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ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

Piloting discovery interview technique to explore its utility in improving dignity in acute care for older people

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Abstract

Background: In 2008 the Foundation of Nursing Studies funded City University London, Brighton and Sussex University Hospitals NHS Trust (BSUH), University College London Hospitals NHS Foundation Trust (UCLH) and NHS Improvement to work together to pilot the use of discovery interviews to improve dignity in care for older people in hospital. Both hospitals were in the National Health Service (NHS) in England. The use of discovery interviews for this purpose has not been previously documented.

Aims and objectives: This project aimed to use the discovery interview technique in two NHS organisations to explore and improve aspects of dignity in care for older people.

Methods: This project aimed at service improvements that were stimulated by interviewing older patients and their relatives (n=12) about their experiences of in-patient care using discovery interview technique. Introducing this technique to each trust required a practice development framework. Evaluation of the impact of the project was undertaken through one focus group with UCLH staff, six one-to-one interviews with project team members and written reports from the two trusts.

Results: While the use of discovery interviews led to changes on the two wards where patients were involved in discovery interviews, wider organisational changes were not achieved. The discovery interview process did not develop as anticipated, and findings reflect the importance of good leadership, skilled facilitation and a culture that welcomes patient feedback. A complex organisational context meant that the project was not always seen as the core daily business of the trust and this led to setbacks in progress.

Conclusions: Lessons learned about the importance of organisational groundwork prior to sharing discovery interview stories with staff are supported by recommendations from an earlier evaluation of discovery interviews.

Implications for practice:

- Discovery interviews are a valuable way of finding out about patient experiences and of promoting staff learning and service developments
- The impact of discovery interviews depends on the support and receptiveness of the wider organisational culture, so time spent educating key stakeholders in the organisation and tying the project into the business of the organisation is time well spent
- Preparation should include intensive working with clinical teams to explore their understandings of dignity and develop their preparedness to listen to patients' stories

- The discovery interview process is best targeted at stable ward teams with the support of a practice development approach
- Project teams need adequate support to enable them to lead change and to manage the uncertainty and setbacks of the innovation journey. Active learning sets for project teams can be a useful support and create the reflective space needed to explore complex concepts such as dignity

Keywords: narratives, older people, person-centred practice, user involvement, hospitals

Background

Dignity in care is a complex phenomenon and requires a multi-faceted approach to achieve it (Levenson, 2007; Nicholson et al., 2010c; Tadd et al., 2011). The concept of dignity is used here as:

> *'…being 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.' (Royal College of Nursing 2008, p 8)*

National and local work has highlighted the difficulties of delivering care to older people who are acutely ill in ways that promote their dignity. The skills, knowledge and attitudes of front-line staff have been recognised as important factors in delivering care with dignity (Nicholson et al., 2010a,b,c) however at the time the project was conceived, little was understood about effective interventions that promote dignity.

In addition, evidence was growing of the power of patient narratives (stories) in prompting practitioners to reflect on and improve the way they deliver care (Bridges et al., 2008; Bridges and Nicholson, 2008; Hurwitz et al., 2004 ;Newman, 2003). Discovery interviews were developed through the UK Department of Health's Modernisation Agency as a way for practitioners (and others involved in service provision) to gather in patient stories and to share them with local colleagues to reflect on them together and to decide what service changes are needed that may help to enhance patient experiences. Discovery interview technique has since been used with a variety of patient groups (coronary heart disease, whole health communities and older people in urgent care) and early evaluations suggested that this could be a useful tool for service improvement (Matrix, 2005).

At the outset of this project, Brighton and Sussex University Hospitals NHS Trust (BSUH) audit evidence from the Essence of Care, Healthcare Commission's annual in-patient survey, Patient and Public Involvement Forum Carewatch Survey in 2007 and other internal audits showed whilst some work relating to privacy and dignity was well embedded in the organisation, there were other areas that required further work. BSUH team members anticipated that gaining insight through discovery interviews would be of local benefit in understanding priorities and developing workplans to improve older people's experience of acute care services.

At University College London Hospitals NHS Foundation Trust (UCLH) there was a Dignity in Care Work Stream Group that had been in place for two years and reported to the Older Person's Strategic Steering Group. Work that this group carried out had highlighted the need to ensure robust patient feedback on experiences of dignity in care was embedded and owned in practice by clinical teams. Patient stories had been used as part of practice development programmes, but it was anticipated that discovery interviews would enable a deeper level of understanding locally (leading to change and development) which would complement other methods of feedback within the organisation.

The project team anticipated that enabling front-line nursing staff at both organisations to take time out to explore care experiences from the perspective of patients would motivate them to improve the care they deliver and, through a programme of support offered in each of the two organisations, to gain the skills to share the stories with local teams and prompt wider service improvements.

This project aimed to explore the value of the discovery interview technique in two NHS organisations in stimulating service improvements that promote dignity in acute care for older people. The use of discovery interviews to focus on dignity in care for this patient group had not been previously documented. The project team anticipated that information on the processes and outcomes of this change project could be useful to other hospitals, and other providers of health and social care, thinking of training staff in discovery interview technique.

Project outcomes

This project aimed to use the discovery interview technique in two NHS hospitals in England to explore and improve aspects of dignity in care for older people. The key outcomes the project aimed to achieve were:

1. Both organisations are able to implement discover interview process through to service improvements
2. Positive outcomes for patients i.e. dignity is maintained, promoted
3. Older peoples' stories are valued: increased value put on 'hearing' older people's 'stories'; principles of discovery interviews used in an ongoing way; development of use of discovery interviews as means of feedback on patient experience; deeper understanding of issues facing older people
4. Identifying learning that can be shared: project team identify learning about discovery interview process; project team identify learning about development process; capture and share lessons learned, including interviewing people with dementia; participants develop greater reflection and understanding of practice through active learning sets; learning shared throughout the organisation using discovery interviews
5. Practice change/new ways of working: 'freedom' to work in new ways; staff can identify new ways of working/thinking to maintain dignity; practice change in clinical area(s) based on discovery interviews; tangible/visible changes; a change in practice; adaption into ongoing development
6. Patient stories resonate with staff experience

Methods and approaches

This project aimed at service improvements that were stimulated by interviewing up to 60 older patients and their relatives about their experiences of in-patient care using discovery interview technique. Introducing this technique to each organisation required a wider management process described below. Evaluation of the impact of the project was undertaken through one focus group with UCLH staff, one-to-one interviews with project team members and written reports from the two organisations. Ethical approval for the whole project across both organisations was granted in June 2008 from MREC (Multicentre Research Ethics Committee) Wales.

<u>Project management</u>

The chief investigator for the work was Jackie Bridges (then at City University, London). She oversaw the training process and the use of discovery interview technique at both organisations through liaison with each project lead (Caroline Davies at BSUH followed by Claire Martin; Jonathan Webster at UCLH followed by Gillan Johnson) and attendance at training events.

Wendy Gray is the national lead for the development of discovery interviews. Jackie provided the training and advice on the quality and implementation of the process. For instance, an important part

of preparation for new interviewers involved submitting a 'practice tape' of sufficient quality following their training. Wendy provided training to two people from each organisation to ensure that they had the skills to adequately appraise these practice tapes.

Kate Sanders provided the link for the project to the funders, contributed to the training programme and provided practice development support to each organisation throughout their involvement, including running active learning sets (Dewing, 2010) for discovery interviewers at UCLH.

Each organisation's project lead was responsible for overseeing the conduct of the project at that organisation, and for drawing on Jackie, Wendy and Kate's expertise as required. Discovery interviewers at each organisation were encouraged to draw on the support of local project leads where this was needed.

Discovery interviews

Discovery interviews are one-to-one, face-to-face semi-structured interviews conducted by health service staff trained in the technique that focus on individuals telling their stories of care in their own words. Resulting narratives are then shared with local teams to prompt the action planning of wider service improvements. Discovery interviews were selected as the method of choice because of their potential for better understanding service user experiences and using these to improve services. Other comparable techniques, such as experience-based design (Bate and Robert, 2007) and patient stories (Large et al., 2005), would also have been relevant to consider, but the first author had already explored the use of discovery interviews in an earlier project and was keen to learn more about their implementation through this project (Bridges et al., 2008; Bridges and Nicholson, 2008).

At an early stage, Wendy Gray established links with each organisation to help them prepare the ground for the discovery interview process. Much of her advice to the organisation leads focused on embedding the process and the learning in the wider organisation and decision-making about the process - which patient groups, clinical areas, involving the clinical teams, developing the interview spine. As part of this process, Wendy attended the Older People Service Steering Group meetings at each organisation. Caroline Davies and Jonathan Webster took the lead in their own organisations in identifying suitable clinical areas and discovery interviewers, negotiating local support, and determining local processes for using the discovery interview technique, including the development of local interview spines.

Discovery interview training took place across three workshops, each lasting for one day. The overall workshop programme was developed by the project team who also agreed the proposed programmes for the individual workshops. Trainees were hospital staff working in or with the clinical areas selected for the pilot, who had expressed an enthusiasm for taking part and whose manager supported their role in the project. Most trainees were nursing staff. Others included two complaints managers from BSUH and an occupational therapist from UCLH. The three training workshops were:

- September 2008: 'Working with clinical work based cultures' by Kate Sanders and Dr Jonathan Webster
- September 2008: 'Discovery interview training' by Wendy Gray, NHS Improvement
- October 2008: 'Including people with dementia in discovery interviews' by Dr Jan Dewing

Five people at BSUH and four people at UCLH undertook the full training. The numbers were small to enable enough support to be given to staff involved by their organisation. Training was shared between the two organisations, to give the project shared ownership and for people to learn from others in other organisations. In addition, two people from each organisation attended a half day workshop run by Wendy Gray on 'tape reviewer training' to equip them with the skills to evaluate the

practice tapes mentioned earlier. All potential interviewers were expected to submit a practice tape and have this evaluated by a qualified assessor, before proceeding with discovery interviews.

Involving patients

The project planned to conduct discovery interviews with people aged 75 and over who have been admitted at least 48 hours beforehand, and their relatives.

The exclusion criteria were as follows:

- Patients/relatives who would not be able to cope physically with an interview of 45 minutes
- Patients/relatives who would be unable to cope mentally/psychologically with an interview lasting 45 minutes
- Patients/relatives who are distressed at any stage of the process from first being approached through to the interview itself
- Patients with an inability to make known and communicate their choices and preferences either verbally or non verbally
- Patients or relatives who are not fluent in the English language
- Patients/relatives who have made a formal complaint to the hospital

The project team planned to include people with dementia in the study, and the training outlined above reflects this. Methods for including people with dementia in the project were developed with guidance from Dr Jan Dewing, a specialist researcher and in accordance with the requirements of the Mental Capacity Act. In addition, the project was reviewed and approved by an ethics committee with expertise in reviewing proposals for research involving people with diminished capacity to consent.

Potential participants were approached by the interviewer and provided with information about the study. Those patients wishing to consider inclusion in the study were given a minimum of 24 hours thinking time prior to signing a consent form. Patients (and/or their relatives) were explicitly told that they were able to withdraw from the study at any time. They were reassured that participation, or non-participation, would not affect their care in any way. Patients were also asked if their relative could be approached, if they had one, to participate in the study. For the purposes of this project relatives are defined here as individuals, usually family members, identified by the patient as providing an unpaid caring role for the patient, or who plays a significant part in the patient's life.

In-patients who consented to be part of the study, and their relatives, were interviewed a minimum of 2 days after their admission. This took place within a private area on the ward or elsewhere in the hospital, depending upon the wishes of the patient and the suitability of the ward setting. A general interview 'spine' was developed to guide the development of local spines:

- Journey in getting to the ward: what happened at home, visit to accident and emergency department (A&E)
- Getting to the ward
- Arriving on the ward
- Being on the ward
- (Getting home)
- (Arriving at home)
- (Settling at home)
- I'm particularly interested in finding out about patient dignity. What do you understand by the term?
- Do you have any stories (about this admission/visit) about your dignity being preserved, or about your dignity being threatened?
- Do you have any suggestions for how care and services here should be changed to make sure that patient dignity is preserved?

The spine developed by BSUH tended to focus more on the patient's journey, while the UCLH spine explored the concept of dignity more explicitly.

Evaluation

Jackie Bridges and Maria Tziggili gathered evaluative data from individuals involved in the project with a focus on identifying the perceived processes and outcomes of the discovery interview process, and the perceived barriers and facilitators to achieving the desired outcomes. These data were gathered at two project meetings, from a focus group held with four UCLH staff and the project co-ordinator from the Foundation of Nursing Studies, and from one-to-one interviews held with six project team members. Each organisation's written reports were also used to contribute to the evaluation.

Detailed handwritten notes were taken of project team meetings and shared with participants afterwards for corrections. The focus group and interviews were audio-recorded using a digital recorder. The focus group took place at a UCLH hospital site in May 2009 and the interviews were held in various locations chosen by the interviewees between September 2009 and June 2010. The focus group lasted 42 minutes and interviews between 36 and 67 minutes (mean interview length=51 minutes). For the focus group and the interviews, a series of questions was used to initiate and broadly guide discussions, but participants were also encouraged to guide the discussion and to identify and talk about topics that had not been raised by the facilitator/interviewer. The involvement of all staff in the evaluation were included in the ethics application and agreed procedures were used to ensure that individuals understood their part in the research, understood how the data were to be handled and used, and freely consented to take part. As will be evident below, care has been taken in reporting to ensure that individual participants are not linked with particular points of view.

The audio-recordings of the focus groups and interviews were transcribed and thematically analysed alongside the other datasets. As initial themes in the data developed, comparisons of subsequent data with the emergent themes enabled the themes to be further developed and added to. This approach enabled a set of final themes to be developed that are reported in the next section. Findings were shared with project team members to enable them to comment.

Project overviews

While the above information reflects what was planned for the project and the early stages of setting it up, each hospital had different experiences with 'what happened next'. The following is a summary of how the project developed in each hospital together with key events. Separate reports are available that provide more detail (see http://www.fons.org/library/report-details.aspx?nstid=13769).

BSUH had a slow start to the process, the first discovery interview not taking place until over a year after the training. The reasons for this delay are explored later. By this time, just one of the original discovery interviewers remained involved and she interviewed patients from her own ward (a surgical neurological unit) when they attended the outpatient unit following discharge. A great deal of effort focused on preparing the ward team to listen to and work with the material from the discovery interviews. This preparation was led by Kim Bateup, the ward manager, and centred on three privacy and dignity workshops. The aim of the workshops was to raise awareness and understanding of dignity in care, particularly with older people, and to prepare the staff for feedback from patients. During the workshops patient experiences were shared from the discovery interviews that had been carried out and used to stimulate discussion, reflection and action planning. As a result changes were made to the ward environment, particularly in relation to patient mealtimes, and to

improving communication with patients. Following this work on the ward, staff then shared their experiences by running a workshop for multidisciplinary staff on two rehabilitation wards. The workshops were very positively evaluated by staff who took part.

The project at UCLH adopted what they termed a transformational approach to change by focusing on work-based cultures and running an active learning set for individuals who had been involved in the training programme. Active learning is defined by Dewing (2010) as 'an approach for in-depth learning that draws on, creatively synthesizes and integrates numerous learning methods. It is based in and from personal work experience of practitioners' (p 22). The active learning was facilitated by Kate Sanders and the group met six times between November 2008 and January 2010. Activities focused on supporting the work of individuals in the discovery interview project and on exploring the concept of dignity, and were the foundation for staff to work with their colleagues on individual units. Using workshops, Gillan Johnson met with staff on the individual units to explore the concept of dignity, identify key issues and plan actions. As staff's understanding of dignity developed and as they became oriented to patients' views, in later workshops Gillan felt ready to share two of the stories from the discovery interviews that had taken place. Staff at these later workshops responded positively to hearing the stories and were able to identify some resulting key learning.

Findings

Findings are presented in relation to the four main themes: discovery interview process led to changes, process not as expected, developing culture and leadership are critical factors, and organisational contexts that constrained the developments.

Discovery interview process led to changes

Both organisations identified a number of changes that had resulted from the use of the discovery interview process. The changes cited tended to relate more to personal and professional changes, particularly for the people who had participated in the initial training and had stayed involved in the project.

'The staff nurses who did the discovery interview training found it fantastic' (M1)

'It was really good for the nurses on the ward [to hear the discovery interview stories]. They weren't aware that the patients felt so positive about the way they work' (M3)

'Being involved has made me more aware of the difficulties of preserving dignity when different people understand different things by it. Things have come up that I hadn't even thought of. It's really broadened my horizons' (M4)

'I saw how individuals increasingly valued patient experience through better understanding' (M5)

Some practice changes were also cited, but with the exception of the dementia work (see below), were all located on the wards involved suggesting that the process had not influenced services in the wider organisation.

As a result of project development work with staff on the ward at UCLH, staff reviewed how meals were given to patients, put actions in place to ensure that curtains around the bed stayed closed during intimate procedures and one staff members distributed a questionnaire to colleagues focusing on their own dignity at work. At BSUH, action planning focused on improvements in the ward environment, particularly in relation to mealtimes, and improving communication with patients and families.

No patients with dementia were interviewed as part of the project, and project leads attributed this to general nurses' lack of skills and confidence in dealing with people with dementia. However, the training workshop that focused on involving people with dementia in discovery interviews triggered new thinking for the BSUH senior nurse for practice development who attended – *'It started to change my understanding and thinking about dementia in quite a profound way'*. Her role in the organisation enabled her to initiate a great deal of work on dementia including a dementia steering group, a six day dementia educational programme for nurses and ensuring that a new hospital development was designed as a positive environment for people with dementia.

Most participants saw the potential for the discovery interview stories to be used across the organisation as a way of stimulating service improvements, but felt that the organisational context constrained their potential (see below). Also, while those who were interviewed recognised that the discovery interview process could be an ongoing tool for use by organisations, doubts were felt as to the sustainability. The sustainability at UCLH related strongly to the loss of key individuals over time, but also to the constantly shifting organisational context:

'The NHS is forever merging, changing, morphing, being challenged, reconfigured, and I think all those things make sustaining change very difficult' (M5)

Throughout the project, participants in both organisations continued to value its potential as a way of listening to patients and getting an understanding of their experiences, but as the next section illustrates, the process did not develop as expected.

Process not as expected

Implementation of the discovery interview process was different in a number of ways to what was anticipated at the outset. The discovery interview consultant brought to the project a model of how the discovery interview process could be successfully implemented, based on experience of the process in other settings but, while this model was shared with the teams at both organisations, what happened in practice was different. For instance, the discovery interview consultant recommended particular time periods between for instance interviewer training finishing and each interviewee submitting a practice tape but for both organisations, loss of staff from the project and the distractions of other organisational objectives meant that getting the process underway took significantly longer than anticipated and ended up focused on one clinical area in each organisation.

Another example was that of the interview 'spine', a series of open-ended prompts to guide patients to tell their story. The discovery interview consultant advised that the spine be developed with clinical teams prior to interviewer training, but following decisions about what patient groups were to be included and what parts of the journey staff were interested in focusing on. BSUH staff followed this model of working, but UCLH staff preferred to incorporate more direct questioning about dignity in their spine (for example 'What does dignity mean to you?', 'What does it mean to you to be treated with dignity by our staff?')

Project leads at both organisations felt that the attendant requirements to the discovery interview process, such as interviewer training and tape quality review, were over-prescriptive and didn't allow for existing staff abilities or for adapting the processes in a way that worked locally.

'It's very, very tightly controlled….to maintain quality of interviewing – but I'm not convinced it needs to be so tightly controlled' (M1)

One project lead described the discovery interview process as technical and lacking creativity, and expressed a preference for a more locally driven approach. In contrast, the discovery interview

consultant was keen for staff at both organisations to be able to draw upon the nine years of experience that had been built up about how to optimise the discovery interview process.

At UCLH the project developed into a practice development project with discovery interviews being viewed as one tool within a wider process of cultural change. One UCLH participant said that the project developed into something that she hadn't anticipated and that required a greater time commitment than she had originally thought, and another interviewee said that after the initial training sessions she would have benefitted from having the project mapped out more clearly. In addition, a lack of confidence in dealing with people with dementia meant that no one with dementia was included in the discovery interviews at either organisation, in spite of training aimed at specifically addressing this need. Both organisations changed project lead half-way through, one leaving the organisation altogether.

'When [project lead] left we lost a lot of the momentum to do with the project. It kept feeling like ten green bottles. We started off with this group and then one by one, people kept leaving for various reasons' (M4)

Neither organisation had anticipated the intensive preparation they needed to do with clinical teams before sharing the stories from the discovery interviews and subsequently focused on this above all other activities for much of the project.

'For me the stories are very precious pieces of information. We've asked patients for something very personal, very valuable and I feel a real strong sense of responsibility that we should do the best thing by them. If we sit in front of a group of staff and it just doesn't touch them, I feel that's a real missed opportunity' (M6)

As a result of project start-up delays and the focus of preparing teams to listen to the discovery interviews, far less discovery interviews were carried out than expected (eight at BSUH and four at UCLH) and were shared with clinical teams at a later point in time than expected, often months after the interview had been conducted. While participants were disappointed by this outcome, this was outweighed by the value they attributed to the practice development work focused on preparing teams to hear the stories.

Developing culture and leadership are critical factors

A key lesson that participants cited was that the discovery interview process needs to be embedded in a culture that enables change and development and that thrives on patient feedback, and that developing such a culture required time, resources and facilitation skills. Practice development was identified as some participants as key to the discovery interview process being successful.

'The programme of practice development that underpinned using discovery interviews was where the big change happened' (M5)

'There are definite skills in relation to facilitation, working with staff to enable them to understand what change is needed and enable them to be part of working out how that change can be achieved' (M6)

'When you look at how is care experienced here, you have to look wider at how do we provide care and what influences it… to widen the discussion to factors that influence how you care for a patient' (M6)

Similarly, within the discovery interview process, one participant identified how strong facilitation is needed:

'I think in presenting the narrative in its entirety, the facilitation needed to help team members unpick what this story is telling us is very complex. How do the team really listen to the discovery interview and hear what is being said and use it' (M5)

Good leadership was cited as being imperative. At UCLH changes in ward leadership and a lack of a ward manager involvement in the project on the one ward where discovery interviews took place impeded progress for some months. In contrast, at BSUH the leadership of the ward manager was cited as critical to the positive outcomes from the project.

'Some wards and departments do not have good clinical leadership. Good nurse leaders prioritise dignity because that is what nursing is about. The weaker ward leaders get overwhelmed by bed pressures, financial pressures, and lose sight. They believe in it but don't have good leadership and management skills so dignity doesn't get prioritised. Staff also aren't managed well so nursing stops being a reflective job and becomes a series of tasks, so they don't see the person anymore' (M1)

'At [BSUH] the ward manager is an integral part of the project and I believe that active commitment from the ward manger is key to enabling change in a ward area. It sends out very strong messages to the rest of the nursing team…While the manager at UCLH has been active, she didn't come until half-way through and her support has since been very useful. If she had been there from the outset the project might have progressed much more quickly' (M6)

Two people commented on the particular attributes of the ward manager at BSUH and her contribution to the project:

'[She] is very positive, forward-thinking, but also in a very matter of fact kind of way. A real can-do attitude. She thinks this is really important and so that message will be strongly spread through her team. She looks for opportunities to involve all the members of her team and play to their strengths and support people who might not be comfortable, but finding their niche and getting them on board. I think that might well be one of the keys, gaining the active involvement of the ward manager.' (M6)

The development work with ward teams in the form of workshops focusing on dignity was seen in both organisations to have yielded rewards by offering staff opportunities for reflection on dignity and on their practice. In addition, the active learning sets held for UCLH staff directly involved in the discovery interview project were seen as central to the progress of the project and to individual development.

'[Active learning] gives people opportunities to experience different ways of learning, development that they could then take back to the workplace to share with other team members for the purpose of looking at different ways of working to improve ways to improve care' (M6)

'It was really helpful in helping us focus, helping prepare the wards for feedback' (M3)

'I enjoy doing things like that [the active learning set]. It's a treat…It's good to be able to sit back and reflect on things, to talk quite openly without being judged. It made me feel supported and valued' (M4)

This sense in which the discovery interview process on its own was unlikely to lead to sustainable change is also reflected in the findings in the next section.

Organisational contexts that constrained the developments

At both organisations, the chief nurse/chief nurse's deputy signed the original funding application and this reflected already established work visible at board level in both organisations around dignity in care and older people's care experiences. However, both organisations experienced how wider organisational pressures impacted on subsequent project progress, in spite of individual commitment to the discovery interview process happening and, at BSUH, in spite of the visible involvement of the chief nurse. At BSUH, the project lead had to prioritise other work over keeping the discovery interview process moving, at one point working clinically for six weeks instead of carrying out her practice development role. The work got going once a practice development nurse was appointed to support her. A similar situation happened to the second project lead at UCLH whose practice development work had to 'go on the back-burner' when the swine flu crisis erupted. Overall participants reflected that while some organisational commitment had been gained, the project did not enjoy a high priority in complex organisations needing to balance a range of critical pressures:

'I think [the project] was looked at as a side-dish and not the main course' (M3)

'All the project team members have been positive but there have been times when they've been disillusioned and you feel like it's all too much, but it's working with them to identify what you can achieve, what you can move forward, but sometimes even your best intentions aren't enough because there are too many other things that take precedence in the environments that they're working in' (M6)

One person commented how individual perceptions of dignity can lack an appreciation of its complexity as a concept and therefore senior managers can underestimate the organisational effort needed to attain and sustain it:

'The danger with something like dignity is that we just put it in a tick-box…but the complex attitudes and behaviours are the most difficult things in a situation to change or measure. We polarise something that is complex and multifaceted like dignity into something like gender separation [mixed-sex wards]' (M5)

This person went on to comment on how technical learning in their organisation was valued over experiential learning, and how common assumptions were made that you could teach people what dignity is by running a course on it. Another participant commented on the importance of organisational preparation at an early stage:

'Some of the things we talked about very early on, systems and processes needing to be set up, weren't. If you charge ahead with training people as interviewers and you don't have the systems in place that lock the work into an organisation's top priorities…then you can't go ahead with what you are training people to do' (M2)

Participants felt that it was important for the sustainability of the work that the discovery interview process was not seen as a project but as part of what the organisation does. For instance, BSUH explicitly related the project to organisational objectives and all their practice development work was accompanied by a business case so that senior managers could see the relevance to achieving organisational objectives. Participants also suggested that stories from discovery interviews were more likely to be listened to across the organisation if fed back in conjunction with data from other sources such as National Patient Survey data.

Discussion

The original project outcomes were achieved but not on the scale originally anticipated. Outcomes were largely restricted to the staff directly involved in the project and to the ward teams who cared directly for the patients interviewed. Wider organisational change was not realised. The limited number of interviewers and discovery interviews carried out have meant that we cannot draw conclusions about interviewers' skills or about the particular characteristics of stories that deepen understanding and stimulate service improvements.

While this project is of relevance to other NHS organisations considering service improvement work of this kind, the findings may be of wider relevance to other organisations in other countries, depending on the reader's judgement as to contextual similarity. The findings reflect a complex, conflicted organisational culture in which thoughtful patient-centred work struggles to thrive and survive. The findings reflect that tools such as the discovery interview process can make a contribution to staff learning and service change, that these processes are supported by attention to organisational culture, by good leadership and the use of practice development, but constrained by a lack of wider leadership and other organisational priorities. The links between achieving dignity in care and the need for a supportive organisational context can be seen in other work related to dignity and/or compassion in care (Firth-Cozens and Cornwell 2009; Royal College of Nursing, 2008; Tadd et al., 2011). Patterson et al. (2011) found that a shared philosophy of care and good leadership at ward level were critical to a positive team climate for acute care for older people, findings echoed by those from this project. While the two organisations varied in their adoption of the discovery interview process and the recommended model for its implementation, they had remarkably similar journeys, and can each claim successful although only local change. It is probable that developments at BSUH will continue, given the stable ward leadership, but that at UCLH too few of the original team remained at the end of the project to be able to sustain the new ways of working developed.
The findings also resonate with the original Matrix evaluation (Matrix, 2005) and reinforce the importance of preparing the groundwork for the discovery interview process. Matrix recommended the following:

- 'Support resources should be refocused on sharing stories and achieving service improvement. No discovery interviews should be undertaken until arrangements have been made for the stories to be shared'
- 'Work should be undertaken to ensure that discovery interviews are integrated with other aspects of patient and carer involvement and service improvement'
- 'Discovery interviews should not take place until it is clear that the approach fits within the strategic vision of the organisation that is required to support it'
- 'Work should be undertaken to ensure that while 'on the ground' experiences of implementation are taken into account, the core methodology is adhered to or adapted as necessary, including further clarity to ensure that all discovery interview teams are aware that they should not be 'theming' their interviews' (p 3)

Based on our findings, we endorse the first three of these recommendations from Matrix, and suggest that a practice development approach may be helpful in achieving them. The fourth reflects the tension we found between the recommended discovery interview model and organisational views on implementation, but we have insufficient evidence from this project to either reject or endorse this particular recommendation.

Lessons learned

In addition to the Matrix recommendations, our lessons learned for other organisations thinking of using the discovery interview process to focus on dignity in care are:

Discovery interviews are a valuable way of finding out about patient experiences and of promoting staff learning and service developments.

The impact of discovery interviews and experience of those involved is dependent on the support and receptiveness of the wider organisational culture, so time spent at the outset of a project, and then throughout the project, educating key stakeholders in the organisation and tying the project into the business of the organisation is time well spent. If the project is not viewed by senior managers as core business, it is unlikely to succeed. Active involvement by senior managers in the project, including conducting discovery interviews, could help with aligning organisational and project objectives.

Adequate preparation is key and includes intensive working with clinical teams to explore their understandings of dignity and develop their preparedness to listen to patients' stories. This work could take place before interviewers are trained and this could improve the timeliness of the stories eventually gathered and shared.

The discovery interview process relies on attention to culture and good leadership, so is best targeted at stable ward teams with the support of a practice development approach.

Project teams need adequate support to enable them to lead change and to manage the uncertainty and setbacks of the innovation journey. Active learning sets for project teams can be a useful support and create the reflective space needed to explore complex concepts such as dignity.

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