KEYWORDS DIGNITY | ACUTE CARE | DIGNIFIED CARE

Everybody matters 1: how getting to know your patients helps to promote dignified care

This project revealed 'see who I am' as a main theme for patients. Guidance is offered on how nurses can make small changes to their practice to address this

AUTHORS Caroline Nicholson, PhD, MSc, BSc, HV/DNCerts, RGN, is dignity development nurse; Mary Flatley, PhD, BSc, RGN, is lead research and development nurse; both at Royal Free Hampstead Trust and City University; Charlotte Wilkinson, DH, MA, MSc, RGN, is lead research and development nurse, Barnet and Chase Farm Hospitals Trust and City University; Julienne Meyer, PhD, MSc, BSc, CertEd (FE), RNT, RN, is professor of nursing/project lead, School of Community and Health Sciences, City University; Patricia Dale, RGN, is dignity development nurse, Royal Free Hampstead Trust and City University; Lucinda Wessel, RGN, is dignity development nurse, Barnet and Chase Farm Hospitals Trust and City University.

ABSTRACT Nicholson C et al (2010) Everybody matters 1: how getting to know your patients helps to promote dignified care. *Nursing Times;* 106: 20, 12-14.
The Dignity in Care Project aims to develop practical interventions to promote dignified care in hospitals, embedded in the project slogan: "Everybody matters: sustaining dignity in care." It is a nurse led research collaboration with Royal Free Hampstead and Barnet and Chase Farm Hospitals Trusts and City University.

Practical interventions devised by the project are presented around three main themes that emerged from the views of older people and their relatives (Bridges et al, 2010; 2009). The first theme of "maintaining identity – see who I am" focuses on knowing about people, while the second of "creating community – connect with me" recognises that in the act of caring, nurses receive as well as give. The last theme of "shared decision making – involve me" looks at how decisions about care are made.

This first article in a three part series summarises the project and focuses on the first theme. It reports on practical initiatives to enhance dignity in hospitals by enabling nurses and patients/carers to know and value each other as people.

INTRODUCTION

Within the demands of acute work in hospital, the multifaceted nature of dignity often remains invisible and difficult to translate into a set of behaviours or procedures. Health and social policy has recently stressed the importance of this concept (Department of Health, 2008).

Dignity and privacy have been identified as a core standard by which all healthcare organisations are measured. However, Help the Aged, in Davies et al (2007), described dignity as a "hurrah" word – a term of general approval often loosely cited as an essential ingredient but frequently without consensus over its meaning.

Furthermore, there is little evidence on how to put dignified care into practice or on how the competing demands of the healthcare system affect its delivery.

The Dignity in Care Project (DCP) is underpinned by an appreciation of the realities of delivering dignified care in the modern NHS. This is exemplified by the story in Box 1, taken from practice.

DIGNITY IN CARE

The project uses a systems approach, working with ward nurses, patients and their carers and hospital managers. It is guided by the centrality of relationships in delivering high quality, dignified care.

Nolan et al (2006) argued that the experiences of staff, patients and relatives are central to developing good care environments. Cummings et al's (2010) recent work on nursing leadership notes "by investing energy into relationships with nurses, relational leaders positively affect the health and wellbeing of their nurses, and, ultimately, the outcomes for patients".

Thus the project works in partnership with staff to think about practice and possible changes, with a focus on the positive aspects of care. Using a combined approach of action learning and appreciative enquiry we have worked alongside nurses to change practice.

We began by appreciating what it is like to work in an acute hospital. By doing shifts, observing practice and collecting the views of nurses, patients and families, we developed an understanding of what helps and hinders dignified care.

This understanding was gained through a combination of feedback from nurses on the wards and monthly action learning sets (meetings in which groups meet to support each other in their learning) off the ward with ward mangers, junior matrons and nurses particularly interested in dignity.

BOX 1. PRACTICE EXAMPLE

It is 11am. Edith,* a healthcare assistant, and I have already washed three patients, changed two who were doubly incontinent and we are in the middle of getting a woman ready for discharge home. The place is frantic. There are two planned procedures, three discharges and a ward round to be done, and we are one staff member down.

Molly* shouts across from the opposite bed in the bay: "Can I have my wash now?" I look at Edith; she rolls her eyes and notes that if one of us does not go on break soon we will mess up the whole rota with lunchtime. She says something about needing to keep things moving and she looks tired. Edith calls back to Molly that she "will have to wait". Molly grumbles and asks why she is last.

I go over to her and start to explain the morning we have had, and the fact that we need to get people ready for transport. I stop. Molly is crying.

As I hold her hand I begin to think about why she might be so disturbed. Molly's companion for these past weeks is leaving but she is staying. Molly has no family and will be placed in a care home when the formalities are agreed. She wipes her eyes and says she will wait.

* Names have been changed.
Source: extract from project field notes

These dignity leaders helped to collect evidence and then consider with the project team what interventions might help.

A main issue was that interventions needed to be feasible for nurses in a busy environment and relevant to their everyday work. We came to see these as small processes that occur over time. Bigger projects with more obvious impact have a corresponding need for substantial effort and rarely available time. However, it became clear that small things often had the power to make a real difference, both to staff and to patients and relatives.

Supporting ward nurses to implement interventions is essential and sustaining change in practice is both exciting and challenging.

During this project we worked intensively with a select number of wards (dignity development units) and, more widely, through action learning sets with clinical leaders across the hospitals. These sets have proved a powerful place for colleagues, often "siloed" in their clinical areas, to learn and share knowledge with each other and formulate ideas before returning to implement them in practice.

We have attempted to mirror this cycle of reflection and action on the wards by taking a short time to stop, look and listen to each other about a possible change.

'SEE WHO I AM'

Being in hospital can affect people's sense of individuality; with a unique life history, likes and dislikes are part of who they are.

Although formal ward assessments may ask some personal questions, the information gathered does not always influence the care received.

This carer sums up the need to see beyond the immediate problem to the person when giving dignified care:

> **"Some staff, they did not seem to treat my wife as an overall patient, that is, they only gave information about specific problems, the immediate, no understanding of the bigger picture, and also what I was going through."**

Below are some practical suggestions on how nurses can both reflect on and change their everyday practice to see beyond "the immediate task" to the "person behind the patient" – a phrase used by the King's Fund (Goodrich and Cornwell, 2008) to help illuminate the meaning of dignity. For ease these are considered under the following headings and summarised in Table 1:

TABLE 1. WAYS TO CHANGE EVERYDAY PRACTICE

Creating dignity conversations throughout the shift	**Nursing handover:** does your handover include information about patients whose dignity may be at particular risk that shift? **Time to talk?** Does your shift have times that allow staff to share patient care issues? For example, during "huddling", when nurses group together naturally; **Are nurses supported by the team** to give dignified care in difficult situations? For example, by buddying up, checking out, time out.
Seeing the person: getting to know the people you are caring for by…	**Routine morning conversations** between nurses and patients at the beginning of the shift; **Rounding with dignity:** using routine care practices such as observations/medication rounds as an opportunity to connect with people.
Promoting awareness of dignity throughout the ward environment	**Being curious about everyday practice:** helping staff to "stop, look and listen" through observation. For example, do we call patients by their name or their bed numbers when conversing with colleagues? **Thinking about dignity for yourself, your colleagues and those you care for:** examples are dignity workshops, a dignity noticeboard, values exercise.

- Creating dignity conversations throughout the shift;
- Seeing the person: getting to know the people you are caring for;
- Promoting awareness of dignity throughout the ward environment.

Creating dignity conversations

Although nurses may agree that dignity is central to nursing, delivering dignified care is getting lost (Royal College of Nursing, 2008). Promoting dignity requires intentional and practical ways to embed it into everyday work.

- **Nursing handover:** The Health Foundation's (2009) Safer Patients Initiative asserted that effective communication is a vital factor in improving clinical practice and patient outcome. Linking this into dignity may mean adding a specific question to the safety briefing which asks staff to identify people at particular risk of their dignity being diminished that shift, such as a planned procedure which may mean lunch is missed.
- **Time to talk?** Long working days and reduced staff overlap between shifts can mean nurses do not informally get together to talk about caring. The Compassionate Care Project (2009) in Scotland identified the need for caring conversations, that is, points in the shift when staff get together to talk about emerging issues around care. In this project, we talk about "huddling" – using times when nurses naturally group together, perhaps waiting for the meal trolley, and intentionally focusing this time to reflect and talk about care.

Recognising and valuing these huddles can be used to support fellow staff in the practice of caring. Caring can be difficult, whether due to the circumstances surrounding the patient/family or because of our own humanity. Working as a team and helping each other is important dignity work. Intentional times to stop and talk about the shift can allow staff to feel valued and supported in their caring work.

Seeing the person

The average length of stay in one of our trusts is three days for an elective procedure and four days for non-scheduled admissions. With 12 hour shifts, this may mean nurses see a person only once.

This means it cannot be assumed that getting to know patients will just happen over time. Below are some practical tips to get to know people in the moment.

- **Routine morning conversations:** in this project, nurses are supported to introduce themselves to their allocated patients at the beginning of each shift. They are encouraged to ask how patients are and, if a person is new to the ward, how they would like to be addressed and if they have any concerns for that day. This "simple" connection can be challenging as it may stimulate discussions around priorities and time pressures.

Ongoing support is important to facilitate working in this way and to allow space for such conversations and the possible implications that replies may bring. On one occasion, a patient told the nurse that the name by which she had been known all her life was not the "proper" name on her medical notes which all care staff had been automatically using. This "proper" name was one the patient associated with being naughty as a child.

BOX 2. THE SOLER COMMUNICATION TOOL

S Squarely face the person; "I am with you"
O Open posture
L Lean towards the other; be responsive
E Eye contact. Direct, appropriate.
R Relaxed. Being comfortable in using your body as a vehicle of communication and expression

Source: Egan (1990)

- **Rounding with dignity:** routine care practices, such as "doing the obs" or "doing drugs" can be reframed as opportunities to see the person you are "doing" things to. Communication tools such as SOLER (Egan, 1990, Box 2) can help staff to think about how they present themselves to patients when carrying out activities. This "small" change requires courage and support to put into practice. Clearly, some encounters need to be more task oriented but they can still be carried out with an appreciation of the person's individuality.

Promoting awareness of dignity

- **Being curious:** hospitals are busy places and, as part of the project, we have been encouraging staff to have curiosity about what they do and the effect this may have on dignity.

Various team staff used the following short observation exercise to help them to stop, look and listen to their everyday surroundings and routines.

Top tips for observing your own surroundings:

- Stay in your own clothes;
- Try to think of yourself as a stranger;
- Observe for 10-20 minutes;
- Try not to intervene;
- Do not take notes at the time;
- Write up your notes immediately after you have finished;
- Draw a line down the page. On the left hand side write what you saw and on the right hand write what you thought and felt about what you saw;
- Bring your notes to a meeting to share with colleagues.

Two widely reported themes are:

- The high degree of background noise in which people work and are cared for, such as pumps left on after an infusion or a bleeping bed mattress. This is much more noticeable to people who are confined to bed or a chair. One nurse found it so unbearable during this exercise that he had to stop observing and turn off a pump that had been left on. This background noise is exacerbated by staff shouting requests for assistance or queries about drug keys;
- The almost universal practice of calling people by bed numbers rather than names. Clearly, there are occasions when it is important to locate a patient quickly and a bed number is appropriate. However, in most conversations between professionals, people were referred to as beds, for example: "Bed 19's daughter is on the phone" (clerk to nurse). Giving people names is an essential part of acknowledging their personhood; this does not apply only to patients and relatives. You may wish to reflect on how many staff members, including support staff, are referred to by name. How might you want to raise the profile of naming both staff and patients in your ward area?
- **Thinking about dignity for yourself, your colleagues and those you care for:** promoting awareness of the issues around dignity and looking at values and attitudes is an important part of changing practice. Dignity workshops, feedback to the team on some of the exercises and ideas and a noticeboard can all keep dignity in people's minds (see Box 3 for useful resources).

CONCLUSION

Dignity, unlike some aspects of care, cannot be reduced to a set of procedures or handbooks. This has its challenges but also creates exciting possibilities.

It brings to the fore the personhood of professionals, patients and family members. It also challenges each of us to think about where and how we work.

Dignity is about drawing on the capacity and leadership of all nurses. The following field note captures the importance of the small things by which every nurse can promote dignity. Small things change people and practice and can have far larger consequences than we might know.

Dora*, a healthcare assistant, smiles at Mr Smith*: "Can I take your blood pressure?" He holds out his arm, somewhat mechanically. Dora unfastens his watch, commenting on its shape and how grand it is. Mr Smith's face breaks into a smile, "My dad gave that to me [after a pause]… can you imagine me having a dad, long gone now?" Dora bends over to put the cuff on and gently pats his arm: "Yes, I can, gone but not forgotten eh…." It is a fleeting moment but I remember it as I write up my notes; I imagine Mr Smith does too. ●

***Names have been changed.**

Part 2 of this series, to be published in next week's issue, focuses on values and expectations and ward culture

BOX 3. USEFUL RESOURCES

Leadership in Compassionate Care programme: tinyurl.com/leadership-compassion

DH Care Networks – Dignity in Care: tinyurl.com/network-dignity

The Point of Care: Improving Patients' Experience: tinyurl.com/improving-patient-experience

RCN Dignity campaign: tinyurl.com/rcn-dignity

REFERENCES

Bridges J et al (2010) Older people's and relatives' experiences in acute care settings: systematic review and synthesis of qualitative studies. *International Journal of Nursing Studies;* 47: 1, 89-107.

Bridges J et al (2009) *Best Practice for Older People in Acute Care Settings (BPOP): Guidance for Nurses.* London: RCN Publishing/City University. tinyurl.com/best-practice-older

Compassionate Care Project (2009) *'Caring Conversations': Little Things Make a Big Difference.* Conference organised by NHS Quality Improvement Scotland, NHS Education Scotland and the Public Service Ombudsman, at Murrayfield Stadium, Edinburgh, 20 March.

Cummings GG et al (2010) Leadership styles and outcome patterns for the nursing workforce and work environment: a systematic review. *International Journal of Nursing Studies;* 47: 3, 363-385.

Davies S et al (2007) *Dignity on the Ward. Promoting Dignity in Hospital: A Guide for Hospital Staff.* London: Help the Aged, in association with RCN.

Department of Health (2008) *High Quality Care For All. NHS Next Stage Review Final Report.* London: DH. tinyurl.com/darzi-final-report

Egan G (1990) *The Skilled Helper: a Systematic Approach to Effective Helping.* London: Chapman and Hall.

Goodrich J, Cornwell J (2008) *Seeing the Person in the Patient: the Point of Care Review Paper.* London: The King's Fund. tinyurl.com/point-care-review

Nolan M et al (2006) *The Senses Framework: Improving Care For Older People Through a Relationship-Centred Approach.* Sheffield: School of Nursing and Midwifery, University of Sheffield.

Royal College of Nursing (2008) *Defending Dignity: Challenges and Opportunities for Nursing.* London: RCN. tinyurl.com/defending-dignity

The Health Foundation (2009) *Making Our Hospitals Safer: Journeys on the Safer Patients Initiative.* tinyurl.com/hospitals-safer