



Patient Dignity – Promoting Good Practice

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April 2004 – April 2005 (end of first year of three year programme)

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Summary of project

The Patient Dignity programme started in April 2004 and is planned to continue into 2007. This report will describe the programme and identify the outcomes and learning from the first year. The programme consists of workshops for both qualified and non qualified staff and follow up support for those members of staff who choose to promote a change in practice. The philosophy that underpins the programme is based on the normative-re-educative change strategy. In the first year, 95 staff in four hospitals across the United Lincolnshire Hospitals Trust accessed Patient Dignity – Promoting Good Practice workshops and 25 chose to develop their own project to promote good practice.

Background

This programme was set up as result of doctoral research which had been conducted in three hospitals (Matiti, 2002). The aims of the research were to identify how patients and nurses perceived patient dignity, to investigate the extent to which patient dignity was maintained and identify nursing care activities in maintaining patient dignity. The implications for nursing education and development of policy on clinical practice were also examined. A number of positive issues emerged as a result of this research but some negative issues were also raised. These included a lack of resources e.g. faulty curtains, and a lack of knowledge and skills amongst some nurses. Nurses and patients identified the need for further updates for staff.

Aim of the programme

The aim of the programme is to raise awareness of and encourage active involvement of nurses, midwives and health care support workers in the promotion of patient dignity. It consists of several components:

- Workshops
- Follow-up support
- Sharing good practice days

The philosophy underpinning the programme is based on the normative-re-educative change strategy (Keyser and Wright, 1998). This strategy supports the idea that people need to be involved in the change process and that the culture within which people work affects the change process. The power to make changes lies with the participants and the role of the project leaders/facilitators outside of the workshop is led by the participants. This approach links to participating and delegating leadership styles as identified by Keyser and Wright (1998).

Outline of workshops

The initial plan was to run half day workshops for qualified nurses and health care support workers. These were to explore the concept of dignity and discuss skills required to promote dignity. This plan was then revised to include the opportunity for each member of staff to develop an action plan on an aspect of patient dignity that they wanted to develop in their own practice. It was felt that this would extend the influence of the workshops from the classroom into practice. An outline of the workshops is given in Table 1.

Table 1. Workshop outline

Introduction	Aim of session Format of session	Exposition
Stage 1	Identify the components of the concept of dignity 'What does the term dignity mean to you?' Discuss with your colleagues Use a spider diagram to illustrate your thoughts	Group work
Stage 2	Review of current practice	Individual reflection
Stage 3	What do you do to maintain patient dignity? S.W.O.T. analysis	Feedback examples
Stage 4	Theoretical framework Evidence base of current practice Outline of research Examples of findings	Exposition/discussion
Stage 5	Identify personal opportunities for improvement Return to S.W.O.T. analysis	Individual reflection Need/problem identification
Stage 6	Future planning for practice Formulation of action plan Write an action plan – goal and associated actions	Goal setting Formulation of plan
Summary/Evaluation	Review the aim of the session. Has the session achieved the aim? Identify the opportunity for follow up including availability of support	Individual reflection Exposition

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The workshops were incorporated into the in-service training programme of one hospital trust. They were scheduled at monthly intervals and rotated around the three major sites, which are between thirty and forty miles apart. Many of the staff selected the workshop from the trust training prospectus, others were advised to attend to assist with the achievement of NVQs or as part of the overseas staff nurse adaptation programme.

It was decided to alternate sessions for health care support workers and qualified nurses. The rationale for this was to remove any boundaries attributable to grading and to ensure that each person felt able to contribute their personal views rather than looking to a 'senior' person to provide the 'correct' answer. In the second year of the programme the workshops have been accessed by staff from other departments such as the breast clinic and X-ray, enabling the programme to begin to develop an inter-professional approach.

The publicising and booking of the workshops and Sharing Good Practice Day was administered by the staff of the trust's in-service training department.

Permission for staff to develop and implement action plans was sought from the directors of nursing for each site. Once the support of the directors of nursing had been obtained, the matrons and ward/department managers were contacted to inform them of the programme and resulting projects. Staff attending the workshops were informed that senior staff within the trust were supportive of the programme thereby empowering them to identify aspects of practice that could be improved and to act as internal change agents.

Format of the workshop

Introduction

At the beginning of the session, participants were asked what expectations they had of the workshop. Their expectations varied, some of the examples were:

- A lead lecture on how dignity should be maintained
- Policies and procedures relating to the maintenance of dignity
- Some did not know what to expect as they were asked to attend the workshop by their manager

The underpinning assumption of the facilitators was discussed with participants. This was that participants already have personal and professional experience of maintaining patient dignity. As a consequence of this assumption, the proposed format of the session was that the concept would be explored in a discussion rather than lecture format. This was based on the philosophical principles of androgogy (Knowles, 1998). The objectives were therefore that each participant would have the opportunity to:

1. Explore the concept of dignity
2. Discuss how patient dignity is currently being maintained
3. Identify skills required to maintain patient dignity
4. Explore factors which can influence the maintenance of patient dignity
5. Produce an action plan to improve the maintenance of patient dignity

Stage 1 – Defining dignity

Dignity is a word used frequently in the health care setting but without precise definition. It is assumed that healthcare staff have a shared understanding of the meaning of dignity and it is taken for granted concept relating to nursing practice. Johnstone (1994, 257) stated that: 'the term has been freely used and there is room to question whether those who use it have a clear understanding of what exactly they mean.' This also emerged from Matiti's (2002) research and therefore the project leaders believed that it was important for the participants to have an opportunity to explore the concept of dignity in general and apply it to their own practice.

Some of the participants found the concept of dignity to be vague, and most of the participants said that it was the first time they had consciously reflected on their own dignity. They found the exercise of exploring the concept useful in relation to practice.

Stage 2 – Review of current practice

Participants were asked to identify and share examples of good practice in their working areas. This was one way of involving every participant in the discussion. The workshops provided a forum for sharing and valuing participant's previous experiences in relation to maintaining patient dignity. Some participants also talked about some bad practices they had observed. Participants offered suggestions to overcome bad practices therefore the sessions provided opportunities for finding solutions to some of the barriers to promoting dignity.

Stage 3 – S.W.O.T. analysis

S.W.O.T. analysis is an acronym for: Strengths, Weaknesses, Opportunities and Threats. The rationale for utilising a S.W.O.T. analysis was that it enabled participants to reflect on themselves and to reflect on factors affecting the maintenance of patient dignity. Participants were asked to identify:

- personal strengths and weaknesses in relation to their ability to maintain patient's dignity
- opportunities and threats (barriers) arising from their ward/departmental environment/culture

Participants were advised that the analysis could remain confidential but that they could share information with the group if they wished and that they would need to consider these factors when formulating their action plan.

The strengths which were commonly identified by the participants included the knowledge base and experience (personal and professional) which they have accumulated in their life time.

One example of personal weakness among the participants was lack of assertiveness skills. For example:

"It is hard to tell your colleague or doctor that I am washing a patient in here (curtains)".

Some participants expressed that they did not have this skill. Although some of the issues raised were personal, participants did choose to share experiences.

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Opportunities identified included ward/departmental meetings and study days.

The threats mainly centred on the shortage of resources e.g. shortage of staff and lack of private areas.

Stage 4 – Theoretical framework

The research findings (Matiti, 2002) that led to the development of the programme were presented to participants. The findings from Matiti's study provided participants with a much wider perspective and provided a theoretical framework allowing them to make a link between their own analysis of the concept and theoretical conceptualisation of the concept and further relate it to practice. Additional references were given to the participants.

Stage 5 – Identification of opportunities

Each participant was asked to reflect on how dignity was maintained in his or her practice area and then was asked to identify an aspect of patient dignity which they felt could be improved. _

Stage 6 – Action plan

An illustration of an action plan was presented to the participants. This action plan asked the participant to consider:

- why she wished to make a change
- what the specific change was
- who needed to be involved in the implementation
- how the plan would be implemented
- when – a time plan for the implementation

Participants then started to develop action plans individually or in pairs or trios if they worked on the same ward/department.

A number of participants expressed lack of power, as one of the threats to the implementation of the action plan. The majority of health care support workers felt and expressed that they could not make a difference in the ward. A common statement was:

"Even if we say something, no one will listen to us."

They expressed that they were at the bottom of the hierarchy in the health care setting and as result of this it was going to be hard to be listened to. This also applied to some of the qualified nurses. Staff did not feel that they had the power to initiate change in their working practice.

To help empower the participants they were informed that letters would be written to their ward/departmental managers asking them to support the participants in implementing their action plans. The follow up support offered by the facilitators was also explained.

Evaluation.

Participants were asked to evaluate the workshops. All the sessions were very positively evaluated. The following are some of comments from the participants:

*"The sessions have enlightened me and made me very aware of how little I did know."
(H.C.S.W.)*

"This course is very helpful and valuable for me. I got the opportunity to think about maintaining patient dignity." (Registered nurse)

"I have found it (the workshop) surprisingly informative and liked the relaxed atmosphere." (Registered nurse)

"Has stimulated me to rethink about my current practice. I enjoyed the morning very much. Thank you." (Registered nurse)

Negative comments included:

"A half day session was not enough to explore the concept." (Registered nurse)

"Maybe extending the course to a full day and elaborating more on the subject content." (Registered nurse)

Follow up support

All participants were sent a letter confirming that support was available from the project leaders/facilitators a few days after the workshop and also 2 months after attending the session.

A date to meet for a review of progress was negotiated with each participant. The facilitators visited participants in their working areas. Contact was also made via the telephone and e-mail. The frequency of contacts with the participants depended on the confidence of the participant and progress of the action plan. The aspects that participants wished to discuss during these meetings included:

- Exploration of opportunities to promote patient dignity in their own clinical area – both discussion of initial ideas and how to draw up an action plan
- Identification of who to negotiate with
- Clarification of what constitutes an 'acceptable' project
- Confirmation that they had followed the guidelines and that they had met the facilitators' expectations

The facilitators responded to the participants' needs by encouraging them to reflect on their clinical area's needs and their own SWOT analysis, which they had compiled in the workshop, providing clarification and on one occasion, with the participant's agreement, liaising directly with her manager.

Although the participants were not asked specifically about the role their managers had played in supporting them, the examples that were volunteered were positive. In some instances the manager worked with the participant to develop their project and one manager presented on behalf of a participant who was unable to attend the Sharing Good Practice Day. Other managers, at departmental and directorate level, supported their staff member by attending the Sharing Good Practice Day. Overall the projects would not have progressed without managerial support.

This approach to supporting projects did however present challenges. These included:

- A lack of financial means to support projects

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- The need to travel distances of up to 40 miles between sites in order to provide face to face support
- The time available to facilitators
- The importance of ensuring people felt empowered – some staff had difficulty accepting that they could influence and develop practice

All participants were invited to participate in a Sharing Good Practice Day, either by attending or by providing an oral or poster presentation. Additional support to develop presentation skills was offered, on an individual basis, to the participants who chose to present.

Sharing Good Practice Day

The first year of the programme culminated in a 'Maintaining Patient Dignity -Sharing Good Practice' day. This was a forum for participants to share what they had implemented. It also publicly acknowledged the good work of the participants. The day was attended by staff and some of the participants' managers. Six participants choose to present orally and posters were displayed. The day received positive evaluations from those who attended.

Facilitator's reflection on the programme

The project leaders/facilitators identified the following learning points from the first year of this programme:

- The importance of using androgical principles of learning i.e. ensuring relevance of learning to practice and linking to a current need to change practice e.g. discomfort with current practice as in Lewin's (2002) unfreezing stage or the implementation of health policy, for example *Essence of Care* (2003) benchmarking which includes a specific benchmark for privacy and dignity. Some of the staff who attended the workshops were actively involved in benchmarking within the Trust.
- The enthusiasm of practitioners to engage with a nebulous concept and apply it to practice
- The need to empower others to make changes to practice by facilitating the normative – re-educative change strategy. Specific examples included:
 - identifying the role of the facilitator to go beyond the workshops to enable change to happen
 - the fundamental importance of balancing support and standing back to ensure ownership remains with the participant
 - the need to listen to participants regarding their individual needs for support
- The value of extensive collaborative working to initiate and maintain ongoing support for the programme, the participants and the individual projects. This collaboration involved the in-service training department, trust managers at middle and senior levels, the University of Nottingham and the Foundation of Nursing Studies

Conclusion

The perceived benefit of the programme is already evident in the positive evaluations of the workshops, follow up visits and of the 'Sharing Good Practice Day.' Positive attitudes to patient dignity have been reinforced and participants have developed a heightened awareness of promoting dignity. By valuing the contributions made by all grades of staff, the dignity of participants has also been enhanced. The inclusion of action plans has led to a transition from theoretical concept to practical application. This transition has been

achieved through collaborative working and empowering of staff.

Recommendations/further developments

- To continue the workshops – this has been agreed for dates until 2007
- To involve other health care practitioners – x ray and breast care staff have now attended workshops
- To develop a focus on inter-professional learning
- To develop an assessment tool for clinicians to identify patients views on how to promote dignity
- To review the progress of the action plans completed in 2004/5

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