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The views of older people and health professionals about dignity in acute hospital care

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THE VIEWS OF OLDER PEOPLE AND HEALTH PROFESSIONALS ABOUT DIGNITY IN ACUTE HOSPITAL CARE

Abstract

Aims and Objectives: This paper reports the findings from interviews conducted as part of a wider study on interventions to support dignified care in older people in acute hospital care.

The data in this paper present the interview data.

Background: Dignity is a complex concept. Despite a plethora of recommendations on how to achieve dignified care it remains unclear how to attain this in practice and what the priorities of patients and staff are in relation to dignity.

Design: A purposive sample of older patients and staff took part in semi-structured interviews and gave their insight on the meaning of dignity and examples of what sustains and breaches a patient's dignity in acute hospital care.

Method: Thirteen patients and thirty eight healthcare professionals in a single metropolitan hospital in the UK interviewed. Interviews were transcribed verbatim and underwent a thematic analysis.

Results: The meaning of dignity was broadly agreed on by patients and staff. Three broad themes were identified; the meaning of dignity, staffing level and its impact on dignity, and organisational culture and dignity. Registered staff of all healthcare discipline and student nurses report very little training on dignity or care of the older person.

Conclusion: There remains inconsistencies in the application of dignified care. Staff behaviour, a lack of training and the organisational processes continue to result in breaches to dignity of older people. Clinical nurses have a major role in ensuring dignified care for older people in hospital.

Relevance to clinical practice: There needs to be systematic dignity related training with regular refreshers. This education coupled with measures to change the cultural attitudes in an

organisation towards older peoples' care should result in long term improvements in the level of dignified care. Hospital managers have an important role in changing system to ensure that staff deliver the levels of care they aspire to.

Keywords: Acute Care, Dignity, Patient's Experience, Healthcare professionals, Older people

1. INTRODUCTION

Dignity is a vague, complex and multidimensional concept and of universal concern to healthcare professionals and patients (Valentine et al. 2008, Baillie 2009, Jacobson 2009, Barclay 2016, Papastavrou et al. 2014). Dignity is an aspect of patient care that is repeatedly identified as central to the way health care professionals interact with patients and their families. Furthermore, respect for human dignity is a core ethical principle of nursing internationally (International Council of Nurses 2012).

2. BACKGROUND

In the United Kingdom (UK), ensuring patients receive dignified care is a professional responsibility for nurses, doctors, allied healthcare professionals and pharmacists through their individual regulatory bodies' codes of conduct (Nursing and Midwifery Council 2015, General Medical Council 2013, Health and Care Professions Council 2016, General Pharmaceutical Council 2012) and is a fundamental care standard according to the Care Quality Commission, the independent regulator for health and social care in England (Care Quality Commission 2016). Being treated with dignity (and respect) is a National Health Service (NHS) value enshrined in the NHS Constitution for England (Department of Health 2015). Yet there have been numerous instances where it has been reported that dignity is not always promoted for patients (Francis 2013, The Patient's Association 2013). Despite a plethora of recommendations (from governments, independent bodies and charities) on how to achieve dignified care (Department of Health 2001 a&b, Commission on Dignity in Care for Older

People 2012), it remains unclear how to attain (or maintain) this in practice and what the priorities of patients and staff are in relation to dignity. Older people are seen as particularly vulnerable to breaches of dignity with the Parliamentary Health Service Ombudsmen's Care and Compassion report making particularly distressing reading (Parliamentary and Health Service Ombudsman 2011). Personal dignity is particularly vulnerable during the process of becoming old and during the deterioration of physical and mental health (Anderberg et al., 2007; Hall & Høy 2011) linked with becoming dependent on others (Rasmussen and Delmar 2014). Older people have inconsistent experiences in areas of acute care such as emergency and urgent care services (Bridges & Nugus 2009), or when having surgery (NCEPOD 2010). The UK National Health Service (NHS) is experiencing ever-greater pressure on finances, waiting times, length of stay and staffing. In these circumstances maintaining dignity is not always seen as a priority.

Nurses across the UK have reported concerns, and indeed, distress about being unable to preserve dignity for patients due to organisational and environmental constraints, staffing issues and lack of resources (Baillie et al. 2008). Internationally, studies from the UK (Baillie 2009; Calnan et al. 2013), other European countries (Hall and Høy 2011; Rasmussen & Delmar 2014; Ferri et al. 2015), the United States (Jacelon 2003), Canada (Jacobson 2009), Iran (Ebrahimi et al. 2012; Torabizadeh et al. 2013) and Taiwan (Lin & Tsai 2011; Lin et al. 2011), have revealed that dignity in acute hospitals is affected by patients' health and functional status, the physical environment and culture, and care approaches and interactions with staff. A recent systematic review found no studies that directly evaluated interventions to improve the dignity of older people in acute care settings (Zahran et al. 2016).

1.1 Objectives:

The aim of this qualitative study was to explore inpatient and staff views on dignity, as an initial phase of a larger 2-year mixed method study attempting to improve dignity for older people in acute hospital care. The larger study was an action research study which also conducted structured observations of staff-patient interactions during care episodes, collected electronic patient surveys rating dignity, gave detailed feedback from interviews, observations and surveys to each participating ward, and offered wards a range of support interventions to enable them to improve dignified care.

3. METHODS

3.1 Setting and participants

The larger dignity study ran on seventeen wards at a large London acute healthcare organisation across three hospital sites. Six wards were medical speciality wards, three were acute admission wards, four wards were surgical, three were older person wards (two medical and one surgical), and one was an oncology ward. We included patients who were (a) over 65 years old, (b) well enough to be interviewed and (c) having sufficient command of English to read the participant information sheet, give informed consent and participate in the interview. The participants were identified by the ward staff according to the inclusion criteria.

Posters about the research were displayed in communal areas of the hospital sites inviting staff from any healthcare discipline and student nurses working on a project ward to contact the Project Manager if they wished to be interviewed. Following discussion about the project they were given the participant information sheet. In addition, staff interviewees were recruited using a snowballing technique.

3.2 Data collection

The interviews were conducted at a mutually agreed time and venue. Patients were interviewed on their ward, either in a day room (that was marked private), a private office, or their own

single room. Three patients were interviewed at their bedside in a bay at their own request. All staff were interviewed in a private office on hospital premises. Interviews were used to capture the experiences of patients and staff regarding dignity and dignified care. The interviews were conducted with a purposively selected sample of patients and staff from across the participating wards. After several consultations, the Steering Group agreed two interview schedules, one each for patients and staff. Similar questions were created for both interview schedules to ensure similar themes, adapting the language used for the two groups. The interview schedule (Table 1) provided a semi-structured approach to interviewing participants, with prompts and probing questions included to gather meaningful data. There were two strands in the questions: 'self' and 'organisation'. 'Self' questions were intended to capture the interviewee's experiences and perceptions of dignity and dignified care. 'Organisation' questions were centred on identifying the hospital's culture and quality of provision surrounding dignified care to older people in hospital. Demographic information was obtained to provide contextual data. Participants gave written consent and interviews were conducted by MTG and CN except three which were conducted by student nurses on a research internship who had training and experience in interviewing. The interviews were audio-recorded and the participants reassured that all identifiable information would be anonymised. All interviews were transcribed verbatim and professionally transcribed. We offered to return transcripts to participants for comments and corrections. Two of the participants (staff) requested this and no correction/comments were received. We addressed all the topics in every interview and continued to recruit interviewees until apparent data saturation was reached.

Table 1. The interview schedule

<p><u>Self:</u></p> <ul style="list-style-type: none">• What is your understanding of dignity?• The interviewee's experience and/or observation of dignified and undignified care• Knowledge and skills that help provide dignified care• Examples of going the 'extra mile' for dignity <p><u>Organisation:</u></p> <ul style="list-style-type: none">• The interviewee's feelings about the organisation's attitude towards older patients• Terms (or labels) used to describe older patients• Staff attitude and behaviours• How the organisation could ensure the dignified care of older patients• Whether leadership makes a difference to the provision of dignified care	s
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3.3 Data analysis

A pragmatic thematic analysis was utilised to analyse the data (Braun and Clarke 2006). This was done in six stages which are (1) familiarisation with the data. The transcribed interviews were separately read and re-read by at least two of the researchers whom became very familiar with the data. (2) Coding. Initial codes were created and subsequently revised as required. Similar codes were sorted and arranged into categories. (3) Searching for the themes. At this point we had long list of different codes and were focused on the broader level of themes and involved sorting the different codes into potential themes. The themes were identified and named with any further revision being undertaken as appropriate. (4) Reviewing themes. This involved defining the individual themes and the relationship between them. Some sub-themes are identified in this stage (5) Defining and naming themes. This stage involved identification of how each theme affects entire data, naming the themes and explained each themes in a few sentences. To address issues of rigour and trustworthiness the coding framework was agreed by two authors (MTG and GA). Discussion between the

authors (face to face and by email) was used to reach consensus on themes and subthemes before the last stage of the data analysis (writing up).

3.4 Ethical considerations

The study was approved by the Brent Research Ethics committee (reference number 14/LO/1683) and the Hospital's Research & Development department. Written informed consent was obtained from all participants and they were told that they had a right to withdraw from the study at any time without giving a reason and without affecting their care. All participants were assured of their confidentiality and anonymity. Participants giving 'concerning' information, such as patients reporting poor care experiences, incidents revealed during the interviews or staff participants discussing poor practices of other staff members were discussed between the lead researchers and action taken according to local hospital policy.

4. RESULTS

In total, fifty-one interviews were conducted. Thirteen were with patients; their ages ranged from 65-91 years. There were five men and eight women. Eleven patients were white (British, Irish or other), one was black British and one was not stated. More staff (38) than patients were interviewed to sample a variety of different health professions. There were thirteen nurses, nine doctors, four occupational therapists, three pharmacists, three physiotherapists, three student nurses, two healthcare assistants and one ward administrator. Nine of the staff interviewees were men and twenty nine were women. Twenty-nine of the staff were white (British or Other), three were black (British or Other), three were Asian (British or Other), one was Mixed Race, one was African-Indian and one was not stated. Individual staff experience since graduating in their profession, ranged from 1 to 40 years with median of 10 years (the student nurses, healthcare assistants and ward administrator were excluded from this calculation). The interviews lasted for a maximum of 36 minutes for patients and 79 minutes for staff.

Three overarching themes emerged with nine sub-themes (Table 2).

Table 2 Themes from patient and staff semi structured interviews

<u>Themes</u>	<u>Sub-themes</u>
1. Meaning of Dignity	Shared patient and staff understanding of dignity
	Differences between patients and staff in understanding of dignity
	Experiences of dignity
2. Staffing level and its impact on dignity	Staffing levels
	Staff behaviours
	Communication
3. Organisational culture and dignity	Organisational culture towards older people
	Effective leadership
	Knowledge, skills and training

These themes are presented below. Themes 1 and 2 cover individual issues; theme 3 covers the organisational issues. Verbatim quotes are given in italics to illustrate the themes, with participant number, and profession for the staff, in brackets. There was broad agreement about the dignity related issues across the range of healthcare professionals interviewed and so results are not presented separately.

4.1. The meaning of dignity

The first theme refers to the understanding of, and meaning of dignity to the individual participant. It is particularly important to understand what dignity means to older patients and staff to see if there are any differences in perception.

4.1.1 Shared patient and staff understanding of dignity

There was a generally shared understanding between patients and staff of what dignity meant to them. The majority reported it included mutual respect; being treated with respect and treating others with respect, as you would treat one of your own family. Respect should be applied to everyone:

“Well, it’s just; you get treated in a decent way, a proper manner.” (Patient 12)

“It’s the way people treat you as opposed to the things they do to you.” (Registered Nurse: Staff 24)

For many patients and staff dignity meant that every individual is unique and that staff should be mindful of their psychosocial and physical needs:

“Dignity is if somebody is treated appropriately for their age, for their mental health, for their physical needs and emotional needs.” (Patient 5)

“Appreciating that different people may need different approaches to ensure dignified care and being sensitive to that.” (Registered Nurse: Staff 38)

In terms of giving dignified care, staff talked about how to ‘care’ and in some cases specified how the care or comfort should be given and/or communicated:

“Responding promptly to care needs and making people feel as comfortable as possible.” (Physiotherapist: Staff 5)

Staff support and compassion through difficult events was valued by patients:

“He [nurse] spoke, he held me, he cuddled me, and encouraged me to scream it out, to let it out. And I did. And the panic passed.” (Patient 6)

Often dignity was more obvious where it was not observed than when it was:

“Dignity is very difficult to define. Maybe it is more recognisable when it’s not there. And often dignity is often associated with negatives and not positives.” (Doctor: Staff 16)

4.1.2. Differences between staff and patients’ understanding of dignity

While there was much agreement between patients and staff, there were some apparent differences. Some patients seemed to accept that maintaining privacy and dignity was difficult in hospitals. It seems that patients lost control and felt powerless, but accepted that as a patient you have to adhere to what hospital staff impose:

“When you are in hospital you forget about privacy, you’re here as a patient, and it’s up to them...” (Patient 1)

Patients also talked about losing control or power in terms of hospital activity, especially if they misunderstood, or felt they were lost in the ‘system’. This aspect was not explicitly discussed by staff. Delays in treatment or attention were seen predominately by patients as undignified:

“And I feel completely isolated. I’m trying to call out for – I know you’ve got a buzzer, you call out for the nurse and, you know, that I’m waiting for a [bed] pan or whatever... (Patient 12)

For staff, supporting patients to have an element of influence at an inevitably stressful time was important:

“I make sure I give the patient control over whatever the interaction is with me.”
(Occupational Therapist: Staff 11)

Some patients felt ignored or not listened to despite several attempts to draw staff attention. This left the patient feeling powerless and unable to control their surroundings:

“A few times I’ve asked them “would you speak to my son?” but they haven’t.... They’ve got his home number, his work number and his mobile number...what more do they need on my file?” (Patient 11)

The staff also expressed dignity in terms of rights, equality and humanity. This was not expressed by patients:

“Access to, basic human rights; food, water and being able to speak freely.” (Doctor: Staff 14)

Staff also felt that a facet of dignity was an obligation to maintain confidentiality and this was often commented on in tandem with privacy. Although respecting privacy was mentioned once by a patient, it was much more prevalent in the staff responses than the patients:

“I see people walk behind closed curtains; it is undignified because you don’t know what the person is doing and you are just entering without asking, without permission.” (Healthcare Assistant: Staff 25)

For patients, dignity meant feeling valued as a person, this gave them the sense that they are valued as a human being and not seen as an object. Often it was the small touches that mattered:

“A nice nurse comes and offers to go down and get me a [news]paper.” (Patient 12)

Staff also placed additional emphasis on a dignified death:

“It’s about human beings delivering care to other human beings at a time of need and there’s no more time of need than actually to ensure a dignified death.” (Doctor: Staff 29)

4.1.3. Experiences of Dignity

The majority of examples described by patients and staff during interviews reflected positive dignified care. However, some patients related experiences of both dignified and undignified care, sometimes on the same ward, sometimes in comparison to a previous ward and on occasion, a different organisation. Interaction with patients varied between staff where some staff left the patient feeling insignificant, while others made them feel worthy:

“And I said “please can you help me?”. She said “no you are in rehabilitation, you don’t get any help, you’ve got to do it yourself ”so I was struggling....” (Patient 13)

“She was absolutely brilliant. Caring...I mean what a different between the first one [nurse] and the second one [nurse]” (Patient 3)

Staff experiences of dignified care included individualising their approach to patients, giving patients a choice and involving them in making decisions about their care:

“Ensuring the patient’s wishes are fulfilled, be cared for in a way they want to and having a say in their decisions.” (Pharmacist: Staff 3)

Other staff expressed concerns about undignified care which was often cited as not seeing patients as individuals:

“I find nursing staff generally say “A1” [bed number], they don’t necessarily say [peoples] names (Doctor: Staff 14)

When patients were asked to comment on their worst experience of undignified care, by far the most examples related to continence care. Some staff were reported not to act in a sensitive and compassionate manner. This patient was in a vulnerable position, left feeling humiliated and shameful:

“I asked for the bed pan, because I was so exhausted ... A girl (HCA) came in, turned off the buzzer and said “We are doing handover; no one can help you now.” (Patient 5)

Staff attitude to continence care was felt by patients to impinge on dignity, even if the staff approach was not directly related to a continence related activity:

“However, they know I had diverticulitis and they’re giving me laxatives ... And the nurse came the next morning and chuckled and I told her what had happened [faecal incontinence], and she half chuckled. And that upset me so much, I can’t tell you.” (Patient 11)

Similarly, staff expressed undignified continence care as making incorrect assumptions about a patient’s continence, not supporting a patient with a continence issue, causing patient incontinence, and when toileting was not a priority:

“We’ve seen on loads of wards, there’s an automatic default that you put people in pads and it’s ridiculous. And I think that a massive insult to people’s dignity.” (Registered Nurse: Staff 38)

Other types of undignified care expressed by patients and staff related to poor communication, during personal care tasks, a lack of help by healthcare staff, the hospital’s processes and, witnessing conflict between staff.

Staff and patients had a broadly shared understanding of dignity. Where their perception varied related to apparent power differentials between staff and patients.

4.2 Staffing Level and its impact on dignity

The second theme refers to the importance of staffing level and staff behaviour for dignified care.

4.2.1. Staffing levels

Effective dignified care was felt to require sufficient staffing level to ensure patients have individual attention. There was a shared perception by both patients and staff of sub-optimal nurse staffing levels and that heavy workloads during both the day and night shifts compromised patients' dignity:

“Being short staffed makes patients have to wait longer for help with meals. Cold food is not nice.” (Registered Nurse, Staff 17)

The feeling that staff were too busy to do things differently was often expressed:

“There’s a rapid turnover [of patients] here that staff don’t have the time to go into more depth with them.” (Registered Nurse, Staff 6)

“Staffing is a problem, but that won’t change. Nurses who are stretched are not able to provide the level of care needed.” (Doctor, Staff 15)

Concerns over staff shortages were expressed by all staff participants. The effect of being busy or short-staffed was expressed by the staff, but not patients:

“We need more staff. I mean you can’t do it [provide dignified care] when you’re rushed off your feet.” (Doctor, Staff 7)

These perceived staffing shortages meant that patients are not attended to promptly:

“Sometimes I think, and I know it’s not the nurses’ fault, but if you want help for any reason ... I do sometimes have to ring twice. (Patient 8)

This perceived understaffing could lead to unacceptable practices. Patients had concerns over some poor practices during night shifts:

“There was another nurse one night ... And the first thing she’d done when she came in to my room was switch off the alarm [so that it could not be used]...” (Patient 4)

And this was corroborated by staff

“Some patient accounts of night shift care are fairly hair-raising!” (Doctor, Staff 29)

4.2.2. Staff behaviours

Staff attitudes and behaviours contributed to a patient’s feelings of dignity. There was a perception among staff and patients that the behaviour of some individual staff members was atypical and patients expressed this inconsistency as part of undignified care:

“You either get them like that, they’re jolly, they’re kind, they are – nothing is too much for them. And then you do have the other type, where everything is a chore.” (Patient 3)

Staff also viewed some colleagues’ behaviour as contributing to undignified care:

“It is things like any doctor walking past somebody whose bum is hanging out of their gown and not doing anything about it.” (Doctor: Staff 29)

Patients reported that some night staff would not help them in the usual ways that would occur during a day shift:

“I said I want to go to the loo ... But they wouldn’t let me, they gave me a bedpan. ... She [staff member] said “We won’t take you to the toilet of a night”.” (Patient 13)

At night, some patients felt they were a problem to staff:

“I have that experience especially on the night shifts. Most of them [at night] are very lazy, very lazy, very unhelpful and during the day shifts, they are ok” (Patient 14)

And this was corroborated by staff:

“And I’m talking simple things like call bells. On that night, they [call bells] were taken away from patients because they were calling too much” (Registered Nurse, Staff 36)

Some of the staff were felt to be lacking in social skills, and occasionally were reported to be overtly rude and unkind:

“But in my opinion they are too familiar ... at first they [the staff] call everyone “mama” which I hated.” (Patient 14).

Staff articulated a strong connection between how they felt about observing dignified or undignified care and how they felt about themselves as a healthcare professional. With dignified care, staff repeatedly used words like ‘proud’, ‘feel good’, ‘motivating’ and ‘important’, and with undignified care, ‘frustrating’, ‘angry’, ‘embarrassed’, ‘compromised’, and ‘demoralised’:

“I think if you are delivering what you consider to be good care; it does make you feel good. And the converse is true, when you’re seeing bad things happen, it makes you feel bad ...” (Doctor: Staff 7)

One patient recounted how she had complained about a staff member’s behaviour and this was taken seriously by the ward manager and matron and the staff member did change behaviour. But another did not feel believed when they reported poor behaviour:

“[after an episode of urinary incontinence]... So I said [to the nurse in charge] “I was told to do it in the bed”. So she [the nurse] said “I can’t believe that”. I said “I must be dreaming”. And she said “Yes, you must be” ... so it makes out I am a liar.” (Patient 11)

One patient wanted to report poor care, and felt obstructed from doing so at the time. However, was ultimately able to do so albeit anonymously:

“I tried to [report it] but she wouldn’t let me because she was worried I think ... I get a paper survey through the post which I like to do. I feel that’s the only way.” (Patient 5)

Staff also discussed the difficulties of tackling poor performance. Several staff was aware of colleagues who did not always provide optimal care, but seemed at a loss to know what to do. Some dismissed in as “just the way they are” and seemed pessimistic about being able to implement changes:

“I will raise issues if I think this is really unacceptable, but I find I’m a lone person.”
(Registered Nurse: Staff 6)

“Staff leave or move on to other roles as they are put off by poor care given by other staff.... We need to reduce the blame culture, raise concerns more and role model instead of criticising the staff.” (Registered Nurse: Staff 36)

Staff appeared resigned to poor behaviour:

“Some people are practically good and you can teach them technical things. But you can’t teach an attitude or change someone’s personality.” (Registered Nurse: Staff 24)

“It’s difficult to change the attitude of the doctors when they only work in a place for a week or so.” (Registered Nurse: staff 10)

4.2.3. Communication

Communication was a theme shared by patients and staff. Patients expressed their concern about not being welcomed to a ward or department and reported how communication could help or hinder navigating through the hospital system:

“I was put into X [ward name] ... So I waddled down to somebody and a doctor was next to her said, “Oh, I didn’t know you were here, nobody told me.” (Patient 5)

For some staff, it was a lack of time to communicate that was an issue:

“There’s not enough time to communicate effectively with patients resulting in poor care.”

(Physiotherapist: Staff 31)

For other staff, it was the ability to communicate itself that was the issue:

“I think a lot of our staff are scared of communication ... The patient is ... labelled as difficult and ‘let’s just leave him alone because it’s easier,’ you know?” (Registered Nurse: Staff 36)

Having staff and patients from different language or cultural backgrounds could create communication difficulties:

“...a lot of them have accents, yes. Some [staff] are very nice, but I couldn’t understand a word they were saying.” (Patient 13)

“Staff do talk in a different language in front of patients. I think it’s highly undignified.” (Registered Nurse: Staff 24)

But this was not always the case and staff were often seen to be trying hard to communicate with patients who did not speak English:

“It’s difficult...she’s no English and they [staff] still try to persevere.” (Patient 9)

And in some cases, staff from other cultures was seen as good role models, but their skills were unappreciated and devalued by peers:

“I was working with an overseas nurse. And I was overwhelmed at the amount of care and dignity shown by that girl.” (Registered Nurse: Staff 36)

It was clear that both staff and patients viewed sub-optimal nursing staffing levels as a major obstruction to dignified care. Lack of reporting and addressing poor performance with respect to dignified care was identified as an issue.

4.3. Organisational culture and dignity

The third theme addresses the central role of organisational culture in underpinning dignified care.

4.3.1. Organisational culture towards older people

Patients were mostly very positive about the care they had received. This view was reinforced by some patients and staff across most disciplines who said that the hospital's attitude and culture toward older patients was good and had evolved of late through the development of specific teams, pathways and services:

“Well generally with the NHS, I'm always pleased to hear of people like [patient's name] having a pacemaker fitted at eighty-nine ...” (Patient 5)

“I think it's quite good. I think there is a lot being done by the organisation to improve the experience of older people.” (Registered Nurse: Staff 6)

However, there was a perception among the majority of staff that the hospital and NHS does not prioritise care of older people. Other priorities, such as reducing length of stay, often override the needs of many older people for giving time and building relationships, particularly for those who are frail or have a cognitive impairment:

“I mean, historically they [the Trust] haven't been interested at all. I think they considered them [older people] a burden” (Doctor: Staff 23)

Other staff held strong views over the attitude of the organisation towards the Geriatric speciality. It appears that ageism, stereotyping, and prejudices against older people still exist:

“There needs to be an attitude change towards elderly care, other staff think we are not proper nurses like them and elderly care is a dumping ground.” (Registered Nurse: Staff 1)

4.3.2. Effective leadership

Some staff respondents clearly identified that good leadership which prioritised relational care, could make a difference to dignity:

“Having a senior member of staff who is your role model and will practice dignified care is the best way for others to learn through observation.” (Physiotherapist: Staff 5)

Good leadership tended to be less visible to patients than to staff. However, some patients had noticed good leadership:

“They [senior nurses] set a good example; they cope with it very, very well. And I’m really pleased with them, I’m proud of them.” (Patient 2)

Where a leader was less confident to act or there was a lack of leadership it was noted by both staff and patients:

“Definitely leadership has an effect, because if it’s rotten at the top, it’s just the way the whole thing is going to work.” (Doctor: Staff 19)

“It’s always come from the top. Whatever your staff is doing, is come from [sic] the person who is in charge of the staff.” (Patient 14)

4.3.3. Knowledge, Skills and Training

Only one staff member (a registered nurse) stated they had expressly received a dignity and respect training session that was provided by the hospital. Two other staff members, (another registered nurse and a doctor) stated they had received dignity training as a sub-topic of another issue, such as dementia. Staff identified other hospital training as having an older person focus,

but not an explicit dignity focus. These training sessions included the Healthcare Support Worker's Care Certificate and other training on various clinical topics (continence care, dementia, safeguarding, pressure ulcer prevention and falls management training).

Staff reported varied pre-registration training about caring for older patients. Therapists (one physiotherapist and two occupational therapists) reported a great deal of undergraduate training in older person care. Doctors (who graduated between 1986 and 2008), also felt they received training. Only two nurses (who both graduated in 2005) of thirteen interviewed, reported their nurse training included how to care for older adults. The four current nursing students reported they have had no older person training at all during their pre-registration programmes.

Both patients and staff were asked about what knowledge and skills they felt were required in order to provide dignified care. Patients felt that kindness was an important skill:

"I think they've already got it. Kindness and yes, those are kind people." (Patient 4)

For staff it was more about empathy and sensitivity:

"Despite the busyness of the shift, staff must be able to maintain being 'sensitive' to patients." (Registered Nurse: Staff 24)

The staff were clear that training and the acquisition of communication skills (verbal and non-verbal) were important:

"If we can have training ... role play would be a good thing and then they [staff] will realise how their body language is and how they treat the patient." (Ward Administrator: Staff 4)

Staff expressed the following ways of positively communicating: diplomacy, advocacy, the ability to explain, tone of voice and therapeutic touch. Patients did not emphasise communication skills at all.

However, some patients and staff felt there was another ingredient, something less tangible:

“I think life experience; knowledge about everyone.” (Student Nurse: Staff 13)

Both groups acknowledged that some training was needed:

“Staff who have been in post a long time forget how to treat people and refreshing them would be good.” (Healthcare Assistant: Staff 23)

Some patients and staff were more explicit about what training was required:

“If wards are specifically for people, for elderly, or people who are over sixty-five, they [all staff] should have training in a short course in how to care for people.” (Patient 5)

Organisational culture is central to all aspect of dignified care provision. Staff require appropriate managerial interventions and support to deliver the level of dignified care which they would like to provide. Systematic and appropriate managerial intervention is required to support staff.

5. DISCUSSION

The majority of interviewees in our study were generally in agreement about what constitutes dignified care and most were positive about their experiences of dignified care in term of respect, comfort, compassionate care and treating the person as a unique individual. Similarly, Baillie and Gallagher (2011) found that nursing staff believed that treating people as valued individuals was the core factor that promoted dignity. Patients were very complimentary about individual staff members, and staff articulated occasions where they had “gone the extra mile” for patients. However, only one patient referred to a whole team as being great or excellent, leading to questions about how a whole culture of dignified care can be supported so patients experience consistently dignified care from all staff.

Staff and patients agreed that dignified care meant mutual respect and having self-respect. Both groups described ways of how to treat a person with dignity and emphasised maintaining privacy and confidentiality. There were also some differences between staff and patients: patients reported that undignified care involved any form of depersonalisation (being ignored, not valued or treated like a burden), a lack of control and/or autonomy. Patients saw a hospital environment as a place where they have to accept breaches of dignity. Staff on the other hand spoke of human rights, equality and good death. In her philosophical account about dignity, Barclay (2016) argues that for healthcare professionals, a clear understanding of the meaning of dignity is needed in order to protect dignity in healthcare settings.

Despite previous qualitative evidence on what dignity means, in terms of what promotes or breaches dignity, there is still lack of consensus on what dignity means (Barclay 2016). Barclay proposed a less 'deconstructed' account of dignity could be more useful than complex lists (p.137). Furthermore, she suggested a simpler core philosophical concept of dignity that can be applied to existing qualitative literature. Barclay's synthesis emphasised that dignity can be maintained when patients are able to live according to their standards and values, respect them as human beings and treat them as equals. These standards and values can be compromised in ill health when a human being is most vulnerable. Similarly, Jacobson (2009) asserted that violations of dignity are more likely to occur when people are vulnerable. Violation of dignity is more common when there is power relation between people, when someone has more power, authority, knowledge, wealth, or strength than the other (Jacobson 2009) and results in patients experiencing shame, humiliation, feeling of powerlessness or helplessness as a result of undignified care (Barclay 2016). This was expressed by patients in our study on several occasions and most strongly associated with continence care. They were forced to abandon their standards of public decency esteem and status (Barclay 2016); these findings echoed those of stroke patients' experiences of fundamental care (Kitson et al. 2013).

Dignity was also associated with individuality and control, findings that supports previous research about perceptions and experiences of dignity in England (Baillie 2009), Denmark (Hall and Høy 2011) and Taiwan (Lin et al. 2011). Barclay (2016) continues to emphasise that patients feel stripped of their status as unique individuals with little control over their surroundings, their minds and bodies making them dependent on others to maintain their standards and values. Another perspective is that all people possess human dignity by virtue of being human, regardless of their ability to be autonomous (Nordenfelt 2003; Jacobson 2007) but that other types of dignity can be threatened or lost: social dignity, which is experienced through interactions (Jacobson 2007) and dignity of identity, which is threatened by illness (Nordenfelt 2003) and affected by mental and physical ability (Baillie 2009).

There were many individual dignity breaches cited by both staff and patients. Some of these breaches relate to individual staff behaviours and these findings support previous research (Baillie 2009; Torabizadeh et al. 2013; Nilsson et al. 2015, Rasmussen and Delmar 2015). Continence issues were particularly distressing and undignified for patients, echoing previous findings about the indignity associated with urinary incontinence (Baillie 2007; Kitson et al. 2013). Concerning in the current study was that some patients' incontinence was apparently induced by staff behaviour, supporting previous observational research (Tadd et al. 2011). Francis (2013) referred to continence as 'this most basic of needs,' in his report highlighting significant concerns in this area of care. Other breaches of dignity related to communication, including how staff manage their or their patient's cultural differences, supporting previous work in the UK (Webster & Bryan 2009) and Iran (Torabizadeh et al. 2013). The perception that staff are too busy echoes other work about nursing tasks left undone: nurses report prioritising more technical aspects of care and find insufficient time to attend to relational care and talking to patients (Ball et al 2013). Maben et al (2012) reported that due to the complexity of older people's care, high demands and staff shortages, staff had to compromise the dignity

of patients to ensure that they met their physical care needs quickly and safely. Staff also reported tensions between the Hospital's promise to ensure 'excellence in patient care', their personal and professional aspirations for delivering good patient care and the reality of the workplace which created ethical dilemmas and low morale amongst staff. A UK-wide survey of nursing staff's experiences of dignified care reported that the majority had sometimes left work feeling they had not given the dignified care they had aspired to, resulting in moral distress (Baillie et al. 2008).

Staff attitudes and behaviour are strong themes in the wider literature. In Australia, Higgins et al (2007) interviewed nurses in acute care settings and reported that nursing older people was viewed as an unattractive specialty, low status where a culture of ageist stereotyping existed. In their literature review of dignity in the care of older people, Gallagher et al. (2008) reported lack of respect, intolerance, impatience, and being patronising to patients. Liu et al.(2012) reviewed 51 international studies of health professionals', including students', attitudes to older people and older patients. The review revealed a range of neutral to positive attitudes but notably, while medical students' and doctors' attitudes have improved over time, possibly due to increased educational input, student nurses' and qualified nurses' attitudes have become more negative. Similarly, Hanson's (2014) review of five international studies of nurses' and student nurses' attitudes towards caring for older people and found mainly negative attitudes, which appeared to be linked to a lack of knowledge about ageing.

Rees et al (2009) found that ageism is one of the major sources of the ethical issues that arise for nurses caring for older people, suggesting that education and organisational change can alter ageist attitudes. Similar findings were earlier reported in Canada and USA (Palmore 2004). Jacobson (2009) describes the violation of dignity in healthcare as rudeness, indifference, condescension, disregard, objectification, restriction, labelling, contempt, discrimination and abjection amongst other staff behaviours. In our recent review (Zahran et

al. 2016), staff attitudes and behaviour were reported to have significant impact on promoting or threatening older people's dignity. Gallagher et al (2008) suggested that nurses need support and education and adequate resources to help them understand dignity. This was echoed by participants in our study (Table 3).

Another important factor in promoting dignity is effective communication and leadership (Maben et al 2012, Zahran et al., 2016). If there is a shared understanding on an individual level, why is it difficult to manage in practice and what are the long term effects of compromise for patients and staff? Patient expectations may fall and this may contribute to a loss of trust over time. For staff, the chronic acceptance of providing care that is compromised, either by them or within the processes in which they work, may lead to task orientated behaviours in order to cope (thus compounding the problem), decreased morale, staff shortages and difficulty in recruiting and retaining staff. These are all issues that the wider NHS is currently attempting to deal with.

In the UK eighty-one per cent of patients who responded to the National Inpatient Survey (patients aged 16 years and over), felt they were 'always' treated with dignity and respect. This leaves almost a fifth of respondents reported that they were 'sometimes' or 'not' treated with dignity or respect. Over the course of twelve yearly inpatient surveys, this figure is virtually unchanged (Picker Institute Europe and Care Quality Commission 2015). Therefore, there would seem to be many barriers to dignified care on a personal and organisational level some of which are longstanding and apparent, and some of which may not yet be known.

6. LIMITATIONS

The participants were from a single metropolitan hospital and views might be different elsewhere. It was not possible to provide translation services in this study and this precluded participants who were not fluent in English. It was not possible to interview the most unwell

patients or those without the capacity to consent, thereby perhaps excluding those most vulnerable to breaches of dignity. The opinions of other ethnic groups should be explored in more depth to ensure a representative sample of patients and staff.

Almost three times as many staff were interviewed as patients. This may limit the transferability of the findings of shared and different understanding of dignity.

7. CONCLUSIONS

This study illustrates that there are similarities and difference in opinions of older patients and staff in relation to dignity and dignified care in an acute NHS healthcare organisation. Staff behaviour and organisational process have an effect on an older patient's dignity. Dignity related training for staff should be considered to improve the delivery of dignified care. Whilst most care is felt to achieve dignity, there is still room for improvement at an individual and organisational level.

8. RELEVANCE TO CLINICAL PRACTICE

Dignity is a complex concept. It is about how staff and patients relate to each other as people, not just what staff do to patients. The authors and the Steering Group for the overall project discussed our interview findings and developed some recommendations for clinical practice. We recommend that the multidisciplinary team are given systematic dignity-related training with regular refreshers. For example, training on continence management training seems important, and was provided in our hospital as a result of our findings. This education coupled with measures to change the cultural attitudes in an organisation towards older peoples' care should result in long term improvements in the level of dignified care. However, it is clear that many shortfalls in dignified care are not the result of deficiencies in staff capability or attitudes, but are a result of excessive workloads. Hospital managers have an important role in workload planning to ensure that staff deliver the levels of care they aspire to.

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Summary Box

What this paper contribute to wider global clinical community?

- There is little existing literature which explores and contrasts healthcare professionals' and patients' perspectives on dignity in acute care. This paper fills that gap. The meaning of dignity to healthcare professionals and patients was similar.
- The experience of patients receiving and staff providing dignified care was broadly positive, in contrast to existing literature.
- Healthcare professionals reported a low level of dignity-related training and patients were able to state where they felt the healthcare professional's deficits were.

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