

Defending Dignity –
Challenges and
opportunities for nursing



Contents

Acknowledgements	4
Report authors	5
Summary	6
1 Introduction	8
1.1 The RCN Dignity Survey	8
1.2 Context	8
1.3 Method	10
1.4 Report structure	10
2 Profile of respondents	11
2.1 Sex, age and ethnicity	11
2.2 Country and region	12
2.3 Employment and job description	12
2.4 Patient/client group contact	12
2.5 Place of qualification	12
2.6 Decade of qualification	13
2.7 Years of experience	13
2.8 Qualifications	13
2.9 Summary	14
3 Initial and continuing education relating to dignity	15
3.1 Teaching and learning about dignity in initial training/education	15
3.2 Where and how learning took place during initial training/education	15
3.3 Influence of initial training/education on understanding & practice	15
3.4 Development of understanding since assuming employment	15
3.5 What has influenced understanding of dignity most?	15
3.6 Summary	15

2 Defending Dignity

4 Dignity and the physical environment	17
4.1 Aspects of the physical environment that help maintain, promote and deliver dignified care	17
4.2 Aspects of the physical environment that prevent the maintenance, promotion and delivery of dignified care	18
4.3 Aspects of the physical environment that need to change to help practitioners maintain, promote and deliver dignified care more effectively	20
4.4 Summary	21
5 Individual/practitioner, team and organisational prioritisation of dignity	22
5.1 Individual prioritisation of dignity	22
5.2 Individual aspiration to prioritise dignity	22
5.3 Organisational prioritisation of dignity	22
5.4 Team prioritisation of dignity as a philosophy of care	22
5.5 Ability to challenge policies or actions that compromise dignity	22
5.6 Response to colleagues who compromise patients' dignity	22
5.7 Views of organisation's ability to deliver dignified care & patient/client involvement in care decisions in organisation	23
5.8 Summary	23
6 Dignity and the employing organisation	24
6.1 Aspects of the organisation that help maintain, promote and deliver dignified care	24
6.2 Aspects of the organisation that prevent the maintenance, promotion and delivery of dignified care	25
6.3 Aspects of the organisation that need to change to help practitioners maintain, promote and deliver dignified care more effectively	28
6.4 Summary	31
7 Ability to deliver dignifying care	32
7.1 Views of own ability to deliver dignified care	32
7.2 Practitioners' rating of the dignity of care delivered	32
7.3 Importance of patient dignity to individual practitioners	32
7.4 Importance of patient dignity to own organisation	32
7.5 Time to deliver dignifying care	32
7.6 Staff distress	32
7.7 Summary	32
8 Dignity and care activities	34
8.1 Introduction	34
8.2 Care activities that may compromise dignity	34
8.3 Steps taken to minimise loss of dignity	36
8.4 Practice initiatives that promote dignity in care	37
8.5 Summary	40

9 Discussion	42
9.1 Initial and continuing education relating to dignity	42
9.2 Dignity and the physical environment	42
9.3 Dignity and the employing organisation	43
9.4 Prioritisation of dignity	44
9.5 Dignifying care activities	44
9.6 Dignity, ethics and nursing	45
9.7 Summary	46
10 Conclusion and Recommendations	47
11 References	49
12 Appendices	52

Acknowledgements

We are grateful to nurse colleagues, patients and carers within and outside the Royal College of Nursing who helped to develop, pilot and manage the survey questionnaire.

Without the generosity of nurses, health care assistants, nursing students and others who completed the questionnaire the survey would not have been possible. We thank them for their frank and thoughtful contributions. Thanks are also due to Smith and Nephew who provided funding for the survey.

Published by the Royal College of Nursing, 20 Cavendish Square, London, W1G 0RN

© 2008 Royal College of Nursing. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means electronic, mechanical, photocopying, recording or otherwise, without prior permission of the Publishers or a licence permitting restricted copying issued by the Copyright Licensing Agency, 90 Tottenham Court Road, London W1T 4LP. This publication may not be lent, resold, hired out or otherwise disposed of by ways of trade in any form of binding or cover other than that in which it is published, without the prior consent of the Publishers.

Report authors

Report commissioned by The Royal College of Nursing

Lesley Baillie RGN, BA (Hons), RNT, MSc, PhD

Lesley is Principal Lecturer for clinical skills developments in the Faculty of Health and Social Care at London South Bank University. She was previously Senior Lecturer in Adult Nursing at the Open University. After qualifying as a registered nurse she worked in acute care settings in Buckinghamshire and Norfolk and continues to practise part-time as an Accident and Emergency Department nurse. Her publications include a textbook *Developing Practical Nursing Skills* which emphasises caring nursing practices and will be published in its 3rd edition in 2009. Previous research has used varying methodologies including surveys, action research and qualitative designs and has focused on both health care and education of nurses, particularly skills development. Lesley completed a doctoral thesis about patient dignity in 2007 and her research has been published and presented in a number of arenas.

Ann Gallagher SRN, RMN, BA (Hons), MA, PGCEA, PhD

Ann is Senior Research Fellow in the Faculty of Health and Social Care Sciences, Kingston University & St George's University of London. Prior to this she worked at the Open University as Assistant Director (Academic Lead) on the open learning nursing programme. She qualified as an SRN at the Royal Victoria Hospital in Belfast and as an RMN at West Park Hospital in Epsom. Her MA and PhD studies, and the majority of her research and scholarship, are in the field of applied and professional ethics. In 1999 she began researching dignity in care on a project with David Seedhouse at Middlesex University. Ann has recently completed *Ethics in Professional Life: Virtues for Health and Social Care* with Sarah Banks of the University of Durham. She is a member of the South East Research Ethics Committee and of clinical ethics committees at St Christopher's Hospice and St George's Hospital.

Paul Wainwright SRN, DipN, DANS, MSc, RNT, PhD, FEANS

Paul is Professor of Nursing and Associate Dean (Research) in the Faculty of Health and Social Care Sciences, Kingston University & St George's University of London. He was previously Reader in the Centre for Philosophy and Health Care at Swansea University. He qualified as an SRN in Southampton, has an MSc in Nursing from Manchester and a PhD in professional ethics from University of Wales. He has published books, book chapters and articles on various aspects of nursing philosophy and professional ethics as well as completing a range of empirical studies. He is a member of two clinical ethics committees and chairs the Faculty Research Ethics Committee. He is also a Fellow of the European Academy of Nursing Science.

Executive summary

Dignity is a complex concept but a value and philosophy that is central to nursing. The Royal College of Nursing (RCN) believes it is at the very heart of good nursing care.

There have been a number of research studies that have investigated dignity and indignity in care, but these have tended to focus on the perspectives of patients and carers. Little attention has been paid, until now, to the perspectives and experiences of nurses, health care assistants and nursing students who work with people at vulnerable stages in their lives in diverse settings. In February 2008, the Royal College of Nursing conducted a membership survey to investigate nurses' awareness of dignity and the barriers which prevent dignified care being given to patients and clients in a wide range of health care environments. More than 2,000 nurses, nursing students and health care assistants took part.

The survey found a high level of awareness of dignity and sensitivity to dignity issues amongst nursing staff, combined with a strong commitment to dignified care and concern in relation to dignity violations. The survey results were in keeping with previous research in pointing to three main factors that maintain or diminish dignity in care: the physical environment and the culture of the organisation (Place), the nature and conduct of care activities (Processes) and the attitudes and behaviour of staff and others (People).

Many survey respondents described the environment of care, particularly in the acute hospital sector, as overcrowded and with poorly screened bed spaces. Mixed sex accommodation compounds this problem. In some cases there are inadequate and unsuitable bathroom and toilet facilities. In addition to wards being overcrowded, respondents also reported a lack of treatment rooms, day rooms or quiet areas where intimate procedures or confidential discussions can be conducted. As one nurse said: "Our ward is cramped, old fashioned, badly designed with poor resources and poor maintenance." Another said: "Pressure is on to fit as many patients in the physical space available, especially with emergency beds going up in times of crisis."

The findings of the survey suggest that the culture of the organisation has a tendency to compound the problems within the physical environment. Survey respondents were critical of

management bureaucracy, of unrealistic expectations, of a quick fix attitude, a "culture of rushing", of managers who were "target driven" and who pay "lip service" to dignity in care. Management, it was suggested, often had different priorities. Respondents pointed to inadequate material resources such as equipment, linen and towels, and insufficient staff and time to deliver dignifying care. The importance of dignity-promoting attitudes and behaviours amongst nurses and others was also highlighted, as was the need for role modelling and appropriate staff development activities.

Government policies were identified as both supporting and undermining dignity in care. On the one hand policies such as *Fundamentals of care*, *Essence of care*, and the prison *Decency* agenda were viewed positively as supporting dignified care practices. On the other hand NHS targets were identified as having the potential to undermine dignity. Whilst the creation of a performance-driven culture has led to some benefits for patients, respondents were critical of organisations that prioritised targets over dignity and efficiency over quality of care. One respondent vividly described the impact on nurses: "The constant battle of meeting targets in surgery, A&E four-hour waits, reducing length of stay which can at times leave staff feeling harassed in delivering care in a dignified and timely way." Another said: "The organisation needs to understand we are looking after people not things and the most important part of our job is the patient not a four-hour target." There appears to be a paradox here of a government that has declared "zero tolerance" of undignified care, but that persists in allowing mixed sex accommodation and setting management targets that may themselves be inherently undignifying.

A picture emerges from the survey of nursing staff who have inadequate time or resources to deliver dignifying care, and who leave work feeling upset or distressed because they are unable to give the kind of dignified care they know they should. In spite of this the survey reveals a willingness within the profession to respond practically and creatively to the everyday challenges to dignity in care which nurses encounter. Respondents also displayed a keen sense of the responsibility to overcome such challenges. As one nurse explained: "I believe there is always a way around obstacles

and primarily it is you, yourself, your actions, standards and behaviour that deliver care.”

Despite such expressions of individual commitment, our survey shows that nursing staff experience the combined pressure of targets, high patient throughput, and inadequate staffing levels. A plea from one respondent illustrates this:

“Need more money to invest in staff/patient ratio. Please, this would give me time just to sit and talk to my patients without continually being aware of all the tasks I still have to undertake. Patients often don’t discuss their fears/ anxieties or even something as simple as themselves because they can see how busy we are. Hospitalisation must be an extremely lonely time for some patients!”

Other respondents raised the issue of skill mix, emphasising the need to match the ratio of registered nurses with patient dependency.

Powerful as the findings of this survey are, this report is only one piece of work in a complex area. From the data we have identified some general recommendations and areas for further debate. These recommendations are divided into categories for government, organisations and individuals.

Macro-level – Role of government

- Consideration of the paradoxical effects of health policy: if government is serious about delivering dignified health care services there must be a serious debate about the impact of targets and other policies on dignity and care.
- A renewed commitment to single sex wards.
- Nurse/patient ratios and skill mix must be appropriate to provide dignified care.
- Nursing and other care staff should be involved in the design of health care environments.

Meso-level – Role of organisations

Employing organisations, higher education institutions, the Royal College of Nursing and other Royal Colleges have an important contribution to make to the development of dignity in care:

- there must be sufficient investment in the physical environment in care settings to demonstrate that staff and patients are valued and respected. This includes ensuring adequate standards of cleanliness, sufficient material resources (equipment, towels, gowns, bed linen) to deliver dignifying care
- organisational cultures and ways of working must make patient care the first priority
- organisations must demonstrate respect for the dignity of staff in tangible ways
- organisations must ensure that training opportunities and materials to promote dignity are available for staff in a user-friendly format
- organisations must develop policies and practices that support dignity in care, including the development of an ethical climate,

appropriate organisational values and systems for reporting and whistle-blowing.

Micro-level – Role of individual responsibility and accountability

- Individual 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 regarding their performance.
- Attitudes and behaviours that diminish dignity must be challenged, therefore individuals should know how to influence change and report dignity deficits.
- All health care staff should be aware of the potential to enhance dignity by role modelling.

8 Defending Dignity

1 Introduction

Dignity is a complex concept and a central nursing value. Health and social care policies across the United Kingdom (UK) have emphasised the promotion of dignity in care. Research and media reports have identified dignity deficits in care that have resulted in embarrassment, distress and harm to patients¹ and their families. Reports and incidents of undignified care challenge the dignity of patients, nurses and the profession.

The Royal College of Nursing Dignity Campaign aims to celebrate dignified care and to redress deficits in care. The initial scoping exercise for the RCN UK project on dignity involved the analysis of findings from focus groups, surveys and meetings with internal and external key stakeholders (*Appendix A*). This report describes the findings from the RCN dignity survey. Over 2,000 nurses from across the UK shared examples of good practice regarding dignity, identified areas for improvement and suggested strategies to develop dignified and dignifying care.

The working definition of dignity that underpins the RCN Dignity Campaign sought to address the complexity of everyday practice and to highlight the significance and scope of the concept:

Dignity is concerned with how people feel, think and behave in relation to the worth or value of themselves and others. To treat someone with dignity is to treat them as being of worth, in a way that is respectful of them as valued individuals.

In care situations dignity may be promoted or diminished by: the physical environment; organisational culture; the attitudes and behaviour of nurses and others; and the way in which care activities are carried out. When dignity is present people feel in control, valued, confident, comfortable and able to make decisions for themselves. When dignity is absent people feel devalued, and lacking in control and comfort. They may lack confidence and be unable to make decisions for themselves. They may feel humiliated, embarrassed or ashamed.

Dignity applies equally to those who have capacity and to those who lack it. Everyone has equal worth as human beings and must be treated as if they are able to feel, think and behave in relation to their own worth or value.

Nurses should, therefore, treat all people in all settings and of any health status with dignity, and dignified care should continue after death (RCN, 2008).

1.1 The RCN Dignity Survey

The RCN Dignity Survey is one of a range of initiatives that underpin the RCN Dignity Campaign. The survey was designed to gain the perspectives of nurses, health care assistants and nursing students regarding the maintenance and promotion of dignity in everyday practice. The contributions of those who participated in the survey help readers to better appreciate opportunities to promote dignity in care and to understand the challenges confronted by practitioners as they deliver care. These insights should be helpful to practitioners, patients, managers, professional bodies, policy-makers, politicians and others.

1.2 Context

Respect for patients' dignity is considered essential for professional nursing practice, both nationally and internationally. The International Council for Nurses (2006) states that respecting people's right to dignity is inherent in nursing. UK nurses have an absolute duty to uphold patients' dignity and can be held to account for their actions should they not do so. The Nursing and Midwifery Council (NMC) Code of Professional Conduct states that nurses must:

Make the care of people your first concern, treating them as individuals and respecting their dignity (NMC, 2008, p.2).

In 2003, the Royal College of Nursing (RCN) produced a definition of nursing comprising six defining characteristics, the fifth of which states that nursing has:

a particular value base: nursing is based on ethical values which respect the dignity, autonomy and uniqueness of human beings (RCN, 2003, p.3).

The RCN (2003) further states that these values are included in codes of ethics and are professionally regulated. Thus, the RCN endorsed the view that respecting patients' dignity is central to nursing. More recently, RCN Chief Executive and General Secretary Dr Peter Carter identified dignity as the first of six steps to transform the NHS:

Step one – Ensure dignity for every patient, client and service user. For example, we should develop, implement and monitor national nutrition standards for patients (Carter, 2008, p.26).

Increasingly, health and social care policy documents stress the importance of dignity in care while acknowledging that patients' and clients' dignity is often under threat. There have been reports of institutional abuse and neglect since the inception of health and social care facilities (see, for example, Robb, 1967), so reports of deficits in care relating to dignity are not just a recent occurrence. In 1997 the *Observer* newspaper led a media campaign entitled *Dignity on the Ward*, which raised concerns about poor standards of care for older people in hospital. This led to the UK Health Advisory Service's (1998) report which recommended establishing a national service framework, comprising key indicators of quality care and service provision.

While these concerns focused on older people, a wide range of organisations has drawn attention to the importance of dignity across the lifespan and in relation to patients with diverse needs. The Royal College of Midwives (2005) has discussed the dignity of neonates and highlighted the importance of dignity for women in labour. A recent government report (House of Commons 2008) raised concerns about the human rights and dignity of people with learning disabilities and about deficits in care they have experienced (Mencap, 2007). The dignity of children has been explored in research (Reed *et al.*, 2003) and addressed in practice guidelines (University College London, 2008). Studies have indicated that adults of all ages are concerned about their dignity and can be vulnerable to a loss of dignity in health care (Seedhouse and Gallagher, 2001; Matiti, 2002; Baillie, 2007). Reports from the Picker Institute (Richards and Coulter, 2007) and from the Health Care Commission (2007) highlight the need to address issues relating to dignity in care.

Dignity has been on the NHS agenda for some time, with health policies emphasising its implementation across the four UK countries. In 2005 NHS Scotland launched new guidance on nursing care of older people, recognising concern about dignity issues. The guidance detailed aspects of fundamental care and how it can be provided in a dignified way (NHS Improvement Scotland, 2005a, 2005b, 2005c). Dignity is also emphasised in *Delivering Care, Enabling Health: Harnessing the Nursing, Midwifery and Allied*

Health Professions' Contribution to Implementing Delivering for Health in Scotland (Scottish Government, 2006), which focuses on a rights-based approach to care underpinned by a values base for practice, which includes that patients, families and carers should be treated with dignity and respect.

The Welsh Assembly Government's (2003) *Fundamentals of Care* includes a section 'Respecting people', which asserts people's rights to dignity and privacy in health and social care. In 2006 the Welsh Assembly Government launched a *National Service Framework (NSF) for Older People in Wales*, which was to provide the main policy drive for dignity in care in Wales. In 2007 the Welsh Assembly Government announced a *Dignity and Respect in Care* programme for Wales, to take forward the NSF standards relating to person-centred care and age discrimination.

In Northern Ireland *Essence of Care* benchmarks (which include privacy and dignity) were adopted and have since been reviewed (Northern Ireland Practice and Educational Council for Nursing & Midwifery [NIPEC], 2007). The current (2008) Department of Health Social Services and Public Safety (DHSSPS) proposals for the future commissioning and performance management of health and social care² seek to place dignity at the centre of a reformed and restructured service. The draft strategy requires that 'dignity, respect, equality and fairness for patients, relatives and staff are at the core of the health and social care system'. RCN Northern Ireland is already engaged in partnership working with the DHSSPS and others on issues such as nutrition and hygiene that fit implicitly within the broader dignity agenda. But there is a clear need to build upon this in order to focus more explicitly on measures to enhance dignity.

In England the *Essence of Care* (DH, 2001a) and the *National Service Framework (NSF) for Older People* (DH, 2001b) both included sections emphasising dignity in care. The *Essence of Care* provided best practice statements for benchmarking *Privacy and Dignity* for all age groups. In 2004 the DH published *Standards for Better Health* which included core standards specifying that staff must treat patients and relatives with dignity and respect, and that the care environment must support privacy and confidentiality. In 2006 the DH launched a *Dignity in Care* campaign (DH, 2006) and set out a ten-point 'Dignity Challenge' to be applied across the health and social care sector (See *Appendix B*). The campaign initially focused on dignity for older people, but from August 2007 was extended to Mental Health Services to focus on tackling stigma, inpatient services (the therapeutic environment, safety and privacy, extending rights to advocacy), and older people's mental health. The campaign is likely to extend to other vulnerable client groups in future, for example people with learning disabilities.

Research studies have focused on the perspectives of patients and carers regarding dignity and indignity in care, and these have given valuable insights for policy makers and health and social care teams. However, comparatively little attention has been paid to the perspectives and experiences of nurses, health care assistants and nursing students who work with many vulnerable people in diverse

10 Defending Dignity

settings. The RCN survey aimed to provide nurses with a forum to share experiences, views and concerns about providing dignified care in practice. Most importantly it enabled nurses to share examples of good practice and to detail the obstacles and challenges encountered as they set out to deliver dignified care in their everyday practice. Thus respondents were provided with an opportunity to shape and influence care provision to maximise opportunities for dignified care.

1.3 Method

The survey was developed by members of the project team. Questions in the initial draft of the questionnaire were informed by the dignity research literature, policy documents and meetings with key stakeholders during the scoping phase of the Dignity Campaign. The questionnaire was piloted over a three week period to ascertain its clarity, relevance, flow and respondent attention and interest (De Vaus, 2001). Nurses and service users were invited to comment on the questionnaire to ascertain if the questions asked were those considered important by them in relation to dignity. Finally, the survey was completed by 20 stakeholders to check for ease of completion.

The survey was designed as an electronic questionnaire, in line with previous RCN surveys. While this approach inevitably means that only those with access to the internet would be able to participate, internet usage is widespread throughout the UK and particularly among the professions. With the combination of home internet connections and access through workplace and college libraries and study facilities it is unlikely that any nurse would be unable to access the survey if they wished. Past experience suggests that online surveys on the RCN website attract good response rates and electronic surveys are cost effective. The RCN Dignity Survey was posted on the RCN website in February 2008 and the questionnaire link emailed to 70,000 RCN numbers (*Appendix C*). A total of 2,047 questionnaires were returned. Free text data was analysed using Atlas Ti and quantitative data was managed using an Excel spreadsheet.

Respondents worked in a wide range of roles in diverse practice contexts, and with client groups with different needs and of all ages. This suggests that the survey broadly reflects the diversity of nurses across the UK, although it cannot in the strict sense be said to be representative. There is also the possibility of bias in that those who participated may be those who are most sensitive to and perhaps most committed to dignity in care.

1.4 Report structure

The report results are organised around the questionnaire topics.

Section 2 examines the demographic and professional profile of nurses, health care assistants and nursing students who participated in the survey.

Section 3 discusses respondents' views regarding initial and continuing education relating to dignity.

Section 4 explores the relationship between dignity and the physical environment – what promotes and prevents dignity in care, and what changes would help promote dignity?

Section 5 discusses individual practitioner, team and organisational prioritisation of dignity.

Section 6 explores the relationship between dignity and the employing organisation – what promotes and prevents dignity in care, and what changes in the organisation contribute to the development of dignity in care?

Section 7 examines practitioners' ability to deliver dignifying care and the importance of dignity to the individual and to the organisation. It also discusses the role of time and distress in relation to dignity in care.

Section 8 focuses on care activities and on the steps that practitioners take to minimise the loss of dignity and to promote dignity in care. It also presents practice initiatives to promote dignified care.

Section 9 discusses overall findings in relation to previous research about dignity in care.

Section 10 presents conclusions and recommendations.

¹ Different terminology can be employed to refer to people who use health and social care services, for example, service users, clients and patients. We have opted for the term 'patient' as this was the most common term used by survey respondents.

² Subject to consultation, which ended on 12 May 2008.

2 Profile of respondents

The survey attracted a considerable level of interest with a total of 2,048 people taking part. This of course represents a small fraction of the total workforce. There are in excess of 600,000 nurses and midwives on the NMC Professional Register while, according to the English Department of Health, in September 2007 there were 376,737 qualified nurses, midwives and health visitors employed by the NHS. There were also 106,825 'nursing auxiliaries or nursing assistants'. Over the last three years the DH in England has commissioned slightly over 20,000 nursing students training places per year, so we can assume a population of around 60,000 nursing students in England. The nursing workforce in England is thus somewhere in the region of 550,000 individuals, with equivalent but smaller populations in Scotland, Wales and Northern Ireland. Not surprisingly, detailed statistics on the demographic profile of the workforce in a format that enables comparisons between different data sets are not easily available.

We can however say that our sample included a wide range of respondents from across the four countries with a good mix of ages, ethnic background, levels of qualification, clinical specialist areas, places of work and a range of experience. The following graphs and charts give a graphic illustration of the make-up of the sample.

2.1 Sex, age, and ethnicity

The proportion of males to females in our sample is slightly higher than in the UK workforce, where the figure of 10% is usually quoted as the proportion of males. In our sample the proportion of men was 14%.

As can be seen from Figure 2 and Table 1 below, our sample

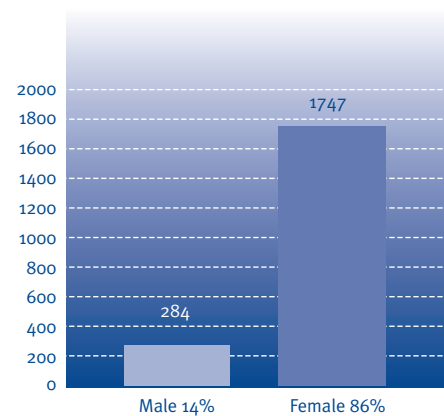


Fig 1:
Sex of respondents

compares quite closely with the age distribution of the English NHS qualified nursing workforce. Our sample contains rather more people in the 18–24 age group, which reflects the inclusion of nursing students and unqualified staff in our survey, but otherwise the age range is remarkably similar.

The ethnicity of respondents was diverse, although the majority (88.82%) described themselves as White British. The next largest single category was “Any other white background” at 3.7% (76 respondents), the same percentage as those who did not wish to answer the question. The non-White-British proportion of the sample was therefore 11.18%, while for the English NHS qualified nursing workforce this proportion is 17.7%, suggesting that respondents from ethnic minority backgrounds are slightly under-represented in our sample. The ethnic minority categories

Table 1: Age of respondents compared to age of English NHS Qualified nursing staff

Age	18–24	25–34	35–44	45–54	55–64	65 or over
RCN Data	11.9%	22.6%	28.4%	29.7%	7.2%	0.21%
DH Data	2.80%	23.62%	33.69%	29.46%	10.07%	0.36%

12 Defending Dignity

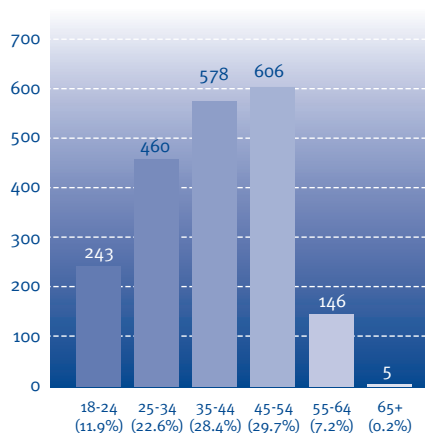


Fig 2:
Age of respondents

used reflect those used by the RCN Diversity Unit and do not match the categories used by the UK Census, so we cannot make direct comparisons with national statistics.

2.2 Country and region

The RCN divides its membership into regions that are not co-terminous with NHS regions, so precise comparisons are difficult. However, the sample appears to represent a good spread across the whole of the UK, with the South East the largest group at 14%.

2.3 Employment and job description

Respondents were asked to select which description best fitted their employer. Not surprisingly the largest proportion worked in acute hospital NHS Trusts (29.6%). Recent NHS re-structuring complicates the picture as foundation trusts, which may also be acute hospital trusts, account for a further 11.4%. However, there were good numbers from most mainstream clinical areas, including community and primary care, higher education and mental health, with smaller numbers from groups such as prison nurses and the armed forces. The category “Other” included nurses from NHS Direct, boarding schools, and hospices.

The diversity of job titles used by respondents also reflects the changing nature of the workforce, although “Staff Nurse” accounted for 20.9% of the sample and nursing students for 17.6%. The third largest group was Clinical Nurse Specialist at 8.8%.

2.4 Patient/client group contact

Respondents worked with a wide range of clients, many of them working with more than one category. Adults represented the largest single category (17.6%), with older people at 13.3% and women at 12.4%. Clearly these groups are not mutually exclusive as one person could fit all three categories, but this reflects the difficulty of categorising nursing work.

2.5 Place of qualification

There has been much coverage in the media of the number of nurses who qualified outside the UK but now work here and this, at least anecdotally, has been associated with concerns about dignity

Fig 3: Ethnicity

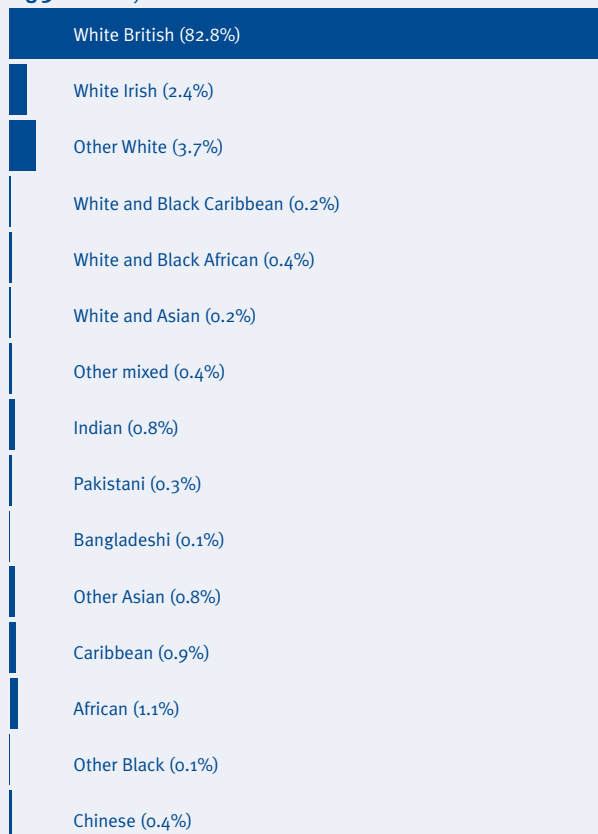


Fig 4: Country or region

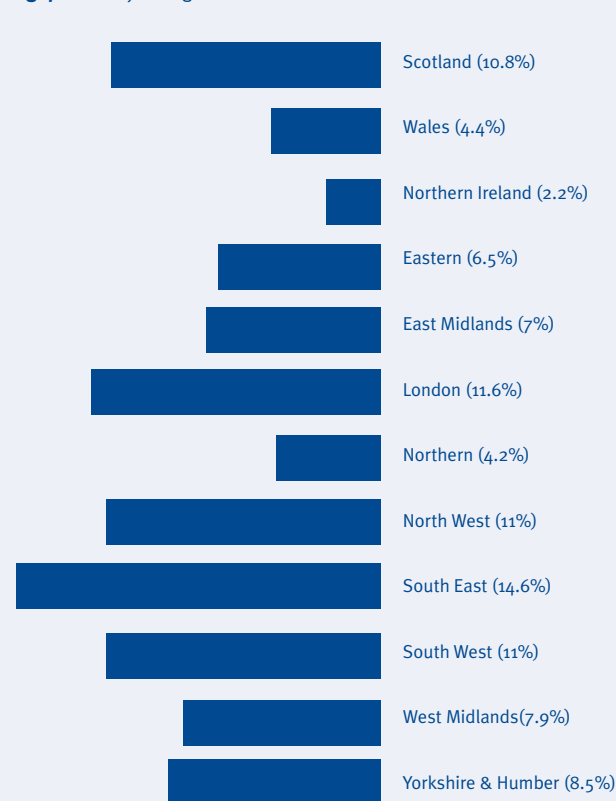


Fig 5: Employer

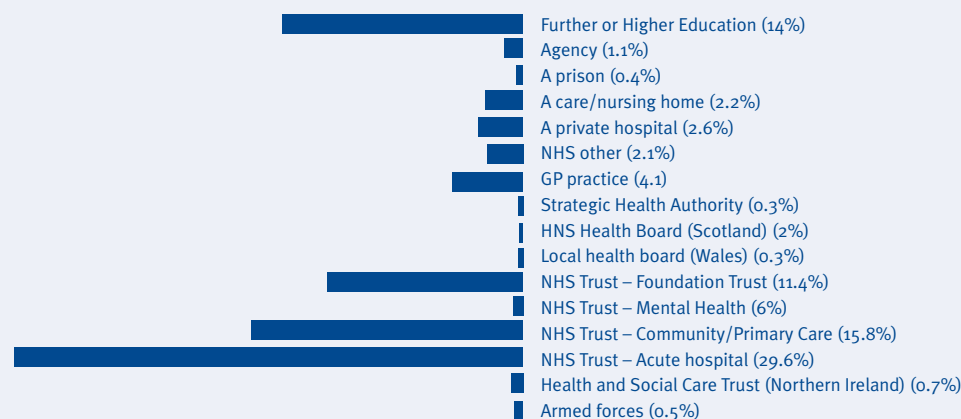
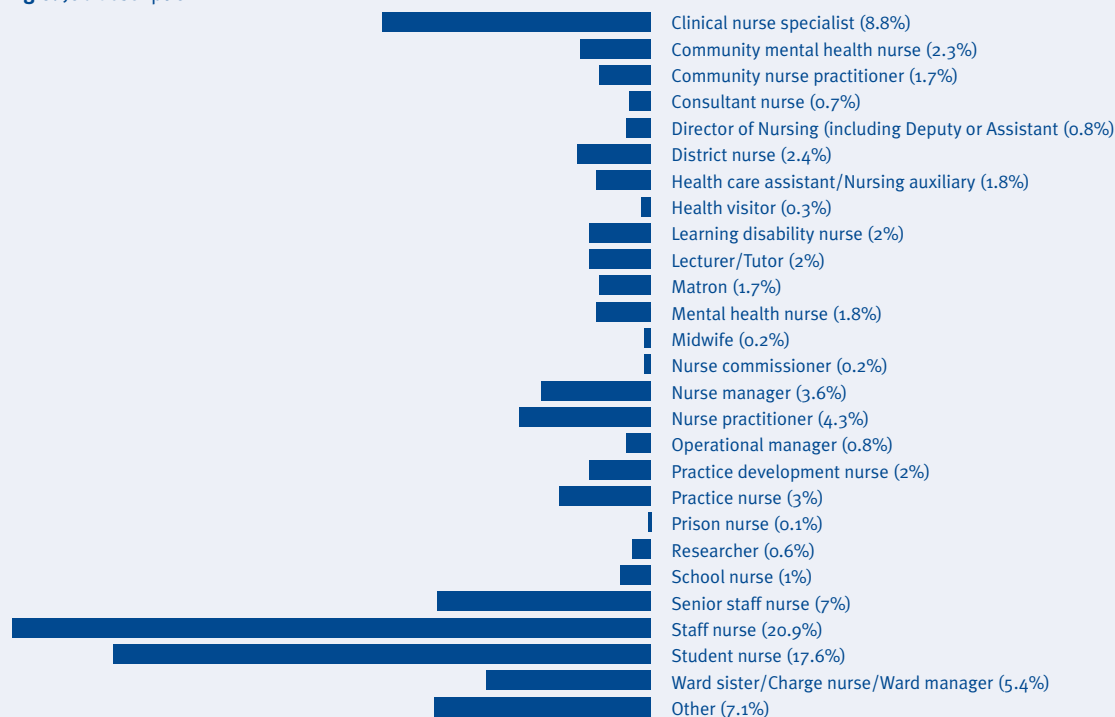


Fig 6: Job description



and general issues of cultural sensitivity. Of our respondents 6.6% qualified outside the UK, but we did not collect more detailed data on place of qualification. The number is also difficult to interpret because our sample includes unqualified staff and nursing students, but the question concerned place of qualification, so unqualified respondents would not have answered the question.

2.6 Decade of qualification

Respondents reflect a wide range of length of time since qualifying, with roughly equal numbers qualifying in each of the last three decades, and quite a sharp fall in the fourth and fifth decade. No respondents qualified prior to the 1960s.

2.7 Years of experience in nursing

The data for years at work cannot, of course, be compared with the decade in which nurses qualified, as the former applies to all respondents while the latter applies only to qualified staff. The total work experience of the sample is extensive, with 32% having more than 20 years experience.

2.8 Qualifications

When indicating their qualifications respondents were invited to “tick all that apply”, thus revealing the impressive number of qualifications held but not offering any hierarchy. Nevertheless, it is interesting to note that 23.7% of respondents were educated to

14 Defending Dignity

Fig 7: Client group

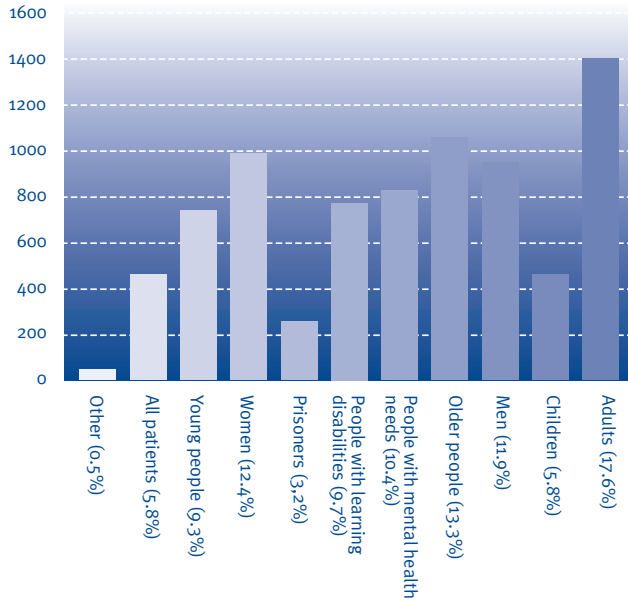


Fig 8: Qualified in UK

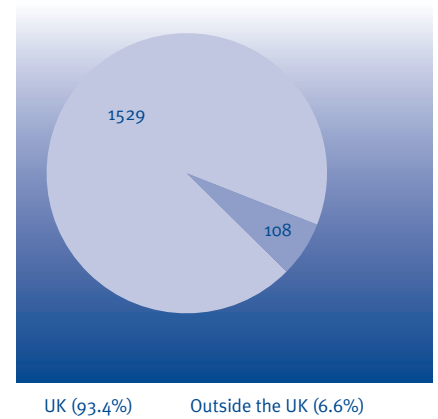


Fig 9: Decade of qualification

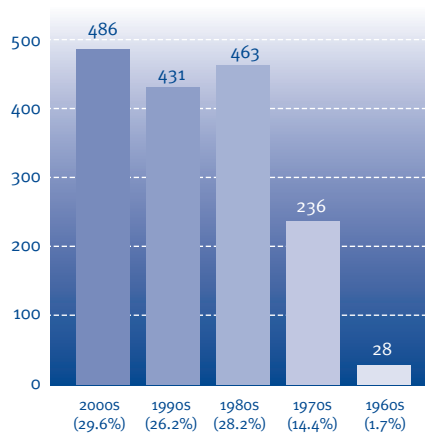
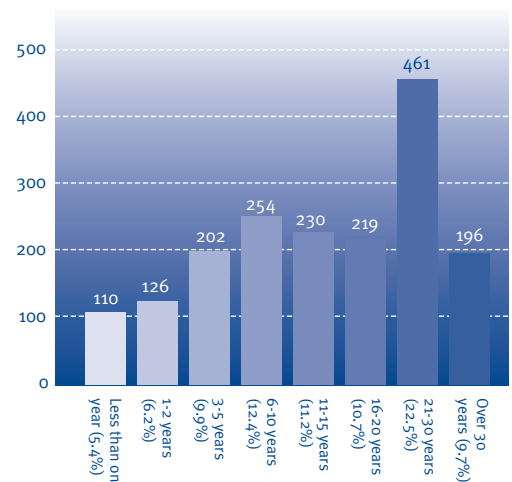


Fig 10: Years of work

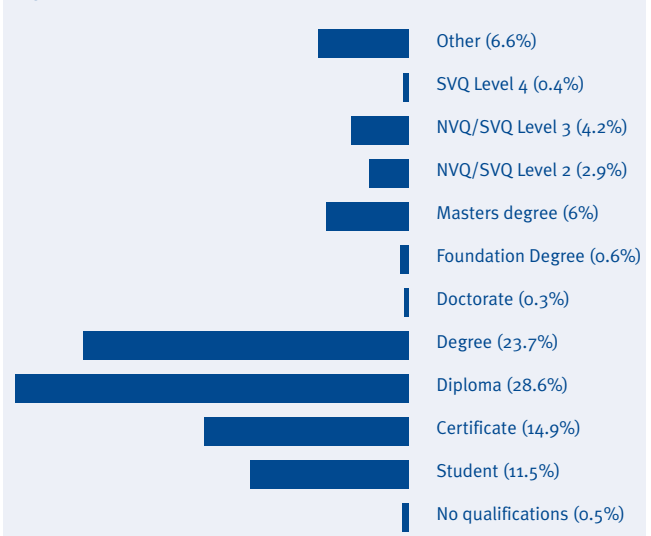


degree level, although only 6% had achieved a Master's degree and only 0.3% had doctorates.

2.9 Summary

The survey sample, therefore, suggests a good cross-section of the nursing workforce although it cannot be said to be representative. There was no evidence that the electronic questionnaire disadvantaged any particular group, with older respondents for example being well represented.

Fig 11: Qualifications



3 Initial and continuing education relating to dignity

3.1 Teaching and learning about dignity in initial training/education

It is reassuring to note that the majority of respondents recalled learning about dignity in their initial training. The majority of this learning took place in the classroom, with the practice placement a close second. The mentor or supervisor was the third strongest influence, and on the assumption that most mentoring will have taken place in the practice setting it would be reasonable to combine these and say that the great majority of learning took place in practice, reinforced by strong input in the classroom. Finally, the majority of respondents agreed that this learning had made a considerable impact on their practice.

3.2 Where and how learning took place during initial training/education

The most important single source of learning about dignity in initial training was the classroom, with practice placements second and the mentor third. However, if we assume that mentorship takes place in practice placements it follows that these two could be combined, making practice by far the most important setting.

3.3 Influence of initial training/education on understanding and practice

The majority of respondents agreed that their initial education or training had been influential in shaping their understanding of dignity.

3.4 Development of understanding since assuming employment

After taking up employment, respondents indicate a range of influences on the development of their understanding of dignity. Not surprisingly, professional practice is the single most powerful influence, followed closely by feedback from patients and clients.

3.5 What has influenced understanding of dignity most?

Respondents selected the one thing that had most influenced their

understanding of dignity and they again indicated the powerful impact of practice. Feedback from patients, good role models and initial training were also important, as were personal experiences of care, either for themselves or for a friend or relative. This all underlines the importance of the experience of care in practice for developing an awareness of dignity.

3.6 Summary

Overall we are left with a strong sense that the majority of respondents were very aware of the importance of dignity, having been taught about it in the classroom and in practice as nursing students, and having continued to develop that understanding in their professional practice. That development appears to have been heavily influenced by experience, practice, working with influential role models and by feedback from patients. Formal educational programmes, whether in-house or in colleges and universities, appear to have relatively limited impact. This contrasts with the free text responses as many respondents noted that some of their colleagues lacked training and that further education and training was required.

16 Defending Dignity

Fig 12:
Taught about dignity in training

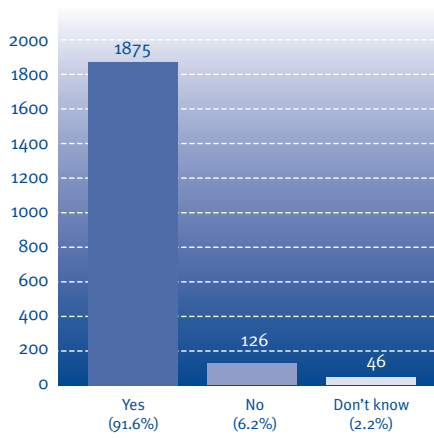


Fig 15:
Source of development

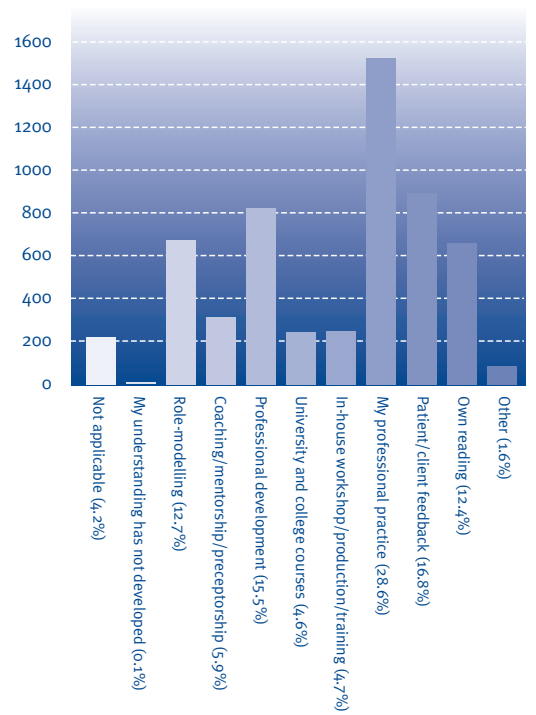


Fig 13:
Source of learning

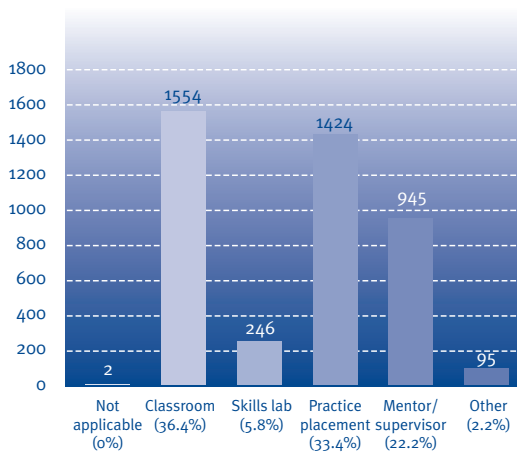


Fig 16:
Influence of understanding

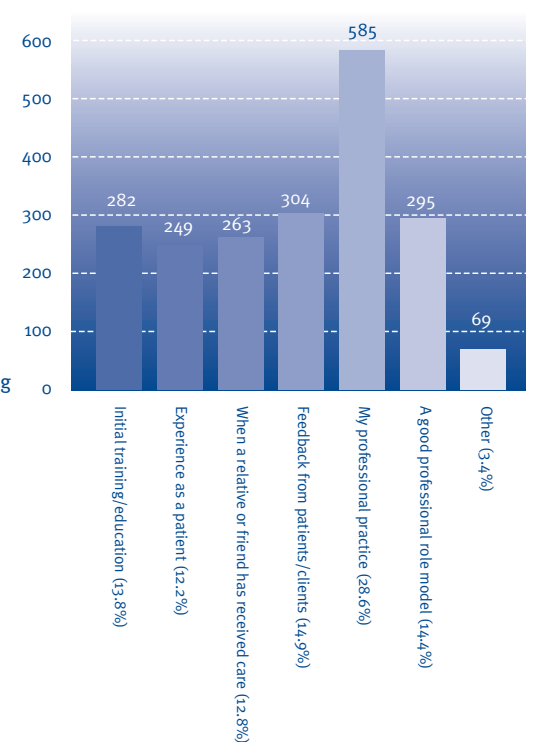
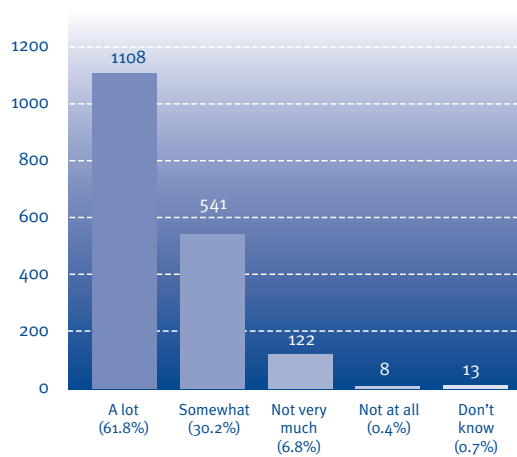


Fig 14:
Influence of learning



4 Dignity and the physical environment

The responses in this section highlighted the diverse range of care environments in which nurses work, including: patients' own homes; prisons; acute care settings; ambulances; care homes; schools; and aircrafts. Each of these present opportunities for dignified care, but also challenges. The relationship between the state of the environment and the communication of dignity and care was clear:

Space between beds, properly fitted curtains, clean and tidy well maintained environment (an environment that is cared for communicates that care is present in that environment), a space to have private conversations, a waiting area for relatives, adequate supplies of sheets and blankets, adequate manual handling equipment, up to date bedside furniture and other clinical equipment (if it looks like it's broken then we communicate that we feel the patients are only worth second rate equipment – does not inspire confidence), food in appropriate amounts served when patients need it. (Matron. NHS Trust, Acute Hospital)

Many respondents identified positive attributes of the physical environment which helped them to provide dignified care. These related to aspects maintaining physical and informational privacy and dignity, aesthetically pleasing surroundings and single sex accommodation, toilet and washing facilities. However, respondents also reported working in physical environments which are far from ideal, for example overcrowded, poorly screened bed spaces, sometimes further compounded by being mixed sex, with a subsequent lack of privacy and embarrassment for patients. Basic requirements such as adequate and suitable bathroom and toilet facilities were often lacking. In some instances patients had to use commodes at the bedside simply because the number of toilets on the ward was inadequate or did not provide the space for transfers.

Not only were wards often overcrowded there was also a lack of treatment rooms, day rooms or quiet areas where intimate procedures or confidential discussions could be conducted. The lack of such facilities was not confined to hospital settings but was also reported in outpatient areas, schools and other community settings.

While community nurses fared better on many of these issues they reported that home environments lacked space and facilities, while acknowledging that they had little control over these environments. Nurses in a range of settings reported inadequate equipment which also hampered dignified care.

The following sections detail aspects of the physical environment which help nurses maintain, promote and deliver dignified care, those aspects which prevent dignified care, and what nurses need in the physical environment to be able to provide dignified care.

4.1 Aspects of the physical environment that help maintain, promote and deliver dignified care

Respondents identified a wide range of environmental factors that contribute to the maintenance of dignity. There were three main themes: aspects of the environment that maintain physical and informational privacy and dignity (for example curtains, doors, screens and private rooms for consultations); aesthetic aspects of the physical environment (for example space, colour, music, furnishings, décor); and the provision of single sex accommodation, toilet and washing facilities.

Curtains were considered a necessary, albeit imperfect, means for maintaining dignity and physical privacy in care. Respondents highlighted the importance of curtains fitting well without gaps. There was reference to strategies such as putting "do not disturb" signs or cards and clips or pegs on curtains to deter intrusion, and to prevent a loss of physical privacy and dignity where patients may be exposed and embarrassed when observed by others.

Many respondents pointed out that people often forget that curtains are not soundproof. Attention needs, therefore, to be given to the privacy of information or confidentiality. Respondents outlined strategies in place to maintain dignity, for example:

Curtains are well fitted around bed spaces, there are no gaps. We have do not disturb signs to put on curtains while we are busy behind them. We have a separate room to take

18 Defending Dignity

patients/families into to have private discussions. Unit is bright, well decorated, clean and uncluttered in patient areas. (Staff Nurse, NHS Trust, Acute Hospital)

The impact of the aesthetic aspects of the physical environment is referred to in many of the free text responses. There is reference to, for example, the importance of cleanliness, good lighting and space (as the example here) and also to the importance of décor, furnishings, colour and music in contributing to the maintenance of a dignifying environment.

The importance of single sex accommodation, toilet and washing facilities was a recurrent theme in the responses. Respondents viewed single sex provision as a significant contributory factor to dignified care. The provision of single rooms was highlighted as a key dignity promoting facility. Respondents who work in patients' homes emphasised their role as a "guest" and considered that it was generally easier to maintain dignity in this setting. Community nurses gave examples of activities that maintained dignity such as offering choice, closing doors and drawing curtains.

4.2 Aspects of the physical environment that prevent the maintenance, promotion and delivery of dignified care

Some nurses responded that no environmental aspects prevented them delivering dignified care, either because their care environment was conducive to dignity, or because they considered that their own behaviour could overcome environmental barriers, for example:

I believe there is always a way around obstacles and primarily it is you yourself, your actions, standards and behaviour that delivers care. (Clinical Nurse Specialist, NHS Trust, Acute Hospital)

However, most respondents cited at least one environmental barrier to dignified care, with many listing a range of problems encountered related to the physical environment, for example:

Our ward is cramped, old fashioned, badly designed with poor resources and poor maintenance. Cupboards with drawers that don't open so that patients have nowhere to put their belongings, no stimulation, no televisions or poorly positioned TVs (small, placed high on the wall, receive only 1 channel), curtains that don't run properly or hang off. No showers only old baths that necessitate the patient to be hoisted in even if they don't want to... I could go on and yes it is an NHS trust and no I don't work in the third world!! (Senior Staff Nurse, NHS Trust, Care of Older people)

Some respondents identified that poor environmental cleanliness affected dignified care describing that poor décor – "shabby" or "neglected" surroundings – were a problem. The general physical structure of the environment was referred to by many staff, for example:

Some premises used do not foster the feeling that staff or clients are respected, as they are old, inadequate or too small. (School Nurse, NHS Trust, Community/Primary Care)

The layout of health care settings caused concerns, either because it hindered patients' and families' access to staff and facilities or because it prevented privacy, for example:

Layout stops speedy bell to response times, patients feel cut off. (Matron, NHS Trust, Acute Hospital)

Relatives'/bereavement room is situated in a difficult area of the ward to access and is not ideally situated close to the patients. (Senior Staff Nurse, NHS Trust, Acute Hospital)

Ability to see patients in cubicles from public corridors (Ward Manager, NHS Trust, Acute Hospital)

In prisons the following environmental aspects acted as barriers to dignity:

Shared cells, gates, locked doors. (Head of Healthcare, Prison)

A number of respondents referred to the difficulties of caring for patients in multi-bed set-ups: bays of four to six patients were often referred to with occasional reference to dormitories or Nightingale wards:

It can be difficult to maintain dignity for people suffering from acute mental health problems in dormitories. (Ward Manager, NHS Trust, Mental Health)

A lack of available single rooms was a common problem. In hospitals single rooms were prioritised for patients with infections, rather than patients with additional privacy needs:

Side-wards used for infection control not for end of life care as previously. (Staff Nurse, NHS Trust, Acute Hospital)

Too few single rooms for terminally ill or emotionally disturbed patients. (Nurse Manager, NHS Trust, Acute Hospital)

However, occasionally disadvantages of single rooms were highlighted:

Because all these rooms are single, if my nurses are in another room they may not be able to immediately attend another patient, this has led to isolation, incontinence, anger and a strain on the therapeutic relationship. (Ward Manager, NHS Trust, Acute Hospital)

In multi-bed layouts curtains or screens were the central way of providing privacy, but many staff identified problems stating that they were in poor condition, did not fit properly, were not soundproof, were flimsy or transparent:

Curtains so close to the bed that you open them accidentally as you move around the bed. (Student Nurse)

Curtains aren't soundproofed so always feel it's hard for patient to 'open up' knowing they'll be overheard. Other patients in bay also get to overhear bad news/any diagnoses being given. (Nurse Practitioner, NHS Health Board)

However, many respondents highlighted that staff behaviour was a problem too because staff (including other nurses, doctors, therapists, cleaners) did not see curtains as a barrier to their entry even if signs or pegs were in place. Clearly organisational culture is influential on such practices (see Section 6). Many respondents recounted that the problem of multi-bed set-ups was exacerbated when bed spaces were too small to provide dignity while care was delivered, for example:

Bed areas too small to be able to fit staff and equipment behind to give care, making curtains etc useless. (Senior Staff Nurse, NHS Trust, Acute Hospital)

In some instances, because of other priorities such as bed management issues and infection control, curtains were absent completely:

When wards are deep cleaned curtains are removed and sent to laundry the bed spaces continue to be used without curtains. (Staff Nurse, Agency)

Pressure is on to fit as many patients in the physical space available, especially with emergency beds going up in times of crisis. In one ward I have worked in the 'emergency space' does not even have curtains. (Staff Nurse, NHS Health Board)

Four-hour trolley wait targets – results in elderly pts being moved onto wards on trolleys as 'extra' pts – no bed – no curtains etc. (Practice Development Nurse, NHS Trust, Acute Hospital)

Bed management issues and their impact on dignity are explored in Section 6. A mixed sex environment further compounded the lack of privacy in multi-bed environments with small bedspaces:

Certainly having a mixed sex ward doesn't help, elderly female patients often feel unhappy about sharing facilities with men. (Student Nurse)

One respondent referred to the "Gov fiasco and u-turn over single sex wards", indicating frustration with the situation. Problems occurred whether or not sleeping accommodation and bathrooms were separate and arose in mental health as well as acute settings:

Difficult to maintain dignity of patients who due to being unwell i.e. manic are disinhibited towards opposite sex. (Mental Health Nurse, NHS Trust, Mental Health)

Mixed sex ward with men & women housed in separate 4 bedded bays or side rooms. Confused patients who may wander in to inappropriate areas. Attempts to have separate toilet & bathroom facilities not always followed by patients. (Senior Staff Nurse, NHS Trust, Acute Hospital)

It is a mixed sex ward and as a lot of the women are undergoing reconstructive breast surgery, they have in the past expressed concern about men on the ward, though males and females do have separate bays and washing facilities. (Staff Nurse, NHS Trust, Foundation)

Many respondents referred to a general lack of space in care environments; this barrier to dignified care applied across settings, including schools and patients' own homes as well as in hospital, and affected relatives as well as patients:

Children in hospital need a parent to stay in with them, most often. However, there is very little provision made for parents to store clothing, toiletries, their child's and their own. Parents need to provide their own food and there does not tend to be much kitchen space for them to do so. Many of our patients have long admissions. So it is hard for parents to look after themselves, keep their spirits up and maintain their own dignity. (Staff Nurse, NHS Trust, Acute Hospital)

Physical/geographical restrictions with home e.g. nursing someone on a low double bed, or in one-roomed accommodation with other family members present. (District Nurse, NHS Trust, Community/Primary Care)

As well as crowded sleeping accommodation, many staff reported a lack of treatment/assessment rooms, day rooms and rooms where quiet conversations (for example delivering bad news) or treatments (for example injections) could take place:

Sometimes when working in schools it is difficult to see a young person or child in a private room due to lack of rooms. (Practice Development Nurse, NHS Trust, Community/Primary Care)

Nowhere for a patient to lie down to receive IM injections other than on their bed in a shared dormitory. (Mental Health Nurse, NHS Trust, Mental Health)

Shared dining areas could also cause embarrassment, for example for people with swallowing problems or who need assistance to eat. Treatment rooms did not always have lockable doors, posing challenges to nurses performing intimate procedures:

Unable to lock consulting room door to prevent people entering the room during procedures such as when taking cervical smear. (Practice Nurse, GP Practice)

20 Defending Dignity

Where quiet rooms were present they were often unsuitable and had such thin walls that conversations could be overheard outside, and there were interruptions by other staff, noise and telephones:

Our client group consists of women with problems in the early stages of pregnancy attending for an emergency assessment and scan. Possible miscarriage. Quiet room adjacent to consultation room. No window. Very small. Crying heard in adjoining room. Equally voices of couples with good news heard in quiet room. (Clinical Nurse Specialist, NHS Trust, Foundation)

Bathroom and toilet facilities were frequently reported as inadequate with problems related to positioning, access, numbers available, size and layout:

Having bathrooms within the bed bay – people can be heard on the toilet, washing, vomiting. (Staff Nurse, NHS Trust, Acute Hospital)

I work in an ITU and there is no dedicated toilet or shower room for patients. They use a communal toilet which is also used by relatives and staff. (Senior Staff Nurse, Private Hospital)

Inadequate facilities- e.g. – toilets – resulting in patients being forced to use a pan [or] bottle rather than go to the bathroom as only 1 patient toilet exists for a whole dept. (Staff Nurse, Agency).

These problems were further compounded where facilities were shared between men and women:

On some of the wards, washing stations in some of the bathrooms have only curtains so people have to wash with little privacy as the curtains rarely close if a wheelchair or bathing chair is in there. In a mixed sex ward this can be embarrassing for some people. (Student Nurse).

Problems also included bathrooms without proper locks, sinks without plugs and non-adapted facilities reducing independence.

Equipment issues (further addressed from an organisational perspective in Section 6) also caused problems for many nurses in relation to availability, appropriateness, maintenance and currency of equipment:

Lack of essential equipment such as hoists which could assist the patient to regain their independence. Without such equipment nursing staff may be unable to transfer a patient out of bed and so instead of being able to go to the bathroom to wash the patient might have to be assisted to wash in bed and this reduces their dignity. (Student Nurse)

Community staff reported waiting too long for delivery of suitable equipment and also the excessive paperwork involved. Equipment for moving and handling drew particular comment, but

there were also concerns that hoists were undignified. There were a few comments related to meal provision, in particular lack of food suitable for people with religious requirements, vegetarians and vegans.

Respondents had many ideas about how the physical environment could be changed to enable them to provide dignified care, and these are presented in the next section.

4.3 Aspects of the physical environment that need to change to help practitioners maintain, promote and deliver dignified care more effectively

While many staff identified changes needed in the physical environment, some suggestions related to organisational issues such as culture, workload, training and staffing. These issues are addressed in Section 6. A few respondents reported that no change was needed. Some clarified that this was because the environment was already suitable while others responded that the environment did not detract from dignified care as staff behaviour was the key issue:

The physical environment is a little shabby but this does not prevent us from delivering dignified care. (Clinical Nurse Specialist, NHS)

There are more important things than the physical environment. You can treat people with dignity in the car park if you have to. (Practice Development Nurse, NHS Trust, Acute Hospital)

Not sure about changes in the physical environment, I think it is the attitude of health care professionals that needs changing. (Helpline Nurse, Charity)

However, most staff considered the physical environment did have an important impact and that changes were needed to assist the delivery of dignified care. Unsurprisingly, these changes related closely to the problems reported in Section 4.2. Thus a few staff considered better cleaning was necessary and some staff referred to decor:

More effective decor to stimulate and encourage rehabilitation of patients instead of blank walls. (Practice Development Nurse, NHS Trust, Acute Hospital)

There were many comments relating to general structure and layout, including homeliness, smaller and better integrated care homes and better facilities, for example play areas for children, availability of refreshments, better signposting and signs on doors. The tensions between privacy and safety relating to layout were portrayed in the following comment:

The layout of the clinical areas needs to be such that nursing staff can safely observe vulnerable people whilst providing dignity to all. (Service Improvement Manager, NHS Trust, Acute Hospital)

There were many general comments about greater space being needed; these related mainly to wards, waiting rooms and reception areas:

Wards designed with space and patient comfort as a priority. (Matron, NHS Trust, Acute Hospital)

Bigger neonatal nursery to allow space between patients/ family. (Staff Nurse, Health Authority)

While large dormitories or Nightingale wards were referred to only rarely by respondents, many nurses in hospital settings considered that bays of four to six patients with small bed spaces and inadequate curtains presented barriers to dignified care. Some respondents suggested that multi-bed areas should be reduced in bed occupancy or eliminated:

Ideally I would like to see the abolition of dormitories. Patients should each have their own bedrooms. In so doing they will feel more valued. (Mental Health Nurse, NHS Trust, Mental Health)

The need for larger bed spaces drew many comments, for example:

It would be lovely if there were fewer patients in each bay so that they each had more space. (Student Nurse)

Many respondents suggested that more single rooms were needed, for example:

Single rooms with en suite facilities would be the best for providing dignified care. (Student Nurse)

However, some respondents highlighted disadvantages of single rooms, as they could affect safety and reduce patient interaction and support:

More side rooms would afford more dignity but other aspects of patient care would suffer such as easy observation of confused patients at risk of falls and acutely unwell patients... many patients value social interaction with other patients in their bay. (Staff Nurse, NHS Trust, Foundation)

The provision of single rooms is no panacea, but many respondents felt that having more available would be advantageous. There were many comments regarding the need to improve curtains and screens, particularly that they must fit properly (perhaps including clips or Velcro) and be more substantial with plenty of material. However, respondents frequently referred to staff behaviour needing to change too; respecting that drawn curtains signified that privacy was required and awareness of confidentiality and discretion when talking to patients behind curtains (see Section 6):

Absolute do not enter at all costs when a potential procedure is being performed that may be undignified. (Clinical Nurse Specialist, NHS Trust Community/Primary Care)

Some staff suggested that curtains should be installed around examination couches in treatment rooms. Others suggested that curtains should be replaced by walls or room dividers:

...as they are more sound and smell proof and provide a more secure barrier between beds. (Student Nurse)

Many respondents suggested that wards should be single sex only, for example:

Separate wards for male and female patients would greatly help to maintain, promote dignified care in a more effective way. (Staff Nurse, NHS Trust, Acute Hospital)

The need for treatment rooms and quiet rooms was often suggested; comments particularly emphasised a need for rooms for private and personal discussions:

Women/couples need a quiet private space following the sad news of miscarriage. (Clinical Nurse Specialist, NHS Trust, Foundation)

A quiet area for individuals who need time away from others rather than being isolated in their bedrooms. (Learning Disability Nurse, NHS Trust, Foundation)

Dedicated quiet room needed for “breaking bad news”, discussing prognosis and supporting family and carers. (Clinical Nurse Specialist, NHS Trust, Acute Hospital)

Soundproofing such rooms was suggested and some respondents also identified that rooms to make confidential calls were required.

There were many comments about the need for improved bathroom and toilet facilities: that they should be accessible, well-designed and equipped, and single-sex. There were also comments that equipment should be fully functional, sufficient, provided more speedily, and be more suitable, for example electronic beds for all patients and appropriate hoists.

4.4 Summary

Most nurses considered that the physical environment had considerable impact on their ability to deliver dignified care. While some nurses appreciated that their care setting assisted them to promote patients’ dignity, for many others the physical environment actually hindered them in providing dignified care. Staff are faced with working in cramped surroundings, with inadequate means to provide privacy for patients, and basic aspects, such as adequate bathrooms, toilets and equipment are lacking, all of which poses barriers to dignified care.

5 Individual/practitioner, team and organisational prioritisation of dignity

5.1 Individual prioritisation of dignity

The majority of respondents clearly give dignity a high priority in their practice. On a scale from one (lowest) to six (highest), a high proportion of respondents rated the priority they could give to dignity from four to six. Most respondents were also clear that their organisations and their teams gave dignity a high priority. However, a number of respondents clearly felt that their organisations did not give dignity as high a priority as they might wish.

5.2 Individual aspiration to prioritise dignity

A much higher proportion of respondents would like to give dignity an even higher priority.

5.3 Organisational prioritisation of dignity

Slightly over three quarters of respondents strongly agreed or agreed that their organisation did prioritise dignity, but that leaves almost one in four nurses who did not agree with this statement.

5.4 Team prioritisation of dignity as a philosophy of care

85% of respondents agreed that their team prioritised dignity.

5.5 Ability to challenge policies or actions that compromise dignity

Most respondents also said that they would feel able to challenge organisational policies or the actions of colleagues that compromised dignity.

5.6 Response to colleague who compromised patients' dignity

89.4% said they would challenge a colleague who compromised patient dignity. This means that one in 10 respondents were either unsure or would not.

Fig 17: Priority you can give dignity

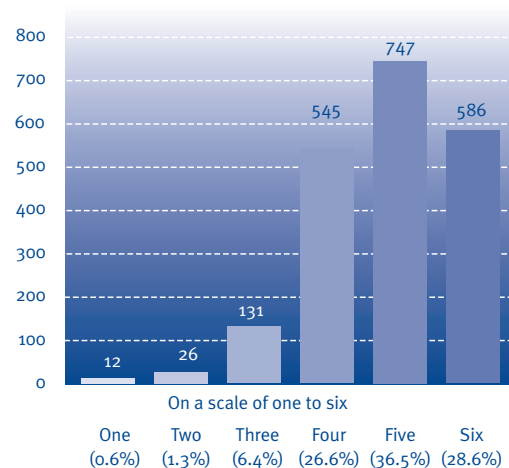


Fig 18: Priority you would like to give dignity

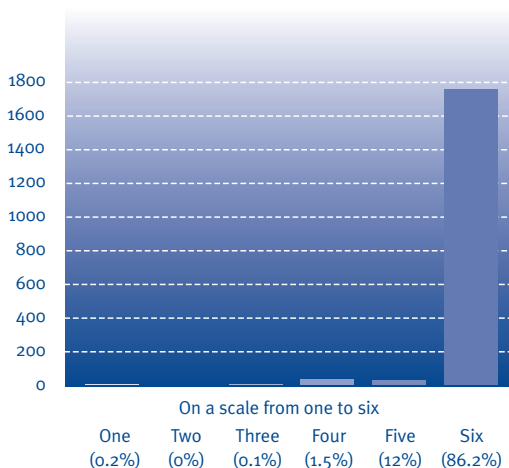


Fig 19: My organisation prioritises dignity

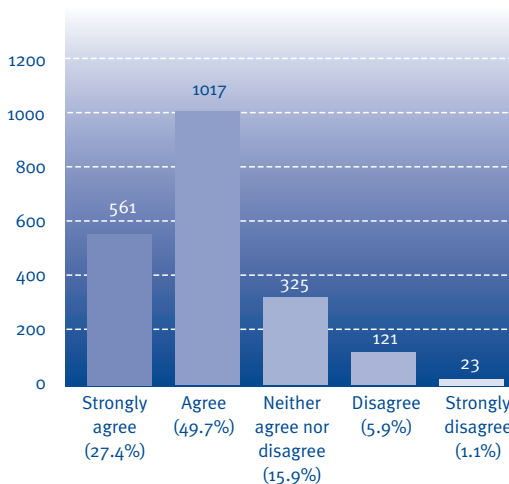


Fig 20:
My team
prioritises
dignity

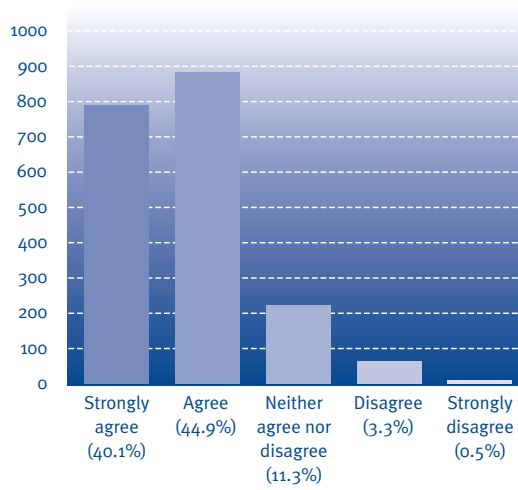


Fig 21:
Comfortable
challenging
policies

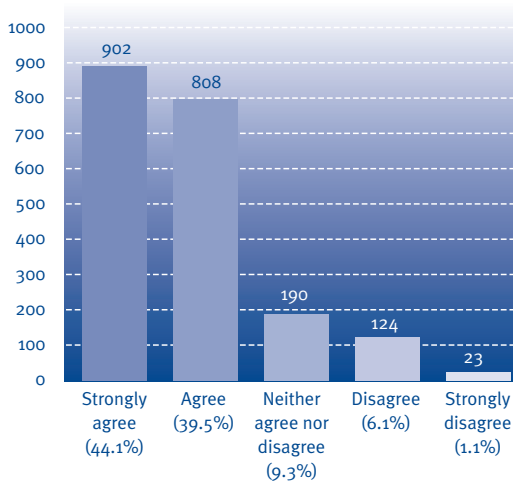


Fig 22:
I would
always
challenge a
colleague

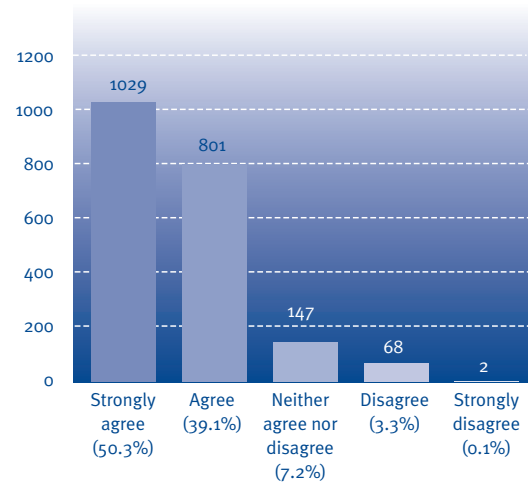
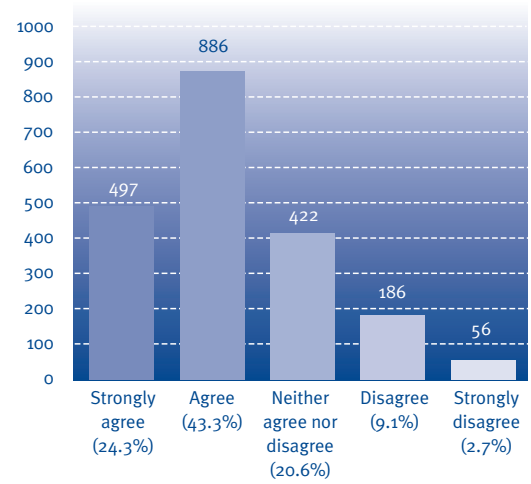


Fig 23:
Happy for
a relative
to be a
patient



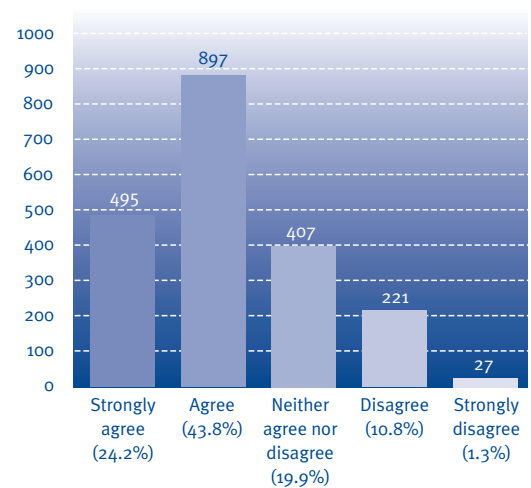
5.7 Views of organisational ability to deliver dignified care and patient/client involvement in care decisions

Respondents also appeared confident about the quality of care given in their organisation, with many stating that they would be happy for a relative or close friend to be cared for in their institution. They were also confident that patients or clients would be involved in decision making about their care. However, in both cases there were a number of respondents who were less confident.

5.8 Summary

A picture therefore emerges of nurses who are committed to giving dignified care but who are not always confident that their organisation will demonstrate the same commitment, or that the care delivered will meet the standards to which the nurses aspire. Nurses appear willing to challenge policies and the practice of others if they feel this is necessary, but of course we do not know if such challenges are effective. While the majority of respondents would be happy for a close relative to be a patient in their institution, over 30% neither agreed nor disagreed, or actually disagreed. This perhaps reveals some greater degree of unhappiness with the quality of care.

Fig 24:
Patients
not always
involved



6 Dignity and the employing organisation

The term 'organisation' has different meanings referring, for example, to the act or process of organising and, as a noun, to something made up of parts and to a group of people or structure where people co-operate and are organised to fulfil particular purposes. Health and social care organisations are complex, diverse and have different, sometimes conflicting, purposes. Previous research has identified aspects of the employing organisation as contributing to the promotion or diminution of dignity in practice (see Section 9). Responses to this survey question confirm the importance of a wide range of aspects of the organisation that contribute to or compromise dignity in care. Respondents referred to: staff attitudes, awareness and knowledge; leadership and role modelling; teamwork; resources (human and material); and organisational culture and philosophy. When these aspects are inappropriate or inadequate dignity is reduced. NHS targets are an additional issue identified as an aspect of the organisation that diminishes dignity in care.

6.1 Aspects of the organisation that help maintain, promote and deliver dignified care

Staff attitudes, awareness and knowledge of dignity in care were perceived to be a significant contributory factor to dignified care. Respondents suggested that appropriate attitudes and awareness of dignity should not be restricted to nursing staff:

Staff attitudes that respect a consultation is not disturbed i.e. peeping through curtains to ask about another problem. (Clinical Nurse Specialist, NHS Trust, Acute Hospital)

Interdisciplinary awareness that dignified care MUST be a priority. (Staff Nurse, NHS Foundation Trust)

All nursing and medical staff have [the] same awareness and respect of dignity in the care environment. (Senior Staff Nurse, NHS Acute Hospital)

Respondents stated that appropriate and adequate staff and

material resources were necessary to maintain dignity in care. There were many references to the importance of "well-trained", "excellent", "quality", "enough" and "highly qualified" staff. It is not, therefore, sufficient that there is an adequate patient/nurse ratio – staff must also be appropriately skilled. It was also suggested that staff not only make the most of available resources but that more staff should be available when necessary:

High qualified nurse patient ratio with effective support from unqualified staff. (Director of Nursing, Independent Hospice)

Good staff to patient ratio. Willingness to use more staff if necessary. (Ward Manager, Hospice)

Staff making the best of what is available to them. (Senior Staff Nurse, NHS Trust, Acute Hospital).

Support from leaders and managers in maintaining and promoting dignity was also a strong theme in the free text responses. Respondents referred to, for example, leadership that was clear, strong, understanding, approachable, open and caring. There was also reference to "good leadership", to the "support of management", to "supportive line managers who listen" and to "forward thinking management". Respondents also made reference to the role of matrons in maintaining dignity and suggested that managers may need to be interventionist:

Management by a matron who obviously greatly respects patient dignity. (Staff Nurse, NHS Trust, Foundation)

We have strong leadership at management level who are doing their utmost to improve practice. I receive the minutes from the senior nurses' meetings. However, I do not see this being activated at the shop floor hence all I can infer is that if the person in charge is very plausible their voice is heard and not the voice of front line staff. Only way one can overcome this is by management to do spot checks without prior warning. (Nurse Practitioner, NHS Acute Trust)

The importance of role modelling was highlighted and discussed in relation to people in management and leadership roles (for example, the Director of Nursing and senior management), but not exclusively so:

I have recruited a competent team who role model and challenge one another. (Operational Manager, Care/Nursing Home)

There is a huge drive to promote dignity with workshops etc however this is not always delivered to the staff at the bedside and this includes our medical colleagues. Unless someone comes around to role model and challenge poor standards then talking about it is not the best solution. Again it results in being a tick box exercise to meet the government agenda. (Senior Staff Nurse, NHS Trust, Acute Hospital)

I do think that I am a good role model. When working with new staff and nursing students I discuss dignity and diversity matters relating to the environment and care plans. (Senior Staff Nurse, NHS Trust, Acute Hospital)

It is, therefore, considered important that nurses at all levels role model dignity in their practice and that others can learn from this. What becomes clear from the survey is that dignity is not only the concern of nurses but is influenced by, and impacts on, teamwork. Respondents referred to the importance of an “experienced team, used to working together”, to supportive teams and to “willing and happy team members”. There was also reference to the role of mutual respect in teams, to care as a collaborative endeavour, to viewing error in positive terms, and to the wider team recognising individuals’ right to dignity in care:

Good team working with respect for each other able to address any issues felt compromised care and dignity. (Nurse Practitioner, NHS Trust, Acute Hospital)

Working well within a team, on our ward we tell each other if we think someone else is compromising a patient’s dignity i.e. curtains not pulled fully, pt wheeled to bathroom slightly exposed. (Staff Nurse, NHS Trust, Acute Hospital)

We work as a supportive team, where mistakes are not judged but used as opportunities to learn. We try to be open about our failures and seek help from each other constantly. We encourage our patients to do the same. If our patients can see where things can improve, we want to know. (Staff Nurse, NHS Trust, Acute Hospital)

An excellent team from medical professionals to receptionists who recognise the importance of an individual’s right to dignity & privacy. A practice manager who is open and responsive to both the patients and staff

and who acts immediately upon any problems which may arise and which may impact on the delivery of patient care. (Practice Nurse, GP Practice)

In addition to the role of the team in maintaining dignity, respondents referred to the role of a positive culture supporting dignity, for example where teams adopt a culture “where dignity is highly valued”, a culture of inclusion that “puts patients first” and where there is “respect for one another”. There was also reference to the importance of understanding and appreciating different culture:

... working in a multicultural team makes you more aware of the needs of different cultures. Care is about involving the patient not just about what the Dr/nurse wants. (Staff Nurse, NHS Trust, Acute Hospital)

The role of organisational or team philosophy, policies and mission statements was highlighted as contributing to dignity in care:

The organisation’s website and philosophy of care help staff to focus on the right attitudes to maintaining dignity etc. (Nurse Manager, Care/Nursing Home)

There were references to the role of *Essence of Care* benchmarks in maintaining dignity:

We use *Essence of Care* to help embed the culture of promoting privacy and dignity. Our organisation always listens to me as a matron when patient care is potentially being compromised. (Matron, NHS Trust, Community/Primary Care)

There are, therefore, a range of organisational factors which contribute to maintaining and promoting dignity in care.

6.2 Aspects of the organisation that prevent the maintenance, promotion and delivery of dignified care

Those aspects of the organisation that help maintain dignity can, according to the respondents, also diminish dignity should they be inappropriate or inadequate. In addition, there were many references to the role of targets and the perceived lack of time to deliver dignifying care.

Inappropriate staff attitudes, lack of knowledge regarding dignity and patient needs, too much “informality”, a lack of commitment and care, “forgetfulness” about the importance of dignity, and behaviours such as “barging in” behind curtains were highlighted. Other nurses, health care assistants, doctors and paramedics were referred to as demonstrating attitudes and behaviours that compromised dignity in care. Bank and agency nurses who were unfamiliar with the area were viewed as presenting a challenge to dignity in care:

Too many nurses on the same shift who are unfamiliar with

26 Defending Dignity

the ward. For example, on occasion, some shifts I have worked have been comprised entirely from newly qualified, agency and bank staff. Everything takes much longer and aspects of privacy and dignity can sometimes suffer. (Staff Nurse, Agency)

One respondent distinguished between staff and the organisation as follows:

It's not the organisation, it tends to be individuals within the organisation that prevent us maintaining, promoting and delivering dignified care. For example, we have a senior nurse who insists on all patients being undressed. They say so that a doctor can examine them properly and quickly. Not all the patients need to be undressed and placed into a hospital gown. This is old school nursing and does not need to be done. However, the nursing staff are constantly being reprimanded for not undressing patients. (Staff Nurse, NHS Trust, Foundation)

Some respondents thought that nothing should prevent staff from delivering dignified care:

Nothing should prevent any nursing professional from maintaining a standard of care that would meet one's own expectations of care delivered. If all nurses provided a level of care in expectation to themselves then there would be no reason for complaints. (Staff Nurse, Local Health Board)

If you want to give good care nothing can prevent you. I would say staff (who) hinder dignity (are) the ones that don't seem to care!!!! (Staff Nurse, NHS Trust, Foundation)

Explanations for dignity lapses or failings were suggested, for example ignorance, lack of experience and lack of knowledge regarding dignity. Reference was made to "poor outdated attitudes, particularly in some of the long stay inpatient learning disability services". Other reasons why staff might not prioritise dignity were suggested, for example low morale and motivation, short-term contracts, lack of training and workload:

Poor attitude of healthcare professionals and low staffing and issues with morale during and after restructures. Staff on 3 month temporary contracts. (Nurse Manager, NHS Trust, Acute Hospital)

I feel we could do more in the department itself in training in this area. On the whole I feel the main problem or rather difficulty lies with the medical staff rather than nursing staff when it comes to patient dignity. I am not sure what if any training that they receive. (Senior Staff Nurse, NHS Trust, Foundation).

Lack of staff and those staff that are employed are of low

education and often of low motivation. Care staff earn very low wages. (Staff Nurse, Care/Nursing Home)

The repetitive nature of the job can mean that calls can be either dealt with automatically rather than taking each caller as an individual (Health Adviser, NHS Direct)

It was also pointed out that it can be difficult to challenge people who do not respect the dignity of others:

Not all staff [are] comfortable to challenge the practice of others. (Lecturer, University/College, Higher Education)

Nurses are not treated with respect themselves and this will affect the care they give. Hierarchy – some senior doctors seem to think they are above the basics. It is difficult to challenge staff who do not respect others. (Staff Nurse, NHS Trust, Foundation)

Respondents were critical of "management bureaucracy", unrealistic expectations, a "quick fix" attitude, managers who pay "lip service" to dignity, and those "who forget they were nurses". There was also criticism of managers who are unsupportive, who do not provide leadership on "the importance of dignity", and who do not act as role models or challenge poor practice. A lack of experienced, passionate, focused and "clear" and "visible nursing leadership" was suggested as compromising dignity. It was proposed that leaders were "appointed for management skills rather than clinical skills". Both "sets of skills" were identified as important in relation to dignity. Management was also described as "bullying and heavy handed". A relationship between nurse leadership and finance was also suggested, and there was a perception that management had different priorities:

"... aren't we doing well" and let's all pat ourselves on the back management and never mind the wards are running with two/three staff for 28 patients. (Nurse Practitioner, NHS Trust, Foundation)

The quick fix attitude of certain managers that the type of specialised care we deliver can be accommodated "on the hop". I feel that if our elderly patient group were more vocal about having to be moved to 2 or 3 different locations in one morning to get a bed/chair space, then it would help to [promote dignity] (Nurse Practitioner, NHS Trust, Acute Hospital)

Money, as always, there is a lot of talk about the importance of nursing leadership in delivering good quality care, but a failure to put money where organisational mouth is, in terms of creating properly valued roles for nurses. Nurses in this trust have been systematically discriminated against, relative to other professions, through the implementation

of Agenda for Change. (Nurse Manager, NHS Trust, Community/Primary Care)

A lack of resources was highlighted as one of the main factors contributing to a lack of dignity in care. One respondent used a war metaphor as she described her predicament as “a constant battle for staff and resources”. There were pleas for material resources such as gowns, linen and towels, and many references to dignity challenges that are due to short staffing and unsatisfactory skill mix. A nursing student in an acute hospital stated that “the number of unqualified staff on the wards has an impact”. Other references to resources included:

A review of resources and ward establishment figures would be beneficial to allow nurses time to provide that “bit extra” to incorporate social activities into the care experience – attitudes of some staff, to try and change from task orientation to person centred care. (Ward Manager, NHS Trust, Community/Primary Care)

Rarely fully staffed, difficult to convince HR to let us advertise for new staff in timely fashion. Manager is not approachable, I have no idea who the trust director is, have never met him or seen him on the wards. Never enough clean pyjamas and nighties on ward so some patients are left in gowns which display their bottom, never enough soap. (Staff Nurse, NHS Trust, Acute Hospital)

Problems with linen supplies caused concern to a few respondents – both the quality and availability:

Sometimes we do not have enough clean linen meaning patients have to wait for clean towels and sheets sometimes till after lunch. (Staff Nurse, NHS Trust, Acute Hospital)

Never having enough towels to cover people during bed baths and the towels provided are miniscule. (Student Nurse)

Respondents also raised clothing issues, mainly the indecency of hospital gowns and lack of availability of other nightwear:

Gowns that have no tapes – open at back. Gowns that will not fit adequately – open at back. Pyjamas bottoms that gape open esp. when pt catheterised. (Staff Nurse, NHS Trust, Acute Hospital)

We often run out of hospital pyjamas and pants which results in patients having to wear soiled nightclothes until fresh pyjamas/nightdresses can be sourced. This happens regularly at weekends. (Staff Nurse, NHS Trust, Acute Hospital)

Having to “make do and mend” – getting supplies and

equipment can be a challenge! (Health care Assistant/ Nursing Auxiliary, NHS Trust, Community/Primary Care)

NHS targets were viewed by some as antithetical to dignity in care. Responses relating to NHS targets were generally worded in the strongest terms suggesting a good deal of practitioner concern and frustration. Respondents referred to organisations that were “target led not patient led”, and managers who slavishly focused on “quantitative targets” rather than “softer quality issues” in care. There was a perception that patients were “rushed in and out”. One respondent asked “why shouldn’t someone have another night in hospital if they need it mentally not just physically?” Other responses suggested that targets resulted in staff feeling harassed, critical of organisational priorities and, in some instances, determined not to allow targets to compromise care:

The constant battle of meeting targets in surgery, A&E four-hour waits reducing length of stay which can at times leave staff feeling harassed in delivering care in a dignified and timely way. (Director of Nursing, NHS Trust, Acute Hospital)

[The] organisation is target driven and pays lip service to delivering dignified care. [It] does not actively promote dignified care, rather prioritises A&E breach targets, MRSA bacteraemia targets at the expense of this. (Clinical Nurse Specialist, NHS Trust, Acute Hospital)

Pressure to move patients out of A&E due to four-hour target means patients can be moved before care completed (they may be soiled, distressed, dying); lack of beds and lack of single sex accommodation and side rooms. (Consultant Nurse, NHS Trust, Acute Hospital)

Resources are stretched – staffing has been “right-sized” which feels like there is no-one available at peak periods to address the quality issues – all the focus seems to be on quantitative targets – until the Healthcare Commission visit us! (Practice Development Nurse, NHS Trust, Foundation)

Apparent lack of recognition of its [dignity’s] importance. Very often the organisation appears to concentrate on only those things that score points with government and not what scores points with patients and staff. Many ward staff feel over worked and under-valued which affects morale. (Clinical Nurse Specialist, NHS Trust, Acute Hospital)

There was also criticism of bed managers:

There are people with no clinical experience [bed managers] who will move people around from ward to ward with no thought of what is best for the patient. It is often a fight I lose in trying to get an appropriate patient to my area – all because of systems in place to meet government

28 Defending Dignity

targets and these systems are followed to the letter. (Ward Manager, NHS Trust, Foundation)

Despite being a rehab ward we are often sent patients with EMI needs who do not get the treatment they deserve because we are not mental health trained. Even though medical staff see and assess patients as not being suitable for our area of care they are overruled by bed managers desperate to free beds in the acute sector no matter at what cost. (Senior Staff Nurse, NHS Trust)

A lack of time to deliver dignified care was, in many instances, related to staff shortage and targets. Staff had, many respondents stated, insufficient time to deliver care with dignity. There was reference to “overwhelming workloads”, and to pressured and hurried care with patients waiting, resulting in care deficits. The perception that patients’ needs were not being met, and that staff felt dissatisfied, frustrated and perhaps distressed by such situations, is suggested in the following responses:

The continual push for effectiveness and efficiency, sometimes patients just need time and that can’t always be timetabled like a set of recipes. (Clinical Nurse Specialist, NHS Trust, Foundation).

Time: staff feel under a great deal of pressure to get as much work done in their shift as possible, which at times is hurried and is not always well organised. This then does not lead to dignified care. (Practice Development Nurse, NHS Trust, Acute Hospital)

Pressure of time management is the biggest factor – we are always short of time/cutting appointment times down to fit everything in and to meet government goals/deadlines/quaff points etc which are supposed to improve pt care but everyone knows it is making things worse. (Practice Nurse, GP Practice)

Time constraints, poor staffing in relation to work load prevents nurses from being able to do their best, this is such a big, always bypassed issue it is the most frustrating thing in the world! (Staff Nurse, NHS Trust, Acute Hospital)

By swamping us with paper work and form filling, which can literally take hours of work. Writing about dignified patient care promotion and delivery takes precedence over ACTUAL care. Also delay and prevarication over requests for essential equipment, especially electric variable height beds etc. (District Nurse, NHS Trust, Community/Primary Care)

References to a “cattle culture” and to a “culture of rushing” within the organisation support the view that a lack of time, targets and prioritisation of tasks over people results in dignity deficits. In

addition, a nursing student’s response suggests a theory/practice gap regarding dignity in care:

When going on to placement, what is taught in the classroom isn’t always carried out in practice, as a nursing student when you try to apply what you have learnt some qualified staff see it as time wasting. (Student Nurse)

On my first day in placement I was asked to help with bed baths. The curtains were drawn, the bed clothes pulled back and the patient undressed and left lying naked on the bed. I had been taught to use towels etc to cover any part of the patient that wasn’t at that moment being washed. This was not the procedure I was witnessing and most of the nurses and auxiliaries I work with follow this procedure. (Student Nurse)

This section has summarised some of the organisational factors which respondents think compromise dignity in care. The next section discusses suggested changes to the organisation and strategies to promote and develop dignity.

6.3 Aspects of the organisation that need to change to help practitioners maintain, promote and deliver dignified care more effectively

Respondents were creative in their suggestions regarding dignity-promoting organisational changes. Responses supported the need for managers “who listen and value staff”, who are “approachable”, and who “put care ahead of finances”. There were different views about the contribution of senior staff to the promotion of dignity in the organisation. It was suggested, for example, that it was beneficial for matrons to have a hands-on role in clinical practice, and that role modelling, educational history and monitoring are also important:

Sisters need to be supernumerary to lead by example and ensure that patients receive the care and attention they deserve. (Operational Manager, NHS Trust, Acute Hospital)

More financial support for wards wishing to improve the environment, more qualified staff who have an educational history about treating patients with dignity, more staff in general so staff have more time to spend with patients. (Student Nurse, NHS Trust, Acute Hospital)

More frequent checks from matrons/clinical nurse managers to highlight good and bad practice in individual clinical areas. (Clinical Nurse Specialist, NHS Trust, Acute Hospital)

Better tracking of the patient experience to highlight issues during the patient journey where patient dignity is compromised. (Clinical Nurse Specialist, NHS Trust, Acute Hospital)

Whole systems approach, local management commitment, time has come for a more firm approach through appraisal and PDP senior management support. (Nurse Manager, OH Provider)

There was reference to positive organisational change and an awareness of progress still to be made:

Things are changing with a proactive chief exec who makes efforts to meet with staff from all disciplines regularly at her briefings involving the new hospital build and seems to listen more to staff. Still a long way to go but at least the effort is being made. Elimination of medical patriarchy would help e.g. some surgeons unwilling to allow patients time to assimilate information, dress for theatre (if first on list), hassle nursing staff to rush admissions etc. (Clinical Nurse Specialist, NHS Trust, Acute Hospital)

There was also a view that organisations are not responsible for dignity failings but rather it is the responsibility of the individual professional:

Professional responsibility and less of a nanny state culture! It is not the organisation that is responsible it is the individual practitioner who should have been trained to this level and should have compassion, understanding and empathy, and adhere to their code of conduct. (Lecturer, Armed Forces)

Not all respondents were sympathetic, therefore, to the view that the organisation is responsible for dignity failings, arguing that this was a matter of individual and professional responsibility.

There was a good deal of emphasis on dignity training and education with support for “protected learning”, investment in nurse education and service user involvement:

There needs to be more training given to the whole multi disciplinary team in regards to the holistic care of patients which will enable us to promote and maintain dignity for all who use this service. (Student Nurse)

Need to place more priority on customer care training in the trust. We are now in a business environment and need to learn some lessons from the private sector. (Matron, NHS Trust, Community/Primary Care)

Investment in nurse education, protected learning time, better staffing levels, improved clinical leadership. Role models and gatekeepers of dignified care giving. (Nurse Manager, NHS Trust, Acute Hospital)

My organisation needs to educate staff on cultural differences and challenge them to look at their upbringing/ whatever influences have made them hold fast to their

bigoted/racist views. Agreement that we need more senior CLINICAL staff to work alongside less experienced staff to act as role models. (Staff Nurse, NHS Trust, Community/ Primary Care)

Again I feel that the Directorate are energetically working to this and are at this moment forming the steering group (multi professional), with organisational psychologists etc developing the training format. Initially looking at the vision [...] and then offering intensive training in all aspects of the patient journey. We will also be involving users, not just carers to give their perspective and wishes which it is felt will provide a further impetus for this practice to develop and continue. (Nurse Manager, Health & Social Care)

One respondent referred to specific training and responses to what is perceived as unsupportive and indifferent management:

Training in communication, whistleblowing, protection of staff when they whistleblow rather than being viewed as a trouble maker when you take things to management who say they are too busy or have to give you an appointment in the next 2 weeks, by that time you just can't be bothered. Because if managers have no patience and understanding, what do you expect when staff do not receive the support? Some staff can get too resentful of others who are working towards raising standards in the workplace and that starts with managers themselves who pretend, and I mean, pretend to care, quoting stuff like policies but on a practical level they really couldn't be bothered, pretending they are busy and going out for cigarettes behind walls in the grounds despite no smoking policies. (Nurse Manager, NHS Trust, Mental Health)

Several respondents suggested that staff would benefit from being on the “receiving end” of care by assuming a patient role:

HCPs need to put themselves in the patients' situation, how many of them would like to lie naked and exposed on a hospital bed having one or two strangers stand over them and perform a bed bath, washing intimate places. This is a distressing scene and even more distressing in the case of care of the elderly where upbringing has taught them not to expose themselves. (Student Nurse, NHS Trust, Community/ Primary Care)

To listen to what patients say they want (before complaints come in not after) and act on this. Physical environments take time to change, but putting beds into day rooms and quiet rooms has been a detrimental step and could easily be changed. Allow staff to attend education sessions and provide extra resources to cover for study leave. Medical staff have protected learning and it's time nurses had the

30 Defending Dignity

same. I believe if every person who works in the NHS had to be a patient for just one day it would open their eyes!! (Clinical Nurse Specialist, NHS Trust, Acute Hospital)

Staff need a higher level of English to work with the public and other staff. All staff should be made a patient so they can be on the receiving end of care, better communication and feedback from middle management (Staff Nurse, Agency)

Other suggestions included making available “different sizes of nightwear for men and women”, increasing staffing levels, improving time management, not discussing patients “at the end of the bed”, and having more involvement from patients and the public:

Improving amount and quality of linen & clothing. Currently all PJs and nighties have “hospital property” written all over it. Surely more neutral items would be better. (Staff Nurse, NHS Trust, Acute Hospital)

Unfortunately I feel that staffing levels and the lack of senior nursing staff is the most important factor, which is sad for me, and my colleagues, as there is very little we can do about it. This causes low morale, increased sick leave, and leads to more problems. (Staff Nurse, NHS Trust, Acute Hospital)

Patients should be nursed on wards appropriate to their needs and not moved as outliers to totally inappropriate wards just because one area has a bed crisis. Staffing levels need to match patient dependency with more registered nurses. I work shifts when I am responsible for 14 patients, including up to 4 immediately post major orthopaedic surgery, with others needing total care, and several having IV medication (Staff Nurse, NHS Trust, Foundation)

Need more money to invest in staff/patient ratio. Please this would give me time just to sit and talk to my patients without continually being aware of all the tasks I still have to undertake. Patients often don't discuss their fears/ anxieties or even something as simple as themselves because they can see how busy we are. Hospitalisation must be an extremely lonely time for some patients! (Staff Nurse, NHS Trust, Acute Hospital)

Respondents also suggested how actual and potential changes in services might impact on the quality and continuity of care. There was also a suggestion that care philosophies have moved from a focus on quality to safety:

Hospice care is based on high staff to patient ratio enabling us to give high quality holistic care. As Palliative care

changes and the needs of patients change a decision needs to be taken to fund the extra staff needed to maintain the same standards. (Ward Manager, Hospice)

I feel strongly that the current situation of admission wards leads to frequent ward moves for patients during their stay most being mixed sex wards. I feel that this regime of moving from A&E to admission bed to short stay bed to appropriate ward means that on each move a little more information and rapport is lost and the whole idea of continuity of care is very hard to maintain. Even in surgery the majority of our patients are admitted to one ward and discharged from recovery to another ward for post-op care. The days of being able to escort your patient to theatre and reassure them that you'll be there to collect them and care for them post-op are long gone. I find that very sad. (Staff Nurse, NHS Trust, Acute Hospital)

Bridging the gap between utopia and the reality of working in a cash strapped trust, with a reduced workforce, who were told that “quality” couldn't matter anymore and just try and maintain safety and that “mistakes” would happen. (Clinical Nurse Specialist, NHS Trust, Acute Hospital)

The need to address bed management issues was also suggested:

Addressing bed management issues, Delayed discharges balancing resources with the demand and capacity to care effectively for patients and ensure they receive appropriate treatment in the most appropriate place. (Nurse Advisor, NHS Trust, Foundation)

The view that a focus on NHS targets is an aspect of the organisation that needs to change was expressed in strong terms with implications for managers and politicians:

The organisation needs to understand we are looking after people not things and the most important part of our job is the patient not a 4 hour target. (Nurse Manager, NHS Trust, Acute Hospital)

Take the NHS off the political agenda, and stop using it as a pawn!! Basically, Westminster needs to butt out! (Nurse Practitioner, NHS Trust, Acute Hospital)

Remove the NHS from politicians' sphere of influence, allow the nursing and medical staff to care for the patients properly. (Staff Nurse, Armed Forces)

One respondent asserted that the patient must come first and suggested that management and professionals may have different priorities. There was also a suggestion that there was a certain amount of luck involved regarding the timing of discharges and admissions:

Put the patient first at organisational level – we battle at ward level to maintain standards but battle constantly with the white collar element who often have no experience of professional caring. Patients are just numbers to them! Consideration for elective surgical patients – more often than not a bed is not available for them and it is a case of keeping fingers crossed that discharges will happen in order to get them in – hence the wait in the corridor. (Staff Nurse, NHS Trust, Acute Hospital)

It was also suggested that dignity should not be considered as an exclusively nursing issue:

Pay a little more than lip service to dignity. Call other professions, particularly medicine, to account. There still seems to be an emphasis on dignity belonging primarily to the arena of nursing and measuring it as such. (Senior Staff Nurse, NHS Trust, Acute Hospital)

Investment in dignity and the need to publicise good practice was highlighted, and again the importance of listening:

Fund promising initiatives, learn from other trusts and implement good ideas by resourcing them properly. Listen actively to patients and their families not just the complaints, but when people feel cared for and about [what] they say has made a difference and it is often the qualitative things they mention not just the speed at which things happen. (Practice Development Nurse, NHS Trust, Acute Hospital)

Respondents asserted that the scope of dignity in organisations also extended to staff members:

Need to be able to control how referrals are made and when staff can see people, in essence having sufficient staff available to deliver timely care. As community nurses we are always unrealistically expected to cope with any new change without staff being accorded sufficient time to assimilate the changes. If staff are treated with dignity and respect it follows that patients will as it is part and parcel of the working culture. (Community Nurse Practitioner, NHS Health and Social Care Trust)

At the moment we have incredibly busy days. My last shift I only stopped for lunch at 4pm and did not have time to have a drink with it. I did not have time to drink a hot drink from 10am to 6pm. I think nurses need to be treated with dignity if we are to deliver the same. (Staff Nurse, NHS Trust, Acute Hospital)

The view that the dignity of staff needs to be respected is persuasive. The organisation would appear to have a key role in this.

6.4 Summary

For most respondents the organisation is perceived to have a very significant impact on dignity in care. A wide range of aspects of the organisation were identified as contributing to or compromising dignity in care. Respondents referred to staff attitudes, awareness and knowledge; leadership and role modelling; teamwork; resources (human and material); and culture and philosophy. When these aspects are inappropriate or inadequate dignity is reduced. NHS targets were an additional feature identified in relation to aspects of the organisation that prevented the maintenance of dignity. Tensions within the organisation, between the drive to deliver dignifying care and to meet government targets, seemed particularly challenging for staff.

7 Ability to deliver dignifying care

7.1 Views of own ability to deliver dignified care

Respondents were asked several questions about their own ability to give the level of dignified care that they would wish. Again there is evidence of practitioners' desire to give good care but some evidence that this is not always possible. Asked about their ability to give dignified care almost half the respondents said they were always able to give dignified care, but nearly as many said they could only sometimes give it.

7.2 Practitioners' rating of the dignity of care delivered

Perhaps not surprisingly respondents overwhelmingly rated the dignity of the care they gave as good, very good or excellent.

7.3 Importance of patient dignity to individual practitioners

Respondents stressed the importance of dignity, but again there is the suggestion that dignity may not be as important to the organisation. 84% of respondents rated the importance of dignity to them at six on a scale of one to six.

7.4 Importance of patient dignity to own organisation

In comparison to the importance of dignity to the individual, only 32% of respondents felt that the organisation rated the importance at six.

7.5 Time to deliver dignifying care

It would perhaps not be surprising that practitioners would say that they did not have sufficient time to give dignified care. However, 35% said that they did, while 61.7% said that they only sometimes had sufficient time. It is of course questionable as to whether providing dignity necessarily requires more time, although in some circumstances it clearly does, as supported by the free text comments.

7.6 Staff distress

The survey asked if respondents ever feel upset or distressed because they are unable to give the kind of dignified care they knew they should. Practitioners clearly find their inability always to give the level of dignity they would wish distressing; 70% of respondents said that they sometimes left work feeling upset or distressed because they had not been able to give dignified care, and 10.9% always felt this way. Interestingly, nurses who qualified outside the UK were even more likely than UK-qualified nurses to feel upset or distressed.

It seems reasonable to categorise this as moral distress, that is where people feel unable to do the right thing, and more will be said about this in the discussion section.

7.7 Summary

A picture emerges of nurses who rate dignity as very important, but who do not feel their organisation always gives it such a high rating. Many nurses sometimes leave work distressed knowing that they have not been able to give the standard of dignified care that they would wish.

Fig 25:
Have been able to give dignified care

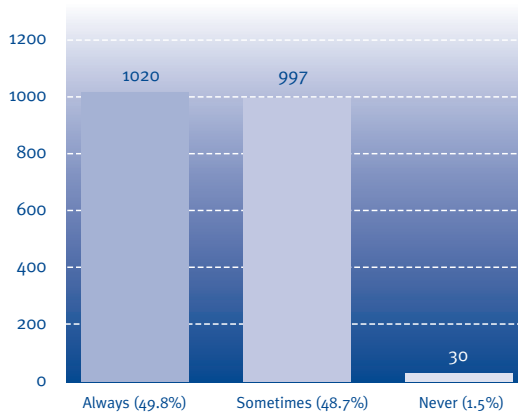


Fig 26:
Rating the dignity of the care you give

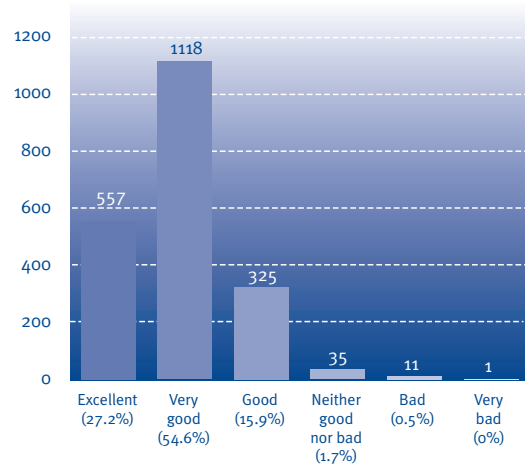


Fig 27:
Importance of dignity to you

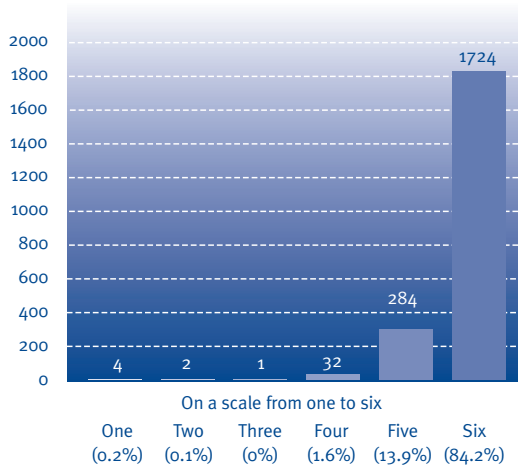


Fig 28:
Importance of dignity to the organisation

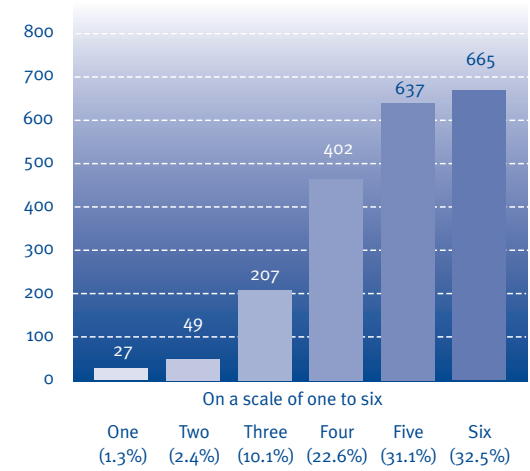


Fig 29:
Enough time to devote to dignity

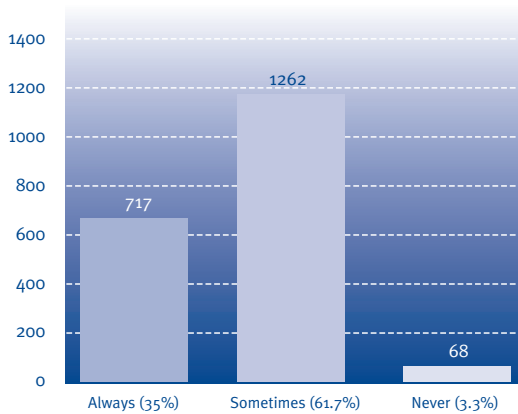
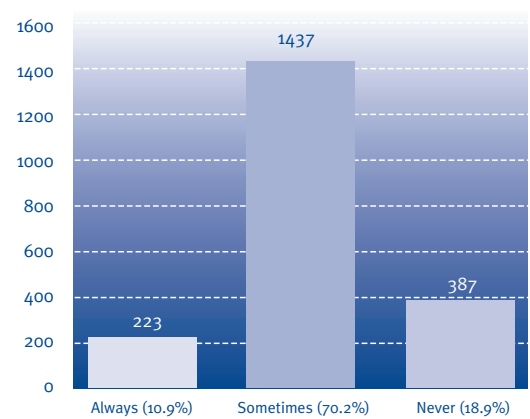


Fig 30:
Are you ever distressed?



8 Dignity and care activities

8.1 Introduction

Those who responded to the survey were acutely aware that many care activities they are involved in can compromise dignity and that many people's health conditions render them vulnerable to a loss of dignity. The physical environment and staff behaviour had the potential to compound such situations further. Clearly the potential for such situations to cause distress to both patients and staff is immense. However, nurses also detailed the steps that they undertook to promote dignity during care, portraying sensitivity, thoughtfulness and commitment in their approach:

Modified diets are served onto everyday plates; use of the correctly sized spoon or fork; where there is dribbling, the use of a tissue to clean excess; the involvement of the individual in the activity (even in a small way); privacy is offered; verbal interactions with the individual are adult and not infantilising; checking to see that the individual is comfortable with the way that I am "assisting" them; the individual is offered the opportunity to wash their hands before and after the meal (even if they will play no part in the activity); care is taken to spill no food, but if clothes are soiled, assistance is given to change them. (Ward Manager, NHS Trust, Acute Hospital)

The survey revealed that there are many initiatives to promote dignity in care but nurses also described their own individual strategies. Initiatives related to organisation of care and practice development, staffing, education, patient/client involvement and privacy enhancement. There was evidence of implementation of national initiatives at local level, such as protected mealtimes and dignity champions.

8.2 Care activities that compromise dignity

Many respondents identified one or more activity which might compromise dignity or a vulnerable patient group. Table 1 lists the groups of activities; the specific procedures related to these groups are listed in *Appendix D* and these indicate the very wide range of care activities nurses are involved in. The care activities identified

mainly involve personal care, procedures related to intimate areas of the body, care involving emotions, and procedures which are possibly painful or anxiety-provoking.

Respondents often identified physical environmental and organisational factors (see Sections 4 and 6) which rendered patients more vulnerable during these care activities, for example:

Patients in anaesthetics who are unconscious being urinary catheterised in full view of the entire operating theatre department, medical, non-medical and in full view of clerical staff. (Ward Manager)

Due to poor staffing we had to leave a patient who we knew had defaecated in the bed for 40 minutes before anyone was able to help clean him. (It was a surgical ward and

Table 1: Groups of activities that may compromise dignity

- Support with hygiene and dressing
 - Support with elimination
 - Support with nutrition
 - Communication
 - Intimate procedures/examinations
 - Invasive/technical procedures
 - Exposing procedures
 - Medical procedures
 - Medicine administration
 - Moving and handling
 - Physical health check
 - Emergency care
 - Admission/transfer/discharge/appointments
 - Mental health care
-

the patients returning from theatre had priority). (Student Nurse)

Giving enemas etc. behind a bedside curtain knowing other pts, relatives, staff are nearby and within ear shot. (Nurse Manager, NHS Trust, Community/Primary Care)

Provision of emergency medication in a classroom setting for prolonged seizure. Classrooms are not fitted with enough screens to provide for the promotion of dignity within this setting. (School Nurse, NHS Trust, Community/Primary Care)

Trying to talk and listen to patients about sensitive and upsetting things at the bed side with other patients in close proximity and with staff constantly trying to interrupt to offer drinks, check observations or make light hearted chit chat – even if the curtains are round the bed. (Clinical Nurse Specialist, NHS Trust, Acute Hospital)

Care activities were also at times made more undignified by the presence of visitors and relatives, both the patients' own and those of others:

Relatives tend to walk in on care expecting to be able to chat whilst I am doing personal care, which can be particularly embarrassing for some of my clients. (Community Nurse Practitioner, Self-employed)

Too many visitors around for too long mean the patients do not receive as much privacy as I would like. It is hard to use a bedpan etc in a room full of visitors with only a curtain for privacy. (Student Nurse)

Respondents often identified not just the care activities that might threaten dignity but people for whom this activity would be particularly undignifying. For example, they considered that people particularly vulnerable to loss of dignity during bedbathing included those who have had a stroke, young people and children, those with communication difficulties, with dementia, physical disability, sedated/ventilated patients, people with terminal illness and those with a hearing impairment. Respondents often identified that some of these procedures required a number of staff to be present, which they considered increased embarrassment. Examples included patients with spinal cord injury who required manual evacuation of faeces needing to be log-rolled by five staff members, chaperones needing to be present for intimate examinations, and more staff needing to be present for care of very obese patients, for example for positioning for administration of an enema.

Examples of compounding factors relating to medicine administration included immunisations with young, frightened girls and chemotherapy for a prisoner in chains or a person with communication difficulties. In relation to patients undergoing

surgery, factors increasing indignity included: lack of environmental privacy during pre-operative preparation; exposure and positioning on the operating table; and recovering patients who are distressed and disorientated in an open area. Factors possibly impacting on dignity in admission, transfer and discharge procedures included patients who were particularly vulnerable (for example, who have a terminal illness), transfers later at night, day case admission of a person unable to speak English, and discharge of anxious, frightened patients. In mental health care compounding factors included people who are wheelchair users being physically restrained, and where restraint is carried out in view of other patients or the public due to environmental constraints.

Respondents identified many groups of people who they considered to be particularly vulnerable to a loss of dignity (see Table 2).

These people were considered vulnerable because of the care activities they required (for example, personal care, symptom control, observation), their behaviour (for example, disinhibition) or their difficulty in understanding or consenting to care needed

Table 2: People vulnerable to a loss of dignity

- People who are terminally ill
 - People with mental health problems, including: dementia, delirium, self harm
 - People undergoing surgery: during anaesthesia, post-operatively and particularly surgery of intimate areas of the body (eg. gynaecological or urological surgery)
 - Unconscious or semi-conscious patients, including ventilated/sedated patients
 - People with impaired communication
 - People with serious physical illness
 - People with major disability, including spinal injuries
 - People with acute cardiac illness/surgery
 - People with visual or hearing impairment
 - People with infections
 - Women with gynaecological problems, including infertility, early labour or miscarriage
 - Children and young people with cancer
 - Women who have been sexually assaulted, raped or abused
 - People under the influence of alcohol/drugs
 - People with challenging needs
 - People with uncomfortable symptoms: pain, vomiting
-

36 Defending Dignity

(for example, if confused or unconscious). Again, compounding factors were often identified relating to staff behaviour (for example, medical practitioner's reluctance to prescribe adequate pain relief for a person with terminal illness) or environmental factors (for example, a person with dementia and disinhibited behaviour in a mixed sex environment). Thus, staff could be caring for vulnerable patients undergoing potentially undignifying procedures, in an environment not conducive to dignity, with unsupportive colleagues. However, respondents often went to great lengths to protect patients' dignity in these situations, and these steps are described in the next section.

8.3 Steps taken to minimise loss of dignity

Table 3 summarises how respondents protected patients' dignity when carrying out the care activities they identified as potentially undignifying. Respondents referred to steps related to privacy,

communication and physical care when describing how they conducted particular care activities. In relation to privacy they described how they used the physical environment to best effect, their own behaviour, managing other people in the environment, including colleagues and visitors, and how they provided bodily privacy. They also explained the communication they used to promote dignity, interactions which made patients feel comfortable, in control and valued. Respondents described that preparation for care activities was key; this included preparing for the particular procedure, arranging the environment, ensuring timeliness, appropriate equipment and involvement of other staff. Many described promoting independence during care activities and ensuring physical comfort.

Respondents' descriptions of promoting dignity during particular procedures included steps from the themes in Table 3. It was the combination of these aspects which ensured that dignity

Table 3: How nurses protect dignity during care activities

Privacy

Physical environment

- Side rooms
- Quiet/private room/area
- Bathroom/toilet use
- Curtains/screens/blinds
- Curtain clips/pegs/signs
- Managing smells
- Auditory privacy

Staff behaviour

- Discretion
- Respect for personal space
- Prevent/manage interruptions
- Sensitivity to culture/religion

Managing people in the environment

- Staff: number present, gender
- Other patients
- Family
- Ward visitors/public

Bodily privacy

- Covering body
- Minimising time exposed
- Privacy during undressing
- Clothing

Communication

Interactions that make patients feel comfortable

- Sensitivity
- Empathy
- Developing relationships
- Non-verbal communication
- Conversation
- Reassurance
- Professionalism
- Family involvement

Interactions that make patients feel in control

- Explanations and information giving
- Choices and negotiation
- Gaining consent

Interactions that make patients feel valued

- Giving time
- Concern for patients as individuals
- Courteousness

Physical care actions

Preparation

- Procedure
- Environment
- Timeliness
- Equipment
- Staff involvement

Promoting independence

Physical comfort

was promoted as much as possible during care procedures which were potentially undignified. For example, one nurse's description of promoting dignity during support for breastfeeding includes privacy, communication and physical care actions:

Talk with the mother first about what is to be expected. Choose a time that the unit is likely to be less busy. Move baby's cot to an area of the room that is least likely to be disturbed. Ask mother/parents if they want any visitors present. Provide a screen if requested. Allow mother time to adjust to having the baby in the feeding position before offering advice. Allow mother the option of expressing in her room or the nursery. Use breastfeeding consultant to provide continuity of care. (Staff Nurse, Health Authority)

A respondent who described steps to promote dignity during a bedbath also referred to privacy, communication and physical care actions:

Patient involved in discussion re care for the day and is in agreement. Ensure that I have all equipment I require. Ensure I have an assistant to facilitate safe moving and handling. Inform colleagues that I will be undertaking bedbath. Ensure curtains closed. Encourage patient to do as much as they can for themselves during the procedure. Ensure that only the area being washed is uncovered, that patient is covered and warm throughout procedure. Ensure that patient is involved in conversation. Do not speak about "what did you do last night" over patient. Offer patient toilet if required. Ensure teeth and mouth clean. Offer drink. Tidy up. Leave patient comfortable with buzzer, drink and that patient has everything they need before leaving them. (Practice Development Nurse, NHS Trust, Acute Hospital)

Staff also described organisational steps which were applied on a more planned basis rather than at the time, including organisation of care and services available, challenging practices which compromised care, staffing approaches (teamwork, staffing levels), and education (role-modelling and training). For example, in relation to organisation of care and services available:

We always make patients aware of the services they can offer and at consultations advise that we can use language line or rebook with an interpreter. (Nurse Practitioner, GP Practice)

All counselling is now done "in house", negating the need for prisoners to attend outside practitioners while handcuffed to a prison officer. (Nurse Manager, Prison)

Respondents described how they challenged care which compromised dignity, for example:

Completing incident forms when care is felt to be unsafe or of a poor quality. (Nurse Practitioner, NHS Trust, Acute Hospital)

Employing teamwork to promote dignity during care activities was described too, for example:

Staff on the unit are all very experienced and comfortable in dealing with such situations [providing personal care to acutely confused patients who are verbally and physically abusive]. This activity often involves several members of staff to ensure both patient and staff safety. Once any physical transfers which might require two staff have been undertaken staff are all confident and competent in assisting the patient with their personal care needs in a way that minimises distress. It is impossible to be completely dignified when assistance is required with personal aspects of care but staff agree that the reduced "audience" enhances patient dignity and is worth the minimal increase in risk of them being abused by the patient. (Ward Manager, Health Board)

Respondents also described staffing approaches to deal with certain situations, for example:

I try to allocate a health care assistant to watch the dementia patients that show these tendencies [public undressing] and avoid the incident happening. (Staff Nurse, NHS Trust, Acute Hospital)

Some respondents described aiming to be a role model to others during care activities that might compromise dignity. Training to enhance performance was also described:

The psychiatric liaison team provide care plans, role modelling, education and training to acute care colleagues. (Clinical Nurse Specialist, NHS Trust, Mental Health)

Good up to date training, de-escalation techniques. (Mental Health Nurse, NHS Trust, Mental Health)

Overall respondents clearly identified strategies to protect patients' dignity during potentially undignifying procedures. There were also many dignity-enhancing initiatives reported, which the next section details.

8.4 Practice initiatives that promote dignity in care

The vast majority of survey respondents identified initiatives to promote dignity in care, although some of these were respondents' own individual care approaches similar to those detailed in Section 8.3, and often referred to communication and privacy. Respondents described aiming to treat others as they would wish to be treated or as if they were caring for their own family. The responses related to organisational initiatives emerged in five themes: organisation of care; staffing; education; patient/client involvement; and privacy enhancement.

38 Defending Dignity

Organisation of care

With regard to organisation of care, there was a wide range of new services and practice developments described for diverse client groups, including people who are homeless, Jehovah's Witnesses, breast-feeding mothers and women undergoing medical termination of pregnancy. A number of respondents referred to developments in terminal care, in particular implementation of the Liverpool Care Pathway³. Developments relating to patients' nutrition were also described, for example protected mealtimes and greater choice of menu. Examples of new services included:

Now have an overnight service so that if conditions change overnight people don't struggle and get distressed. The feedback has been very positive as patients and relatives feel supported particularly if patients are very ill. (Community Nurse Practitioner, NHS Health and Social Care Trust)

Self-referral to our "living life to the full" classes held in the local community (non-health care setting), no records are kept. Very informal. Emphasises life skills and non-medicalisation of life experiences, such as depression, stress and anxiety etc. Clients feel reassured that they will not have medical records, and that it is all about self-management of one's life. (Community Mental Health Nurse, NHS Trust, Mental Health)

Enhanced care of learning disability patients via dedicated fast track to ward, via hospital co-ordinator. (Senior Staff Nurse, NHS Trust, Acute Hospital)

Pamper days for patients; these provide complementary therapies, chocolate, hair dressing and nail care followed by a three course lunch. (Nurse Practitioner, Hospice)

Communication and availability of support and services in the community for people who are blind or become partially sighted, as an extension to the treatment they receive at their hospital appointment making them more independent and able to live a life of dignity. (Staff Nurse, NHS Trust, Acute Hospital).

Health promotion activities discovered that obesity is one issue within the company employees. We are providing online support and advice to these staff members who may otherwise be too embarrassed to seek out face-to-face support. (Operational Manager, Health Care Company)

There were many physical environment enhancements described which was encouraging given the deficits identified in Section 4. Some of these initiatives related to new buildings where more single rooms had been built, or new facilities developed, for example:

We have a discharge suite. This allows us to have a patient in an area separate to the ward. There are kitchen & bathroom facilities & a sofa bed to allow carer/spouse etc to stay to totally mirror/practise being at home. (Discharge Liaison Nurse, NHS Trust, Community/Primary Care)

Other initiatives related to plans for environmental improvements, for example:

We are all keen for the development of an assessment room in which patients can be assessed in privacy, and are hoping for its construction as soon as possible. Currently we are waiting for a response from our PCT. (Nurse practitioner, NHS Trust, Community/Primary Care)

Changes to the use of the existing physical structure were also identified, for example:

We created a quiet non-environmental room within the outpatient clinic in which to "counsel" pts receiving bad news or who are distressed. Within the new facility we have a purpose built room that will allow pts to leave without passing through the clinic again. (Clinical Nurse Specialist, NHS Trust, Foundation)

Ward was redesigned in 2006 with less patients per room, allowing more space and less sharing of toilet/shower facilities. (Staff Nurse, NHS Health Board)

Unfortunately there were some references to initiatives in the physical environment which had since been thwarted:

Attempted to develop admission lounge with private areas, toilets, etc worked very well for a short while until beds were escalated to accommodate in-patients. (Matron, NHS Trust, Acute Hospital)

Some staff referred to initiatives relating to improvements in equipment provision and availability which had enhanced dignity. There were many references to audits and benchmarking (sometimes related to *Essence of Care*), for example:

Essence of Care benchmarking & audits around privacy and dignity. Key recommendations identified and implemented. (Practice Development Nurse, NHS Trust, Foundation)

A number of staff referred to policies and guidelines that had been, or were being, developed to promote dignity. Examples included:

Safeguarding strategy and whistleblowing policy has allowed staff to highlight situations where patients' dignity is being compromised. (Tutor/Lecturer, Private Hospital)

Best Practice Standards for Privacy & Dignity to ensure all staff understand the "Trust's expectations". (Practice

Development Nurse, NHS Trust, Acute Hospital)

My matron has allocated the rewriting and updating of the home's policies and procedures to me – when doing this I am ensuring the promotion of dignity is integral to each policy or procedure where applicable. (Staff Nurse, Care Home)

Some respondents' examples of initiatives referred to "Dignity champions" or "Older people's champions", for example:

We have introduced dignity champions who are nurses and health care assistants with a real interest in upholding our patients' dignity and working with their teams to change practice and culture. (Clinical Nurse Specialist, NHS Trust, Community/Primary Care)

Other initiatives related to staffing are considered next.

Staffing

Staffing initiatives related to leadership, teamwork, staffing levels and mix, staff support and the culture/ethos of the staff. There were a number of comments about leadership initiatives, which had potential for a major impact:

The implementation of the supervisory ward sister across all wards following the success of the pilot, by empowering the sisters to take back the leadership of their areas it has reduced complaints, improved staff morale and therefore quality of care to patients while still managing most of the time to meet national and local targets. This in turn is improving staff retention. (Director of Nursing, NHS Trust, Acute Hospital)

We have a stop and look programme, matrons are challenged to walk the wards with staff of different grades and challenge them to look into a patient bay and think that if it was their family member in there, would they be happy/confident about their care? This has made nurses really look at their practice and how their patients are treated. (Operational Manager, NHS Trust, Acute Hospital)

Teamwork to promote dignity which included multidisciplinary teamworking was also raised by a number of staff. Examples of initiatives included:

Joint clinic with the learning disability nurses to improve care of this client group when they experience prolonged and/or repeated convulsive seizures, to improve first aid given, use of rescue treatment, prevention of premature death. (Clinical Nurse Specialist, NHS Trust, Acute Hospital)

Some respondents referred to changes to staffing levels, roles or mix of staff. Developments included housekeepers, roles focusing on

nutrition, and use of volunteers. Other new roles included:

The school have employed me as a hands-on school nurse to help ensure that everyone's health care needs are met in a professional nursing manner. (School Nurse, County Council)

There were comments about gender of staff and trying to ensure that both male and female staff were available on shifts so that where possible patient preference could be met, particularly when undergoing intimate procedures such as catheterization. Some respondents described "fighting" for higher staff levels to improve staff to patient ratios and ensuring that high quality staff were recruited. Respondents identified support for staff to assist them to deliver dignified care which included the availability of clinical supervision and facilities for staff, for example:

We have managed slowly to get all our staff a locker in the staff changing rooms used by all clinic staff so they do not have to change in toilets/treatment rooms. They can hang up their clothes and leave looking presentable at the end of the day. (Clinical Nurse Specialist, NHS Trust, Acute Hospital)

This latter example indicates that for staff to care with dignity they too need to be treated with dignity. The culture and ethos of the staff also drew many comments, including:

A high level of confidentiality and respect for clients is expected at all times as part of the culture in which the team operates. (Community Mental Health Nurse, NHS Trust, Community/Primary Care)

Our ethos is to give time to patients to express their fears/anxieties trying to establish and meet their needs as far as providing symptom control and helping them with all aspects and issues involved with palliative/end of life situation. (Staff Nurse, NHS Trust, Community/Primary Care)

Some respondents identified educational initiatives which are considered in the next section.

Education

Educational initiatives included role-modelling, training and promoting awareness. Comments related to role-modelling described how respondents demonstrated good practice in dignified care to other staff or learned from others' role modelling, for example:

All residents now have the option of locking their rooms and all carers knock on doors before entering. I consciously role model this and emphasise it if I see it forgotten. (Matron, Care Home)

All nursing students and new staff involved in caring for patients undergoing stoma surgery spend a day with me

40 Defending Dignity

so they can become involved in the practical care of stoma patients while they are supernumerary, and can gain an insight into the needs and concerns of these patients. I hope it is helpful to observe me interacting with these patients and discussing what is normally a private bodily function with a (I hope!) degree of sensitivity and dignity. (Clinical Nurse Specialist, NHS Trust, Acute Hospital)

Many educational initiatives were described which aimed to increase awareness about dignity and train staff to provide dignified care, for example:

Communication project where staff are educated through reflection, person centred care. (Lead Nurse, NHS Trust, Acute Hospital)

Patients helping in the design and input of the professional nurse curriculum so their voices can be heard. (Lecturer/tutor, University/College of Further or Higher Education)

Some specific examples of educational sessions included communication, continence, cultural aspects and “Let’s respect”⁴. Nursing students described both university-based sessions where they learned about dignity, which included reflection and role play, and learning from staff on practice placements. Initiatives to promote awareness about dignity were also described:

We held a campaign to highlight importance of privacy & dignity with notice boards devoted to same. Staff wrote poems etc to highlight problems. (Senior Staff Nurse, NHS Trust, Acute Hospital)

Patient and client involvement featured in some initiatives identified and these are discussed next.

Patient/client involvement

There were many initiatives which harnessed patient/client involvement. These included obtaining feedback, working in partnership, and information development so that choice could be facilitated. Feedback was accessed in various ways, such as patient/service-user forums, questionnaires and follow-up mechanisms, for example:

We have a follow-up nurse who contacts patients post discharge to give them an opportunity to talk about their experience & brings any issues back to us at our monthly meeting. (Ward Manager, NHS Trust, Acute Hospital)

Partnership initiatives related to care planning, joint decision-making, meetings/forums, facilitating choice and independence, and family involvement. Examples included:

A democratic drug free leisure group for patients committed to maintaining a drug free environment on the unit. (Nurse Practitioner, NHS Trust, Mental Health)

We have started an initiative called Choice and Partnership, which is about working in partnership with clients so that they have a real choice over whether they will work with our services and if not then we assist in finding the right service to meet their needs. (Community Mental Health Nurse, NHS Trust, Community/Primary Care)

A number of respondents described initiatives relating to information provision, for example:

Leaflets in 13 different languages, so that the client can read for themselves, if possible, about TB, and why we’re screening for it, and not to feel disempowered by having to ask others. (Health Visitor, NHS Trust, Community/Primary Care)

Sexual health board in a private room for teenagers, and the room for teenagers only to chill. Allows them a private place to relax and find information, ask questions without parents or other patients/parents listening. (Staff Nurse, NHS Trust, Acute Hospital)

Initiatives to enhance privacy were also described.

Privacy enhancement

Privacy enhancing initiatives related to the physical environment, staff behaviour, managing people in the environment and bodily privacy. Regarding the physical environment, respondents described use of siderooms and private areas, and enhanced bathroom and toilet facilities. Many respondents identified use of pegs, clips or signs to advise other staff not to enter curtains or screens, and Velcro to close curtains more effectively was reported. Some respondents reported initiatives to provide a single sex environment, for example:

Separate waiting areas for men and women while waiting for their procedures. This allows for comfort and preservation of dignity, especially to culturally sensitive patients. (Staff Nurse, NHS Trust, Foundation)

Initiatives relating to staff behaviour included discretion, confidentiality and preventing interruptions during care activities. Respondents also described managing people within the environment to promote privacy, for example:

We limit numbers of people entering endoscopy room. (Senior Staff Nurse, NHS Trust, Acute Hospital)

Initiatives to enhance bodily privacy included the prevention of unnecessary undressing and providing appropriate clothing, for example dressing gowns, and redesigned theatre gowns.

8.5 Summary

Respondents identified a wide range of care activities which could threaten dignity and were also well aware of the vulnerability of many patients and clients. Unfortunately, staff behaviour and the environment where care activities took place could increase the likelihood of indignity occurring during some care activities. However, respondents also described their commitment to protect dignity when patients and clients were in these vulnerable situations. Respondents identified an array of initiatives to enhance dignity across diverse care settings and it was therefore evident that despite the many challenges detailed in this report, promoting dignified care is a high priority to nurses.

³ The Liverpool Care Pathway is a quality improvement framework for caring for people who are dying. It aims to transfer the model of excellence used in hospices to other settings. See http://www.mcpcil.org.uk/liverpool_care_pathway

⁴ “Let’s Respect” is a toolkit aimed at staff caring for people with mental health needs in acute hospital settings. See <http://www.olderpeoplesmentalhealth.csip.org.uk/lets-respect.html>

9 Discussion

The findings of the survey highlight the importance of the physical environment, organisational culture, the attitudes and behaviour of nurses and others, and the way in which care activities are carried out. The importance, therefore, of **place** (physical environment and organisational culture), of **people** (the attitudes and behaviour of nurses and others), and of **processes** (care activities) is borne out by the data. What this survey emphasises more acutely than previous studies about patient dignity is the potential of organisational and government policies regarding targets and staffing ratios to diminish dignity in care. As the largest reported survey of nurses' experiences of dignity, the results are illuminative, offering insights into the reality of attempting to provide dignified care in diverse settings across the UK.

9.1 Initial and continuing education relating to dignity

How nurses learn about dignity and how they try to provide dignified care has been little explored previously, although there are reports of hospital-based workshops on dignity (for example Matiti and Cotrel-Gibbons, 2006). This survey's results were reassuring in that most respondents had learned about dignity both in formal education and in practice, which they believed had had a positive impact. The NMC's (2007) Essential Skills Clusters initiative (to be implemented in September 2008) has further emphasised that nurses must be able to provide dignified care. Both nursing students and lecturers described university-based education to develop understanding of dignity. While many nursing student respondents found that their practice placement experience reinforced and continued their university-based learning about dignity, some reported that culture and staff attitudes provided a barrier to dignified care.

Survey respondents had continued to develop their understanding of dignity in various ways, but often through their own practice and experience with patients and clients as well as through further education. The results also highlighted that personal experiences as a patient or relative had influenced nurses' understanding of dignity. Despite appearing satisfied with their own

educational preparation, many respondents considered that other staff lacked education about dignity, including health care assistants, multidisciplinary team members (particularly doctors), and managers. Calnan *et al.* (2005) identified that a lack of staff training impacted negatively on dignity in care. For patients to experience dignity in health care, all staff, not just nurses, need awareness and understanding. Encouragingly, when respondents were asked about dignity-promoting initiatives many identified education and training events, but it was suggested that more such developments are needed.

9.2 Dignity and the physical environment

Respondents worked in a very wide range of settings and it was clear that while a conducive physical environment supported dignified care, many staff struggled against significant obstacles which could clearly be demoralising. A lack of space was a key barrier to dignity, supporting previous studies (HAS, 2000, 1998; Seedhouse and Gallagher, 2002). The benefit of single rooms for patients with increased privacy needs has been identified (Matiti, 2002) but many respondents experienced a lack of availability. It was clear that, for infection control reasons, demand for side rooms has increased substantially, and while respondents recognised the importance of infection control measures they regretted the resulting negative impact on dignity, thus highlighting conflicting priorities.

The results indicated that in multi-bed spaces, effective curtains and screens are crucial, but as in previous studies (Gallagher and Seedhouse, 2000; Matiti, 2002; Jacelon, 2003) many respondents reported problems with them, such as that they were ill-fitting and flimsy. There was widespread concern about curtains providing a lack of auditory privacy, supporting previous research (Matiti, 2002; Walsh and Kowanko, 2002; Widäng and Fridlund, 2003). The problem was further compounded by the small size of bed spaces and the lack of other quiet rooms or treatment rooms, where procedures or discussions could be carried out in private. Overall many respondents experienced barriers to providing privacy for patients, particularly in in-patient settings. However, there were

also challenges in other environments, including schools and community, which have not been highlighted in previous studies. In contrast, some respondents reported that their care settings enhanced their ability to provide dignified care, as the physical environment provided privacy. Other aspects of the physical environment necessary for dignified care were also highlighted, including a clean and pleasant environment, which supports previous research (Gallagher and Seedhouse, 2000; Baillie, 2007). Inadequate bathrooms and toilet facilities were reported as barriers to dignified care, which have also been identified in other studies (HAS, 2000, 1998; Gallagher and Seedhouse, 2000; Matiti, 2002). The lack of basic elements for dignified care thus contributes to a daily struggle for many staff during care activities.

The survey's results indicate widespread concerns about the negative impact of mixed sex care environments on dignity, supporting previous research in acute and older people's care (Gallagher and Seedhouse, 2000; Woolhead *et al.*, 2005; Baillie, 2007). Even where there is single sex sleeping accommodation and bathrooms, respondents pointed out that it was challenging to prevent mixing within the environment and that many patients were in vulnerable conditions. The results identified concerns about mixed sex wards in mental health settings too despite Mind (2004) having recommended single sex accommodation for mental health service users. In 2007, the Chief Nursing Officer for England acknowledged that achieving single sex accommodation for all patients remained challenging. A DH commissioned survey of 2,000 people (Ipsos MORI, 2007) found that staff thoughtfulness and hospital cleanliness were of greater concern to patients than being in a single sex ward, but that older people, women, and patients having gender-specific operations (such as hysterectomy) were less tolerant of mixed sex accommodation. Obviously the latter statement applies to most people in acute settings and many in other environments too.

Overall respondents were clear about the type of physical environment they needed to deliver dignified care – clean, pleasant, adequate space, availability of single rooms and private rooms for discussions and treatments, effective curtains, screens and door locks, sufficient well-designed toilets and bathrooms and, with the exception of some specialised units, single sex care settings. These are fundamental ingredients for nurses to deliver dignified care, but many survey respondents did not work in such an environment.

9.3 Dignity and the employing organisation

Despite many respondents highlighting environmental constraints, most stated that they would be happy for a relative or friend to be cared for in their employing organisation. They were also generally confident that patients and clients are involved in care decisions – an important aspect in dignified care. Clearly the physical environment is only one factor that impacts on dignity and organisational aspects are also important.

Some respondents reported support from leaders and managers which assisted them to deliver dignified care. The importance of

role-modelling in practice was also highlighted. Unfortunately, many respondents reported that organisational management had a negative impact on dignity, in particular bed management strategies to meet targets led to patients being repeatedly moved between wards, often to inappropriate settings and, as in Baillie's (2007) study, to mixed sex accommodation. In Calnan *et al.*'s (2005) study UK professionals identified that a task-oriented culture, high pressure work, NHS priorities, and managerial targets hindered their ability to provide dignified care. Survey respondents described feeling harassed and pressurised and they suggested that managers needed to be more supportive to their staff and that bed management issues needed resolving. The benefits of teamwork to deliver dignified care were apparent and respondents identified the importance of a dignity-promoting culture and philosophy, supporting previous research (HAS 2000, 1998; Gallagher and Seedhouse, 2000; Baillie, 2007). The benefits of having a multi-cultural team to deliver dignified care was also identified which has not been previously suggested.

Respondents identified that attitudes of staff themselves were particularly influential and could have a negative effect on patients' dignity. Other studies have highlighted that staff attitudes which showed that patients were valued underpinned the delivery of dignified care (Nåden and Eriksson, 2004; Bayer *et al.*, 2005). Respondents reported that other staff, of all disciplines, often breached privacy by entering curtains or rooms without warning, supporting many previous studies (Lai and Levy, 2002; Matiti, 2002; Ariño-Blasco, 2005; Baillie, 2007). Although many staff described strategies to prevent this (such as pegs on curtains), even then staff behaviour did not change, indicating that underlying attitude was at fault.

The importance of adequate levels of good quality staff was highlighted in the survey's results but many respondents reported inadequate staffing levels which, as in other studies (Matiti, 2002; Seedhouse and Gallagher, 2002; Reed *et al.*, 2003; Calnan *et al.*, 2005), negatively impacted on dignified care. This was compounded by high workload with pressure to meet targets, leading to care deficits and staff who felt dissatisfied and even distressed. Respondents suggested that increased staffing levels would assist them in providing dignified care. Previous studies support their comments as staff shortages have been found to make patients feel rushed and less valued as human beings and individuals (Matiti, 2002; Walsh and Kowanko, 2002). Calnan *et al.* (2005) reported that staff caring for older people admitted that high workload prevented them being able to provide quality personal care. Mind (2004) has previously highlighted poor staffing levels and over-reliance on agency staff in mental health settings.

Improved staffing levels and appropriate skill mix are relevant to the quality of care and to staff wellbeing more generally. There is evidence that patient outcomes can be linked to the input of registered nurses, staff turnover, morale and job satisfaction (RCN, 2006). A study by Rafferty *et al.* (2007) found that hospitals in England with the most favourable staffing levels (lowest patient

44 Defending Dignity

to nurse ratios) had “consistently better outcomes than those with less favourable staffing”. Patients in hospitals with the highest patient to nurse ratios had higher mortality, nurse job dissatisfaction and burnout levels were higher, and nurses were more likely to report low quality of care. Low staffing levels also impacts on nurse retention. These findings are in keeping with US research (Aiken *et al.*, 2002). RCN (2006) policy guidance points out that there are no nationally set mandatory nurse staffing levels, nor is there agreement on how to measure and model ward staffing requirements. Nevertheless, it is suggested [RML1] that a benchmark of 65% registered nurses to 35% health care assistants should be maintained for general wards.

As in other studies (HAS 2000, 1998; Matiti, 2002; Seedhouse and Gallagher, 2002; Enes, 2003), some respondents identified a lack of equipment and linen which affected their ability to deliver care. Ill-fitting and exposing hospital gowns and nightclothes have also been previously identified (Matiti, 2002; Walsh and Kowanko, 2002; Baillie, 2007).

9.4 Prioritisation of dignity

While almost all respondents had high aspirations to provide dignified care, the survey results indicated that almost half considered that they only achieved this sometimes rather than always. Time constraints posed by workload and inadequate staffing levels were clearly influencing factors as almost two-thirds of respondents stated that they only sometimes had enough time to deliver dignified care. This has huge implications in terms of patients' and clients' care experiences, nurses being able to comply with their Code of Professional Conduct (NMC, 2008), and the impact on nurses themselves as professionals and human beings. Indeed the finding that 70% of respondents sometimes left work feeling distressed or upset as they had been unable to give dignified care is of considerable importance. A good deal of attention has been given to the phenomenon of moral distress in nursing. Moral distress may be experienced as when nurses are unable to do what they think is the ethical thing to do. As McCarthy and Deady (2008, p.254) put it “they know what is the right thing to do, but they are unable to do it; or they do what they believe is the wrong thing”. The constraints that contribute to moral distress may be internal (relating to individual or personal failings) or external (relating to the situation the person finds themselves in). Internal constraints might include fear, anxiety, lack of confidence or motivation. External constraints would include organisational factors such as lack of resources or disabling management. Research exploring the impact of moral distress on nurses found that it is related to moral suffering, negative emotions, self-doubt and self-blame (McCarthy and Deady, 2008, p.257), and burnout (Sundin-Huard and Fahy, 1999).

Compounding this situation, some respondents believed that dignity was not a high priority to their employing organisation, with many considering that their team's prioritisation of dignity was higher than that of their employing organisation. This seems to be in keeping with findings from the Healthcare Commission National

NHS staff survey conducted in 2007 (HSC, 2008) which suggests that just 46% of staff think that the “care of patients/service-users is my trust's top priority”. As it is the organisation that is likely to control much of the environment and its resources, both individual staff and their teams could feel frustrated by their efforts to provide dignified care in a sub-standard care environment. As respondents repeatedly pointed out, one thing that does drive the organisation's agenda is the need to meet government targets, which were seen by some respondents as a major obstacle to dignity. The four-hour waiting target in A&E for example resulted in patients being moved around the hospital repeatedly, sometimes in the middle of the night, patients being nursed on trolleys in already full wards, and the continued use of mixed sex accommodation.

It was encouraging that a high proportion of respondents reported that they would challenge policies or colleagues compromising dignity, which is important as many patients and clients are very vulnerable. Following the 1998 Public Interest Disclosure Act, employees speaking out about malpractice are protected by law and employers are expected to have whistle-blowing policies (DH, 2003), which were mentioned by a few respondents. Firth-Cozens *et al.*'s survey (2003) identified many barriers to reporting bad practice and that only 56% of nurses reported concerns about practice. They also found that nurses' experiences of reporting bad practice were often negative, highlighting the need for staff support. Ray (2006, p.438) argues that when organisations do not support people who whistleblow there is “a failure of organisational ethics”. The Healthcare Commission (2008) reported that while 78% of staff said they would report any concerns about negligence or staff wrongdoing, 36% did not have knowledge of confidential reporting systems.

9.5 Dignifying care activities

Respondents were highly aware that they were involved in care activities which could potentially threaten dignity for vulnerable people. Previous research has indicated that dignity is at risk during care activities leading to bodily exposure (Lai and Levy, 2002; Matthews and Callister, 2004; Baillie, 2007). However, this survey's results provide a much more comprehensive picture of care activities and their potential impact on dignity. Unfortunately, respondents reported that an inadequate physical environment, and organisational aspects including staff behaviour, could increase the likelihood of dignity being diminished during care. However, as in Baillie's (2007) study, respondents explained how their own behaviour – provision of privacy, communication and physical care actions (including careful preparation and physical comfort measures) – could do much to prevent loss of dignity during care activities.

Respondents emphasised privacy during procedures (environmental, bodily and auditory) which might be undignifying, supporting previous research (Gallagher and Seedhouse, 2000; Matiti, 2002; Matthews and Callister, 2004; Ariño-Blasco *et al.*, 2005; Baillie, 2007). Studies have indicated that humanistic caring

approaches promote dignity, including treating patients as human beings (Walsh and Kowanko, 2002; Enes, 2003), holistically (Widäng and Fridlund, 2003), and conveying a caring attitude (McClement *et al.*, 2004). Such approaches are primarily portrayed through interactions and, as in Baillie's (2007) study, respondents emphasised how they used communication to promote dignity during care activities which they identified might have threatened dignity. Respondents emphasised treating patients with empathy (Matthews and Callister, 2002; Enes, 2003), giving time (Söderberg *et al.*, 1997; Walsh and Kowanko, 2002), reassurance (HAS 2000, 1998; Matthews and Callister, 2004; Baillie, 2007), and acting in a professional manner (Widäng and Fridlund, 2003; McClement *et al.*, 2004; Baillie, 2007).

Helping patients to feel in control (through information-giving and explanations, offering choices and seeking consent) has been highlighted in many studies; Matiti (2002) concluded that control impacts on all other aspects of dignity. Facilitating choices and decisions to promote dignity is well supported in previous research (Matiti, 2002; Enes, 2003; Matthews and Callister, 2004; Woolhead *et al.*, 2005; Baillie, 2007) as is providing information and explanations (Lai and Levy, 2002; Enes, 2003; Bayer *et al.*, 2005; Baillie, 2007). Some respondents also emphasised developing relationships with patients; the importance of a trusting nurse-patient relationship to promote dignity has been identified in both adult (Matiti, 2002) and children's wards (Reed *et al.*, 2003). Respondents described enabling independence during care activities where possible, supporting previous research (Matiti, 2002; McClement *et al.*, 2004; Calnan *et al.*, 2005; Baillie, 2007).

Respondents identified a wide range of people who they considered were particularly vulnerable to loss of dignity, mainly because of their health conditions and the care activities then required. While much health policy and previous research has focused on older people's dignity, the survey results indicated that people of all ages and in varied settings could be vulnerable. The respondents thus confirmed that dignity is of wide concern and that dignity in care must be recognised as a high priority for people of all ages and in any health care setting, and is therefore central to all health care professionals' practice.

Initiatives to promote dignity in care are wide and varied, and include new services, practice developments, physical environment enhancements, education, patient/public involvement and privacy measures. No previous study has surveyed UK staff about initiatives to promote dignity, so these results provide valuable information for care organisations and governments. Some initiatives involved teamworking across disciplines and sectors. There are clearly many individual nurses, teams and organisations who are prioritising dignity enhancement in practice. There was evidence that national policies and initiatives, such as *Essence of Care*, dignity champions and protected mealtimes, were being implemented. Some respondents reported written guidelines and policies to support dignity in care, in contrast to previous research which found a lack of written guidance (Calnan *et al.*, 2005; Baillie, 2007).

9.6 Dignity, ethics and nursing

The introduction stated that dignity is a central nursing value appearing, for example, in the NMC Code (2008). The RCN (2008) working definition of dignity emphasises the way people "feel, think and behave in relation to the worth or value of themselves and others." Dignity is, therefore, a self-regarding value where nurses will consider their own worth or value as people and as professionals; in this sense it is central to the individual's self respect and identity (Wainwright and Gallagher, 2008). This can be promoted or diminished by the people nurses work with and by their employing organisation. Dignity is an other-regarding value in that it requires nurses to respect the dignity of others: all patients including those who have or lack capacity; patients' families; colleagues and nursing students; and those who have died.

How respect and disrespect for dignity is demonstrated has been discussed in some detail in this report, for example by staff attitudes and behaviour, by aspects of the physical environment and by the employing organisation. Many respondents suggested that environmental and organisational factors were responsible for indignity in care. There were, however, some views that dignity is a responsibility of individuals and nothing should prevent the delivery of dignifying care. Professional ethics does, for the most part, focus on the actions and on the character or dispositions of individual professionals (dispositional approach). Insights from social psychology (for example, Zimbardo, 2007) in particular have challenged this perspective presenting evidence that individuals may be more influenced by the situations, systems or organisations they find themselves in (situational approach). And even when individual practitioners, through their own strength of character and ingenuity, succeed in retaining dignity in the face of organisational constraints (giving dignified care in the car park if needs be, as one respondent put it) the fact of having to struggle against all the odds is an indication of an organisation that does not place sufficient value on its staff or patients.

Data from this and other reports suggest that professional ethics must accommodate individual responsibility and accountability, as well as the constraining and enabling influences within organisations (Banks and Gallagher – in press). As Reiser (1994) states: "Institutions, like their individual members, have ethical lives and characters." Reiser identifies a range of institutional values (humaneness, reciprocal benefit, trust, fairness, gratitude, service and stewardship, and dignity), and while all of these values are worthy of further discussion it is dignity which is of most interest for our purposes here. Reiser's view is worth quoting in full:

Support for the value of dignity in an organisation declares a respect for the person and the views of individuals, asserts that they have a standing and worthiness as human beings independent of their status in the organisation, and thus protects them against the exercise of undue authority. Emphasising dignity is a stimulus to assure that those affected by policies or actions will have a voice in shaping

46 Defending Dignity

and approving them. This not only protects nursing students, subjects [*research respondents*], and patients, who are more vulnerable to domination than most individuals who work and live within a hierarchical authority, it also elevates the standing of staff, who are shown regard when the organisation asks for their views. This linkage between work and workplace governance, in turn, enhances the effectiveness of the organisation.

Respondents in this study focused, for the most part, on factors that promoted or diminished dignity in relation to patients. However, some respondents did refer to the dignity of nurses and to the need for organisations to demonstrate respect for this. The Healthcare Commission report (2008) found that only 26% of NHS staff felt that their employer valued their work. Dignity in the context of ethics and nursing cannot, therefore, be restricted to staff responses to patients and others, but must also include organisational responses to staff. As one respondent said:

If staff are treated with dignity and respect it follows that patients will as it is part and parcel of the working culture.

9.7 Summary

In summary, the survey's results indicated that while some nurses work in environments which support dignity in care, many others struggle with poor physical and human resources, working for organisations that do not prioritise dignity as highly as they themselves do. In the care activities they carry out, nurses are acutely aware of potential for indignity and are committed to ensuring that dignified care is delivered despite the constraints. There are developments to enhance dignified care in many organisations, but much more needs to be done to support dignified care.

10 Conclusion and recommendations

Findings from the RCN Dignity Survey suggest that there is a high level of dignity awareness and sensitivity amongst respondents and a strong commitment to dignity in care. Respondents expressed concern and frustration in relation to dignity violations. The physical environment, the employing organisation (**places**) and the attitudes and behaviour of other staff and visitors (**people**) were highlighted as having the potential to enhance or diminish dignity in care.

In relation to the organisation, government policies were, paradoxically, identified as contributing to supporting and undermining dignity in care. Policies such as *Fundamentals of Care*, *Essence of Care* and the prison *Decency* agenda were viewed positively as supporting dignifying care practices. On the other hand, NHS targets were identified as having the potential to undermine dignity in care.

A considerable number of respondents stated that they had felt upset or distressed because they were unable to give the kind of dignified care they knew they should. The implications of, what appears to be, moral distress may be significant for individual practitioners and also for health care organisations. Research has shown that although some positive consequences may follow from moral distress, it may also result in nurses leaving the profession, blaming the organisation, avoiding interactions with patients and feeling emotionally exhausted and abandoned (McCarthy and Dedy, 2008). Implications for the organisation may, therefore, include increased complaints, poor staff morale and increased staff turnover. Moral distress, in relation to dignity in care, is an area that warrants further research.

Respondents identified a wide range of care activities (**processes**) which could threaten dignity. The behaviour of staff and others, and organisational issues such as the availability of resources and the physical environment, can increase the likelihood of indignity occurring during some care activities. Respondents identified a range of sensitive and creative initiatives to enhance dignity across diverse care settings. It was therefore evident that despite the many challenges detailed in this report, promoting dignified care is a high priority to many nurses. Not all respondents,

however, felt that dignity was an equally high priority for their employing organisations.

What this report highlights most acutely is that dignity is not just the responsibility of nurses. It is, rather, affected by the behaviour of all staff. At the highest (macro) level, dignity is the business of government. Consideration should be given to the view, arising from the survey, that there is a paradox in relation to health policy. Some policies undoubtedly contribute to the promotion of dignity in care whereas others diminish it. In future discussions with the profession regarding appropriate staffing levels and skill mix it is, in the light of the survey results, important to consider the impact on patient and staff dignity. Respondents were unequivocal in condemning the negative impact of government targets on dignity in care.

Dignity is also the responsibility of employing organisations (meso level). They have a significant role in ensuring that adequate resources are in place, and that the physical environment and culture is respectful of the dignity of patients and staff. At the micro level individual nurses are also responsible for dignity in care. However, they do not and should not have a monopoly on dignity-promotion; rather dignity needs to be viewed as the business of all staff.

This report has detailed findings from the largest survey of members of the UK nursing workforce regarding dignity in care. The commitment of respondents to dignity in care was very evident in the survey as were their concerns about factors that compromise dignity. The physical environment, organisational culture (including the impact of government targets, resources and staffing ratios) and people's attitudes and behaviour, have a considerable impact on dignity in care. Respondents provided many examples of good practice in relation to dignity in care and demonstrated a good deal of sensitivity and creativity in responding to challenges to dignity.

There is, however, no room for complacency. As one respondent stated:

Dignity is a concept that is as unique and individual as each of those in our care. This is why it is essential that those in receipt of care are actively involved in decision making

48 Defending Dignity

in respect of the care they receive. This requires time and I believe that time to care has become almost a luxury and this is the largest obstacle facing us in delivering good quality care with dignity. (Public Health Manager, NHS Trust, Community/Primary Care)

It is appropriate to consider dignity as an objective and universal value in the context of human rights. It is also necessary to consider the subjective dimensions of dignity. Ultimately, dignity in care occurs during the encounter between an individual nurse (or other member of staff) and a particular patient in a particular context. However dignifying the environment or organisational culture might be, without a nurse's sensitivity, humanity and ability to be responsive, dignity in care will not occur.

Recommendations

Powerful as the findings of this survey are, it is only one piece of work in a complex area. Whether they come from a single respondent or from many, the comments are not necessarily a sufficient basis on which to make sweeping generalisations. However, there are some general recommendations and areas for further debate that flow logically from the data.

Macro-level – Role of government

- Consideration of the paradoxical effects of health policy: if government is serious about delivering dignified health care services there must be a serious debate about the impact of targets and other policies on dignity and care.
- A renewed commitment to single sex wards.
- Nurse/patient ratios and skill mix must be appropriate to provide dignified care.
- Nursing and other care staff should be involved in the design of health care environments.

Meso-level – Role of organisations

Employing organisations, higher education institutions, the Royal College of Nursing and other Royal Colleges have an important contribution to make to the development of dignity in care:

- there must be sufficient investment in the physical environment in care settings to demonstrate that staff and patients are valued and respected. This includes ensuring adequate standards of cleanliness and sufficient material resources (equipment, towels, gowns, bed linen) to deliver dignifying care
- organisational cultures and ways of working must make patient care the first priority
- organisations must demonstrate respect for the dignity of staff in tangible ways
- organisations must ensure that training opportunities and materials to promote dignity are available for staff in a user-friendly format
- organisations must develop policies and practices that support dignity in care, including the development of an ethical climate,

organisational values and systems for reporting and whistle-blowing.

Micro-level – Role of individual responsibility and accountability

- Individual 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 regarding their performance.
- Attitudes and behaviours that diminish dignity must be challenged, therefore individuals should know how to influence change and report dignity deficits.
- All health care staff should be aware of the potential to enhance dignity by role modelling.

11 References

- Aiken LH, Clarke SP, Sloane DM, Sochalski A, Silber JH (2002) Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction *Journal of the American Medical Association*, 288, pp.1987–1993.
- Ariño-Blasco S, Tadd W and Boix-Ferrer JA (2005) Dignity and older people: the voice of professionals. *Quality in Ageing*, 6(1), pp.30–35.
- Baillie L (2007) *A case study of patient dignity in an acute hospital setting*. Unpublished thesis. London South Bank University.
- Banks S and Gallagher A (in press) *Ethics in Professional Life: Virtues for Health and Social Care*, Basingstoke: Palgrave Macmillan Ltd.
- Bayer T, Tadd W and Krajcik S (2005) Dignity: the voice of older people, *Quality in Ageing* 6(1), pp.22–27.
- Calna M, Woolhead G and Dieppe P (2005) Views on dignity in providing health care for older people, *Nursing Times*, 101(33), pp.38–41.
- Carter P (2008) Voices, *Nursing Standard*, 22(28), p.26.
- Chief Nursing Officer (2007) *Privacy and Dignity – a Report by the Chief Nursing Officer into Mixed-sex Accommodation in Hospitals*, London: DH.
- Department of Health (2001a) *Essence of Care: Patient-focused benchmarking for health care practitioners*, London: DH.
- Department of Health (2001b) *The National Service Framework for Older People*, London: DH.
- Department of Health (2003) *Whistle-blowing in the NHS policy pack*, London: DH.
- Department of Health (2004) *Standards for Better Health*, London: DH.
- Department of Health (2006) *About the Dignity in Care campaign*. Available from: <http://www.dh.gov.uk> (accessed 22/08/06) (web).
- Department of Health, Social Services and Public Safety (2008) *The review of public administration. Health – the story so far*. Available from: <http://www.dhsspsni.gov.uk/index/hss/rpa-home/rpa-newpage-2.htm> (accessed 01/04/08) (web).
- De Vaus DA (2001) *Surveys in Social Research*, 5th Edition, London: Routledge.
- Enes SPD (2003) An exploration of dignity in palliative care, *Palliative Medicine*, 17(3), pp.263–269.
- Firth-Cozens J, Firth RA and Booth S (2003) Attitudes to and experiences of reporting poor care, *Clinical Governance*, 8(4), pp.331–336.
- Gallagher A and Seedhouse D (2000) *The practical implications of teaching philosophy to practitioners. Dignity: a pilot study*. Unpublished report.
- Health Advisory Service 2000 (1998) *'not because they are old': An independent inquiry into the care of older people on acute wards in general hospitals*, London: Health Advisory Service 2000.
- Healthcare Commission (2007) *Caring for Dignity: A National Report on Dignity in Care for Older People While in Hospital*, Commission for Healthcare Audit and Inspection, London. Available from: http://www.healthcarecommission.org.uk/_db/_documents/Caring_for_dignity.pdf (accessed 23/03/08) (web).
- Healthcare Commission (2008) National NHS staff survey 2007 Commission for Healthcare Audit and Inspection, London.
- House of Commons (2008) *A Life Like any other? Human Rights of Adults with Learning Disabilities*. Available from: <http://www.publications.parliament.uk/pa/jt200708/jtselect/jtrights/40/40i.pdf> (accessed 23/03/08) (web).
- International Council for Nurses (2006) *Code of Ethics for Nurses*, Geneva: ICN.
- Ipsos MORI (2007) *Survey of 2000 Adults conducted between March and April 2007*, London: DH.
- Jacelon CS (2003) The dignity of elders in an acute care hospital, *Qualitative Health Research*, 13(4), pp.543–556.
- Lai CY and Levy V (2002) Hong Kong Chinese women's experiences of vaginal examinations in labour, *Midwifery*, 18(4), pp.296–303.
- McClement SE, Chochinov HM, Hack TF, Kristjanson LJ and Harlos M (2004) Dignity-conserving care: application of research findings to practice, *International Journal of Palliative Care*, 10(4), pp.173–179.

50 Defending Dignity

- Matiti MR (2002) *Patient dignity in nursing: a phenomenological study*. Unpublished thesis. University of Huddersfield School of Education and Professional Development.
- Matiti M and Cotrel-Gibbons L (2006) Patient Dignity – Promoting Good Practice Project. In: Shaw, T. and Sanders, K. (Eds.), *Foundation of Nursing Studies Dissemination Series*, 3(5), pp.1–4.
- Matthews R and Callister LC (2004) Childbearing women's perceptions of nursing care that promotes dignity, *Journal of Obstetrics, Gynaecologic and Neonatal Nursing*, 33(4), pp.498–507.
- McCarthy J and Deady R (2008) Moral Distress Reconsidered, *Nursing Ethics*, 15 (2), pp.254–262.
- Mencap (2007) *Death by indifference*, London: Mencap.
- Mind (2004) *Ward watch*, London: MIND.
- NHS Improvement Scotland (2005a) *Working with dependent older people towards promoting movement and physical activity*, Edinburgh: NHS Improvement Scotland. Available from: <http://www.nhshealthquality.org/nhsqis/2727.html> (accessed 30/05/08) (web).
- NHS Improvement Scotland (2005b) *Working with dependent older people to achieve good oral health*, Edinburgh: NHS Improvement Scotland. Available from: <http://www.nhshealthquality.org/nhsqis/2475.html> (accessed 30/05/08) (web).
- NHS Improvement Scotland (2005c) *Maximising communication with older people who have hearing disability*, Edinburgh: NHS Improvement Scotland. Available from: <http://www.nhshealthquality.org/nhsqis/2776.html> (accessed 30/05/08) (web).
- NHS Quality Improvement Scotland (2005) *Best Practice Statements*. Available from: <http://nhshealthquality.org/nhsqis/2074.htm> (accessed 03/03/08) (web).
- Nåden D and Eriksson K (2004) Understanding the importance of values and moral attitudes in nursing care in preserving human dignity, *Nursing Science Quarterly*, 17(1), pp.86–91.
- Northern Ireland Practice and Education Council 2007, *Review of Essence of Care*, Belfast: NIPEC.
- NMC (2007a) *Introduction of Essential Skills clusters for pre-registration Nursing programmes*, NMC Circular 07/2007.
- Nursing and Midwifery Council (2008) *The Code: Standards of conduct, performance and ethics for nurses and midwives*, London: NMC.
- Ray SL (2006) Whistleblowing and Organisational Ethics, *Nursing Ethics*, 13, pp.438–445.
- Reed P, Smith P, Fletcher M and Bradding A (2003) Promoting the dignity of the child in hospital, *Nursing Ethics*, 10(1) pp. 67–76.
- Reiser SJ (1994) The ethical life of health care organisations, *The Hastings Center Report*, Vol. 24, Issue 6, pp.28–36.
- Richards N and Coulter A (2007) *Is the NHS becoming more patient focused? Trends from the national surveys of NHS patients in England 2002–2007*, Picker Institute, Oxford. Available from: http://www.pickereurope.org/Filestore/Publications/Trends_2007_final.pdf (accessed 23/03/08) (web).
- Rafferty AM, Clarke SP, Coles J, Ball J, James P, McKee M and Aiken LH (2007) Outcomes of variation in hospital nurse staffing in English hospitals: Cross-sectional analysis of survey data and discharge records, *International Journal of Nursing Studies*, 44, pp.175–182.
- Robb B (1967) *Sans Everything: A Case to Answer*, Nelson, London.
- Royal College of Midwives (2005) Dignity and neonatal care. Available from: http://www.rcm.org.uk/results.php?search_rcm=dignity (accessed 23/03/08) (web).
- Royal College of Nursing (2003) *Defining Nursing*, London: RCN.
- Royal College of Nursing (2006) *Policy Guidance: Setting Appropriate Ward Staffing Levels in NHS Acute Trusts*, London, RCN Policy Unit.
- Scottish Government (2006) *Delivering Care, Enabling Health: Harnessing the Nursing, Midwifery and Allied Health Professions' Contribution to Implementing Delivering for Health in Scotland*, Edinburgh: Scottish Government. Available from: <http://www.scotland.gov.uk/Publications/2006/10/23103937/4>
- Seedhouse D and Gallagher A (2002) Undignifying situations, *Journal of Medical Ethics*, 28(6), pp.368–372.
- Söderberg A, Gilje F and Norberg A (1997) Dignity in situations of ethical difficulty in intensive care, *Intensive and Critical Care Nursing*, 13(3), pp.135–44.
- Sundin-Huard D and Fahy K (1999) Moral distress, advocacy and burnout: Theorising the relationships, *International Journal of Nursing Practice*, 5, pp.8–13.

University College London (UCL) *Institute of Child Health Clinical Guidelines*. Available from: <http://www.ich.ucl.ac.uk/search?words=dignity&submit.x=14&submit.y=5> (accessed 23/03/08) (web).

Wainwright P and Gallagher A (2008) On different types of dignity in nursing care: a critique of Nordenfelt, *Nursing Philosophy*, 9, pp.46–54.

Walsh K and Kowanko I (2002) Nurses' and patients' perceptions of dignity, *International Journal of Nursing Practice*, 8(3), pp.143–151.

Welsh Assembly Government (2003) *Fundamentals of care: guidance for health and social care staff*, Cardiff: WAG.

Welsh Assembly Government (2006) *National Service Framework for Older People in Wales*, Cardiff: WAG.

Welsh Assembly Government (2007) *Dignity and Respect in Care*. Cardiff: WAG. Available from: <http://wales.gov.uk/publications> (accessed 23/03/08) (web).

Widäng I and Fridlund B (2003) Self-respect, dignity and confidence: conceptions of integrity among male patients, *Journal of Advanced Nursing*, 42(1), pp.47–56.

Woolhead G, Calnan M, Dieppe P and Tadd W (2005) Dignity in older age: what do older people in the United Kingdom think?, *Age and Ageing*, 33(2), pp.165–170.

Zimbardo P (2007) *The Lucifer Effect: How Good People Turn Evil*, London, Rider.

12 Appendices

Appendix A Scoping Exercise Activities

The scoping for the project has been both purposeful and opportunistic. It has consisted of the following activities:

- Analysis of the findings from three Multidisciplinary focus groups held in 2007 in acute hospital trusts
- Analysis of a survey of 300 pensioners attending the National Pensioners Parliament in May 2007
- Analysis of practice data submitted by RCN members for the RCN evidence submission into the House of Lords enquiry on Human Rights for older people
- Analysis of detailed material developed from RCN internal stakeholders Dignity scoping day in May 2007
- Analysis of written material gathered at congress Dignity fringe in April 2007
- Discussions held with Age Concern in relation to joint work on preparation of nursing students and health care assistants
- Discussions held with City and Guilds
- Discussions held with Help the Aged
- Discussion held with Ian Philp's specialist professional forum
- Exploratory discussion held with Deputy CN for England
- Beginning to map key external UK stakeholders
- Discussions with acute hospital trusts x 2 and major care home provider x 1
- Discussions held with CSIP and the Health Care Commission
- Discussions held with a range of RCN staff.

The RCN internal stakeholders' day, the congress fringe event and a range of conversations with nurses in practice and professional advisers at the RCN generated material which was generic (cross sector and specialty). This material was therefore used to inform the project scope and validated by material generated by the older people specific data. Both generic events sought to understand and share perceptions of dignity in care and to begin the conversation about what is it that the RCN can do to inform and support nursing practice.

Appendix B The Dignity Challenge

<http://www.scie.org.uk/publications/practiceguides/practiceguide09/challenge/index.asp> (accessed 23/03/08)

High quality care services that respect people's dignity should:

1. have a zero tolerance of all forms of abuse
2. support people with the same respect you would want for yourself or a member of your family
3. treat each person as an individual by offering a personalised service
4. enable people to maintain the maximum possible level of independence, choice and control
5. listen and support people 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 as care partners
9. assist people to maintain confidence and a positive self-esteem
10. act to alleviate people's loneliness and isolation.

Appendix C The RCN Dignity Survey

The Royal College of Nursing is about to launch a new campaign on dignity, and we need your help with a special survey that will enable us to understand the issues you face as an individual practitioner with this fundamental aspect of care.

The survey is open to all nursing staff (including nursing students, healthcare assistants and nursing auxiliaries) working in the public, private and voluntary sectors. The questions cover a number of issues including: the education and training you have received on dignity during your career; and the way the environment you work in and the culture of your organisation affects the quality of care you are able to provide.

The survey will take about 15 minutes to complete. But by taking part, you will be helping the RCN to develop a series of resources that can be used by frontline nursing staff like yourself to raise awareness of this issue with your teams and colleagues, and support the care you provide.

All answers to this survey will remain anonymous. Please answer the questions as honestly as possible.

Thank you for taking part.

RCN Definition of Dignity

The working definition of dignity that underpins the RCN Dignity Campaign is described below:

Dignity is concerned with how people feel, think and behave in relation to the worth or value of themselves and others. To treat people with dignity is to treat them as being of worth, in a way that is respectful of them as valued individuals.

In care situations, dignity may be promoted or diminished by: the physical environment; organisational culture; by the attitudes and behaviour of nurses and others and by the way in which care activities are carried out. When dignity is present people feel in control, valued, confident, comfortable and able to make decisions for themselves.

When dignity is absent people feel devalued, lacking control and comfort. They may lack confidence and be unable to make decisions for themselves. They may feel humiliated, embarrassed and ashamed.

Dignity applies equally to those who have capacity and to those who lack it. Everyone has equal worth as human beings and must be treated as if they are able to feel, think and behave in relation to their own worth or value.

Nurses should, therefore, treat all people in all settings and of any health status with dignity, and dignified care should continue after death.

Questionnaire

- Q1** Which Country or English region do you work in?
- Q2** Which of the following best describes your employer?
- Q3** Which of the following best describes your job?
- Q4** Which of the following patient/client groups do you have contact with as part of your practice?
- Q5** (For Registered Nurses Only) Where did you qualify as a registered nurse?
- Q6** (For Registered Nurses Only) In which decade did you qualify as a registered nurse?
- Q7** How many years have you worked as a Registered Nurse or Healthcare Assistant/Nursing Auxiliary?
- Q8** Which of the following qualifications do you have? (Tick all that apply)
- Q9** Part A During your initial training/education to become either a Registered Nurse or Healthcare Assistant/Nursing Auxiliary, were you taught or do you remember learning about dignity?
- Q9** Part B (For people who answered 'Yes' to Part A only) In that case, where or how did you learn about dignity during your initial training/education?
- Q9** Part C (For people who answered 'Yes' to Part A only) How much did this initial training/education influence your understanding of dignity and your professional practice?
- Q10** (All) Since becoming a Registered Nurse or Healthcare Assistant/Nursing Auxiliary, how have you developed your understanding of dignity?
- Q11** Name the one thing that has influenced your understanding of dignity the most.
- Q12** What things about the physical environment you work in help you to maintain, promote and deliver dignified care?
- Q13** Next, what things about your physical environment prevent you from maintaining, promoting and delivering dignified care?
- Q14** And finally in this section, what things about your physical environment need to change to help you maintain, promote and deliver dignified care in a more effective way?

54 Defending Dignity

- A** My organisation prioritises dignity as a philosophy of care in its policies and procedures and in its services for patients/clients
- B** My team prioritises dignity as a philosophy of care in the way it cares for patients/clients.
- C** I would feel comfortable challenging any policy or action of my organisation that I felt compromised the dignity of my patients/clients.
- D** I would always challenge a colleague who compromised a patient/client's dignity.
- E** I would be happy for a close relative to be a patient of my organisation, knowing that he or she would receive dignified care.
- F** In my organisation, all patients/clients who are able are fully involved in decisions about their care.
- G** I always leave work knowing I have been able to give my patients the quality of dignified care I would wish.

Q16 What things about your organisation help you to maintain, promote and deliver dignified care?

Q17 What things about your organisation prevent you from maintaining, promoting and delivering dignified care?

Q18 And finally, what things about your organisation need to change to help you maintain, promote and deliver dignified care more effectively?

Q19 Thinking about your practice, how would you rate the dignity of care you give to your patients/clients?

Q20 On a scale of 1 to 6, how important is the dignity of your patients/clients to you as an individual practitioner? 1 = Not very important; 6 = Extremely important

Q21 On a scale of 1 to 6, how important is the dignity of your patients/clients to the organisation you work for? 1 = Not very important; 6 = Extremely important

Q22 Do you have enough time to devote to the dignity of your patients/clients as part of your daily routine?

Q23 On a scale of 1 to 6, how much priority can you give to the dignity of your patients/clients as part of your daily routine? 1 = Low priority; 6 = High priority

Q24 On a scale of 1 to 6, how much priority would you like to give to the dignity of your patients/clients as part of your daily routine? 1 = Low priority; 6 = High priority

Q25 Do you ever feel upset or distressed because you are unable to give the kind of dignified care you know you should?

Q26 Please describe a care activity you undertake with your patients/clients that, because of the type of procedure or condition of the patient, is most likely to lead to a loss of dignity.

Q27 Now, please describe the steps you take to minimise the loss of dignity with that particular care activity.

Q28 And finally, please describe one initiative in your own area of practice that promotes the dignity of service users and/or nurses.

Q29 What sex are you?

Q30 What is your age?

Q30 How would you describe your ethnicity?

Appendix D

Care activities which potentially compromise dignity

Activity group	Specific procedures
Support with hygiene and dressing	Bed-bathing Bathing Showering Shaving Dressing Last offices
Support with elimination	Bedpan/commode Taking patient to the toilet Dealing with incontinence Urine sampling/testing Changing nappies Stoma care Urine output measurement
Support with nutrition	Meal-times and assisting with eating Naso-gastric/percutaneous endoscopic gastrostomy (PEG) feeding Breast feeding support
Communication	Personal/sensitive discussions Telephone assessment/information giving Needs assessment Ward rounds Discharge planning Facilitating group work/family therapy Cognitive assessment/Mini-mental examination Case conferences/multi-agency review Delivering unwelcome news Discussing diagnosis and management, including end of life issues Counselling
Intimate procedures/examinations	Urethral catheterisation/removal of catheter/catheter care Urological procedures (eg, bladder scan) Application of urinary sheath Cervical smear screening Childbirth Bowel preparation Breast examination Digital rectal examination/stimulation Manual evacuation of faeces Vaginal examination/removal of foreign body/swab Administration of enemas/suppositories (including barium enemas) Intra-uterine insemination Continence assessment Post surgery checks: gynaecological, urological, breast surgery Genitalia examination Breast prosthesis fitting

56 Defending Dignity

Activity group	Specific procedures
	<ul style="list-style-type: none">Fitting of intra-uterine contraceptive deviceSexual health screening: genital samples, examinationsInsertion of vaginal ring pessaryRemoving vaginal packChecking vaginal lossPerineal examinationErectile dysfunction investigation
Invasive/technical procedures	<ul style="list-style-type: none">Suctioning tracheostomiesConnection to haemodialysis or peritoneal machine via tunnelled catheterNaso-gastric tube insertionDrainage carePlaster changeIntravenous cannulation and venepunctureLumbar punctureWound dressing (particularly of intimate body areas: pilonidal sinus, colorectal, thoracic, sacral ulcer, genitalia, penile abscess, groin, abscess on buttock, peri-anal)Airway management/intubationEndotracheal suction/airway removalChest drain insertion and removalEye treatmentsHead lice treatmentFemoral arterial line insertionCentral venous cannula insertion, care and removalInsertion and removal of monitoring linesShaving of groin prior to procedures and fitting haemostatic device to groin
Exposing procedures	<ul style="list-style-type: none">Examining femoral access for dialysisInspection of insulin injection sitesMRSA swabbingPhototherapyUltrasound scanAccessing indwelling devicesPre angiogram assessmentBone marrow aspirationElectrocardiogramAssessment of skin surfacesChecking for BCG scarTeaching self-injecting (on thigh)Physical examination requiring undressing eg. chest examination, abdominal examinationMole screeningUndressing for minor surgical procedureAnkle brachial pressure measurementUndressing for measurementsAssessing hip joint movementWearing operation gownExposure for skin healing (eg. infected eczema, nappy rash)

Activity group	Specific procedures
Medical procedures	<p>Surgery (examples: medical termination, embryo transfer, breast surgery, breast augmentation, urethroplasty, cosmetic procedures, removal of retained placenta, gynaecological surgery)</p> <p>Femoral angiographies</p> <p>Prostate biopsies</p> <p>ERCPs</p> <p>Cardiac: cardioversions, pacemaker, coronary angioplasty/angiogram</p> <p>Source isolation</p> <p>Laser treatment for varicose veins</p> <p>Investigations: colonoscopy, sigmoidoscopy, cystoscopy, endoscopy, colposcopy, prostatic biopsy, transvaginal ultrasound scanning</p>
Medicine administration	<p>Immunisation</p> <p>Chemotherapy</p> <p>Intramuscular injections including depots</p> <p>Oral medication (including observation of ingestion)</p> <p>Nebuliser administration</p> <p>Intravenous medicine administration and infusion</p> <p>Subcutaneous injection, including insulin</p> <p>Contraceptive injection</p> <p>Administration of controlled drugs</p> <p>Topical applications: skin creams</p> <p>Emergency contraception</p> <p>Supervised pharmacy visit</p> <p>Blood transfusion</p>
Moving and handling	<p>Transfers in corridors</p> <p>Hoisting: from floor following fall, to bathroom from bedside areas, onto toilet, in and out of bed, into bath, in bays, in lounge areas</p> <p>Transfer from trolley to operating table and back</p> <p>Moving patients in bed</p> <p>Transfers from bed to shower trolley</p> <p>Transfer onto shower chair</p>
Physical health check	<p>Weighing</p> <p>Food diary examination</p> <p>Spirometry</p> <p>Specimen collection (eg. urine, sputum)</p> <p>Company medical</p> <p>Pre-operative screening</p> <p>Health check/assessment</p> <p>Well woman/well man screening</p> <p>Sexual health screening</p> <p>Tuberculosis screening</p> <p>Breast self awareness</p> <p>Pregnancy test</p> <p>Drug screening</p>

58 Defending Dignity

Activity group	Specific procedures
Emergency care	Resuscitation, including defibrillation Care of patient with sudden illness (eg. collapse) Dealing with drug reaction Injury on sports field Seizures: administration of emergency medication, rectal diazepam Patients with multiple trauma
Admission/transfer/discharge /appointments	Transfers between wards Emergency admission Discharge planning (particularly end of life, complex discharge) Moving patient within ward Transfer to care home Transfer to other departments Clinic attendance Initial assessment Day case admission
Mental health care	Seclusion and locked environment Mental health risk assessment Admission to mental health ward Sectioning under Mental Health Act and care of detained patients Maintaining safety Physical restraint Mental health care for prisoners Observation (eg. for person with suicidal thoughts, /self harm/risk of absconding) Drug screening Escorting patients with delusions and behavioural problems in public Night security check of bedrooms De-escalation of agitated patients Mental health triage assessment Personal management of violence and aggression Dealing with disinhibition Assessment of older person with mental health needs Dealing with psychological distress/crisis Rapid tranquillisation Substance misuse assessment Dealing with young people with mental health problems Identification of psychological treatment following assessment

Notes

60 Defending Dignity

Notes



June 2008

Published by the
Royal College of Nursing
20 Cavendish Square
London
W1G 0RN

020 7409 3333

RCNONLINE
www.rcn.org.uk

RCNDIRECT
www.rcn.org.uk/direct
0845 772 6100

*The RCN represents nurses and nursing,
promotes excellence in practice and shapes health policies.*

Publication code 003 257