion and Endorsement of Dignity in National Health Strategies

The first of the national policy initiatives considered is the ‘Patient’s Charter’ (DH, 1991) originally published in 1991 by the then Conservative Government and updated in 1995 and 1997 by subsequent governments. It set out rights and standards (later versions used the term ‘expectations’ as opposed to ‘standards’) for patients of which privacy, dignity and religious and cultural beliefs was one of nine standards. One of the criticisms of the Patients Charter has been that dignity was identified as a standard rather than a formal right (Stocking, 1991). It is interesting to note that nearly twenty years later the NHS Constitution, equivalent to the Patient’s Charter, has set out the right for patients to be treated with dignity and respect in accordance with human rights (DH, 2009a). The Patient’s Charter also stated the right to be given a clear explanation of the treatment proposed, informed of any risks and, where appropriate, any alternatives. Furthermore the right to complain about NHS services was also identified which, as will be discussed later in this chapter, became one of the key challenges within the Dignity in Care campaign. Two key national strategies for the NHS over the last decade make a number of references to dignity. The first, the NHS Plan (DH, 2000b) identifies dignity within the core principles of services shaped by patients and meeting patient needs, and within a commitment to improve care for older people. The later review of the NHS, titled ‘High Quality Care for All’ (DH, 2008a) has dignity and respect integral to the definition of High Quality Compassionate Care; however dignity within the document is predominantly discussed in relation to End of Life Care. It is of note that the most recent ‘Equity and Excellence – Liberating the NHS’, (DH, 2010d) new strategy for the NHS, makes only one reference to dignity throughout the document, which is in the context of a sustainable adult social care system. It may be argued that this lack of focus on aspects of quality should be considered a particular concern given the current significant pressures to the continued level of funding of the NHS.
1.5.2 Strategies related to Older People and Dignity

Dignity has received particular attention within policy and guidance for older people that has included the National Service Framework for Older People (DH, 2001a) which set out eight standards to improve the quality of care and treatment for older people (see Table 1.3). Dignity was identified as part of one of four themes, entitled ‘Respecting the individual’ that focussed on ageism and person-centred care. Person-centred care was identified as an approach to ensure people were treated as individuals, that choice was promoted and that they received appropriate packages of care. It has been suggested that person-centred care has its origins within Rogerian humanistic theory (Ashburner, 2005), which has been widely adopted by nursing (McCormack & McCance, 2006). However it has also been argued that the policy agenda of person-centred care has been hijacked by the language used to promote a consumerist approach to healthcare (Ashburner, 2005). A New Ambition for Old Age (DH, 2006b) identified ten programmes under three themes, the first of which was Dignity in Care. It was of note that this was published seven months before the National Dignity in Care campaign was launched and offers a diverse range of areas within the programme of Dignity in Care that considered specific aspects of care such as nutrition, dignity within services such as, mental health, and recognition of the need for dignity within regulation and assessment of quality. It is of note that around this time high profile campaigns were also launched on the importance of patients having their nutritional needs met in hospital, entitled ‘Hungry to be Heard’ (Age Concern, 2006), best practice around using the toilet in private in hospital, entitled ‘Behind Closed Doors’ (British Geriatric Society, 2006), and the Joint Parliamentary Committee on Human Rights (JCHR, 2007) that highlighted serious concerns around a number of aspects of care related to dignity in hospitals. The success of the two earlier campaigns were their ability to target single issues under the umbrella of dignity, to key audiences of both the public and professionals, where tangible improvements were easily achievable.

1.5.3 Policy and Guidance for Nursing and Care Delivery

The nursing profession has played a key role in driving policy to address concerns related to dignity from the report by the Standing Nursing and Midwifery Advisory Committee on the development of standards for the care of older people (DH, 2001a) as well as taking the lead in implementing Essence of Care Benchmarks (DH, 2001b; DH, 2003a; DH, 2006c; DH, 2007b; DH, 2010a). These twelve benchmarks for the fundamental aspects of care (see Table 1.3) have
developed over a period of time since 2001, with the ‘Privacy and Dignity’ benchmark (DH, 2001c) recently rebranded as ‘Respect and Dignity’ (DH, 2010a). Whilst privacy is no longer in the title, it remains within the factors relating to the benchmark that include: attitude and behaviours; that people experience care that maintains their confidentiality; that people’s modesty is protected; and that there is access to private areas. Respect and dignity are also integral to a number of the benchmarks around different aspects of care, in particular: bowel, bladder and continence care; the care environment; communication; food and drink; and personal hygiene. Along with the focus on care processes has been the development of new roles in Senior Sisters – Modern Matron (DH, 2000). Ten key responsibilities were identified for Modern Matrons (DH, 2003b) that included making sure patients are treated with respect, as well a number of other responsibilities that directly relate to and support this: leading by example; making sure patients get quality care; ensuring staffing is appropriate to patient needs, ensuring patients’ nutritional needs are met; improving wards for patients; and resolving problems. An evaluation of these roles identified a positive impact on: improving standards of nursing care; improving the patient environment; improving skill mix and staff retention; improving staff morale; encouraging staff development; and substantially reducing the number of formal complaints from patients and their families. However the evaluation also identified significant variability in the implementation of these roles nationally (RCN, 2004). This highlights the particular challenge of implementation of a national policy that involved local application of a new nursing role of the modern matron, and where guidance developed over a period of time, as opposed to being in place from the outset.

Nursing has also led a project entitled ‘Confidence in Caring’ within England to explore ‘caring’ and identify how dignity and caring could be improved (DH, 2008b), which developed a framework for best practice that identified different actions within healthcare organisations to create confidence in care for patients. These centred on five confidence creators, of which dignity was a key part of ‘personalised care for and about every patient’. To create confidence in care, different levels and actions were identified as: the means within the organisation, for example through strong leadership; the actions for a team, such as effective communication throughout a shift; and the skills and will of individuals, for example, well organised or skills in handling conflict effectively. Whilst this project is well thought out, it was not widely publicised at the time and therefore may not have achieved significant impact. However, at the same time the Royal College of Nursing launched its own campaign ‘Dignity at the Heart of everything we do’ (RCN, 2008b) with materials developed for nurses to support improvements in practice that have been evaluated as well received and have enabled the development of other dignity
related initiatives (Baillie & Gallagher, 2010). More recently a commission set up by Gordon Brown, the then Prime Minister, on the future of Nursing and Midwifery (DH, 2010b) identified seven themes relating to the role of nurses and the delivery of care, with the first of these being ‘High Quality Compassionate Care’. Dignity was referred to within this theme in relation to the importance of tackling poor practice, with an emphasis on the responsibility of both individual nurses and midwives and senior nursing managers to “champion quality from the point of care to the board” (DH, 2010b, p. 5). However, it has been argued that it failed to address the current shortcomings in basic nursing care, yet “restated requirements for compassion, competence and leadership without addressing why they are lacking” (Bradshaw, 2011, p. 1799). It is also of note that there appears to have been a shift in language to the use of compassion and care as opposed to dignity through recent strategies and guidance. Meyer (2010) highlights that compassion is a term that has been used in Scotland as opposed to dignity and that the term compassion implies an emotional investment on the part of the caregiver (Meyer, 2010, p.71). Use of the term compassion may enable healthcare professionals to more easily consider this as part of their personal and professional qualities and values, as opposed to dignity which may be considered a more elusive concept.

1.5.4 Policy to Address Mixed Sex Accommodation

Finally, the issue of mixed sex accommodation has gained increasing focus over the past five years which may be attributed to greater awareness that the practice of mixing patients of the opposite gender in the same bedded areas has been widespread, as reported by a third of patients within the National Patient Survey (Richards & Coulter, 2007). The National Patient Survey’s are questionnaires completed annually from a sample of up to 850 patients who have received care within each acute healthcare Trust in England. This prompted action by the Chief Nursing Officer for England who published guidance (DH, 2007b) that provided detail on definitions of mixed sex accommodation, and identified ways to address the mixed sex accommodation, and that no area was exempt from this guidance. In addition a privacy and dignity challenge fund of £100 million was announced (DH, 2009b) to support environmental improvements to provide same sex accommodation for all patients. More recently published data from the Department of Health has indicated that tens of thousands of people are still being placed in mixed sex accommodation across NHS hospitals in England (DH 2010b) and set out a new reporting schedule of breaches of patients being mixed with a patient of the opposite sex and increased accountability to eliminate this practice. However, it is of note that
whilst the NHS Constitution (DH, 2009a; DH, 2010e) identifies that patients have specific rights in relation to the quality of the care environment it makes no mention of a right to single sex accommodation.

Review and discussion of these four areas relating to policy and guidance has identified an increased focus on dignity over the past ten years, as well as more recent use of related concepts of compassion and care. Policy and guidance on dignity can be seen to have had greater impact where there has been a consistent focus and leadership, for example in the area of the care of older people, and where nursing has played a central role in seeking to improve the fundamentals aspects of care. The role and impact of voluntary and professional bodies on the dignity agenda can be seen to have been particularly effective in raising public awareness of dignity as well as ensuring that it is high on the department of health policy agenda. However there remains aspects of dignity, for example mixed sex accommodation, where a continued policy drive to address this has had limited success. The next section will review the National Dignity in Care campaign and work that was undertaken to inform the key messages within the campaign.

1.6 The National Dignity in Care Campaign

In November 2006 Ivan Lewis the then Care Services Minister launched a National Dignity in Care campaign (DH, 2006a) as a major government initiative to set out expectations of health and social care providers around aspects of dignity. The aim of the campaign was to address concerns related to dignity and to provide patients and the public with a clear understanding of what they should be able to expect from a service that respects dignity (SCIE, 2006, p. 7). This work was supported by a number of national listening events and an online survey completed by over 400 people over a ten week period that involved members of the public, with half of the respondents being professional health and social care staff (DH, 2006d). Findings from the survey have been reviewed in depth by Gallagher, Li, Wainwright, Rees-Jones, and Lee (2008) who comment that ‘whilst this is not rigorous research, it represents an official account that has shaped future policy’ (Gallagher et al, 2008, p.5). The ten most common issues that were identified from the survey are summarised in the Box 1.2.
Box 1.2 Findings from the Public Survey – ‘Dignity in Care’ - Major Issues

1. Clarifying what dignity is – lack of clarity about what dignity is and what minimum standards should be. Responses suggested a range of meanings, for example, privacy, courteous treatment, having choices about care and consideration for cultural and religious needs.

2. Complaining about services – difficult to make a complaint about services with a complaints system that is not adequate and needs to be more accessible, independent and powerful.

3. Being treated as an individual – people were not listened to or treated an individual and were being cared for as a group. Suggestions for good practice included: talking to people as individuals and not stereotyping them; encouraging independence and giving people time and choice.

4. Privacy in care – People not having enough privacy when receiving care. The importance of the environment that included: curtains and private rooms, and protecting privacy of information.

5. Assistance in eating meals – not enough assistance or time allocated to users to eat meals.

6. Access to lavatory/bathroom facilities – often insufficient access to lavatory/bathroom facilities with staff unavailable to help and alternatives offered such as commodes, that people found embarrassing and undignified.

7. Being addressed by care staff appropriately – the importance of using proper titles and not calling people ‘love’, ‘dear’, ‘poppet’ and so on.

8. Maintaining a respectful appearance – lack of care, time and resources and laundry damages were said to people not appearing well-groomed.

9. Stimulation and a sense of purpose – it was felt that lack of stimulation can speed decline and make people feel isolated, therefore, having stimulated activities and a sense of purpose (when in a care home or at home alone) are important.

10. Advocacy services – there were insufficient advocacy services for vulnerable adults and that these would support people in making complaints.

Adapted from (DH, 2006a, p. 4; Gallagher et al, 2008, p. 6)

Less frequent but nevertheless important concerns were also highlighted with two other areas identified as ‘minor issues’ for which there were a smaller number of comments, see Box 1.3.

Box 1.3 Findings from the Public Survey – ‘Dignity in Care’ - Minor Issues

1. Language barriers between care staff and service users – difficulties in communication and cultural differences in care, which, it was suggested, could be tackled through improved training and better recruitment and retention policies

2. Mixed sex facilities – being placed in mixed sex facilities makes people feel uncomfortable and feedback was given that this should stop as it was one of the most obvious ways to respect people’s privacy.

These twelve, major and minor issues present a range of quite specific concerns related to the way in which care was provided, as well as issues relating to facilities and environment, and resource issues such as sufficient staffing, activities to stimulate a sense of purpose, and advocacy. It is of note that aspects of care, previously reported, such as, assistance with meals, and privacy feature in major issues list, whereas concern related to mixed sex facilities was only
considered a minor issue. The survey informed the development of the ten elements of the Dignity in Care campaign, listed in Box 1.4, which may be considered themes identified to target particular aspects of care. However, whilst links can be drawn between a number of the twelve issues identified in the survey and the ten elements there is no explanation given from the Department of Health survey, or subsequent publications, how the issues from the survey informed the structure of the Dignity in Care campaign.

**Box 1.4 Ten elements of the Dignity in Care campaign**

1. Zero tolerance to all forms of abuse  
2. Support people with the same respect as you would want for yourself or a member of your family  
3. Treat each person as an individual by offering personalised services  
4. Enable people to maintain the maximum possible level of independence, choice and control  
5. Listen and support people who want to express their needs and wants  
6. Respect people’s right to privacy  
7. Ensure people feel able to complain without fear of retribution  
8. Engage with family members and carers in care partners  
9. Assist people to maintain confidence and a positive self esteem  
10. Act to alleviate people’s loneliness and isolation

Following the launch of the National Dignity in Care campaign many healthcare NHS Trusts within England progressed work on the campaign to improve dignity in care (HCC, 2007) using some of the national resources developed to support this work (SCIE, 2006). However, whilst a wide range of resources were accessible, it may be argued that the campaign had high aspirations and made unrealistic and vague expectations due to the breadth and depth of the elements included within the Dignity in Care campaign.

The following section provides a detailed description of the context of one acute healthcare Trust at the time of the launch of the Dignity in Care campaign, where the evaluation study subsequently took place.

**1.7 Context of the Hospital at the time of the National Dignity in Care Campaign**

The acute healthcare Trust where the evaluation study took place may be considered a large teaching Trust based in the South of England with over one thousand hospital beds. At the time of the launch of the Dignity in Care campaign and during the period of the evaluation study a merger with another hospital was proposed and implemented with a new
organisational structure that affected senior and middle management roles, including nursing leadership roles, during 2007 and 2008.

Before the merger, the record of the Trust on patient experience over the previous two years had raised concerns, which were documented in two major reports. Firstly, the annual National Patient Survey for the acute healthcare NHS Trust, undertaken by the Picker Institute for the Healthcare Commission for 2007 (Picker, 2007) had identified a wide range of poor performing areas that related specifically to elements of the Dignity in Care campaign. These included: mixed sex sleeping areas and shared toilet and bathroom facilities, a lack of confidence and trust in nurses, inadequate privacy when discussing conditions and treatment, limited information and explanations about treatment and medications, and a failure to treat patients with respect and dignity. Below average results on these key areas of patient care placed the performance of Trust in the lower quartile of acute healthcare Trusts in England. Secondly, at the beginning of 2007 a qualitative study was undertaken by nurse within the acute healthcare Trust that focussed on older people’s experiences of accessing urgent care (Dawood, 2007). This highlighted a range of concerns related to dignity that included: the negative experience of being allocated a bed in a mixed sex bay; older patients needing help to fill in forms, such as menu forms; problems with communication, for example, discussions on whether or not to resuscitate, particularly with patients with dementia or acute confusion. This illustrates an acute healthcare Trust with many of the concerns highlighted in earlier reports and significant challenges in relation to organisational change. It is also of note that this was despite a cyclical annual programme of work on the essence of care benchmarks completed over the previous four years, with action plans developed and owned locally. However, these had little impact in improving the results from the National Patient Survey. As a result of this failure to address patient concerns the nursing leadership within the organisation was particularly responsive to utilising the National Dignity in Care campaign as a mechanism for positive change to improve the quality of patient experience.

The next section describes the key processes and actions in the local application of the Dignity in Care campaign.

1.8 Local Application of the Dignity in Care Campaign

Significant work was undertaken as part of the local application of the Dignity in Care Campaign, which are summarised in the table 1.3.
### Table 1.3 Local initiatives undertaken as part of the Dignity in Care campaign

<table>
<thead>
<tr>
<th>Action</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discussion paper developed on the Dignity in Care campaign that was presented to a number of nursing and management forums</td>
<td>February – March 2007</td>
</tr>
<tr>
<td>Trust wide Dignity Steering Group established with senior leads from each of the clinical directorates, representation from each of the professional groups, patient and public involvement representation and membership from human resources, estates and facilities.</td>
<td>May 2007</td>
</tr>
<tr>
<td>Collaboration and external agencies for developed with Local PCT’s, Health and Social Care Advisory Service (HASCAS), Kings Fund, Help the Aged and Royal College of Nursing</td>
<td>June 2007 onwards</td>
</tr>
<tr>
<td>Baseline gap analysis undertaken against ten elements of the dignity challenge</td>
<td>July 2007</td>
</tr>
<tr>
<td>Work prioritised with an action plan identified five of the ten points identified within the national Dignity in Care campaign: 1. Element one: Zero Tolerance to all forms of abuse, 2. Element three: Treat each person as an individual, 3. Element four: Enable people to maintain the maximum possible level of independence, choice and control, 4. Element five: Listen and support people who want to express their needs and wants, and 5. Element six: Respect people’s right to privacy</td>
<td>July 2007</td>
</tr>
<tr>
<td>Structure developed to report and support work around Dignity</td>
<td>July 2007</td>
</tr>
<tr>
<td>Key pieces of work developed: Communications Plan, PPI Action Plan, Education project to improve care of patients with Dementia</td>
<td>August 2007</td>
</tr>
<tr>
<td>Dignity Training Workshops supported, funded and took place at on one Hospital site</td>
<td>September and October 2007</td>
</tr>
<tr>
<td>Dignity Training Workshops supported, funded and took place at a second Hospital site</td>
<td>January and February 2008</td>
</tr>
<tr>
<td>Sub groups established looking at Hospital Gowns, Red Pegs</td>
<td>January 2008</td>
</tr>
<tr>
<td>Pilot of Red Peg project across 5 Wards in each Hospital</td>
<td>March 2008</td>
</tr>
</tbody>
</table>

Key milestones during 2007, prior to the study taking place, was; the development of a discussion paper, the establishment of a Trust wide Dignity Steering Group, agreement for funding of a series of Dignity Training Workshops, a gap analysis undertaken of policies and practice, and identification of five priority areas from the ten elements of the Dignity in Care campaign. The Dignity in Care campaign was first considered at various nursing and management forums during February and March 2007 with a discussion paper that set out the ten points of the dignity challenge and key questions for the organisation and departments to consider whether practice and policies were in place to address each of the points of the challenge (SCIE, 2006). Some guiding questions were identified to initiate discussion (see Box 1.5).
Box 1.5 Guiding questions to develop discussion across the organisation on the Dignity in Care campaign

- How do we know we have respect for people’s dignity?
- How can dignity be observed in practice?
- Where is it demonstrated (through documentation) that dignity is at the centre of the Trust’s thinking and processes?
- How can we ensure that dignity is embedded into training and education, and ensure that students training within the hospital consider dignity central to the care they provide?

The discussion paper also proposed key actions/next steps to progress work around dignity (see Box 1.6).

Box 1.6. Key actions proposed as part of the discussion paper on the next steps to progress initiatives on the Dignity in Care campaign

1. Review of existing policies and practice to consider how these address the ten point dignity challenge
2. Undertake a gap analysis and action with identified leads responsible for each of ten point dignity challenges across the organisation.
3. Recognition that whilst the initial approach of the Dignity in Care campaign focussed on older persons; the agenda for meeting the Dignity in Care campaign was relevant across all services.
4. Establishing a Dignity Steering Group with a wide range of professionals across the organisation
5. Development of Dignity Training Workshops for a wide cross section of staff

A Trust wide Dignity Steering group first met in May 2007, chaired by the Director of Nursing, involving a wide range of professionals including; nurses, allied health professionals, medical staff, and managers, representing different disciplines and departments of the acute healthcare Trust. This group took the lead in directing work in response to the Dignity in Care campaign. One of the actions of the group was to identify the need for a gap analysis, which was undertaken by dignity leads within each directorate of the hospital against the ten elements of the Dignity in Care campaign. This informed the identification of five locally determined priority areas and actions to progress each of these five elements over the following twelve month period. Table 1.4 sets out these five elements, the rationale for prioritising these locally, and the key actions identified to improve dignity within each element. In addition to the actions identified in the table, a number of initiatives were developed and progressed during the Autumn of 2007 to Summer 2008 to support improving aspects of dignity within the five elements prioritised. These included: multi-professional dignity training workshops; a project group on developing a communications plan with staff; a group looking at a new more dignified hospital gown; and a plan for patient and public involvement that involved patient and carer focus groups giving feedback on proposed plans to address the Dignity in Care campaign locally.
Table 1.4 Five priority areas of the Dignity in Care campaign identified within the acute healthcare Trust

<table>
<thead>
<tr>
<th>Local Priority</th>
<th>Rationale for prioritising these elements locally and identified actions</th>
</tr>
</thead>
</table>
| 1. Element 1. Zero tolerance to all forms of abuse | There had no recent training for staff within the Trust around Adult Protection including identification, reporting and management of abuse. In addition the need to review the Policy on Adult Protection, working closely with local partner organisations was identified.  

**Actions:** 1) Establish training programme on Adult Protection and include within Hospital Induction for all staff. 2) Work with partner organisations to agree Policy on Adult Protection |
| 2. Element 3. Treat each person as an individual | National Patient Survey results for the Trust identified healthcare professionals as talking about patients at the end of the bed and not including them in the discussion about their illness and treatment plan.  

**Actions:** 1) Increase awareness of the Trust Privacy and Dignity Policy. 2) Provide further training for staff on equality and diversity. |
| 3. Element 4. Enable people to maintain the maximum possible level of independence, choice and control | Addressed aspects of maintaining independence involving issues around managing continence, discharge, issues around Do not resuscitate orders, and mental capacity. Additionally this was an aspect of dignity where work was taking place to further improve the way patients nutritional needs were met, as an essence of care benchmark.  

**Actions:** 1) Implementation of a campaign to support protected mealtimes. 2) Roll out of ‘Red Trays’ across all wards to ensure patients with additional nutritional needs are identified and additional support provided. |
| 4. Element 5. Listen and support people who want to express their needs and wants | The element included the need to demonstrate effective interpersonal skills with people with confusion and dementia, which was an area where work had been done over the past two years within the Trust. Further work was needed to build on this in order for healthcare professionals to recognise the particular needs of patients with confusion and dementia.  

**Action:** 1) Utilise good practice pack from Department of Health entitled ‘Lets Respect’ to promote the needs of people with dementia. 2) Establish a dedicated study day on meeting the needs of people with dementia in hospital. |
| 5. Element 6. Respect people’s right to privacy | The Trust was identified as performing poorly in the area of mixed sex accommodation.  

**Actions:** 1) Trust action plan developed to more effectively report, monitor and address any breaches of mixed sex accommodation. 2) Roll out of a ‘Red Peg’ project, with the use of red clothes pegs on closed curtains around beds to prevent intrusions and promote privacy |

Whilst there has been very little reference to local implementation of the national Dignity in Care campaign within the literature, one survey of 200 community healthcare staff reported on the priorities from the national ten points in relation to organisation, team and individuals (Jones & Aranda, 2009). Priorities identified by these community staff show some similarities within the acute hospital setting, where three out of the five priorities were also identified within the acute hospital setting as can be seen in table 1.5.
Table 1.5  Priorities from the Ten Point Dignity Challenge in a Community Setting

<table>
<thead>
<tr>
<th>Top three challenges identified</th>
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<tbody>
<tr>
<td><strong>For the organisation to prioritise</strong></td>
</tr>
<tr>
<td> Enable people to maintain the maximum possible level of independence, choice and control</td>
</tr>
<tr>
<td> Treat each person as an individual by offering a personalised service</td>
</tr>
<tr>
<td> Support people with the same respect you would want for yourself or your own family</td>
</tr>
<tr>
<td><strong>For their team to prioritise</strong></td>
</tr>
<tr>
<td> Enable people to maintain the maximum possible level of independence, choice and control</td>
</tr>
<tr>
<td> All ten points of the dignity challenge</td>
</tr>
<tr>
<td> Listen and support people in expressing their needs and wants</td>
</tr>
<tr>
<td><strong>For individuals to prioritise</strong></td>
</tr>
<tr>
<td> Listen and support people in expressing their needs and wants</td>
</tr>
<tr>
<td> Treat each person as an individual by offering a personalised service</td>
</tr>
<tr>
<td> Assist people to maintain confidence and positive self esteem</td>
</tr>
</tbody>
</table>

(Jones & Aranda, 2009, p.31)

However key areas that differ within the acute hospital setting included: raising the awareness and understanding of issues to do with safeguarding vulnerable adults; considering ways to improve patient privacy, as the hospital had a poor record on placing male and female patients in bays together; and seeking to improve the care of patients with confusion and dementia in hospital.

This section has set out the local priorities and actions to improve aspects of care from five elements of the Dignity in Care campaign that were determined by consensus following a detailed gap analysis, that considered the results from recent National Patient Surveys.

1.9 Chapter summary

This chapter started with the definition of dignity from the National Dignity in Care campaign and identified some key reports that have raised serious concerns, prompting a particular focus on dignity in healthcare settings. The role and responsibilities of nurses in relation to dignity for patients has been considered in relation to professional codes and bodies. Key policies and guidance developed by the Department of Health have been reviewed where considerable attention has been given to dignity over the past twenty years within acute healthcare settings. Recognition of some of the shifts in emphasis in relation to the importance of dignity and the use of language have been identified, as well as the key role that the nursing profession has played in a continued focus on fundamental aspects of care. The context of the acute healthcare Trust has been described where the study took place that included detail of its
implementation of the national campaign to improve aspects of care related to dignity. The next chapter reviews research related to dignity, identifying gaps in the evidence particularly in relation to the evaluation of the national Dignity in Care campaign within an acute healthcare Trust.
Chapter 2  A Review of the Literature Relating to Dignity

2.1 Introduction

The understanding of the nature of dignity through concept analyses, philosophical and ethical perspectives on dignity is considered followed by a review of the literature on the experiences and meaning of dignity identified by patients and healthcare professionals, and the implications for practice. Evaluation of initiatives to improve dignity for patients are also reviewed with gaps in the evidence and the need for a systematic evaluative study of the Dignity in Care campaign identified.

2.2 Understanding the nature of dignity

In developing an understanding of the nature and complexity of dignity a number of writers (Davies et al, 1999; Jacobs, 2000; Coventry, 2006; Jacobson, 2007; Gallagher et al, 2008) have drawn on the work of one of the early philosophers, Aristotle, who saw dignity as a moral virtue. More recently Kant identified a sense of absolute worth in relation to dignity, and rationality and autonomy as key characteristics of this (Kant, translated by Ellington, 1993). However, many authors have referred to the difficulties of defining dignity (Shotton & Seedhouse, 1998; Jacelon, Connelly, Brown, Proulx, & Vo, 2004; Tadd, 2005; Jacobson, 2007). It has also been written that the absence of dignity appears to be much easier to describe and observe (Woolhead, Calnan, Dieppe, & Tadd, 2004) with several authors (Haddock, 1996; Seedhouse & Gallagher, 2002; Marley, 2005) referring directly to attributes of a lack of dignity.

A number of concept analyses of dignity have been undertaken to identify key attributes and antecedents to define dignity (Mairis, 1994; Haddock, 1996; Johnson, 1998; Jacobs, 2001; Fenton & Mitchell, 2002; Jacelon et al, 2004; Marley, 2005; Griffin-Heslin, 2005; Coventry, 2006; Anderberg, Lepp, Berglund, & Segesten, 2007). Five of these studies were undertaken within the UK (Mairis, 1994; Haddock, 1996; Fenton & Mitchell, 2002; Marley, 2005; Griffin-Heslin, 2005), four in the USA (Johnson, 1998; Jacobs, 2001; Jacelon et al, 2004; Coventry, 2006) and one undertaken in Europe (Anderberg et al, 2007). These studies represent a wide range in quality, with some having asked patients and the public to help define the concept (Jacelon et al, 2004; Anderberg et al, 2007), others that asked colleagues and student nurses (Mairis, 1994; Haddock, 1996; Jacobs, 2001; Marley 2005) and finally, those that did not go further than reviewing professional literature (Johnson, 1998; Fenton & Mitchell, 2002; Coventry, 2006). Several of the studies carried out their analysis of the concept of dignity
informed by one of two theoretical frameworks (Walker & Avant, 1988; Chin & Kramer, 1991) that use a systematic approach to review evidence and test out the defining attributes of the concept (Mairis, 1994; Haddock, 1996; Fenton & Mitchell, 2002; Jacelon et al, 2004; Marley, 2005; Griffin-Heslin, 2005; Anderberg et al, 2007). However, this systematic approach was not used by all the studies that developed a concept analysis and definition of dignity (Johnson, 1998; Jacobs, 2001; Coventry, 2006). A table in Appendix 1 sets out each of these concept analyses, the framework used to explore the nature and meaning of dignity, the definition and comments. Key themes identified from the review of these concept analyses include:

- Dignity as an inherent characteristic of being human (Mairis, 1994; Haddock, 1996; Nordenfelt, 2003; Jacelon et al, 2004; Marley, 2005) and that people have a unique individuality (Jacelon et al, 2004; Anderberg et al, 2007).
- The subjective nature of dignity which includes self respect, pride, self confidence and self esteem (Mairis, 1994; Haddock, 1996; Jacobs, 2000; Jacobs, 2001; Jacelon et al, 2004; Marley, 2005).
- An element of autonomy, self determination, choice and control with recognition within this that some patients will not have capacity for choice and control (Mairis, 1994; Haddock, 1996; Nordenfelt, 2003; Marley, 2005; Griffin-Heslin, 2005).
- The importance of maintaining boundaries from threats to an individual’s dignity (Haddock, 1996; Marley 2005).
- The attitude of care towards patients, that may be considered behavioural, is an essential part of dignity which can be conferred to another to enable quality of life, peace, comfort, communication, empowerment, advocacy and involvement in decision making (Fenton & Mitchell, 2002; Jacelon et al, 2004; Anderberg et al, 2007).
- That providing dignity was considered to be developmental, as opposed to an inherent quality, that can be learnt and developed through training, education and reflection (Jacelon et al, 2004; Anderberg et al, 2007).

However there are tensions and contradictions in the understanding of dignity relating to: its objective nature as well as being subjective; public as well as private; individual as well as collective; intrinsic as well as external and extrinsic; hierarchical and as democratic; as unconditional and static, as contingent and dynamic; as inherent, bestowed or achieved; and as descriptive and prescriptive (Jacobson, 2007, p. 293). Jacobson argues that some of the difficulties around definitions of dignity relate to not specifying whether dignity is human dignity or social dignity. Human dignity is referred to as the ‘Menschenwürde’ which is a
German word meaning the inherent, inalienable value that belongs to every human being, and was identified as one of four types of dignity (Nordenfelt, 2004). Whereas social dignity, whilst grounded in human dignity, is defined as “contingent, comparative and contextual, and is experienced, bestowed and earned through interaction in social settings” (Jacobson 2007, p. 294). Social dignity can also be considered as consisting of ‘dignity of self’ and ‘dignity in relation’, with dignity of self relating closely to a fourth type of dignity of dignity of personal identity (Nordenfelt, 2004) and dignity in relation refers to a process of reflecting worth and value back to an individual through word or deed.

The aspects of dignity identified through the review of concept analyses and typologies of dignity demonstrate the importance of the worth and respect for individual patients through care and attentiveness. These are integral to the conduct, ethics and accountability of nurses, identified in section 1.3, and aspects of care that have been found lacking in published reports, discussed in section 1.4. The next section reviews research studies related to the meaning and experience of dignity identified by patients and healthcare professionals, and those studies where an evaluation of an initiative to improve dignity, within an acute healthcare Trust, has been undertaken.

2.3 Research on the meaning and experience of dignity and its implications for practice

This section consists of two parts. The first part reviews research related to the meaning and experiences of dignity in acute healthcare settings, from the perspective of patients and healthcare professionals, and the learning gained from these studies, to improve practice. The second part reviews those research studies where an evaluation of an initiative to improve dignity within an acute healthcare setting has taken place. A systematic search of the literature on dignity was undertaken using free text terms and MeSH terms which defined the subject being searched in the following databases: CINAHL, British Nursing Index and Medline to identify the most relevant primary and secondary research that used quantitative, qualitative or mixed methods. Key terms used as part of the search for primary research included: dignity, dignity in care, patient experience, hospitals, nursing, and evaluation. The search reviewed research studies published during the past fifteen years, in the same period that concept analyses have been reviewed, the earlier review of policy and guidance relating to dignity, and reports that were published related to concerns around dignity in care. In addition studies were identified through personal knowledge in this area and discussions with other experts in
the field about studies that had particular relevance to dignity in care. The aim of this review was to develop an understanding of previous work in this area, critically appraise studies and identify the gaps in the current evidence in this area (Silverman, 2000) with particular consideration for any evaluations of dignity undertaken within an acute healthcare Trust. A summary of these studies can be seen in a table form in Appendix 2.

The studies have been grouped according to those involving patients and carers, those involving professionals, and those involving patients and professionals. The review described below considers studies in order of International, European and finally evidence from studies within the UK. The review first considers studies undertaken within acute healthcare settings that relate to patients.

2.3.1 Studies involving patients

A Canadian study explored the meaning of dignity from terminally ill cancer patient perspective (Chochinov, Hack, McClement, Kristjanson, & Harlos, 2002). This study used a qualitative methodology using a grounded theory approach with the use of semi-structured interviews of a consecutive sample of fifty patients, with an age range of 37 to 90. The study developed a model comprising three main categories of illness related issues that included an individual’s level of independence in relation to their cognitive acuity and functional capability. Illness related issues also included symptom distress that consisted of physical distress and psychological distress which was made up of medical uncertainty and death anxiety. Dignity conserving repertoire was the second major category that included dignity conserving perspectives that consist of: continuity of self, role preservation, generativity/legacy, maintenance of pride, hopefulness, autonomy/control, acceptance and, resilience/fighting spirit. Dignity conserving repertoire also included; living in the moment, maintaining normalcy, and seeking spiritual support. The third major category was a social dignity inventory, which included; privacy boundaries, social support, care tenor, burden to others, aftermath concerns. It was identified that if any of these themes of dignity within the illness related concerns and social dignity inventory were affected this would diminish an individual’s sense of dignity. A model was also proposed that considered the interrelatedness between these two themes and that the dignity conserving repertoire could be a means to ‘buffer’ the patient’s sense of loss of dignity, however this effect would be diminished further if the individual had limited dignity conserving repertoire. The author also refers to dignity diminishing behaviours; however these
were not identified in the findings. The implications of the study were that there were a range of factors within the dignity conserving repertoire that could be supported and enhanced to mitigate against the loss of an individual patient’s dignity. The study also identified the need for further research to develop and evaluate interventions that promote dignity. Whilst the focus of this study was on terminally ill patients, that may not be applicable to patients in acute healthcare settings, its inclusion in this review was as a model of dignity that has made a significant contribution to knowledge of how those aspects of the patient and their illness may diminish or conserve a patient’s dignity.

Two Swedish studies by some of the same authors explored the conceptions of integrity from different gender perspectives (Widang & Fridlund, 2003; Widang, Fridlund & Martenson, 2008). Both studies used a qualitative methodology with a phenomenological approach and conducted semi-structured interviews with purposive samples of seventeen males (Widang & Fridlund, 2003) and fifteen female patients (Widang et al, 2008). In both studies dignity was identified as one of the key themes of integrity. It is of note that the term integrity is often used in studies emanating from Sweden as a term that may appear to be synonymous to dignity. The Swedish understanding of the concept of “integrity and that of privacy is the individual’s right to unlimited protection from unjustifiable trespass in his or her own personal sphere” (Randers & Mattiasson, 2004, p. 64) which relates to maintaining boundaries from threats to an individual’s dignity identified within the concept analyses of dignity (Haddock, 1996; Marley, 2005).

Male patients (Widlang & Fridlund, 2003) identified three concepts of dignity of: ‘being seen as a whole person’; ‘being respected’; and ‘being seen as trustworthy’. Female patients (Widang et al, 2008) identified two themes of: ‘being respected’ and ‘not being exposed’. For male patients (Widlang & Fridlund, 2003) ‘being seen as a whole person’ was described as consideration for the person’s physical, psychological, social and existential needs, with an example of concerns highlighted where an individual was being treated in relation to a medical condition as opposed to a whole person. In relation to ‘being respected’ this related to being listened to, the door being knocked before a person entered their room, and not having their body exposed more than was necessary. For female patients (Widang et al, 2008) ‘being respected’ referred to where the professional was attentive and listened in a sensitive manner, providing care with respect. ‘Not being exposed’ focussed on bodily exposure which resulted in feelings of vulnerability and isolation as well as an apparent lack of control over the situation by caregivers, as well as a lack of information to the point where patients did not dare or know
how to complain. Whilst this second theme appears to differ from the earlier study of Male patients by Widang and Fridlund (2003) where not being exposed was referred to in their second theme relating to dignity of ‘being respected’. The earlier study involving male patients was the only one of the two to identify a third conception of dignity of ‘being seen as trustworthy’ or genuine in their illness which is an aspect of dignity that has been reported previously, in two other studies (Söderberg, Gilje & Norberg, 1997; Enes, 2003).

For male patients (Widlang & Fridlund, 2003) the two other themes within this study related to integrity of ‘self respect’ and ‘confidence’ and contains several points that other studies have considered within the concept of dignity, as opposed to integrity. These included sub themes of: having control over oneself – related to personal information and decision making, keeping information confidential – with an example used related to lack of confidentiality during the admission of a patient, and trusting professionals – with a high level of knowledge, good communication skills and empathy. For female patients (Widang et al, 2008) the two other themes related to integrity were: ‘maintaining the self’ - which represented the patient’s relationship with herself, and ‘confidence’ - which was associated with the relationship between patient and professional caregivers.

Particular implications of note from these two studies were the importance of the relationship between the patient and nurse, and that “nursing care must preserve and respect patients’ integrity, even in threatening and violating situations, which demand the utmost sensitivity” (Widang & Fridlund, 2003, p. 55). In addition, issues identified related to being treated as a whole person, being respected, as well as the concerns raised around not being trusted or treated as genuine, being exposed, and having a fear of complaining are of particular importance in the dignified care of patients. Whilst relatively small and not undertaken within the UK National Health Service (NHS) these two phenomenological studies provide valuable insight into the meaning and experience of dignity, and some gender differences in relation to the importance of not being exposed, particularly identified by female patients.

A UK study explored patient’s understanding of privacy and dignity and whether patients felt their privacy and dignity were met within a mixed gender ward (Whitehead & Wheeler, 2008b). This study used both quantitative and qualitative methodology through the use of a self report questionnaire comprising two open and 16 closed questions. A convenience sample of 40 (9 women & 31 men) coronary by-pass graft patients, between the ages of 35 to 89 years, within a mixed gender ward completed the questionnaire. Similar age distribution and length of hospital stay was identified across both groups of male and female patients. Quantitative
findings from this sample identified a statistical difference between male and female responses in relation to the importance of privacy with greater importance being attributed by women \((P=0.037)\). However, although significant, it was a convenience sample, where the total population for this small sample is drawn from is not reported, therefore it is difficult to know how representative this group was. In addition the results identified that 52.5% of both groups of patients were neither happy nor unhappy being nursed on a mixed sex ward. Whilst this apparent indifference on the part of patients to mixed sex wards is of interest, again it is difficult to generalise on the basis of the sample size.

Qualitative findings were also gained using two open questions with the self report questionnaire, using content analysis based on grounded theory. Themes revealed were grouped relating to privacy and dignity. Privacy themes included: privacy of information, e.g. having one’s conversation not being overheard, privacy of person and body, e.g. not being viewed during one’s private moments (e.g. performing toilet functions); exerting personal control e.g. matters of relating to one’s care; able to be alone at one’s choosing; gaining respect from professionals; having one’s hospital records and files removed from visitors attention/space; having one’s own/personal space; everyone should value privacy as essential or important, especially in mixed sex wards; the value of single as opposed to mixed sex wards/bays; freedom and privacy to worship and; right to perform an intimate activity of daily living e.g., using the toilet in private and alone, only having staff present if essential.

Themes relating to dignity included: absence of embarrassment, e.g., shown up in front of others; having one’s privacy and dignity respected; being treated humanely, like a human being and not as an object; being treated with respect as well as respecting others; being treated with sympathy, consideration and compassion; to be treated as an individual; when all staff introduce themselves and say who they are before treating you; being able to maintain one’s privacy e.g., treated in private, out of public gaze; a feeling of being in control, e.g., over decisions and private bodily functions; when staff explain your treatment and changes and what is going to happen; being listened to and get heard; desire to have own personal space and independence and; acknowledgement for the need for peace of mind at a stressful time.

The authors also discuss a uniqueness of their findings in relation to patients defining privacy and dignity in relation to creating conditions for them to worship. The limitations of the study was the use of a self reported questionnaire for qualitative data in this study may not be the most effective technique to gather rich data of this nature. The questionnaire was also completed whilst patients were on the ward, with a potential issue being that participants
could have felt less able to highlight concerns for fear of it affecting their care. In addition the sister in charge of the ward was involved as a researcher for the study that could have inhibited the responses by participants fearful that subsequent treatment might be affected. It was noted that efforts were made to reduce bias through the use of a self reported questionnaire, as opposed to interviews, and a guarantee of anonymity for respondents. This study however provides a detailed picture of the patient’s needs for privacy and dignity and the interrelated nature of these two concepts. The authors suggest that further consideration should be given to the designs of hospitals and wards that better address issues of privacy and dignity.

A further study, undertaken in the UK, explored older people’s experiences of hospital and their views on dignity and how it could be promoted (Webster & Bryan, 2009). This study used a qualitative methodology with semi-structured interviews of a purposive sample of ten patients, aged from 73 to 83. Patients were interviewed at home following discharge from hospital. Factors identified that had the potential to promote dignity included: privacy for the body, cleanliness, independence and being able to exert control, sufficient time from staff, attitudes to older people and communication. This study suggests that independence and effective communication are of central importance in maintaining dignity through achieving control of their situation. The participants observed that factors such as staff speaking inappropriately and patients waiting for personal care undermined older people’s perceptions of dignity. Several participants feared for their own dignity should they have cognitive problems later in their lives. Although a qualitative study with a purposive sample which interviewed only ten patients, it focussed on relatively well and independent older people. However, the particular relevance to practice was the need for staff to be aware that communicating in a way that conveys empathy and responds to the individual as a valued person is an important factor in maintaining dignity. In addition, it highlights the need for nurses on hospital wards to take measures to safeguard the dignity of older people with cognitive problems who have difficulty in making their needs known.

The next two studies were focussed on: patient’s experience of urgent care in a number of hospitals across the UK (Bridges & Nugus, 2010); and the experience of being a patient hospitalised within one hospital (Dawood & Gallini, 2010). Whilst the focus of these studies was on the patient experience, dignity was identified as a key word within the published papers and each of these two studies were identified as contributing to the discussion on the evidence relating to dignity. Both studies used a qualitative methodology with the use of discovery interviews. Discovery interviews enable the individual to have the opportunity to talk about
their particular experiences, with only occasional prompts to consider the experience of different parts of the pathway of care, and were developed as a technique to stimulate improvement activities (Bridges, Gray, Box, & Machin, 2008).

The first, (Bridges & Nugus, 2010) considered the experiences of older people in urgent care within thirty one NHS Trusts across England, and involved sixty nine patients over the age of 75, and twenty seven relatives. Analysed data was considered in relation to the six senses framework as part of a relationship centred approach to care for older people (Nolan, Brown, Davies, Nolan, & Kennedy, 2006). Three key dimensions of sense of significance were identified as: the primacy of technical, medical care; an imbalance of power; and the subordination of patients’ non medical needs. Older people identified that they felt that they did not matter; an example was given of a patient being led to the toilet, but not given assistance to get back and a planned physiotherapy assessment that did not happen. Being perceived to be treated differently to other patients was in part attributed to being because of their age. In addition, there was a recognition that nurses had to juggle their needs against those of other patients and for some this was understandable, however for others this contributed to diminishing their sense of ‘significance’ and legitimacy in being there. In relation to the sense of ‘security’ this was identified as relating to being in the right place to treat a medical problem, however the intensity of this sense of ‘security’ was discussed as something that could lead to an imbalance of power. Whilst the six senses framework (Nolan et al, 2006) was identified as a valuable way for nurses to provide dignified care, this appears to have been applied retrospectively as opposed to being evaluated as part of the study, and consequently lacks evidence of its effectiveness in practice. The wider organisation and cultural features of these dimensions of care affecting the patient’s sense of ‘significance’ were also highlighted and the need for development interventions to target both individual practitioners and wider organisational culture. This study is relevant as it presents the experiences of older people within urgent care in the context of a relational approach to care that also highlights wider organisational issues.

The second study (Dawood & Gallini, 2010) was undertaken within an acute healthcare trust in England and involved interviews with eighteen patients, between the ages of 25 – 90, and two carers to gain insights into their experience of being in hospital. Four themes were identified of: pain; environment; care and attentiveness; and information and communication. In two themes - pain, and care and attentiveness - patients described sympathy for the patients who were sicker than themselves or nurses who were very busy, and for one patient this was to the point of delaying their own need for pain relief. In relation to the environment, this study
identified that mixed sex accommodation was not an overriding concern for patients and their families, rather competence, vigilance and, most of all kindness, were seen as a greater priority. Whilst the interviews identified areas of concern and how these were being addressed the paper did not fully reflect the use of discovery interviews as enabling staff to understand the experience of an individual as a person, rather than a patient. It has been suggested that hearing discovery interview stories may help healthcare teams to develop congruence with service users’ perceptions, expectations and needs to provide patient centred care (Bridges et al, 2008).

In summary, these studies have considered the meaning and experiences of patient related dignity and reveal a wide range of findings from conceptual aspects of dignity (Widang & Fridlund, 2003; Widang et al, 2008) to the practical reality of dignity (Whitehead & Wheeler, 2008b; Webster & Bryan, 2009 Dawood & Gallini, 2010), and the wider organisational and cultural elements of how dignity is diminished for older people (Bridges & Nugus, 2010). Consensus between the studies focus on aspects of: privacy (Whitehead & Wheeler 2008a; Whitehead & Wheeler 2008b; Webster & Bryan, 2009; Dawood & Gallini, 2010) choice and control (Webster & Bryan, 2009) and related to this, the need for information (Whitehead & Wheeler, 2008b), and how a person is addressed (Whitehead & Wheeler, 2008b; Bridges & Nugus, 2010). The theme of staff having sufficient time to spend with patients (Webster & Bryan, 2009) is described in different ways, in other studies, as; an aspect of staff being seen to be busy with administration affecting their ability to have time to give care and attentiveness (Dawood & Gallini, 2010) and similarly, a patient being forgotten after having being taken to the toilet, in a theme of an imbalance of power (Bridges & Nugus, 2010). It is of note that this reflects concerns highlighted in the published reports identified in section 1.4, of: failure to maintain privacy, inadequate communication, and a lack of respect, staff shortages, as well as organisational and system failures.

Finally, seven qualitative studies and one quantitative study have focussed on patient’s experience of dignity in hospital represent both International and European perspectives. The studies represent a range of settings and experiences to include: acute care, from terminally ill cancer patients (Chochinov et al, 2002), patients receiving medical or surgical care (Widang & Fridlund, 2003; Widang et al, 2008; Whitehead & Wheeler, 2008b; Dawood & Gallini, 2010), and two studies that considered the experiences of older people; accessing urgent care (Bridges & Nugus 2010), and their experience of hospital admission (Webster & Bryan, 2009). These studies have provided additional understanding of the meaning of dignity, the
identification of dignity categories for individuals, the ways in which dignity can be conserved or diminished and the impact of the relationships between patients and healthcare professionals, as well as issues related to the wider organisation.

The review now considers studies undertaken within acute healthcare settings that relate to professionals.

2.3.2 Studies involving healthcare professionals

Whilst a number of studies involve patients and healthcare professionals two were identified as considering solely the views of healthcare professionals in relation to dignity in their practice.

From an international perspective, a Taiwanese study (Lin & Tsai, 2011) explored how nurses maintain patients’ dignity in clinical practice. A qualitative methodology with in-depth interviews was used, involving thirty nurses. Whilst a sampling strategy is not identified the criteria for participation was that nurses had been qualified and working for three months in medical or surgical wards, were at least 20 years old and were able to speak Chinese or Taiwanese. Findings identified five themes of: respect (including autonomy, holistic care, beliefs and culture, informed consent); protecting privacy (including; privacy of the body, private space, privacy of condition); emotional support (including; encouraging, listening, empathy, appropriate language, spiritual well-being), treating all patients alike (including; equal care), and maintaining body image (including; physical appearance). The study proposed a model that suggests the five themes and sub themes are the key actions required to maintain patients’ dignity. Implications for practice identified from this study were the need to enhance education programmes on dignity that utilise these five themes. Whilst findings from an in-depth qualitative study of healthcare professionals in a hospital in Taiwan may not be considered transferable to the UK it is of note that these findings are similar in nature to those of studies within the UK and Europe, relating to: respect and autonomy, privacy, and listening and effective communication.

Within the UK, The Royal College of Nursing (2008a) commissioned an online survey of its membership to investigate nurses’ awareness of dignity and barriers that prevented dignified care being given to patients and clients in a wide range of healthcare environments. Over 2000 nurses, students and healthcare assistants took part, from a wide range of healthcare settings across the UK in February 2008. Findings related to the physical environment within acute healthcare settings of: overcrowded wards and poorly screened bed spaces; mixed sex
accommodation; as well as inadequate and unsuitable bathroom and toilet facilities; lack of treatment rooms; or quiet rooms where intimate procedures and confidential discussions could be conducted. Cultures were identified as having a tendency to compound the problems of: management bureaucracy; of unrealistic expectations; quick fix attitude; culture of rushing; target driven; and paying “lip service” to dignity in care. It was suggested that management had different priorities to nurses, and that there were often inadequate resources of linen, towels and insufficient time to deliver care. Three key factors were identified for maintaining or diminishing dignity as: the physical environment and the culture of the organisation (place); the nature and conduct of care activity (processes); and the attitudes and behaviour of staff and others (people). Recommendations for practice were described at different levels of: macro level – role of government; meso-level – role of organisations; and micro-level – role of individuals as seen in Box 2.1.

### Box 2.1 RCN report recommendations for Governments, Organisations and Individuals

#### Macro-level – Role of Government
- Consideration of the paradoxical effects of healthcare policy where there is the potential for targets and policy to impact on the provision of dignified care
- Renewed commitment to single sex wards
- Appropriate ratios of nurses/patients and skill mix to be in place to provide dignified care
- Nursing and other care staff involved in the design of healthcare environments

#### Meso-level – Role of Organisations
- Sufficient investment in the physical environment and resources
- Organisational cultures that make patient care the first priority
- Organisations that demonstrate respect for the dignity of staff
- Training and opportunities and materials to promote dignity are available to staff
- Develop policies and practices that support dignity in care, including ethical climate, appropriate organisational values and systems for reporting and whistle blowing

#### Micro-level – Role of Individual Responsibility and Accountability
- Nurses and other professionals must take advantage of opportunities to develop their understanding of dignity in care
- In aspiring to dignifying care individuals should be reflective, engage in critical self scrutiny and invite feedback from others
- Attitudes and behaviours that diminish dignity must be challenged – therefore individuals should know how to challenge and report dignity deficits
- All healthcare staff should be aware of the potential to enhance dignity by role modelling

Adapted from (RCN, 2008a, p. 7)

The limitations of this survey are the uni-professional nature of the study, and that respondents are more likely to be activists and may not represent the wider population of nurses. However, the study is unique in the wide range of healthcare settings from where respondents worked and the large sample size. The focus on responsibilities at different levels provides a mandate
to improve policy, systems and practice, with a range of resources developed and promoted to nurses on dignity to improve practice.

In summary, these two studies considered the experiences of nurses and how they were able to meet patient’s needs in relation to dignity from very different perspectives. The first, being, a small qualitative interview study within an acute healthcare setting in Taiwan, that identified five themes relating to providing dignified care to patients that are consistent with other studies in the UK. The second, a large scale survey of nurses’ views on Dignity in England, in support of a campaign by the Royal College of Nursing on Dignity, considered particular challenges that nurses faced at an individual level, organisational level, and policy level to provide care that meets patient’s dignity. It can be seen that a number of the themes identified by professionals mirror those identified within the patient studies of: privacy (Whitehead & Wheeler, 2008a; Whitehead & Wheeler, 2008b; Webster & Byan, 2009; Dawood & Gallini, 2010; Lin & Tsai, 2011) respect (Whitehead & Wheeler 2008b; Lin & Tsai 2011) and nurses having insufficient time to care (RCN, 2008a) with patients identifying that nurses did not have time to spend with patients (Webster & Bryan, 2009), to be able to provide care and attentiveness (Widang et al, 2008) and return to patients to meet their needs (Bridges & Nugus, 2010). Finally, whilst one of the patient studies highlighted the wider organisational and cultural issues related to dignity in terms of themes, such as imbalance of power (Bridges & Nugus, 2010) these may be seen as specific concerns by professionals, where change was needed, for example, in relation to contradictions between policies affecting patient dignity, and organisational culture that puts patient dignity first (RCN, 2008a).

The review now considers studies undertaken within acute healthcare settings that relate to patients and professionals.

2.3.3 Studies involving both patients and carers and professionals

This next group of nine studies have considered both the patient experiences and healthcare professional’s views and practice in relation to dignity through a range of approaches.

An Australian study (Walsh & Kowanko, 2002) considered the perceptions of dignity using a qualitative methodology with a phenomenological approach. Five patients and four nurses were interviewed using a convenience sample. The themes identified for patients included: being exposed, having time, being rushed, time to decide, being seen as a person, the body as an object, being acknowledged, consideration and discretion. For nurses the themes identified
included: privacy of the body, private space, consideration of emotions, giving time, the patient as a person, the body as an object, showing respect, giving control, and advocacy. In addition, very similar emotions were identified by both patients and nurses in response to violations of dignity, such as anger, embarrassment and shame. However, the value of humour was identified by both patients and nurses to reduce embarrassment. It is of note that there are similarities between the themes identified by patients, with three themes related to time: having time, being rushed and, time to decide. Again with nurses, there are similarities between the themes relating to privacy and private space. In particular, it was noted that there was a high level of consensus between both groups on themes such as; privacy of the body and being exposed, having and giving time, and consideration. It is of note however that themes of ‘giving control’ and ‘advocacy’ identified by the nurses were not identified by patients in any similar language. No specific recommendations for practice were made, however it was questioned how, if the perceptions of patients and nurses are shared – ‘why do such situations continue to arise?’ and ‘what strategies can be put in place to minimise the occurrence of this distressing phenomenon?’ The limitations of the nature of this small study using a convenience sample are recognised and suggestions made for a larger study involving a sampling matrix to include maximum variation which might better inform the development of guidelines for the maintenance of dignity in hospital settings.

A North American study (Jacelon, 2003; Jacelon, 2004) used a qualitative methodology using grounded theory to illuminate the experience of older people over the age of 75, the meaning of their experience, and to develop a theory on the social processes involved in hospitalisation. The sampling strategy was to focus on older people over the age of 75 admitted to hospital for medical reasons and to gain multiple perspectives from family members and nurses. Data collection involved interviews with twenty five participants (five patient interviews at admission, discharge, and follow up, four family members, and six registered nurses) as well as 40 participant observations. The findings focussed on the concept of personal integrity as well as detailing a number of stages within the process of hospitalisation. Dignity was one of three properties of personal integrity, along with autonomy and health, and comprised two attributes: self dignity which was explained through an example of how patients had dressed themselves to feel good about themselves by wearing earrings; and interpersonal dignity which was described as something that was both positive and negative and could be taken away by the attitude and treatment of some hospital staff. It also notes that patients tried to manage their outward appearance visible to nurses so as not to bother nurses, where they appeared to be busy (Jacelon, 2003, p. 551), which reflects findings by Bridges and Nugus (2010) and
Dawood and Gallini (2010) where patients considered both the nurses and other patients when making requests for assistance. This study is particularly valuable in describing an adaptive process and strategies that patients use to maintain their dignity as they go through at different stages of hospitalisation. There is some congruence with work by Matiti (2002) that identified a cycle of adjustment that involves choice and control as part of a process of a patient accepting a level of loss of dignity, however Matiti’s work did not consider this in relation to a series of stages of hospitalisation. Similarly, the dignity conserving repertoire (Chochinov et al, 2002) provides strategies for patients to ‘buffer’ against loss of dignity, however these do not consider the interpersonal strategies identified by Jacelon (2003) that patients engaged with nurses to promote their own dignity.

A major study entitled ‘Dignity and older Europeans’ (Tadd, 2005) based on the notions of dignity developed by Nordenfelt and Edgar (2005) considered the views of older people, professionals and younger members of society on dignity for older people in six countries across Europe (Spain, Slovakia, Ireland, Sweden, France and UK). A qualitative approach was used gathering data predominantly through focus groups (Calnan & Tadd, 2005). The overarching aims of the study were to explore the views of each group on dignity, the perceptions of older people and working with older people, their experiences of dignity and undignified care and their opinions of what constitutes dignity. Three hundred and ninety one older people participated through 89 focus groups and 18 individual interviews. The key findings were set out in three main themes of: respect and recognition (which included self respect as well as respect and recognition from others and the impact of not being acknowledged, as well as the reciprocal nature of respect), participation and involvement (which included a sense of social isolation in retirement and related to this was a sense of lack of equality), and dignity in care (which related to ageism, the impact of dependency and loss of autonomy).

For healthcare professionals there were four hundred and twenty four people within 85 focus groups that included; medical, nursing, managerial, paramedical and social work from hospital, residential and community settings. For healthcare professionals the key findings that relate to practice were around working with older people, where views included the rewarding nature of the work, the perceptions of working with older people as being part of a ‘Cinderella’ service or the often negative media attention following concerns related to care issues. Views of dignified care included the importance of autonomy and independence, respect, maintenance of individuality, encouragement of involvement, effective communication practices, and person
centred and holistic care. Undignified care was associated with invisibility, depersonalisation, humiliation as well as abuse and mechanistic approaches to care. In addition professionals criticised the systems as being focussed on economics as opposed to people and that there was a lack of coordination and integrated care, which has similarities to concerns raised by Seedhouse and Gallagher (2002) around an organisation’s culture, systems and resources.

Whilst this study did not involve hospital patients, a single approach of focus groups was used to gather data, and there are challenges in the translation of terms related to dignity across European countries, the study does provide an extensive picture of the views of older people and professionals across Europe about dignity, which had not previously been undertaken. A number of the themes from both older people and professionals of respect, autonomy, maintenance of individuality have been described in earlier studies (Chochinov et al, 2002; Matiti, 2002; Walsh & Kowanko, 2002; Jaconel, 2003; Jaconel, 2004; Whitehead & Wheeler, 2008b; Webster & Bryan, 2009, Lin & Tsai, 2011) and concept analyses (Mairis, 1994; Haddock, 1996; Johnson, 1998; Jacobs, 2001; Fenton & Mitchell, 2002, Jaconel et al 2004; Marley 2005; Griffin-Heslin, 2005; Coventry, 2006; Anderberg et al, 2007). However this study also emphasises issues relating to professional practice in describing the importance of person centred care as well as frustrations with systems where this did not appear to be the primary focus of organisations.

A study in three care settings for older people in the UK (Gallagher & Seedhouse, 2002; Seedhouse & Gallagher, 2002) explored the meaning of dignity, factors that promoted or enhanced dignity as well as what makes dignity difficult, from the perspective of patient and relatives. This study also sought to consider the impact of an educational intervention of a day seminar on dignity to nurses and healthcare assistants, which is considered further in the section relating to evaluations. The study used a qualitative methodology with interviews of nine patients and seven relatives. A sampling criterion for participation was not identified in the published papers in relation to either group. Findings identified that dignity depends on four areas of: staff behaviour, attitudes and competence; the environment; resources available, and; the condition and/or behaviour of the patient. For staff behaviour, examples given were where getting to know patients did not appear to be a priority, and not addressing little things that demonstrate care and attention; for example including a saucer with a cup of tea. Within the environment, privacy was highlighted in relation to curtains not being wide enough, or not enough space between beds resulting in hitching of partially-closed curtains leaving patients exposed. In relation to a lack of available resources the examples given
focussed on inadequate staffing, linen and equipment. Finally within the area of condition or
behaviour of patients, nurses described the challenges of caring for patients who were
confused and exposing themselves. Recommendations were made for healthcare
organisations and education establishments to: explain components of dignity to staff,
establish education programmes that encourage reflection, facilitate reporting of bad practice,
establish good role models, continually stress the importance of seeking to understand
patients’ needs, and undertake further research on what circumstances impact on dignity in
practice. In addition, reporting of issues related to lack of resources and poor environments
were encouraged. The particular value of this study is its clarity of focus on staff attitude,
inadequate resources and poor environment, and patient condition which remains highly
relevant to nursing practice nearly ten years after it was published. It can also be seen as one
of the earliest studies to highlight issues related to the lack of resources that included the need
for adequate staffing and concerns related to poor physical environments, staff attitude and
the need for training that were identified in previous reports related to dignity (Davies et al,

A study undertaken in the UK (Matiti, 2002; Matiti & Trorey, 2004; Matiti & Trorey, 2008)
explored how patients and nurses perceive dignity and the extent to which it is maintained
through nursing activities. The study used a qualitative methodology using a phenomenological
approach, with semi-structured interviews of 102 patients (49 female and 53 male) and 94
Nurses (87 female and 7 male), across three hospitals. Convenience sampling was undertaken
for patients with an age range of between 18 to 85 years, who were identified as
representative of the local population. The sample of nurses was purposive to enable a
representative group of nurses at different grades relating to experience and seniority, as well
as inclusion of healthcare assistants and student nurses. Eleven categories of patient dignity
were identified of: 1. Privacy; 2. Confidentiality; 3. Need for information; 4. Choice; 5.
for patients; and 11. Nurse – patient communication. It is noted that nurses came up with
similar categories to those identified by patients except ‘control’, so it was suggested that
nurses did not readily appreciate the importance of control for patients in relation to their
dignity in hospital (Matiti, 2002, p. 105). However, this differs from the study by Walsh and
Kowanko (2002) where it was the nurse who identified ‘giving control’ as a theme that patients
did not identify. Matiti (2002) uses the term ‘necessary submission’ in relation to patients’
anticipated and perceived losses of dignity within hospital and suggested a theory of perceptual
adjustment where patients will go through a process of denial, anger and resignation to accept
losses of dignity as a worthwhile price to pay for the treatments received during a temporary stay in hospital. Matiti’s theory involves a cycle of adjustment, within which patient choice and control are key factors in enabling patients to adjust to an accepted level of loss of dignity. Exceptions to this are patients who have limited or no time to adjust in the case of patients being admitted as an emergency and patients who disassociate from their experience of loss of dignity, which the authors term as a perceptual maladjustment. Patients with lack of capacity are not discussed in relation to the theory. This study is particularly valuable in developing an understanding of how patients manage their losses of dignity, how individual their perceptions of losses of dignity are, and the process of adjustment. The importance of choice and control to enable patients to adjust to losses of dignity is a particular consideration for nurses in promoting patients’ dignity.

A further study in the UK (Baillie, 2007a) explored the meaning of patient dignity, and how patient, staff and environmental factors can affect patient dignity. The study used a qualitative methodology using case study approach on a urological ward in an acute hospital. Purposive sampling was used with data being collected through twelve participant observations over four hour periods with follow-up patient interviews, post discharge and interviews with a further twelve patients, as well as interviews with thirteen staff, observations of twelve staff handovers and interviews with six senior nurses and review of Trust documentation. A model of patient dignity in hospital was developed that identified factors threatening and promoting dignity. Those factors threatening dignity were identified as: lack of privacy, heightened bodily exposure and mixed sex environment; patient impaired health threatened their dignity due to loss of function, intimate procedures and psychological impact; and staff being curt, authoritarian and breaching privacy. Whereas factors identified as promoting dignity were: a conducive physical environment; patients’ own attitudes and developing relationships with staff; and a dignity-promoting culture and leadership and other patients’ support. The value of this study is that it provides a clear framework of key areas related to the patient, staff and environment and in particular focuses on the importance of staff attitude and behaviour in threatening or promoting dignity for patients.

A study, as part of a project entitled “Seeing the person in the patient” (Goodrich & Cornwell, 2008), explored patient experience, and has also been considered within this review as the findings focus on dignity and the way in which people are cared for in hospital across all age groups. The project commissioned by The Kings Fund, a charitable body that seeks to understand and influence healthcare policy in the UK. The study drew on a range of sources
including qualitative interviews considering what good and poor care feels like and whether it was possible from accounts to uncover what lies behind the experience. Eight patients and two relatives were interviewed with different experiences and a mix of gender and age, from a range of hospitals across the UK. Ten members of staff were interviewed from medicine, nursing and secretarial support from within a London teaching hospital. Key themes identified were: ‘the unreliable quality of care’ - as a result of variability between staff on an hour by hour, shift by shift, day by day basis and being different within different wards; ‘seeing the person in the patient’ – through either recognising a patient’s personal needs or not addressing their needs; ‘who is in charge?’ – where patients found it difficult to find someone to talk to where nursing or medical who was in charge, and; ‘the patient as a parcel’ - where patients reported often being moved through an emergency department to an admission ward, to another ward, moved due to an infection, or the bed being needed for another patient and the manner in which this was communicated and at unacceptable times, for example, in the middle of the night. It is interesting to note that the theme of ‘seeing the person in the patient’ echoes one of the antecedents for preserving dignity in caring for older people identified by Anderberg et al (2007). Whilst a small sample, significant efforts were made for the findings to be representative of a wider experience of patients. These findings highlight issues of responsibility and accountability for the quality of individualised care where patients are able to get appropriate responses to requests for information. Furthermore, serious concerns are highlighted in the lack of care and consideration that systems are not patient centred. Despite highlighting major concerns, there were no specific recommendations from this study, however, subsequent work has sought to transform the quality of care through practical interventions such as work that has been developed related to: hospital pathways, Schwartz centre reflective rounds (multidisciplinary reflective case reviews) and, experience-based co-design (involving patients in a collaborative approach on the design, development and improvement of aspects of hospital care).

A further study (Tadd et al 2011a; 2011b) exploring the care of older people in acute NHS hospitals in the UK used a qualitative methodology guided by an ethnographic approach. Four hospital sites were purposively selected to reflect a range of organisational and systems characteristics that may impact on the provision of dignified care. Observations and interviews were carried out across a total of sixteen wards within the four hospitals. The inclusion criteria for the forty interviews (20 male and 20 female) with older people was that they were 65 years of age or over, two to four weeks post discharge and cognitively able to participate in the interviews. Twenty five carers from the ages of 25 to 84 were identified on the basis of being a
carer of those patients participating in the study. Thirty two managers were identified across the four hospitals at executive or senior management level in relation to aspects of dignity within the organisations. Seventy seven ward staff interviewed represented a broad range of professional groups that also included student nurses, healthcare assistants, domestic staff and receptionists. In addition 617 hours of non participant observation was carried out across the 16 wards within the four hospitals. Four overarching themes were identified of: ‘Whose interests matter’, ‘Right place - wrong patient’, ‘Seeing the person’, and ‘Influences on dignified care’. For ‘Whose interests matter’ discussion considered where conflicts of interests had been identified between the hospitals, the staff and patients, with a culture that was risk averse and defensive, where care was undervalued, and where professional accountability and discretion are replaced by standardised checklists, pathways and audits, that cultivated an attitude that if an aspect of care could not be measured it doesn't matter. ‘Right place wrong patient’ focussed on concerns where wards were not designed around the needs of older people, particularly those with cognitive impairments and there was a skills gap amongst staff. ‘Seeing the person’ – identified the values and ideals that staff had coming into healthcare from training related to dignity that they were rarely able to fulfil and were left disconnected, disillusioned and crushed. Finally, ‘Influences on dignified care’ – were described as the level of priority this was given at hospital Board level alongside competing priorities. From this study, a number of implications for policy and practice were identified that related to: education for all staff given the high numbers of older people and those with dementia in acute hospitals, that consideration is given to the design of hospital environments for older people, that clinical governance takes a broader approach to measuring patient quality as opposed to checklists, and that ward managers and ward staff are enabled to challenge poor practice. It is of note that the issues identified around conflict of interest are similar to those identified within the RCN (2008a) study, where the paradoxical effects of competing healthcare policy were highlighted. In addition there is similarity between the reference to ‘seeing the person’ and the earlier references using the same terminology by Goodrich and Cornwell (2008) and seeing the person behind the disease by Anderberg et al (2007). This study is highly relevant as it considers dignity from multiple perspectives and data sources within the context of the current healthcare management and policy within acute hospitals.

Finally, the review has also considered a study undertaken in the UK (Woogara, 2004; Woogara, 2005a; Woogara, 2005b) that focussed predominantly on patient privacy, and has been included due to the interrelated nature of privacy and dignity. A qualitative methodology with an ethnographic approach was used with the principles of grounded theory and
phenomenology to guide the research process and analyse the data. The sampling method was described as opportunistic to recruit a range of patients, nurses and doctors. Semi structured interviews were carried out with eighteen patients, six doctors and sixteen nurses. Within the observation phase of the study fifty five patients and twelve nurses were informally interviewed (unstructured) within day to day conversation. Eleven categories of privacy were identified of: 1. Conceptions of Privacy; 2. Territory and space; 3. Control and choice; 4. Personal care and depersonalisation of the patient; 5. Privacy of patients’ information; 6. Professional ‘blind spots’ and habituation; 7. Ward layout and logistics; 8. Patients’ coping mechanisms; 9. Visitors and relatives; 10. Regulatory and government standards; and 11. Professional rationale for ‘overriding’ patients’ privacy. In particular the findings highlighted the low expectation of privacy of patients in Hospital and the ways in which they coped with the lack of privacy and dignity through adopting the sick role. Older patients were particularly vulnerable when wearing a gown as they were often unable to tie it at the back, and there was a prioritisation within busy wards that were often short staffed where privacy and dignity were seen as less important than receiving medical treatment. These findings are particularly relevant to this study in that it explored in detail patients and a range of healthcare professionals perspectives on privacy and dignity in an acute hospital, in the context of statutory and health policy and guidance.

In summary nine qualitative studies involving both patients and healthcare professionals have been reviewed, two international studies, Australia & North American (Walsh & Kowanko, 2002; Jacelon 2003, 2004), one European study (Bayer et al, 2005; Arino-Blasxo et al, 2005) and six studies undertaken in the UK (Seedhouse & Gallagher, 2002; Matiti, 2002; Woogara, 2004; Baillie, 2007a; Goodrich & Cornwell, 2008; Tadd et al 2007a). A range of qualitative approaches were used that included: phenomenology (Walsh & Kowanko, 2002; Matiti, 2002), grounded theory (Jacelon, 2003, 2004) a case study (Baillie, 2007a), and ethnographic approaches (Woogara, 2004; Tadd et al, 2011a). Reflecting the different qualitative approaches, data were collected using a range of data collection methods to include interviews (Walsh & Kowanko, 2002; Jacelon 2003, 2004; Seedhouse & Gallagher, 2002; Matiti, 2002; Woogara, 2004; Baillie, 2007a; Goodrich & Cornwell, 2008; Tadd et al 2011a), focus groups (Bayer et al, 2005; Arino-Blasxo et al, 2005), and participant observation (Jacelon, 2003, 2004; Woogara, 2004; Baillie, 2007a; Tadd et al, 2011a). These studies also range in size, from small interview studies of five patients and four nurses (Walsh & Kowanko, 2002) to much larger interview studies of 102 patients and 94 nurses (Matiti, 2002); a multi-centred study involving a number of healthcare Trusts (Tadd et al, 2011a) to one where Dignity was considered across six European countries.
to provide a wider perspective of the views of older people, the public and professionals to dignity.

The next section of this review now considers those studies where some form of evaluation took place to assess a particular intervention or strategy to improve dignity.

2.4 Research evaluating an initiative to improve dignity

This final group of six studies, involved research of an intervention or strategy adopted to improve dignity in care within an acute hospital setting. These are of particular interest to understand both the nature of the evaluation and their outcomes in seeking to improve dignity within hospitals.

A Swedish study (Randers & Mattiasson, 2004) explored the value of an educational intervention on ethics in relation to patient autonomy and integrity. The study used a qualitative methodology using participant observation. Observations took place in two settings at six and twelve month follow up periods. Thirty healthcare professionals (seven registered nurses and twenty three healthcare assistants) working with older people were involved in the study. Whilst the sampling strategy is not discussed in the paper there appears to be a representative group of nurse between the ages of 21 to 65 with 2.5 years to 35 years experience, although all the participants were female. Six descriptions of care were discussed situated within a theoretical framework of autonomy (Collopy, 1988) and a conceptual model of integrity, which highlighted the importance of ethical aspects of care in the interactions between patients and healthcare professionals. Discussion highlighted the need for improved ethical care of patients, and the importance of individualised care that was sensitive to patients’ different responses to illness. Similarities can be seen to studies that have identified: illness related issues (Chochinov et al, 2002), embodiment (Street & Kissane, 2001) and encroachment of personal boundaries (Söderberg et al, 1999). The importance of recognising the lack of equality between healthcare professionals and older people whose frailty and dependence affects the ethical quality of encounters was also highlighted and reflects the dimension of imbalance of power related to a sense of security with medical care identified by Bridges and Nugus (2010). However, the published paper did not discuss whether the educational intervention had positively affected the practice of healthcare professionals in relation to autonomy and integrity.
A study in the UK (Seedhouse & Gallagher, 2002) also sought to evaluate an educational intervention of a day seminar on dignity for eighteen nurses and healthcare assistants. Pre and post intervention interviews of staff, patients and relatives were undertaken, as well as recorded observations of attitudes and behaviours of staff. The study reported that the educational intervention failed to demonstrate improvements in practice. However qualitative data was gathered using interviews to: explore occasions where dignity could not be provided, the opportunities and barriers for the promotion of dignity, as well as suggestions of ways to improve dignity. Four themes were identified from both staff and patient interviews (the authors work also included a study involving patients and relatives, reviewed earlier, in section 2.4.3) of: staff behaviour, attitude and competence; the environment; resources available; the conditions and/or behaviour of patients. In particular the need for improvements in the organisations that were involved the study in relation to each of the themes was highlighted. In addition, whilst the efforts of staff to uphold patient dignity in demanding circumstances were recognised, concerns were highlighted around the organisation of care, systems to support this and inadequate resources.

This third study reviewed in this section (Crow, Smith and Keenan, 2006, 2007) sought to evaluate a new education module ‘Fostering Dignity in Healthcare settings’ as part of an action research project. The module was developed jointly between an acute healthcare trust and a university and was in response to concerns raised by patients from a focus group on issues of dignity and respect. The module was open to all hospital staff and individuals were encouraged to write a pledge to make an improvement in their area of practice, to enhance dignity and respect. The students on the first three modules reported that it had re-ignited their enthusiasm and passion for promoting dignity and respect and they had plenty of ideas for improving this aspect of care. Further detail on the participants was not included in published papers. However it was also identified that following completion of the module individuals often felt isolated and powerless to carry their ideas forward. The students identified the need for a space to meet other like-minded ‘champions’ of dignity and respect to nurture and sustain their enthusiasm and ideas that often got swamped by other demands.

A further action research project by the same authors (Crow, Smith & Keenan, 2010) was developed as a result of their earlier study that was part of a ‘Dignity and Respect Action Group’ where the aim was to provide continuing education, inspiration, motivational and practical help to all those trying to promote dignity and respect in the hospital. Five key factors were reported as supporting the effectiveness and sustainability of the group that related to: 1.
A ‘bottom-up’ approach in a favourable political context where momentum was supported by an increasing national focus on dignity. 2. Optimising the role and contribution of individual group members, through the organisation and structure of the group, use of practical skills and attitude to supporting the group’s aims. 3. The culture of the group was seen to be different to that of other hospital groups or committees in how individuals interacted, and were supportive of each other. 4. The membership, fluidity and diversity of the group were highlighted as beneficial through openness to new staff interested in joining the group including service users and a wide cross section of staff attending from different hospital services. 5. Creating success and building on it where the group provided a repository function for staff reporting back on tangible improvements that they had made, continually monitor the effectiveness of changes and support other colleagues who were struggling to make changes.

These two studies are particularly relevant as they are action orientated to improve practice in relation to dignity and identify some of the ways this has been done, such as the use of a written pledge to improve dignity and support for champions through a dedicated group. Both of these studies highlight the challenges, of competing demands in the workplace, and enablers, related to the political context, that staff encountered in seeking to improve aspects of dignity. However, the papers published focus predominantly on motivation and change management, as opposed to further information on participants, and specific improvements or outcomes in relation to patient dignity, or how this related to the Dignity in Care campaign.

A further action research study (Nicholson et al, 2010a; Nicholson et al, 2010b; Nicholson et al, 2010c) which sought to improve dignity in two acute healthcare Trusts, took place over two years working with ward nurses, patients, their carers, and hospital managers. The study was informed by a systematic review and synthesis of qualitative studies of older people’s and relative’s experiences in acute care settings (Bridges, Flatley & Meyer, 2010) which identified three key features of care as consistently mediating negative feelings and promoting positive experiences which involved: maintaining identity for the patient – “see who I am”, creating community – “connect with me”, and shared decision making “involve me”. A series of three papers expand on these three features of care with ways to change everyday practice. These included; creating dignity conversations throughout the shift, getting to know the people you are caring for, promoting awareness of dignity throughout the ward environment, creating values around caring, putting yourself in another’s shoes, promoting communication that connects with the person, enhancing shared decision making in ‘everyday care’, engaging patients whose condition/context challenges involvement, and valuing collecting and acting on
the different perspectives of being in hospital. Whilst there is limited description of the methods, an observational tool (Shortened Quality of Interactions Schedule, Dean & Proudfoot, 1993) was used to help nurses consider the quality of their communication with patients and identify areas for improvement. This study is particularly relevant as it has provided experiential description of the application of the three features of care to improve dignity for patients in acute healthcare settings. In addition the publication of these papers in a less academic nursing journal also sought to make this work much more accessible to nurses providing care. However the published papers make little reference to the Dignity in Care campaign, and focussed on promoting a framework for best practice that did not identify what differences the study had made in improving dignity for patients in two acute hospitals.

A further UK study, published in two papers (Baillie & Gallagher, 2010; Baillie & Gallagher, 2011), evaluated the Royal College of Nursing’s campaign (RCN) ‘Dignity at the Heart of Everything We Do’. This evaluation used a qualitative methodology with multiple case studies of three independent care homes, three NHS hospitals, and one NHS mental healthcare trust. It is of note that the RCN campaign, which came two years after the launch of the Department of Health’s Dignity in Care Campaign, was UK wide and nursing workforce focused, as opposed to the Department of Health which covered all of health and social care within England. Fifty one staff were interviewed, with between five to nine nurses on each site. The first paper (Baillie & Gallagher, 2010) explored the challengers and enablers to the RCN Dignity campaign. Enablers were identified as: staff receptivity and creativity; organisational support and leadership; and campaign resources. Challenges to the RCN Dignity campaign were identified as: time constraints; and staff attitude and insight. The second paper (Baillie & Gallagher, 2011) considered nurses’ strategies to respect dignity in care across these different settings. The findings described an overarching theme where participants sought to treat people as valued individuals within their specific care settings. Sub themes included: recognising vulnerability to loss of dignity; enhancing privacy; improving communication with patients/families and building relationships; care environment improvements; and addressing issues that matter to individuals. The nature of this evaluation of the RCN Dignity campaign and its findings are highly relevant to this study, although do not give broader contextual issues within the organisations that could have contributed to the effectiveness of the RCN Dignity campaign.

In summary these final group of six studies reviewed focussed on reporting on an intervention or strategy to improve aspects of dignity for patients in Hospital. Whilst one study was
undertaken in Sweden (Randers & Mattiasson, 2004) the other five were undertaken in England (Seedhouse & Gallagher, 2002; Crow et al 2006; Crow et al, 2010; Nicholson et al, 2010a; Baillie & Gallagher 2010). All the studies were qualitative with a variety of research methods using focus groups and interviews and one also using pre and post intervention interviews following an educational day on ethics related to dignity in practice (Seedhouse & Gallagher, 2002). For the three studies considering the value of an educational intervention there was limited information in published papers on the perceived benefits of these interventions. Three of the studies used an action research approach Crow et al 2006; Crow et al, 2010; Nicholson et al, 2010a) to support changes in practice to improve dignity, although as identified there was also limited information in published papers on the detail of the processes involved in the study and the outcomes for patients and professionals. The final qualitative study reviewed published in two papers (Baillie & Gallagher, 2010; Baillie & Gallagher, 2011) gave a broader insight into how nurses used educational resources and were able to improve aspects of dignity for patients.

This next section will now bring together the synthesis of these reviews from patient, carers, healthcare professionals and where the study has involved a strategy to improve dignity in care.

2.5 Summary of themes identified from the review of primary research

Twenty four studies have been reviewed, that have explored the views and experiences of patients, carers and healthcare professionals in relation to dignity in care. A wide range of qualitative approaches have been utilised to undertake research in this area that have included: phenomenology, grounded theory, ethnography, case studies and action research, through the use of; questionnaires, interviews, and observations. From these studies a number of themes were consistently identified:

Respect for patients and the importance of effective communication that involves patients being listened to with sensitivity and attentiveness (Seedhouse & Gallagher, 2002; Widang et al, 2003; Whitehead & Wheeler, 2008b; Webster & Bryan, 2009; Widang et al, 2008; Dawood & Gallini, 2010) were considered key feature of promoting dignity, however, an issue identified by patients, was a concern that they were considered believable and trustworthy (Widang & Fridlund, 2003). Furthermore the role of the nurse was also highlighted in: how patients were addressed (Whitehead & Wheeler, 2008b; Bridges & Nugus, 2010); protecting patients from threatening and violating situations (Widang & Fridlund, 2003) and; safeguarding the dignity of
patients with cognitive impairment and communication difficulties (Webster & Bryan, 2009; Baillie & Gallagher, 2011). However, the importance of staff attitude and behaviour as the basis for the nurse-patient relationship was identified by Seedhouse and Gallagher (2002) and Baillie (2007a).

Closely related to this was a social aspect of dignity was also highlighted (Chochinov et al, 2002) where one study identified nurses value of the use of humour as part of their relationship with patients (Walsh & Kownako, 2002).

For both patients and professionals a critical aspect of dignity was privacy and not being exposed to others (Seedhouse & Gallagher, 2002; Widang et al, 2003; Matiti & Trorey, 2004; Woogara, 2004; Whitehead & Wheeler, 2008b; Baillie, 2007a; Widang et al, 2008; Webster & Bryan, 2009; Dawood & Gallini, 2010) as this contributed to their sense of self respect (Matiti & Trorey, 2004) or a sense of vulnerability, isolation and loss of control when privacy was absent (Widang et al, 2008). Privacy has also been identified as an interrelated concept to dignity that has been investigated in depth, with a number of facets identified that also included; privacy of information and conversations between patients and healthcare professionals, as well as privacy of one’s own space and belongings (Woogara, 2004; Whitehead & Wheeler, 2008b).

Information and explanations of treatment and care and involvement in discussions and decisions were identified within several studies (Whitehead & Wheeler, 2008b; Webster & Bryan, 2009; Bridges et al, 2009; Nicholson et al, 2010c) and; the importance of choice, control and autonomy were also identified (Walsh & Kowanko, 2002; Matiti 2004). However, differences were also noted between studies, where in one study, nurses had not identified the importance of ‘control’ for patients (Matiti & Trorey, 2004) and in another nurses, nurses had identified the ‘giving control’ as a particular theme (Walsh & Kwanko, 2002).

Seeing the person in the patient was identified within the concept analysis by Anderberg et al (2007) and has been referred to by five of the studies (Widang & Fridlund, 2003; Goodrich & Cornwell, 2008; Bridges et al, 2010; Nicholson et al, 2010a; Tadd et al, 2011a; Tadd et al, 2011b). Each of these studies proposed this as an approach to caring for patients, with a particular reference to increasing a patient’s sense of significance, where this had been described by older people as being diminished within hospitals (Bridges & Nugus, 2010). It has also been evident within these studies that there have been a number of references to approaches of care as: being person centred (Arino-Blasco et al, 2005), patient centred (Chochinov et al, 2002; Tadd et al, 2011a), and relationship centred (Widang & Fridlund, 2003;
In addition a six senses framework (Bridges & Nugus, 2010) was proposed within one study, as a valuable way for nurses to provide dignified care.

Models of how patient dignity is promoted or threatened has been developed from work involving both patients and nurses (Baillie, 2007a) as well a particular focus on how nurses maintain patient dignity (Lin & Tsai, 2011) that has some similarities in relation to the behaviours to promote or maintain dignity. The process patients go through when admitted to hospital in relation to their dignity has also been conceptualised within a cyclical model (Jacelon, 2004) that has some similarities to the cycle of perceptual adjustment, developed by Matiti (2002). Factors that can buffer against loss of dignity have also been identified as part of work on a ‘dignity conserving repertoire’ (Chochinov et al, 2002).

It has also been evident from three studies that patients recognise that nurses have to ‘juggle’ their needs against those of other patients (Jacelon, 2003; Bridges & Nugus, 2010; Dawood & Gallini, 2010) and that patients reported feeling sympathy for other patients exposed to, for example, delayed requests from nurses who were very busy (Dawood & Gallini, 2010). The ability for nurses to meet patient requests and spend time with patients has been identified as a particular factor that affects dignity in care highlighted in a number of studies by both patients and nurses focussing on lack of time and inadequate staffing levels (Gallagher & Seedhouse, 2002; Seedhouse & Gallagher, 2002; Woogara, 2004; RCN, 2008a; Goodrich & Cornwell, 2008; Crow et al, 2010; Bridges & Nugus, 2010).

The wider organisational and cultural context of dignity within acute hospitals has also been referred to in a number of studies with concerns raised around healthcare systems that treat patients as a ‘parcel’ (Goodrich & Cornwell, 2008) and that technical medical care was seen as having greater importance than other aspects of care (Bridges & Nugus, 2010). Conflicts of interest have been identified within the ways in which governance addressed risk that appeared to be at the cost of patient dignity (Tadd et al, 2011a; Tadd et al, 2011b). Furthermore the RCN (2008a) has also highlighted the paradoxical effects of competing healthcare policy that has the potential to undermine dignity in care. This is in contrast to the view of the World Health Organization (WHO, 2008) that defines a high performing health system as one that should be “responsive to people’s needs and preferences, treating them with dignity and respect when they come in contact with the system” (p. 2). Whilst these studies have considered the wider organisational context of dignity, only one has studied this in
relation to the RCN Dignity campaign (Baillie & Gallagher, 2010; Baillie & Gallagher, 2011) and little information was given on the broader contextual issues within the organisations involved.

Evaluative studies involving a strategy to improve dignity in care within acute healthcare organisations, have offered: valuable insights into evidence based care (Bridges et al, 2010), its application (Nicholson et al, 2011a), and effective change management (Crow et al, 2006; Crow et al 2007; Crow et al, 2010). However these have given no further insights into how aspects of the National Dignity in Care campaign was implemented and what effect it has had on the care of patients and nursing practice.

Indeed, whilst a number of the studies reviewed predate the National Dignity in Care campaign, there have only been four studies undertaken and published as a result of the increased focus and concern related to dignity in care (RCN, 2008a; Dawood & Gallini, 2010; Nicholson et al, 2010a; Baillie & Gallagher, 2010; Baillie & Gallagher, 2011). The study by Baillie and Gallagher (2010, 2011) is the only one that has looked at what has been learnt from the RCN Dignity campaign. Furthermore, since the launch of the Department of Health’s Dignity in Care campaign there have been only two major research studies which have looked at the culture and care of older people in acute hospitals (Patterson et al, 2011; Tadd et al, 2011b). These were funded by the National Institute for Health Research within the Department of Health, and they considered dignity as a central aspect of care. However, no study has been identified that has documented an evaluation of the response to the National Dignity in Care campaign within an acute healthcare Trust. This is surprising given the serious and enduring concerns raised around dignity in care through both statutory and independent reports and the media, and the ongoing profile that the national Dignity in Care campaign has received since its launch.

Finally, following this comprehensive review of the literature it is clear that there was a need for a study to evaluate the implementation of the national Dignity in Care campaign within an acute healthcare Trust. However undertaking an evaluation of this nature poses a particular methodological challenge due to the complex nature of acute healthcare organisations, which will be addressed within Chapter 3. The gap in the evidence and the challenge of evaluating a local response to the Dignity in Care campaign provided strong drivers for undertaking an evaluative study, alongside a range of concerns identified within practice, as discussed in the next section.
2.6 Motivation for this study

At the time of the launch of the national Dignity in Care campaign my role within the acute healthcare organisation was as Lead Nurse for Older People and Stroke services. I had particular responsibility, in a modern matron role, for the quality of patient care and I was acutely aware of deficiencies in care as a result of issues related to: safeguarding of vulnerable adults, insufficient staffing levels, complaints, the need for effective leadership, and improvements needed within ward environments. The Dignity in Care campaign provided a unique opportunity to bring together a number of concerns under one framework, as a tool to be able to communicate the different aspects of dignity, with a national profile. I worked closely with, and received enthusiastic support and strong leadership from, the Head of Nursing, Lead Consultant for Medicine for Older People, and the Director of Nursing to develop an organisational wide response to implementation of key elements of the dignity campaign. As has been discussed the review of the literature related to dignity identified that there had been no systematic evaluation of the national Dignity in Care campaign within an acute healthcare Trust. Capturing, within an evaluative study, patient experience in relation to dignity, the level of support and engagement from staff, the range of initiatives developed and the benefits of these for patients, within a complex healthcare organisation was an instinctual next step that was felt to be both exciting and challenging.

2.7 Chapter summary

Whereas Chapter 1 reviewed the nature of reported concerns related to dignity, the accountability of nurses for the dignity of patients, and the translation of the Dignity in Care campaign within one healthcare Trust, this chapter provides an overview of the literature which has addressed the understanding of the nature of dignity, the meaning and experiences of dignity, and evaluations of initiatives to improve dignity. Concept analyses and reviews of the nature of dignity have identified that dignity is an inherent characteristic of being human, that it is both social, as well as subjective experience whereby the importance of autonomy, choice, and control, and the ability to maintain personal boundaries, the importance of the attitude of care, which can be learnt. The literature has also identified key themes in relation to the meaning and experience of dignity for both patients and professionals with consistent themes identified related to respect, privacy, the need for sensitive communication, information and explanations about treatments and care along with recognising the
importance of attitude of care. This mirrors the concerns identified within published reports related to a lack of dignity reviewed in chapter 1. Models and frameworks have also been considered that have developed thinking in this area to inform practice, enabling healthcare professionals to understand some of the processes patients may go through in adjusting to hospitalisation, and a loss of dignity.

Evaluations of initiatives to improve dignity have also been reviewed with a range of educational interventions, participatory action research, and an evaluation of the RCN Dignity campaign. However evaluation research into the implementation of the Dignity in Care campaign within an acute healthcare Trust is limited and the literature search identified no evaluation of such work. Finally the motivation for this study has been described as an area of practice where there was a need for improvement and one where a systematic evaluation had not previously been undertaken in this setting. The next chapter discusses in detail the objectives of the study and the methodology adopted to meet this particular challenge.
Chapter 3 Methodology and Data Analysis

3.1 Introduction

This chapter sets out the aims and objectives for the study, its design, the ethical considerations including consent, access and selection of participants as well as the process of data gathering, and a detailed description of the process of analysis.

3.2 Aims and Objectives of the Study

The key aims of the study were to describe the work undertaken by one acute healthcare NHS Trust in response to the national Dignity in Care campaign, the processes involved in seeking to improve aspects of Dignity in Care for patients including the context of the organisation. Gaining differing perspectives from patients, healthcare professionals, senior managers and executives was identified as important in order to understand the outcomes for individuals and the organisation in relation to the Dignity in Care campaign.

The research study objectives were to:

- Document and describe work undertaken in response to the National Dignity in Care campaign within an acute healthcare Trust.
- Describe the context of the wider organisational issues and culture influencing the work to improve dignity in response to the Dignity in Care campaign.

 Patients
- Capture the experiences and concerns of patients in hospital in relation to dignity.
- Identify whether there had been any improvement in dignity in care since a previous admission.

 Healthcare Professionals
- Explore with a cross section of healthcare professionals attitudes, knowledge, roles and responsibilities with regard to the response to the Dignity in Care campaign.
- Capture the challengers and enablers for healthcare professionals implementing changes into practice and its impact on patients’ experiences of dignity.

 Senior Managers and Executives
- Explore with a cross section of senior managers and executives the attitudes, knowledge, roles and responsibilities with regard to the response to the Dignity in Care campaign.
- Capture the challenges and enablers to the range of work undertaken to respond to the Dignity in Care campaign and its impact on the organisation.

### 3.3 Epistemology

Since the aim of the study was to understand and interpret a wide range of experiences and views of patients, healthcare professionals and senior managers in relation to the Dignity in Care campaign it was quickly recognised that a positivist approach would not have been able to address the nature of the inquiry, in considering the richness of personal experiences as well as the influences of organisational issues and culture.

Achieving these aims required an approach using an interpretivist paradigm to be able to find a way through the complexity of issues at both an individual and organisational level, in a specific setting and context. Therefore a naturalistic interpretive approach was taken, with the use of qualitative methodology using in-depth interviews as the central method of gathering data to explore experiences, understanding, attitudes, processes, initiatives and their perceived impact in responding to the Dignity in Care campaign. Complementing the one to one semi-structured interviews was a review of Trust documentation.

It was also of particular note that as the researcher I had a significant role and responsibility to lead on work to improve dignity within medicine for older people and supporting work across the hospital. Being actively involved in initiatives to improve dignity as well as driving a coordinated response made me question whether an action research approach to study would be a valuable method to both participate and gain insight into the change processes and outcomes for both patients, healthcare professionals and senior managers in responding to the National Dignity in Care campaign. However, following investigation into the practical application of action research it was not considered feasible due to the significant period of time required to carry out a study using this approach. Phenomenology was also an area that was considered as being valuable in exploring the experiences of individuals; however it has limited focus on the organisational, contextual issues and practical aspects of what was being considered in relation to changing practice to address the Dignity in Care campaign. It was also noted that previous researchers had utilised this approach (Walsh & Kowanko, 2002; Matiti 2002). An approach was required that could enable the researcher to describe the experiences, understanding and attitudes, as well as detailing change processes, and examine the interplay of a range of factors that may have been challenges or enablers to initiatives.
within the local campaign to improve dignity for patients, within the context of an organisation and its culture.

3.3 Research Methodology

I considered that in order to evaluate the complex range of issues related to the response of an acute healthcare Trust to the Dignity in Care campaign to use an illuminative evaluation, as it focuses on qualitative methods, inductive analysis and naturalistic enquiry (Robson, 2005, p. 178). Parlett and Hamilton (1976) identify the goal of illuminative evaluation:

“to discover and document what it is like participating in a scheme ... and in addition to discern and discuss the innovations most significant features, recurring concomitants and critical processes” (Parlett & Hamilton, 1976, p. 9)

Illuminative evaluation was developed as an alternative approach to study innovative programs of education, in response to perceived limitations of traditional evaluation, and has been characterised as concerned with description and interpretation rather than measurement and prediction (Parlett & Hamilton, 1976, p. 147). Parlett and Hamilton (1976) also explain that illuminative evaluation is not a standard package but a general research strategy and stress that “illuminative evaluation, like the innovations and learning environments that they study, come in diverse forms” (Parlett & Hamilton, 1976, p. 92). As well as essentially valuing the diverse opinions and belief systems of individuals, illuminative evaluation emphasises the context in gaining an understanding of the education programme concerned. This means that a central part of the investigative process involves the researcher actively discovering the social, institutional, political and cultural context of the education programme in all its complexities (Parlett & Hamilton, 1972). Illuminative evaluation is also considered particularly useful for disentangling complexities and providing clues as to important relationships that shape the processes and outcomes of educational programmes (Parlett & Hamilton, 1972).

Central to the understanding of illuminative evaluation are two concepts, namely instructional system and the learning milieu. The instructional system, also described as catalogue, is an idealized specification of a new programme or innovation, which for this study is the work that was undertaken in response to the National Dignity in Care campaign within one acute healthcare Trust. The learning milieu is the setting and context within which learning takes place which again for this study is the acute healthcare Trust, where the context of the Trust was discussed in detail in section 1.7. Traditionally evaluation of educational programmes have
required administrating of pre and post tests to what, change in behaviour, knowledge. Parlett and Hamilton (1972, p. 10) claim “this approach ignores that fact that an instructional system, when adopted, undergoes modifications that are rarely trivial”. In the practice setting or the learning milieu, grand objectives, as outlined in the instructional system, are commonly reordered, re-defined, abandoned or forgotten. This is something that was considered similar to initiatives that are developed within healthcare, and in particular where a national strategy or campaign is translated into local practice. The context of this study was no exception where significant organisational changes were taking place in a merger with another hospital, as described earlier in section 1.7.

Furthermore, Parlett and Hamilton (1972) argue that acknowledging the diversity and complexity of the learning milieu is an essential prerequisite for the serious study of educational programmes (innovation). It can be seen that the acute healthcare setting also offers a unique environment where social, cultural, institutional and psychological variables are present both within clinical environments and the wider organisational setting. It is of note that Illuminative evaluation is an approach that has been used widely within the nursing and healthcare to explore a wide range of education and practice developments (Sloan & Watson, 2001; Russell, Greenhalgh, Boynton, & Rigby, 2004; Ellis, 2006).

In particular these qualitative studies demonstrate how illuminative evaluation has enabled the investigation of fundamental process issues. In one study, the authors used illuminative evaluation to evaluate clinical supervision on “its performance as opposed to applause” to ensure that they specifically considered “the reciprocal interactions between supervisor and supervisee where multiple perspectives are illuminated” (Sloan & Watson, 2001, p. 671). In another study the use of illuminative evaluation provided for an open ended and collaborative approach, exploring perceptions and experiences as well as working with stakeholders to progressively clarify and agree the critical processes in the communication of evidence (Russell et al, 2004). Using this approach illuminated the value of informal social processes in relation to the communication of evidence in healthcare by a range of healthcare professionals both within and across organisations. Finally, Ellis (2006) used illuminative evaluation, combined with a case study approach, to consider the wide range of processes involved in continuing professional education (CPE) for nurses, for example, individual motivation and receptivity in practice areas and how these shaped the outcomes of CPE were identified. The use of this approach has particular relevance to one of the aims of the study, that of considering the value of the Dignity Training Workshops, one of the actions used to support improvements in Dignity
in Care. Since both the description and illumination of key processes and outcomes related to the Dignity in Care campaign were a central aim of the study illuminative evaluation was deemed a suitable research methodology to adopt.

3.3.1 Data Collection Method

The key source of data was one to one semi-structured interviews with key stakeholders, see Box 3.1.

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<tr>
<th>Box 3.1 Data Source</th>
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<tr>
<td>One to one semi-structured interviews with three key stakeholder groups of:</td>
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<tr>
<td>i. Patients,</td>
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<tr>
<td>ii. Healthcare professionals involved in a range of work on the Dignity in Care campaign and</td>
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<tr>
<td>iii. Senior managers and executives with wider responsibility for patient experience and dignity</td>
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</tbody>
</table>

Interviewing is recognised as a particularly valuable research tool to gather rich data from individuals (Kvale, 1996; Legard, Keegan, & Ward, 2003). One description of interviewing is as a ‘conversation with a purpose’ (Web & Web, 1932, p. 130); however this may not do justice to the complex nature of the interview process. Legard et al (2003, p. 142) identify key features of interviewing as a flexible, interactive and generative process between two individuals in which meaning and language is explored in depth. The researcher used semi-structured interviewing to provide a degree of structure with a pre-specified order of the questions and how they were phrased (Arthur & Nazroo, 2003), (see also semi-structured interview schedules: Appendices 10, 11 & 12). Interviewing is also recognised as a skill where the researcher is responsible for the interpersonal process of ‘pacing the interview’ (Lincoln & Guba, 1985) and the use of techniques such as ‘probes’ to draw out further detail and ensure the richness of the data (Patton, 1990). The interview questions set out within the schedule were reviewed with supervisors prior to interviews taking place and a practice interview was undertaken by the researcher to also consider the appropriateness of the questions and gain clarity of where the researcher may need to manage the pace of the interview and probe to explore an area further. This study identified a cross section of key stakeholders to enable greater insight into work responding to the Dignity in Care campaign, which will be discussed further in relation to the sampling strategy.

In addition a review of Trust documentation took place to gain an insight as to how initiatives were being carried out, what progress was being made and further illuminate findings from the
interviews. The review of these documents aimed to augment the data collected from interviews and provide detail of work being undertaken on the Dignity in Care campaign as well as a narrative of the wider organisational context. Permission was gained for access to these documents from the Trust. The following flow chart (figure 1) illustrates the study design from negotiating access to carry out the study within the acute healthcare Trust and each stage of the research process. Each step of the process is discussed in detail below in relation to ethical issues, selection and recruitment of participants, data collection and analysis.

**Fig 1 Research Flow Chart**

**Negotiating access (May to July 2008)**
- Study was proposed to the Trust wide Steering group and gained support for an evaluation of the Dignity in Care initiatives.
- University and NHS Research Ethics Committee approval sought and gained

**Recruitment and preparation (August to November 2008)**
- The researcher approached individuals to participate in interviews
- The researcher identified key documentation to review

**Further preparation and planning (July – September 2008)**
- Pilot interview to review the appropriateness and relevance of interview topic schedule.
- Finalisation of interview schedule
- Organisation and planning of interviews

**Data Collection (August to December 2008)**
- Undertake one to one semi-structured interviews
- Detailed review of documentation

**Begin process of analysis**
- Transcription of interviews verbatim and familiarity developed with the data
- Developed detailed mapping and charts of data as part of framework analysis

**Interpretation**
- Synthesis of data to develop meanings and themes from the interviews
- Review of Trust documentation and other local and national report findings, as well as pertinent evaluation literature
3.4 Ethical issues

Whilst planning the research study, ethical requirements were fulfilled as set out in the Research Governance Framework for Health and Social Care (DH, 2005) that included compliance with minimum requirements relating to research governance indicators.

An ethical approval application was initially made, as part of the project proposal to the School of Health Sciences and Social Work, Portsmouth University Research Ethics Committee in April 2008. Following a favourable response a further ethical application was submitted to the NHS Local Research Ethics Committee (LREC) in May 2008 with approval given in July 2008 (see Appendix 3) following further consideration of issues identified and addressed in Table 3.1.

Table 3.1 LREC Ethical Review: Conditions of approval and response

<table>
<thead>
<tr>
<th>LREC CONDITIONS OF APPROVAL</th>
<th>RESPONSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) A10-1: Specify where patient and healthcare professional will be interviewed</td>
<td>As specified in A10-3 patients and healthcare professionals will be interviewed within private rooms within the Hospitals, for which the researcher has access.</td>
</tr>
<tr>
<td>2) A20 The researcher cannot make the first approach to recruit patients to the study. This should be done by the patient’s clinician</td>
<td>The researcher will not directly approach patients. The first approach will be made through the nurse in charge within individual’s wards with an understanding of the inclusion and exclusion criteria</td>
</tr>
</tbody>
</table>
| 3) A64 Please explain how the conflict of interest and possible bias of the CI Andrew Gallini interviewing healthcare professionals, whilst being one of the leads for the Dignity Challenge will be addressed | • The researcher was involved in jointly initiating work around the ‘Dignity Challenge’ however this is now led by the Director of Nursing through the Trust wide Dignity Steering Group  
• The researcher has not played a lead role in the projects and dignity workshops  
• The researcher will not interview any individual who is line managed by the researcher in his role as Lead Nurse in Medicine within the Trust  
• The research will reflect prior to interviewing on any possible prejudices and influences that may have the potential to affect responses  
• The researcher will arrange to listen and discuss practice interviews with supervisors to review the interviews.  
• Within qualitative research it is recognised that there can be value in the researcher understanding the organisation and individuals as individuals being interviewed may be more willing to be open and share experiences  
• Transcripts of interviews will also be returned to participants to check these are an accurate record of the interview. This will also provide an additional means for participants to agree with the content of their interview. |
| 4) Patient information sheet | Revised and amended. Version 4 can be seen in Appendix 5 |

| Patient information sheet | Revised and amended. Version 4 can be seen in Appendix 5 |

| 5) Consent Form | Revised and amended. Version 3 can be seen in Appendix 6 |

| Patient information sheet | Revised and amended. Version 4 can be seen in Appendix 5 |

| Consent Form | Revised and amended. Version 3 can be seen in Appendix 6 |
A key concern identified related to where patients and healthcare professionals were to be interviewed, how approaches were to be made to patients, how the potential conflict of interest of the researcher would be managed, and a particular further point was added to the information sheet and consent form that care would not be affected if the patient declined to be interviewed after initial discussion.

A parallel process to the application to NHS ethics was the application to the healthcare NHS Trust’s research governance framework. Approval was gained (Appendix 4) and as an employee of the acute healthcare NHS Trust there were no additional requirements, such as a Criminal Records Bureau (CRB) clearance and an honorary contract. The next section details the sampling strategy and the step by step process of recruitment.

### 3.5 Sampling strategy and recruitment

This section will detail the step by step process that the researcher took in approaching each of the key stakeholder groups of: patients, healthcare professionals, and senior managers and executives, and the rationale for their inclusion in the study. A collaborative approach which engages key stakeholders is fundamental to an effective evaluation (Chen, 1990, p. 78). For each of these groups a purposive sample (Robson, 2005, p. 265) was used. A purposive sampling strategy was chosen as it enables the broadest scope of information to be gathered in order to understand the particular context of the evaluation and insights from the participants (Guba & Lincoln, 1989). Table 3.2 presents the participants and the rationale for their inclusion.

**Table 3.2 Participants and rationale for their inclusion**

| 1. Interviews with Patients who have had previous hospital experience – the criteria being that they had had a previous admission or a long term admission over the timescale of the Dignity project to a clinical area where project initiatives had taken place; able to identify if they had noted any changes in the care provided following initiatives to improve dignity for patients. | Purposive sample of 10 Patients |
| 2. Interviews with Healthcare Professionals - the criteria being that they had been (1) involved in work programmes addressing different aspects of dignity (approximately 20 Healthcare Professionals) or (2) had attended one of the Dignity Training Workshops (108 Healthcare Professionals) | Purposive sample of 15 Healthcare Professionals |
| 3. Interviews with a cross section of Senior managers and Executives on the range of work undertaken to respond to the dignity challenge and its impact on the organisation – the criteria being that they had roles with organisation wide responsibilities related to dignity | Purposive sample of 10 Senior managers & Executives |
The following sub sections detail the process of recruitment and interviewing to demonstrate a transparent ethical approach that took place for all participants in each of the three groups.

**3.5.1 Interviews with Patients who have had previous hospital admissions prior to the Dignity in Care campaign**

Ten patients were carefully selected to be interviewed to provide a cross section of male and female patients (of a wide age range) who had all had previous hospital admissions prior to the Dignity in Care campaign initiatives; the purpose of which was to identify if patients had experienced any improvements in aspects of care related to dignity in comparison to previous admissions.

**3.5.1.1 Recruitment process**

Patients were identified through the support of seven ward managers who were approached by the researcher to assist with recruitment of patients across seven different wards within the hospital. A range of hospital wards were identified to ensure a wider representation of patient groups, as opposed to patients all being from one ward, each of which had a focus for a specialist area of medicine. An explanation of the nature of the study was given by the researcher to the ward managers, along with information sheets. The ward managers then identified patients who met the criteria of having previous hospital admissions and who were medically stable. When a patient was identified who met the selection criteria (by the ward manager) an initial approach was made explaining the study and giving the patient the information leaflet (see Appendix 5). The ward manager subsequently followed up the next day to see if the patient was interested in talking further to the researcher about participating in the study. The researcher was therefore not directly involved in making the first approach to patients, which could have been perceived as some form of coercion. In ensuring fully informed consent from patients to participate in the study it was also important that the information they received as well as the consent form were clear, accessible and in plain English and that patients understood that they could withdraw from a study at anytime without this affecting their care.

Ten patients were identified that were willing to participate and were interviewed during October and December 2008, following a subsequent approach by the researcher who checked that the patient had understood the information sheet and were happy to participate. On the whole patients who were identified as meeting the criteria for the study were interviewed.
There was however two patients who were initially identified, but later did not participate in
the study. The first patient became unwell and was therefore not able to be interviewed, and
the second patient who was willing to participate had been discharged from the hospital prior
to the researcher arriving on the ward. Once a patient agreed to take part a date and time was
arranged for the interview to take place that allowed at least 24 hours “thinking/reflection”
time for the patient prior to signing a consent form. Interviews took place in a private or quiet
room on a hospital ward.

3.5.1.2 Interview Schedule

A semi-structured interview approach was used to enable the interviewer to explore the
experiences of patients. In order to achieve the aims of the study a different interview
schedule was specifically tailored to guide interviews for each group. Patients were asked
about their experience of dignity in hospital (Appendix 10). A summary of the key questions is
set out in Box 3.2.

<table>
<thead>
<tr>
<th>Box 3.2 Summary of key questions from Semi-Structured Interview Schedule for Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>- What has been your experience of dignity in hospital</td>
</tr>
<tr>
<td>- Have you noticed any changes in your care in relation to dignity during your most recent admission as compared to previous admissions, also considering mixed sex accommodation</td>
</tr>
<tr>
<td>- Discuss particular projects, such as ‘Red Pegs’ to improve privacy and whether this had been noticed and made any difference</td>
</tr>
<tr>
<td>- Any suggestions for improvements</td>
</tr>
</tbody>
</table>

3.5.1.3 Patient Participants

Participants included six male and four female participants with an age range from early 20’s to
late 70’s. Two patients were from the infectious diseases ward, a further two patients were
from the elderly care ward, and a further two patients were from the endocrine ward, along
with one patient each from the stroke ward, oncology ward, gastrointestinal ward, and
neurology ward. Only one patient had experienced one previous admission, with five patients
having two previous admissions, and the remaining four patients having as many as five or
more previous admissions. These details are also set out in Table 3.3 of Patient Participants in
order of age and gender.
Table 3.3 Patient Participants

<table>
<thead>
<tr>
<th>Gender &amp; Age</th>
<th>Type of Ward</th>
<th>Number of Previous Hospital Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male 20’s</td>
<td>Infection Diseases</td>
<td>2 previous admissions</td>
</tr>
<tr>
<td>Male 40’s</td>
<td>Gastrointestinal Ward</td>
<td>2 previous admissions</td>
</tr>
<tr>
<td>Male 40’s</td>
<td>Neurology Ward</td>
<td>2 previous admissions</td>
</tr>
<tr>
<td>Male 50’s</td>
<td>Endocrine Ward</td>
<td>Greater than 5 previous admissions</td>
</tr>
<tr>
<td>Male 60’s</td>
<td>Stroke Ward</td>
<td>2 previous admissions</td>
</tr>
<tr>
<td>Male 80’s</td>
<td>Elderly Care Ward</td>
<td>Greater than 5 previous admissions</td>
</tr>
<tr>
<td>Female 20’s</td>
<td>Infectious Disease</td>
<td>1 previous admission</td>
</tr>
<tr>
<td>Female 60’s</td>
<td>Endocrine Ward</td>
<td>Greater than 5 previous admissions</td>
</tr>
<tr>
<td>Female 70’s</td>
<td>Oncology Ward</td>
<td>Greater than 5 previous admissions</td>
</tr>
<tr>
<td>Female 70’s</td>
<td>Elderly Care Ward</td>
<td>2 previous admissions</td>
</tr>
</tbody>
</table>

This next section considers the healthcare professionals who participated in the study, their role and level of involvement in the work related to the Dignity in Care campaign.

3.5.2 Interviews with Healthcare Professionals involved in work programmes addressing different aspects of dignity

Fifteen healthcare professionals were carefully selected to who had been involved in attending dignity workshops or a range of projects as part of dignity work programmes. Given the numbers of staff attending dignity training workshops and different types of involvement in work to improve dignity fifteen healthcare professionals were identified to be able to capture the range of experience, attitudes and progress on dignity work across different professional groups.

3.5.2.1 Recruitment Process

Healthcare professionals were identified through attendance lists for the dignity workshops and staff actively involved in groups working on specific work programmes that were developed in response to the Dignity in Care campaign. Individuals were approached through an invitation letter sent by email, along with a copy of the information sheet on the study. When an individual identified their interest in participating in the study a meeting was arranged for the interview to take place. Further explanation of the information sheet was given and the participant signed the consent form for the interview and its recording. All interviews took place in the office of the individual healthcare professional or the researcher.
3.5.2.2 Interview Schedule

In order to meet the aims of the study the interview schedule for healthcare professionals was focussed on their understanding, attitude and involvement, with specific questions for those individuals who had attended a dignity training workshop (Appendix 11). A summary of the key questions is set out in Box 3.3.

<table>
<thead>
<tr>
<th>Box 3.3 Summary of key questions from Semi-Structured Interview Schedule for Healthcare Professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Can you tell me about your understanding of the Dignity in Care campaign?</td>
</tr>
<tr>
<td>- What’s your awareness and involvement in work to date on the Dignity in Care Campaign?</td>
</tr>
<tr>
<td>- Can you tell me your thoughts on the value of this work around dignity?</td>
</tr>
<tr>
<td>- Any suggestions for improvements in patient dignity?</td>
</tr>
</tbody>
</table>

Additional questions if the individual had attended a Dignity Training Workshop

- How did you get to hear about the Dignity Training Workshops?
- How did you find the Dignity Training Workshop?
- What was your commitment from the Dignity Training Workshop?
- Have you been able to progress your commitment, and what challenges and enablers have there been in relation to this?

A particular concern raised by the ethics committee was the potential for conflict of interest where the researcher was a healthcare professional working within the hospital environment, with a particular role that related to the nature of the study. There has also been considerable debate looking at role conflict for both a researcher and healthcare professional and the challenges presented by this (Wilkes & Beale, 2005). A reflective journal was kept during the course of the data collection and process of analysis to enable the researcher to consider opinions, thoughts and prejudices. As part of the sampling healthcare professionals were selected by the researcher to ensure that none of the individuals who were approached were directly line managed by the researcher.

3.5.2.3 Healthcare Professional Participants

Fourteen healthcare professionals took part in the interviews held between August and December 2008. It was not possible to interview one of the healthcare professionals due to time constraints and change of circumstances during the period that the interviews took place. The range of different healthcare professionals and their role and type of involvement is set out
in Table 3.4 in order of seniority and grouped according to professional role. From this there were eight female and six male participants. Two consultants were interviewed, as well as a consultant nurse, and four senior nurses with different areas of responsibilities. Four nurses working at a similar level of: ward manager, clinical nurse specialist and practice development roles were also interviewed, as well as three other staff from different professional roles and departments within the hospitals. Three healthcare professionals were members of the dignity steering group and nine individuals had attended dignity training workshops, two of which went on to facilitate workshops.

**Table 3.4 Healthcare Professional Participants**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Role/ Area of Work</th>
<th>Type of Involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Consultant Geriatrician</td>
<td>Dignity Steering Group member &amp; Assisted with Dementia Training</td>
</tr>
<tr>
<td>Female</td>
<td>Consultant Geriatrician</td>
<td>Involved in Adult Protection Training</td>
</tr>
<tr>
<td>Female</td>
<td>Consultant Nurse – Accident &amp; Emergency</td>
<td>Dignity Steering Group member</td>
</tr>
<tr>
<td>Female</td>
<td>Senior Nurse - Medicine</td>
<td>Dignity Steering Group member and Lead on Red Pegs and hospital gowns</td>
</tr>
<tr>
<td>Male</td>
<td>Lead Nurse Quality – Nursing Directorate</td>
<td>Lead on Essence of Care, Red Peg Project &amp; Protected Mealtimes</td>
</tr>
<tr>
<td>Female</td>
<td>Senior Midwife</td>
<td>Attended Dignity Training</td>
</tr>
<tr>
<td>Male</td>
<td>Site manager</td>
<td>Attended Dignity Training</td>
</tr>
<tr>
<td>Female</td>
<td>Specialist Nurse – Infectious Diseases</td>
<td>Attended Dignity Training</td>
</tr>
<tr>
<td>Male</td>
<td>Ward Manager-Rehabilitation</td>
<td>Attended Dignity Training</td>
</tr>
<tr>
<td>Female</td>
<td>Practice Development Nurse Medicine for the Elderly</td>
<td>Attended &amp; Facilitated Dignity Training</td>
</tr>
<tr>
<td>Male</td>
<td>Practice Development Nurse Medicine for the Elderly</td>
<td>Attended &amp; Facilitated Dignity Training</td>
</tr>
<tr>
<td>Female</td>
<td>Head Physiotherapist</td>
<td>Attended Dignity Training &amp; Involved in Adult Protection Training</td>
</tr>
<tr>
<td>Female</td>
<td>PALS Officer</td>
<td>Attended Dignity Training</td>
</tr>
<tr>
<td>Male</td>
<td>Chaplain</td>
<td>Attended Dignity Training &amp; Assisted with care of patient with Dementia Training</td>
</tr>
</tbody>
</table>

The next section identifies the senior manager and their roles, and involvement in work on the Dignity in Care campaign.

**3.5.3 Interviews with Senior Managers and Executives about the range of work undertaken to respond to the Dignity in Care work and its impact on the organisation.**

Ten senior managers and executives were identified as holding key clinical and managerial positions having sufficient breadth of roles and responsibilities related to dignity at an
organisational level to reflect on the response across the organisation to the Dignity in Care campaign.

### 3.5.3.1 Recruitment Process

Senior managers and executives were identified by the researcher, who had an understanding of the roles and responsibilities of these individuals and their particular contribution to work on the Dignity in Care campaign in the Trust, for example, being responsible for drawing up the action plan for mixed sex accommodation. An invitation letter was sent by email, along with an information sheet, inviting them to participate in this evaluation. When an individual identified their willingness to participate in the study a meeting was arranged for the interview to take place, further explanation of the information sheet was given and the individual signed consent prior to the interview and its recording took place. As with healthcare professionals, senior manager and executives were also interviewed in their own office or the office of the researcher.

### 3.5.3.2 Interview Schedule

For senior managers the interview schedule was also tailored to draw on knowledge and understanding of the dignity in care campaign within the Trust as well as the value of the campaign and its impact on the organisation (Appendix 12). A summary of the key questions is set out in Box 3.4.

<table>
<thead>
<tr>
<th>Box 3.4 Summary of key questions from Semi-Structured Interview Schedule for Senior Managers and Executives</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Can you tell me about your understanding of the Dignity in Care campaign?</td>
</tr>
<tr>
<td>- What’s your awareness and involvement in work to date on the Dignity in Care Campaign?</td>
</tr>
<tr>
<td>- Can you tell me your thoughts on the value of this work around dignity and its impact on the organisation?</td>
</tr>
<tr>
<td>- Can you tell me about your thoughts on performance monitoring around aspects of dignity?</td>
</tr>
<tr>
<td>- What do you think are challenges and enablers to improving dignity within the organisation?</td>
</tr>
<tr>
<td>- Any suggestions for improvements in patient dignity?</td>
</tr>
</tbody>
</table>
3.5.3.3 Senior Manager and Executives Participants

From ten senior managers and executives invited, all accepted and were interviewed between August to December 2008. Table 3.5 sets out the ten senior managers and executives in order of seniority, eight female and two male participants in the study. Three of these were executives, two of which were female and one male. The range of roles and responsibilities related to those with overall organisational responsibilities for dignity or aspects of patient care and involvement that related closely to dignity. In addition four of the senior managers and executives were members of the dignity steering group.

Table 3.5 Senior Manager and Executives Participants

<table>
<thead>
<tr>
<th>Gender</th>
<th>Role</th>
<th>Responsibility for Dignity within Role and Involvement in Dignity work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>Managing Director</td>
<td>Responsible Officer for the organisation</td>
</tr>
<tr>
<td>Male</td>
<td>Director of Operations</td>
<td>Attended Dignity Training</td>
</tr>
<tr>
<td>Female</td>
<td>Director of Nursing</td>
<td>Executive Responsible for Patient Experience</td>
</tr>
<tr>
<td>Female</td>
<td>Acting Director of Nursing</td>
<td>Developed Eradicating Mixed Sex Accommodation action plan</td>
</tr>
<tr>
<td>Female</td>
<td>Associate Director of Nursing</td>
<td>Executive Lead for Essence of Care</td>
</tr>
<tr>
<td>Female</td>
<td>PPI Manager</td>
<td>Lead for Patient and Public Involvement and led on focus groups on Dignity</td>
</tr>
<tr>
<td>Female</td>
<td>Head of Nursing</td>
<td>Dignity Steering Group member</td>
</tr>
<tr>
<td>Male</td>
<td>Equality &amp; Diversity Manager</td>
<td>Dignity Steering Group member &amp; Lead for Equality and Diversity</td>
</tr>
<tr>
<td>Female</td>
<td>HR Skills Consultant</td>
<td>Dignity Steering Group member &amp; Consultant on Staff Development and Recruitment</td>
</tr>
<tr>
<td>Female</td>
<td>Head of Therapies</td>
<td>Dignity Steering Group member</td>
</tr>
</tbody>
</table>

A further important area related to consent is confidentiality and this is addressed within the next section.

3.5.4 Confidentiality

The importance of confidentiality was recognised and it was explained that the patients, healthcare professionals, senior managers and executives would not be identifiable and that the transcripts of the interviews and any quotations used in the findings would incorporate pseudonyms to preserve anonymity. Participants were also given the option to withdraw from the study at anytime. For patients who identified serious concerns around their care it was identified that a discussion would take place with the individual and information would be
provided about the Patient Advice and Liaison Service (PALS) or Complaints service. In practice, concerns were highlighted from the experiences of patients and due to the nature of these concerns it was discussed with two patients at the time of their interview whether they wished to discuss these further with a PALS advisor or make a formal complaint, however they chose not to at that time. In relation to members of staff, if serious concerns were raised around aspects of practice they have observed, again the researcher identified that they would direct them to the most appropriate Trust Policy and procedure, for example the whistle blowing policy. In practice this was not something that was required.

3.5.4.1 Confidentiality in relation to storage of Data

Digital recordings and any transcribed data were kept in different locations, lock and key and on a password protected computer, with restricted access, to ensure security of data. The electronic audio files and transcripts have been kept according to guidance of both the University of Portsmouth and the Research Ethics Committee. Following publication of the thesis all electronic audio and data files will be destroyed.

The next section gives further explanation of the process of data collection.

3.6 Data Collection

Interviews were carried out at a mutually convenient time and place for the participants and researcher. Interviews lasted between fifteen to forty minutes. Each interview was guided by the use of a semi-structured interview schedule and digitally recorded. The aim of the interviews was to enable participants to explore their experiences of involvement and identify outcomes from the response to the Dignity in Care campaign. In each group the schedule of questions started off with narrow focussed questions exploring experience, knowledge and awareness and led on to more open questions to draw out from individuals their perceptions, views and concerns. The opportunity for healthcare professionals, senior managers and executives to also talk about challenges and enablers as well as current systems and further improvements was identified as being a balanced approach that would engage individuals to participate and share from their personal experience and professional roles and responsibilities. This proved to be an effective approach as it gathered very rich data, which is an approach supported by (Kvale, 1998).
In addition to interview data, documentary evidence within the Trust was also reviewed as part of the study. Review of documentation involved documenting and reviewing a wide range of written evidence that related to the Dignity in Care campaign within the healthcare Trust. Key documents reviewed included: Minutes of the Dignity Steering group and Sub groups, a Communications Plan for the Dignity in Care work, an Evaluation report of three Dignity Training Workshops, the Trust Action plan related to mixed sex accommodation, Essence of Care reports, and Picker survey reports. Whilst the role of the researcher meant that he had access to documentation it was also important that permission was sought to review these documents as part of a research evaluation.

The next section goes on to discuss the process of data analysis in detail.

3.8 Data Analysis

The data analysis was a step-by-step approach to give clarity to the process of interpreting the information from the interviews and documentary evidence (Kvale, 1996). A ‘framework’ analysis method developed by Ritchie and Spencer (1994) was selected for the systematic analysis in this study as it is an atheoretical matrix based method for managing, describing and interpreting qualitative data. The ‘framework’ method enables analysis to be transparent through processes within a set of five interconnected stages of: 1) familiarisation, 2) identifying a thematic framework, 3) indexing, 4) charting, and 5) mapping and interpretation (Ritchie & Spencer, 1994). Originally the framework analysis method was designed to help healthcare and policy researchers to analyse data systematically whilst capturing the creative and conceptual ability of the analyst to determine meaning, salience and connections (Ritchie & Spencer, 1994, p. 177). The final aim of the analysis was to gain greater understanding of impact and outcomes of the Dignity in Care campaign on patients, healthcare professionals and the organisation. This matrix based method was therefore identified as appropriate to be able to systematically analyse the data and compare data across sets. Table 3.6 sets out the main stages of the framework.
Table 3.6 The Framework analysis method (Adapted from Ritchie and Spencer 1994)

<table>
<thead>
<tr>
<th>1. Familiarisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immersion of the data occurs with the researcher listening to each recording of the interviews, undertaking transcription of the interviews, and reading the transcript several times to develop a familiarity with the data and get a sense of the whole. This enables issues, groups of issues and emerging themes to be identified and then used to construct an index of categories with which to methodically label or classify the data.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Identifying a thematic framework.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once an exhaustive list of codes and categories has been developed during familiarisation the next step is to devise a thematic framework. The final list is organised under a smaller number of headings representing higher order main themes.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Indexing</th>
</tr>
</thead>
<tbody>
<tr>
<td>The thematic framework will then be applied systematically to the data coding the data according to the index. The researcher then looks for patterns within the coding and the context in which these arise.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Charting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charts are then used to rearrange the coded data into the thematic framework. The charts will comprise of main headings and sub headings drawn from the thematic framework.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Mapping and interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The charts are reviewed and patterns searched for. They are used to define concepts explored in research, to identify their key characteristics, and to map the range of responses. Associations between themes are looked for to search for explanations for the findings.</td>
</tr>
</tbody>
</table>

3.7.1 Process of Data Analysis

1. Familiarisation

Familiarisation took place through listening to the digital recordings numerous times, making notes or memos and transcribing each of the interviews verbatim. During the process of transcribing, each interview was formatted to be able to number each line of text within the transcript. In addition a coding system was developed to identify each group and participant, of: P = Patient, H = Healthcare Professional and S = Senior Manager or Executive. Each individual was identified with a number relating to the participants within each group that were set out within the tables of participants 3.3, 3.4, and 3.5. A wide margin to the right of the text was also formatted within the transcripts to be able to annotate written comments that enabled the process of identification of categories, themes and issues to explore further.

2. Developing a thematic framework

The thematic framework was developed over a period of time prior to and during the stages of analysis. A very early framework was considered from the structure of the interview questions and the initial familiarisation of the data, which can be seen in Appendix 13. Following this a
The process of highlighting text was undertaken with different coloured highlighter pens and from this a process of extracting data from the transcripts took place. At an initial stage this took place through the use of scissors and staples to collate data on different groups and later this took place through copying and pasting electronically from a word document into an excel spreadsheet.

3. Indexing

Indexing took place early on in the process of analysis so that the trail of data was not lost and to provide a systematic method of identifying the source of data. Indexing is a process of sorting and collating categories of data, as opposed to coding which is a process of capturing dimensions or content that has already been more precisely defined and labelled (Ritchie, Spencer & O’Connor, 2007). This was done by gathering together any relevant information highlighted by participants within the transcripts on a particular theme. Further sorting and collation of data then took place in relation to the categories or sub themes within the theme. An example of this can be seen in Appendix 14 relating to the theme of ‘Improvements’ with a number of sub themes that were initially identified within this. The next process was a further checking of comments within transcripts and putting these on to charts to map across participants and themes and beginning to make decisions relating to the content of themes and sub themes, as opposed to collating data.

4. Charting

Charting continued the detailed process of looking at each of the initial themes and categories that were identified. Having collated a large number of categories and, in many cases similar issues, across the categories this meant they could be brought together under one heading or a new title that better described the content of the theme or sub theme. An example of this was ‘Understanding of and Attitude toward the Dignity in Care campaign’ which was originally identified as two themes of: Understanding of the Dignity in Care campaign’ and ‘Attitude to the Dignity in Care campaign’ (see Appendix 13) which gave greater coherence as one larger theme, as opposed to two themes with related issues.

I then started to consider each of the data sets related to patients, healthcare professionals and senior managers and executives separately. A next step was considering the data from healthcare professionals, senior managers and executives together and following discussion with academic supervisors, a later stage was the consideration of patient data alongside that of healthcare professionals, senior managers and executives. A note from the researcher’s
reflective diary in Box 3.5 describes a number of decisions that were made over a period of time from early drafts of data, discussions with academic supervisors and how this influenced decisions around grouping and merging of data sets. Whilst this was a time consuming process it enabled greater reflection on the congruence and dissonance between data sets and themes.

<table>
<thead>
<tr>
<th>Box 3.5 Excerpts from reflective note on process of analysis - Example 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Further development of thematic framework, Charting and Mapping</strong></td>
</tr>
<tr>
<td><strong>September 2010</strong></td>
</tr>
<tr>
<td>- Groupings of data items developed separately for each group of patients, healthcare professionals and senior managers</td>
</tr>
<tr>
<td><strong>October 2010</strong></td>
</tr>
<tr>
<td>- Data items for healthcare professionals and senior managers charted and brought together. Separately data items for patients also charted.</td>
</tr>
<tr>
<td><strong>27th November 2010</strong></td>
</tr>
<tr>
<td>- Decision made following academic supervision to merge patient data items with healthcare professionals and senior managers.</td>
</tr>
<tr>
<td><strong>28th November 2010</strong></td>
</tr>
<tr>
<td>- Identified the need to go through all the data again and produce charts to map the items coded against each item</td>
</tr>
<tr>
<td>- Work on mapping using framework analysis - Picking up some different, new/additional quotes and comments</td>
</tr>
<tr>
<td><strong>17th December 2010</strong></td>
</tr>
<tr>
<td>- Further sorting and organisation of charts in each theme - This identified where there were gaps in the charts – I then went through each transcript again to identify if I had missed references to the sub-themes within the transcripts</td>
</tr>
</tbody>
</table>

It also identified the need to go back to the ‘drawing board’ as initial processes were not robust enough and required more detailed indexing and charting and mapping which then took place through the use of a spreadsheet. This process involved inputting data onto a spreadsheet with a line for each participant and a column for each of the key reference or quotes relating to each of the sub themes belonging to this theme. This was repeated for each theme across all three groups of participants and an example of this can be seen in Appendix 15. The value of doing this was that it made the process more efficient and transparent. However, Ritchie et al (2007) identify two particular challenges within charting of, firstly the ‘danger of losing the context or location of the material’ (p. 229), and secondly summarising ‘the context to best retain the context and essence of the point without losing the voice of the respondent’ (p. 231). These specific challenges were addressed by the collation of other relevant material into word documents that were considered alongside the spreadsheets using the note function within the cells of the spreadsheet to input direct quotes for easy reference to provide the thick description that best supported a summarised comment.
5. Interpretation

Interpretation developed, as further analysis took place through the process of charting and reflecting on the nature of comments made and the meaning behind these and the consistency of comments. For example the need and ability to better measure dignity, reporting to the Trust Board on this and the use of exemplars from other areas of healthcare management that included infection control. Links and associations were also made between themes and these were, in some cases, drawn together or the themes and sub themes retained with an acknowledgement that a particular issues was relevant across a number of themes. An example of this was the contrast of meaning of dignity that had been identified between the patient experience at the individual level and the focus of healthcare professionals and senior managers and executives that was often related to systems and initiatives. This was evident in the themes of: patient experiences in hospital, understanding of, and attitude towards the Dignity in Care campaign, and wider issues that were raised around dignity. There was a also sense of gaining coherence through interpretation by considering the opposing aspects of an issue within a theme such as organisational change as identified within example 2, Box 3.6.

In addition hunches were identified when exploring and interpreting the data and again these were highlighted in a reflective journal to be developed and considered further. An example of this can be seen in Box 3.7 relating to how dignity ‘fitted’ within the thinking of healthcare professionals and senior managers.

<table>
<thead>
<tr>
<th>Box 3.6 Excerpts from reflective note on process of analysis - Example 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpretation – gaining coherence</td>
</tr>
<tr>
<td>10th December 2010</td>
</tr>
<tr>
<td>• Challenges and enablers - considering these as flip sides of each other instead of standalone themes</td>
</tr>
<tr>
<td>- Organisational change offering challenges such as vacancies in line manager posts, focus on new structures delaying work on dignity - flip side does provide opportunities through bringing new ways of working and new people and ability to put dignity at the top of the agenda and include in new business plans</td>
</tr>
<tr>
<td>- Operationalising dignity – translating into practice – similarities to the comments on culture and translating vision and values into behaviour, use of role modelling - flip side is challenging people’s attitudes and lack of leadership</td>
</tr>
<tr>
<td>- Equivalence / agreement between patients not wanting to be left and feeling that nurses are very busy and don’t have time for them and comments by healthcare professionals and managers on the whole about the need for staff to have more time to spend with patients</td>
</tr>
<tr>
<td>17th December 2010</td>
</tr>
<tr>
<td>• Flip sides of challenges and enablers much clearer after further charting work on the framework – now six sub themes of - Operationalising Dignity, Organisational Change, Privacy &amp; Environment, Resources, External Drivers, Feedback and evaluation</td>
</tr>
</tbody>
</table>
This process of interpretation also involved a constant checking of participants transcripts for confirmatory data that was then able to identify the numbers of participants who agreed with a particular issue. An example of this can be seen in the number of patients who felt strongly about the inappropriateness of the continued use of mixed sex accommodation.

In summary, the framework analysis method has provided a clear and systematic method to inform the management, meticulous referencing and analysis of the large amount data gathered from the 34 interviews and reviews of documentary evidence. The final overview of the themes and sub themes can be seen in Table 3.8. The next section will discuss how this evaluation has been able to demonstrate rigour.

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**Box 3.7 Excerpts from reflective note on process of analysis - Example 3**

**Interpretation – developing ideas for discussion**

10th December 2010

- Interesting to note how people describe dignity in relation to initiatives as opposed to what it means to people – has the increased focus on dignity and all the work that has gone morphed people’s view of what dignity is so that their point of reference when talking about dignity is protected mealtimes or national standards and quality markers as opposed to patient experience

17th December 2010

- Note about the way that particularly managers but also healthcare professionals try to ‘fit’ dignity in their thinking into the frameworks and structures that they have i.e., as part of new business plans, with individuals responsible, almost from a project management perspective that has the risk of compartmentalising it as an issue that is being dealt with through a process – however patients do not see Dignity in this way as they see it from the individual interaction and whether this affords them respect and courtesy and privacy or not and in relation to the care and communication that they observe to other patients -

*Identified at this stage as an idea to develop further during the discussion around how this change in language to talk about dignity in organisational terms distances managers and healthcare professionals from patient experience*
Table 3.7 Overview of Themes and Sub Themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient experiences in Hospital</td>
<td>1. Experiences of dignity and vulnerability</td>
</tr>
<tr>
<td></td>
<td>2. Privacy and mixed sex accommodation</td>
</tr>
<tr>
<td>2. Understanding of, and attitude towards,</td>
<td>1. Endorsement of the Dignity in Care campaign</td>
</tr>
<tr>
<td>the Dignity in Care campaign</td>
<td>2. Individual involvement and responsibilities</td>
</tr>
<tr>
<td></td>
<td>3. Attitude of staff towards patients’ dignity</td>
</tr>
<tr>
<td>3. Dignity Training Workshops</td>
<td>1. Motivation to attend Dignity Training Workshops</td>
</tr>
<tr>
<td></td>
<td>2. Feedback on the Dignity Training Workshops</td>
</tr>
<tr>
<td></td>
<td>3. Personal commitment from the Dignity Training Workshops</td>
</tr>
<tr>
<td>4. Improvements identified as supporting</td>
<td>1. Raised awareness</td>
</tr>
<tr>
<td>Dignity for patients</td>
<td>2. Initiatives to improve dignity for patients</td>
</tr>
<tr>
<td>5. Challenges and Enablers related to the</td>
<td>1. ‘Operationalising’ Dignity</td>
</tr>
<tr>
<td>the Dignity in Care campaign</td>
<td>2. Organisational Change</td>
</tr>
<tr>
<td></td>
<td>3. Nurses’ ability to meet patients needs related to dignity due to time</td>
</tr>
<tr>
<td></td>
<td>constraints</td>
</tr>
<tr>
<td>6. Wider issues raised around Dignity</td>
<td>1. Training</td>
</tr>
<tr>
<td></td>
<td>2. Improving the patient experience</td>
</tr>
<tr>
<td></td>
<td>3. Performance management</td>
</tr>
</tbody>
</table>

3.8 Reflexivity and Promoting Rigour

Considerable debate has taken place over the evaluation of quality and rigour in qualitative research (Sandelowski, 1986; Sandelowski, 1993; Koch, 1994; Koch & Harrington, 1998; Slevin & Sines, 2000; Maggs-Rapport, 2001; Sandelowski & Barroso, 2002; Rolfe, 2006) with a range of approaches proposed for researchers to be able to demonstrate rigour. These range from alternatives to the positivist approaches to rigour through the use of terms of: credibility, transferability, dependability, and confirmability proposed by Lincoln and Guba (1985) to replace the established validity, reliability and generalisability. A similar set of terms of: credibility, fittingness and auditability were proposed by Sandelowski (1986) and Beck (1993).

These terms also need to be considered in light of the evaluative nature of the study. In relation to credibility House (1980) makes a compelling argument for coherence of evaluation reports being an essential component in the degree to which audiences will perceive it as credible. Every evaluation, he says must have a minimum degree of coherence: “the minimum
coherence is that the evaluation should tell a story. There must be either an explicit or tacit sequence of events (or more accurately interpretation of events) for the reader to use as a guide to valuing” (House, 1981, cited in Patton, 1990, p. 102). In addition, ‘coherence’ in the analysis and reporting of an evaluation may also be considered as to whether the voices of participants have been represented fairly and that can they see that the conclusions reached are evidenced in the data itself. This issue of presentation of the study is also addressed by Maggs-Rapport (2001, p. 380) who identifies that an integral element of ‘good evidence’ is the dependability of a study in displaying the appropriateness of the science behind the method and the effective transference of knowledge to others should be of paramount concern. I would suggest that credibility and coherence has been achieved through the detailed and transparent record of the data collection and analysis process of this study presented within this thesis.

In relation to transferability Parlett and Hamilton (1976) identify that whilst the goal of illuminative evaluation is not to generalise to other settings, they have argued that certain common elements may emerge which may be useful in ‘illuminating’ similar processes in related contexts. Whilst the contextual nature of the organisational culture may be very different from one healthcare Trust to another there may be some similarities between acute healthcare NHS Trusts in relation to their adoption and implementation of national targets and campaigns that could prove beneficial to other organisations. However, it is argued that the level of detail provided on the context of the organisation and the participants in this study enables the reader to determine for themselves whether their setting is similar, and hence consider the relevance and transferability of findings from this study to their own organisation and area of practice.

In relation to dependability and confirmability Maggs-Rapport (2001, p. 373) identifies the importance of defining the relationship questions and methodology as part of a whole approach to methodological rigour. It should be recognised that the methodological approach as much as the study findings, helps define participant and researcher experience. Furthermore, the case for reflexivity to be a fundamental part of the process of undertaking qualitative research and presented within a research report has been eloquently made (Koch, 1994; Koch & Harrington, 1998; Rolfe, 2006). A reflective journal, it is argued, enables the reader to have a clear insight into the numerous decisions that are made by “detailing each interpretative turn of its makers” (Koch & Harrington, 1998, p. 889) so that the reader is able to decide if it is believable and plausible. A reflective journal was kept throughout the study and
in particular during the interview period and analysis period with extracts used, as described earlier in the process of interpretation (see examples within Box 3.5, 3.6 and 3.7), to detail the researchers thinking, giving a clear audit trail of the decision making at different stages of the research process.

3.9 Chapter summary

This chapter has provided a clear justification and detailed understanding of the research approach of illuminative evaluation and how this has informed the study design. Sampling of patients, healthcare professionals and senior managers has also been described that has protected both patients and healthcare professionals. The step by step process of analysis has been described to promote an understanding of some of the nuances of analysis and interpretation that are not often easily represented within published qualitative studies. Finally the documentation of the research process and reflexivity throughout that process provides a clear audit trail to support the credibility and coherence of the study. Having clearly set out the strategy and processes for the study the next chapter presents the findings from the data sources to build a picture of the complex range of issues involved in the response to the Dignity in Care campaign within the acute healthcare Trust where the study took place.
Chapter 4  Findings

4.1 Introduction

Chapter 3 set out the methodology for the study, the particular approach used for this evaluation, sampling, data collection and the process of analysis. This chapter presents the findings that have been developed from the framework analysis into six themes and sixteen sub themes, as identified in Table 3.7, that encompass all three data sets for patients, healthcare professionals and senior managers. As has been discussed in the methodology chapter, (3.6.1.1, 3.6.2.1 and 3.6.3.1) in order to meet the aims of the study, there were some differences in the questions asked of the patient group as compared to healthcare professionals and senior managers and executives. This also led to decisions being made around the integration of data from the three different groups during analysis. As a result, patient data is integrated for each group throughout the findings, although this data features more strongly in some themes as opposed to all of the themes. These include: Theme 1: Patient experiences in hospital, Theme 2: Improvements identified as supporting dignity for patients, Theme 5: Challenges and enablers related to the Dignity in Care campaign, and Theme 6: Wider issues around dignity.

4.2 Theme 1: Patient experiences in Hospital

The main focus of this theme is patient experiences in hospital which has primarily drawn on the data from patients. Whilst a wide range of experiences related to dignity were identified two sub themes have been considered of: 1. dignity and vulnerability, and 2. privacy and mixed sex accommodation, which was a particular area that the study looked at and was included in the interview schedule for patients. The two sub themes related to this theme can be seen below in Box 4.1.

<table>
<thead>
<tr>
<th>Box 4.1 Theme 1 Patient experiences in Hospital - sub themes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sub Themes</strong></td>
</tr>
<tr>
<td>1. Experiences of dignity and vulnerability</td>
</tr>
<tr>
<td>2. Privacy and mixed sex accommodation</td>
</tr>
</tbody>
</table>

4.2.1 Sub Theme 1: Experiences of dignity and vulnerability

Patients were asked about their current and previous experiences in hospital and whilst there were a couple of positive experiences of the treatment and care that patients had received (P6 & P9), on the whole the examples given by patients were of a range of difficult experiences. Key issues from patients’ experiences are summarised in Box 4.2.
Box 4.2 Range of patient experiences related to Dignity and Vulnerability

- Patients having very little control in what they could do as part of their daily activities and routine (P1 & P2),
- Lack of facilities to be able to get a drink water independently, make a cup of tea or fridge space on a ward to keep food (P1)
- Noise and disturbance to the point of not being able to sleep (P2 & P3)
- Loss of privacy and being left exposed with hospital gowns (P1, P2, P5, & P9)
- Lack of information and communication between different professionals involved in a patients care (P1, P2, P5, P6, & P9)
- Being left cold when a nurse had not returned with an additional blanket (P3)
- Nurses did not have time to spend with them or return to them when they said they would (P3)
- Patients observing incidents where there was a lack of care and dignity towards other patients (P1, P2, & P3)

An example of the routine of the hospital that led to a loss of control and choice, and a sense of ‘putting up’ with the experiences of being in hospital can be seen below:

“it’s quite intrusive you know, but that’s part of what having an illness is you know, you’re coming here for people to look at you and they prod you and take blood and stuff. But it’s an institution and you have to go along with the, you know, the rules of the institution, not that I want to break them but you know, you have to get up at a certain time, eat at a certain time turn the lights off at a certain time. And that takes a bit of getting use to, but I don’t let that phase me I just think I’m here to get well and you just do what you have to do.” (P2, 52-58)

Disturbance was also a particular issue that three patients experienced and for some this was noise from other patients, their televisions and staff (P1, P2, & P3), for other patients it was where the lights were left on or it appeared that they could not be turned off in the ward above the bed area (P2):

“the annoying things are the things that don’t work, like that light doesn’t work. That light doesn’t go off and if they turn that off they turn the other lights off, so they can only turn that light off at 1’0 Clock. So I stay up till one. Because it just shines right in and that’s annoying. And bins don’t close properly so they just put a foot on the pedal and it just slams down and you know I just think those things are unnecessary [...] Well they don’t have them on this ward [silencers for rubbish bins] and I’m quite easy going and my friend came in a she said, “Oh my god, report it, report it”, and I said, “I’ll report it when I’m going home.” (P2, 58-62)

This level of disturbance from noise and light was identified by these patients as being a key element of their experience that they had no control over managing (P1, P2 & P3), but they felt unable to complain (P2). The noise affected their ability to sleep and function normally (P1 & P2) and increased their sense of vulnerability about being in hospital and not being treated as
an individual. Noise at night was also an area where the Picker Patient Survey results for the previous year had indicated that the Trust performed below the national average. Whilst important to patients, these examples relating to the hospital routine that limited an individual’s choice and control, and noise and light disturbance affecting the patient’s ability to sleep were not identified by healthcare professionals in the Trust gap analysis of practice and policies against the ten points of the Dignity in Care campaign.

There were three examples from patients where they had witnessed incidents of a lack of care and dignity towards other patients (P1, P2, & P3). These examples highlighted aspects of vulnerability related to; older people, patients with confusion or dementia (P1 & P2), and those patients where English was not their first language (P1). In addition two of the incidents witnessed related to patients who had fallen (P1 & P2). It was acknowledged by each of these patients interviewed that this would probably not have happened to them as they would have been able to speak up in some way to protect their dignity; however it did contribute to their own sense of vulnerability of being in hospital and fears that that could happen to them in the future. The impact of witnessing this lack of care and dignity was felt to be an upsetting experience:

“there was one incident where he fell over and one of the junior nurses came over and was just, I thought she was quite hideous in the way she dealt with him and just kind of walked off and left him there and said I’m not, I can’t pick you up and he has been told so many times and I just thought it was really out of order to speak that way in front of other patients and somebody, they came back fairly quickly with somebody but the way she spoke was just I thought really out of order and it made me quite angry to observe it – you know he obviously has his difficulties and English wasn’t his first language and you know she just kind of walked off and left him there and was kind of quite cold towards the way she spoke to him, so just some of the observations you kind of can be a little bit upsetting to watch when you see people being just vulnerable, you know being potentially treated like that” (P1 48-60)

It is interesting to note the specific reference by this patient to ‘junior’ nurse where it is implied the nurse was younger and less experienced, and appears to be less caring towards the patient who had fallen. Whilst the points relating to vulnerability within this example relate closely to some of the issues identified by patients, in particular the examples of a lack of care and dignity, a number of the other issues identified in earlier in Box 4.3 could also be considered as leaving patients feeling vulnerable, relating to loss of control of their environment, lack of facilities, and a lack of information.
These experiences present a wide range of elements of dignity and vulnerability that in some cases differ in the ways in which patients describe aspects of dignity as compared with healthcare professionals and managers. The second sub theme that is discussed looks specifically at experiences related to privacy and mixed sex accommodation for patients in hospital, which was a particular area that the study explored.

4.2.2 Sub Theme 2: Privacy and mixed sex accommodation

A central issue for patients was privacy, which was identified in a number of areas of their care, such as having to use a commode by the bed (P1), and the lack of attention paid to patients’ privacy when providing some care to them and the use of hospital gowns (P1, P2, P5 & P9). Three healthcare professionals also identified as a particular problem where dignity was not maintained because gowns were often left untied, or did not provide sufficient cover so patients felt this caused a loss of dignity (H5, H7 & H8). In addition the Trust Dignity Steering Group minutes identified a proposed pilot of new more dignified hospital gowns within the admission wards, however this had not progressed at the time of the study. Furthermore, patients who observed other patients experiencing a loss of privacy had increased feelings of vulnerability (P2 & P5). Examples of where patient’s privacy was compromised can be seen in Box 4.3.
Box 4.3 Examples where patient privacy was compromised

Privacy related to use of a commode next to the patient’s bed - Patient
“just being in a bed in an open ward and you know not having the curtain around you and you know going to the toilet a lot and having urgency and at night having to use a commode by the bed is difficult – you just have to get on with it” (P1 36-39)

Lack of attention paid to privacy - Patient
“they don’t often pull the curtains when they’re examining, not really examining them, but having them doing exercise and things. And I sit right here and you can see up their gowns and you know catheters and things, you know it’s, they’re not aware, you know the patient isn’t exactly aware, so I think when there is a patient that is not fully aware, they’re often not as careful [...] and I had visitors in and you could see her bag, bladder bag or whatever you call it, hanging down and I actually had to say, “Nurse can you just get a blanket to put over her knees”. You know, so I think it’s alright for people like me, but I think its hard on the elderly, and I think, even if they don’t know that their dignity is being not violated but you know it isn’t being protected, I still don’t think it’s right” (P2 85-88 & 102-107)

Recognition of the lack of privacy related to Hospital Gowns – Healthcare Professional
“quite a number of complaints we would get [...] was about patients’ dignity. A classic example was that relative would come in and find that their mother was in a gown that was open at the back so it was about the kind of feedback we were getting through complaints that relatives or families were unhappy or concerned about the dignity of the patient. And that’s how it kick started it for me. There were other things you know, you go around the hospital and you’re observing patients’ being wheeled in chairs, men wearing gowns and being exposed and that’s something I’ve been working on for a number of years [...] But as you walk around the hospital you can see it’s happening everywhere.” (H5 32-40)

Each of these examples further highlights the vulnerability of patients being exposed where they had little or no control over the situation. A major concern for half of the patients interviewed both on their previous and current admission was that patients of both genders were mixed within bays (P1, P2, P3, P5, & P9). This was something that has previously been referred to in the context of the Trust, in section 1.7, as it had been identified in the National Patient survey as an area where the Trust had performed below average as compared to other acute healthcare Trusts. There was also a sense that patients did not have any choice or information in where they had been placed on a ward. When this was alongside patients of the opposite sex there was a sense that they had to put up with it. The example below refers to the experience of a male patient who described very clearly how intimate and private procedures to a female patient in the bed next to him were easily overheard causing acute embarrassment:

“I didn’t like it and I’ve never liked it, I have written in to the hospital before [...] there was a woman moved in the bed next to me who was ninety odd and the woman over
the road was ninety-two and because you can’t help but hear, the ninety year old was having a woman’s catheter put in, which I probably found more embarrassing than she did and I’m really not happy, I know it’s done but I’m not a believer in it, I know it’s done for shortage of beds and it’s mainly in the observation wards that you get the mixed but I don’t think it’s fair on either sex. I know they say men should get used to it, but men make funny noises at the best of times, when you know you’ve got a ninety year old lady next to you it’s not nice” (P5 40-51)

When talking about their current experience two patients (P5 & P9) highlighted that the government was supposed to be eradicating mixed sex wards, however this did not appear to have happened. One patient commented on the contradictory guidance for hospitals seeking to have single sex wards on the one hand and on the other hand being expected to run at full bed occupancy:

“The one thing I think is still the same thing, it should not be mixed wards wherever they are. I mean I can understand that bit being men and this bit being women, even like on the main wards, if they’ve got a bay of six women, but I’ve been on a bay of six men and if there’s an empty bed it could be a women that’s put in or vice versa, you could be the only man amongst five women which I don’t think is fair to either sex, I really don’t. I know that Government policy is to have the hospitals running at full occupancy” (P5, 153-159)

However, this was not the experience of all patients as a few patients (P1 & P9) did identify that they had been in their own room or a single sex ward:

“No I wouldn’t have that, I don’t believe in that. The Government was going to do that a long time ago ...., separate them, but they wasn’t doing it, but they do it in here don’t they, cause they’ve got the different wards, which is the best thing.” (P9 30-32)

Whilst patients talked from their own personal experience of what it was like to be in a mixed sex bay, healthcare professionals appeared to take a pragmatic approach given the constraints of the environment they are working in:

“I think it’s important that we have a mixed sex ward, but by that we don’t have patients on the same sort of environments so each bay is male or female, we don’t mix the sexes as such [...] Then you get into the scenario, where do people go to the toilet? Are we using single sex toilets? I think the answer is, we try our best, but we don’t always have the toilets labelled male or female use, it very much depends on need and necessity.” (H2, 41-49)

Echoing an earlier point made by a patient about full bed occupancy and bed shortages (P5), a healthcare professional identified the capacity of the hospital around bed management and
availability meant there were times when patients were admitted to mixed sex areas due to these constraints:

“The bed issues continue to be a problem of moving patients quickly through the system, so I think that can be done but people need to be very aware of the dignity issues around it as well.” (H10, 177-179)

This again may be seen to refer to the contradictory nature of managers and healthcare professionals trying to meet an access target at the expense of a meeting a patient’s needs for dignity in care. However at a senior management level an action plan was drawn up to eliminate mixed sex accommodation that had been required by the strategic health authority. The main focus of the action plan was identified responsibilities for senior nurses and managers for increased monitoring through daily audits and reporting of any occurrences of a breach of single sex accommodation. Only one reference was made in the action plan to the need to canvass feedback from patients on their views and expectations in relation to mixed sex accommodation.

An example where special recognition was given to protecting privacy was within the maternity ward which stood out as an exemplar of good practice:

“we always are very particular because we are aware that it’s very intimate examinations that we do and all our rooms have a door and then have a curtain between the door and the bed, because sometimes you do have to have the door open, especially if you’re looking after more than one woman in labour but you can still pull the curtain in that respect.” (H3, 49-52)

This raises the question as to how privacy and dignity appears to be given a different level of importance within a maternity setting as opposed to a ward with older people.

It can be seen that the experiences of patients do not respect their right to privacy and contrast with the approach of healthcare professionals, where the focus of healthcare professionals was on the constraints of the environment they are working in and how they can best manage patient privacy as opposed to those of patients who found the practical aspects of being in a mixed sex bay embarrassing and considered that it should no longer be happening. Indeed the introduction of further monitoring to eliminate mixed sex accommodation created an additional ‘top down’ target which was undertaken without wider engagement of staff and patients. The next theme explores in more depth the understanding of the dignity challenge by healthcare professionals and senior managers and a range of attitudes towards the dignity challenge.
4.3 Theme 2: Understanding of, and attitude towards, the Dignity in Care Campaign

This theme was drawn predominantly from healthcare professionals and senior managers and executives by eliciting their understanding of the Dignity in Care campaign. Consideration has also been given to the roles and responsibilities for Dignity in Care and the individual contributions towards improving dignity for patients. A wide range of attitudes to dignity was also identified as well as expectations of how staff should behave towards patients. The sub themes of this theme are listed in Box 4.4.

Box 4.4 Theme 2 Understanding of, and attitude towards, the Dignity in Care campaign and sub themes

Sub Themes
1. Endorsement of the Dignity in Care Campaign
2. Individual responsibilities and roles
3. Attitude of staff towards patients’ dignity

4.3.1 Sub Theme 1: Endorsement of the Dignity in Care campaign

There was wide recognition amongst senior managers and healthcare professionals of the importance of the Dignity in Care campaign as a national campaign as well as a good understanding of how this was being adopted within the Trust. One senior manager (S1) made specific reference to the date of the launch of the Dignity in Care campaign, whilst five healthcare professionals (H1, H2, H4, H6 & H11) and three senior managers (S1, S3 & S5) talked about the ten point dignity challenge and that the Trust had identified priorities from these to focus on making improvements in the way that care was provided for patients. For one senior clinician (H13) the Dignity in Care campaign was seen as a re-badge of earlier work on standards set out in the National Service Framework for older people:

“I think it’s finally officially been recognised by people in the Department of Health that dignity is a major concern for people using our services and I think the emphasis tended to be on clinical issues, you know people getting good quality treatment, but particularly from the NSF for Older People it became certainly apparent from speaking to older people themselves that the things that they were most concerned about was being treated in a way that didn’t acknowledge that they were people in their own right, you know being treated with a lack of respect and dignity and this is something that the Department of Health has taken on board in the last year or so I think and it’s been rebadged as the dignity challenge and we are now challenged to treat people in a way that respects their rights and maintains their privacy” (H13 4-15)
The vulnerability of patients was recognised by six of the fourteen healthcare professionals (H1, H2, H6, H7, H8 & H10) and over half of the senior managers (S4, S5, S6, S7, S8 & S10) as a central focus of the Dignity in Care campaign as identified below:

“But for me, where the dignity challenge certainly is most important, is where the patient, for whatever reason cannot make decisions about their treatment, or have some impairment of decision making and who are vulnerable in the hospital system, so people for whom we need to be extra specially alert [...] and it’s about basic standards of care for the most vulnerable people in our hospital and that for me is the frail elderly, and the frail elderly particularly with cognitive impairment, so that’s certainly for me why the dignity challenge is important, because it’s actually highlighted the particular problems that that group of patients actually face within acute services.” (H8 5-21)

Both healthcare professionals and senior managers talked about how they understood elements of dignity as relating to specific aspects of care. These are summarised in Box 4.5.

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<thead>
<tr>
<th>Box 4.5 Understanding of elements of Dignity (Healthcare professionals, Senior Managers and Executives)</th>
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<tr>
<td>- Respect toward patients and between professionals (H2 &amp; H4)</td>
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<tr>
<td>- Safeguarding and protection of vulnerable adults (H6, H11, S1)</td>
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<tr>
<td>- Right to privacy and to ensure that patients were not exposed (H5, H6, H7)</td>
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<tr>
<td>- Ability for patients to feedback their concerns and addressing concerns at ward level (H12, S2)</td>
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<tr>
<td>- That patients have choices and ability to be as independent as possible (H2)</td>
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<tr>
<td>- How we communicate with patients including calling the patient what they want to be called (H5, S3)</td>
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<tr>
<td>- Advocacy (H6, H9)</td>
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<tr>
<td>- The environment (H6, S1 &amp; S7)</td>
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<tr>
<td>- Making sure that all the appropriate arrangements are made in preparation for discharge (H12)</td>
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The range of patient experiences related to dignity and vulnerability identified in Box 4.2 differs from that of healthcare professionals, senior managers and executives understanding of the elements of dignity. Both groups identified the importance of privacy and patients not being exposed, however there were a number of points that were quite different between the groups. For example patients included points to do with having choice and control in relation to noise and disturbance and being able to make a cup of tea, whilst healthcare professionals and senior managers spoke in terms of those elements of dignity defined by the national campaign, such as ‘Safeguarding of Vulnerable Adults’, the need for ‘Respect for Privacy’, and the importance of patients having choices and the ability to be as independent as possible. This contrast between patients’ concerns and healthcare professionals’, senior managers’ and
executives’ perspectives of dignity suggests a different way of thinking about dignity that for healthcare professionals and senior managers does not appear to be grounded in the personal experiences of patients. However one healthcare professional expressed the issues of dignity in care much more from the patient perspective as opposed to discussing them in terms of the elements from the Dignity in Care campaign:

“The dignity challenge was actually to make people aware of the dignity of the patient, making sure they called the patient by what they actually wanted to be called, making sure that the patient was dressed, so that they were not half naked, making sure that the curtains are always pulled round the bed if the patient was being washed, and that people didn’t barge into that area if the curtains were closed. Making sure people were aware that if the curtains were closed then they would have to ask if it was alright for them to go in or if the person could come out and speak to them or if they could wait until later on for an answer. Making sure when someone was being washed they were covered as well so that they weren’t being exposed at all times.” (H7, 18-25)

Whether such initiatives were going on in other hospitals was also questioned: “I think if you went to another hospital […] they might not have even registered it [dignity in care campaign]” (H11, 35). For a number of healthcare professionals and senior managers there was a sense of shame and insult to nursing that there was a need for a Dignity in Care campaign (H6, H9, H10, S1 & S3), for example:

“In some ways I feel the dignity challenge is almost an insult to nursing … I think dignity should be at the very heart of everything we do as nurses, and I felt in one way it was very sad that we actually had to have it challenged to promote patients’ dignity. On the other hand from the positive perspective I think it has focused everybody’s minds on what’s important to patients and it has made us sit up and address these issues that clearly we haven’t addressed or continuously addressed to date. So it’s really about promoting the patient’s dignity in every aspect and particularly people who are vulnerable and are much more likely to lose their dignity through illness or infirmity or just being frail and it’s about promoting that and protecting that more than anything else.” (H10, 3-13)

This quote further endorses the importance of dignity in care for patients, as well as recognising the need for greater attention to be given to addressing concerns around lack of dignity to patients. It may also describe the way that concerns raised at a national level have been instrumental prompting the need for a national campaign on Dignity in Care. At a local level there was recognition of the need for a greater focus on dignity due to recent poor results in the National Patient Survey (H5, H8, H9, S1, S3, S4, S9). In particular the results of the National Patient Survey had identified concern related to: having confidence and trust in nurses, not getting clear answers to questions from nurses, getting the chance to talk to a
nurse when needed, and patients feeling that both nurses and doctors were talking in front of them as if they were not there. One healthcare professional (H10) and one senior manager (S5) identified that there was a “huge task” (H10 233) ahead to improve dignity for patients and recent work was just the beginning. A metaphor of a journey was used by the healthcare professional that describes a long road back for some staff to providing dignity in care to patients:

“I think that we’ve only just begun and I think that it’s a long road and I think that it’s fantastic that we’ve started you know this whole sort of emphasis on dignity because it’s really, really so important. And with our population ageing, living longer, having sort of multiple pathologies coming into hospital is going to put them more and more at risk, and I think that we really need to up our game in this area and change our whole approach to the older person in hospital and it’s going to take a huge task to do it, continuous education and emphasis and endorsement from senior people, but I think it’s a really good thing to be doing and I think every aspect of it needs to be addressed and I don’t think you know, in a Trust like this it is any use whatsoever having superb outcomes from clinical trials if we fail the individual as a person and if we don’t ensure their dignity” (H10 227-237)

The use of the term game in the above quote is interesting as it points to an overall team or service performance, as opposed to an individual approach to dignity in care, and references to the need for education and endorsement contrast with patients’ experiences of dignity and vulnerability, set out within the first theme.

This sub theme has illustrated that there was a high level of understanding of the Dignity in Care campaign and consideration of what dignity meant in practice, however this was often discussed in terms of the ten elements of the Dignity in Care campaign as opposed to patient experience. Indeed while some healthcare professionals and senior managers acknowledged the nature of dignity and vulnerability a contrast can be seen with the patient experience theme in how dignity is referred to, with an approach that appears to be focussed on the service and systems as opposed to the experience of patients. This theme also identified a sense of shame at the need for such focus on dignity and recognition of the significant work involved and a long journey back both for individuals and the hospital given recent poor results from the National Patient Survey.
4.3.2 Sub Theme 2: Individual involvement and responsibilities

A wide range of types of involvement in the Dignity in Care campaign work by healthcare professionals, senior managers and executives was evident, with particular contributions to improving dignity for patients related to individual roles. This demonstrated strong engagement by these groups of professionals interviewed. Involvement included can be seen in Box 4.6.

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<tr>
<th>Box 4.6 Involvement by Healthcare Professionals and Senior Managers in the Dignity in Care campaign</th>
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<tbody>
<tr>
<td>- Patient and public involvement through focus groups on dignity (S 10)</td>
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<tr>
<td>- Their role within elderly care (H5, H10, S7)</td>
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<tr>
<td>- Participation in the Hospital Dignity Steering Group (H5, H10, S2, S7 &amp; S10)</td>
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<td>- With spiritual care and support (H1)</td>
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<tr>
<td>- As a dedicated lead for quality in the Hospital (H9)</td>
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<tr>
<td>- Having co-facilitated dignity training workshops (H6, H7 &amp; S1)</td>
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<tr>
<td>- Involvement in training on dementia (H1 &amp; H8)</td>
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<tr>
<td>- Attending values workshops (H5 &amp; S2)</td>
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<tr>
<td>- Leading on work around the promotion of red pegs (H5 &amp; H9)</td>
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<tr>
<td>- All aspects of the role (H10)</td>
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<tr>
<td>- Involvement of staff in a patient and carer experience discovery interview study (Documentary evidence)</td>
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For one healthcare professional (H10) dignity was about their personal and professional ethical approach towards people, in all aspects of their role:

“Well it’s very central to my role because I think it’s such an all encompassing and it’s such a pervasive concept that really it starts from the very point of your contact with an individual, the way you speak to them. You know even if you walk past somebody who looks like they’re a little bit lost, you’re denying them a little bit of dignity I think, particularly as we are or we profess to be caring individuals and we profess to be professionals, so I think if we really were as professional as we claim we are we would stop and help people. So I think that’s the very, very beginning [it] is addressing people appropriately and giving people your time, that affords them dignity.” (H10 15-21)

Two examples of references to individual’s involvement and contribution can be seen in Box 4.7.
Involvement in patient and care focus groups

“we set up a series of focus groups so we could bring users and carers together to really try and assess what their knowledge was and how much awareness there was about the dignity challenge and to get them to really contribute to the discussion and to tell us what their experience was and what their priorities were, how they’d like to see us take some of the issues forward so I think that was a very successful piece of work and I think you know we need to now make sure that we build on that” (S1 40-45)

Involvement in training on dementia

“[I] contributed to some of the workshops that they’ve been doing for the dementia project [...] I was on the panel if you like [...] I would join the group for the last session for about an hour and to use the term broadly it was about ethical care of elderly people [...] I thought those were very useful and for me it was quite an eye opener to realize that actually a lot of attitudes towards elderly people depends upon where you as an individual in the spectrum” (H1, 157-169)

A particular area that was highlighted was around who is responsible for the dignity of patients. Two senior managers (S3 & S9) made comments on the responsibility for dignity lying with nurses as the professional group that provide the greatest amount of care to patients and are in a unique position to lead and role model their behaviours to other staff, however this can sometimes be perceived as other professional groups not taking responsibility for the dignity of patients. The value of the Dignity in Care campaign being multi-professional was also highlighted by both healthcare professionals and senior managers (H1, S1 & S6). There was also a recognition that nurses did not need to be wholly responsible for dignity in care for patients (H8 & S10) and that other clinical staff, such as therapists and medical, should be expected to take greater responsibility for dignity of patients. However, it was not questioned that nurses had a particular responsibility for dignity, indeed the comment below illustrates the view that ward charge nurses are in a key position to effect change:

“I think it’s up to people locally and I would say the ward sisters and the ward charge nurses to really take the rein on this for their ward areas and to try and implement it and really get the message across to everybody, look this is really, really important” (H2, 92-95)

Whilst it can be seen that there was some differences in relation to where the responsibility lies between healthcare professionals, there was a wide range of involvement in work to improve dignity for patients that individuals saw as an integral part of their role, as opposed to additional work on top of their existing responsibilities.
4.3.3 Sub Theme 3: Attitude of staff towards patient’s dignity

There was a breadth of issues identified about the attitude of staff towards patients’ dignity and these were considered as two related elements of challenges, and expectations of staff attitude. A key challenge that was identified was translating organisational values into attitudes and behaviours, which was raised by one healthcare professional (H5) and half of the ten senior managers (S1, S2, S3, S5 & S8). Negative feedback from patients on staff attitude was identified as a particular concern (S7, S8 & S9) as well as the difficulty in challenging attitude and behaviour (H13, S3 & S7). Concern was raised around the nature of clinical treatment and care having become more technical and this being seen as having greater importance than caring aspects of clinicians (S5). Perhaps related to this, was a concern voiced around the vocational nature of nursing and whether this is still the case given the academic qualifications that individuals can gain as part of their training (S1). Examples of these challenges related to attitude of staff towards patient dignity can be seen in Box 4.8.
Closely associated to some of the challenges that were identified, which were related to staff attitude, were expectations of staff towards patients’ dignity. In particular, in seeking to address the challenges around attitude it was identified that there was a need to reconnect with “old fashioned values” (H6 12) and the fundamental basics of nursing (H6, H9, S1, S3 & S7). Furthermore, an expectation was identified that dignity towards patients, carers, staff and the public should be part of “really good customer care practices where staff go out of their way everyday to make patients feel safe and understood” (S1 74) as opposed to the structured patient contacts. This reflects an example given earlier in 4.3.2 of a healthcare professional’s view of their responsibility in relation to dignity as “central to their role [...] and all encompassing” (H10 15). One healthcare professional reflected on the media coverage of

Box 4.8 Examples of challenges related to attitude of staff towards patient dignity

Translating organisational values and into culture and attitudes and behaviour towards patient dignity

“I know staff that have been on attitude and behaviour training and communication training, safeguarding adults, dignity training, I know staff that have been on that but actually I’m not convinced that it translates into their practice. Certain staff not everybody. And I think that to take this forward we need to have staff, more staff than what we’ve got on board to understand the importance of it and accept that they have a responsibility in delivering this challenge.” (H5 56-160)

Negative patient feedback on staff attitude

“You know every piece of patient feedback talks about staff attitude and I know we are doing something to tackle it but I am not sure we are doing enough” (S7 111-112)

Addressing concerns around staff attitude and behaviour can be difficult

“One of the huge things that we need to address is staff attitude and I am not sure we are doing that well enough now and I think that’s a huge priority and that’s staff attitude to each other as well to patients because if you don’t get it right to each other then you know it’s not going to happen with staff to patients” (S7 99-103)

Recruitment of the right individuals into nursing

“I think we maybe are not are always attracting the healthcare staff into the profession that we maybe would like to attract in – we’ve got some fantastic students and we’ve got some poor students we’ve got people who clearly want a career in healthcare, we’ve got people who clearly don’t want to a career in healthcare but maybe want to get a university education or whatever - so I don’t know if that’s tied up in it a bit” (S1 152-156)

Competing aspects of nursing

“I think there may be a risk that some clinical staff see clinical care, the very technical side of clinical care as the primary raison d’être of their role and how the patients feel about the whole experience of the clinical technical care as either not their role or not an important part of their role and that there may therefore be some lagging resistance to taking all that seriously.” (S5 190-191)
examples of lack of dignity in care given to patients and its impact in raising issues and expectations. Again this is referred to earlier in section 4.3.1 where there was a sense of “shame” (S1 103) and “insult to nursing” (H10 3) that there have been major concerns around “treating people with respect” (S1 101) and that there was a need for a Dignity in Care campaign. In addition it was identified that different cultures had a role in shaping the attitude towards dignity in care for older people (H1 & S1) and it was suggested that there are lower expectations of the level of dignity in care within this country as compared to some other countries. Examples of expectations of staff attitude towards the dignity of patients can be seen in Box 4.9.

Box 4.9 Examples of expectations of staff attitude towards the dignity of patients

Need to reconnect with the basics of nursing

“It was very much around looking at things from a patients points of view, particularly a caring aspect and treating people with respect and dignity [...] I think people assume because it’s quote ‘fundamental or basic’ that everyone’s doing it and I think also that some people don’t have an awareness of their impact on other people and so I think it’s, I think generally it is high on peoples agendas but I still think there’s a few just basics that we haven’t got in place and some of those are really difficult basics but like politeness” (S3 4-5 & 72-76)

Dignity being within everything that we do as professionals

“What it means is imparting what dignity is about to staff across therapies and getting them to understand what in their day to day practice, particularly around how they treat patients’ on the ward, [off the ward] in outpatients and if they see people wandering round the hospital. So in the whole sphere of what they do, so that’s how I would kind of sum it up” (S6 3-7)

Expectations of public and media

“There’s been an awful lot of press, I think it’s in the Daily Mail in particular, about dignity on the wards focusing specifically on elderly people. I have to say the articles have not always been complimentary, they are quite sensationalist in a lot of ways and they don’t always point out the good work that goes on, it was mainly the negatives rather than the positives. But I think it’s certainly raised awareness within the general public. (H2 79-84)

Different cultures

“I think that’s a particular cultural thing in the UK you know because there are areas in the world, for instance the Mediterranean and Africa I think and other places were actually elderly people are actually treated with a great deal of respect and are looked to provide wisdom in the community” (H1 210-214)

This theme illustrates that there has been a high level of support and involvement in the Dignity in Care campaign in the hospital. Whilst some staff clearly see dignity as part of their role, and in particular nurses are seen as the main providers of care and consequently are seen as responsible for patients’ dignity, there remains some lack of clarity around whether there is a wider responsibility for dignity with healthcare professionals other than nurses. The attitude and expectations of staff towards the dignity of patients have identified some particular
challenges at an individual level, profession based, as well as wider societal concerns. The next theme focuses on a specific initiative to improve dignity in care for patients: dignity training workshops.

4.4 Theme 3: Dignity Training Workshops

Dignity Workshops were a specific training initiative to enable a wide cross section of healthcare staff to understand the elements of the Dignity in Care campaign. The training comprised of: what the hospital had chosen as key priority areas to focus on, support for staff to consider aspects of these priorities within their own practice area, and what they could do to improve dignity for patients. This theme is drawn from the data from nine healthcare professionals who attended dignity workshops and a report evaluation the first set of three workshops. In relation to the healthcare professionals, their views were explored on their reasons for attending dignity training workshops, feedback on the workshops, and what their commitment to improve aspects of dignity in their areas of practice had been as a result of the workshops. These three sub themes relating to aspects of the dignity training workshops are listed in Box 4.10.

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<tr>
<th>Box 4.10 Theme 3 Dignity Training Workshops and sub themes</th>
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<tr>
<td>Sub Themes</td>
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<tr>
<td>1. Motivation to attend Dignity Training Workshops</td>
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<td>2. Feedback on the Dignity Training Workshops</td>
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<tr>
<td>3. Personal commitment from the Dignity Training Workshops</td>
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4.4.1 Sub Theme 1: Motivation to attend Dignity Training Workshops

From the fourteen healthcare professionals interviewed nine had attended the dignity training workshops. The reasons individual healthcare professionals attended dignity workshops included: four being requested to attend by their line manager (H2, H6, H7, & H11), and five noticing information for the dignity workshops on the hospital’s internal website (H1, H3, H4, H12, & H14). However, it is of note that two healthcare professionals in a management position felt it was their role to attend and feedback to colleagues (H3 & H11). One healthcare professional, who identified that she had received an email from her line manager to attend, also reported being motivated by the enthusiasm of a colleague having attended an earlier workshop and talking about it and what he wanted to do as a result of attending (H6). Three healthcare professionals (H2, H7, & H11) reported that they had been emailed a flyer for the dignity workshops by a senior manager, for whom this was “one of her pet subjects” (H7, 151).
It is of note that from the nine participants who attended dignity training workshops nearly half of these, from different departments, attended on the suggestion of their line manager, which supports the comment made by one of the participants that “it’s very dependent on your management structure as to what is on their agenda as to what you get to” (H11, 87-88). This indicates recognition on the part of some managers of the value of the dignity training workshops. Examples of references to the reason and motivation for attendance at the dignity training workshops can be seen in Box 4.11.

**Box 4.11 Examples of reasons for attending dignity training workshops**

**Role as a manager to attend to feedback to colleagues**
“because they were advertised to go and I’m in a management position I felt that if I could go and other colleagues couldn’t attend then I could cascade the information down” (H3 12-14)

**Motivated by feedback from a colleague**
“one of the charge nurses from one of the wards actually went to the study day as well and he actually came back with all the information saying that this is fantastic we should be looking at some of these aspects that we can improve care on. And he was quite keen in looking at communication in particular for his ward.” (H6 30-34)

**Line manager expecting requesting individual attended**
“I think I might have been asked to go on one or I’m quite interested in the whole X factor emotional intelligence because I’m managing people and I’ll tell you why medicine for the elderly directorate is proactive in this area and [my clinical lead] will have said go on one, so she will have flagged it up so it’s very dependent on your management structure as to what is on their agenda as to what you get to so I will have been told to go on it also as my role as cascading I’m a manager who has all the inpatient staff to develop and following the dignity workshop I then gave it to the therapy staff in a potted version ... so I was probably selected because I would then cascade it” (H11 82-91)

**Information on Dignity Workshops from Intranet**
“From the Intranet site, and basically just looked up on the intranet site and went along and it was very very good it was very good, listening looking and seeing all the information that’s available for this type of challenge and I think it’s important as well that all staff know there are people and members of staff who are actually helping patients and improving their care ... well I’ll be honest with you – our manager [...] who is manager of the PPI she likes us to get involved in all sorts of things, so we need to get out there and part of the PALS service is to know what’s going on out there so when we have a patient that comes in and sees us we can say right there are certain training for staff about dignity and about what they need to improve on the way they are talking and communicating with patients so [she] is very much full on get involved in everything so that’s what we do we are a bit nosey really but you know” (H12 26-30 & 33-40)

This sub theme illustrates both the range of reasons that led these healthcare professionals to attend the dignity training workshops and some insight into their motivation to attend.
4.4.2 Sub Theme 2: Feedback on the Dignity Training Workshops

A key Trust document that was reviewed was an evaluation report on three Dignity Training Workshops that took place in autumn 2008. It identified a wide group of multi-professional staff attending who gave positive feedback on the content and style of day, with opportunities to share experiences and reflect on practice. Feedback also identified a number of staff who were motivated to act and ‘get started’ in improving an aspect of dignity within their own area of practice. This was very similar to feedback from those healthcare professionals who were interviewed who had attended the dignity training workshops where a range of outcomes were identified that included: reflecting on the importance of dignity (H2 & H6), considering relevance to own practice (H3, H11, & H14), sharing information and experiences (H2, H4, H6, H7 & H14) and developing understanding of different aspects of dignity (H4, H6, H7, & H14). Examples of references to these are listed in Box 4.12.
Two healthcare professionals (H6 & H7) went on to co-facilitate dignity training workshops and for one (H6) she found the structured presentation limited her ability to be more involved in the delivery and discussion of the elements of the Dignity in Care campaign and its application within the hospital. Another healthcare professional commented that it felt like a long day (H7):
“A lot of it I found was actually very interesting, I did find it quite long, but that’s probably because of what I do, I try and do a lot of the dignity stuff anyway because of what I do and how I do it. I enjoyed the fact that we had quite a lot of different specialties on the day that I was there. I think there were only four nurses on the day that I was there, the rest was actually physiotherapists, OTs, and that was quite good to see how they looked at it. On the days that I co-facilitated it, we mostly had nurses and that was probably not as mind opening as it were, because you don’t often see, from another point of view, what’s going on” (H7 57-64)

The value of the workshops being multi-professional was particularly beneficial in discussing the different aspects of dignity and identifying the things that could be done to improve dignity, which was commented on by several healthcare professionals (H1, 4, H6, H7, H12, & H14):

“I found them really interesting and just it was really good mingling with people from different areas and just trying to put across those within the group work how you could do it positively because I think a lot of the time you think oh but I haven’t got the time or I haven’t got the resources, but actually there are little things that you can put into place whether you are a healthcare assistant a cleaner, or the ward manager or a clinical nurse specialist or a doctor that can improve privacy and dignity and it doesn’t have to be costly and it doesn’t have to be time you know productive, you can actually put little things into place and if everybody’s doing it will actually you know raise the game” (H14 89-97)

This feedback has identified a range of ways in which these healthcare professionals gained from the workshops both at an individual level in reflection on the importance of dignity and its relevance to their own areas of practice as well as the value of working together in small groups and sharing information and experiences with a wide range of professionals. The combination of these factors appears to have been particularly beneficial for attendees at the workshops.

4.4.3 Sub Theme 3: Personal commitments from Dignity Training Workshops

For those attending the dignity training workshops there was an expectation that they would make a personal commitment to improve an aspect of dignity from the five Trust priorities of the Dignity in Care elements within their own workplace, which had been undertaken by all except one healthcare professional. From the nine healthcare professionals who attended the workshops the commitments identified could be grouped into tangible projects or actions to improve aspects of dignity in practice or through sharing education and resources (see Box 4.13), and a number of individuals identified changes to their behaviour to improve the dignity
and respect to both patients and colleagues (see Box 4.14). In relation to actions to improve dignity as described below in Box 4.13 these included addressing confidentiality, privacy and interruptions in an outpatient clinic (H14), making educational resources related to adult protection available to a wider group of staff (H6). The importance of sharing information and cascading this to other members of staff was also identified by five of the nine healthcare professionals (H3, H6, H7, H11, & H12) who attended the workshops.

Box 4.13 Examples of personal commitments following the Dignity Training Workshops related to projects or actions to improve dignity for patients

Sharing information and cascading the training to other staff (H3, H6, H7, H11 & H12)

“I formulated a shared drive to put things on, so on the therapy shared drive so there a dignity steering group folders so that staff can look at it and if I get a newsletter I let them know at the staffing meeting to go and have a look at it so I facilitate and prod reminders about dignity” (H11 109-114)

Initiative to prevent interruptions to Out Patient clinic rooms during consultations (H14)

“I stuck all the posters [on the outpatient clinic room doors to make] people think stop if you want to knock you have to wait for somebody to say it’s okay to come in because the door is closed for a reason, but also they can phone first and they haven’t, but they don’t know the phone number so that’s why we did the list inside each room of the phone numbers of all the other consultation rooms so that you know you’ve got it there you don’t have to do anything, you don’t have to go searching on the intranet, you don’t have to ring, [or] go out to reception and say what room number is, you know it’s there all ready” (H14 205-213)

Identified the need for a dedicated triage area to promote privacy for patients (H3)

“Well I found that the most useful things that made me think was when the ladies do [arrive] in labour they come to the reception area which is an open public area, it’s near the waiting room where the door is always wedged open and it’s there where you actually have to ask some questions about the pregnancy because we have two sides to the labour ward and we have to know which side to send the lady to – whether she’s high risk or low risk or even if she doesn’t need to be on the labour ward she can go to the day assessment unit or the birth centre, so we actually do a little bit of a triaging there. It’s only a verbal triage, it isn’t any intimate examinations but we do need to ask the lady some questions and particularly if she hasn’t brought her hand held notes it’s made me realize that we should just take the lady through into an empty room and if she just sits in a chair just to get that history.” (H3 25-36 & 38-45)

However it was also interesting to note the consideration of approach as well as actions to improve aspects of dignity and it may be that the reflective style of the workshops enabled attendees to consider the experience of patients and their practice.
### Box 4.14 Examples of personal commitments following the Dignity Training Workshops relating to behaviour towards patients and colleagues

**Personal behaviour in respecting each other (H1, H2 & H11)**

“I think it was the respect thing. We need to learn to respect each other. I think without mutual respect, and that can be nurse to nurse, nurse to patient, patient to nurse, nurse to relative, I think there’s always going to be a bit of a dilemma. Listening to each other [...] I sometimes feel that nurses like to talk a lot, but sometimes they may need to remain silent a little bit longer and listen to what’s actually being said a little bit more. Because I think if you listen carefully, really focus, the chances of retaining that are a lot better than if you don’t. So it’s not a case of talking the talk, it’s walking the walk really. I think you can only do that by actually listening” (H2 151-159)

“my personal commitment was to always say good morning and hello to all the staff and to smile and, you know, I now really make a conscious effort if I walk into the photocopy room and [name] is sitting there I would have probably just photocopied and walked straight out but I will say good morning have you had a good day and generally compliment people on you know how they have done making more of an effort to informally make people have eye contact with me and smile when I leave” (H1 119-125)

**Introducing myself and pulling the curtains when going to put in new cannula (H4)**

“my job consists of being the first person on call arriving in the situation. I remember that prior to going on these particular study days I was very flippant you know blasé about it, because I was doing it every day. But it has made me think that there were two or three pointers that I took from it. One was giving them privacy, when I was doing for example cannulation, I just went there and said you are going to have a cannula and just did it, but now I actually have to listen to them and give them a choice, pay them the respect, treat them as an individual. Just treat them with their proper names. You know it wasn’t just hello you going to have a cannula and find out more details about the patient prior to approach.” (H4 25-33)

The evaluation report of three of the Dignity Training Workshops, which was accessed during the review of Trust documents, also considered the range of commitments made by attendees and grouped these according to six themes of: 1. Communication – which involved listening and improving communication with patients. 2. Engagement – with patients and their carers to facilitate choice, empowerment and independence. 3. Privacy – that involved maximising privacy in bed and bathroom areas as well as keeping patients dressed. 4. Staff working together – to better understand patients’ needs and challenge indignities. 5 Environment – that included preventing intrusions, cultural awareness, and making sure the rest period is adhered to, and 6. Other areas – that included additional focus on training and resources related to safeguarding of vulnerable adults. These expand on the commitments that individual healthcare professionals reported and also highlight the links with the five priority areas within the Dignity in Care campaign that were identified.
How the commitments were going to be put into action were also discussed by three healthcare professionals (H2, H3 & H14), which highlighted where there were challenges to making commitments a reality or where the process went particularly well (see Box 4.15).

**Box 4.15 Examples of challenges related to putting commitments into practice**

**Spreading the word (H2)**

“[I] spoke to as many people as possible. I was almost sick of speaking to people. This is what it’s all about, this is what we’re going to have to do, [and] this is how it’s going to work. I have to say, I would describe my management style normally as being quite democratic, but I have to say on this occasion it changed drastically. It was like very, very autocratic and very completer finisher. This is what we’re going to do; this is what we need to achieve it within this time frame and so on and so forth.” (H2 169-175)

**Where it was a challenge to implement the commitment (H3)**

“It hasn’t always been easy to implement because we don’t always have a spare room for that type of case, or an actual spare midwife. Because it does tend to be a receptionist that is at the desk that is the first point of contact for the woman in labour and then the receptionist does have to go and find a midwife to come and do the verbal triage. So it can be difficult for that midwife because she’s also coordinating the shift or looking after somebody else in labour and to actually come away from that to try and find an empty room to speak to her. But we try and do it as much as we can really.” (H3 38-45)

**Where implementing change to stop intrusions into clinic rooms was successful (H14)**

“I’ve addressed the clinic nurses team and sort of said this is what I’m going to roll out and I had a roll out date and so when I’d got all my posters laminated ready, so from, these posters are going to be put up on such and such a date please can you now start, you know it’s you know your responsibility to follow them as members of staff […] so there [was] no effort involved and I think sometimes when change is, you know, minimal, because that’s a minimal change but it’s effortless for those who just have to follow it rather than the person who did it but it didn’t even create much for me to do it and that’s sometimes I think when it can be successful if it doesn’t require much for other people to do” (H14 171-175 & 212 217)

The use of personal commitments can be seen to have been an effective tool in stimulating change as a result of the Dignity Training workshops that involved tangible changes to the environment as well as behavioural changes that involved an individual reflecting on their approach with patients and colleagues. In addition, the challenges of implementing change were also highlighted as well the benefits where there was a smooth and effective change process within a department. The next theme explores key areas where progress had been made in relation to the wider organisation to improve aspects of Dignity in Care.
4.5 Theme 4: Improvements identified as supporting dignity for patients

Identification of early achievements in the work to improve dignity for patients was a key part of this evaluative study that was focussed on with healthcare professionals and senior managers. Patients were also questioned on some of the specific initiatives that they could have been aware of and affected their care, such as the use of ‘Red Pegs’ to prevent intrusions into curtained areas. However, improvements and initiatives in this theme refer to wider organisation achievements and projects as opposed to individual commitments identified in the previous theme. Two sub themes are presented on raised awareness of the Dignity in Care campaign within the hospital and specific initiatives to improve aspects of dignity in care. Box 4.16 lists the sub themes identified within this theme.

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4.5.1 Sub Theme 1: Raised awareness

Three of the fourteen healthcare professionals (H9, H10, & H13) and seven of the ten senior managers (S1, S2, S3, S4, S6, S7, & S10) identified raised awareness as a particularly positive outcome of the work to promote and improve dignity:

“I think probably the most positive aspect is that it has raised awareness, and I think that’s something that needed to be done very seriously. I wouldn’t think its resolved issues, far from it, I think it’s you know, the beginning of a long road. I think that some health professionals had moved so far away from dignity issues that it’s going to be quite a long walk back.” (H10, 45-48).

Whilst it was voiced, that for some healthcare professionals there was a long journey to get back to providing dignity in care, there was also a sense that this was mirrored at an organisational level, where it was identified that dignity had previously not been high on the corporate agenda. It was also noted that concerns related to poor results for the hospital in the National Patient Survey were identified by both healthcare professionals and senior managers (H9, H13, S4, & S6) as an additional driver for the hospital to utilise work on dignity as a positive way to start to address areas of concern:
“Dignity wasn’t really high on the corporate agenda as such up until the last year, 18 months I would say, until the dignity challenge was launched. It’s become more of an issue related to Picker survey outcomes, because of our scoring as a Trust with that and because of that, because of the targets that we have to meet and our public image, the dignity challenge has been embraced much more by the Trust Board” (H9, 9-15)

Evidence of elements of raised awareness was considered in terms of the effective promotion and communication of dignity work in the hospital (S6 & S7), engagement of staff (S2 & S4) and a recognition that raised awareness was “the first step in to bring about change” (S2, 68). Indeed promotion of the Dignity in Care campaign was actively managed through a dedicated ‘Communications Plan’ that supported the level of raised awareness through a range of focussed communication within the organisation that included: dedicated pages on the intranet, articles in the hospital magazine. In addition communication with patients and external stakeholders was also considered by senior managers and executives (S2, S4 & S7) to have raised the profile of dignity and expectations of levels of care, as well as further acknowledging the importance of this work. Examples of raised awareness can be seen in Box 4.17.

Box 4.17 Examples of raised awareness of work on the Dignity in Care campaign

Promotion of dignity
“I guess there been so much publicity about dignity I think dignity now registers in people’s minds where it might not have done” (S7, 60-61)

Engagement of staff (S2 & S4)
“I think what went well was that it did engage people in the organisation and there was work that went on and the examples I gave around people going back to outpatients wanting to make a difference and gave examples of practical things such as the red pegs was very successful - it was everywhere in the organisation and that there were clinical champions driving it forward, I think looking at what we could have done better were the more practical things that we could have done to move the agenda forward” (S4 107-113)

Change processes
“so I think to a certain extent it has started to bring some awareness, which for me is always the first step to bring about change and you know you can have resistance to change and some of the comments were the pegs are too small, no one can see them, you always lose them there’s always some negative feedback you have to take into account but in actual fact something is moving, something is happening and it created awareness across the Trust that something is being done” (S2 67-73)

One senior manager (S4) referred to a particular example of a presentation about proposals to undertake work on the Dignity in Care campaign to the Trust Board, along with structures being
put in place through a dedicated steering group to lead on work on the Dignity in Care campaign within the hospital:

“the paper that was put together that was presented to the board that was well received and I think at a board level it opened up some of the executives’ eyes to some of the issues of what had happened to patients and what needed to happen to make a change, there was also the fact that there was the working group that was set up, and that was multidisciplinary and that included people from outside the organisation” (S4, 23-29)

Positive feedback from this presentation to a Trust Board meeting was also noted within the Dignity Steering Group minutes. An outcome from the Board meeting was greater recognition of issues related to dignity and further endorsement by Board members of the work being undertaken responding to the Dignity in Care campaign.

One senior manager (S6) identified a direct link between raised awareness and patient feedback around how patients are communicated with:

“I think it’s also helping around how patients are communicated to and that they are communicated appropriately about their care and that they – because it links with the Picker survey and all that stuff. You can see, certainly we’ve seen within our own service where comments come via inpatients or outpatients cards. You know you can see a lot of what patients say are around communications and there’s a lot of very positive comments and some of that might have happened anyway but some of it is through heightened awareness of some of this stuff” (S6, 41-49)

However, it was noted that although there had been increased awareness at all levels of staff in the hospital of the Dignity in Care campaign, there was a question around how this translated into improvements in the quality of care for patients:

“I think [although] it [has] registered in nurses’ minds now, it’s much more far reaching, so you know, that has to be a good thing, but having said that I am not sure about the impact on patient care” (S7, 62-64)

This indicates a note of caution when considering the achievement of widespread communication to a range of staff about the dignity campaign as to whether the increased level of awareness had had an impact on improving dignity in care. It is clear that whilst a dedicated communications plan had enabled publication across the hospital in a range of media work on the dignity campaign, informal communication about both the importance of dignity for patients and a number of initiatives to improve practice had also been very effective in communicating the relevance of dignity to a large number of staff. It was also noted that whilst
the raised awareness related to dignity was considered the first step in journey it was also seen as a very positive step forward towards a wider cultural change.

4.5.2 Sub Theme 2: Initiatives to improve dignity for patients

Key projects that were identified as making improvements for patients included: Protected Meal Times, Quiet times (H2 & H9), and the introduction of a Red Tray system, used in place of standard meal trays, as a mechanism to identify those patients who required additional support or assistance with their meals (H1). A dedicated training project on dementia, with a funded facilitator, was felt to be particularly beneficial in getting staff to think differently about the needs of patients with dementia (H1, H8, H10, & S1). In addition several thousand Red Pegs were purchased and introduced to clinical areas across the whole hospital as part of an initiative to improve privacy (H1, H2, H4, H6, H8, H10, H13, S1, S2, S3, S5, & S8). The Red Pegs are plastic red clothes pegs used to attach to patient curtains to identify to hospital staff and visitors that they should ‘stop, wait and ask’ before entering closed curtains, so as not to disturb a patient, as described very clearly by one healthcare professional:

“the pegs are very visible and people have them on their uniform or have them in their pockets, and they’re at the nurses’ stations so they are there and still visible. And some of the patients ask about them, and they’re like ‘why are we having the washing pegs on the curtains for?’ You know, but they are quite good, because it means someone can’t stick their head behind the curtains, it means something’s going on. Yeah, I like them, I think they are a simple cost effective way and they’re easy for patients to understand.” (H6, 161-168)

Each of these initiatives were seen by both healthcare professionals and senior managers as tangible mechanisms that had been introduced to improve aspects of dignity for patients. These initiatives were also individually discussed within the Dignity Steering group and feedback given on progress and review results of an audit of an Essence of Care combined benchmark for the ‘Care Environment’ and ‘Respect and Dignity’, that also reviewed the use of Red Pegs. Findings from the audit identified that Red Pegs were observed as being used appropriately and effectively to prevent intrusions into curtained patient bed areas in most ward areas, with the exception of one ward where Red Pegs were not in use that was considered to be a supply issue to that area. Concerns were also feedback that the ‘Red Pegs’ were being used exclusively by nurses, as opposed to the wider multidisciplinary team, of therapists and doctors.
In addition, the training project on the care of patients with dementia was identified as having made noticeable improvements through attention to detail of individual patient care needs, and symptoms such as agitation (H8), by being more understanding and proactive in meeting patients’ needs (H10), and by spending more time sitting and talking to patients (H12). Examples of these can be seen in Box 4.18.

**Box 4.18 Examples of initiatives to improve aspects of patient dignity**

**Training project on the needs of patients with dementia**

“The biggest improvement that I have noticed is and as I am saying because we’ve sent so many nurses on the dementia project that they have changed their approach to the older person [...] and particularly the confused older patient, and their change has been in terms of the tolerance and almost a pro-active response to how they behave with a more confused patient.” (H10 67-71)

**Training project on the needs of patients with dementia**

“I’ve noticed that the nurses are a lot more patient with the patients that have got dementia, you know they will actually sit with them I mean I have gone on the wards and they have actually sat [...] because when I actually went with one of my volunteers early this week there was two nurses sitting with a patient that actually had dementia and she only had early stages of dementia, but she was very very happy, very happy, she was very happy with the nurses” (H12 103-113)

**Protected quiet time**

“I think for me it means... patients in hospital rarely get I would say quality quiet time and I think that is important for us. There are several ways we can do this. We are trying for example, to restrict visiting between one and three o’clock in the afternoon... and that allows some quiet time. We are trying to reinforce that more strictly than we’ve actually been, it’s a fairly new initiative” (H2 49-54)

**Red Tray**

“The other thing I think is really important and this is mainly about elderly care or patients who for one reason or another, are unable to feed themselves or find difficulty in feeding themselves, but obviously they’re not on nil by mouth or whatever, they should be fed and diet is an important part of their healing process if you like, is the red tray system whereby if a patient does have difficulty in that area, their food is placed on the red tray and members of staff on wards, members of staff working on [the] ward be they healthcare workers or whatever, will know that actually patient, Ethel or Garfield or Fred, whatever their name is, but it is known, merely by seeing the red tray and the food on their plate they need some help with their feeding” (H1 78-87)

For both healthcare professionals and senior managers the Red Pegs were a very effective practice change as they were seen as “highly innovative, dreamt up clinically and therefore a good chance of success” (S8 24-25) and were able to engender wide ownership by significant numbers of staff who used them in their everyday care of patients. Further comments and discussion on Red Pegs related to individuals’ involvement in the promotion and launch of the
initiative (H5, H6 & H9) and the educational value of Red Pegs in promoting patients’ privacy (H1, H2, H6 & H7) and they also highlight the permission given by the initiative to challenge others where they may not respect patients’ privacy (H1, H5, H6, H7 & H9). Comments were also made of the Red Pegs being observed in practice as promoting patients’ privacy (S6). Examples of references to these points can be seen in Box 4.19.

Box 4.19 Examples of comments made on Red Pegs by Healthcare professionals and Senior Managers

Promotion
“I was involved in the working group [on Red Pegs] my role was to assist in rolling it out across [Hospital names]. Doing a lot of education going around explaining to them what it is, literally campaigning for it. I had the help of […] band 7’s, one from [a couple of the wards], and we’ve literally been going out there and saying this is what it’s about, explaining, going along to like handovers or meetings and just saying OK this is what it’s about this is what we’re doing, here’s the people you can contact to get more information for it and trying to promote it. […] And just on a day to day basis as you go around and observe are they using pegs are they not and just constantly reminding people.” (H5 73-86)

Educational
“One of the issues that used to bug me rotten was you’d get people coming in or a hostess, just suddenly see the hostess’s hand appear or they physically come in and try and remove a water jug, and I’d say to them, well actually the screen is around me and there’s something intimate going on here like you’re bed bathing a patient, for example. I think what I did was, I got someone to attach red pegs to all the screens in actual fact, and then went through it and then spoke to people individually, including relatives as well. They’ll come in and say well actually there’s something going on at the moment can you wait and then take them to the notice board and say “this is what it’s all about”. We have notices on the doors as well, for people coming in saying “you’re entering a red peg zone”, but sometimes I think when people are anxious to see someone or if there is a problem or if their loved one is very, very ill they don’t see the notice at the door.” (H2 125-137)

Gave permission to challenge
“When I go on to wards I actually see staff stopping and thinking about what it is that they’re actually going to do, or if they haven’t stopped and asked, the person that is behind the curtain has challenged them. And I think that’s a massive change because quite frankly people weren’t challenging, when they were interrupted. So I think that’s a step in the right direction.” (H5 111-116)

Observed as working in practice
“For example I was on the stroke ward yesterday and it was interesting just seeing what was kind of going on, you know there was evidence of respect there in a certain sense just because you know there were various things going on, various patients’ and you know people were being sensitive to the fact that they shouldn’t really go behind the curtains for example, so you could visibly see what was going on” (S6 32-37)

Whilst patients had seen notices about the Red Pegs (P2, P4 & P5) and considered the idea helpful in protecting patient privacy (P4) they were not aware of them being used or did not appear to have had any explanation about Red Pegs (P2, P4 & P5). However, two patients
identified that their experiences had been that they had not been interrupted (P2 & P4) when behind the curtains around their bed and there was also a sense of bemusement that a whole initiative using red clothes pegs was needed to stop healthcare staff entering closed curtains around a patient’s bed (P4). Example of these can be seen in Box 4.20.

Box 4.20 Examples of comments made on Red Pegs by Patients

“I haven’t found [red pegs], no I haven’t, I’ve seen signs on doors, but I haven’t had anybody walk in when I’m being examined. So I think once the curtains are drawn people don’t really come in. Even, I have problem at night, the nurses will just call out, “Are you alright there”? in the morning or, “Do you want a cup of tea”? So they don’t sort of charge in.” (P2 82-84)

“I think it’s a good idea [Red Pegs]. But whilst the curtains are drawn I don’t get interrupted anyway, so, nobody interrupts me. They call you first, the nurses will call me, [...] or whatever their name is, but nobody comes just bursting in. But it’s a good idea with the red pegs to let people know that you’re busy, but it’s obvious you’re busy if the curtains drawn, so it’s both really” (P4 48-52)

“Yes, I know what you mean don’t just stick your head in without knocking [...] Not here I haven’t, no. No I can’t say that I have not in this bay anyway, no. [...] and on the admission ward? [...] Certainly not, I didn’t even know about it then. It’s only when I’ve seen the signs around various bits of the hospital you know – yeah.” (P5 65 & 70 & 72-73)

One healthcare professional (H2) described how he wanted to encourage patients and carers to have a role in using the red pegs to promote their privacy, although identified particular challenges where a patient was very ill and the relative was distressed and where information displayed on a ward may not get noticed by relatives:

“We’re going to try and encourage patients to use the red peg. So, relatives have come in and said what does this red peg mean and we explain it to them. So we can tag the actual screens like wait, listen so on and so forth, but patients will rarely say ‘well actually can I have a red peg, I’d like to have some privacy’ and I think that’s something we need to actually look at, maybe in a bit more depth and try and encourage that” (H2 55-60)

It was of note that this was the only healthcare professional who spoke of talking to patients and relatives to enable their involvement in the use of red pegs.

Finally, two healthcare professionals (H5 & H6) reflected a concern that since the initial launch of the red pegs the momentum had not been sustained:

“The red peg initiative has been kind of used around the Trust. It had brilliant people campaigning and getting out on to the wards and delivering them. It is used, but not as effectively as it could be yeah, and I think that’s one of the things about it. Unfortunately the momentum of all those Senior people getting out and delivering it
their training has stopped and as a result people aren’t sort of continuing it” (H6 137-142)

This may identify a particular challenge with initiatives and campaigns in sustaining the level of effort to ensure that they do not lose their focus in achieving the benefits for patients. This theme has considered innovative solutions to improve dignity in care for patients that have had high levels of engagement from healthcare professionals. However their impact has not been particularly noted by patients nor have patients been encouraged to use red pegs. The next theme focuses on specific challenges and enablers in relation to applying the Dignity in Care campaign locally.

4.6 Theme 5: Challenges and Enablers related to the Dignity in Care campaign

This theme presents data drawn from healthcare professionals and senior managers where key challenges and enablers were identified in changing practice to improve dignity. Patients’ data is also referred to in this theme, in relation to the challenge of staff having time to spend with patients. The sub themes for this theme are listed in Box 4.21.

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4.6.1 Sub Theme 1: ‘Operationalising’ Dignity

‘Operationalising’ dignity may be defined as where the national Dignity in Care campaign was translated into local application within the hospital and into individuals’ practice, and was identified as a particular challenge (H5, S1, & S7). This sub theme also considers leadership, role modelling and communication as well as how the Dignity in Care work could be integrated and sustained as part of the business of the hospital. In ‘operationalising’ work on dignity it was recognised that there was a need for staff to work differently (S5), that would “probably take years to change the culture” (S10, 187), and that sustaining and mainstreaming dignity into the structures and targets of the organisation was also identified as a challenge (S5 & S9). However enablers were also identified, where one senior manager (S1) referred to the inclusion of dignity within the organisation’s business plan and work to embed dignity within the values of the organisation. References to these particular challenges and enablers can be seen in Box 4.22.
In order to translate the guidance and policy into local plans and individual practice some key challenges and enablers were identified of: Leadership and role modelling, communication, and integrating this work with other hospital wide initiatives as well as learning from other areas of good practice. Leadership was discussed by six of the fourteen healthcare professionals (H2, H5, H6, H7, H8, & H9) and only six of the ten senior managers (S1, S4, S7, S8, S9, & S10). There was also recognition that whilst there was strong leadership (H2, H7, H8, H9, S1, S4, S7, S8, S9, & S10) supporting the work on dignity there were gaps in leadership (H8, S2, & S10) within the organisation. What may be considered a related issue was identified in 4.3.2, where groups of staff were identified as needing to take greater responsibility for the dignity of patients. Examples of challenges and enablers of leadership and role modelling can be seen in Box 4.23.
A further example of role modelling can be seen where healthcare professionals referred to themselves in their descriptions of promoting best practice or challenging poor practice that in some cases can promote or threaten dignity. Examples of this can be seen in the Box 4.24.

Box 4.24 Examples of healthcare professionals challenging practice related to dignity

“It’s trying to get people out of the mindset of managing frail, elderly people, or any patient for that matter, but my particular interest is the frail, elderly along purely ‘protocolised’ pathways and actually that we approach them with humanity, we communicate with them, we respect their basic human rights, we actually respect them as individuals and we deliver care, which we would want for ourselves or our families, who are in hospital. To me that is the fundamental thrust of the dignity challenge and actually what we can do in our day to day role is actually just flag up both to medical staff and nursing staff when standards fall below what we regard as being the basic” (H8 28-45)

“And in the sort of environment that I work on, rehabilitation, I think one of the key things is to enable people to reach their maximum potential. On a typical day on the ward when we’re looking at patient choice, something as simple as the menu, we have a hostess goes round and consults the patients what they want from the menu, but that is done in collaboration with the staff, so if for example the hostess may say “what would you like for lunch, I have shepherd’s pie” and the patient says “yes that’s fine”. We have to prompt the hostess – ‘well actually give them the full choice’, because some patients will immediately agree with what’s offered to them, and it may not be appropriate. So that’s a very simple example of trying to ensure the patient gets the full potential to make a choice in something as simple as choosing their meals.” (H2 63-74)

An essential means to enable ‘operationalising’ dignity for patients was that of effective communication, which was identified as a particular challenge by three healthcare professionals (H3, H8 & H9) and four senior managers (S2, S3, S6, & S10). In particular the
importance of staff having a shared understanding of their role in supporting work to improve dignity was identified (H2). However, it was also recognised that there were significant challenges in achieving effective communication, particular to a large number of staff (S2, S3 & S6). Examples of challenges and enablers in communication can be seen in Box 4.25.

**Box 4.25 Examples of challenges and enablers in communication**

**Communicating across a large organisation**

“having to communicate across a very large organisation and getting key messages out is I think a real challenge” (S3 46-47)

“So I think there is constant challenge about how the whole dignity agenda is communicated to everybody and the importance of it.” (S6 79-81)

**Keeping the communication going**

“we could do better and keeping that conversation going and which sometimes it is very difficult as everyone wants to talk about their own initiatives” (S2 150-152)

**Communication to get all staff on board**

“I think everybody needs to be on board from people like the ward hostess, right up to the senior person on the ward. No-one is absolutely exempt from this. It’s very much a team effort, so I think there’s an issue with communication as well. Communication between yourself and your team as to what this is all about, where it’s going, how we need to get it to the next stage, I think is key, because we had a role in the general staff meeting shortly after I attended this to make the message actually known. I think it’s improved, but I still think there’s room for further improvement. I did find it very, very useful though, I have to say.” (H2 114-122)

The next step on from ‘operationalising’ the Dignity in Care campaign within the Trust was mainstreaming and integrating dignity within a range of existing work identified by healthcare professionals and senior managers in order to sustain the focus on improving dignity in care. The Patient Environment Action Team (PEAT) which involves an annual assessment and inspections of aspects of care related to the environment, nutrition and cleanliness was identified as including dignity as “explicit in the core standards, but it’s also implicit, and there’s the whole PEAT agenda” (S1, 91-92 & S10). The essence of care benchmarking (S1 & S7) was also identified where the focus on dignity could be sustained as well as was work developing a new steering group related to patient experience (S1 & S5). In addition further drivers that were identified as supporting a continued focus on dignity were the patient experience target within the NHS Operating Framework, and the need to improve results in the National Patient Survey managed by Picker Institute (S5 & S9):
“Well it links, I don’t know if it is for the Trust, but certainly from the nursing agenda, it links in with essence of care for patient environment also healthcare commission standards for better health and given our previous Picker survey report it’s a question of us having to show that we’re doing something to address these issues.” (H9, 30-34)

Two senior managers (S1 & S6) talked of dignity being integrated at different levels within the organisation of: the individual level and their professional accountability, the managerial level where there were certain expectations that employers had of individuals in their roles and responsibilities and being able to use the Knowledge and Skills Framework (KSF) to support this, and at an organisational level the requirements to meet particular standards:

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<tr>
<th>Box 4.26 Example of accountability for dignity being integrated at different levels of employee, manager and organisation</th>
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<td>“I think it is built into professional codes of conduct – so if I register as a nurse I have got my code of conduct and if I register as a therapist I am part of the HPC so it’s built in to that – so on an individual basis so if I am trained to do it and its built into my professional code of conduct and if I buy into my professional [code] it’s got to be part of my, part of my daily activity –and then if my employer’s going to performance manage me it’s going to be part of what they measure me on so from an employee level I think it is really built in that that’s assuming that people have regular 1:1s and have appraisals and if you look things like if you look at like, if you look at people who aren’t doctors and if you look at the way with agenda for change there’s the framework for people’s development it’s kind of built in with that in all sorts of bits of the KSF if you like the KSF if you use the KSF – it’s really in the core standards of that. So for agenda for change banded staff it’s completely in the individual’s employment performance framework, in terms of hospital performance or targets or NHS performance I think it’s implicit in a lot of the healthcare core standards” (S1, 67-82)</td>
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However, a particular challenge to sustaining the work to improve patients’ dignity was the nature of a campaign as a one off national or local promotion that had no end date. Indeed there was a degree of concern highlighted by a number of healthcare professionals (H9, 10 & 13), that:

“unfortunately the problem is with all these initiatives, it’s not just enough to have, you know, one campaign, you’ve just got [to] keep on and on and on and on and on doing it” (H13 130-132)

One senior manager also voiced concerns and raised questions, that this was a particular challenge with projects in the NHS and that it was not always clear what happens to them:

“another challenge and this is something that often happens with NHS projects is it sort of withers on the vine. It was created as a national programme and it hangs around for
years and years and years, and then people sort of wonder years later ‘is it still going? Has it died? Has it moved or changed or [become] something else?’ (S5 211-214)

This sub theme has identified a wide range of challengers and enablers of: translating dignity into practice, integrating it within different levels of the organisation as well as within other existing work where there are requirements to meet certain standards, and how the continuity of new initiatives as part of the local dignity work can be sustained and not lose impetus.

4.6.2 Sub Theme 2: Organisational Change

During the period when work was going on to promote and improve dignity, major organisational change took place across the hospital that was considered to be a significant challenge to progress work on dignity by both healthcare professionals (H5, H6, & H9) and senior managers (S4, S5, S7, & S10). In particular it was identified that the changes to the organisational structure had lead to delays in progressing particular initiatives (H5, H6, S4, S5, & S10). In addition to this it was also recognised by one senior manager that further work would be required to involve and engage a wider group of staff who had previously not been involved in the work on the dignity challenge as a result of the organisational change. Similarly, a senior manager (S10) identified that the organisational change that had taken place would be likely to affect the progress of work to facilitate a culture change to improve the dignity in care for patients. However, a comment was made by one senior manager (S6) that working together on dignity during and following organisational change had been positive in developing a common approach and that there were opportunities for change (S1). References to these particular challenges can be seen in Box 4.27.
Box 4.2 Challenges and Enablers associated with promoting work on dignity associated with organisational change

Challenges

Delays in progress due to vacancies in line management posts

“it will need some more management attention than previously and there could be a challenge there because there are a lot of vacancies at the level of line manager posts. A lot of line managers are working operationally to cover roles and that could mean that the level of attention that’s desired isn’t available yet and that might cause a lag in effective implementation.” (S5 207-211)

The need for commitment from a wider group of staff

“we had a group of very committed people at [...], I think what was missing from that was the buy in from the rest of the organisation so it was very much lead by [one division] and lead by a group of people who were championing that cause but I also think there needed to be a lot more input from other areas in the rest of the hospital” (S10 17-21)

Organisational change affecting the ability to bring about culture change

“it is probably going [to], - it will almost feel like taking some steps back because of the organisational changes, that is going to be even more difficult to attain, it’s probably going to take longer ” (S10 188-190)

Enablers

Bringing together the best from different approaches

“there have been different approaches around the different sites, and I suppose a good approach is that it has all sort have come together” (S6 17-19)

Opportunities from change

“we haven’t had change overload but actually where there’s so much change -it’s a way to reinvent everything I mean I really enjoy going to places where you just reinvent a new way of doing stuff because we’ve [changed the structure], we’re new and let’s do it this way and I also I am not sure that at ward level or in a department I am not sure what the exact impact of the change is I’ve been working on [the] same ward for three years and it feels the same as it was two years ago and I am not that all of the upper echelons of the change – yes they’ve configured the ward differently, yes there’s an ambulatory area, yes you can see some of the strategic things but when you are on the ground it doesn’t feel too scary the change really” (S1 181-190)

Whilst particular challenges have been identified in work to promote and improve dignity associated with organisational change several of these points have previously been referred to in 4.3.1, such as culture change and commitment within leadership and communication. However a key point has been made about the potential delays for practical reasons of individuals not being in post, and the need for additional communication to engage different groups of staff. The opportunities from change and bringing people together were seen as positive enablers to increase the richness of the work on dignity.
4.6.3 Sub Theme 3: Nurses’ ability to meet patients’ needs related to dignity due to time constraints

A particular challenge that was identified by four patients (P2, P3, P5 & P8), four healthcare professionals (H1, H4, H8 & H13) and two senior managers (S1 & S5) was the ability for nurses to have time to meet some of the patients’ needs. Patients identified how straightforward requests of nurses related to time were not able to be met, that included: waiting for long periods for attention, where one patient commented that “You can wait all night sometimes if they’re busy” (P8 35), nurses not coming back to them when they said they would (P1), and nurses not having time to sit and talk to patients (P3). Three patients referred to how busy nurses appeared to be, where one patient attributed busyness, to nurses not taking the time to pull curtains around a patient (P2), whilst another patient identified the busyness of nurses as the reason why he had not been offered a wash (P10). Examples of these comments can be seen in Box 4.28.

Box 4.28 Patients experiences of nurses not having time to meet their needs related to dignity

Patients reported nurses as not returning in the given time that they had said that they would

“And I’ve noticed when you come into A&E they do bring you in and leave you a little while and you’re not well and then you get the doctor in that’s ok and the nurse comes in and sees how you are and all that, but they say I won’t be long I’ll go and get something, I’m getting something and they’re gone half an hour. And it’s the same when they come back someone else comes in and says just a minute I won’t be long.” (P1 7-12)

Nurses observed as too busy to do simple things to protect a patients dignity

“I think it is a problem with the elderly and they are very busy nurses’ and I was a nurse and I do understand but these little things only take two minutes, you know just to pull a curtain round.” (P2 107-109)

Just having five to ten minutes to spend time talking with a patient

“Well I think first of all it’s the people you have to improve. Because without the people you can’t improve anything and I think they should be a bit more flexible, sort of spending time with the patients’ like and have a chat with them and something like that but you meet an awful lot of people that make it hard when you come into hospital and if you get nobody that’s going to talk to you and be nice to you, well of course that will put you off. So if you could get somebody who will come into you and chat to you, and make time as they’re going along, we know they’re busy, but if it was just five minutes or ten minutes, that’s it” (P3 264-272)

Attributing not being offered a wash due to the busyness and throughput of the ward

“I wasn’t washed by anybody, and I was very unwell, wasn’t kind of offered to me – yeah it was quite, it was a much madder ward than this in terms of busyness and throughput – yeah but I don’t want to be moaning but yeah it is always the basic things” (P1 127-130)
Healthcare professionals also identified a range of points that are comparable with the points made by patients around having time to meet patient needs related to dignity. These included: staff often being disturbed when trying to sit and talk to patients (H4) and recognition that staff were busy and pressurised for time (H8 & H13) and that because of this it is important “to be even more vigilant about not compromising patients’ dignity” (H8 83). There was also awareness by healthcare professionals that this was also a particular concern of patients, as can be seen in Box 4.29.

**Box 4.29 Example of concerns by patients of staff having time to spend with them from the perspective of healthcare professionals**

“Time – one of the biggest complaints we get from older people is that the nurses no longer have the time to sit and talk to us and they really notice that and they really feel that’s a deficiency and they will also say doctors don’t give us all the information, doctors do all these blood tests and they don’t tell us why they are doing it and I can understand why people have that concern but if I were to sit down and explain to everyone of my patients why I am doing the blood tests I could only treat a quarter of the patients I treat and I think similar with nurses they are under tremendous pressures and I think years ago patients, we didn’t have the pressure to get people out of hospital that we do now, so I think patients stayed in for much longer they actually had fewer investigations, we were under far less pressure and I think people did have much more time just to sit and chat which I just do not think we have that time now and I think we need to take the opportunities to chat whilst you’re doing something else, but it isn’t that easy” (H13 70-82)

However, the same healthcare professional highlighted that this was not the case in all areas of the hospital as within rehabilitation settings, the focus of care on patients, who often had a longer length of stay in hospital, enabled nurses to develop relationships with patients (H13):

“Certainly we see a big difference on the rehab wards, on the rehab wards I think we are able to get to know people as human beings better just because they are there for longer than generally they are on an acute ward so I think it is a time difference and it’s the nurses on the rehab wards are not run ragged doing the acute interventions” (H13 86-89)

A particular challenge that was highlighted by one healthcare professional (H10) and senior manager (S6) was competing targets that may affect the focus on dignity, such as time going into achieving the eighteen week target from referral to treatment and the four hour target in Accident and Emergency departments, where whilst benefits for patients were acknowledged from reducing waiting times there were concerns that the level of care that patients should receive may not be able to be given:
Box 4.30 Example of concerns as well as benefits to previous changes in ways of working by healthcare professionals that affected patients care

“one of the downsides that came up, out of that, was that possibly some of the little things that we did have time in the past to do for patients like, talking to them a bit more or finding out a bit more about them, you know, were missed out because of the speed in which we had to get them through, out the department. I would argue that you know, getting them through the department at great speed is a lot more dignified than actually having lots of time to talk to them but having them lying around in corridors without any dignity whatsoever, and without any facilities because A&E departments are not set up with showers, lots of toilets, or you know any degree of comfort particularly for elderly people. Trolleys are so hard to lie on and they’re bad for people and definitely bad for older people who will get a pressure sore after a couple of hours on a trolley. But there was a concern with this sort of speed that the person was processed through the emergency department actually meant that some of the quality had gone out of care.” (H10, 137-147)

Three senior managers and one health care professional considered the issues of staff time from a perspective of whether there was sufficient staffing resource (H1, S3, S5, & S10). For the healthcare professional a comment was fed back from a workshop on dignity where nurses had stated that they recognised the importance of dignity “but, you know we can’t do this because we haven’t got the resources” (H1, 128). Two of the senior managers (S5 & S10) questioned whether the focus on dignity and patient experience may identify the need for further resources and in particular consideration of staffing levels:

“we know we should be doing it but you know this is a busy ward, we don’t have time to sit by the side of the bed and chat to a patient for fifteen minutes, this is a reality check the real world that we live in and maybe we need to stop just you know brushing over the difficult things like staffing levels” (S10, 203-207)

However, one senior manager (S3) made the point that providing dignity to patients “doesn’t cost anything more to do, it’s about attitude and it’s about the culture that we give to people” (S3, 148). A further point was made by one senior manager challenging the view that nurses should not be busy (S1) that was inherent in the points made earlier by healthcare professionals that the pressurised way of working could lead to compromising a patient’s dignity:

“there is a time factor and for me that shouldn’t be a barrier and I should I be able to say like if you’re the patient I can’t stay with you right now but I’m going to come back in 15 minutes or whatever - sometimes nurses think they are busy but actually we pay them to be busy that’s a really horrible thing to say but we pay them to be busy and I
don’t think time should be an excuse but I do think that time can be a slight barrier” (S1, 161-166).

This one specific challenge highlighted that patients did feel that their needs were not always listened to or met. There was also a common recognition by both patients and healthcare professionals of issues to do with being busy, pressurised for time and not being able to spend time with patients, however this was not the case in all settings. The senior managers’ points differed from those of the patients and healthcare professionals, and included the point that dignity should be able to be provided within the current ways of working at no additional cost. In addition an opposing point was made that there may need to be consideration of staffing levels to meet patients’ dignity and recognition of the economic implications of this, however staffing levels were not considered as part of this study. The next theme considers some key areas of improvements that have been realised through work to improve dignity for patients.

4.7 Theme 6: Wider issues raised around dignity

This final theme has identified some wider issues raised around dignity that include: training, improving the patient experience, and performance management that patients, healthcare professionals and senior managers considered should inform further work on dignity within the hospital. These sub themes are listed in Box 4.31.

| Box 4.31 Theme 6 Wider issues raised around dignity |
| Sub Themes |
| 1. Training |
| 2. Improving the patient experience |
| 3. Performance Management |

4.7.1 Sub Theme 1: Training

Whilst a programme of dignity workshops was one specific training initiative the value and need for further training was reiterated a number of times by senior managers and executives (S1, S5, S8, S9 & S10) and healthcare professionals (H6, H7, H9 & H11). These included a range of issues related to the need for training on dignity: to be mandatory as part of a culture of customer care (H6, H9, & S8), and within the induction programme to the hospital for all new staff. It was also identified that training related to dignity should have the same level of importance given to other types of training, for example, Advanced Life Support, and Infection Control (H8, H10 & S6). One healthcare professional (H6) and two senior managers (S1 & S7)
also identified the need for dignity to be part of the pre-registration training for nursing students. References to these issues can be seen in Box 4.32

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<th>Box 4.32 Reference to the need for further consideration of training on dignity</th>
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**Customer Care Training**

“there’s a lot of work needs doing in terms of education about what they would call in industry customer care and I know nurses are supposed to be professional carers but I think now because we’ve got such a diverse workforce, particularly at this Trust, sometimes the education that the nurses will have received about caring, doesn’t actually compare to the training that originally people of our generation of nurses would’ve had. I think there’s a difference there and that’s why some of this has occurred.” (H9 141-150)

**Similar level of importance accorded to dignity training as other types of training**

“we can never sort off take our foot of the pedal over training. And I still feel that we probably we don’t give enough training to these softer issues and certainly in emergency care and acute care generally, there’s a huge emphasis on making sure the people have got things like ALS [Advanced Life Support] skills, and trauma training and skills training you know, ventilation training, all these sort of more advanced skills, but, there is just as much skills in managing and dealing with somebody who is very confused or people who are compromising in other ways, for example, people who have got learning disabilities and very little teaching ever goes on around protecting those sort of individuals or looking after their dignity. And I think that that’s a real challenge, funding needs to be built in, it needs to be mandatory that sort of training. (H10 160-181)

“You’re probably going to need some refreshers so you’re going to have to test people. Is it a bit like hand-washing, ‘glow and tell’, do we need to go and kind of you know, not say, what do you know about dignity? There needs to be some sort of, a bit like essence of care, do you need to go round and do some, I don’t know checks, somewhere along the line, because that’s what keeps people’s game up I think. It certainly does with infection control. As soon as you hear the you know the Health Care Commissioner popping round you know, everybody gets the 10 point plan on everything you need to know about infection control and anybody can be asked in a particular area what the issues are and what you need to know and it gets you know, people read it. So I think some of that is quite important and it’s probably spot checks in some respect, it’s no different to a PEAT visit, you know. So it links with some of that as well.” (S6 171-185)

**Consideration of dignity within pre-registration training for nurses**

“What I’d like to see is ... going back and looking at speaking to some of the providers for the universities for pre-reg and saying to them is this actually part of your curriculum? Are you actually instilling these values? Because I can tell that's not happening. And that will be a real, real, asset if that actually happens, cause that would build their foundation for them to actually move on” (H6 215-225)

This sub theme has presented a range of issues related to training on dignity for healthcare staff as being essential and mandatory at induction within the organisation, and as integral to customer care training. The cultural diversity of workforce was considered a potential reason for there being differing approaches to dignity in care. It has also to be questioned whether there is a dignity component within the pre-registration training for nurses and individuals recalled their experience of nurse training as one where the basics of care were instilled as a
value. Dignity training has also been considered a softer skill that may be more difficult to teach and measure and does not appear to have the same level of importance as other more technical and critical care training. It has been argued that dignity should have equal importance to life support training. Finally, a further comparison was made with infection control training and monitoring as an exemplar for staff to be able to achieve a similar level of adherence to high standards of practice in relation to dignity.

4.7.2 Sub Theme 2: Improving the patient experience

Patients identified key areas where often simple improvements would make a significant difference to their experience in hospital, these included: having the facilities to promote independence, such as being able to make a cup of tea and store personal food in a fridge on the ward (P1), managing and caring for confused patients in better environments (P8), changing gowns to improve privacy and dignity of patients (P2) and improving communication and the information given to patients (P6). As has already been identified earlier in 4.2.2, three patients were aware of government drives to eradicate mixed sex accommodation. Examples of references to these points can be seen in Box 4.33.
Box 4.33 Identified areas for improvement by patients

**Facilities to promote independence**

“I mean having better facilities just being able to get a cup of tea or you know going to get your own water, having to ask for everything all of the [time], for absolutely everything, it just makes you feel more of a patient and sick and helpless, those I mean it’s always the way, it’s those really really basic things that make a lot of difference when you’re kind of in that helpless and vulnerable position, isn’t it about being empowered about doing as much as you can for yourself” (P1, 111-116)

**Managing and caring for confused patients in the better environments**

“Well there’s not much you can do really especially in this ward where you have people wandering about. Couple of old ladies they tried to get into different beds, they’re a bit senile aren’t they? That’s what this ward’s all about, people with dementia I suppose I don’t know what they can do, unless you had some private wards, I don’t know what they can do to improve it. Unless you went private somewhere, cost you a bomb, I really don’t know. What can they do?” (P8, 106-111)

**Improving hospital gowns to improve privacy**

“I would have standard things like tie the ladies gowns, you know if they’re elderly, you know make sure they’re covered, just you know, talk to them for five minutes. I think half of them are just really lonely and their privacy, you know, if the nurses’ are taking them on and off the bed, pull the curtains, just pull the curtains you know. You know it doesn’t affect me, but I’m going to be old one day and I might be at that stage and that’s why I think you know, I feel very sorry for the elderly because we all come to that at one stage of our lives you know. Some of us die before we get like that, but if we live in to an old age, chances are we will be like that and it doesn’t take a lot to do that” (P2, 166-174)

**Information and communication**

“I think they, they should have more, more information for the patient. Because when the doctor told me that it might be TB, because I didn’t know anything about TB at all, I was really down and the way the things going on, people in kitchen, some nurses’ the way they come to home, they didn’t help at all. I was really really down. Really really down, I start to become ill in a minute, you know.” (P6, 73-78)

In contrast to these practical improvements identified by patients, healthcare professionals and senior managers appear to focus more on how organisational systems, such as business cases and policies, and current and new initiatives, such as red pegs and dignity champions, can improve Dignity in Care. Indeed discussion on further progressing initiatives included work towards gaining new ‘dignity’ hospital gowns to reduce the risk of bodily exposure, where the dignity steering group had provided support to address an obstacle relating to negotiations with the Trust’s external linen provider. However it was also noted that there were a number of comments on possible changes to the work with the red pegs that included: modifications could be made to the red pegs, such as making them larger (H1 & H9, promoting the red pegs with professional groups that have not been as engaged in their use (H9), education and involving patients and carers to understand their use and have a role in being able to use them
(H2 & H6), and consideration of a re-launch of the red pegs (H1 & H9). An example of reference to some of these changes was:

“I think in theory I think the red pegs work well or should work very well, it has been suggested that the size of the red pegs [be] changed, it should be made larger and I think that’s actually probably a very good idea and it has also been suggested that there should be, if you like, a re-launching of the red peg system and again, I think that’s a good idea as we all need reminding of things and it’s easy to go out on the wards, minus red pegs – which I normally take, attached to my shirt actually – but it’s easy to go out on the wards, minus red pegs and when you get on the ward and draw the curtains and you think, you know, the red peg. Another area if I may be so bold where I think the red peg system needs maybe a little more promotion is with doctors and my experience is that with a lot of initiatives there is an reluctance to involve doctors where they should be involved” (H1 64-75)

One initiative which healthcare professionals and senior managers (S9) were particularly keen to take forward was in developing champions for dignity further so that individuals were clearly identified as champions within teams and departments with a coordinated list of dignity champions across the hospital (S2 & S9):

“I think that you know I would see champions through all levels so not only senior champions but you know have a champion in your area which would be band 5 could, be a healthcare assistant” (S2 145-147)

Within this sub theme it was noted that there was some alignment of areas for improvement identified by patients, healthcare professionals, and senior managers relating to the need for a more dignified hospital gown, and the care and management of patients who were confused. Patients also identified by a number of ways in which patient experience related to dignity could be improved by addressing often simple practical and behavioural issues. However it has also been apparent that this was in contrast to the views of healthcare professionals and senior managers, where their focus was on organisational systems and developing and implementing initiatives that failed to address the personal experience of dignity of patients.

4.7.3 Sub Theme 3: Performance Management

Performance management was a tool that was considered to be a particularly important lever to drive improvements in patient experience and dignity (S3 & S5). This was discussed in a number of ways of that included external performance management by commissioners, where
three senior managers (S1, S3, & S9) talked about the particular interest and involvement of
the commissioning Chief Executive in wishing to see improvements in patient experience:

“The chief executive in one of our local PCTs [has] asked to come to us because he wants
to understand the quality measures that we have across the whole organisation related
to the patient experience” (S1 46-49)

This increased focus on patient experience was identified as positive in supporting work to
address aspects of dignity and develop indicators for the Trust board (S3 & S4). It was also
highlighted by several healthcare professionals and senior managers the need for greater
communication between wards and the Trust board on the level of information on aspects of
dignity (H5, H9, S3, S8 & S9). In particular the way in which infection control was reported at
Trust Board meetings was felt to be an exemplar for reporting clear information on the level of
performance for the Trust to inform board members on the management of aspects of
infection control (H8, S3 & S6). Other examples that were referred to as effective performance
management, that were reported to the Trust Board, and had achieved improvements for
patients, were Accident and Emergency four hour waiting times targets (H8 & H10) and the
National Stroke Sentinel Audit (S8). An approach that was considered to be effective with
previous targets in other areas of clinical practice such as waiting times in accident and
emergency was the ‘stick’ approach (H8 & H13) that should be replicated for dignity:

“I think the stick approach works provided we can come up with some decent targets
you know measurable dignity targets and we have to because we’ve got so many other
targets that we just have to meet, if dignity is to get anywhere then we have to,
unfortunately have it [as] a target driven approach if people are going to do it” (H13 99-
108)

It was of particular interest to note that three of the healthcare professionals (H8, H10 & H13)
who were senior clinicians supported the use of targets to ensure that there were
consequences for not providing care with dignity. It was also identified that to underpin this
there was a need for effective methods of gaining feedback from patients and carers to be a
measure of quality and in particular the level of dignity that patients experienced. Six senior
managers (S1, S3, S5, S7, S8 & S10) highlighted the importance of tracking and monitoring
patient feedback, with one identifying a particular value in publishing results within clinical
departments as a method of providing a further lever to improve practice:

“in the Trust that I was at before they got to the point where we [were] publishing the
data outside the ward on a big chart and my god it made a big difference because the
nurses didn’t want to be confronted with that” (S3 98-101)
It was also questioned by one senior manager (S3) whether the hospital was being rigorous enough in asking questions of patients as the feedback from ongoing patient questionnaires did not appear to get to the board meetings. However, two senior managers (S3 & S9) identified that there was:

“gallons of information in this Trust and others in fact this Trust in some of the information we get back is worse than others in terms of dignity” (S3 22-23).

However, quantifying improvements in the quality of care related to dignity may be a particular challenge as was identified by one healthcare professional (H8):

“I think it’s hard to measure it in any particular kind of quantitative way, but I certainly am much more aware that certainly the professional groups who have been on the training days, are much more aware of dignity for patients, well, I think the red pegs, are in a very obvious way highlighted the importance of privacy and maintaining patients’ basic dignity. But I’m getting the impression that it’s a trickle down effect, that you highlight the problem to the more senior staff and a selection of other staff, who go on the training days and there is a sort of trickledown effect from them to other people. So if they themselves see somebody whose dignity is being compromised for one reason or another, they are much likely to say something or take action to stop it and I’m much more aware of even sort of basic stuff like gowns on and just tying up somebody’s gown once you’ve examined them, rather than just leaving it flapping. Junior doctors certainly, are much more aware of the importance of that kind of interaction with patients, that actually you can’t just come in, do your doctor bit and go away again and actually have virtually no communication with the patient and just leave the restoration of dignity to somebody else.” (H8 55-70)

This sub theme has considered approaches to performance management of dignity through the use of: targets and quality indicators drawing on exemplars from other areas where performance management and of an aspect of a service and quality has been consistently demonstrated and the approach that was used to achieve this. The importance of robust patient feedback and using information from this as a further lever to improve practice was also highlighted as was the particular challenges of gaining qualitative feedback all of which have the potential to increase accountability for dignity in care.

4.8 Chapter summary

These findings have captured a range of patient experiences relating to vulnerability and dignity, at times a lack of privacy and risk of bodily exposure, as well as distress by patients observing indignity to other patients. In addition, simple improvements within the
environment and facilities for accessing drinks and storage of food were identified as enabling
greater control and independence. These findings have also documented the level of understanding of key professionals, their attitude and level of support for the Dignity in Care work in the Trust. A number of initiatives were discussed as having a positive impact in raising awareness and enabling staff to reflect on patient experience and make changes to their own areas of practice. A key enabler for this was the Dignity Training Workshops where the reflective style that enabled discussion and sharing of experiences relating to patient care was identified as motivating staff to act to improve patient dignity. The use of personal commitments was identified as an effective tool to stimulate both practical and behavioural change. The particular context of the Trust and challenges relating to a recent merger were evident in having an impact on translating the national Dignity in Care work within the Trust. However, it was also apparent that a significant degree of consideration had been given to integrating and sustaining work to improve aspects of care related to dignity through new and existing initiatives and structures. Wider issues have been considered that related to further training, initiatives, and improvements in systems, facilities and environments, and the measurement of dignity in care within the Trust. Finally, an issue that was identified across the findings has been a contrast between the personal experience of patients in hospital and that of healthcare professionals and senior managers where the focus was predominantly on organisational systems and initiatives to improve dignity. Chapter 5 will discuss in detail key findings in relation to the Trust priorities for the national Dignity in Care campaign alongside previous research and theory, and where these findings make a contribution to knowledge in this area.
Chapter 5 Discussion

5.1 Introduction

This chapter will discuss key findings in relation to the current evidence base. As an evaluation of the response to the Dignity in Care campaign within the acute healthcare Trust, the discussion will be framed initially by the five elements of the Dignity in Care campaign prioritised within the Trust: 1. Element One, zero tolerance to all forms of abuse, 2. Element Three, Treat each person as an individual, 3. Element Four, enable each person to maintain the maximum possible level of independence, choice and control, 4. Element Five, listen and support people who want to express their needs and wants, and 5. Element Six, respect people’s right to privacy. Further discussion will centre on some of the wider issues identified from the findings related to: change processes, training, and measurement of dignity. Finally, this chapter also considers some of the key limitations to the study.

5.2 Review of the findings in relation to the five priority areas of the Dignity in Care campaign identified by the acute healthcare Trust.

This first section focuses on the five priority areas identified within the Trust (see section 1.8 and Table 1.9) taken from the ten areas identified nationally (see section 1.6 and Box 1.5), around issues of: vulnerability and dignity, how being disturbed affects patient’s sense of being treated as an individual, being able to access drinks and store food as part of enabling independence, how nurses appeared not to have time to talk and listen to patients, and the experience and right to privacy.

5.2.1 Element 1. Zero Tolerance to all forms of abuse

Vulnerability is a key feature in relation to abuse of vulnerable people. Since the time of the launch of the Dignity in Care campaign there has been a change in language and approach in relation to the abuse aspect of this element, from ‘Adult Protection’ to ‘Safeguarding Vulnerable Adults’, which includes a greater element of prevention than previously, and involves upholding a person’s fundamental right to be safe through empowerment, protection, promotion of well being and rights (Reece, 2010). Vulnerability has been defined as:
“the outcome of complex interactions of discrete risks, namely of being exposed to a threat, of a threat materializing, and of lacking the defences or resources to deal with a threat”

(Schröder-Butterfill & Marianti, 2006, p. 9).

It is with this focus that the discussion has reviewed patient experiences in relation to dignity and vulnerability of self, and vulnerability of others, while in hospital.

5.2.1.1 Vulnerable Self

The findings from patient interviews particularly highlighted vulnerability related to where patients were less able to advocate for themselves, protect themselves from a loss of dignity, and had a lack of choice, and very little information and communication. Examples included: patients being left to lie on hard trolleys in the accident and emergency department; a patient not being offered a wash during his time in hospital; and a further example of where a patient had requested an additional blanket which was not provided as the nurse did not return to the patient.

5.2.1.2 Vulnerable Others

This study also identified a further aspect of vulnerability where patients recognised that a loss of dignity would have happened to them had they not been able to speak up, and could happen to them in the future. Furthermore, observing indignities towards other patients from healthcare professionals left these patients feeling distressed on behalf of the other patient, as well as vulnerable to the potential for loss of dignity themselves. One particular example of this was one patient observed an incident where a nurse was observed by another patient to initially walk past a patient who had fallen and then came back and stated to the patient that she could not pick him up. Further examples included patients wearing hospital gowns which often left them exposed, and those patients who were unable to verbalise their needs clearly due to confusion and dementia, or where English was not their first language, were also seen to be particularly vulnerable to a loss of dignity.

In previous research various causes of vulnerability have emerged, many of which are similar to this study’s findings. Of note, Baillie and Gallagher (2011) identified fear, anxiety, having a life threatening diagnosis, communication difficulties and bodily exposure as aspects of vulnerability to a loss of dignity identified by nurses. Widang et al’s (2008) study, involving fourteen female patients, also refers to vulnerability in relation to loss of control and isolation around not being exposed either bodily or through information being overheard. Woogara (2004) also highlighted that older people were particularly vulnerable when wearing a gown as
they were often unable to tie it at the back. However, Webster and Bryan (2009) refer to patients’ fear of one day themselves becoming frail and vulnerable.

Related work in this area has focussed on a taxonomy of dignity violations that has sought to define and categorise the different types of dignity violations (Mann, 1998; Jacobson, 2009). From the example described earlier where the patient was left lying on the floor Mann’s (1998) definition of ‘humiliation’ may illustrate this type of dignity violation, whereas in relation to Jacobson this example may relate to a combination of ‘rudeness’ and ‘indifference’, which she describes as being a familiar experience of all users of healthcare services (Jacobson, 2009, p. 1544). This suggests a wider experience of indignity than individuals who may be more vulnerable to a loss of dignity.

These findings have illustrated from the experience of patients a lack of recognition of the vulnerability of patients to a loss of dignity and a limited use of effective strategies, used by nurses to meet patient needs sensitively. This differs from the work by Baillie and Gallagher (2011) where nurses had recognised the vulnerability of patients to a loss of dignity and highlighted the strategies they used to prevent indignities. This study also adds further detail to the specific groups of patients who may be vulnerable due to communication difficulties and lack of ability to advocate for themselves, for example, those where English is not a first language, and those patients with confusion or dementia.

However, this study has also identified that any patient can feel vulnerable to a loss of dignity in hospital, as a result of observing indignities towards other patients, which has not previously been reported within other studies. This raises serious questions as to how the vulnerability to a loss of dignity can be better recognised by nurses and care be provided in such a way that it values the unique needs of each patient.

5.2.2 Element 3. Treat each person as an individual

The findings identified examples of patients not being treated as an individual that included: disturbance by both noise at night, as well as lights being left on at night to the point that individual patients reported not being able to sleep, which was confirmed as an issue highlighted as a particular concern from the results of the National Patient Survey. In addition the routine within the hospital of: the time that patients were woken, eating at a set times, and lights off at a certain time resulted in patients feeling a loss of choice and control. This led to a sense of resignation, putting off, or a concern about complaining until patients had left
hospital, was also described. However, one nurse gave an example of how previously he had been flippant and blasé in his approach to patients, and having attended a dignity training workshop he had made an effort to address patients by their preferred name and given the patient an explanation of the procedure, such as planning to carry out re-insertion of a cannula before starting to insert the new cannula.

Patients being disturbed by noise at night has been identified as a concern within the National Patient Surveys, 2002-2006 (Picker, 2007), which identified an increase in the percentage of patients bothered by noise at night from both patients (38%) and staff (19%) during the period of 2005-6. In addition, Woogara (2001) reviewed human rights in relation to dignity and highlighted the right to control one’s personal space and territory. Woogara (2005a) also refers to patients not being able to sleep due to noise at night and light disturbance, as well as being routinely woken at 6am, by the lights being switched on and given a cup of tea. The literature reviewed identified models of how patients managed their loss of dignity in hospital, and the sense of resignation identified in the findings has also been described within the ‘Perceptual Adjustment Levels’ (Matiti, 2002). Resignation was identified in relation to an anticipatory phase of the loss of dignity, whereas the patients in this study described their sense of resignation as something that had been experienced, and was ongoing. Matiti (2002) implored nurses to be aware of the levels of perceptual adjustment to a loss of dignity that patients go through, the dynamic nature of this, and the nurse’s role in supporting patients’ dignity through communicating information and responding to patients’ needs empathetically.

In considering the point identified within the study related to complaining, and putting off complaining until after discharge from hospital, this has been acknowledged as a particular concern in relation to dignity and human rights (JCHR, 2007). It was of note that, ensuring people feel able to complain was one of the other points of the Dignity in Care campaign, which the Trust did not choose to focus on as part of its dignity action plan.

One theory that may explain why patients do not feel treated as an individual has been identified as: ‘routinisation’ and task orientated organisation of care that has been described as a direct result of staff shortages, resulting in work overload and time pressures, and increased throughput of patients resulting in what has been called an ‘intensification’ of nursing work (Maben, Latter, & Macleod Clark, 2007, p. 104). However, an alternative psychoanalytical view of ‘routinisation’ has been proposed by Menzies (1988) that this practice is an attempt to eliminate decisions, so that having precise instructions on how to carry out standardised nursing procedures and tasks was noted as a means to reduce the need for discretion and
decision making. However, more recent consideration of the routines experienced by nurses identified these in three groups: pragmatic, obstructive, and meaningful (Rytterstrom, Unosson & Arman, 2011). Indeed the Kings Fund Point of Care work in the UK has recently promoted the use of ‘intentional rounding’ as a structured process to carry out checks within individuals patients at set intervals to support essential care (Goodrich, 2011; Fitzsimmons, Bartley & Cornwell, 2011). These suggest another alternative view where the routine is focussed on the needs of the patient as opposed to trying to reduce the demands on the healthcare professional. These theories and practices provide valuable insights into the possible wider causes of these disturbances and lack of individualised care; however the study’s findings do not provide further evidence to support or refute these theories.

It is of note that whilst ‘treating each person as an individual’ was one of the five priority areas of the Dignity in Care campaign for the Trust, these particular patient issues, identified above, were not addressed within the action plan. However it is also clear from the example of the healthcare professional that the individual commitments by healthcare professionals had the potential to improve care to be more individualised.

These findings, evidence and theories suggest the need for ways to improve the care environment to enable beds spaces to have more personalised environmental controls, as well as reinforcing the use of models such as perceptual adjustment levels to better understand how patients manage with a loss of dignity and as a result of this seek more effectively to meet patients’ needs to support their dignity. In addition consideration should be given to seeking to address the causes of ‘routinised’ care, and where the organisation of care does not treat people as individuals there should be a reappraisal of the current practices and priorities to ensure that the care of patients’ dignity is given the utmost priority.

5.2.3 Element 4. Enable people to maintain the maximum possible level of independence, choice and control

The findings from this evaluation study identified a particular issue with the lack of facilities for storing personal foods and being able to independently access drinks. Facilities are often not considered in relation to dignity, their absence has a potential to impact on a patient’s dignity by restricting their ability to access basic requirements to enable a patient’s recovery or maintenance of health. Whilst this issue was identified by patients, it was had not been
identified by healthcare professionals or senior managers and executives either within interviews or within the gap analysis and action plan relating to these five priority areas.

Other studies have reported similar findings. Woogara (2001) reviewed privacy in light of the Human Rights Act 1988 with specific reference to patients’ rights to privacy in NHS Hospitals. Privacy in this context referred to the right to enjoy one’s own property which included having facilities to be able to store personal belongings, such as a locker. Tadd et al (2011b) refer to ‘disempowering spaces’ where the design of wards, use of notice boards and in some areas removal of lockers to ‘de-clutter’ wards and reduce risks related to falls and infection control, could disorientate, dismay and deject older people in hospitals.

In addition, previous regulatory core standards within the NHS and essence of care benchmarks for food and drink identified the need for 24 hours a day access to food and drink and facilities to be able to store food brought in (HCC, 2007; DH, 2010a). It is also of note that particular work took place within the acute healthcare Trust on the Essence of Care benchmark for Nutrition to implement ‘Red Trays’ for patients with increased nutritional support needs and ‘Protected MealTimes’, which was prior to the study taking place. It is apparent from the findings that these initiatives were not noted by patients and did not address patient’s concerns to be able to independently access food and drinks. These findings confirm current evidence where concerns have been raised around the care environment in other Trusts that does not support independence, choice and control; however it is also a particularly concerning example, given statutory requirements and best practice guidance in this area and that work had focussed on improving care related to nutrition. This can also be seen to be another example of where Trust and Staff perspectives of what matters for dignity seems different from patients’ perspectives.

5.2.4 Element 5. Listen and support people to express their needs and wants

The findings highlighted a particular concern from patients, healthcare professionals, senior managers and executives of nurses being able to spend time talking and listening to patients. Closely related to this, patients, healthcare professionals, and senior managers also identified an issue of ‘busyness’, where staff did not have sufficient time to spend with patients. However spending time and being with patients has been described as the basis for acknowledging humanity (Benner & Wrubel, 1989).
Busyness has been defined as ‘an individual being fully occupied in a particular activity’ with an example used of “she seemed too busy even to talk to me” (Collins Dictionary, 2011). This closely relates to Mann’s (1998) first violation of dignity that involves people ‘not being seen’, and again relates to the violation of ‘indifference’ identified by Jacobson (2009). The impact of this has been described as diminishing an individual’s sense of significance (Bridges & Nugus, 2010). However, it may also be argued that the observation of busyness is subjective, where an individual may perceive, because of the healthcare professional’s level of activity that they are too busy to attend to their needs, when in fact they may be willing and able to disengage from another activity to meet their needs. However, as identified in the review of the literature, three studies considered patients’ awareness and response to the busyness of nurses (Jacelon, 2003; Bridges & Nugus, 2010; Dawood & Gallini, 2010).

Further discussion within literature has focussed on insufficient time for staff to give care (HAS 2000; DH, 2001a; Seedhouse & Gallagher, 2002; Walsh & Kowanko, 2002; Enes, 2003; Nolan et al, 2004; RCN, 2008a). A particular example given by Walsh and Kowanko (2002) was of a nurse in charge being interrupted on a number of occasions, whilst assisting a patient to shower, due to staffing shortages. It has also been identified that high workload, lack of time and stress affect nurses being able to empathise with patients (Baillie, 1997). Indeed the term ‘impoverished environments’ (Nolan, Davies, Brown, Keady, & Nolan 2002) has been used to describe a physical environment where staff shortages, resulted in lack of time to give anything other than physical care. However, Maben et al (2007) identified that in environments where there was adequate staffing, good skill mix, a culture of support, and professional development, ideal practice flourished and individuals were able to sustain their values and ideals, offering high quality patient care. An earlier paper from this study also considered the organisational factors that ‘sabotaged’ nurses’ ability to meet their ideals of providing high quality patient care that included staff shortages, time pressures, role constraints and work overload (Maben, Latter, & Macloed Clark, 2006).

These findings have focussed on a particular challenge relating to nurses’ ability to meet patients’ needs of having time to sit and listen, due to time constraints. Whilst these concerns related to nurses having sufficient time to spend with patients may be subjective, there is also considerable evidence in the literature of the issues relating to staffing shortages. Issues relating to sufficient staffing levels to meet patient needs are not new, and are ones that the NHS and other healthcare providers will have to continue to grapple with given the current economic climate within the UK. However, what is not considered in discussions about finite
staffing levels and resources is the practice of those nurses who do make time to talk to patients, and how they achieve this as part of their manner and approach, in what may often be a ‘busy’ schedule. This is an important area of practice that should be acknowledged and given greater consideration as it has the potential to inform best practice.

In addition the Trust Dignity action plan identified the training and support to improve the care of patients with Dementia as a key action within this element. The findings highlighted that there had been a change of approach by some nurses that involved sitting with patients.

5.2.5 Element 6. Respect people’s right to privacy

This section considers privacy in relation to auditory and visual privacy including the issue of mixed sex accommodation and strategies used to manage and protect patients’ privacy.

5.2.5.1 Auditory privacy

In relation to auditory privacy patients and healthcare professionals identified issues that included: the difficulty of patients having to use a commode next to the bed knowing that other patients could hear them; where large numbers of staff on ward rounds could be overheard by other patients; and where a male patient described his distress overhearing an older female patient having a urinary catheter inserted, in the bed next to him.

Woogara (2001) refers to the right to protect one’s medical and personal information and the right to expect treatment with dignity during intimate care as part of an individual’s Human Rights. It may be argued that this was not upheld in either of these cases. In particular the use of a commode has been identified by patients and healthcare professionals as a threat to dignity (Jacelon, 2003; Baillie, 2007a). Woogara (2005b) also identified that the personal information of patients who were cared for in a bay often becomes public information. Again, the Picker’s (2007) review of trends from the National Patient Surveys identified that patients felt they had less privacy when discussing their condition on the ward. It is also of note that in a Swedish study (Back & Wikbald, 1998) patients rated being able to talk to their physician in private above other aspects of privacy.

These findings relating to auditory privacy are consistent with previous studies that have considered this particular aspect of privacy; furthermore they highlight the degree of importance that should be given to aspects of care relating to auditory privacy. The next part of this section considers visual privacy.
5.2.5.2 Visual privacy

Lack of dignity relating to visual privacy was also highlighted in the study by patients and nurses, and in particular where patients felt, or witnessed a lack of consideration for their privacy and dignity. Examples included: curtains not being closed during examinations when physiotherapists were exercising patients, or when nurses who were attending to patients did not recognise the need to cover up patients so that they were not exposed and did not have their catheter bags on display; the frequent use of hospital gowns exposing the backs of patients when going between hospital departments and; patients within a mixed sex bay feeling vulnerable to bodily exposure to patients of the opposite gender.

Bodily exposure in relation to dignity, and in particular the use of hospital gowns has been reported in a number of studies (Gallagher & Seedhouse, 2002; Seedhouse & Gallagher, 2002; Walsh & Kowanko, 2002; Woogara, 2005b; Baillie, 2007) with the impact of this being to depersonalise these patients as individuals. Ballie and Gallagher (2011) identified examples of strategies used by nurses to enhance the privacy of patients through; the development of a policy for hospital patients to be adequately covered up when attending the outpatients department, and an example of taking patients to the toilet rather than using a commode.

The continued use of mixed sex accommodation was also a key finding from the 2006 National Patient Survey where the level of patients having to share a sleeping area (bay) with patients of the opposite gender had risen to almost a third of patients (Picker, 2007). This practice has been described as unacceptable (Page et al, 1995; Rhodes et al, 2003; Picker 2007; Baillie, 2008) and has been particularly concerning in light of governmental drives to eradicate the practice of patients of the opposite gender using the same sleeping area and toilet facilities (see also section 1.5).

However, in common with a more recent Department of Health report (DH, 2010b) this study has highlighted that several patients had experienced being nursed in a mixed sex bay on their previous admissions and for a few patients on their most recent admission. There were a range of strong feelings about this that included: the distress that this was continuing to happen, as well as an awareness that the government was supposed to be ‘sorting this out’; and the suggestion that the reason for this continued mixing of sexes in hospital bays was that the government was at the same time also pushing for hospitals to run at full occupancy. This final point illustrates, from a patient perspective what commentators have termed as “conflicts of interest” (Tadd et al, 2011b, p. 9) between the priorities of healthcare Trusts, and those of staff
and patients, and the “paradoxical effects of health policy” (RCN, 2008a, p. 48) where there is the potential for targets and policy to conflict with the provision of dignified care.

As has been described, the study also presented a particularly distressing example of a male patient overhearing an older female patient in the bed next to him being catheterised. It is of note that studies on privacy in hospital have considered how a lack of privacy affects different genders and age groups (Parrott, Burgoon, Burgoon, & LePoire, 1989; Back, & Wikblad, 1998; Rhodes, Leathley, Watkins, & Sharma, 2003; Baillie, 2008; Whitehead & Wheeler, 2008b). Parrott et al (1989) identified that female patients feel more violations of privacy than males do, and Whitehead and Wheeler (2008b) identified that females valued their privacy more highly than the men; nevertheless men, in this study, also valued their privacy. In relation to age, Back and Wikblad (1998) identified that younger patients had higher privacy preferences compared to older patients. However, Baillie (2008) highlighted the perception from one nurse that “for older people and those going through distressing things, I think it is easier if there are single sex bays” (Baillie, 2008, p. 1222). Mann (1998) also refers to injuries to dignity resulting from violations of personal space. It is argued that this study has given examples of violations of personal space both in terms of auditory and visual privacy, from the example of a patient overhearing an intimate procedure to patients describing how they had felt exposed in hospital gowns or witnessed other patients being left exposed through a lack of care and attention.

As with earlier findings this study differs from others in that it portrays the distress of patients overhearing intimate care procedures being undertaken to patients of the opposite gender, and patients observing the lack of attention given to other patients’ privacy. It was also apparent that there was limited awareness by healthcare professionals of the nature of this experience, as their focus appeared to be on managing difficult situations that included insufficient single sex toileting areas and pressure to move patients to free up hospital beds.

5.2.5.3 Strategies to manage and protect patient privacy

The study also explored in depth the use of a ‘Red Peg’ as a mechanism to promote privacy and stop intrusions as one of the several initiatives undertaken as part of the response to the Dignity in Care campaign. The findings identified that several thousand ‘Red Pegs’ had been purchased for this initiative which had gained strong engagement from a wide range of healthcare professionals and senior managers to promote privacy; it also had enabled staff to have permission to challenge colleagues who were not respecting the privacy of patients.
Whilst patients considered the initiative a good idea they had very little awareness that it was already in place, but in practice patients did not report interruptions, when curtains were drawn around them. The potential value of patients being actively involved in the use of ‘Red Pegs’, was highlighted by healthcare professionals within the study to support and enable patients to have greater control over maintaining their privacy and dignity.

Currently there no published studies on the effectiveness of ‘Red Pegs’ in promoting privacy and dignity, although there are published articles that report their value in improving consistent quality care (Davis, 2010). However a number of studies have also considered the ways in which nursing staff have tried hard to manage privacy for patient, and the mixing of patients of the opposite gender (Walsh & Kowanko, 2002; Baillie, 2007; Baillie, 2008) with a particular strategy being communication that included apologies to patients, moving patients at the earliest opportunity to single sex bays, and turning the bed in such a way to give greater privacy and to reduce the degree to which patient’s privacy and dignity was compromised (Rhodes et al, 2003; Walsh & Kowanko, 2002; Baillie, 2007; Baillie, 2008).

This study contributes to knowledge in this area as an example of an effective tool to assist healthcare professionals to improve and protect patients’ privacy where there was high level of ownership across a wide range of staff groups. The study also noted that the Red Pegs enabled staff to challenge colleagues who were not observing their use in maintaining patients’ privacy. However, patients did not report awareness of their use and the study was not able to report on an improvement in privacy for patients as a direct result of their use. One approach to measuring the effectiveness of the use of ‘Red Pegs’ on maintaining privacy and preventing intrusions would be through the use of observational studies.

On considering the basic human needs relating to auditory and visual privacy and dignity within the environment it is difficult to understand: why these continue to not be met; why it has been necessary for policies to be written to direct this level of practice; and why there continues to be mixing of patients of the opposite sex given successive attempts by governments to eliminate mixed sex sleeping and use of toilet and washing facilities within hospitals.
5.2.6 Summary of discussion on findings in relation to the five priority elements of the Dignity in Care campaign

The review of the five prioritised elements of the Dignity in Care campaign has identified key issues related to the vulnerability of particular groups of patients that has included those patients with communication difficulties and cognitive impairment and that all patients have the potential to feel a sense of vulnerability to a loss of dignity. In addition the need for patients to have greater control over the environment within the hospital bed space, to be able to better manage disturbance from noise and light, has been highlighted. Access and storage to food and drink has also been highlighted as a particular area of concern. The issues of nurses spending time to listen and support patients is complex and a number of factors have been discussed relating to workload and staffing shortages, how patients may manage their requests and the subjective nature of this, as well as the manner and approach of the nurse. Finally this section has reviewed the issue of privacy where the study has identified particular concerns relating to patients being exposed and continued use of mixed sex accommodation, in spite of action plans and national drives to deliver same sex accommodation and facilities. However the use of ‘Red Pegs’ has been found to have widespread clinical support and can be seen as a positive initiative that requires further work to empower patients to be able to use the ‘Red Pegs’ to support maintenance of their privacy and further study to quantify whether it has also had a positive impact on patients in maintaining their dignity.

This next section will discuss a range of wider issues that were identified within the findings related to change processes, training, and performance management of dignity.

5.3 Wider issues related to the Dignity in Care campaign within the organisation

The following issues bring together some of the wider issues identified across the findings relating to change processes to improve, and sustain the Dignity in Care work, the contrast between the experiences of patients and the focus of healthcare professionals, senior managers and executives, the importance of training to enable healthcare staff to reflect on their practice and behaviour, and the performance management and measurement of dignity.
5.3.1 Change processes and sustainability of the Dignity in Care campaign

The first and most important step in the change process that was identified within the findings was a raised awareness of the Dignity in Care campaign across the Trust. This was achieved through two routes:

1. Discussion and communication about the nature of the problems and actions being progressed to improve dignity within key organisational committees, and

2. A number of high profile initiatives that both raised awareness and engaged staff in these initiatives that included the roll out and use of ‘Red Pegs’ to promote privacy, training for staff to meet the needs of patients with dementia, and posters within an Out Patients department to stop intrusions into clinic rooms.

At an individual level the degree of raised awareness and further processes related to change is congruent with a transtheoretical model used to describe changes in behaviour of individuals in relation to their readiness to act out new behaviours, which involve five stages of: precontemplation, contemplation, preparation, action, and maintenance (Prochaska & DiClemente, 1984). More recent work that has identified a number of processes and activities for influencing behaviour change (Prochaska, Prochaska & Levensque, 2001) has particular relevance to this study as identified in table 5.1.

Table 5.1 Process and activities relating to sustainability after Prochaska et al (2001)

<table>
<thead>
<tr>
<th>Processes</th>
<th>Activities related to the Dignity in Care work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consciousness raising</td>
<td>Relating to becoming aware of a different way of working with patients, such as training on the needs of patients with Dementia that enabled staff to think differently about the way that care was being provided</td>
</tr>
<tr>
<td>Self re-evaluation</td>
<td>Where an individual reflects on current practice and recognises the need for change, such as the individual who identified the importance of introducing himself and giving an explanation of what he was going to do</td>
</tr>
<tr>
<td>Self liberation</td>
<td>Believing that a change can succeed and making a firm commitment to it, such as the individual who developed and implemented posters to prevent intrusions within an outpatient clinic.</td>
</tr>
<tr>
<td>Counter-conditioning</td>
<td>Substituting new behaviours and cognitions for the old ways of working, such as the nurse who chose to introduce himself and explain what he was doing as a change in practice</td>
</tr>
</tbody>
</table>

However, whilst this addresses the process of change related to the behaviour of an individual the study also described examples of leadership and role modelling best practice and
challenging poor practice that sought to improve practice with other individuals and teams. This approach is consistent with findings from other studies and reports that have supported the importance of role modelling to create climates that staff have the courage to challenge poor practice (King’s Fund, 2009; King’s Fund, 2011). In addition a systematic review on leadership styles and outcomes for nursing has identified the effectiveness of transformational and relational leadership as opposed to leadership styles focused on tasks (Cummings et al, 2010).

At an organisational level, the review of key policies, development of an action plan to address mixed sex accommodation, inclusion of dignity in business cases, and the visit from a Primary Care Trust Chief Executive, demonstrated a high level of support and engagement in the Dignity in Care campaign in the Trust. Whilst a number of change theories exist (Lewin, 1951; Schein, 1969; Ackerman, 1997) one that has been used widely within the National Health Service (NHS Institute for Innovation and Improvement, 2011) is that of Lewin (1951) whose three step linear transitional model of planned change involves seeking to achieve a known desired state different from the existing one. Lewin’s theory is predicated on a model of change that moves from ‘unfreezing’ the current systems, processes and behaviours to ‘change’ towards a new way of working that needs to undergo ‘refreezing’ in order for individuals to establish their new way of working, and not return to their previous processes and behaviours. This theory utilises a force field to describe the driving and opposing forces for change.

As identified, key driving forces were the need to improve dignity in care in the hospital that were also part of external targets in relation to the quality of patient experience and mixed sex accommodation. Directly related to this was a high level of senior management support given to the dignity in care work, as well as high profile initiatives to improve dignity that achieved a high level of engagement and ownership by staff. In contrast to the driving forces, the opposing, restraining forces could be identified as the major organisational change that took place, the lack of involvement of some groups of staff in dignity work such as medical staff, and concerns about how the dignity campaign within the Trust would be sustained. Whilst it is difficult to measure the differing forces, it was apparent that from the level of raised awareness, engagement and motivation of large numbers of staff getting involved in initiatives to improve dignity that the driving forces outweighed the restraining forces. On this basis the response to the Dignity in Care campaign in the Trust had had a positive impact through achieving widespread support of its aims and initiatives.
However the merger of the healthcare organisation with another healthcare Trust that took place during the period of the Dignity in Care campaign presented a particular challenge in progressing aspects of the work to improve dignity and affected the future direction of continued work to improve dignity. The findings identified delays in the Dignity in Care work due to changes in the organisational structure that led to periods of vacancies in new management posts, a lack of clarity as to roles and responsibilities in relation to dignity in care work, and a particular challenge in communicating across a much larger organisation. The enlargement of the organisation following merger also necessitated further assessments of gaps in policies and practices in relation to dignity across the new organisation and gave a sense of taking two steps forward and one step back.

Evidence of mergers and organisational change in healthcare concur with these findings of the study, where it has been identified that there can expect to be a 25% - 50% drop in productivity when going through a large scale change (Tetenbaum, 1999) and Fullop et al (2002) identified that the disruption caused by mergers results in significant delays in the implementation of planned service development.

These areas discussed related to the driving forces to enable change and the merger of the organisation highlight a particular challenge of sustainability of the Dignity in Care campaign work within the Trust. The findings identified particular concerns that work to improve dignity in the Trust should not ‘whither on the vine’, as other NHS projects were viewed as having done through a lack of clarity in the stages of a campaign and how it is integrated or ended. Indeed solutions were proposed to integrate and mainstream the Dignity in Care campaign within the organisation at different levels as well as with new ideas, existing work and continuing to build on initiatives as part of the Dignity in Care campaign.

The issue of sustainability has been given particular attention within the NHS as a result of numerous drives to modernise and improve services (Buchannan, Fitzgerald, & Ketley, 2007) and was an area that was identified as a concern as to how the local and national campaign would be sustained and mainstreamed into the acute healthcare Trust. Sustainability has been defined as:

“when new ways of working and improved outcomes become the norm. Not only have the processes changed, but the thinking and attitudes behind them have fundamentally altered and the systems surrounding them are transformed in support. In other words it has become integrated or mainstream way or working rather than something added on.”

Whist the effectiveness of the Dignity in Care campaign may have been related to the top down support for this work it could be argued that the widespread support for the aims and initiatives is consistent with a ‘bottom-up’ approach in a favourable political context where momentum was supported by an increasing national focus on dignity (Crow et al, 2010). Indeed integration of work on the dignity campaign at different levels in the organisation is consistent with a number of factors identified as affecting sustainability that include: individual, managerial, leadership, and organisational (Buchannan et al, 2005). In addition other factors affecting sustainability that were also evident from the findings were: cultural – relating to innovations such as the red pegs that achieved cult status, and political and contextual – in terms of new senior managers and executives following the merger and their particular interest and support for the dignity work. Whilst each of these factors may have had differing levels of impact on the sustainability of the dignity work, it is clear that a number of these factors to enable sustainability were in place within the organisation.

5.3.2 Differences between patient experiences and the focus of healthcare professionals and senior managers

The findings identified a number of themes where there was a contrast between the patient experiences and the focus of healthcare professionals and senior managers that was often related to systems and initiatives. These differences were apparent within the sub themes of: privacy and mixed sex accommodation, endorsement of the Dignity in Care campaign by healthcare professionals and senior managers, and further improving patient experience related to practical issues, such as improvements to the environment and behavioural aspects of care. For healthcare professionals and senior managers their focus appeared to be more on organisational systems such as: action plans to address mixed sex accommodation that had limited acknowledgement of patient views and experience. In addition there was a focus on policies and initiatives such as ‘Red Pegs’ and ‘Protected Meal Times’ as opposed to the simple requirements of patients such as being able to control the light and noise, being able to make a cup of tea, and for nurses to be able to spend time with patients.

The importance of addressing little things that demonstrate care and attention has been widely reported in a number of studies (Gallagher & Seedhouse, 2002; Dawood & Gallini, 2010; Nicholson et al, 2010a; Baillie & Gallagher, 2011). Separately concerns have also been raised
around a target culture in the NHS over the past ten years where organisation systems the processes of clinical work have taken precedence over patients’ interests (Tadd et al, 2011).

So while previous research has highlighted addressing little things as important what I think has not been so clearly shown before is the gap, within one organisation, of the importance of these details from patients’ perspectives in contrast to what the organisation thinks is important.

It is also suggested that the merger with another Trust and subsequent top down restructuring of managerial roles had also resulted in a shift from an organisational focus on patient experience to one where there was greater focus on meeting regulatory standards and targets. This raises a serious question on how campaigns can be set up and implemented within organisations in such a way that they are able to maintain the focus on the individual needs and experiences of patients.

### 5.3.3 Training and personal commitments to improve dignity

The findings identified the importance of training related to dignity, by both healthcare professionals and senior managers. In relation to the dignity training workshops the role of line managers suggesting staff attend workshops was instrumental in individuals seeing this as an important agenda for the Trust. However it was also of note that there were also individuals who identified the dignity training workshop as important for them to attend to influence and cascade to line reports and colleagues.

This concurs with evidence from a longitudinal study considering the factors influencing the outcomes from continuing professional education, where the motivation of individuals and support of line managers was identified as a key factor enabling positive outcomes (Ellis, 2001; Ellis & Nolan, 2005).

The value of the dignity training workshops for participants was also identified as providing opportunity to reflect on dignity related to an individual’s own area of practice, to work in small groups, and to work with a range of multi-professional colleagues.

A systematic review of the evidence relating to interdisciplinary learning (Cooper, Carlisle, Gibbs, & Watkins, 2001) identified the benefits of interdisciplinary learning as being primarily related to knowledge, skills, attitudes and beliefs. A literature review of the impact and effectiveness of inter-professional education that predominantly focussed on primary care
found limited evidence of its effectiveness. However, it did suggest potential benefits in relation to positive changes in attitudes and perceptions of other professionals as well as increased knowledge of the role and function of other professionals (RCN, 2006).

An aspect of this study that was of particular interest was the identification of personal commitments by healthcare professionals attending the dignity training workshops to improve an aspect of dignity within one of the five priority areas set out by the Trust. The nature of the commitments identified related to a focus on both tangible actions to improve dignity as well as an open and honest reflection of an individual’s behaviour and how this could be improved towards patients and colleagues. It was also suggested that a more reflective style of the workshops facilitated a more open and honest consideration of practice.

This is comparable with other work that involved nurses using ‘pledges’ to improve an aspect of dignity within their own area of practice that also enabled both practical and behavioural change (Crow et al, 2006). In addition, the use of educational resources in the RCN Dignity campaign were identified as “successful in triggering staff to critically reflect on their own practice and recognise improvements that were necessary” (Baillie & Gallagher, 2010).

Whilst both healthcare professionals and senior managers endorsed the importance of ongoing training, a particular issue that the findings identified was recognition that training related to dignity was considered a softer skill and one that did not appear to receive the same level of importance as other more technical and critical care training, such as, advanced life support. Exemplars from other areas of practice were identified as potential means to redress this balance and included a comparison with infection control training and monitoring in order to achieve a similar level of adherence to high standards of practice in relation to dignity.

Nursing research has explored the focus on interpersonal care as opposed to technical care from the experiences and perceptions of patients (O’Connell, Young, & Twigg, 1999; Attree, 2001; Calman, 2006) with differing outcomes. Attree’s (2001) study identified the importance of care that was individualised, patient focussed and related to need, provided humanistically through the presence of a caring relationship by staff who demonstrated involvement, commitment and concern. However, Calman’s (2006) study considering patients’ views of nurses’ competence described technical care and nursing knowledge as the foundation of competent nursing practice, however once this was assumed the interpersonal aspect of nursing care became the most important indicator. In addition, Bridges and Nugus (2010)
identified concerns with a focus on technical medical care and how this may lead to an imbalance of power between staff and patients.

This study differs from others in describing the tension between how the ‘softer’ skills training relating to dignity can be given the same level of importance as technical skills, and proposing an alternative model for dignity training to adopt, in relation to infection control. Whilst there may be a value to considering this approach it may not be able to reflect the more experiential aspects of training on dignity. However, considering other exemplars of good practice within healthcare to support practice related to dignity is discussed further in this next section on performance management and measuring dignity in care.

5.3.4 Performance management and measuring Dignity in Care

The study identified a particular requirement from senior managers for performance management of the quality of patient experience in relation to dignity. This was in part driven by the external factors of the poor results in the National Patient Survey as well as a visit from the Chief Executive for the Primary Care Trust. The need for information on dignity to be able to be communicated from the wards to, and discussed at, Trust board was identified as a priority for the organisation. Exemplars from other aspects of care were used, that included: infection control, waiting time targets for accident and emergency and the National Stroke Sentinel Audit. In addition the importance of gaining patient feedback as a measure of dignity that could be published within departments was also considered vital as a method of stimulating improvements. The challenge of measuring dignity quantitatively to report to a Trust board was also identified.

The study reflects a growing recognition of the importance of ward to board accountability for patient care (King’s Fund, 2009). The study identified current indicators that illustrated effective reporting to the Trust board, such as infection control, that were offered as an exemplar for healthcare staff to identify a small number of key indicators on dignity. Whilst the comparison with exemplars of this nature has not previously been reported, the development of indicators for patients’ experience, dignity and compassion have received increasing attention (Help the Aged, 2008; Griffiths, Jones, Maben, & Murrells, 2008; King’s Fund, 2009; Coulter, Fitzpatrick, & Cornwell, 2009; Patterson et al, 2011; McCance, Telford, Wilson, MacLeod, & Dowd, 2011). However, whilst the challenge of measuring and reporting data relating to dignity was described in the study, previous work has been undertaken (King’s Fund, 2008; Coulter et al, 2009) that has considered a range of methods and techniques to gain
feedback on patient experience that includes the use of; quantitative data, review of complaints, patient reported outcomes and patient stories (King’s Fund, 2008). However it has been reported that the use of direct feedback from patients is likely to remain the core method of measuring patient experience (Coulter et al, 2009).

Whilst exemplars have been identified within this study to model monitoring and reporting of performance of dignity, these often use quantitative data that can be more easily aggregated across a number of clinical areas to give a Trust wide measure of performance. These measures will be of limited value if they are not able to provide the narrative of patient experience. Furthermore, it has been discussed earlier that the types of initiatives that have been measured, such as the use of Red Trays and Protected Meal Times may not measure those aspects of dignity that are important to patients.

5.4 Limitations of the study

A key feature of this study has been to consider the views of a wide range of sources including: patients, healthcare professionals, senior managers and executives, as well as reviewing documentation in relation to work on the Dignity in Care campaign within one acute healthcare Trust. These data sources can be seen to be representative of a wide range of patients and healthcare professionals, as well as senior managers and executives with a range of responsibilities related to dignity. However, limitations in relation to representation of the groups were that the sample of healthcare professional participants did not include junior grades of staff, as those interviewed were senior professionals, who would be expected to be more knowledgeable about initiatives taking place within the Trust. In addition other groups not included in this evaluation study were carers, or external stakeholders, such as commissioners of healthcare, or providers of education for healthcare professionals.

It was also noted that during the process of interviewing healthcare professionals, senior managers and executives there was a sense of individuals seeking to provide the ‘right’ answers to questions, which was particularly evident in relation to questions around understanding of the Dignity in Care campaign and the areas that the Trust had prioritised. Furthermore, review of key documents has provided additional information that would not have been gathered from interviews, such as the mixed sex accommodation action plan, and enabled confirmation of the degree of relevance and importance of issues such as the evaluation report of the dignity workshops.
A limitation of the methodology was that in relation to a number of initiatives, such as Dignity Training Workshops and Red Pegs, that could be considered as the instructional milieu (Parlett & Hamilton, 1972), whilst there was rich description of their use, there was limited information on the impact on improving aspects of patients’ dignity. It is suggested that observational studies over a period of time may provide the ability to capture this information and further inform practice. In addition, further interviews over a period of time could have enabled data to be gathered that could have substantiated whether or not changes in practice as a result of innovations were sustained.

Whilst the context of the acute healthcare Trust was a central feature of this illuminative evaluation that has provided unique insight into the implementation of the national Dignity in Care campaign, this study needs to be considered in light of the complex nature of healthcare organisations and the wider organisational change that is taking place within the NHS. It has been argued that the goal of illuminative evaluation is not to generalise to other settings, however there may be certain common elements that emerge which may be useful in ‘illuminating’ similar processes in related contexts (Parlett & Hamilton, 1976). A number of examples may be considered in relation to the processes involved, such as: Dignity Training Workshops, roll out of ‘Red Pegs’ across all clinical areas, and the impact of organisational change on the implementation of a national campaign to improve aspects of care.

Finally, this evaluation study which was carried out eighteen months after the Trust commenced its response to the national Dignity in Care campaign, has documented a wide range of initiatives developed to improve dignity within practice. It may be argued that a longer period is required, prior to undertaking an evaluation, to capture the impact of changes to practice and their effect on the Dignity in Care provided to patients. However, the particular strength of this evaluation has been the rich data gathered that has illuminated a number of issues related to the experiences of patients, such as vulnerability and dignity, as well as the ability to compare across data sources the different perspectives of each sample, and identify, where at times, there was a contrast in the priorities of healthcare professionals as compared to the needs of patients.

5.5 Chapter summary

Discussion has centred on the priority areas to improve aspects of dignity identified by the acute healthcare Trust in July 2007, along with wider issues highlighted during the period of the
study at the end of 2008. Areas where new knowledge has been identified included: further detailing aspects of vulnerability and dignity, as well as the distress caused by patients observing indignities towards other patients, and a contrast between the experiences of patients and the focus of healthcare professionals and senior managers on systems and initiatives to improve dignity that often failed to address the simple requirements of patients for their dignity. Findings are consistent with other work in this area related to: levels of disturbance at night, a reluctance to complain, inadequate facilities to store food and access drinks, as well as concerns in relation to nurses being able to spend time with patients. The discussion has highlighted the recognition that patients continue to experience mixed sex accommodation and a lack of care for their privacy in spite of patient concerns and government efforts to deliver same sex accommodation. However the use of ‘Red Pegs’ to improve privacy and prevent intrusions were identified as a particularly effective tool that engaged a wide range of staff, where there are currently no published studies evaluating their effectiveness. A further initiative that was effective in engaging staff in improving their practice was the use of personal commitments as an action from the Dignity Training workshops, which has been used previously with similar changes to practice.

A particular challenge has been the complex nature of a large acute healthcare Trust where significant organisational change was taking place that directly impacted on the implementation of the national Dignity in Care campaign within the Trust. However change theory has considered how a range of driving forces at both organisational and individual level has been effective in enabling the widespread support of the aims and initiatives to improve Dignity in Care. The importance of sustaining work to improve dignity has also been considered in light of current evidence, with key factors in place within the organisation to enable this. Further learning that has also been identified supports an ongoing focus on Dignity in Care within the Trust, was on the measurement and performance management of dignity, which has included consideration of exemplars from other areas of practice.

The next chapter will identify key recommendations for professional practice and reflect on learning throughout the study.
Chapter 6  Implications for Professional Practice and Reflection

6.1 Introduction

From the synthesis of the findings and evidence, key implications for professional practice are considered in relation to care provision, the acute healthcare Trust, training for healthcare professionals, the nursing profession, and further research. In addition the researcher’s reflections throughout the study are considered.

6.2.1 Care provision

Key implications for professional practice relating to care provision are:

- Further consideration should be given in relation to the nurse’s role in identifying and supporting patients who are particularly vulnerable to a loss of dignity, that includes patients with communication difficulties and where English is not a first language, and those patients with confusion or dementia.
- Greater recognition of the impact of distress from one patient observing indignity towards other patients and being able to respond effectively to both the support needs of the patient observing indignities as well as addressing the indignities towards patients.
- The need for ways to improve the care environment to enable bed spaces to have more personalised environmental controls for patients to be able to take control over the lighting and noise at night, as well as having the ability to store food and make drinks.
- For nurses to uphold patients’ privacy and dignity in relation to bodily exposure and in situations where caring for patients in mixed sex accommodation is continuing to take place, ensuring these incidents are reported and addressed at a senior management level.
- Empower patients to use ‘Red Pegs’ to be able to maintain their privacy and dignity and prevent intrusions into curtained areas.

6.2.2 Acute healthcare Trust

Key implications for professional practice relating to the acute healthcare Trust are:

- Achieve action plans to address mixed sex accommodation and deliver same sex accommodation.
- Work should be developed to engage patients to be able to utilise the red pegs to have a greater role, where able, in protecting their dignity. One effective approach to involving patients that has gained an increasing evidence base is the use of experience based co-design (King’s Fund, 2011b) that actively recruits patients to play a joint role in improving services.
- Identify mechanisms for patient to raise concerns in a safe and supportive way, without fear of it affecting their care.
- Develop expectations of professional behaviours that promote and support patients’ dignity. This then provides a standard against which poor practice can be identified and addressed.
- Review current practice in relation to staff not having time to spend with patients to be able to identify whether this relates staff shortages and ‘routinised’ care, and whether this leads to an organisation of care which does not treat people as individuals.
- Give further consideration to the concerns highlighted relating to the contrast between patient experiences and the focus of the organisation on systems and initiatives and seek ways to actively involve patients in identifying further developments to improve dignity.
- Ensure that the Dignity in Care work is supported through further integration of this work along with continued development of both new and existing initiatives.
- Develop measures to report dignity at board level that include measures identified by patients and capture the qualitative nature of patient experience, as opposed to aggregating scores within wards and departments of achievements in relation to a particular initiative.

6.2.3 Training of healthcare professionals

Key implications for professional practice relating to training of healthcare professionals are:

- Reinforce the value of existing models and frameworks to inform practice such as the perceptual adjustment levels developed by Matiti (2004) for healthcare professionals to better understand how patients manage with a loss of dignity and as a result of this seek more effective ways to meet patients’ needs to support their dignity.
- Utilise the use of reflection as an approach to improve practice to enable healthcare professionals to consider and connect with the experience of patients. The value of patient stories, discovery interviews and ‘emotional touchpoints’ have gained increasing recognition in enabling improvements in care (Bridges et al, 2008; King’s Fund, 2009;
Dewar, Mackay, Smith, Pullin, & Tocher, 2009). These approaches present innovative opportunities for healthcare professionals to engage in better understanding the personal experiences of patients receiving care, therefore addressing the issues of importance to patients.

- Training, as in the case of Dignity Training Workshops and Training on the needs of patients with dementia can also provide opportunities for reflection to enable staff to think differently about the way that care is provided.
- At an individual level the use of personal commitments to improve dignity in care as a result of dignity training was effective in engaging healthcare professionals to make changes within their own area of practice and should be considered as a technique to stimulate improvements in care.

### 6.2.4 Nursing Profession

Key implications for the nursing profession from this study are:

- A personal and professional responsibility to identify and protect patients vulnerable to a loss of dignity as a result of admission to hospital, in line with the NMC Code.
- To uphold patients’ privacy and dignity in relation to bodily exposure and in situations where caring for patients in mixed sex accommodation is continuing to take place, ensuring these incidents are reported and addressed at a senior management level.
- To actively involve and empower patients in maintaining and promoting their own dignity.
- To identify and report when there are occasions where staffing levels affect the ability to provide dignified care to patients.
- Take a lead role in continuing to identify and develop initiatives to improve dignity in care for patients.

### 6.2.5 Further research

Key implications for professional practice relating to research are:

- Further exploration of the relationship between vulnerability and dignity as to whether triggers can be identified to improve care as a result of staff recognising vulnerability, thus preventing poor practice.
• The sense of distress and vulnerability felt by patients who observe indignities towards other patients has not previously been reported within other studies and warrants further exploration.
• The practice of nurses who do make time to talk to patients, and how they achieve this as part of their manner and approach, in what may often be a ‘busy’ schedule is an area that should be given further consideration as it has the potential to inform best practice.
• In addition observational studies of the effectiveness of ‘Red Pegs’ in maintaining patients privacy and dignity and preventing intrusions should be undertaken.
• Further evaluations should also be undertaken to consider the response to the Dignity in Care campaign within other healthcare organisations, compare responses across organisations, as well as considering how initiatives to improve dignity are sustained over a longer period of time.

This next section will now consider the researcher’s reflections throughout this study.

6.3 The Researcher’s reflections

The experience of undertaking the professional doctorate and in particular the study presented within this thesis encapsulates some of the key aims identified within the literature on Professional Doctorates in the UK (Fell, Flint & Haines, 2011). These were developing expertise in practitioner research related to the use of an evaluation methodology, enhancing the value of a major project that has involved studying the response to the Dignity in Care campaign within one acute healthcare Trust, and a significant personal achievement that is recognised professionally within the workplace.

At the outset of the study the motivation for exploring this area of practice was identified as related to concerns about care and as an opportunity to use the national Dignity in Care campaign locally to improve a number of priority areas. Whilst there are inevitable highs and lows during a lengthy period of academic study the aim to explore patients’ experiences of dignity and understand the nature of the implementation of a national campaign to improve dignity within a complex organisation of an acute healthcare Trust has continued to be a driving force, as well as highly relevant and important in informing practice.

Having a key role in the organisation as a Lead Nurse for Older People during this period of the Dignity in Care campaign enabled much greater understanding of some of the particular issues related to aspects of the provision of care, the nature of the Dignity Training Workshops, as
well as some of the particular contextual issues of the organisation. This also supported key relationships in negotiating access and undertaking interviews to enable these to be purposive and representative.

As a novice researcher a particular challenge that has been a central aspect of undertaking this study, and a feature of previous work at this academic level, has been the degree of analysis required to be able to develop knowledge through understanding, interpretation, and synthesis of evidence in a rigorous systematic approach. Whilst the analogy of learning to drive may not be entirely appropriate it does suggest that an additional set of skills have been gained that are particularly valuable, and can be applied within professional nursing and managerial roles that often involve consider latest evidence, new techniques and equipment, undertaking detailed investigations and reviews of clinical and organisational governance.

Since the period of the launch of the national Dignity in Care campaign and undertaking this study it is with a mixture of disappointment that further concerns related to Dignity in Care continue to be reported within the media, along with an acknowledgment of the benefits of greater recognition that this focus has provided. However, heightened public awareness and media interest often appears to be short-lived with little or no impact on practice and the care given to patients. Whereas the experience of the researcher undertaking this study was that by having a national campaign, with a significant programme of work locally, generated a lot more thinking and discussion about patient experiences of dignity, with staff highlighting concerns related to care that lacked dignity. However, the approach taken to improve practice is particularly important as it demonstrates the issues related to role modelling and transformational leadership that the study has identified as being effective in changing practice. The opportunities to involve patients and their carers within many of the stages of this process, enables greater connection with the personal experiences of patients that have the potential to bridge the contrast that was identified in the study between patient experiences and the focus of healthcare professionals and managers on systems and initiatives.

The value of reflection was recognised within the study as enabling individuals to consider the experience of patients and their own commitment to improve care for patients. Reflection has also previously been identified by the researcher as personal style of learning and professional development (Gallini, 2007) and has been a central theme of undertaking this illuminative evaluation, developing knowledge and learning in a key area of practice that is central to the way care is provided to patients. This sense of deepening awareness and learning has been
articulated particularly well by Senge, Scharmer, Jaworski, & Flowers (2005) who refer to the intimate relationship between reflection and learning:

“All learning is about how we interact in the world and the type of capacities that develop from our interactions. What differs is the depth of awareness and the consequent source of action. If awareness never reaches beyond superficial events and current circumstances, actions will be reactions. If, on the other hand, we penetrate more deeply to see the larger wholes that generate ‘what is’ and our own connection to the wholeness, the source and effectiveness of our actions can change dramatically”

(Senge et al, 2005, p. 12-13).

Finally, outcomes from this evaluation of particular importance relate to the issues of vulnerability and dignity, the need for continued focus on privacy, the contrast between the priorities of professionals as opposed to the experiences of patients, the importance of staff spending time with patients to understand their individual needs, and the value of initiatives that have gained widespread ownership across a large and complex acute healthcare organisation.
References


## Appendix 1 – Table of definitions and concept analyses of dignity

<table>
<thead>
<tr>
<th>Authors</th>
<th>Title/Focus</th>
<th>Derived from</th>
<th>Findings</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marris</td>
<td>Concept clarification in professional practice - dignity</td>
<td>Based on concept clarification model (Walker &amp; Avant 1988) using multiple data sources of dictionaries, professional educational colleagues, two groups of student nurses (20 female in total)</td>
<td><strong>Critical attributes</strong>&lt;br&gt;1. Maintenance of self-respect  &lt;br&gt;2. Maintenance of self esteem  &lt;br&gt;3. Appreciation of individual standards&lt;br&gt;&lt;br&gt;<strong>Antecedents</strong>&lt;br&gt;1. Dignity is a human quality  &lt;br&gt;2. Self advocacy promotes dignity  &lt;br&gt;3. Dignity may be demonstrated by behaviour, speech conduct and dress  &lt;br&gt;4. Dignity is developed by individual life experiences&lt;br&gt;&lt;br&gt;<strong>Definition</strong> - Dignity may be said to exist when an individual is capable of exerting choice or control over his or her behaviour, surroundings in the way he or she is treated by others. He or she should feel comfortable with his or her physical and psychosocial status quo.</td>
<td>Definition does not address issues related to people who are more vulnerable and unable to advocate for themselves – whilst the author refers to this as a “dignity is a personal possession unless one becomes vulnerable or can anticipate its loss” and refers to those groups of individuals most vulnerable who may be incapable of self advocacy she does not explain why this group of people are not included within the definition. Also of note that patients were not interviewed.</td>
</tr>
<tr>
<td>Haddock</td>
<td>Towards further clarification of the concept 'dignity'</td>
<td>Concept analysis informed by Chinn &amp; Kramer (1991) framework of analysis of multiple data sources including dictionaries, literature and poetry and fifteen colleagues, friends and family and model and contrary case studies</td>
<td><strong>Possessing dignity</strong>&lt;br&gt;1. One has to value oneself, to believe in oneself and behave as an important human being, such that one is at least of equal worth, but also remains a unique individual, in relation to others in all contexts&lt;br&gt;2. One strives to maintain the boundary containing these beliefs when they are threatened from within or outside the self&lt;br&gt;3. Feelings of worth, and individuality need to be communicated to others through verbal expression, behaviour, appearance, persona possession and one’s environment&lt;br&gt;&lt;br&gt;<strong>Definition</strong> - Dignity is the ability to feel important and valuable in relation to others, communicate this to others, and be treated as such by others, in contexts which are perceived as threatening. Dignity is a dynamic subjective belief but also has a shared meaning among humanity. Dignity is striving for and its maintenance depends one’s ability to keep intact the boundary containing beliefs about one self and the extent of the threat. Context and possession of dignity within oneself affects one’s ability to maintain or promote the dignity of another.</td>
<td>Also refers to the presence of the nurse as a key intervention affecting patients dignity of:&lt;br&gt;- Erosion of dignity&lt;br&gt;- Maintaining dignity&lt;br&gt;- Restoring or giving dignity&lt;br&gt;- Connecting dignity to humanity&lt;br&gt;Haddock also does not fully address issues relating to the those individuals where their dignity may be compromised due to lack of self advocacy such as individuals with dementia. As with Marris (1995) patients were not interviewed.</td>
</tr>
</tbody>
</table>
| Johnson   | Analysis focussed on dignity in relation to dying     | Review of literature                                                          | **Dignity coupled with terms such as**: peace, comfort, autonomy, control and quality of life  
**Did not offer a definition**                                                                 | Review did not include research with patients, carers or healthcare professionals                                                                                                                     |
<p>| Jacobs    | Access students views                                 |                                                                                | <strong>Student meanings of dignity included</strong>: pride, self confidence, self esteem,                                                              | Identified as a complex concept that                                                                                      |</p>
<table>
<thead>
<tr>
<th>(2000 &amp; 2001) USA</th>
<th>A concept analysis of dignity as it relates to older people receiving care</th>
<th>Not clear whether this was Walker and Avant (1995) or Chin &amp; Kramer (1991) –</th>
<th>Definition - “Dignity appears to be a conceptual something that all persons have and therefore can lose. Dignity is a conceptual something that all persons are born with and want to die with” (2000: 31)</th>
<th>Self respect, values, what makes one human, part of inner being, worth and uniqueness, trustworthiness, being solemn, earnest, reverent, and being respect of others (including protecting privacy)</th>
<th>Could not be fully defined given the reference to something and one that could be attained and well as lost – views of patients, carers and nurses not sought as part of study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fenton &amp; Mitchell (2002) UK</td>
<td>A concept analysis of dignity for older adults</td>
<td>Classic concept analysis (Walker and Avant 1995) three stage analysis of: theoretical, fieldwork and analysis. Involving major review of literature combined with five focus groups with a total of 23 older people.</td>
<td>Literature and focus group data organised into four themes of: Philosophical, attribution, behavioural and developmental. Three defining attributes: 1. Dignity is a characteristic of being human 2. It may be subjectively felt as an attribute of the self 3. It has an external, behavioural component 4. It has a developmental as it can be learnt</td>
<td>Dignity is a state of physical, emotional and spiritual support, with each individual valued for his her uniqueness and his or her individuality celebrated. Dignity is promoted when individuals are enabled to do the best within their capabilities, exercise control, make choices and feel involved in the decision-making that underpins their care</td>
<td>There were references to literature but not wide range data sources and there did not appear to be case studies from the published article or any interviews with patients or professionals</td>
</tr>
<tr>
<td>Jacelon et al (2004) USA</td>
<td>A concept analysis of dignity</td>
<td>Concept analysis informed by Chinn &amp; Kramer (1991) framework of analysis of multiple data sources including review of professional literature, surveyed ten people from nursing and non nursing backgrounds</td>
<td>Grouped responses after Haddock (1996) – the dignified self – self pride, self respect, is understood, control of privacy, true to self, enjoys own self image, able to achieve own goals, hopeful, the undignified self – lack of control, embarrassment, feeling exposed in body, lack of privacy, having ones wishes thwarted, allowed to be unkempt, seeing others treated unworthily and characteristics of other people who can confer dignity – listener, respect for uniqueness and wholeness, is capable or robbing and restoring the dignity of another</td>
<td>Described dignity as being “a quality that existed both in people and for people; that is both a possession and a gift” (2005:84)</td>
<td>Most comprehensive concept analysis and definition of dignity for older adults. Involved a major review of literature and focus groups with older people</td>
</tr>
<tr>
<td>Marley (2005) UK</td>
<td>A concept analysis of dignity</td>
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<td>No patients interviewed as part of the analysis.</td>
</tr>
<tr>
<td>Griffin-Heslin (2005) UK</td>
<td>An analysis of the concept of dignity</td>
<td>Walker &amp; Avant (1995) model of concept analysis with particular focus on the concept within an accident and</td>
<td>Defining attributes of the concept of dignity: Respect, Autonomy, Empowerment, and Communication. Antecedents of dignity: - Possession of dignity within oneself, value for oneself and others</td>
<td>Partial focus on the challenges of maintaining dignity within and Accident and Emergency Dept. Also undertaken as part of an analysis</td>
<td></td>
</tr>
<tr>
<td>Nordenfelt &amp; Edgar (2005) European</td>
<td>The four notions of dignity</td>
<td>Dignity and Older Europeans Project – Qualitative - using focus groups and individual interviews</td>
<td>Theoretical model of four kinds of Dignity</td>
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<td>1. The dignity of merit 2. The dignity of moral statue 3. The dignity of identity 4. Menschenwürde</td>
<td>Theoretical model developed as part of European study – not clear how the data informed this model</td>
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<thead>
<tr>
<th>Coventry (2006) USA</th>
<th>Concept analysis of care with dignity</th>
<th>Not clear what method of concept analysis has been used – however there is wide reference to literature outside of nursing and model cases to represent care with dignity</th>
<th>Attributes for care with dignity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Dignity is an inner feeling of well-being, personal worth, and self respect.</td>
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<td>Feelings of dignity can be affected by interactions with others.</td>
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<td>A covenant is agreed on in the form of the caregiver-patient relationship.</td>
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<td>The patient's autonomy needs to be recognized.</td>
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<td>Guidelines for how to respect individual diversity are set by each partner in the relationship.</td>
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<td></td>
<td></td>
<td>The patient does not have a decrease in the feeling of dignity related to the care provided.</td>
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<td>Concept theoretically defined as “Dignified care is provided when the caregiver and patient agree on a course of care that recognizes the patient's autonomy and individuality. In the course of receiving this care, the patient does not feel an avoidable loss of personal worth as a result of the caregiver-patient interaction.”</td>
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<td></td>
<td></td>
<td>Not clear what method of concept analysis used or strategy for reviewing literature. No interviews undertaken.</td>
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</table>

<table>
<thead>
<tr>
<th>Anderberg et al (2007) Sweden</th>
<th>Preserving dignity in caring for older adults: a concept analysis</th>
<th>Adapted Walker &amp; Avant (1995) model of concept analysis without the construction of cases</th>
<th>The attributes of preserving dignity are individualised care, control restored, respect, advocacy and sensitive listening. Antecedents are professional knowledge, responsibility, reflection and non hierarchical organisation. The consequences are strengthening life spirit, an inner sense of freedom, self respect and successful coping</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>May be seen as a development of work by Jacelon et al with a focus on preserving dignity – extensive review of literature. No interview with older people undertaken</td>
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</table>

<p>| emergency setting | - To be in a circumstance where a person feels competent and capable |
|                   | - Human beings can be said to have dignity ethically and philosophically as a moral ideal or can express dignity through speech, dress language or actions |
|                   | - Independence and freedom of choice, without these characteristics human beings can lack autonomy and feel out of control |</p>
<table>
<thead>
<tr>
<th>Author, country</th>
<th>Aims of the study</th>
<th>Participants</th>
<th>Study design</th>
<th>Results</th>
</tr>
</thead>
</table>
| Chocinov, Hack, McClement, Kristjanson and Harlos (2002) | To explicate the meaning of dignity for palliative cancer patients and to develop a conceptual framework that describes dignity from the perspective of individuals living with an advanced cancer diagnosis | 50 patients from a specialised care unit in an urban extended care hospital | Qualitative semi-structured interviews using latent content analysis and constant comparison techniques | Major dignity categories, themes and sub-themes related to dignity: 
- Illness related concerns
- Symptom distress
- Dignity conserving repertoire
- Dignity conserving perspectives
  - Continuity of self
  - Role preservation
  - Generativity/legacy
  - Maintenance of pride
  - Hopefulness
  - Autonomy/control
  - Acceptance
  - Resilience/fighting spirit
- Dignity conserving practices
  - Living in the moment
  - Maintaining normalcy
  - Seeking spiritual comfort
- Social dignity inventory
- Privacy boundaries
- Social support
- Care tenor
- Burden to others
- Aftermath concerns |
<p>| Model developed comprised of the three main categories: illness related issues, dignity conserving repertoire, and social dignity inventory as interrelated. This identifies that both the burdensome illness related concerns and taxing social dignity inventory are shown to have a deleterious effect on dignity. The model also shows that negative influences might be buffered by a positive dignity conserving repertoire that includes dignity conserving perspectives and/or practices. In contrast the model postulates that individuals with limited dignity conserving repertoire would be more likely to have a diminished sense of dignity. The author also refers to dignity diminishing behaviours, however these were not identified in the findings. | Develops understanding of how loss of dignity can be buffered through the dignity conserving repertoire. |</p>
<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Year</th>
<th>Country</th>
<th>Study Design</th>
<th>Sample Size</th>
<th>Description of Patients</th>
<th>Description of Study</th>
<th>Findings</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Widang &amp; Fridlund (2003) Sweden</td>
<td>- To describe how male patients conceive integrity</td>
<td>Seventeen male patients – strategically selected</td>
<td>Phenomenological study</td>
<td>Three conceptions of integrity summarised in three description categories of: <strong>Dignity</strong> - Three themes of Being seen as a whole person, Being respected, and Being seen as trustworthy. <strong>Self respect</strong> - Having control over yourself and the situation, Having the courage to set boundaries, Being alone, and Having Self belief. <strong>Confidence</strong> - Keeping information confidential, Trusting the professionals, Having balance between one’s own desires and those of others, Participating, and Being free.</td>
<td>This offers a narrower focus on dignity, where other studies have offered a broader and more inclusive consideration of what dignity means to patients and HCPs. It is of note that the conception of the patient identifying the importance of being trustworthy or genuine in their illness is not an aspect of dignity that has been widely reported in other studies.</td>
<td></td>
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<tr>
<td>Widang, Fridlund &amp; Martenson (2008) Sweden</td>
<td>- To describe how female patients conceive integrity</td>
<td>Fifteen female patients – strategically selected</td>
<td>Phenomenological study</td>
<td>Three conceptions of integrity summarised in three description categories of: <strong>Dignity</strong> - Two themes of Being Respected and Not being exposed. <strong>Maintaining the self</strong> - relationship with herself <strong>Confidence</strong> - associated with relationship between patient and professional care givers</td>
<td>Similar to study of Male conceptions of Dignity as part of integrity – although particular focus on ‘Not Being Exposed’ relating to both bodily exposure and personal information. Both studies identify the importance of the relationship between patient and professional caregivers</td>
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<tr>
<td>Whitehead &amp; Wheeler (2008b)</td>
<td>1. To identify what patients understood by the notion of privacy and dignity  2. To explore patients’ thoughts on whether they felt their privacy and dignity were met within a mixed gender ward, any problems they felt stood in the way of their privacy and dignity and how these needs could be met</td>
<td>Convenience sample of 40 patients (9 women and 31 men) from a cardiothoracic ward</td>
<td>Quantitative and qualitative – self reported questionnaire</td>
<td><strong>Quantitative findings</strong> - Significant difference between male and female in relation to the importance of privacy. - No statistical difference between male and female patients in relation to dignity - 52.5% of patients were neither happy nor unhappy being nurses on a mixed sex ward. <strong>Qualitative findings</strong> - Patients defined and conceptualised privacy - Privacy of information, e.g. having one’s conversation not being overheard - Privacy of person and body, e.g. not being viewed during one’s private moments (e.g. performing toilet functions) - Exerting personal control e.g. matters of relating to one’s care - Able to be alone at one’s choosing - Gain respect from professionals - Having one’s hospital records and files removed from visitors attention/place - Having one’s own/personal space</td>
<td>One of the researchers was the ward sister, however measures take to reduce bias. Gender difference identified in relation to importance of privacy, although small convenience sample. Two opened ended self reported questions relation to privacy and dignity. Provides a detailed picture of the interrelated concepts of privacy and dignity in hospital and makes a particular recommendation as to the need to consider the design of hospitals that better address issues of privacy and dignity.</td>
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</table>
Everyone should value privacy as essential or important, especially in mixed sex wards.
- The value of single as opposed to mixed sex wards/bays
- Freedom and privacy to worship
- Right to perform intimate activity of daily living e.g., using the toilet in private and alone, only having staff present if essential

**Patients defined and conceptualised dignity**
- Absence of embarrassment, e.g., shown up in front of others
- Having ones privacy and dignity respected
- Being treated humanely, like a human being and not as an object
- Being treated with respect as well as respecting others
- Being treated with sympathy, consideration and compassion
- To be treated as an individual
- When all staff introduce themselves and say who they are before treating you
- Being able to maintain ones privacy e.g., treated in private, out of public gaze
- A feeling of being in control, e.g., over decisions and private bodily functions
- When staff explain your treatment and changes and what is going to happen
- Being listened to and get heard
- Desire to have own personal space and independence
- Acknowledgement for the need for peace of mind at a stressful time

| Webster & Bryan 2009 UK | To explore older people’s experiences of hospital and their views on dignity and how it could be promoted | Purposive sample of 10 patients between the ages of 73 to 83 | Qualitative – semi-structured interviews following discharge | Factors that had the potential to promote dignity included: privacy of the body, cleanliness, independence and being able to exert control, sufficient time from staff, attitudes to older people and communication. Participants observed staff speaking inappropriately, patients waiting for personal care, and feared for their own dignity should they have cognitive problems in later life. | Relatively small sample that focussed on relatively well and independent older people
Key recommendation related to the importance of communication that conveys empathy and values the individual and the maintenance of their dignity. |
| Bridges & Nugus (2009) | To explore older people’s experience of urgent care and that factors that influence this experience | 69 patients, 27 relatives across 31 English NHS | Qualitative – semi-structured qualitative discovery | Findings were organised around the senses framework of
- Security to feel safe
- Belonging – to feel part of things
- Continuity – to experience links and connections
- Purpose – to have goal(s) to aspire to
- Achievement – to make progress towards these goals | Validity and relevance was addressed by focus groups of 52 people to discuss findings and transferability of the findings were considered in relation to the number |
<table>
<thead>
<tr>
<th>UK</th>
<th>Trusts interviews</th>
<th>- Significance – to feel that you matter as a person – study identified a diminished sense of significance, a sense that they did not matter</th>
<th>of trusts involved across England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dawood &amp; Gallini (2010) England</td>
<td>To gain an authentic and qualitative insight into patients experiences in Hospital</td>
<td>Twenty patients Qualitative – discovery interviews Four themes of: - Pain - Environment - Care and attentiveness - Information and communication</td>
<td>Whilst not specifically focussed on dignity, it was identified as a result of search of key words. Identified issues of patients delaying calling a nurse, even for pain relief when observing other patients sicker than themselves of noticing how busy nurses were.</td>
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<tr>
<td><strong>Studies involving Healthcare Professionals</strong></td>
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<tr>
<td>Lin &amp; Tsai (2011) Taiwan</td>
<td>To understand how nurses in Taiwan maintain patients’ dignity in clinical practice</td>
<td>Thirty nurses Qualitative descriptive study with in depth interviews</td>
<td>Nurses identified five themes: 1. Respect – autonomy, holistic care, beliefs and culture, informed consent 2. Protecting Privacy – Privacy of the body, private space, privacy of condition 3. Emotional support – Encouraging, listening, empathy, appropriate language, spiritual well-being 4. Treating all patients alike – Equal care 5. Maintaining body image – physical appearance Model developed to inform nurses’ practice on key actions to maintain patients’ dignity. Also identified the importance of education programmes that promoted these five themes</td>
</tr>
<tr>
<td>Royal College of Nursing (2008) England</td>
<td>Survey of membership to investigate nurses’ awareness of dignity and barriers that which prevented dignified care being given to patients and clients in a wide range of health care environments.</td>
<td>Over 2000 responses Internet survey – emailed to all members</td>
<td>Concerns highlighted related to the physical environment within acute healthcare care settings of overcrowded wards and poorly screened bed spaces, mixed sex accommodation and inadequate and unsuitable bathroom and toilet facilities, lack of treatment rooms, quiet rooms where intimate procedures and confidential discussions could be conducted. Cultures have a tendency to compound the problems within the physical environment with a culture of management bureaucracy, of unrealistic expectations, quick fix attitude, culture of rushing, target driven and paying lip service to dignity in care. Suggested that management had different priorities and that there were often inadequate resources of linen, towels and insufficient time to deliver care. Developed recommendations at three levels of: Individual, Organisations, and Government level. Whilst uni-professional and based on a survey that may have captured a more activist group it was the largest participant survey of dignity and went on to promote an RCN Dignity Campaign</td>
</tr>
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</table>
Studies involving Patients, Carers and Professionals

<table>
<thead>
<tr>
<th>Study (Year)</th>
<th>Country</th>
<th>Methodology</th>
<th>Staff and Patient Themes</th>
<th>Findings/Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walsh &amp; Kowanko (2002)</td>
<td>Australia</td>
<td>Case study, observational study</td>
<td>Privacy of the body, private space, consideration of emotions, giving time, patient as a person, showing respect, giving control, advocacy, giving control, showing respect</td>
<td>Patient and nurses perceptions very similar and emotions similar in response to violations of dignity. No specific recommendations for practice – however questioned how if perceptions shared – why do such situations continue to arise and what strategies can be put in place to minimise the occurrence of this distressing phenomenon and that a larger study would be valuable in informing the development of guidelines. Identified the need for a larger study that would inform the development of guidelines.</td>
</tr>
<tr>
<td>Jacelon (2003, 2004)</td>
<td>North American</td>
<td>Qualitative study, interviews</td>
<td>Privacy of the body, private space, consideration of emotions, giving time, patient as a person, showing respect, giving control, advocacy, giving control, showing respect</td>
<td>The study is of particular value in detailing an adaptive process of hospitalisation that has some similarities to Maitili (2002)</td>
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<td>European study:</td>
<td></td>
<td>Qualitative study, interviews</td>
<td>尊重与认可（来自他人和自我），参与与参与，尊严在护理</td>
<td>Extensive study across Europe involving large numbers of people through focus groups. Older people were interviewed as opposed to patients and the challenges of translation were identified.</td>
</tr>
<tr>
<td>Buyer, Tadd &amp; Krajcik (2005)</td>
<td>Voice of Older</td>
<td>Qualitative study, interviews</td>
<td>尊重与认可（来自他人和自我），参与与参与，尊严在护理</td>
<td>Extensive study across Europe involving large numbers of people through focus groups. Older people were interviewed as opposed to patients and the challenges of translation were identified.</td>
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<tr>
<td>Adults</td>
<td>Arino-Blasco, Tadd &amp; Boix-Ferrer (2005)</td>
<td>Voice of professionals</td>
<td>interviews</td>
<td>interviews</td>
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<td>social care professionals and young and middle-aged adults about dignity and their experience of it</td>
<td>Provide health and social care professionals with more understanding of how dignity can be enhanced by developing multi-cultural, interdisciplinary educational materials based on the views of older people</td>
<td>424 healthcare professionals in 85 focus groups</td>
<td>In 6 European countries</td>
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<tr>
<th>Seedhouse &amp; Gallagher; Gallagher &amp; Seedhouse (2002) UK</th>
<th>Pilot study into effects on healthcare staff on an educational intervention (an intensive, day long seminar, conducted by a healthcare philosopher to explain the nature of dignity)</th>
<th>Pre and post intervention – structured interviews of staff, patients and relatives were conducted as well as observations of behaviours and attitudes of staff pre and post intervention A small sample of patients and relatives were also interviewed.</th>
<th>18 nurses and HCA’s at three elderly care residential institutions were asked 1. To give examples of occasions when they had been able and unable to maintain dignity 2. To discuss opportunities for and barriers against the promotion of dignity, and 3. To suggest how dignity might be better</th>
<th>According to the interviews, the extent to which patients are dignified depends on:</th>
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<tr>
<td></td>
<td></td>
<td>1. Staff behaviour, attitudes and competence – examples identified were – not a priority to get to know patients, lack of time, and not addressing little things that demonstrate care and attention like saucer with a cup of tea</td>
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<td>2. The environment – matters of privacy, safety, and aesthetics in the healthcare environment such as curtains not very good or wide enough, locking the main door and not enough space between beds meaning it can be easy to catch closed curtains and expose patients</td>
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<td>3. Resources available – related to human staff, linen and equipment with examples of understaffing, lack of linen and towels and call bells, showers not working</td>
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<td>4. The condition and/or behaviour of patients – examples of confused patients exposing themselves</td>
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Four key themes were identified that are often referred to in other work. This was also one of the first studies to identify the issues of a lack of resources as affecting dignity.

Also considered in relation to research involving an intervention to improve dignity – however the findings were inconclusive.
<table>
<thead>
<tr>
<th>Study</th>
<th>Purpose</th>
<th>Methodology</th>
<th>Key Themes Identified</th>
<th>Usefulness</th>
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<tbody>
<tr>
<td>Matiti (2002)</td>
<td>To explore patients’ views regarding the factors that contribute to the maintenance of their dignity while in hospital, together with their perceptions of whether or not these were realised</td>
<td>Case study involving interviews and participant observation</td>
<td>Six key themes that contribute to the preservation of their dignity: 1. Privacy  2. Confidentiality  3. Communication and the need for information  4. Choice, control and involvement in care  5. Respect  6. Decency and forms of address</td>
<td>Identification of the most important factors that contribute to maintaining patient dignity from a patients perspective will help develop dignified nursing practice</td>
</tr>
<tr>
<td>Baillie (2007)</td>
<td>Explore the meaning of patient dignity, examine how patients’ dignity is threatened and investigate how patients’ dignity can be promoted</td>
<td>Participant observation and 12 patients in Hospital and a further 12 patients following discharge</td>
<td>Developed a model of dignity and the factors threatening and promoting dignity in three areas of; Hospital Environment, Patients and Staff  - Lack of privacy, heightened bodily exposure and mixed sex environment  - Patient impaired health threatened their dignity due to loss of function, intimate procedures and psychological impact  - Staff being curt, authoritarian and breaching privacy  Dignity was promoted by;  - A conducive physical environment  - Patients own attitudes and developing relationships with staff  - A dignity-promoting culture and leadership and other patients’ support</td>
<td>Particularly valuable in developing a model that emphasises that staff behaviour and the hospital environment have an important impact on patient experience of dignity in hospital. In addition identifies the importance leadership and a dignity promoting culture.</td>
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<tr>
<td>Goodrich and Cornwell (2008)</td>
<td>Kings Fund Commissioned project on Point of care – entitled “Seeing the person in the patient” which drew on a range of sources including qualitative interviews considering what good and poor care feels like and whether it was possible from accounts to get at what lies behind the 8 patients and 2 relatives, 10 member of staff – medical, nursing and secretarial</td>
<td>Qualitative - semi structured interviews</td>
<td>Key themes identified included:  - The unreliable quality of care – with huge variations in quality between hour to hour, shift to shift and different on different wards  - Seeing the person in the patient – through recognising a patients personal needs  - Who is in charge- patients found it difficult to find someone to talk to and did not easily know who was in charge  - The patient as a parcel – where patients reported often being</td>
<td>Whilst a small study with no recommendations to improve practice this work has gone on to form the basis of major work to transform the patient experience in hospitals through a number of practical interventions, that have included: Hospital Pathways project, Schwartz centre reflective rounds, experience-based co-design and intentional rounding.</td>
</tr>
<tr>
<td>Tadd et al (2011a, 2011b)</td>
<td>Experience.</td>
<td>Moved through a number of wards, at times in the middle of the night</td>
<td>Makes strong recommendations for reconsidering the way that care is provided to older people in hospitals, and that systems are not focussed on the needs of older people, rather are more focussed on compliance with regulations. In addition recommendations are made of education and training, particularly in relation to people with dementia, that clinical governance takes a broader approach to quality as opposed to checklists and that there is ward managers and ward staff are enabled to challenge poor practice</td>
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</tbody>
</table>
| **UK** | - Older people’s and their carers views and priorities in relation to dignified care  
- Examine healthcare practitioners behaviours and practices in relation to dignified care  
- Identify the occupational, organisation and cultural factors that impact on dignified care  
- Develop evidence based recommendations and guidance for dignified care | Purposive sample with interviews of 40 older people, 25 relatives/carers post discharge and 617 hours of observations of practice in sixteen wards across four hospitals and 79 interviews with frontline staff and 32 senior managers | Main findings  
1. Whose interests matter? – identified the conflicts of interests between hospitals and the needs of patients  
2. Right place – wrong patient – where wards were not designed around the needs of patients, particularly those with cognitive impairment  
3. Seeing the person – identified as the values and ideals of staff that were often crushed by their experience of rarely being able to fulfil the level of care that they wanted to provide  
4. Influences on dignified care – the level of priority given to dignity alongside competing priorities |
| Woogara (2004, 2005a, 2005b) | - Exploring patient privacy:  
1. What issues of privacy arise for patients in the NHS  
2. Behaviours and perceptions on the part of patients, nurses and doctors relevant to privacy  
3. The extent to which intrusions to privacy are set out within regulatory and legislative instruments | Opportunistic recruitment of 18 patients, 16 nurses and 6 doctors and during observation phase 55 patients and 12 nurses | Eleven categories of:  
1. Conceptions of privacy  
2. Territory and space  
3. Control and choice  
4. Personal care and depersonalisation of the patient  
5. Privacy of patients’ information  
6. Professional blind spots and habituation  
7. Ward layout and logistics  
8. Patients’ coping mechanisms  
9. Visitors and relatives  
10. Regulatory and government standards  
11. Professional rationale for ‘overriding’ patients privacy |
| **UK** | | Qualitative ethnographic with principles of grounded theory and phenomenology with semi-structured interviews and participant observation | Whilst the focus of this study is predominantly on privacy there are many interrelated aspects of privacy and dignity.  
The study is particularly valuable in putting privacy in the context of legislation and human rights. In addition the professional blind spots and habituation is a new area that has not been identified in other studies. |
**Research evaluating an initiative to improve dignity**

<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Methodology</th>
<th>Sample</th>
<th>Framework</th>
<th>Findings</th>
<th>Comparison</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Randers and Mattiason (2004)</td>
<td>Sweden</td>
<td>Participant observation (94 hours)</td>
<td>30 female nurses (7 registered &amp; 23 HCA’s)</td>
<td>- To deepen understanding of the relationship between autonomy and integrity between patients and individual healthcare workers in real life situations - Evaluating the value of an educational intervention</td>
<td>Findings based around a conceptual framework of two different types of integrity as being: ‘respect for the patient’s integrity as a state of wholeness’ and ‘respect for the patient’s integrity as a personal sphere’ and within six polarities of autonomy of: 1. Decisional vs autonomy of execution 2. Direct vs delegated autonomy 3. Competent vs incapacitated autonomy 4. Authentic vs inauthentic autonomy 5. Immediate vs long range autonomy 6. Negative vs positive autonomy with six descriptions of care that upheld dignity within this framework or not</td>
<td>Some similarities to Seedhouse and Gallagher (2002) in evaluating an educational intervention that was focussed around the ethics of dignity, however little reference to evaluative nature of the study</td>
<td>All the findings produced as descriptions of care incidences related to a theoretical framework</td>
</tr>
<tr>
<td>Crow et al (2006 &amp; 2007)</td>
<td>UK</td>
<td>Action research project to evaluate a new education module ‘Fostering Dignity in Healthcare settings’</td>
<td>Not identified</td>
<td>Action research evaluation of educational module</td>
<td>Findings identified that students on first three modules reignited their passion for promoting dignity and respect and had plenty of ideas for improving this aspect of care. However it was also identified that following completion of the module individuals often felt isolated and powerless to carry their ideas forward. The students identified the need for a space to meet other like-minded ‘champions’ of dignity and respect to nurture and sustain their enthusiasm and ideas that often got ‘swamped’ by other demands.</td>
<td>Limited discussion and information presented within papers of the details of the studies. These two studies were action orientated to improve practice in relation to dignity and identify some of the ways this has been done, such as the use of a written pledge to improve dignity and support for champions through a dedicated group. Both of these studies highlight the challenges, of competing demands in the workplace, and enablers, related to the political context, that staff encountered in seeking to improve aspects of dignity.</td>
<td></td>
</tr>
<tr>
<td>Crow et al (2010)</td>
<td>UK</td>
<td>Follow on action research project from earlier study on a Dignity and Respect Group</td>
<td>Not identified</td>
<td>Action research evaluation of a Dignity and Respect Group</td>
<td>Key factors related to this study: a ‘bottom-up’ in a favourable political context optimising the role and contribution of individual group members the culture of the group membership, fluidity and diversity of the group creating success and building on it</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Author(s)</td>
<td>Title and Methodology</td>
<td>Implications</td>
<td></td>
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<tr>
<td>Nicholson et al (2010a, b, c.)</td>
<td>Action research dignity in care project based on principles of relationship centred working that involved consideration of staff’s experience of dignity and being able to give dignified care</td>
<td>Two acute healthcare trusts over two years</td>
<td>Three main practice areas of based on a systematic review of older peoples experiences in hospital: 1. Maintaining identity – ‘See who i am’ 2. Creating community – ‘Connect with me’ 3. Shared decision making ‘Involve me’</td>
<td>Current papers do not give further understanding of the outcomes of the study which is primarily focussed on promoting a best practice framework for improving dignity in care.</td>
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</tbody>
</table>
| Baillie & Gallagher (2010, 2011) | Evaluated the RCN’s Dignity at the Heart of Everything we do Campaign | 3 independent care homes, 3 NHS Hospitals and 1 NHS mental healthcare Trust – 51 staff interviewed (5-9 on each site) | Qualitative multiple case study | The first paper (2010) focussed on challenges and enablers to the RCN Dignity campaign:  
Enablers were identified as:  
- Staff receptivity and creativity  
- Organisational support and leadership  
- Campaign resources  
Challenges were identified as:  
- Time constraints  
- Staff attitude and insight  

The second paper (2011) considered nurses strategies to respect dignity across the different settings – Overarching theme was to: Treat people as valued individuals within specific care settings and sub themes of this were:  
- Recognising vulnerability to a loss of dignity  
- Enhancing privacy  
- Improving communication with patients and families and building relationships  
- Care environment improvements  
- Addressing issues that matter to individuals | Valuable insights into different aspects of the RCN Dignity campaign across different healthcare settings with a key focus for the increased sensitivity of nurses to improve dignity as well as the importance of leadership and organisational support. However there was limited information on the context of the organisation and any other measures of the effect of the RC Dignity campaign |
Appendix 3 Local Research Ethics Approval

The Committee on the Ethics of Human Research
Committee Alpha
Institute of Child Health
30 Guilford Street
London, WC1N 1EH
Tel: 020 7699 4130
Fax: 020 7699 4138
Email: luceas@ich.ucl.ac.uk

Our Ref: 08AL 234
21 July 2008

Andrew Gallini

Dear Mr Gallini,

Full title of study: An Evaluation of the Response to the National Dignity Challenge within [ ] NHS Trust
REC reference number: 08/H0716/66

Thank you for your letter of 09 July 2008, responding to the Committee's request for further information on the above research and submitting revised documentation, subject to the conditions specified below.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at http://www.rforum.nhs.uk.

An advisory committee to London Strategic Health Authority
Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application</td>
<td>1</td>
<td>23 May 2008</td>
</tr>
<tr>
<td>Investigator CV</td>
<td></td>
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</tr>
<tr>
<td>Protocol</td>
<td>1</td>
<td>28 May 2008</td>
</tr>
<tr>
<td>Covering Letter</td>
<td></td>
<td>23 May 2008</td>
</tr>
<tr>
<td>Interview Schedules/Topic Guides</td>
<td></td>
<td></td>
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<tr>
<td>Letter of invitation to participant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participant Information Sheet: Healthcare Professionals</td>
<td>2</td>
<td>01 May 2008</td>
</tr>
<tr>
<td>Participant Information Sheet: Patients</td>
<td>2</td>
<td>01 May 2008</td>
</tr>
<tr>
<td>Participant Information Sheet: Managers and executives</td>
<td>2</td>
<td>01 May 2008</td>
</tr>
<tr>
<td>Participant Information Sheet: Patients</td>
<td>4</td>
<td>01 July 2008</td>
</tr>
<tr>
<td>Participant Consent Form: Patients</td>
<td>3</td>
<td>01 July 2008</td>
</tr>
<tr>
<td>Participant Consent Form: Healthcare Professionals, Managers</td>
<td>2</td>
<td>01 May 2008</td>
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<tr>
<td>Participant Consent Form: Patients</td>
<td>2</td>
<td>01 May 2008</td>
</tr>
<tr>
<td>Response to Request for Further Information</td>
<td></td>
<td>09 July 2008</td>
</tr>
<tr>
<td>Letter of invitation to Managers and Executives</td>
<td>2</td>
<td>01 May 2008</td>
</tr>
<tr>
<td>Letter of invitation to Healthcare Professionals</td>
<td>2</td>
<td>01 May 2008</td>
</tr>
<tr>
<td>Research Design Flow Chart</td>
<td>1</td>
<td>28 May 2008</td>
</tr>
<tr>
<td>Sponsor letter</td>
<td></td>
<td>23 May 2008</td>
</tr>
<tr>
<td>Peer review form</td>
<td></td>
<td>01 April 2008</td>
</tr>
<tr>
<td>CV Dr Ann Dewey</td>
<td></td>
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</table>

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.
We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

With the Committee’s best wishes for the success of this project

Yours sincerely

Mrs Patricia Orwell
Chair

Email: Tom.Lucas@ich.ucl.ac.uk
Appendix 4 Trust Research Governance Approval

22 July 2008

Andrew Gallini

Dear Andrew,

Project Title: An Evaluation of the Response to the National Dignity Challenge within Healthcare NHS Trust

R&D reference number: 08/0A/004 Ethics reference number: 08/H0715/66

Principal Investigator: Mr. Andrew Gallini,

I confirm that this project has now been approved by the Research & Development Department. The project may now start at [Redacted] Healthcare NHS Trust site(s). Please note that the start date of the project is the date of this letter and the duration is the same as that provided in your application form.

Before you commence your research, please note that you must be aware of your obligations to comply with the minimum requirements for compliance with the Research Governance Indicators 17 (Data Protection); 25 (Health and Safety) and 22 (Financial Probity). Details of the requirements to be met can be found in the Trust Research Governance Policy in the current R&D Annual Report, R&D Management Office, or on the Trust Intranet under Research & Development. Please also refer to the Research Governance Framework available on www.dh.gov.uk.

Under the Research Governance regulations, Serious Adverse Event Reports, Adverse Reactions and amendments to the protocol or other supporting documents must be forwarded to the Research & Development Office and Ethics Committee.

In accordance with the Research Governance Framework, research projects carried out in the Trust will be randomly chosen by the R&D team for auditing. Please see the attached checklist for documentation that will be required during the audit.

I wish you well in your research.

Yours sincerely,

[Signature]

Professor Myra McClure
Research and Development Management Office
INFORMATION SHEET FOR PATIENTS

Title
A STUDY LOOKING AT THE VIEWS AND EXPERIENCES OF PATIENTS OF DIGNITY IN HOSPITAL

Invitation
My name is Andrew Gallini, Lead Nurse Older People and Stroke services at xxxxx Hospital, which is part of xxxxxx Healthcare NHS Trust. I am undertaking a research study as part of a Doctorate in Nursing at Portsmouth University. I would like to talk to patients about their views and experiences of dignity in this Hospital. You are invited to take part in this research study. This information sheet gives an explanation of the study. Please contact me if there is anything you are unsure of or if you would like more information. Please take time to decide whether or not you wish to take part.

The purpose of the study
Following the launch of the Department of Health’s ‘Dignity in Care’ campaign in November 2006 we have looked at ways to improve aspects of dignity for patients at our Hospitals. This study seeks to find out whether some of the changes in the way we do things have improved the dignity in care for patients. As part of the study interviews will also be taking place with staff to gain their views on projects to improve dignity for patients.

Why have I been chosen?
You have been chosen as you have received care in Hospital as a patient over the past 12 months. I hope to find out what people’s experiences of care for their dignity has been and whether patients have noticed any changes to the care they have received to promote their dignity.

Do I have to take part?
I know that it is not always possible for people to take part in studies and you do not have to. If you do agree to take part you are free to refuse to answer any specific questions and may withdraw from the study at any time without giving a reason. If you decide not to take part your care will not be affected by your decision now or in the future. If you do decide to take part in the study you will be given this information sheet and asked to sign a consent form.

What will happen to me if I take part?
You will take part in an interview lasting no more than an hour. If possible I would like to tape the interview with your permission. The interview will take
place in a private room in the Hospital. Once the tape has been written up I will invite you to read through the interview to check that it gives a clear record of the discussion that took place.

Will my taking part in this study be kept confidential?
Any information you give will be confidential and will be handled only by my supervisor and myself. No names will be attached to the information given and tapes and transcripts will be kept securely according to university regulations. Any subsequent reports of this study or publication will not identify you by name.

What will happen to the results of the research study?
A report will be written which will be given to the University of Portsmouth and will be presented to the Trust Dignity Group to discuss progress on the ‘Dignity Challenge’. I will also discuss the report with patient groups to look at how we can improve dignity for patients.

Who has reviewed this study?
This study has been reviewed by Local Research Ethics Committee. The Trust’s Research and Development Office has also approved this study.

If you feel you would like to take part in the study please let the nurse in charge know and I will contact you to arrange a time for the interview in a private area of the ward. I would be happy to talk to you further about the study before you decide to participate and answer any questions you may have.

Thank you for taking the time to read this. Please do not hesitate to contact the research or his supervisors if you have any questions. Contact details are below.

Study title:
An Evaluation of the response to the National ‘Dignity in Care’ within xxxxxxx Healthcare NHS Trust
Researcher
Andrew Gallini Tel 02392 844426 email andrew.gallini@xxxxx.nhs.uk
Lead Research Supervisor
Dr Ann Dewey Tel 02392 844426 email ann.dewey@port.ac.uk
CONSENT FORM

A study evaluating how an acute healthcare Trust has responded to the National Dignity in Care campaign

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my care being affected.

3. I am willing to be interviewed and for the interview to be tape recorded. I understand that the tape will be kept in accordance with Portsmouth University regulations.

4. I agree to take part in the above study.

__________________________  __________  ______________________
Name of participant                             Date                      Signature

__________________________  __________  ______________________
Researcher                                            Date                      Signature

Andrew Gallini
Lead Nurse Older People & Stroke

Version 3 July 2008
Appendix 7 Invite letter for interview to senior managers on the range of work undertaken to respond to Dignity in Care campaign and its impact on the organisation

Date

Dear

I am currently undertaking a research study on the response to the National Dignity in Care campaign at xxxxxx Healthcare NHS Trust. This research study is also being undertaken as part of a Professional Doctorate in Nursing at the University of Portsmouth. I am hoping to interview a cross section of healthcare professionals, managers and executives as part of this study.

The National Dignity in Care campaign was launched in November 2006 and sets out expectations for health and social care providers to meet a range of aspects relating to patients' dignity. This study seeks to explore and evaluate the response to the national dignity challenge, within xxxxxxxx Healthcare NHS Trust and consider the impact of these developments on the organisation.

If you feel you would like to take part in the study I have included a reply slip and stamped addressed envelope. If you do agree to take part you are free to refuse to answer any specific questions and may withdraw from the study at any time without giving a reason.

Please find enclosed an information sheet about this study.

If you wish to discuss this further please do not hesitate to contact me on the above telephone number.

Yours sincerely

Andrew Gallini
Lead Nurse Older People and Stroke Services

Evaluation of the Response to Dignity in Care campaign

Name: ----------------------------------------------------------------------------------------------------------------------------------

*I would like/do not wish to participate in the study *(please delete as appropriate)

Version 2 May 2008
INFORMATION SHEET FOR HEALTHCARE PROFESSIONALS, MANAGERS AND EXECUTIVES ON THE RANGE OF WORK UNDERTAKEN TO RESPOND TO DIGNITY IN CARE CAMPAIGN

Title
An evaluation of the response to the Dignity in Care campaign in xxxxx Healthcare NHS Trust

Invitation
My name is Andrew Gallini, Lead Nurse Older People and Stroke services at xxxxx Hospital, which is part of xxxxxx Healthcare NHS Trust. As part of a Professional Doctorate in Nursing at Portsmouth University I am undertaking a research study to evaluate the response to the Dignity Challenge within xxxxx Healthcare NHS Trust. You are invited to take part in a research study. The following information gives an explanation of the study. Please ask if there is anything you are unclear about or if you would like more information. Take time to decide whether or not you wish to take part.

The purpose of the study
Following the launch of the Dignity in Care campaign in November 2006 a range of work has taken place to address specific elements of the dignity in care campaign with key projects. The evaluation seeks to explore the response to the national dignity challenge, within xxxxxx Healthcare NHS Trust and identify the outcomes from this work for patients and carers as well as the impact on healthcare professionals and the organisation.

Why have I been chosen?
I hope to interview between fifteen healthcare professionals, managers and executives on their views of the work that has taken place around the dignity challenge and its impact on the organisation.

Do I have to take part?
I realise that it is not always possible for people to participate and you are under no obligation to take part in the study. If you do agree to take part you are free to refuse to answer any specific questions and may withdraw from the study at any time without giving a reason. If you do decide to take part in the study you will be given this information sheet and asked to sign a consent form.

What will happen to me if I take part?
It would involve your participation in a tape-recorded interview lasting no more than an hour. The interview could take place within my work or at your home.
Once the tape has been transcribed you will be invited to read through the interview to check that it gives an accurate recording of the discussion that took place.

**Will my taking part in this study be kept confidential?**
Any information you give will be confidential and will be handled only by my supervisor and myself. No names will be attached to the information given and tapes and transcripts will kept securely according to university regulations.

**What will happen to the results of the research study?**
A report will be written which will submitted to the Group and the University of Portsmouth in March 2009 and will be presented to the Trust Dignity Steering Group for discussion on the outcomes and ways of disseminating the results to a wider community of individuals involved in developing work to improve patients dignity.

**Who has reviewed this study?**
This study has been reviewed by the Local Research Ethics Committee. The Trust’s Research and Development Office has also approved this study.

If you feel you would like to take part in the study I have included a reply slip and stamped addressed envelope. I would be happy to talk to you further about the study before you decide to participate and answer and questions you may have.

Thank you for taking the time to read this. Please do not hesitate to contact the research or his supervisor if you have any questions. Contact details are below.

<table>
<thead>
<tr>
<th>Study title:</th>
<th>An Evaluation of the response to the National 'Dignity in Care campaign within xxxxxxx Healthcare NHS Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Researcher</td>
<td>Andrew Gallini Tel xxxxx email <a href="mailto:xxxxx@.nhs.uk">xxxxx@.nhs.uk</a></td>
</tr>
<tr>
<td>Research Supervisor</td>
<td>Dr Ann Dewey Tel 02392 844426 email <a href="mailto:ann.dewey@port.ac.uk">ann.dewey@port.ac.uk</a></td>
</tr>
</tbody>
</table>

Version 3 July 2008
Appendix 9  Consent form for Healthcare Professionals and Senior Managers

CONSENT FORM

A study evaluating how an acute Healthcare Trust has responded to the National Dignity in Care campaign

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

3. I am willing to be interviewed and for the interview to be tape recorded. I understand that the tape will be kept in accordance with Portsmouth University regulations.

4. I agree to take part in the above study.

__________________________   __________   ____________________
Name of participant          Date           Signature

__________________________________________
Researcher                    Date           Signature

Andrew Gallini
Lead Nurse Older People & Stroke

Version 2 May 2008
Appendix 10  Semi-structured interview schedule for patients who have had experience of changes in practice to improve aspects of dignity

1. Discuss work that has been going on at xxxxxxxx Healthcare NHS Trust to respond to the Dignity Challenge
   - Explore what has been your experience of dignity in hospital
   - Have you noticed any changes in your care in relation to dignity during your most recent admission as compared to previous admissions, also considering mixed sex accommodation

2. Discuss particular projects such as ‘Red Pegs’ to improve privacy and whether this had been noticed and had made any difference

3. Discuss different examples of changes to practice and identify whether patient had experienced any of these?
   - Did they experience any of these changes in practice
   - If so what difference did it make to their experience
   - What was the best thing that helped improved their dignity

4. What else could be done to help to improve their dignity whilst in Hospital

5. From the projects that are taking place to improve patients dignity what else could either within these projects or with additional work to improve patients dignity

6. Discussion groups have taken place to involve patients and carers in how the Trust is looking at Dignity and the work that is taking place
   - what do you think of this approach to involve
   - are there any other ways that we could involve patients and carers in this work

Any suggestions for improvements

Andrew Gallini

Lead Nurse Older People and Stroke Services

February 2008
Appendix 11  Semi-structured interview schedule for of healthcare professionals on the impact on the organisation of the Dignity in Care campaign.

1. Can you tell me about your understanding of the Dignity in Care campaign?
   - e.g. Launch in November 2006 with ten elements etc

2. Can you tell me about your awareness and involvement in any work to date on dignity?
   - e.g., awareness of dignity workshops, gap analysis, action plan, steering group and patient focus groups

3. Can you tell me your thoughts on the value of this work around dignity?
   - Has it made a difference
     – What examples of this are you aware of

4. Can you tell me your thoughts on the impact of this work on the organisation?
   - e.g. values, culture, policies and meetings etc

5. Can you tell me about your thoughts about performance monitoring around aspects of dignity?
   - In particular views of the reporting mechanism for Dignity through the Directorate Quality Boards within Clinical Directorates/Clinical Programmes and the Quality & Safety Committee
   - As an integral part of the Essence of Care Standards and Core Standards for Better Health
   - And views on further performance monitoring of dignity

6. What do you think are obstacles to dignity and improving aspects of the quality of care that relates to dignity within the organisation?

7. Additional questions if the individual had attended a Dignity Training Workshop
   - How did you get to hear about the Dignity Training Workshops?
   - How did you find the Dignity Training Workshop?
   - What was your commitment from the Dignity Training Workshop?
   - Have you been able to progress your commitment, and what challenges and enablers have there been in relation to this?

Lead Nurse Older People and Stroke Services

February 2008
Appendix 12  Semi-structured interview schedule for senior managers on the impact on the organisation of the Dignity in Care campaign

1. Can you tell me about your understanding of the Dignity in Care campaign?
   - e.g. Launch in November 2006 with ten elements etc

2. What’s your awareness and involvement in work to date on the Dignity in Care Campaign?
   - e.g., awareness of dignity workshops, gap analysis, action plan, steering group and patient focus groups

3. Can you tell me your thoughts on the value of this work around dignity and its impact on the organisation?
   - Has it made a difference
     - What examples of this are you aware of

4. Can you tell me your thoughts on the impact of this work on the organisation?
   - e.g. values, culture, policies and meetings etc

5. Can you tell me about your thoughts on performance monitoring around aspects of dignity?
   - In particular views of the reporting mechanism for Dignity through the Directorate Quality Boards within Clinical Directorates/Clinical Programmes and the Quality & Safety Committee
   - As an integral part of the Essence of Care Standards and Core Standards for Better Health
   - And views on further performance monitoring of dignity

6. What do you think are challengers and enablers to improving dignity within the organisation?

   Any suggestions for improvements in patient dignity?

Lead Nurse Older People and Stroke Services

February 2008
# Appendix 13 Early thematic framework – November 2010

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub Themes</th>
</tr>
</thead>
</table>
| 1. Patient experience in Hospital | - Mixed sex accommodation and privacy  
- Hospital experience  
- Indignity  
- Communication  
- Senior Managers and HCP’s experience of dignity in Hospital |
| 2. Understanding of the dignity in care campaign | - National Government initiative  
- Focus on the needs of vulnerable patients  
- Practical aspects of what dignity means to patients  
- Personal contribution/individual role  
- Whose responsibility is dignity |
| 3. Attitude to the dignity in care campaign | - Endorsement  
- Shame – Basic  
- Expectations of staff  
- Raised expectations from the public  
- Attitude and behaviour of staff |
| 4. Challenges | - Organisational Change  
- Operationalising Dignity  
- Competing agendas  
- Leadership and management  
- Feedback and evaluation  
- Resources  
- Environment  
- The Patient's condition  
- Gowns |
| 5. Enablers | - Leadership – Role modelling  
- Seeing dignity as part of their role  
- Empathy  
- Training  
- Communication  
- Teamwork  
- Environment  
- Recruitment  
- Target Driven |
| 6. Improvements | - Raised awareness  
- Protected quiet time for patients  
- Red Pegs  
- Red Tray  
- Care of patients with dementia  
- Training  
- Dementia Training  
- Safeguarding Adults  
- Quality of care |
| 7. Training | - Dignity Workshops  
- Attitude-motivation  
- Feedback on the workshops  
- Personal commitment from the dignity workshops  
- Training |
| 8. Next Phase | - Integrating change  
- Red Pegs  
- Patient and Public Awareness  
- Sustaining the Dignity Work  
- Realising other benefits  
- Performance Management |
Appendix 14 – Example of Indexing - Table of Themes and categories relating to improvements – from Patients, Healthcare Professionals and Senior Managers

<table>
<thead>
<tr>
<th>Senior Manager &amp; Executives</th>
<th>Healthcare Professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raised Awareness &amp; Engagement</td>
<td>“Dignity wasn’t really high on the corporate agenda as such up until the last year, 18 months I would say, until the dignity challenge was launched. It’s become more of an issue related to Picker survey outcomes, because of our scoring as a Trust with that and because of that, because of the targets that we have to meet and our public image, the dignity challenge has been embraced much more by the Trust Board, and because of that I think there will be significant amounts of work from myself as a lead nurse doing dignity work with people in the clinical areas.” (H9 9-16)</td>
</tr>
</tbody>
</table>

“so I think to a certain extent it has started to bring some awareness, which for me is always the first step to bring about change and you know you can have resistance to change and some of the comments were the pegs are too small, no one can see them, you always lose them there’s always some negative feedback you have to take into account but in actual fact something is moving, something is happening and it created awareness across the Trust that something is being done” (S2 67-73)

“I guess there been so much publicity about dignity I think dignity now registers in people’s minds where it might not have done where you know I think it registered in Nurses minds now it’s much more far reaching so you know that has to be a good thing but having said that I am not sure about the impact on patient care” (S7 60-64)

“I think it’s also helping around how patients’ are communicated to and that they are communicated appropriately about their care and that they – because it links with the Picker survey and all that stuff. You can see, certainly we’ve seen within our own service where comments come via inpatients or outpatients cards. You know you can see a lot of what patients say are around communications and there’s a lot of very positive comments and some of that might have happened anyway but some of it is through heightened awareness of some of this stuff” (S6 41-49)

“there was the paper that was put together that was presented to the board that was well received and I think at a board level it opened up some of the executives eyes to some of the issues of what had happened to patients and what needed to happen to make a change” (S4 23-27)

“I think what went well was that it did engage people in the organisation and there was work that went on and the examples I gave around people going back to outpatients wanting to make a difference and gave examples of practical things such as the red pegs was very successful - it was everywhere in the organisation and that there were clinical champions driving it forward, I think looking at what we could have done better were

“Dignity wasn’t really high on the corporate agenda as such up until the last year, 18 months I would say, until the dignity challenge was launched. It’s become more of an issue related to Picker survey outcomes, because of our scoring as a Trust with that and because of that, because of the targets that we have to meet and our public image, the dignity challenge has been embraced much more by the Trust Board, and because of that I think there will be significant amounts of work from myself as a lead nurse doing dignity work with people in the clinical areas.” (H9 9-16)

“I think probably the most positive aspect is that it has raised awareness, and I think that’s something that needed to be done very seriously. I wouldn’t think its resolved issues, far from it, I think it’s you know, the beginning of a long road. I think that some health professionals had moved so far away from dignity issues that it’s going to be quite a long walk back.” (H10 45-48)
there more practical things that we could have done to move the agenda forward” (S4 107-113)

“engage them in that conversation to say so okay you are the frontline delivering this how do you feel we could do this – what are your thoughts around this and have a multidisciplinary team, different grades, different staff groups could be focus groups could be you know different ways to engage them in the how and I don’t know I think that also to engage patients to say this is what we are going to do and how do you feel that we could best do this” (S2 105-110)

“there’s been so much changes I don’t think we haven’t had change overload but actually where there’s so much change -it’s a way to reinvent everything I mean I really enjoy going to places where you just reinvent a new way of doing stuff because we’ve changed, we’re new and let’s do it this way and I also I am not sure that at ward level or in a department I am not sure what the exact impact of the change is I’ve been working on same ward for three years and it feels the same as it was two years ago and I am not that all of the upper echelons of the change – yes they’ve configured the ward differently, yes there’s an ambulatory area, yes you can see some of the strategic things but when you are on the ground it doesn’t feel too scary the change really” (S1 181-190)

Dignity Steering Group

“there was also the fact that there was the working group that was set up, and that was multidisciplinary and that included people from outside the organisation” (S4 27-29)

“I think just in terms of you know it’s not okay just for us to just give dignified care in the hospital it’s the pathway of that care back out to the PCT or back out to the voluntary sector so one of the things it’s really important to note is the work that has been done with the nursing homes, the local councillors, the advocates for people” (S10 205-210)

Protected quiet time for patients

“I think for me it means… patients in hospital rarely get I would say quality quiet time and I think that is important for us. There are several ways we can do this. We are trying for example, to restrict visiting between one and three o’clock in the afternoon... and
that allows some quiet time. We are trying to reinforce that more strictly than we’ve actually been, it’s a fairly new initiative” (H2 49-54)

Red Pegs

“the most obvious one is the red peg initiative, which was part to do with patients’ privacy, so understanding that patients want to maintain some form of dignity through having private space and the idea of the red peg being that if curtains are closed around a patient’s bed space that staff shouldn’t just open the curtains and walk straight in. They should ask if it’s OK to come in, almost like knocking on a door, before you walk in. Trying to give that similar level of permission rather than assuming that a nurse or doctor or anybody else in the hospital who’s around, has implied permission to go anywhere they like. So it creates a little bit of personal space for the patient and there’s been advertising all around for staff and for either visitors or patients, to explain what that is.” (S5 20-29)

“For example I was on the stroke ward yesterday and it was interesting just seeing what was kind of going on, you know there was evidence of respect there in a certain sense just because you know there were various things going on, various patients’ and you know people were being sensitive to the fact that they shouldn’t really go behind the curtains for example, so you could visibly see what was going on” (S6 32-37)

“so the red peg initiative was fantastic, highly innovative, dreamt up clinically and therefore a good chance of success and I think really positive feedback from patients so that’s been a really positive loop for me the other bit for me is and its not related is the Protected meal times as well allowing people to get on and have their meals at the right time – and I think those small things I guess make an enormous difference overall” (S9 23-29)

Red Pegs – Patients comments

“I haven’t found [red pegs], no I haven’t, I’ve seen signs on doors, but I haven’t had anybody walk in when I’m being examined. So I think once the curtains are drawn people don’t really come in. Even, I have problem at night, the nurses’ will just call out, “Are you alright there”? in the morning or, “Do you want a cup of tea”? So they don’t sort of charge in.” (P2 82-84)

“I think one of the real positive things was that a lot of people thought it was a really good idea and that was staff across the boards; doctors, registered nurses’, non registered nurses’, domestics, they thought it was a really good idea but was a bit sceptical about how well it was going to work. I think the biggest obstacles I’ve come across is that it’s in peaks and troughs. Staff are really good they push it forward then it kind of wanes a little bit. And then you have to remind staff and it’s like you’re starting all over again” (H5 89-95)

“When I go on to wards I actually see staff stopping and thinking about what it is that they’re actually going to do, or if they haven’t stopped and asked, the person that is behind the curtain has challenged them. And I think that’s a massive change because quite frankly people weren’t challenging, when they were interrupted. So I think that’s a step in the right direction.” (H5 111-116)

“the pegs are very visible and people have them on their uniform or have them in their pockets, and they’re at the nurses’ stations so they are there and still visible. And some of the patients’ ask about them, and they’re like why are we having the washing pegs on the curtains for? You know, but they are quite good, because it means someone can’t stick their head behind the curtains, it means something’s going on. Yeah, I like them, I think they are a simple cost effective way and they’re easy for patients to understand why.” (H6 161-168)
“Yeah, you can get privacy by drawing the curtains, you get privacy, nobody comes in when the curtains are closed, I mean the curtains are closed, if you want to be secluded you just pull the curtains... What pegs? No, I haven’t seen it” (P4 38-40 & 46)

“I think it’s a good idea. But whilst the curtains are drawn I don’t get interrupted anyway, so, nobody interrupts me. They call you first, the nurses’ will call me, [..] or whatever their name is, but nobody comes just bursting in. But it’s a good idea with the red pegs to let people know that you’re busy, but it’s obvious you’re busy if the curtains drawn, so it’s both really” (P4 48-52)

“Yes, I know what you mean don’t just stick your head in without knocking ... Not here I haven’t, no. No I can’t say that I have not in this bay anyway, no.... and on the admission ward? ..- Certainly not, I didn’t even know about it then. It’s only when I’ve seen the signs around various bits of the hospital you know – yeah.” (P5 65 & 70 & 72-73)

**Gowns**

“I know with the linen contract we are now going to have either dressing gowns back or we either going to have the double fronted backed gowns” (S10 135-137)

**Patients comments**

“Well they are a bit (slight laugh), well they just fall and that’s it. But sometimes they’re handy but I suppose some of them are too long and trailing looking like, you know, not kind of smart. Then you’re going down the corridor and you’re holding the back of them .....taking you hands in, because you can’t let the back of the thing go. That’s a good idea I would think. And I know these are easy to put on and all that but it’s funny just cloth thrown around you, anyway the other ones are worst on the other floors, so up here it’s not too bad, and they’re trailing all down there and you’re trying to walk and you’re tripping, oh those things are terrible. The problem with them is that they tie them at the back, so of course if you want to have a shower or want to do anything you cannot open it, because old people cannot put their hands a way down there and that’s what’s hard. You think they have something on this you could pull like – you know like that light velvet what do they call it, something like that make a great job for them but I don’t care much for them” (P3 185-198)

“Oh they’re awful. I don’t wear the gowns but I see how – they don’t tie it or sometimes they just tie it just loosely and it falls down and people walk by, the nurses’ walk by, and it’s slipping down here, and nobody thinks to go over and tie
it properly, or if they’re sitting in chair and I’ve seen when they have the long
gowns on they should put a long gown on them. But you know a blanket over
their knee or even another nightie if they warm just over their knee and to make
sure their gowns are tied. It’s not much. And the other thing, I’m shocked, is the
washing of the hands, there’s not a lot of that going on from bed to bed and that
goes for them all, except for a few really good ones and doctors’, maybe they go
outside and do it, but I see them very often. I mean they’re good about gloving up
when they’re changing beds and wearing aprons and stuff like that, but I do see a
big improvement, I see a lot more planning and much much cleaner and the
cleaning staff are much better” (P2 130-142)

Needs of people with Dementia

“another thing has been around specifically picking out certain things like dementia or
other clinical conditions where we think that staff may need to be trained to deal with
that particular client group” (S6 14-16)

“you’ve got patients with dementia, so you know, I’ve noticed that the nurses are
a lot more patient with the patients that have got dementia, you know they will
actually sit with them I mean I have gone on the wards and they have actually sat
so I think one of the challenges is having patients that have got dementia but are
now having nursing sit with them or a little bit longer than they were but that’s
not to say that they weren’t receiving the care but as the nurses were so busy they
didn’t always go over and have the time to sit with them, but now they are able to
because when I actually went with one of my volunteers early this week there was
two nurses sitting with a patient that actually had dementia and she only had early
stages of dementia, but she was very very happy, very happy, she was very happy
with the nurses” (H12 103-113)

“The biggest improvement that I have noticed is and as I was saying because
we’ve sent so many nurses on the dementia project that they have changed their
approach to the older person in A&E, and particularly the confused older patient,
and their change has been in terms of the tolerance and almost a pro-active
response to how they behave with a more confused patient.” (H10 67-71)

Training

“It’s a process of, it’s not haranguing people, it’s for me much more of a process of
education and your dignity challenge days certainly I think bore fruit, in that you
sent back people to clinical areas who had a much better understanding of some
of the basic tenets of the dignity challenge and were able to influence day to day
practice. And the same is certainly proving true of the dementia work that’s
happening. People are now going back to clinical areas much more aware of the
Protected Meal Times & Red Tray system

“I think things like protecting mealtimes are enforced in certain areas and do make a difference and people do follow that as soon as that signs up and I think that’s more prevalent on some sites more than other you know, you don’t go near. And it’s protecting the patient from being whisked off and various things happening to them” (S6 37-41)

“The other thing I think is really important and this is mainly about elderly care or patients who for one reason or another, are unable to feed themselves or find difficulty in feeding themselves, but obviously they’re not on nil by mouth or whatever, they should be fed and diet is an important part of their healing process if you like, is the red tray system whereby if a patient does have difficulty in that area, their food is placed on the red tray and members of staff on wards, members of staff working on ward be they health care workers or whatever, will know that actually patient, Ethel or Garfield or Fred, whatever their name is, but it is known, merely by seeing the red tray and the food on their plate they need some help with their feeding” (H1 78-87)

Quality of care

“I think a good marker is care of the demented patient who is very unwell or the dying patient actually, there is a sort of paradigm. I think sometimes the perception is a patient is dying, therefore we can leave them, they don’t need much in the way of care. Well actually, often the reverse is true, they actually need more care, because to die with dignity is so important for the families. I’ve been involved with a case recently of a family who made a tough decision about withdrawing treatment from their frail, elderly mother, but it’s been a very difficult process, but it had been aided by superb nursing care with really fine attention to mouth care, dealing promptly with any kind of agitation or any symptoms, which are common towards the end of life and it makes a huge amount of difference to the experience of the family to see that their relative has died with dignity in hospital and I think that’s something that we sometimes don’t get right. I think dying with dignity is also very important, you know, yes, dignity for the living is very important, but dignity for the dying is also very important” (H8 152-166)

“So I think that patients are listened to more, I think and they are looked well I wouldn’t say they are looked after more because they have always been looked after well but what tended to happen was that when a nurse or doctor went over to a patient you know sometimes you know patients don’t read or they don’t
understand or if you use big words but nowadays I notice that when I go on there they are using more, better words that make patients understand and relatives understand what the doctors and the nurses are saying and I think with more so with the care of the elderly wards I mean from I don't know about 18 months 2 years ago when there was lots and lots of problems and now we don’t get any complaints from the wards, my volunteers go and they are always, a couple of weeks ago I went to see a patient with one of my volunteers and she could say I mean she was so happy with the members of the staff, they are looked after her so, especially [name], perfect I mean she said she really didn’t want to go home but we know she has to go home, but because she felt so comfortable here and that’s want we want, we want people to be able to feel comfortable when they are in a hospital environment” (H12 74-89)

“being an outsider going into a ward I see the improvements so much with the dignity side of it and the fact that when the patients, when I’m helping them filling in our their survey cards all of them are saying they are happy they are on the ward – I have never come across how happy they are on the ward I never come across in the two years, in these two years I have never come across anyone that’s not been happy with the level of the service they have received on any of the wards so its improved but then again before that there needed to be a lot of improvement, there needed to be a little more care and attention taken, but it’s definitely worked whatever has happened out there has definitely worked for the best” (H12 127-136)

“I think it’s hard to measure it in any particular kind of quantitative way, but I certainly am much more aware that certainly the professional groups who have been on the training days, are much more aware of dignity for patient, well, I think the red pegs, are in a very obvious way highlighted the importance of privacy and maintaining patients basic dignity. But I’m getting the impression that it’s a trickle down effect, that you highlight the problem to the more senior staff and a selection of other staff, who go on the training days and there is a sort of trickle down effect from them to other people. So if they themselves see somebody who’s dignity is being compromised for one reason or another, they are much likely to say something or take action to stop it and I’m much more aware of
even sort of basic stuff like gowns on and just tying up somebody's gown once you've examined them, rather than just leaving it flapping. Junior doctors certainly, are much more aware of the importance of that kind of interaction with patients, that actually you can't just come in, do your doctor bit and go away again and actually have virtually no communication with the patient and just leave the restoration of dignity to somebody else.” (H8 55-70)
<table>
<thead>
<tr>
<th>Role</th>
<th>Dignity Challenge as</th>
<th>Knowledge</th>
<th>Wider role/Involvement</th>
<th>Attitude</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Chaplain</td>
<td>Choice and dignity</td>
<td>10 points roll out 6</td>
<td>Education process of staff &amp; Sat on dignity committee</td>
<td>Relating to age and training of nurses</td>
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<tr>
<td>2 Ward Manager</td>
<td>protection, choice, enable them to reach their maximum potential</td>
<td>12 points came to the fore about a year ago - trust working on half of these</td>
<td>Role model</td>
<td>Respect</td>
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<tr>
<td>3 Senior Midwife</td>
<td>protecting &amp; privacy</td>
<td>10 points</td>
<td>Role model</td>
<td>Pet hates gowns untied</td>
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<tr>
<td>4 Site Manager</td>
<td>communication &amp; listening &amp; respecting &amp; putting yourself in their place</td>
<td>10 points</td>
<td>Role model</td>
<td>Pet hates gowns untied</td>
</tr>
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<td>5 Senior Nurse</td>
<td>dignity and respect</td>
<td>10 points from HCASS</td>
<td>Role model</td>
<td>Pet hates gowns untied</td>
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<tr>
<td>6 Practice Development Nurse</td>
<td>comes from HCASS respecting peoples dignity to communication</td>
<td>10 points from HCASS</td>
<td>Role model</td>
<td>Pet hates gowns untied</td>
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<tr>
<td>7 Practice Development Nurse</td>
<td>making people aware of</td>
<td>role model</td>
<td>Role model</td>
<td>Pet hates gowns untied</td>
</tr>
<tr>
<td>8 Senior Clinician</td>
<td>patient-centered approach</td>
<td>10 challenges</td>
<td>Role model</td>
<td>Pet hates gowns untied</td>
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<tr>
<td>9 Senior Nurse</td>
<td>Nationwide initiative to raise dignity</td>
<td>related to picker survey</td>
<td>Role model</td>
<td>Pet hates gowns untied</td>
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<tr>
<td>10 Consultant Nurse</td>
<td>Promoting and protecting</td>
<td>By not attending to pts dignity letting your own dignity down</td>
<td>Role model</td>
<td>Pet hates gowns untied</td>
</tr>
<tr>
<td>11 Physiotherapist</td>
<td>Patient-centered</td>
<td>10 challenges</td>
<td>Role model</td>
<td>Pet hates gowns untied</td>
</tr>
<tr>
<td>12 PALS officer</td>
<td>Preventing complaints</td>
<td>follows on from NSF - rebadged</td>
<td>Role model</td>
<td>Pet hates gowns untied</td>
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<tr>
<td>13 Senior Clinician</td>
<td>Pts treated in a way that acknowledge them in their own right</td>
<td>follows on from NSF - rebadged</td>
<td>Role model</td>
<td>Pet hates gowns untied</td>
</tr>
<tr>
<td>14 Specialist Nurse</td>
<td>privacy and dignity within their consultations</td>
<td>follows on from NSF - rebadged</td>
<td>Role model</td>
<td>Pet hates gowns untied</td>
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<tr>
<td><strong>Senior Manager &amp; Execs</strong></td>
<td></td>
<td></td>
<td>Role model</td>
<td>Pet hates gowns untied</td>
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<tr>
<td>1 Senior Nursing Manager</td>
<td>launched as challenge to organisations</td>
<td>6 out of 10 items</td>
<td>mandate for the HR agenda</td>
<td>Shame - Trained 30 years ago</td>
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<tr>
<td>2 Senior HR Manager</td>
<td>Patient focussed, respecting diversity</td>
<td></td>
<td>mandate for the HR agenda</td>
<td>Shame - Trained 30 years ago</td>
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<td>3 Director</td>
<td>scores worse than so many other trusts</td>
<td>top six key areas</td>
<td>mandate for the HR agenda</td>
<td>Shame - Trained 30 years ago</td>
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