

TITLE

Student nurses' perceptions of dignity in the care of older people

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AUTHORS

Leah Macaden^{1*}

Lecturer

Richard G Kyle²

Reader

Wayne Medford³

Research Fellow

Julie Blundell⁴

Professional Doctorate Student

Sarah-Anne Munoz⁵

Senior Lecturer

Elaine Webster⁶

Lecturer

AFFILIATIONS

¹ Faculty of Health Sciences & Sport, University of Stirling (Highland Campus), UK

² School of Health & Social Care, Edinburgh Napier University, UK

³ School of Medicine, Pharmacy & Health, University of Durham, UK

⁴ Professional Doctorate Student in Health & Social Care, Anglia Ruskin University, Cambridge, UK

⁵ Division of Health Research, University of the Highlands and Islands, UK

⁶ Centre for the Study of Human Rights Law, University of Strathclyde, UK

*** Corresponding author:**

Faculty of Health Sciences & Sport, University of Stirling (Highland Campus)

Centre for Health Science, Old Perth Road, Inverness, IV2 3JH.

Email : leah.macaden@stir.ac.uk

Telephone : +44(0)1463 255641

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Abstract : Background: Dignity lies at the heart of nursing practice, yet evidence suggests that healthcare professionals feel inadequately prepared to deal with challenges around delivering dignity in care and struggle to understand what it means to 'respect human dignity'. Objectives: To examine the factors that student nurses considered promote and inhibit the practice of dignity in the care of older adults. Design: Mixed-methods research design using a questionnaire survey and focus groups. Participants: Student nurses at two university campuses in Scotland who completed an online questionnaire (n=111; response rate 37%) and participated in focus groups (n=35). Results: Students most frequently equated dignity in care with being heard, involvement in decision-making, and ensuring privacy. Four inter-related factors were found to inhibit dignity in care, including environmental, organisational, professional and personal dimensions. Student nurses more easily understood the practical outworking, than the more theoretical aspects, of the idea of dignity. Conclusions: Dignity education needs to occupy a more prominent position in pre registration nursing programmes. This will ensure that students can maximise the learning opportunities afforded by movement between clinical and classroom settings to consider both theoretical and practical aspects of dignity in care.

INTRODUCTION

Respect for human dignity lies at the heart of nursing. Commitments to maintain dignity in care feature prominently in the codes of nursing practice of professional regulators around the world (The International Council of Nurses, 2012). For example, the Code of Ethics of the Nursing and Midwifery Council (NMC) – the professional regulator in the United Kingdom (UK) – states that a nurse must “treat people as individuals and uphold their dignity” (Nursing and Midwifery Council 2015). In their day-to-day practice nurses recognise that maintaining dignity is essential to form those therapeutic relationships with individuals experiencing injury or illness that are most conducive to individuals’ healing (Clucas, Chapman 2014). Moreover, nurses – almost intuitively – understand that the daily outworking of dignity is in treating people with kindness, respect and compassion, with effective delivery of the fundamentals of care, all the while recognising diversity and an individual’s choices and, ultimately, upholding their human rights (The International Council of Nurses, 2012).

When care fails to meet these prescribed standards it is, then, often nursing that is found wanting – and changes to nurse education are considered part of the proposed remedy (Darbyshire, McKenna 2013) (Local Government Association 2013). For example, in his report into care failures at Mid-Staffordshire National Health Service (NHS) Foundation Trust (Francis 2013), Robert Francis noted that the current university based model of training does not focus enough on the impact of culture and caring and recommended an increased focus in nurse training, education and professional development on the practical elements of delivering compassionate care. Moreover, an earlier report of the independent Commission on Improving Dignity in Care, set up in 2011 after a series of care failures involving older

adults in hospitals and care homes (Parliamentary and Health Service Ombudsman.

September 2011), recommended that:

“Student nurses, medical students and other trainee health professionals need to have dignity instilled into the way they think and act from their very first day. Universities and professional bodies must ensure that all aspects of their education and training programmes reinforce the provision of dignified care.” (Commission on Improving Dignity in Care, 2012: 35)

International evidence confirms that health care professionals feel inadequately prepared to deal with challenges around delivering dignity in care (Matiti, Baillie 2011),(Woogara 2004), (Wilson, Hopkins-Rosseel et al. 2012) and suggests that nurses of all educational and career levels struggle to understand what it means to ‘respect human dignity’ (Kalb, O’Conner-Von 2007). This paper emerges from a study that aimed to better prepare student nurses to understand the concept and practice of human dignity (in care) by co-designing dignity education with a cohort of student nurses in a Scottish University. We have reported elsewhere how this co-design process revealed that student nurses perceived human dignity to be embodied, shifting and fragile (Munoz, Macaden et al. 2017) and that there is a risk that effort expended in learning dignity through experimental and experiential educational approaches could be unlearned through negative practice exposure (Kyle, Medford et al. (Under Review)). In this paper we use the care of older adults as a lens through which to examine the factors that students considered promote and inhibit the practice of dignity in care and assess whether the values attributed to human dignity by professional regulators reflect student nurses’ understandings of human dignity. Hence, this paper aims to inform on-going scholarship

around the outworking of dignity in care and development of professional and educational standards that support nurses' practice both in the UK and internationally.

BACKGROUND

Despite its increasing ubiquity as an underpinning principle of contemporary healthcare provision, dignity is an inherently difficult concept to define. Occupying a foundational place within international human rights law, understanding violation of dignity seems intuitive and witnessing such violation arguably motivates us to care about, and seek to promote, dignity in the first place (Kaufmann, Neuhäuser et al. 2011). The term 'dignity' is derived from the Latin 'dignitas' meaning worth (Clark 2010) (Mairis 1994) whilst the Oxford English Dictionary (2002) defines it as "the state or quality of being worthy of honour or respect". Despite this concise definition, dignity is a complex concept, with little agreement around its definition (Clark, 2010), (Fenton, Mitchell 2002) (Kalb, O'Conner-Von 2007) (Enes 2003). Dignity is inclusive of physical, emotional and spiritual comfort with each individual valued for their uniqueness in addition to facilitating choice, control and decision-making alongside enabling someone to do their best with their capabilities (Fenton, Mitchell 2002). Scholars from a range of disciplinary perspectives have put forward a plethora of models and ways of thinking about dignity – its origins, its character, its various dimensions and, of course, its implications in practice (for a succinct overview of different ways of thinking about dignity see (Jacobson 2007). Research in the health context has contributed understandings of individual experiences of dignity, including from the perspectives of care recipients (van Gennip, Pasman et al. 2013), relatives (Skorpen, Rehnsfeldt et al. 2015), nurses (Sabatino, Kangasniemi et al. 2016), and student nurses (Papastavrou, Efstathiou et al. 2016). Student nurses arguably provide a unique and under-investigated perspective on the problems and possibilities of promoting dignity in care in healthcare systems. Educational programmes in the UK and elsewhere involve students

shuttling between the classroom and clinical setting, taking and translating theory from the campus to the practice of contemporary healthcare. Student nurses are therefore ideally placed to cast light on the barriers that might exist to promote dignity in care as well as the ways in which their understandings of dignity are shaped by exposure to practice settings.

METHODS

Study design

Reflecting the interdisciplinary composition of the research team, inclusive of researchers with expertise in nursing education, human rights law and the design and delivery of participatory research, the study used a mixed-methods research design.

Data collection

Data were collected from undergraduate nursing students in a Scottish university through an online self-reported questionnaire and focus groups.

Online Questionnaire Survey

All current students on the three year undergraduate nursing programme (n=303) were invited to participate in an online questionnaire survey delivered using Bristol Online Survey (BOS) (University of Bristol. 2015); 111 (36.6%) students completed the questionnaire. The questionnaire included 12 items focussing on students' understanding of dignity with responses to statements on the questionnaire ranging from 'Strongly Disagree' to 'Strongly Agree' using a five point Likert scale.

Focus Groups

Three focus groups were conducted, involving a total of 35 students from each year of the three-year undergraduate programme at the University (Year 1: n=13; Year 2: n=9; Year 3: n=13). Students worked in 3-4 mini focus groups (Krueger, Casey 2014) with 3-4 students in

each group with individual moderators. Data from the mini focus group discussions were recorded on flip charts and then aggregated through plenary discussion to an agreed set of common themes. Questions used to guide the focus group discussion were:

1. What is your understanding of dignity?
2. What are some of the factors that promote or inhibit dignity in the care of older adults?

Data analysis

Quantitative questionnaire data were analysed using descriptive statistics using SPSS (v.19). Qualitative data from the flip charts were analysed thematically for each of the three cohorts by two of the researchers (LM & JB) and then integrated across the cohorts to identify common themes. The integrated analysis is presented in this paper.

Ethics

This study was reviewed and approved by the School Research Ethics Committee (SREC) of the University. All students provided written informed consent prior to questionnaire completion and focus group participation.

RESULTS

Sample

Nine in ten questionnaire respondents were female (91.0%) and in the adult nursing field of practice (87.4%), and half (54.1%) were aged 18-24 years, reflecting the profile of the nursing programme in the institution (Table 1). Four in ten (40.5%) students had care experience prior to entering their undergraduate programme.

Understandings of dignity in care

Most students interpreted the meaning of dignity for themselves as including the right to be heard (94.7%), the ability to make choices (93.6%), privacy (91.5%), having one's own identity (90.4%), being valued by other people (88.3%), having the freedom to express one's beliefs and opinions (86.2%) and valuing oneself (80.9%) (Figure 1). Most students disagreed that dignity was dependent on factors such as gender (83.0%), age (76.6%), language spoken (78.7%), occupation (75.5%), cultural (74.5%) and religious beliefs (73.4%) (Fig 2).

Students were then asked to agree or disagree with five statements to gain insight into how they understood the concept of dignity when expressed in language frequently used in the professional codes that guide their practice (Figure 3). Ranked by the extent to which students agreed, dignity expressed as 'supporting patients to make decisions about their own care' was the most commonly agreed with statement (89.4%) followed by a belief that 'respect for oneself translates into respect for others' (72.3%). This was corroborated in focus group discussions during which the theme of 'freedom of choice' and 'promoting autonomy' emerged as important aspects of the concept of dignity and the practice of dignity in care. For example, students in the first year of their programme interpreted dignity being synonymous with respect, privacy, patient-centredness, empathy, autonomy, being non-judgemental and non-discriminatory, and feeling secure and valued; arguably adopting more theoretical language common in classroom discussion and prescribed codes of practice. Students with more experience of practice as student nurses in their second and third years shared their understanding of dignity in general and professional terms. In general terms, they perceived dignity to be linked to having freedom and choice to make their own decisions. In nursing terms, dignity meant that nurses had a strong sense of self-awareness, a caring attitude,

empathy, compassion and understanding, and consideration for peoples' preferences that facilitated choices and promoted autonomy for others (patients).

Strikingly, when asked to reflect upon more theoretical aspects of dignity, the number of students who were unsure was sizeable. For example, 31.9% of students were unsure about whether a 'breach of one's human rights is a breach of one's dignity', 26.6% were unsure whether 'human dignity is inherent', and a smaller but still notable proportion of students (19.1%) could not decide whether 'dignity is something that different people have in different measure' (Fig 3).

Promoters of dignity in the care of older adults

Students attending focus groups were united in their views about the caring qualities such as compassion, understanding, empathy, enhancing self-esteem, making people feel valued and acknowledging individual preferences as factors that facilitated the promotion of dignity in the care of older adults. Mirroring the terms students considered were synonymous with the concept of dignity itself, dignity in care was facilitated by being non-judgemental, non-discriminatory, respecting peoples' beliefs, facilitating their choice and autonomy and maintaining confidentiality.

Inhibitors of dignity in the care of older adults

Four overarching themes captured the range of barriers to the promotion of dignity whilst caring for older adults: organisational; environmental; professional and personal barriers (Figure 4). *Environmental barriers* centred on the layout of hospital wards, rather than consideration of promotion of dignity in community settings, perhaps reflecting an underlying perception of the hospital as a public space in comparison to the private space of individuals' homes where much of the work of district and community nurses is delivered.

Conversely, the lack of communal spaces for individuals to express themselves and connect with others was considered by students to inhibit dignity in care (settings). *Organisational barriers* included three sub-themes around resources (financial, training and personnel), increased bureaucracy taking time away from front-line care, and particular cultures within specific clinical environments. *Professional barriers* pointed to changes in the nature of nursing roles and work that students considered were not conducive to promoting dignity in care. Three sub-themes were identified: nursing work (including shifts to task-focussed rather than person-centred care, and time constraints); judgements (including stereotyping, discrimination and ageism as a specific form of discrimination); and a lack of individualisation in care leading to a perceived ‘one size fits all’ approach. *Personal barriers* focussed on the specific attitudes held by individuals (which may have been shaped by practice exposure) including prejudice, behaviours, including a lack of respect and communication skills, and emotions, specifically emotional fatigue which may serve as a barrier to dignity in care.

DISCUSSION

Students in our study most frequently equated the practice of upholding dignity with listening to individuals and involving them in decision-making. Discourses of person-centred care that thread through contemporary healthcare were therefore woven into students’ discussions. Students often shared a belief that the outworking of dignity was located in the relationships between themselves and older adults in their care, echoing the language of codes of practice that require nurses to ‘uphold’ dignity through their actions and advocacy on behalf of patients (Nursing and Midwifery Council 2015). Our study therefore confirms the findings of (Baillie, Cox et al. 2012) that highlighted the importance of being heard to the promotion of dignity and the work of (Randers, Mattiasson 2004) that emphasised how dignity rests in

individuals' abilities to make choices about their care. However, students also noted challenges such as poor communication, inadequate information while obtaining consent, and lack of opportunities for patients to be heard in practice that hindered listening and shared decision-making, potentially leading to a perceived lack of dignity in care (Mangset, Erling et al. 2008)(Matiti, Trorey 2008). Lack of privacy was noted as a key inhibitor of dignity in care (Dwyer, Andershed et al. 2009). Having privacy was the third most frequently noted statement that students equated with dignity in care in our study. In subsequent focus groups, students across all three cohorts shared the same scenario to illustrate this point: ensuring curtains around beds were completely drawn, with the patient covered adequately and the placement of a 'do not disturb / personal care in progress' sign while attending to individuals' personal care needs, which was often forgotten in practice. Moreover, students also expressed major concerns over the layout of the ward environment (Tadd, Hillman et al. 2011) with four or more beds in each bay with only curtains between them. Confidentiality in discussion between patients and healthcare staff during medical rounds or consultations could often not be maintained, potentially compromising dignity in care. Hence, a balance must be struck between enabling older adults to engage with others to prevent social isolation, ensuring that they are heard (Baillie, Cox et al. 2012) in a confidential environment and involved in decisions about their care. Moreover, alongside these potential environmental inhibitors, students pinpointed organisational and professional factors that in combination required to be balanced to ensure that dignity was enacted in each care encounter with older adults. This further emphasises the relational understanding of dignity that emerged through our discussions with students.

Yet, while the practice of upholding dignity in care appeared to be grasped by students in our study, when turning to the more theoretical aspects of dignity as a concept, grey areas opened

up. For example, around a third of students were unsure whether a breach of human rights was equivalent to a breach of human dignity and around a quarter could not decide whether dignity was an inherent human quality. Our study therefore suggests that space should be created in curricula and campuses to enable student nurses to grapple with the concept of dignity and how it relates to dignity in care. Students often noted a disparity between witnessing something different in practice to what was taught in the classroom which presented professional dilemmas for students and left them feeling disillusioned and disempowered, and often attributing 'poor practice' to individuals rather than structural constraints within which individuals worked. Equipping student nurses to negotiate the careful set of interlocking factors that promote or inhibit dignity in care routinely encountered in practice arguably requires students to be able to engage more deeply with the concept of dignity through theoretical engagement and to relate this conceptual learning to the contexts of practice. Hence, echoing calls from others (Matiti 2015) our study concludes that dignity education needs to find an established place in pre-registration nursing curricula and, indeed, continuing professional development to ensure that dignity is practically upheld and theoretically understood, to ensure that healthcare professionals do feel adequately prepared to deal with challenges around delivering dignity in care and understand what it means to respect human dignity.

Strengths and Limitations

Our study has cast light on student nurses' views of promoters and inhibitors of dignity in the care of older adults. In so doing, it harnesses students' unique perspectives as they straddle the worlds of education and practice, and hence is a timely intervention into debates around how to maintain dignity in care. Our research does, however, have two main limitations. First, the experiences and attitudes of participants in this study may not necessarily reflect the wider

student nurse population in Scotland or elsewhere. Second, the questionnaire response rate was relatively low (37%). Findings may not therefore be representative of the three cohorts of nursing students in this institution, and may be prone to selection bias, as those most interested in the concept and practice of dignity in care may have been more likely to complete the questionnaire and participate in subsequent focus groups. Further research across educational institutions is therefore required to discern whether dignity in the care of older adults is interpreted by other cohorts in different ways, perhaps reflecting differences in educational programmes, practice experience or personal characteristics.

CONCLUSION

Students in our study most frequently equated dignity in care with being heard, involving older adults in decision-making, and ensuring their privacy. Students identified a set of four inter-related factors that were perceived to inhibit dignity in care, including environmental, organisational, professional and personal dimensions. Importantly, our study also revealed that dignity's practical outworking was more easily understood by student nurses than more theoretical aspects of the concept of dignity. Dignity education therefore needs to occupy a more prominent position in pre-registration nursing programmes to ensure that students can maximise the opportunities presented by the process of shuttling between the classroom and clinical settings during their learning which enable them to loop practical reflections into theoretical discussion, and vice versa.

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Figure 1: Dignity to me is (n=111)

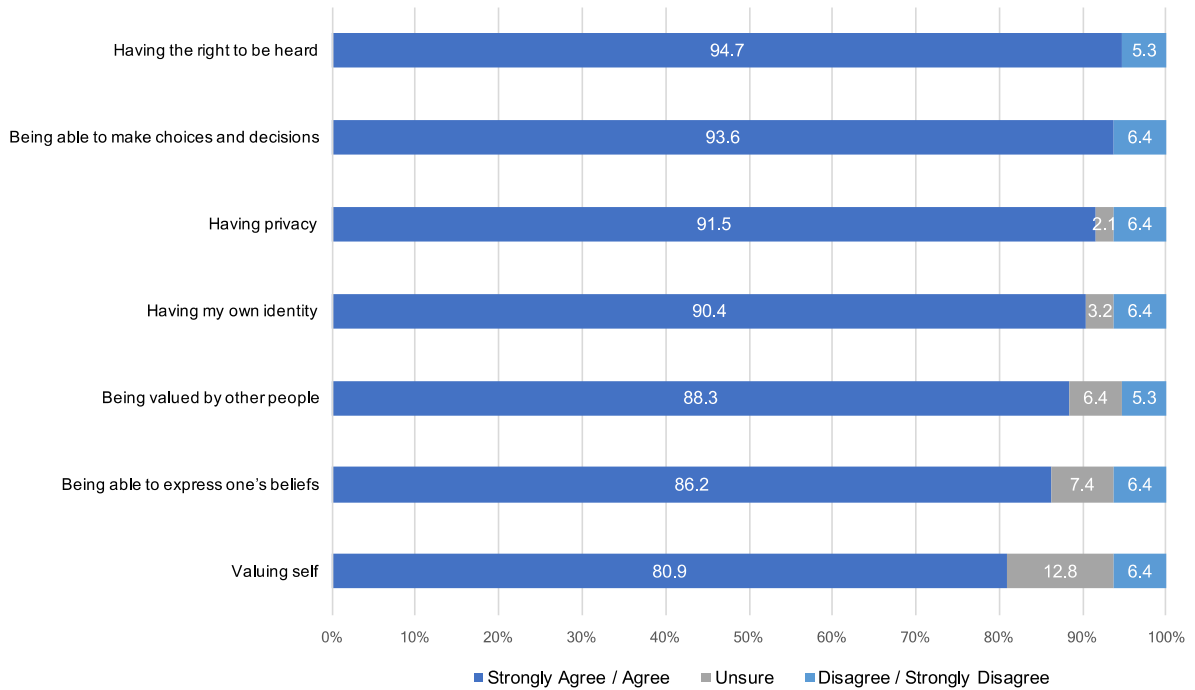


Figure 2: Dignity is dependent on (n=111)

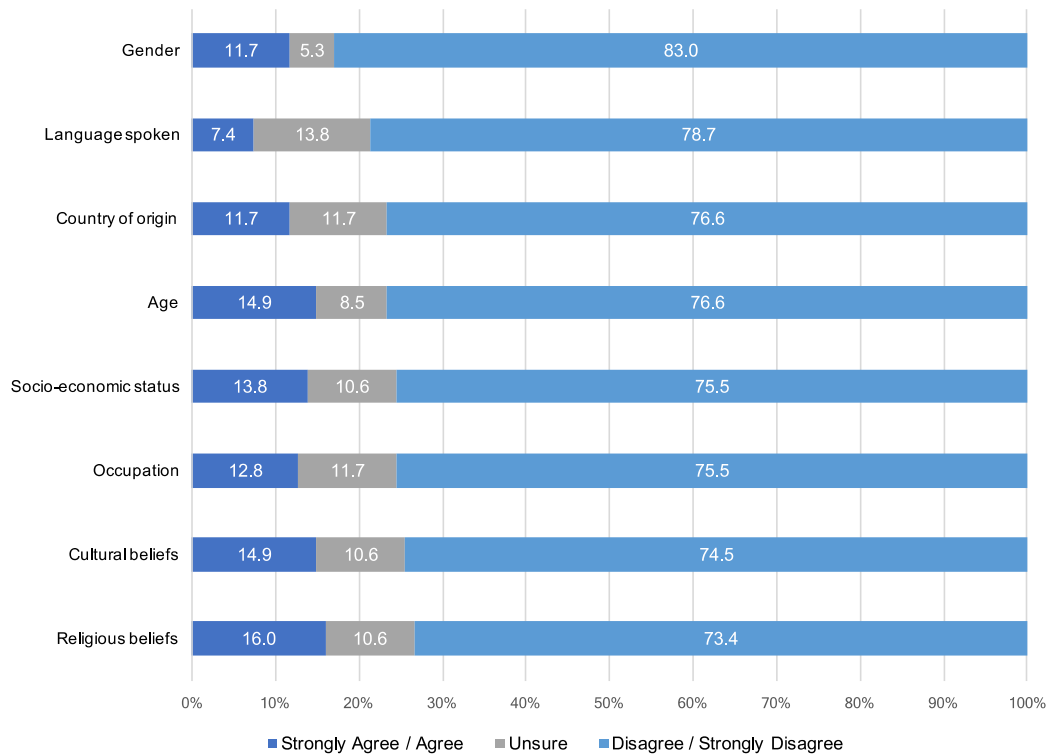


Figure 3: Perceptions / Insights on Dignity (n=111)

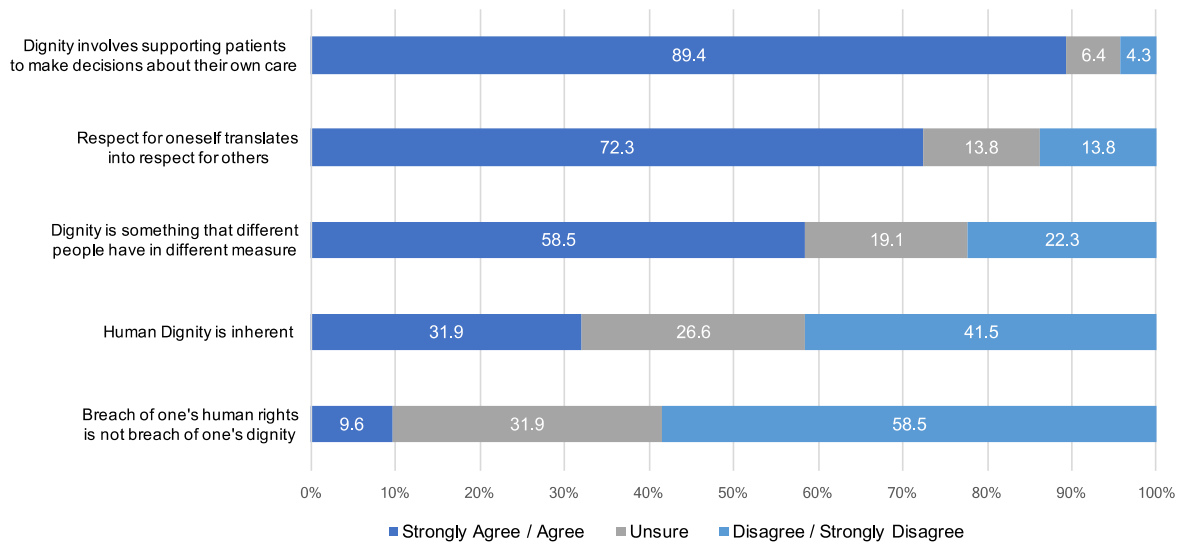
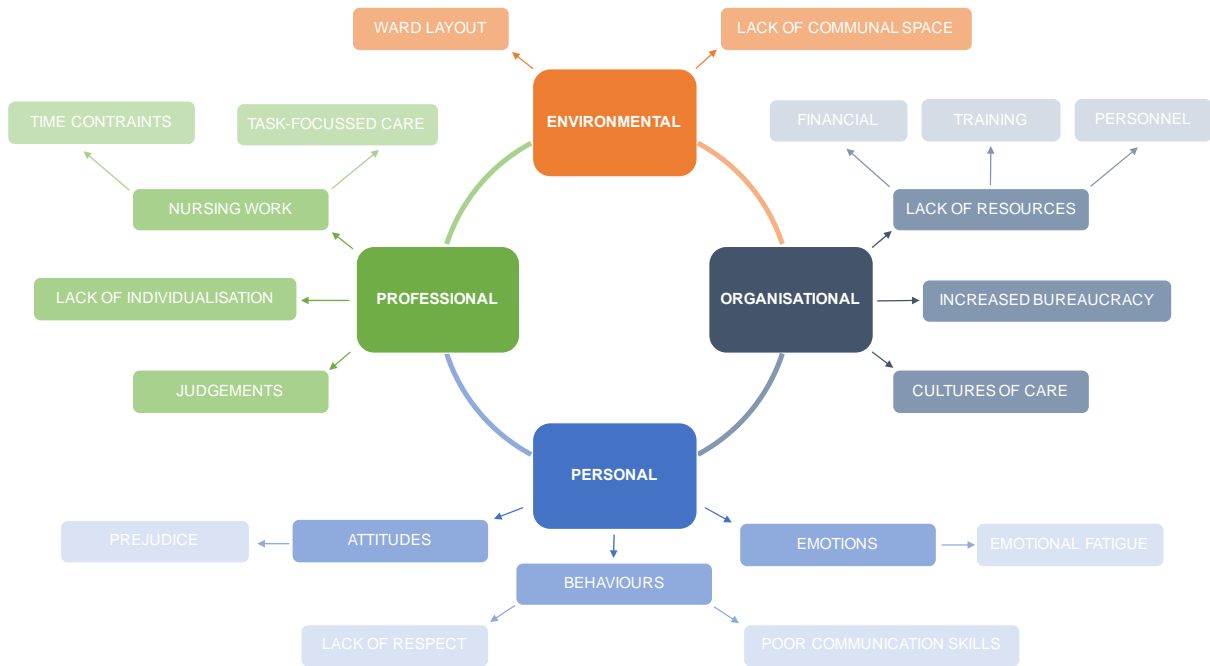


Figure 4: Factors that inhibit dignity in care



TABLES

Table 1: Survey Participant characteristics

	%	n
Gender		
Female	91.0	101
Male	9.0	10
Age		
18-24	54.1	60
25-29	16.2	18
30-39	18.0	20
40-49	9.0	10
50-59	2.7	3
Year of study		
1st	44.1	49
2nd	14.4	16
3rd	41.4	46
Field of practice		
Adult	87.4	97
Mental Health	12.6	14
Previous care experience		
Yes	40.5	45
No	59.5	66