Systematic Review: What interventions improve dignity for older patients in hospital?

Aims and objectives: To review the evidence for interventions to improve dignity for older patients in acute care.

Background: High profile cases have highlighted failure to provide dignified care for older people in hospitals. There is good evidence on what older people consider is important for dignified care and abundant recommendations on improving dignity, but it is unclear which interventions are effective.

Design: Narrative systematic review

Methods: The Cochrane library, MEDLINE, EMBASE, CINAHL, BNI, and HMIC electronic databases were searched for intervention studies of any design aiming to improve inpatients' dignity. The main population of interest was older patients, but the search included all patients. Studies that focused on "dignity therapy" were excluded.

Results: There were no intervention studies found in any country which aimed to improve patient dignity in hospitals which included evaluation of the effect. A narrative overview of papers that described implementing dignity interventions in practice but included no formal evaluation was, therefore, undertaken. Five papers were identified. Three themes were identified: knowing the person; partnership between older people and healthcare professionals; and, effective communication and clinical leadership. The effect on dignity of improving these is untested.

Conclusions: There are currently no studies that have tested interventions to improve the dignity of older people (nor anyone else) in hospitals. Further research using well designed trials of interventions is needed. There is also a need to develop and validate outcome measures for interventions to improve dignity.

Relevance for practice: At present nurses lack robust evidence on how to improve dignity. There is ample evidence on what undermines patients' dignity and there is a need to develop and test interventions designed to improve patient dignity.

Keywords: dignity; acute care; older patients, interventions

What does this paper contribute to the wider global clinical community?

- There is lack of evidence of interventions to improve dignity for older people in acute healthcare settings.
- There is no simple easy solution to delivering dignity in acute care, or any other setting.
- Interventions need to be multi-dimensional involving the patient, their family and healthcare professionals.
- Other countries may have conducted studies using different terminologies (respect, patient satisfaction, stigma).

Introduction

Care of older people is creating significant challeng
characterised by advances in medical technology, driv
throughput by reducing length of stay, and increasing consumer expectations. Activity measures drive hospital throughput but do not necessarily give rise to real improvements in health outcomes, particularly for patients with complex care needs. In this environment, maintaining dignity can be challenging.

In the high-pressure work environment of current acute care, practitioners can become immune to breaches of dignity, as has been highlighted in reports and inquiries (Francis 2013). According to the UK Commission on Dignity in Care, dignity has never been higher on the health care policy agenda, and there are numerousrecommendations on how to improve dignity (British Geriatrics Society 2007). The European Consultation on the Rights of Patients has also set dignity as one of its first objectives (World Health Organisation 1994). Using data from the World Health Organisation's general population surveys, dignity was found to be one of the key features of quality of care (Valentine *et al*. 2008). The concept of dignity is complex and is possibly easier to recognise by its absence than its presence. The word dignity comes from a Latin root for "worthy" or deserving respect. Early attempts to define it in nursing related dignity to maintaining self-esteem, self-respect and a sense of individual uniqueness, with close associations with control and choice (Mairis 1993). Later concept analysis has suggested that dignity is made manifest through behaviour that demonstrates respect for self and others; dignity may be affected by the treatment received from others (Jacelon *et al*. 2004).

Research has explored dignity from the perspective of the older person and healthcare professionals. A qualitative study with 72 older participants has suggested that dignity was
perceived in the forms of identity, human rights, and autonomy (Woolhead *et al*. 2004). People living with dementia at home have reported that three interactional qualities preserve their dignity: experiencing love and confirmation, social inclusion and fellowship and experiencing warmth and understanding within a caring culture while being met as an equal human being (Tranvag *et al*. 2014). Baillie, in a detailed hospital case study using observations and interviews with staff and patients, found that dignity was impacted by environmental privacy, positive interactions with staff, a dignity-promoting culture (staff who made patients feel comfortable, in control and valued) and support from other patients (Baillie, 2009). A narrative review summarising the literature from patients' and nurses' perspectives from 31qualitative and two quantitative studies, concluded that physical environment, staff manners, organisational culture and patient autonomy influenced patients' dignity (Lin *et al*. 2012)

The nursing literature has many examples of recommendations to improve dignity, some focusing on very practical aspects of care such as toileting, privacy and pain management (Birrell *et al*. 2006) while others focus more on communication and relationships (Bridges & Wilkinson 2011). However, there is a lack of reports describing these recommendations being put into practice. Discussion of real life scenarios has been reported anecdotally to help student nurses apply the concept of dignity in their

practice, but no evidence was offered (Goodman 2013).

While recommendations abound, evaluations of whether interventions work are remarkably sparse. Even the major UK commission "Delivering Dignity" offered no evidence on what actually works and is sustainable (National Health Services Confederation 2012), amid the competing pressures in today's hospitals.

Evidence is important in nursing. There is a reported problem with older people consistently receiving dignified care in hospital (Care Quality Commisssion [England] 2012) and there is evidence of what constitutes dignified care from a patient and staff perspective. There are recommendations on how to achieve dignified care, with much expert opinion on what would help improve dignity, but there has been no systematic evaluation as to whether these approaches work in real life situations.

Aim

To review the evidence for interventions to improve dignity for older patients in hospitals.

Method

A systematic review looking atinterventions for improving dignity for older patients in hospitals

Search strategy

The Cochrane library, MEDLINE, EMBASE, CINAHL, BNI, and HMIC databases were searched using a combination of free text searching and Medical Subject Headings (MeSH). We also searched through the lists of references of retrieved papers. HMIC, Open Grey database, Directory of Open-Access Repositories (opendoar) and the Social Science Research Network were searched for grey literature. Facet analysis included the following subject headings and key words: dignity, dignified care, older people, aged, acute settings, promotion, strategy*, program* and intervention*. Studies of any design were included in the search. Empirical/clinically focused papers that described implementation of an intervention aimed at improving dignity in hospitals, or the impact on service provision were also retrieved. Papers that were related to palliative care, end of life, and community settings were excluded.

No relevant reviews were located in the Cochrane database. When searching databases Boolean operators were used to combine searches together with 'search with AND' which limits the search by

finding both words when searching and 'search with OR' which expands the search by finding any of the selected words when searching. Within specific databases it is also possible to search with the use of truncation which helps to find different endings of the word. The search was not limited to English language publications, but no citations in other languages were retrieved. The literature search process is identified in Figure 1.

Four reviewers independently examined titles and abstracts to identify potentially relevant studies. After the searches, initially duplicates were removed and titles were screened for relevance and discarded if irrelevant. Full text papers were scrutinised for the relevance of content, papers were then assessed using the inclusion criteria. The reference lists of papers read by abstract provided no additional studies. The majority of papers retrieved by our search for "dignity interventions" came from palliative and end of life care and focus on an intervention called "dignity therapy", specifically designed to promote reminiscence and improve quality of life for a dying patient. The studies on "dignity therapy" were specifically excluded from the review.

There were no intervention studies found in any country which aimed to improve patient dignity in acute care which included evaluation of the effect. A narrative overview of papers that described implementing dignity interventions in practice but included no patient outcome measures or evaluation of the effect of the intervention was, therefore, undertaken. Five interventions described in seven papers were identified. Selected studies were read and themes extracted. No other papers were found that described implementing interventions to improvedignity in clinical practice.

Results

The five projects identified were all from the United Kingdom, with none retrieved from other countries. One project was described in three separate papers (Nicholson *et al*. 2010a, 2010b, 2010c). One paper focused on newly registered nurses' education (Bruton *et al*. 2012), and the other four were practice development projects. Table 1 summarises the selected projects. Practical strategies were developed to enhance dignity under the following themes: knowing the person, partnership between older people and healthcare professionals, effective communication and clinical leadership. None of the five intervention projects to improve dignity offered any evaluation of changes to dignity resulting from the intervention.

Knowing the person

McCormack and Wright (1999) developed a case management approach to patient care. The project

aimed to facilitate nurses and other multi-disciplinary team (MDT) members to challenge clinical practice, question beliefs, values, and attitudes. They used pre and post data from a Rehabilitation ward with a comparison ward. Data were collected by observation of nursing practice, patient interviews, documentation audit, registered nurse questionnaire, and interview with all members of the MDT. The MDT perceived the patients in their care as having no potential for improvement, the ward was seen as 'the dumping ground' and nurses were uncertain about their role in caring for the older patient (McCormack & Wright 1999, p. 341). Poor understanding and lack of knowledge, skills and expertise of older peoples' needs were identified. An action plan was put in place with the focus on five strategies (see table 1). Post-evaluation data highlighted nurses' intention for introducing person-centred care and changes were introduced to practice. Cultural and structural change was noted. Patients reported some improvements with their care, were more involved in their care, they were able to better communicate with staff and noticed more team work. There was no direct measurement or evaluation of dignity. Indeed the only mention of dignity in the paper is in the title.

Haak (2009) developed a practice project which involved three workshop days to raise staff awareness and understanding of how to maintain dignity when caring for patients with dementia. They developed a six bedded bay for female trauma patients with dementia (the "Forget Me Not bay") and created a working group to facilitate ongoing development in the care of these patients ("Forget Me Not champions"). There were noticeable improvement in understanding of dementia and consequently there were changes in delivery of care. Staff spent more time listening to patients and attending their needs. The relatives also reported that the designated bay improved patients' experience of care. There was, however, no mention of improved dignity in the evaluation report.

Nicolson et al (2010a, 2010b, 2010c) developed the 'Dignity in Care Project' which aimed at developing practical interventions to promote dignified care in hospitals. This was nurse-led research in collaboration between two hospitals and a university in London. The authors conducted interviews and observation to collect data from nurses, patients and families. Three practical interventions emerged from the data and constituted three themes. Firstly "maintaining identity – see who I am" focused on how knowing your patients helps promoting dignified care. Some practical suggestions on how nurses can 'see the person behind the patient' were implemented (see table 1). Changes to practice were validated by staff quotes. There was no evaluation of improved dignity.

Partnership between older people and healthcare professionals

Another theme that emerged from these papers is the partnership between older people and healthcare professionals. Dignity of the older person cannot be promotedwithout partnership and a reciprocal relationship between the older person and healthcare professionals. McCormack and Wright's (1999) found that patients were not involved in making decisions about their care, and a ritualistic culture of the organisation existed.

Similarly, Webster *et al*. (2009) highlighted that dignified care is a partnership between the older person and healthcare practitioners. They developed a six month programme of practice development comprised of five creative arts sessions (using collage; movement/dance; sculpture with clay) combined with in-depth discussions and joint learning with older people. Participants shared their stories and experiences by working together. Reflective learning group meetings and reflective learning exercises for the nurses were held. Tangible interventions were developed to enhance dignity (see table 1). No outcomes for dignity were presented. Some of the challenges faced were poor attendance for reflective learning groups due to work commitments. Health needs of some older people prevented them from joining creative arts sessions. Nicholson *et al.* (2010b) suggest that dignity can be promoted by involving patients and their families in their treatment decisions "shared decision-making – involve me". The authors propose different strategies to involve patients in the decision making about their care (see table1).

Effective communication and clinical leadership

Bruton *et al.* (2012) developed a nurse graduate foundation programme focusing on dignity of older patients in the first 18 months after graduating. The programme comprised an 18 month training programme: three placements (including "elderly mentally infirm" ward) with support from a placement preceptor, three modules (two e-learning), and ongoing reflection and development of a professional portfolio. Participants were asked to provide comprehensive feedback about their experience. Participants and managers felt that three months placement was not sufficient; therefore, placements were extended to six months. Informal feedback suggested increased nurses' confidence and skills development. A thorough evaluation is planned after three full cohorts have completed the programme, but we were unsuccessful in gaining a response from the author for further details. The author indicated in the paper that dignity will be measured using an adaptation of a tool devised from a report

for Help the Aged called 'measuring dignity in care for older people' (Magee *et al*. 2008).

McCormack and Wright (1999) found that nurses were unaware of their strengths and weaknesses and how quality of care can be influenced by individuals and shared leadership. Following an action plan, nurses felt empowered to develop their practice through effective communications and leadership. Similarly, Webster *et al.* (2009) suggested that open and effective communication is central to dignified care. Nicholson *et al.* (2010b) believed that good communication is vital to dignified care. They recognised that nurses receive as well as give through caring, connecting with and creating values around caring "creating community – connect with me", and promoting communication that connects with the person.

Discussion

In our review, lack of awareness of patients' dignity and needs was a common theme that ran across all papers. This echoes findings from Tadd *et al*. (2011) who used semi-structured interviews and non participant observation, and reported four main themes: 'Whose Interests Matter?'; 'Right Place – Wrong Patient'; 'Seeing the Person' and 'Influences on Dignified Care' (p. 32). Hospital staff expressed views that the acute hospital is not the 'right place' for older people, suggesting that there must be a better place for 'them' to be. These views may draw attention to ageism. Many staff lacked knowledge and skills to care for older people. This lack of awareness of older peoples' needs maybe attributed to the attitudes of nurses towards the care of older people. As Hayes (2015, p. 5) has recently commented "to promote dignified, person-centred care, it is essential that age discrimination is tackled, and realistic, balanced attitudes towards older people are promoted'. Liu *et al.* (2013) reviewed 25 studies and reported inconsistent attitudes across qualified and student nurses. These ranged from positive, negative and neutral attitudes. However, Liu *et al.* (2013) point out that there is a discrepancy of attitudes towards older people across different countries, and sometimes within countries.

Expert opinion suggests that education on care of older people combined with positive clinical learning experiences can improve attitudes towards working with older people. Nolan *et al.* (2002) explored students' views and experiences of gerontological nursing. They found that students' views were shaped by their previous experience, placement experience and attitudes of qualified staff. In contrast, a recent study by Welford (2014) suggested that education and clinical placements did not increase nursing student's knowledge or promote positive attitudes in older people's care. Welford asserts that several other factors such as the need to be respected, recognised and valued, and a sense of community in an

organisation need to be considered.

A more recent review explored the attitude of health and social care students towards older people and working with older people (Coffey *et al*. 2015). Overall, nurses' and students' attitudes to ageing and working with older people were mixed. Negatives attitudes arise from the perception that the care of older people is of low status, less attractive, and less important (Nolan *et al.* 2004). Herdman (2002) suggested several factors which contribute to nurses' decision to not to work with older people: lack of resources and a poor physical environment, lack of clinical skills development and lack of career prospects, when compared with other acute areas. Such views will ultimately impact upon the quality of care provided for older people (Liu *et al.* 2013; Welford 2014). Lee *et al*. (2003) argue that such perceptions exist in all health and social care fields.

To promote dignity, enhancing partnership between the older person and healthcare professionals and shared decision making is required. Moreover, avoiding care which is task orientated (Tadd *et al*. 2011) and rather 'Seeing the Person' is widely reflected in the notion of person-centred care. Acquiring knowledge about the person is vital to deliver person-centred care (Clarke *et al*. 2003). The importance of 'knowing the person' and developing an enabling relationship has also been emphasised (Dewing 2004). However, translating this into practice remains a challenge (Ross *et al*. 2014). Nolan *et al*. (2004) suggest that person-centred focuses on individualism and autonomy. They argue that person-centred care is inadequate and propose a relationship-centred approach where several levels of relationship exist. This interwoven relationship between patients, their families, healthcare professionals and the wider community is advocated by Nicholson *et al* (2010c). This was evident in Webster *et al*. (2009). By bringing nurses and older people together, Dewar and Nolan (2013, p.1248) provide a model to help staff to deliver compassionate, relationship-centred care for older people. They feel that this should be based on 'appreciative caring conversations' that enable nurses and patients to really get to know eachother as individuals. Such knowledge enables patients and their families to work with nurses to shape their care.

Effective communication is seen as vital in promoting and maintaining dignity. Woolhead *et al*. (2006) examined the experiences of communication between older people and healthcare professionals in France, Ireland, Slovakia, Spain, Sweden, and the United Kingdom. They conducted focus groups with older people, and with healthcare professionals. Four major themes emerged around forms of address, politeness and privacy, feeling valued, and inclusion and choice. The authors asserted that healthcare professionals failed to apply these to their practice despite being aware of good communication

practices. Tadd *et al.* (2011) not only explored dignity of the patients but also the degree to which staff are treated with dignity and respect by their colleagues, managers, patients and their families. Several organisational factors were often seen to impact on staff members' sense of dignity and resulting in demoralisation. Several barriers were also reported which compromised the promotion of dignity including systemic and organisational factors, clear commitment by all those involved to enable real, sustainable change (Tadd *et al.* 2011). In addition an open, flexible, innovative and nurturing work environment is seen as promoting dignity (Webster *et al.* 2009).

Although these strategies may be useful, the implementation of these strategies in complex busy hospital organisations driven by political initiatives, with many people providing care can be challenging (Nicholson et al 2010a, 2010b, 2010c, McCormack & Wright 1999). There are several challenges to promoting dignity in acute care settings: environment, patients' physical status, and staffing shortages (Tracy & Skillings 2007). Despite these challenges, Tracy and Skillings (2007) suggested development in the areas of education, practice, and research are key strategies to maintain dignity for older people.

Limitations of the review

We have systematically undertaken all steps required to review the literature. The findings of this review suggested no research that specifically looked at improving dignity for older people using well designed trials of interventions including evaluation. Therefore, the evidence provided does not answer the review question. This is, however, an important finding which indicates the need for further research using well designed trials of interventions.

Conclusions

There are currently no studies that directly evaluate interventions to improve the dignity of older people (or other patients generally) in acute care settings. The majority of studies on dignity focus on the views of patients and practitioners on dignity and the meaning of dignity. Reports of interventions that have been implemented in clinical practice are descriptive and without qualitative or quantitative evaluation of their effect on patient dignity. We included papers which focused on practical interventions to promote dignity for older people. Although these papers generally implied success in implementing these interventions, no evidence was presented to support this. Further research using well designed trials of interventions is needed. There is also a need to develop and validate outcome measures for interventions to improve dignity.

Relevance to Clinical Practice

It is unlikely that there will be a simple easy solution to delivering dignity in acute care, or any other setting. Interventions are likely to be multi-dimensional and involve addressing knowing the person as an individual, a partnership between health professionals and the patient and family, and improvements to communication with strong clinical leadership. It is not possible at present to know what will work.

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Table 1: Dignity interventions, implemented in practice

Author, Year **Setting**	**Elements of the intervention**	**Evaluation Methods**	**Results**
Bruton *et al.* (2012) Adult medical and surgical hospital and adult community settings, Wales, UK	Graduate foundation programme focusing on dignity of older patients in the first 18 months after graduating. 18 month training programme: 3 placements (including "elderly mentally infirm" ward) with support from a placement preceptor, 3 modules (2 e-learning), and ongoing reflection and development of a professional portfolio. Objectives: To give new graduatesthe opportunity to gain wide-ranging	Proposed outcome measures: Comprehensive feedback from each nurse on each placement: initial feedback is that 3 months is too short for a placement. Assessment in several unspecified areas of dignity using the Measuring Dignity in	No evaluation published as yet; author could not be contacted.

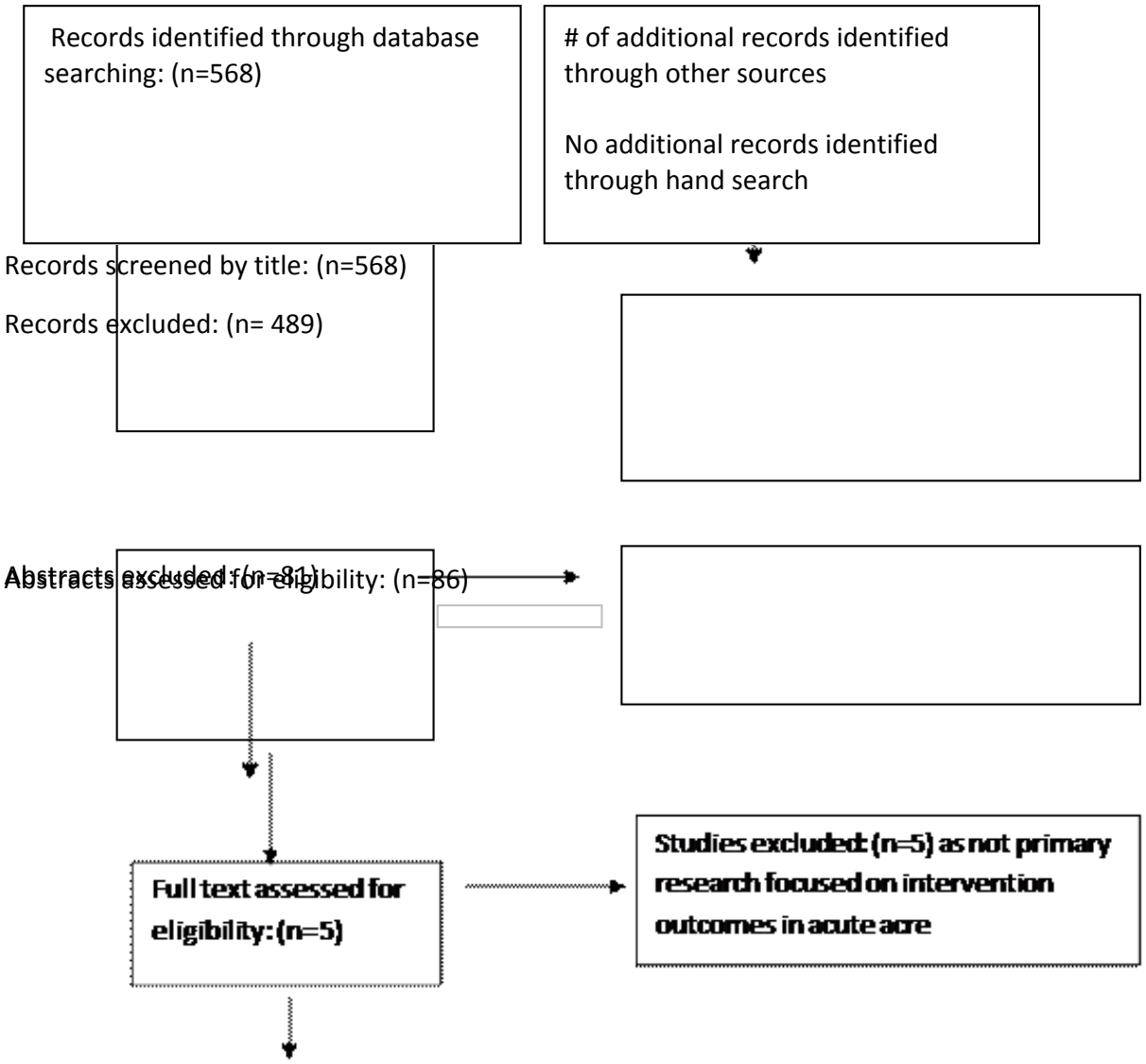
	experience in the first 18 months of graduation, providing them with skills and knowledge to work in any chosen care setting. To provide new graduates with an opportunity to gain a greater understanding of caring for older people with mental health needs to enable transfer of skills to the care of older people in general healthcare settings. To provide new graduates with the experience of working with experienced nurses across the whole pathway of care for patients. To provide the organisation with a future nursing workforce with the attitude, skills and knowledge needed to adapt to caring for people in any setting. To provide the organisation with a flexible nursing workforce	Care for Older People tool is planned (Magee 2008, Help the Aged).	
Haak (2009) Two acute orthopaedic wards in an acute district general hospital, UK	The project involved: • 3 workshop days to raise staff awareness and understanding of how to maintain dignity when caring for patients with dementia (28 trained nurses, 12 healthcare assistants, 5 occupational therapists and 6 physiotherapists) • the development of a designated six bedded bay for female trauma patients with dementia – the “Forget me Not” bay: sense of calm and homeliness, music and fun • a working group of Forget me Not champions to facilitate ongoing developments in care.	Evaluation feedback from both staff and relatives was positive. 20 staff responded to a questionnaire about the bay; 80% who attended workshops completed a questionnaire. 92% felt the care they give had changed, with more emphasis on relating to patients. Knowledge and understanding of dementia has improved and as a result, the care they are giving has changed with more emphasis on taking time and listening to the patients' needs and wants. Relatives feel that the atmosphere created by the designated bay	No direct mention of dignity in the evaluation report

		has a positive impact on patients' experience of care.	
McCormack and Wright (1999) Rehabilitation ward with comparison ward, UK	Practice development project: Developed a case management approach to patient care Facilitate nurses and other MDT members to question attitudes, beliefs and values, and to challenge clinical practice. Implement cultural and structural change. New norms of clinical practice and leadership. Develop a philosophy for practice, attend development days and workshops, introduce practice changes, develop clinical leadership and develop nursing auxiliary competence.	Pre-post evaluation design Observation of nursing practice using (QUALPAC); Patient interviews; Documentation audit; Registered nurse questionnaire (n=22); Interviewed all members of MDT (n=25). Overall quality of care improved; greater continuity of care.	Although the title of the paper concerns dignity, there is no direct mention of interventions to improve dignity nor changes in dignity in the paper
Nicholson *et al.* 2010a, 2010b, 2010 c Acute care: 2 NHS Trusts in London, UK	Dignity in care project. Action learning sets and appreciative enquiry. Facilitators worked alongside nurses. Dignity leaders. Selected wards as dignity development units. 3 main themes: 1. Maintaining identity: see who I am: knowing about people. Seeing the person behind the patient, with routine morning conversations. Creating dignity conversations at handover and throughout the shift, allowing time to talk. Promoting awareness of dignity throughout the ward environment, being curious: stop look and listen to each other about possible change. 1. 2. Creating community – connect with me: nurses receive as well as give through caring. Connecting with and creating values around caring; Putting yourself in another's shoes; Promoting communication that connects with the person; Engaging patients whose condition/context challenges involvement; Valuing, collecting and acting on the different perspectives of being in hospital 3.Shared decision making –	Anecdotal quotes from staff members and researcher(s)	No evaluation

	involve me: how are decisions about care made? Involving people, enhancing shared decision making, engaging patients whose condition or context challenges their involvement, and valuing, collecting and acting on different perspectives of being in hospital Many small changes.		
Webster *et al.* (2009) Acute care, UK	6 month programme of practice development: 5 creative arts sessions (collage; movement/dance; sculpture with clay) combined with in-depth discussions; joint learning with older people. 8 nurses, 8 older people with hospital experience in the past year. Plus reflective learning group meetings for the nurses and reflective learning exercises. Nurse conducted ward projects and shared learning with their team: 1. Promoting increased effective communication between nurses and older people – use of patient diaries. 2. Working with the multidisciplinary team to ensure that dignity in care is an integral part of team meetings. 3. Introduction of: 'Please keep quiet' notices; Review dividers to curtains; Performing theatre check-lists in patients' rooms; Ensuring patients are greeted on arrival in the department; Pre-operative visits to assess and meet patients. 4. Ward-based notice board focused on raising awareness of dignity. 5. Raising awareness of ensuring that curtains are kept closed and that closed doors aren't opened without seeking permission first. 6. Increased vigilance at meal times to ensure that all patients	Some found creative work useful, others found it difficult. Evaluation: usefulness of collaborative learning, sharing experiences, open and honest discussions, sense of empowerment. Broad benefits: ability to share, communicate and learn together. Reported influence on practice through a greater awareness and understanding of dignity in care. Nurse felt energised to take forward work related to dignity in their teams.	No evaluation of changes in clinical practice or impact on patients.

	(who need help) receive support to eat and drink. 7. Increasing awareness of the need to encourage patients to wear their own clothing. 8. Look at the environment of care – introduce music (as part of the Hospital Arts Programme). 9. Meet as a dignity-in-care group eight-weekly, to review progress and agree new actions		

Fig.1. Prisma flow chart of literature search process



Included studies for the narrative review: (n=5)