

**RECONNECTING NURSING AND PATIENT DIGNITY:
AN INTEGRATIVE REVIEW**

by

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Abstract

Preserving dignity is an essential part of nursing. However, there are mounting concerns that nurses are not fulfilling this important responsibility. A gap exists between nursing discourse and practice. The aim of this paper was to examine strategies that have been proposed, or implemented, to translate a conceptual understanding of patient dignity into a central role in daily acute care nursing practice. A greater understanding of strategies offers insight to how nurses can reconnect with upholding patient dignity and provides a starting point for further research.

An integrative review was carried out using Whittemore and Knafel's (2005) updated methodology, which includes 5 stages: problem identification, literature search, data evaluation, data analysis, and presentation. The literature search included the Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed, PsycINFO, and Academic Search Complete databases. The keywords for the search were: dignity, nursing, nursing interventions, patients, nurse-patient relations, and staff development.

Twelve highly relevant publications were identified. These articles consisted of program development initiatives, expert opinion pieces, practice-based journal articles, and a high-profile campaign. Five strategies emerged from the analysis: Training; Reflection and discussion; Imagining the patient perspective; Leadership; and Planning for action. The strategies focused on the individual nurse and nursing relationships. Structural influences had only a limited focus. Although the nurse participants described a greater understanding, a deeper awareness, better skills, and a desire to create change, the impact of the strategies was not evaluated in practice.

Further research needs to assess the impact of the strategies in daily nursing practice, their influence on nursing culture, and the patient experience. A long-term view toward the sustainability of any changes once nurses return to their workplaces must also be taken. In

addition, strategies must focus on the system and how nurses can be supported to uphold dignity within the challenges of acute care.

Preface

This thesis is the original, unpublished, and independent work by the author, J. Roy.

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Dedication

To my parents – Thank you for your encouragement, support, and many hours of babysitting.

To my husband – Thank you for your understanding, patience,
and encouraging me to keep on going.

CHAPTER 1: INTRODUCTION AND BACKGROUND LITERATURE

Dignity is a state of physical, emotional, and spiritual comfort, in which the uniqueness and individuality of a person is respected and valued (Fenton & Mitchell, 2002). To treat a person with dignity is to recognize them as a being of worth. Furthermore, as outlined in the Universal Declaration of Human Rights, dignity is a right that all persons are born with (United Nations, 1948). This right exists in equal amounts for each person regardless of capacity, age, gender, religion, sexual orientation, culture, or social status (McSherry, Pearce, Grimwood, & McSherry, 2012; Royal College of Nursing, 2008a).

The upholding and preservation of the right to dignity has a central place in the nursing profession. The need to be hospitalized is typically a vulnerable stage in people's lives. Impaired health and older age may lead, even temporarily, to many losses, threatening a person's sense of self (Henderson et al., 2009; Whitehead & Wheeler, 2008b). Furthermore, hospitalization and illness create a dependency on others for even the most basic of needs. This can reduce a person's ability to maintain and protect their dignity (Whitehead & Wheeler, 2008a). Patients and nurses are reported as perceiving a certain degree of loss of dignity in the hospital as inevitable (Walsh & Kowanko, 2002). The vulnerability that comes from being a patient and the potential insults from the hospital experience should therefore deepen nurses' desire to handle threatening situations delicately, protecting a patient's personhood and finding alternate ways to uphold dignity.

1.1 The Problem

1.1.1 The Nursing-Dignity Connection

The connection between the nursing profession and dignity is not a new realization. The importance of recognizing and preserving patient dignity has long been supported by nursing theorists, educators, researchers, and clinicians. Florence Nightingale worked to create dignified

conditions for soldiers fighting in the Crimean War. In her well-known “Notes on nursing: What it is and what it is not”, she instructs nurses on the importance of fresh air, light, warmth, cleanliness, quietness, and nutrition to promote healing and restore health (Nightingale, 1969). Throughout her career she stressed individualized care and encouraged nurses to work in the best interest of patients (Miracle, 2008). One can easily recognize the value she placed on each patient. By meeting basic human and personal needs she was upholding the importance of dignity and its place in quality nursing care. Virginia Henderson, similar to Nightingale, argued for person-centered and individualized care. She stressed nursing’s responsibility to help complete the person while they are unwell and unable to do so independently (Henderson, 1964). This involves working with the patient to identify and meet their specific needs, keeping the day as normal as it would otherwise have been, and preserving the person’s sense of worth and self (Henderson, 1964). The nursing theorist Jean Watson believed caring to be the primary function of the nursing profession (Thorne, 2010). An important aspect of this caring was said to include a commitment to the protection of each person’s dignity (Nåden & Eriksson, 2004). Although many more examples could be provided, the writings and actions of these three nurse leaders clearly demonstrate the close and long-recognized link between nursing and respect for dignity.

The connection between nursing and dignity is also supported by the Canadian Nurses Association’s (2008) *Code of Ethics for Registered Nurses*, a document that serves as the foundation of ethical nursing practice. Nurses are accountable to the seven values brought forward by the Code of Ethics, one being to preserve dignity. This value describes how nurses are to recognize, respect, and advocate for the intrinsic worth of each person (Canadian Nurses Association, 2008). Furthermore, preserving dignity is regarded as a professional standard for registered nurses. The professional standards detail levels of performance that nurses are

required to meet in their nursing practice (College of Registered Nurses of British Columbia, 2008). That preserving dignity is listed under the greater standard of ethical practice demonstrates its importance in the provision of competent, safe, and quality care.

1.1.2 Violations to Dignity

1.1.2.1 Background

The above points clearly outline that respect for dignity is regarded as an essential part of the nursing profession. However, there are growing concerns by the public, governing bodies, nurse leaders, and even frontline nursing staff that nurses are not providing the high quality care that upholds its presence (McSherry, et. al., 2012). A rising number of studies, media reports, editorials, and personal accounts highlight that nurses are not taking measures to protect the dignity of those in their care. Insults to dignity are first of all being seen in how patients are treated in relation to the physical environment. Three examples of this include curtains surrounding patient beds not being consistently closed during personal care, the use of commode chairs at the bedside for toileting when the bathroom is a realistic option, and mixed gender accommodation due to bed shortage pressures (Baillie, 2009; Care Quality Commission, 2011; Gallagher, Li, Wainwright, Jones, & Lee, 2008; Healthcare Commission, 2007; Henderson et al., 2009).

Violations to dignity are also being seen in how nurses are enacting their nursing role and the attitude they hold toward patients. Complaints of nurses failing to help patients meet basic human needs are becoming more common. This includes neglecting to assist and encourage patients to eat and drink, failing to help patients with toileting, leaving patients sitting in soiled clothing, and providing insufficient pain control (Care Quality Commission, 2011; Parliamentary and Health Service Ombudsmen, 2011; Patients Association, 2011). In regards to attitude, some

nurses are not maintaining a person-centered approach, failing to appropriately address individualized needs, not taking the time to learn the patient as a person, and generally lacking in empathy (Lakey, 2009; Morris, 2012). Undignified care is, furthermore, being seen in the communication between nurse and patient. Incidents of nurses speaking too loudly, especially in regards to private matters, communicating in a condescending way, failing to provide patients with the nursing call bell, not listening, and not involving patients in decisions are increasing in frequency (Care Quality Commission, 2011; Henderson et al., 2009; Morris, 2012; Parliamentary and Health Service Ombudsmen, 2011). It is of significant concern that the above examples exist in a profession that is believed to have a special role and great responsibility in protecting and promoting the dignity of those in need of their care.

Not all nurses, and perhaps not even the majority of nurses, fail to uphold and promote the dignity of patients. However, that such instances even occur and are said to be on the rise is sufficient reason to question why this might be happening. A common explanation provided by nurses to justify occurrences of undignified care include a lack of time and resources (Baillie, Ford, Gallagher, & Wainwright, 2009; Walsh & Kowanko, 2002). Nurses report working in high-pressured environments often with questionable staffing levels, limited resources, incidents of workplace incivility and bullying, and increasingly medically complex patients (Baillie et al., 2009; Calnan, Woolhead, Dieppe, & Tadd, 2005; Dean, 2012; Felblinger, 2008; Moore, Leahy, Sublett, & Lanig, 2013).

The culture of the organization and the individual wards are believed to be another reason why dignity is being pushed to the wayside. Task-oriented mindsets and a focus on performance measures have infiltrated the functioning of hospital units, drawing nurses away from the patient's personhood and undervaluing care (Baillie et al., 2009; Calnan et al., 2005; Tadd et al.,

2011). The culture of hospital units has also been affected by nursing leadership's limited presence as they are redirected from bedside concerns to focus on such issues as bed management and budgets. It is now a struggle for nurse leaders to be present to influence the unit culture and support nurses in their daily work (Morris, 2012).

A final reason for nurses' failings to promote dignity is a lack of training. It is argued that poor interpersonal and communication skills are contributing to the compromised care (Matiti & Trorey, 2008; Walsh & Kowanko, 2002). In addition, there are gaps in knowledge surrounding what constitutes dignified care and a general lack of understanding of certain patient groups, such as the aging population (Healthcare Commission, 2007; Matiti & Trorey, 2008; Stone, 2011; Tadd et al., 2011). These reasons are not to excuse the violations to dignity, but offer a starting point where changes in nursing practice to better support dignity can be implemented.

1.1.2.2 A Canadian Perspective

The dignity concerns and rationale that have been cited above are largely based in the United Kingdom. This is not to say that similar struggles are not happening elsewhere, including Canadian hospitals. Research has pointed to challenges Canadian nurses face while trying to provide ethical care. For example, a qualitative study in Western Canada explored the meaning of ethics to frontline nurses and how ethical practice is enacted on a daily basis. Although the focus was on ethical care, the preservation of human dignity was described as a feature of this ultimate goal (Rodney et al., 2009). The study findings listed demanding workloads, greater numbers of patients, and increasing severity of illnesses to be the everyday reality of frontline nurses. This reality exists with limited physical resources and distant leadership teams. Nurses report simply not having the time to provide the ethical care they desire and that patients deserve (Rodney et al., 2009; Storch, Rodney, Pauly, Brown, & Starzomski, 2002).

It is clear that the Canadian health care system is experiencing many of the same issues that have plagued the United Kingdom, which opens the door to many of the same problems regarding respect for dignity (Goldman, 2011). These issues are directly related to the corporate ideology that has permeated the system. This ideology has created a culture that bases health care policy and health care delivery decisions on economic and political values. Instead of focusing on the accessibility and quality of care, cost constraint has been deemed of utmost importance (Rodney & Varcoe, 2012). As a result of cost cutting, nurses are faced with demanding workloads, limited resources, and a powerlessness to shape nursing practice (Rodney & Varcoe, 2012; Rodney et al., 2009). This system focuses on that which is measurable, rather than recognizing aspects of nursing work, such as intellectual and emotional care, that cannot be quantified. Efficient nursing practice within the belief that resources are scarce is praised (Rodney & Varcoe, 2012; Rodney et al., 2009; Varcoe et al., 2004). The corporate culture and focus on efficiency are constraining structures, dictating what is to be valued and what is considered an ethical issue. Nursing concerns can be belittled in this milieu, which in turn challenges nurses' abilities to act as moral agents and to practice ethically. Nurses may nevertheless try to meet their professional standards and address the ethical issues they deem important; however, this is often done on their own time and at the expense of their own well-being (Beagan & Ells, 2009; Rodney & Varcoe, 2012; Rodney et al., 2009; Storch et al., 2002; Varcoe et al., 2004). Given this reality, it is not surprising that patient dignity has been placed on the wayside of nursing care, even though the problems do not excuse nurses from their professional and ethical responsibilities.

From a media standpoint, two recent news reports also speak to the reality of care in Canadian hospitals. The first tells the story of a woman who was forced to go through a

miscarriage in a Prince Edward Island emergency waiting room. Although it was known that she was bleeding, nothing was done for her during her more than three hour wait to provide her with privacy or comfort during a devastating time (Thibodeau, 2010). The second story reported the death of a young woman who died while assigned to a hallway bed in a British Columbian hospital. Distaste was expressed regarding the dignity that was offered to this patient, as she passed away in a public area and in general, concerning the dignity nurses are capable of providing when expected to care for patients in hallways (Baker, 2012). Both newspaper articles present a picture of care where a respect for dignity is lacking.

From a personal perspective, I can also attest to violations of dignity during my seven years of acute care nursing, the first year in Quebec and the following six in British Columbia. I have overheard and witnessed many of the same incidents described in the United Kingdom reports - nurses not listening to patients, using “pet” names such as “dear” and “sweetie”, speaking over patients during care, interrupting meals, refusing to assist someone to the bathroom, and even once heard a nurse telling a patient through the intercom to use her pad when she called for a bedpan. There are unfortunately a plethora of other similar stories as well; however, these few are enough to demonstrate the reality of care in our hospitals.

1.1.2.3 Future Challenges

The Canadian health care system is facing many upcoming challenges, and nursing’s ability to uphold and protect the dignity of patients is bound to become even more of a struggle. Canada has an aging population with the very old living longer (Canadian Nurses Association, 2008). By 2029, nearly one in three Canadians will be 65 years and older (Goldman, 2011). This population will require complex medical care to deal with multiple health issues. To further complicate the situation, there will be a continuing and worsening shortage of nurses in addition

to a shortage of other health care professionals. Workloads are expected to increase due to this shortage and the increasing patient acuity, further challenging nurses to provide excellent care within limited capacity (Canadian Nurses Association, 2008; Donnelly, 2010). To darken this already bleak picture, it is likely that leadership will be lacking as there will be a limited number of well-prepared nurse managers to develop quality work environments unless proactive changes take place (Canadian Nurses Association, 2008, 2012). The future of nursing will also be affected by the health care system's increasingly business mindset. The focus on efficiency and savings, resource allocation, and targets will continue to alter the way nursing work is viewed and enacted (Hagenow, 2003; McSherry et al., 2012).

The many challenges I have noted above will have a significant impact on individual nurses, the understanding of the nursing profession, and, most importantly, patients. If no action is taken, nurses will likely find it increasingly difficult to provide dignified care and the news stories of indignity in Canadian hospitals will, unfortunately, become more common. Nurses must come together to courageously challenge this potential future. With their sheer numbers and specialized knowledge, nurses can have a great impact on the health care system, the nursing profession, and the quality of patient care (Canadian Nurses Association, 2012). It is imperative that nurses are supported and encouraged to take proactive steps to protect the presence of dignity in the acute care system, the individual wards, and daily practice. Toward this end, a more careful examination of the meaning of dignity is warranted.

1.2 The Meaning of Dignity

It is often mentioned in present-day health care literature that the absence of dignity is easier to define than its presence (Birrell, Thomas, & Jones, 2006; Franklin, Ternstedt, & Nordenfelt, 2006; Meyer, 2010). In other words, one is more apt to identify a violation to dignity

than to report on respect for the concept. Furthermore, the notion of dignity is criticized for being vaguely defined, lacking a clear and specific meaning, and for being ambiguous in its interpretation and application (Agich, 2007; Coventry, 2006; Jacobson, 2007; Leung, 2007; Pullman, 2004; Seedhouse, & Gallagher, 2002; Seman, 2007; Thompson & Chochinov, 2008; Walsh & Kowanko, 2002). Yet, the concept of dignity has an extensive history in many other sectors, including theology, politics, philosophy, business, law, and education. Regardless of the criticisms, it has also been well-examined, especially in recent years, in the health care arena and is described as a worldwide concern to nurses (Baillie, 2009; Coventry, 2006; Jacobson, 2007).

1.2.1 A Brief History of the Term

The word *dignity* is derived from two Latin words: *dignitas*, meaning merit or worth, and *dignus*, meaning worthy (“Dignity”, 2012; “Dignity noun”, 2010). The Oxford English Dictionary defines dignity as the quality of being worthy or honourable (“Dignity”, 2012). The definition has a different emphasis on the Oxford Reference website, referring to dignity as the state or quality of being worthy of honour or respect (“Dignity noun”, 2010).

Historically, Aristotle’s *Eudemian Ethics* is believed to be one of the earliest writings speaking to the concept of dignity (Gallagher, et al., 2008). Aristotle believed dignity to be one of the 14 virtues of character. He described dignity as the mean state between servility, being overly eager to please, and “unaccommodatingness”, being uninterested in pleasing others (Aristotle, 2005 version, pp. 17). Furthermore, dignity is said to be a quality that leads to happiness, the activity of a good soul and a complete life. It is important to note that Aristotle maintains that one must have the capacity for reason to have the virtue of dignity (Aristotle, 2005 version). In terms of the classical Greek perspective, dignity is viewed as a hierarchical quality.

Only certain people or groups were seen as having dignity based on their position in society.

Dignity was therefore considered a relative and social quality (Jacobson, 2007; Novak, 1998).

The concept of dignity can also be traced back to Biblical times and the Christian middle ages. The Judeo-Christian worldview connects the concept to humanity's special relationship with God. God created humans in His image, giving them responsibility over all of His creation, and blessing them (Genesis 1:26-28a, New American Standard Bible). Dignity is seen as a notion of universal application from this stance - all people have a special worth as all are loved and made in God's image (Jacobson, 2007; Novak, 1998).

A more recent examination of dignity concerns the writings of 18th century philosopher, Immanuel Kant. Kant (1785/2005) maintains that humankind has intrinsic value: "For rational beings all stand under the law that each of them should treat himself and all others, never merely as a means, but always at the same time as an end in himself" (p. 112). People are considered to have an innate and incomparable worth that cannot be sold or traded. Kant describes this as dignity (Kant, 1785/2005). However, it is important to note that Kant believed this intrinsic worth to stem from an individual's rational nature, capacity for morality, ability to act autonomously, and sense of duty to qualities such as fidelity and kindness (Kant, 1785/2005). Dignity, the incomparable worth of humanity, according to Kant is therefore limited to those that meet these prerequisites.

1.2.2 A Contemporary Perspective

The notion of dignity is debated in contemporary literature as well. In an attempt to develop a clearer understanding, the concept is commonly divided into aspects, supporting the idea that there is more than one type of dignity. However, there is little consensus across authors about how each aspect should be labelled with various terms being used. In Canadian ethicist

Pullman's (2004) discussion on the role of dignity in moral discourse, he speaks to the conceptions of basic dignity and personal dignity. Basic dignity is described as the type of dignity that is referenced in international charters, such as the Universal Declaration on the Human Genome and Human Rights, as well as the dignity that is violated when crimes against humanity are investigated (Pullman, 2004). It reflects the intrinsic and unshakeable moral worth of all people (Pullman, 2004). Unlike the universal application of basic dignity, personal dignity concerns the dignity of a specific group of people or the dignity of an individual person. It is subjective, tied to a person or group's perceptions, beliefs, goals, circumstances, and ideas of meaning (Chochinov, 2006; Dresser, 2004; Pullman, 2004). Dividing dignity into the two discussed conceptions brings clarity to the term. However, Pullman argues that this is not a valid reason to abandon the larger concept of dignity. Both conceptions are required for a complete picture of dignity. Closely intertwined, basic dignity and personal dignity work together to heighten our understanding of the concept, our moral nature, and how this is displayed in daily life (Pullman, 2004).

Jacobson (2007), a Canadian health researcher, also argues that dignity has two distinct categories. They are labelled as human dignity and social dignity and must be examined this way in order to make sense of the greater term. Human dignity is defined as the "inherent and inalienable value that belongs to every human being simply by virtue of being human" (Jacobson, 2007, p. 294). It is the dignity that is presented in the United Nations' Universal Declaration of Human Rights (Siegert, 2009). The second category, social dignity, is based on human dignity and is a result of its recognition. Social dignity is influenced by circumstances and interactions and can be further broken-down into the sub-categories of dignity-of-self and dignity-in-relation (Jacobson, 2007). Dignity-of-self reflects a person's self-confidence and self-

esteem – it is the value, the dignity, that one ascribes themselves. On the other hand, dignity-in-relation is the sense of worth that is passed between people in daily interactions (Jacobson, 2007; Siegert, 2009). This framework brings clarity to the overarching term of dignity. Jacobson emphasizes that when exploring or applying dignity, it is critical to use this framework. The type of dignity in question needs to be specified in order to both avoid the typical criticisms of the concept and maintain its value and importance in daily life (Jacobson, 2007).

Parallels can be easily observed between Pullman and Jacobson's types of dignity. The definitions of basic dignity and human dignity are essentially identical and the similarities between personal and social dignity are equally evident. It may therefore be surprising to note that the conceptions of dignity do not stop with the above four examples. An American study exploring patients' and health care professionals' beliefs about factors influencing the preservation of patient dignity at the end of life categorizes dignity as either extrinsic or intrinsic (Periyakoil, Noda, & Kraemer, 2010). Edlund's (2002) doctoral dissertation proposes that people have two types of dignity: absolute dignity and relative dignity (as cited in Stabell & Naden, 2006). As a final example, a study exploring the meaning of dignity to older nursing home residents presents the term as having interpersonal and relational components (Pleschberger, 2007). Although there are some differences between these many forms of dignity, they generally speak to similar ideas.

A particularly influential and frequently referenced writer on dignity is Lennart Nordenfelt. As part of the Dignity and Older Europeans project, Nordenfelt explored the concept, arguing for four types of dignity: the dignity of merit, the dignity of moral stature, the dignity of identity, and the universal human dignity, also referred to as *Menschenwürde* (Nordenfelt, 2004). He describes the dignity of merit as the dignity that comes with holding a specific position, for

example a cabinet minister or physician. Such roles entitle a person to certain privileged rights and respect. The dignity of merit is also said to have a more informal existence, such as in situations where people earn merit through actions that deserve respect. The dignity of moral stature is based on the thoughts and deeds of a person, providing them with a special respect. The dignity of merit and the dignity of moral stature both vary in amount of respect owed and can come and go (Nordenfelt, 2004).

The dignity of identity and the dignity of *Menschenwürde* are said to be particularly relevant to health care professionals (Gallagher et al., 2008). The dignity of identity is based on one's identity as a person. It pertains to a person's sense of self-respect and is further related to feelings of autonomy and integrity as well as personal history and relationship with others (Gallagher et al., 2008; Nordenfelt, 2004). This type of dignity can be violated through the actions of other people, injury, illness, or old age. Such insults can alter a person's identity, affecting their sense of autonomy and integrity and possibly leading to feelings of humiliation and loss of self-respect (Nordenfelt, 2004). In regards to its relevance to health care, dignity of identity can be used to support the notion of individualized care and should encourage health care professionals to be sensitive to the added vulnerability that illness, injury, and aging bring to being a patient (Gallagher et al., 2008; Nordenfelt, 2004).

Nordenfelt's dignity of *Menschenwürde* can easily be compared to Pullman's basic dignity and Jacobson's human dignity. It refers to the intrinsic worth all people have simply for being human. Every person has this value in the same amount, which creates the basis for respect for human rights (Nordenfelt, 2004). Dignity of *Menschenwürde* is of great importance to health care professionals as it stresses the need to recognize the worth of all people, irrespective of their condition (Gallagher et al., 2008).

1.2.3 Dignity in Health Care

In recent years, the concept of dignity has become a popular focus in nursing and health care research. A great deal of this recent research has concentrated on exploring the meaning of dignity from the perspective of patients, family members, and health care professionals. These studies have been completed worldwide, demonstrating universal interest and the importance of dignity in health care.

In a search of nursing and health care research focusing on dignity, twenty-two publications were found looking at perceptions, understandings, and the meaning of dignity in care. Of the twenty-two studies, eight were done in the United Kingdom (Baillie, 2009; Bridges & Nugus, 2010; Dawood & Gallini, 2010; Enes, 2003; Matiti & Trorey, 2004, 2008; Morgan, 2012; Webster & Bryan, 2009), one in Australia (Walsh & Kowanko, 2002), two in Norway (Hov, Hedelin, & Athlin, 2013; Slettebo, Caspari, Lohne, Aasgaard, & Naden, 2009), two in Sweden (Franklin et al., 2006; Melin-Johansson, Axelsson, & Danielson, 2007), and one in Finland (Miettinen, Alaviuhkola, & Pietila, 2001). Furthermore, four studies were based in the United States (Boisaubin, Chu, & Catalano, 2007; Jacelon, 2003; Periyakoil et al., 2010; Periyakoil, Stevens, & Kraemer, 2013), one in Canada (Chochinov et al., 2006), two in Hong Kong (Chan & Pang, 2007; Ho et al., 2013), and one in China (Zhai & Qiu, 2007). In addition to being located in various worldwide settings, the studies were also completed in different health care settings. How the meaning of dignity is understood in acute care, palliative care, and long-term care from the perspective of patients, family members, and health care professionals will now be examined.

1.2.3.1 Acute Care

A number of studies have been completed in the acute care arena. Walsh & Kowanko (2002) completed a small phenomenological study seeking the experiences of five patients and four nurses and their views about how patient dignity is maintained or violated. This was done to develop an understanding of the concept of dignity and to have this understanding grounded in practice. The nurses attributed privacy, especially in regards to the body and room space; control; consideration of emotions; recognition and respect for personhood; advocacy; and offering of time to the meaning of dignity. The patients listed similar elements, including privacy, time, respect for personhood, control, choice, consideration of needs, and nurses' awareness of situations (Walsh & Kowanko, 2002).

Baillie (2009) also explored the perceptions of nurses and patients, using observation and interviews to uncover the meaning of patient dignity. Nurse and patient definitions were found to be similar, both highlighting feelings as central to their understanding of patient dignity. The feelings surrounding dignity were further detailed as feeling comfortable, feeling in control, and feeling valued. Respectful behaviour was another important tenant of the concept. A clearly articulated definition of patient dignity was presented based on study findings: "Patient dignity is feeling valued and comfortable psychologically with one's physical presentation and behaviour, level of control over the situation, and the behaviour of other people in the environment" (Baillie, 2009, p. 33).

A study exploring the meaning of dignity solely from the patient's perspective highlighted four themes supporting a sense of dignity: pain control, an acceptable environment, care and attentiveness, and information and communication (Dawood & Gallini, 2010). The study emphasized the overall theme of listening to patients as a way to ensure respect for dignity.

Patient perceptions of dignity in care were also the focus of a survey study completed in North Wales. Although the participants were not described as acute care inpatients, they were older people who had previously required health care services. Maintaining independence, communication style, individual respect, and personal care were found to be central to the understanding of dignity in care (Morgan, 2012).

An additional study focusing on patient perspectives identified six themes that contribute to the maintenance of patient dignity: privacy; confidentiality; communication style and need for information; choice, control, and involvement in care; respect; and decency and forms of address (Matiti & Trorey, 2008). The study concluded that patients have a clear understanding of dignity, although dignity expectations may change depending on a patient's condition. Nurses must be aware of individual expectations and match these with specific nursing activities (Matiti & Trorey, 2008). In an earlier article, Matiti and Trorey (2004) also explored how patients adjust their dignity expectations. Patients were shown to change how they felt about the six themes depending on the situation and their health at any given time. This process was labelled perceptual adjustment and was described as a self-protection measure, allowing patients to handle violations to dignity that were likely to occur while hospitalized. This supported dignity as a fluid and dynamic concept (Matiti & Trorey, 2004).

Other studies have explored the concept of dignity from the perspective of older adults. A sense of significance, independence, and effective and respectful communication styles were found to be particularly important to the older adult's understanding of dignity. Privacy, cleanliness, respect, and control were also noted to be important to the meaning of the concept (Bridges & Nugus, 2010; Webster & Bryan, 2009). A study exploring the meaning of dignity for five hospitalized older adults found a sense of self-worth and being treated with respect to be

central to the definition. Privacy was another important element in the understanding of the concept. The older adults described dignity as a dynamic concept. During the acute phase of their hospitalization they were more focused on their health. However, as their health stabilized, their focus slowly returned to maintaining dignity (Jacelon, 2003). This process is very similar to the perceptual adjustment described by Matiti and Trorey (2004). The meaning of dignity has also been sought from patients recovering from head injuries. These patients reported self-management, meaningfulness, respect, being heard, and the giving of time by staff to be key to their sense of dignity (Slettebo et al., 2009).

1.2.3.2 Palliative Care

Patient dignity has been described as the overarching goal of palliative care (Chochinov, 2006). A number of researchers have examined the meaning of the concept to those nearing or at the end of life. Enes (2003) explored the meaning of dignity to patients, relatives, and health care professionals in palliative care. Four themes were evident from the interviews: relationships and a sense of belonging, having a sense of control, being recognized as human, and maintenance of self. Patient dignity was overall viewed as a holistic term, including physical, psychological, social, cultural, and spiritual components (Enes, 2003).

The meaning of patient dignity has also been investigated solely from the perspective of family members. A study exploring caregivers' perceptions about palliative family members' quality of life identified dignity as a main theme. Patient dignity was defined by the participants as the recognition of one's personhood, working to preserve autonomy, and maintaining hope (Melin-Johansson et al., 2007). Moreover, dignity has been described by family members as an essential characteristic of good palliative care and contributing to a good quality of life for dying

patients (Miettinen et al., 2001). The family members' defined dignity as having a sense of control, having one's voice heard, and being able to participate in normal family life.

Other studies focusing on dignity near the end of life have found that patients define the concept by speaking about times when their dignity was threatened or violated. Franklin et al. (2006) found that the body was seen as a central component to the concept of dignity. Patients spoke to the many body changes, related to illness and aging, that affected their personal autonomy and identity. Fears of loss of control, dependency, loss of voice, and anxiety over how these may progress in the future were of great concern to the patients and their sense of dignity. However, instances of feeling valued and of worth, which strengthened feelings of identity, were able to uphold the patients' feelings of dignity. This was possible through times with family and supportive staff (Franklin et al., 2006). Another study exploring the perspectives of palliative patients and health care professionals discovered the two groups to have a significantly different understanding of the concept. The health care professionals reported treating a patient with disrespect and ignoring patient wishes as detrimental to the concept of dignity. In contrast, patients felt that receiving poor medical attention and poor pain control violated the meaning of dignity (Periyakoil et al., 2010).

As a final note, a study validating a theoretical model of dignity in terminally ill patients found that feeling like a burden and not being treated with respect were the patients' two greatest concerns regarding their dignity. Their meaning of dignity surrounded feeling valued, maintaining autonomy, and having a sense of worth (Chochinov et al., 2006). This model of dignity has also been explored for its generalizability to a Chinese context, specifically older palliative care patients residing in Hong Kong. Most themes brought forward by the Chinese patients were similar to findings from Western studies looking at the model. A previous theme of

anxiety surrounding death was not found to have a part in the Chinese understanding of dignity. In addition, four new themes were discovered. The Chinese understanding of dignity valued the ability to endure pain, the opportunity to share wisdoms and values to younger generations, finding inner peace and comfort, and a physical and emotional closeness to family (Ho et al., 2013). This study demonstrates the important role culture plays in the meaning of dignity at the end of life.

1.2.3.3 Long-Term Care

Alongside acute care and palliative care, the concept of dignity has been explored in the long-term care arena. Hov et al. (2013) indirectly focused on the concept of dignity, looking at long-term care nurses' understandings of good nursing care in regards to the care of patients nearing the end of life. Preserving patient dignity was found to be a central theme. According to the nurses, preserving dignity meant recognizing the patient as a complete and unique person and caring for all needs, whether they were physical, spiritual, or relational (Hov et al., 2013).

Another study looking at the perspective of long-term care nurses focused on nurses from different cultural backgrounds and how this may alter the understanding of patient dignity at the end of life. Overall many similarities were discovered. Treating patients with respect and honouring their wishes were said to be the most important components of preserving dignity. Helping patients prepare for the end of life, encouraging shared-decision making, and providing high-quality nursing care were also deemed important aspects of the concept. The only difference in the meaning of patient dignity at the end of life between the nurses of various backgrounds was in the understanding of what constitutes respectful care (Periyakoil et al., 2013).

Culture also played a role in three studies that focused on people living in long-term care residences, their families, and their health care professionals. Various concepts were explored with the participants, one concept being the understanding of dignity. The three studies followed the same format with the one difference being the culture of the participants. The first study was based in the United States. Residents felt that dignity meant being treated as an adult and treated with respect. The family members, nurses, and physicians had similar perspectives, stating that dignity involved a respect for personhood. The physicians also listed autonomy, privacy, a sense of control, and a sense of self to be important to the meaning of dignity (Boisaubin et al., 2007). The second study was based in Hong Kong. Residents and their relatives described the meaning of dignity to have elements of autonomy; however, the most important aspect was said to be relationships, particularly the concern and involvement of family. The family relationship provided a sense of worth. The physicians also agreed with this definition. The caregivers were the only group to define dignity further, listing freedom, autonomy, choice, and respect, in addition to family concern, as important elements to the meaning of the concept (Chan & Pang, 2007). The final study was based in Beijing. The residents defined dignity as being able to make decisions independently, having family relationships, and being listened to. The meaning of dignity to family members was quite similar. They listed respect, autonomous choice, and family involvement as important elements. The health care professionals felt that respect, autonomy, and self-determination were main tenants of the concept (Zhai & Qiu, 2007).

1.2.3.4 Summary

The meaning of dignity varied between individual study participants; however, common themes are nevertheless evident across health care domains and amongst the roles of patient, relative, and health care professional. Control, independence, and respect for personhood were

the most frequently mentioned attributes of dignity. Other recurrent themes ascribed to the meaning of dignity included privacy, communication styles, a sense of significance and worth, and being heard. Two studies defined patient dignity as a dynamic concept, its importance fluctuating depending on the acuity of the illness or situation (Jacelon, 2003; Matiti & Trorey, 2004). The understanding of the concept was also to be seen to have some variation across cultures, with three studies (Chan & Pang, 2007; Ho et al., 2013; Zhai & Qiu, 2007) reflecting values of the Eastern world and one study (Periyakoil, et al., 2013) looking at a multicultural sample living in a Western setting. All other studies in this review reflected a Western perspective. It is interesting to note that the meaning of dignity was for the most part shared between patients and health care professionals. Four of the six studies seeking the perspectives of patients and health care professionals found both groups to have a similar understanding of the concept (Baillie, 2009; Boisaubin et al., 2007; Chan & Pang, 2007; Walsh & Kowanko, 2002). This raises the question: If the understanding is comparable, why are insults to dignity still occurring?

1.3 The Significance of the Problem

Violations to patient dignity are not life-threatening - at least not threatening in the same way as a pulmonary embolism or a severe pneumonia. However, disrespect for dignity can have serious effects on the health and well-being of this vulnerable population. When dignity is not recognized and valued, patients can be left with unnecessary feelings of stress and anxiety as well as a diminished sense of self-worth (Healthcare Commission, 2007; Matiti & Trorey, 2004; Whitehead & Wheeler, 2008b). This experience directly affects emotional health and can possibly hinder recovery (Healthcare Commission, 2007). Fractured dignity has been significantly correlated with feelings of depression and hopelessness, a loss of will to live, increased dependency with care, and physical discomforts, such as pain (Chochinov, 2002). It is

also distressing for family and friends who have no choice but to trust nurses with their loved ones (Donnelly, 2010; Morris, 2012). Stress is being added to an already stressful situation. In addition, these incidents have been shown to lead to an overall distrust in nurses and the health care system, eroding the public's confidence in and support for the nursing profession (McSherry et al., 2012). In turn, when dignity is protected, patients report an emotional comfort, which they perceive to support their recovery (Williams & Irurita, 2004). Respect for dignity is also associated with a greater satisfaction in care received and a closer adherence to treatment plans (Beach et al., 2005). This is a positive outcome for the nursing profession, nurse-patient relations, overall patient well-being, and long-term patient recovery.

Furthermore, nurses are affected by violations to patient dignity as well. A 2008 survey by the Royal College of Nursing in the United Kingdom found that eight out of 10 nurse respondents always or sometimes felt distressed, and that they left work upset from being unable to provide patients with a desired level of dignified care. In addition, 65 percent of the respondents reported that they sometimes or never had sufficient time to preserve and promote patient dignity (Royal College of Nursing, 2008b). A Canadian study exploring the values that matter to nurses found that when nurses were unable to enact their stated values they experienced ethical distress (Beagan & Ells, 2009). The incidence, intensity, and understanding of moral distress in nursing practice have in fact been well-covered in the literature (Corley, 1995, 2002; Elpern, Covert, & Kleinpell, 2005; Epstein & Hamric, 2009; Fry, Harvey, Hurley, & Foley, 2002; Hamric, 2000; Rice, Rady, Hamrick, Verheijde, & Pendergast, 2008; Rushton, 2006; Wilkinson, 1987; Wilson, Goettemoeller, Bevan, & McCord, 2013). The Canadian Nurses Association's (2008) *Code of Ethics for Registered Nurses* explains that ethical, or moral, distress occurs when nurses believe certain actions are needed, although do not or cannot take

steps to follow through. The inability to choose and to act in such situations has been related to the ethical climate of a workplace, physical constraints, the values of the greater health care system, factors deemed beyond nursing control, and the believed powerlessness of the nursing position (de Veer, Francke, Struijs, & Willems, 2013; Pauly, Varcoe, Storch, & Newton, 2009; Rodney et al., 2009; Varcoe et al., 2004; Varcoe, Pauly, Storch, Newton, & Makaroff, 2012). As a result, nurses' identity and integrity as moral agents are compromised, leading to feelings of moral distress (Canadian Nurses Association, 2008). The experienced moral distress has been related to feelings of frustration and inadequacy, burnout, increased sick calls, and greater attrition rates (Baillie et al., 2009; Sørli, Kihlgren, & Kihlgren, 2005; Sundin-Huard & Fahy, 1999). These outcomes will impact the quality of patient care, the increasing shortage of nurses, and potential new interest in the nursing profession. This is a clear argument for the seriousness of ethical issues and the need to support and encourage nurses to enact their stated values, including the preservation of patient dignity, in daily practice.

1.4 Addressing the Problem

Respecting and protecting dignity is an essential component of good, ethical, and competent nursing care. It is imperative that all types of nurses, whether they are based in acute care, palliative care, long-term care, or community settings, hold firm to this great responsibility. Yet, as has been discussed, there are concerns that nurses are not taking measures to preserve this critical concept. Dignity's place in the nursing profession has been analyzed in theory, explored in research studies, and is mentioned by nurses; however, it is failing to hold a central role in daily practice. There is an obvious gap between discourse and practice. This raises the question: What is being done to fill this gap? There is already a thorough understanding of the meaning of patient dignity and it has been described as a well-examined topic (Jacobson, 2007; McSherry et

al., 2012). Why then is patient dignity still an issue? A missing piece concerns what is being done to reconnect dignity and nursing. An examination into what is being done to correct the situation is an appropriate next step.

CHAPTER 2: RESEARCH APPROACH AND METHODS USED

2.1 Objective

The aim of this study was to conduct an integrative review exploring strategies that focus on returning the upholding and preservation of patient dignity to the centre of acute care nursing. This examination gave insight into what is needed to help nurses apply the concept in daily work, building a comprehensive understanding of the concept in nursing practice, and offered direction for supporting the profession and future research (Whittemore & Knafl, 2005). The following research question guided the review: What strategies have been proposed, or implemented, to translate a conceptual understanding of patient dignity into a central role in daily acute care nursing practice?

2.2 Design

An integrative review design, as detailed by Whittemore and Knafl (2005), was used to conduct the study. This approach was chosen for a number of reasons, one being that it allows for the reviewing of evidence on a particular topic. Integrative review findings also have direct applicability to practice and can inform research to further advance understandings (Whittemore & Knafl, 2005). These points were especially relevant to the review research question, which sought to reconnect nursing and patient dignity, fortifying the concept's presence in daily nursing practice. In addition, an integrative review approach was an appropriate choice as it is the only design that permits the inclusion of research from diverse methodologies (Whittemore & Knafl, 2005). This allowed for the inclusion of both experimental and non-experimental research, supporting a complete and thorough understanding of the chosen topic.

2.3 Search Methods

Specific criteria were used to decide what literature to incorporate in the review. The criteria were based on the study's purpose, providing focus and boundaries for the search

(Whittemore & Knafl, 2005). As discussed in Chapter 1, the meaning of dignity has been examined from various perspectives. Although differences were seen in the wording of definitions between individual writers and study findings, the understanding of the concept was generally quite similar. The contemporary perspectives and the examination of the concept in health care both defined dignity as the intrinsic worth of all people and the value a person ascribes themselves through perceptions, beliefs, circumstances, and relationships with others. A sense of autonomy, integrity, control, and respect were also highlighted. It is this understanding of dignity that was used in this review.

The main focus of the review was the concept of dignity in acute care nursing practice. As such, only literature examining dignity in this light was included. Acute care patients are at particular risk for experiencing threats to their dignity due to their vulnerable state, the hospitalization, the present state of nursing, and the priorities of the health care system. While the previous chapter examined literature from palliative care, long-term care, and acute care, and dignity is arguably a topic that needs to be discussed in all settings, to focus the search and support the contextual relevance of findings, only literature from the adult acute care population was included. This meant that palliative care that was being provided on an acute care ward was excluded as was literature looking at patient dignity and euthanasia. Pediatric acute care literature was also excluded. Pediatrics is a distinct sector, dealing with a population where dignity, although important, is not necessarily understood due to the age of the patients. Findings may have proven difficult to translate to the care of adults and as such, were excluded from the review. As a final note, only English language publications were considered.

The search was completed using the following four electronic databases: the Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed, PsycINFO, and Academic

Search Complete. CINAHL was used as it provides indexing for a large quantity of nursing literature and was therefore a rich means for addressing the research question (EBSCO, 2012b). PubMed contains over 21 million citations of biomedical research while PsycINFO is a well-known database covering literature in the behavioural sciences and mental health. It includes material pertaining to the psychological aspects of health care (EBSCO, 2012a; U.S. National Library of Medicine, 2012). Both are important resources when examining a nursing-related question. Finally, Academic Search Complete was used as it provides complete coverage of multidisciplinary academic journals, is the largest academic database available, and is said to be an excellent resource for scholarly research (EBSCO, 2014).

Key terms to frame the search included: dignity, nursing, nursing interventions, and patients. The database recommended subject headings were used for each keyword. However, on four occasions a general term was used as well. PubMed did not have the word dignity indexed, instead recommending the use of personhood and humanism. These two terms were searched as PubMed subject headings alongside a straightforward search of the word dignity to access as much relevant data as possible. This also occurred in the PsycINFO search with the terms dignity and nursing interventions. Concerning the first term, dignity, PsycINFO only created it as a subject heading in 2012. It was additionally searched as a general term to ensure data prior to this indexing was reached. Nursing interventions did not exist in PsycINFO with the word intervention being recommended instead. As such, intervention was searched as a recommended subject heading with nursing interventions being added to the search as a general term. The key term nursing interventions also did not exist in the Academic Search Complete subject terminology with the recommended terms leading to no results. This led to nursing interventions being used as a general term. The search terms were then expanded to include: nurse-patient

relations and staff development. The recommended subject headings were again used for each key word.

Dignity has been studied in the health care arena from various platforms. In order to more fully understand the topic, all types of literature were permitted. This included theoretical literature, quantitative and qualitative research, expert opinion pieces, concept analyses, practice-based journal articles, and policy documents. Following the search of the computerized databases, the reference lists of chosen literature were also reviewed for relevant sources.

2.4 Search Outcome

The initial search located a total of 1502 publications - 438 in CINAHL, 587 in PubMed, 302 in PsycINFO, and 175 in Academic Search Complete. Keeping the inclusion criteria and research question in mind, the title of each publication was screened. CINAHL, PsycINFO, and Academic Search Complete provide a list of subject headings with each resulting article. The subject headings touch on the main themes of the examined piece. These were also screened. Those that seemed relevant to the research question were transferred to RefWorks, a web-based bibliography and database manager (RefWorks, 2009). If there was insufficient information in the title or subject headings, or any uncertainty surrounding the potential relevance or appropriateness of a publication, it was included and imported to RefWorks for further review. It was clear when an article needed to be excluded. Most often this was due to a setting other than acute care or when the aim was to explore perspectives, or experiences, of dignity in care. From the original 1502 publications, 488 articles were imported - 230 from CINAHL, 140 from PubMed, 44 from PsycINFO, and 74 from Academic Search Complete. The removal of duplicates led to 366 remaining publications.

The full text of the 366 articles was retrieved and read in entirety. This examination found 92 of the 366 articles to be relevant to the review's aim. Of this new total, 33 were identified as news items, briefs, and short journal articles. These short reports did not put forward any original thought. Instead, they brought awareness to studies, campaigns, and projects that were published elsewhere. As such, it was decided that they should be removed from the total, bringing the sample down to 59 publications.

The next step was to review the references of the 59 relevant articles. This highlighted 34 new possibilities that when scrutinized led to an additional nine documents being included, bringing the total to 68 publications. As this total was thought to be a relatively large number to analyze, it was decided to divide the 68 articles into three sections, based on high, medium, and low relevance, using criteria that will be outlined below in the data evaluation section. Publications that were found to be of high relevance to the research question were the focus of the review. Publications deemed to be of medium relevance were still reviewed for additional insight, but not analyzed or discussed. Articles of low relevance were removed altogether. Twelve highly relevant articles were selected for the review. This included program development literature, expert opinion pieces, practice-based journal articles, and a high-profile campaign.

2.5 Data Evaluation

Whittemore and Knafl (2005) maintain that in an integrative review, how the quality of chosen publications is critically appraised depends on the variety of research designs in the sampling frame. If the research designs are similar, quality can be assessed and compared across material. If the sampling frame is of diverse methodologies, one option is to only assess the quality of studies with discrepant findings. Alternatively, if the sampling frame is made of empirical and theoretical works, the appraisal may have to be completed in multiple steps. This

may be done by examining each chosen work on the authenticity, methodological quality, information value, and representativeness of available information and then coding the work on a two-point scale, either high or low quality (Kirkevold, 1997; Whittmore & Knafl, 2005).

Overall, Whittmore and Knafl (2005) acknowledge that there is no gold standard in the quality appraisal of an integrative review and that it is a complex process. They maintain that a most important point is that the evaluation of the literature be done in a meaningful way.

Due to the diverse nature of this integrative review's sampling frame, a multiple step method was chosen to critically evaluate the literature. Publications were evaluated on relevance to the review research question and methodological rigour. As no appropriate instruments could be found, tools were developed defining how relevance and methodological rigour would be measured, a step that Whittmore and Knafl (2005) state may be necessary. It must be noted that two published integrative reviews were referred to and helped shaped the evaluation tools used in this review (Flinkman, Leino-Kilpi, & Salanterä, 2010; Tranter, Irvine, Collins, 2012).

As stated above in the search outcome section, publications were first evaluated on relevance. Literature was assessed to be of high, medium, or low relevance to the review research question. Articles deemed to be of high relevance were those whose primary focus was on strategies to help reconnect nursing practice with the upholding of patient dignity. Articles of medium relevance referred to literature where the review research question held a secondary focus to the article's main purpose. It also included publications that focused on the review question, however, did not meet all inclusion criteria (for example, pieces that were not set in acute care or did not concentrate on the nursing profession). Articles of low relevance only touched briefly on the research question. Literature was also said to be of low relevance if the

article could be deemed a strategy itself (for example, a concept analysis on patient dignity that could be used in a teaching setting).

The next step in the data evaluation process focused on methodological rigour. This involved examining each publication for particular methodological characteristics and using this information to appraise the overall quality of the work (Cooper, 1989, as cited in Flinkman et al., 2010). Three tools were created to evaluate quality – one for the high-profile campaign and literature on program development, a second for expert opinion pieces, and a third for practice-based journal articles.

The tool for the high-profile campaign and program development articles began by assessing whether the program's purpose and objectives were presented, if the need for the program was supported, and whether the context was provided. Following this, the details of the program structure as well as the description of and research support for the strategies were examined. Lastly, details of recruitment; stakeholder buy-in; feasibility, including transferability and cost; the evaluation of both the program and effects on the concept of dignity; and conclusions offered were assessed.

The tool for the expert opinion pieces looked at whether the article's aims were presented, if the context was provided, and if the expertise of the author was shared. It also evaluated the details of and research support for chosen strategies. The final points assessed included the quality of the publishing journal and the offering of conclusions.

The third tool was tailored for the practice-based journal articles, although quite similar to the one for the expert opinion pieces. It looked for a description of the article's aims, an understanding of context, support regarding the need for the article, and the background of the

author. This tool also assessed the description of the chosen strategies, how they were detailed and the research support that was offered, and looked at the conclusions that were provided.

The appraisal was recorded in a table format. Following the application of the tools the twelve publications were appraised to be of high, medium, or low quality. Publications with a complete and detailed methodological description were said to be of high quality. Those with an incomplete description were said to be of medium quality. Finally, literature with little methodological description was appraised as low quality. No literature was excluded from the review based on the appraisal; however, the rating was taken into account in the data analysis stage, with research of lower quality having less of an impact on the final understanding of the research question.

2.6 Data Analysis

The data analysis stage required a number of steps. The initial phase involved dividing the chosen literature into subgroups (Whittemore & Knafl, 2005). This review separated the literature into subgroups based on methodology. The twelve highly relevant articles were divided into subgroups as follows: literature on program development, expert opinion pieces, practice-based journal articles, and a high-profile campaign. Following this, data from each source was extracted and compiled in a review matrix, a spreadsheet with labelled columns organizing the pertinent points of an article (Garrard, 2011). Six columns were chosen for the matrices. These subheadings were the same for each subgroup: reference, which included author(s), title, journal, date, and location; purpose; design; strategies; strengths, limitations, comments; and relevance. This display of the literature simplified and focused the data, assisting in the comparison and interpretation of the research (Whittemore & Knafl, 2005). The next step involved looking at the similar matrix subheadings across publications, specifically the reference, purpose, strengths and

limitations, and strategies columns. This was done using a simple concept map with the subheading in the centre, surrounded by relevant notes from the review matrix of each publication. The visualization of the data highlighted patterns, themes, and relationships within and across publications (Whittemore & Knafl, 2005). These concept maps were closely examined - the question “What do I see?” being asked over and over again. Ideas were contrasted, compared, and similar points were clustered together. The original publications were frequently revisited to ensure accuracy and that all relevant points were included. This was all recorded on paper. The understanding of dignity and its present state in acute care nursing was kept in mind throughout this process, shaping the interpretive efforts and drawing of conclusions.

A final step of this phase involved bringing the separate findings together for a complete presentation of the evidence on the topic, what it means for nursing practice, and future steps that must be taken. Throughout the analysis, decisions, thoughts, and ideas were recorded in a separate file to document the process (Whittemore & Knafl, 2005).

2.7 Rigour

Steps to enhance rigour were implemented throughout the integrative review. A clearly articulated research question and detailed methodology guided the process and have been described above. Each step was based on Whittemore and Knafl’s (2005) framework for integrative reviews. The framework offers an updated methodology for this review method, systematically outlining the entire process, addressing the known challenges of integrative reviews, and taking care to ensure rigour is upheld. This review’s proposed methods section carefully followed Whittemore and Knafl’s steps. The research question was clearly presented and the elements of the question defined to provide focus and boundaries for the entire process. The plan for the literature search was detailed to promote coverage of all potential and relevant

results. For the evaluation of the data, steps to assess the quality of primary sources were outlined. Ensuring rigour was of particular importance in the data analysis stage. This required a predetermined outline of how this phase would progress. Systematic steps for data reduction, data display, data comparison, and conclusion drawing and verification were identified as recommended and described above (Whittemore & Knafl, 2005). Whittemore and Knafl's framework is an approach focused on upholding rigour. Closely following the framework protected against biases, gave strength to findings, improved the accuracy of conclusions, and presented a comprehensive understanding of the original problem.

The supervisory committee of this Master's thesis also assisted in ensuring the rigour of the review. The supervisor provided support throughout the process, offering clarification and direction, encouraging a thorough exploration of the topic, and challenging my decisions and conclusions. The supervisory committee provided consultation and engaged in discussion on the thesis topic, offering their expertise and experiences. As the graduate student, I maintained communication with the supervisory committee, providing details of progress, plans, and timelines through email and meetings. I sought their advice, expertise, and feedback throughout the process. In addition, I reviewed the literature on dignity and nursing regularly to keep up-to-date on new publications.

As has already been mentioned, I maintained a detailed record of thoughts, ideas, and decisions to support the accuracy of conclusions and the ability of others to replicate the review. The detailed record also involved reflexivity, an awareness of my involvement in the review and how personal biases might possibly interfere with data collection and interpretation (Polit & Beck, 2008). One potential bias was my training as a registered nurse. As I worked through the material, interpreted findings, and offered a final presentation, I was critically aware of my

nursing experiences and values, especially in regards to the nursing profession and patient dignity.

2.8 Dissemination

The goal of this Master's thesis was to produce a document that offered practical insight for nurses in light of the present-day acute care challenges. The intent was to provide valuable information for bedside nurses, nurse leaders, and nurse researchers on how patient dignity can be supported in daily nursing practice, individual nursing units, and hospitals as a whole. Two important steps in the dissemination process included knowing the audience the material needed to reach and choosing a means of communicating the findings (Polit & Beck, 2008). The main audience for this review was frontline nurses and nurse leaders. Frontline nurses have the greatest amount of patient contact by nature of the position and have the ability to directly impact nursing care. Nurse leaders hold a key position that reaches a larger scope of practice. In addition to having the potential to impact the greater health care system, nurse leaders have a central role in supporting innovative nursing practice, driving the profession forward, and promoting quality practice environments (Canadian Nurses Association, 2009).

A multiprong strategy to communicate research is often needed when more than one audience is being addressed (Polit & Beck, 2008). The plan is to publish the findings in a peer-reviewed journal targeting frontline acute care nurses. This will promote the accessibility and understanding of the review. A second step will be to complete an oral presentation in the form of a poster session at a professional conference. This will hopefully reach a greater variety of nurses, including nurse leaders.

CHAPTER 3: RESULTS

3.1 Overview of the Literature

Twelve publications were identified as highly relevant to the research question and organized into four subgroups: program development initiatives, expert opinion pieces, practice-based journal articles, and a high-profile campaign. The literature on program development initiatives referred to reports on hospital-based training programs, projects, or workshops. The high-profile campaign was similar to the programs, but was provided with its own subgroup due to its large scale. Similarities can also be noted between the expert opinion pieces and the practice-based journal articles. While the two could have easily been grouped together, it was decided to maintain two separate groups as they did have a different focus. The expert opinion pieces were written by authors who were clearly sharing their expertise on the subject, and who are frequently cited in the literature on patient dignity and nursing practice. The practice-based journal articles were written by nurses with various backgrounds; some would be considered experts, while others were general nurse leaders. Unlike the expert opinion pieces that offered explicit instructions, the practice-based journal articles were discussion pieces, focused more on heightening awareness and sharing information on patient dignity in nursing practice.

As mentioned above, the program development initiatives were hospital-based training programs, projects, or workshops. The programs were typically created in response to policy recommendations and large-scale inpatient surveys, as well as open forums for service users and staff. They were most often led by facilitators who were not connected to the individual nurses' specific hospital units. The structure of the programs varied in length and frequency of occurrence. The number of nurses per session was kept small across programs to promote discussion and open sharing of ideas (Crow et al., 2006).

The authors of the twelve publications were mainly nurses - most often academic or hospital-based leaders, or a combination of the two working in collaboration. The high-profile campaign did not have a specific author, but was put forward by the Royal College of Nursing, the largest union and professional body for nursing in the United Kingdom (Royal College of Nursing, 2014b). Each of the twelve publications spoke of raising awareness, re-sensitizing nurses, equipping and encouraging nurses, and emphasizing nursing's critical role in upholding patient dignity. The overall aim of the literature was to improve nursing practice and the patient experience, with cultural and institutional changes being listed as additional aims in three cases (Crow et al., 2006; Royal College of Nursing, 2014a; Webster, 2007). Table 3.1 may be referred to for a more detailed overview of the publications.

Table 3.1 Summary of the literature included in the review

Reference	Type of article	Description	Location/audience
Baillie & Gallagher, 2009, 2012; Royal College of Nursing, 2009, 2014a, 2014c, 2014d, 2014e, 2014f, 2014g	High-profile campaign	Titled: “Dignity: At the heart of everything we do”. Initiated following various reports and governmental concern on dignity in care. Launched nationwide in 2008 with an online survey of the nursing community that investigated awareness of dignity and barriers that hinder dignified nursing care. Involved the preparatory work of RCN members, practitioner groups, service user organizations, the voluntary sector, and other stakeholder groups.	United Kingdom. Nurses, including bedside nurses and nurse leaders.
Bruton, Lipp, & McKenzie, 2012	Program development	18 month training program initiated following a review on care by the Older People’s Commissioner for Wales. Developed by a local health board.	United Kingdom. Recent nursing graduates.
Chadwick, 2012	Program development	Half day workshops created in response to an inpatient survey. Commissioned by the director for quality and planned collaboratively with service users, family, and trust staff.	United Kingdom. Mainly practising nurses and occupational therapists.

Reference	Type of article	Description	Location/audience
Crow, Smith, & Keenan, 2006, 2007, 2010	Program development	Collaborative action research project. Commissioned by the hospital in response to a large-scale inpatient survey and a service user open forum.	United Kingdom. Mainly nurses and health care assistants.
Goldwire, 2012	Practice-based journal article	Anecdotal discussion piece recommending strategies.	United States. Nursing students and practising nurses.
Matiti, 2012	Expert opinion	Instruction on how dignity should be included in nursing education.	United Kingdom. Nursing student education.
Matiti & Cotrel-Gibbons, 2006	Program development	The Patient Dignity program involved half day workshops and follow-up support. Initiated as a result of Matiti's doctoral research.	United Kingdom. Nurses and health care support workers.
Matiti, Cotrel-Gibbons, & Teasdale, 2007	Practice-based journal article	Continuing professional development piece helping nurses reflect and develop strategies to promote dignity in practice.	United Kingdom. Nurses.
Oxtoby, 2005	Program development	A one-day workshop using a community theatre group. Initiated by two senior practice development nurses following privacy and dignity audits at the trust.	United Kingdom. Nurses.

Reference	Type of article	Description	Location/audience
Waters, 2008	Practice-based journal article	Discussion piece sharing innovative ways nurses are bringing dignity to the centre of practice.	United Kingdom. Nurses.
Webster, 2007	Expert opinion	Arguing for specific changes in care for the upholding of patient dignity and presenting what is needed for these changes to occur.	United Kingdom. Nurses.
Webster, Coats, & Noble, 2009	Program development	6 month project using creative arts. Minimal details on why the project was initiated. Involved the assistance of a large UK charity focused on the older person.	United Kingdom. Nurses.

3.2 Quality Appraisal of the Literature

The literature was critically appraised using the tools described in the methods section. Over half of the publications were assessed to be of high quality, which referred to literature with a detailed methodological description. This included three program development initiatives (Crow et al., 2006, 2007, 2010; Matiti & Cotrel-Gibbons, 2006; Webster et al., 2009), two expert opinion pieces (Matiti, 2012; Webster, 2007), one practice-based journal (Matiti et al, 2007), and the Royal College of Nursing dignity campaign. These seven publications provided a full description of the methodological characteristics outlined in the different evaluation tools. The literature on program development and the high-profile campaign both offered a detailed and well-supported presentation of the initiatives. The expert opinion pieces and the practice-based journal article were also assessed to be methodologically strong.

A particular strength that warrants noting was the use of a guiding philosophy in two of the twelve publications. The two publications were both program development initiatives and assessed to be of high quality. Matiti and Cotrel-Gibbons' (2006) program pointed to the "normative-re-educative strategy" as an underlining philosophy. This strategy has a strong focus on empowerment. It puts forward that the target population needs to be involved in any change process and that the culture of the participants must also be examined. Furthermore, the power behind change rests with the participants. More than an underpinning philosophy, Crow et al. (2006, 2010) chose to use a practical action research approach for their program. The authors believed that this would be the best method to strengthen understanding, raise awareness, and empower nurses. This method also works to develop the reflective skills of participants, and overall, enhances the quality of professional practice. Moreover, action research has been said to be a good means of bridging a theory-practice gap – a highly relevant point to the research

problem at hand and the research question guiding this review (Munn-Giddings, McVicar, & Smith, 2008; Rolfe, 1996).

Three program development publications were deemed medium quality (Bruton et al., 2012; Chadwick, 2012; Oxtoby, 2005). This evaluation was given to literature with an incomplete description. Examining the three articles, all were found to have a few methodological weaknesses. They were first of all missing details on recruitment. The article on Bruton et al.'s (2012) program did not cover how the extensive leadership team was staffed. Chadwick (2012) failed to provide details on how service-users were reached and Oxtoby (2005) did not mention how the 15 nurses were recruited. Feasibility was furthermore an issue. Bruton et al. (2012) and Chadwick (2012) did not address details of cost, with Chadwick also failing to comment on the feasibility of relieving staff from their bedside duties to attend the workshop. In addition, Bruton et al. (2012) were missing details on stakeholder buy-in. The authors also did not address patient dignity in the program objectives even though it was a key feature of the initiative and included in the evaluation. Another weakness with the article by Oxtoby (2005) was a failure to provide research support for the project's design. Although the authors did offer reasons for the choice of strategy, related research would have strengthened their decisions.

The two remaining publications, both practice-based journal articles, were assessed as low quality (Goldwire, 2012; Waters, 2008). Low quality was defined as a publication with little methodological description. A number of weaknesses were identified in each article. Waters' (2008) article was mainly anecdotal. The author presents a list of innovative initiatives focusing on patient dignity in nursing practice. It is empowering and encouraging to learn of nurses working to uphold dignity; however, the lack of details and the lack of research support for the strategies weaken the quality of the publication. Further weaknesses concern the author's

background and expertise not being shared and the absence of an explicitly outlined purpose. Goldwire's (2012) practice-based journal article included a number of similar weaknesses. The article's purpose is clarified only half-way through the piece, the context and strategies are anecdotal with no research support, and the author's background and expertise are vague.

While appraising the literature, a concern arose regarding the program development and campaign publications and the process of evaluation. Although each of the seven works contained some form of evaluation, they focused on the program itself or the participants' experiences. The evaluations did not consider whether the strategies implemented actually led to a change in nursing care or whether the patient experience was improved. There was also no attention given to documenting long-term change, which would examine the sustainability of any changes once participants return to their workplaces.

Although five of the articles were found to be of medium and low quality, and the literature on program development failed to complete a full evaluation, these publications were nonetheless considered in the analysis and further examined in the discussion. An integrative review considers all available evidence on a topic (Whittemore & Knafl, 2005). The quality of the pieces will be taken into account as conclusions are drawn and will also help direct the next steps that need to be taken.

3.3 Strategies

Five strategies emerged from the analysis of the literature. The strategies are listed as follows: Training; Reflection and discussion; Imagining the patient perspective; Leadership; and Planning for action. Each publication included at least two of the five strategies. The strategies will be presented individually; however, it is important to note that they often overlapped and supported each other.

3.3.1 Training

Training is defined as teaching and instruction to support nursing practice that upholds patient dignity in daily care. Training was used to encourage nurses to learn, question, share, and reflect in order to strengthen understanding and enhance awareness of patient dignity in practice. As the most frequently discussed strategy, it was put forward as an important means of reconnecting nursing and patient dignity in all publications except one expert opinion piece (Webster, 2007). The format of the training strategy included collaborative learning, the dissemination of resources, and addressing knowledge gaps.

3.3.1.1 Collaborative Learning

Traditional classroom, lecture-based teaching was only used in one case (Bruton et al., 2012). There were also only a few instances of independent training - one example being a practice-based journal article that included guided questioning, instruction, and the sharing of ideas to teach readers (Matiti et al., 2007). Instead, the structure of the training typically emphasized a collaborative learning approach in a group format. It was argued that nurses and nursing students already hold an understanding of patient dignity through personal and work experiences (Matiti, 2012; Matiti & Cotrel-Gibbons, 2006). As such, training needs to capitalize on this knowledge and concentrate on collaborative learning, specifically through the exploring of ideas as a group and participatory environments. The opportunity to explore and participate as a group was in fact the backbone of the training strategy in the majority of the program development initiatives (Chadwick, 2012; Crow et al., 2006, 2007, 2010; Matiti & Cotrel-Gibbons, 2006; Webster et al., 2009). It was also a component of the Royal College of Nursing campaign, noted in the training that was offered to the nurse leaders on facilitating the campaign education sessions (Baillie & Gallagher, 2009; Royal College of Nursing, 2014c, 2014d). The

entire collaborative learning structure was described as an effective and meaningful way of reconnecting nursing practice and patient dignity. It was furthermore said to support an understanding of nurses' own dignity and the dignity of others, as well as positive attitudes to dignity's presence in care and a deeper awareness of promoting it in practice (Matiti, 2012; Matiti & Cotrel-Gibbons, 2006). Collaborative learning through the exploring of ideas and participatory environments will now be discussed in more detail.

3.3.1.1.1 Exploring of Ideas

The opportunity to explore ideas, experiences, beliefs and values as a group was observed repeatedly in the literature. It was most clearly identified in two program development initiatives that involved service users (referring to previous patients and their family members) to teach nursing staff (Chadwick, 2012; Webster et al., 2009). The service users were first of all seen in Chadwick's (2012) workshops, acting as co-facilitators with nursing leaders. In these sessions, staff nurses were encouraged to explore what the concept of dignity meant to them and what it might mean to others. They were asked to share and discuss their thoughts and experiences, listen to the service users' stories, discuss the patient situations in light of the concept, and think about how practice could be changed. The program used the power of testimony to instruct the nurses. The chance to hear and explore first-hand patient knowledge and experiences was said to increase nursing's awareness as well as reaffirm and develop understanding of the concept.

Webster et al. (2009) also involved service users in their creative arts project, using a similar exploratory format. In this case, sessions were structured to support the learning of both service user and nurse. The two groups worked together to increase knowledge and understanding of the lived experience of hospitalization, particularly in regards to the concept of dignity. The participating nurses reported that the structure of the program brought the concept

of patient dignity to life and in doing so, developed a raised awareness and understanding of dignity in care.

Alongside practising nurses, an expert opinion piece identified exploratory training as having an important role in the structure of nursing school curricula. Matiti (2012) argued that the opportunity to explore the concept of patient dignity and how it may be applied in practice must start early in nursing school and continue throughout the program. Dignity-related topics to explore were said to include personal values and beliefs, an understanding of one's own dignity, how perceptions may differ, and cultural influences.

3.3.1.1.2 Participatory Environments

In addition to the opportunity to explore the concept of dignity as a group, the collaborative learning approach also emphasized participatory environments. This type of setting highlighted the need for training to involve and engage participants. It was most clearly observed in the programs by Matiti and Cotrel-Gibbons (2006) and Crow et al. (2006, 2007, 2010).

As discussed earlier in the quality appraisal section, Matiti and Cotrel-Gibbons (2006) based their workshops on the normative-re-educative strategy. An important aspect of this philosophy is that people need to be involved in change processes and that the power to create change lies within the person. Workshop teaching was therefore primarily accomplished through classroom discussion, bringing the nurses into the training and learning. Discussion topics included the meaning of dignity, skills required to promote dignity, identifying good practice, the impact of attitudes and beliefs, and how specific situations and the overall environment may influence dignified care. This points to exploratory training, but it also reflects an attempt to actively involve and engage the staff. The nurses' prior knowledge of dignity is acknowledged and they are asked to share and build upon it, recognizing that they are an important source of

information and have a critical role in creating changes in nursing practice and patient care. Although there was little formal evaluation of the participatory aspect of the training, the researchers did reflect that it was an important part of the program.

Crow et al.'s (2006, 2007, 2010) action research project implemented a similar participatory environment, explicitly stating that the number of participants per workshop group was kept small to promote such a setting. The authors felt very strongly about providing a democratic approach to the teaching sessions, engaging the participants in the learning process and empowering them to be involved in the concept. The action group that formed as a result of the action research project also provided a space for continuing training on the concept and was similarly structured with a democratic, participatory focus. Those in attendance were encouraged to discuss ideas, present issues, learn from each other, and share good practice.

3.3.1.2 Dissemination of Resources

The Royal College of Nursing campaign, “Dignity: At the heart of everything we do”, had a strong focus on training nurses on dignity. A main objective of the campaign included disseminating training and practice development materials. The document, “Small changes make a big difference: How you can influence to deliver dignified care”, focused on nurse leaders, teaching them how to make a positive impact on dignity in care in their respective units (Royal College of Nursing, 2009). This resource guides leaders, step-by-step, through the process of identifying dignity issues to creating sustainable change.

The campaign provided, and continues to offer, online training resources. The Royal College of Nursing website shares a working definition of dignity and provides examples of initiatives that have resulted from the campaign (Royal College of Nursing, 2014e, 2014f). The website also links to an interactive online learning resource focused on dignity in practice (Royal

College of Nursing, 2014g). This extensive resource engages nurses in the learning process, teaching them about dignity through straight-forward and detailed instruction, animations, patient stories, case studies, and questions. Although not an exhaustive list, the topics covered in the resources include personal understandings of the concept, caring with dignity, communicating with dignity, and upholding a dignified environment. The interactive tool falls in line with the entire campaign's aim of educating nurses to strengthen understanding and bring dignity into daily practice.

3.3.1.3 Knowledge Gaps

The publications made special comment on content that training must cover. These specifications centered on gaps in nursing knowledge that affected nurses' ability to uphold dignity in practice. Oxtoby's (2005) theatre workshop shared tools to challenge poor practice. The workshop facilitators described this as a means of empowering the nurse participants and giving them practical tools to take back to their workplaces. Similarly, Matiti (2012) emphasized the need for nursing students to receive training on skills to challenge poor practice. Training on diversity and an understanding of one's own dignity were also said to be important topics for nursing students as were holistic elements of patient care and communication training (Goldwire, 2012; Matiti, 2012). Water's (2008) practice-based journal article briefly shared a hospital-based initiative that focused on teaching about the care needs of special populations, such as those with dementia. It was hoped that through this training a culture of caring and preserving dignity would be fostered; however, no details were offered regarding any evaluation of the initiative. Finally, Matiti et al. (2007) sought to develop nurses' understanding of their own dignity. It was argued that without an awareness of our own dignity needs, wants, values, and beliefs, we will be blind to those of others (Burnard, 1997 as cited in Matiti et al., 2007).

3.3.2 Reflection and Discussion

Reflection and discussion were presented as a way to encourage the development of dignified nursing care. This strategy was also described as holding an important role in nursing school education, equipping students with the skills to preserve dignity in practice and working to develop sensitive nurses (Goldwire, 2012; Matiti, 2012). Although reflection and discussion are technically two different concepts, they are closely connected. Discussion flows naturally from reflection, enriching thoughts and often leading to further reflections. As such, I decided that reflection and discussion would be examined under one strategy heading.

3.3.2.1 Reflection

Reflection was described as an organized opportunity for nurses to think about the concept of dignity in detail and its place in nursing practice. Nurses were offered space and time apart from the busyness of the acute care world to contemplate the meaning of dignity. The use of reflection had strong ties with the training strategy, most closely related to the exploratory learning approach that was implemented in the program development initiatives. An important difference though is that while the training strategy was most often group-oriented, reflection was put forth as an individual activity.

The format of the reflection varied. For example, Bruton et al.'s (2012) new graduate program required participants to maintain a reflective diary, recording and analysing experiences. This was done to encourage a deeper understanding of patient dignity and nursing, and to allow participants to track their development throughout the program. Oxtoby's (2005) training course provided participants with reflection sheets, encouraging nurses to make notes about what they were thinking and feeling throughout the theatre event. Crow et al.'s (2006) action research project incorporated reflection into a mentorship experience that involved a

program facilitator visiting the participants' workplaces. During a visit the facilitator and a nurse participant observed the work environment, identified potential issues, and reflected on ways that dignity could be enhanced in practice and the clinical setting. The mentorship helped connect the classroom education and discussion to the practice arena. The reflective writing piece was used to cement these learnings. Participation in creative art forms, such as collage, dance, sculpting, and creative writing, was identified as an additional means of taking part in reflection (Webster et al., 2009). This activity was thought to encourage participants to focus on and contemplate the meaning of patient dignity and make sense of dignity-related experiences.

Regardless of the format, reflection was most often prompted through open-ended questions (Chadwick, 2012; Crow et al., 2006; Matiti & Cotrel-Gibbons, 2006; Matiti et al., 2007; Royal College of Nursing, 2014d, 2014g; Webster et al., 2009). Nurses were asked to consider how their personal beliefs, values, and attitudes about dignity shape their nursing care, to think about the patient experience of hospitalization and the patient understanding of dignity, to reflect on their personal strengths and weaknesses, and to consider how changes can be made.

3.3.2.2 Discussion

The next step of this strategy involves discussion. Discussion focuses on bringing individual reflections together, sharing thoughts and feelings, exploring the concept further, and relating it to practice. In-depth discussion took place either as a group (Chadwick, 2012; Crow et al., 2006; Matiti & Cotrel-Gibbons, 2006; Oxtoby, 2005; Royal College of Nursing, 2014d; Webster et al., 2009) or with an assigned preceptor or mentor (Bruton et al., 2012; Crow et al., 2006, 2007). The composition of the groups is not defined in the literature, with the exception of Matiti (2012), who argued that such discussion should ideally occur between students of different cultural backgrounds. Nonetheless, the literature identifies discussion as an important

strategy that allows for the bringing together of nurses' reflections, the sharing of their knowledge, the chance to create a greater depth of understanding, and the space for nurses to support each other as they strive to promote dignity in practice.

3.3.3 Imagining the Patient Perspective

This strategy describes activities that demand an engagement with the concept from the patient's perspective. It goes beyond the individual reflection and group discussion, and moves past the nurses' thoughts, beliefs, values, and opinions surrounding dignity in care. Imagining the patient perspective asks nurses to empathetically imagine themselves, as it is said, "in another's shoes", taking on the lived experience of patient dignity. The format of this strategy concentrated on role play and written vignettes in addition to a lesser focus on a symbolic cue.

3.3.3.1 Role Play

Role play was put forward as a way to train student nurses about sensitive care and help licensed nurses appreciate changes that are needed in their practice (Goldwire, 2012). It most often involved nurses as audience members in dramatic productions. Surprisingly, the use of role play with nurses engaging in performance was only suggested in one practice-based journal article (Goldwire, 2012). Regardless of who performed the role play, the activity involved nurses being prompted to imagine the patient role and the experience of hospitalization.

Role play was used as the main activity in Oxtoby's (2005) training program. It involved a community theatre company portraying scenes of care upholding patient dignity as well as care that failed to do so. The aim of the theatre session was twofold: to teach the nurses about dignity and to allow them to view an intimate picture of the patient experience away from the hospital and the pressures of daily practice. The authors stressed the importance of the visual and role playing aspects of the session for placing the nurses' in the patient perspective, evoking

emotional and personal responses, and consequently re-sensitizing nurses to the importance of dignity in patient care.

The high-profile dignity campaign also used role play through the filming of non-health care related scenes. The scenes were described as “visual metaphors”, displaying situations of indignity. The main question following the viewing was: “How would you feel if you were treated like this?” (Baillie & Gallagher, 2012, p. 45). The purpose of the film was to prompt nurses’ imaginations to examine the concept from a different lens and, as a result, shed light on the reality of the patient dignity experience in daily practice.

3.3.3.2 Written Vignettes

Written vignettes, both in workshops and in an online learning resource, were another means of encouraging nurses to imagine the patient experience. The vignettes were used to share patient stories of dignity in care, encouraging the nurses to closely engage with the situation and imagine what could have been done differently (Chadwick, 2012; Royal College of Nursing, 2014g; Webster et al., 2009). Crow et al.’s (2007) action research project touched on the use of vignettes as well, but in this instance asked the nurse participants to write the vignettes. The nurses were instructed to write about a work experience from the patient’s viewpoint. The exercise had the nurses immerse themselves in the patient’s reality and imagine the many details of care from the patient perspective. The overall aim of the activity was to strengthen empathy.

3.3.3.3 Symbolic Cue

A final use of this strategy was seen in Water’s (2008) practice-based journal article that shared innovative ways nurses are working to reconnect patient dignity and nursing practice. The author reported on a project titled the “Red Peg Initiative”, which involved nurses using a red peg to secure bed curtains during personal care. The red peg is taught to symbolize patient

dignity. Its use is a visual cue to uphold the concept in practice. Its presence encourages nurses to see the concept with new eyes - to not only hold a conceptual understanding, but to imagine and appreciate what the bed curtains mean to the patient being cared for behind them.

3.3.4 Leadership

Leadership was presented as an important strategy for translating a conceptual understanding of patient dignity into everyday acute care nursing practice. It was furthermore noted to be central to setting and influencing unit culture and as such, affecting the presence of dignity in care (Webster, 2007).

Leadership as a strategy referred to the work of nurses in various types of roles. Unit-based nurse leaders were a particular focus of the high-profile campaign. The campaign, clearly recognizing the great impact nurse leaders can have on the quality of nursing practice and dignity in care, took specific measures to offer direction on how to create change and develop leadership abilities (Royal College of Nursing, 2009). The role of unit-based nurse leaders was also examined in an expert opinion piece and a practice-based journal article (Waters, 2008; Webster, 2007). Other leadership positions included staff preceptors and program facilitators. An important difference between these leaders and the unit-based leaders was that their influence as a leader was temporary, only lasting as long as the program. It is not known whether this difference altered the influence of the leaders. Nonetheless, similar characteristics were noted across all leaders and fall under the categories of presence and support.

3.3.4.1 Leadership Presence

Leadership presence first of all spoke to leaders being visible, an actual physical presence for the nursing staff. High quality care will be delivered by nursing staff with leaders who clearly outline expectations in nursing practice and patient care (Webster, 2007). To define and clarify

these expectations, a leader needs to be actually physically present and visible. Waters (2008) detailed an initiative that was aware of this leadership need and consequently developed a policy outlining the frequency that ward managers were to perform rounds on their respective units. The policy ensured that nurse leaders took time to be physically present for their staff.

Physical presence on its own is not enough. According to the researchers, leadership presence is also based on the assumption that for leaders to have an impact, nurses must understand that there is an interest on the part of the leader. As such, the second component of this strategy involves being attentive. Attentiveness was put forward as a presence that demonstrates a willingness and interest to connect with others. It is a quality that can also be described as being involved and accessible. The facilitators of the Patient Dignity Program reflected these qualities when they offered their availability to the participants as they returned to their places of work (Matiti & Cotrel-Gibbons, 2006). This emphasized the importance of the session learnings on dignity and helped the participants as they tried to change practice. However, this program development initiative did not detail if and how often the availability was sought, nor did it explore the effects of the availability on nurse participant actions.

The impact of leader involvement was also clearly noted in the Red Peg Initiative. The staff that was responsible for the project observed that how well nurses participated in the project largely depended on the involvement of the unit-based nurse leaders (Waters, 2008). Furthermore, Webster (2007) argued that when leaders are involved and accessible, nurses feel listened to - a critical point that is said to encourage the provision of high quality, dignified care. Surprisingly, all six program development initiatives were led by facilitators with only varying degrees of unit-based nurse leader involvement in three of the publications (Chadwick, 2012; Crow et al., 2006, 2007; Matiti & Cotrel-Gibbons, 2006).

3.3.4.2 Leadership Support

In the studies described above, a nurse leader who is physically present, involved, and accessible, offers nurses a form of support. But leadership support is also an active quality, referring to the offering of encouragement and feedback.

Leadership encouragement helps nurses realize and follow through on their ability to create change. Matiti and Cotrel-Gibbons (2006) were undoubtedly aware of this as they offered their continued encouragement as the participants took steps to implement their action plans. This encouragement involved providing clarifications and reassurance, linking thoughts back to workshop learnings, and boosting nurses' confidence when necessary. The authors' also recruited the support of unit nurse managers to empower the nurses as they returned to work. The authors commented that the action plans would not have progressed as they did without the managers' active support.

The dignity and respect action group that was created following Crow et al.'s (2006, 2007, 2010) action research project also touched on the importance of encouragement. It was reported that the support from the group leaders empowered the nurse attendees and helped sustain their passion for reconnecting patient dignity and nursing practice. The support provided by the leaders did help lead to results – the authors detailed a number of dignity-related changes within the hospital that the group has accomplished.

The creation of a vision and a shared understanding of dignified care were identified as a responsibility of good leadership (Webster, 2007). Moreover, good leaders were seen to challenge poor practice, focus on bringing the best out of their staff, and ignite leadership growth and development in all nurses. Feedback from leaders to nurses was described as a way to move toward this goal, providing nurses with specific direction as they make dignity-related changes to

their practice and places of work. One of the three facilitators in Crow et al.'s (2006, 2007) action research project took the time to observe participants' nursing care and work environment, and offer feedback and mentorship on fostering dignity. Feedback, as well as encouragement, was also provided by the preceptors in Bruton et al.'s (2012) new graduate training program. It was thought that the challenges of transitioning into practice, balanced with the feedback and encouragement of the preceptors, would help the new graduates move toward professional growth and develop a vision of how they can have a positive impact on their work and place of employment.

In summary, leadership presence entailed nurse leaders being visible to staff and involved in frontline care in order to lead by example, set the culture of the work area, and lay the foundation for leadership support. In turn, leadership support required leaders to provide staff nurses with feedback on how to improve the upholding of patient dignity in practice and the work environment. Support also spoke to nurses feeling empowered by the encouragement of leadership teams. Overall, visible, involved, and supportive leaders enabled nurses to feel confident and capable to question and challenge care that does not value the person (Webster, 2007). Leadership presence and support are therefore, without question, central to improving nursing practice, including the reconnect of upholding patient dignity and daily care.

3.3.5 Planning for Action

The final strategy to emerge from the analysis of the literature was planning for action. This strategy argues that along with a detailed understanding and stronger knowledge of patient dignity, nurses need guidance on how to commit the concept to daily practice and how to influence this change (Matiti et al., 2007). Planning for action is an especially empowering strategy for nurses, helping them realize the impact they can have on their nursing practice and

the ward culture (Matiti & Cotrel-Gibbons, 2006). The literature used a number of different terms for this strategy, including the creation of action plans, work-based projects, and pledges.

3.3.5.1 Actions Plans and Work-Based Projects

There were no differences noted between the creation of action plans and work-based projects – the use of each term simply reflecting the preference of the author. The action plans and work-based projects were observed in three of the program development initiatives. Following the workshop sessions, facilitators asked participants to identify, in light of their learning, reflections, and discussions, actions that would help them bring the upholding of dignity into their daily nursing practice and clinical settings. These two strategies were also viewed as having an empowering aspect, teaching the nurses that the power to create change lies within them (Matiti & Cotrel-Gibbons, 2006).

The chosen plans were often focused on each nurse's individual practice; however, it was hoped that the separate changes would together infiltrate the ward culture and positively affect nursing practice and the patient experience (Chadwick, 2012; Matiti & Cotrel-Gibbons, 2006; Webster et al., 2009). Participants were asked to discuss the plans for change with their managers (Chadwick, 2012; Matiti & Cotrel-Gibbons, 2006). This provided the nurses with continued follow-up support and encouragement to persevere with their efforts. What to consider in creating change was only outlined in Matiti and Cotrel-Gibbons' (2006) report and included why the change was needed, who needed to be involved, how it would be implemented, and a time plan. The authors recognized that the nurses would not necessarily know how to initiate changes to their practice or workplaces. A variety of projects were shared in the literature, for example: improving communication skills, regularly reflecting on nursing practice, sharing new dignity knowledge with co-workers, and involving discussion of patient dignity in multidisciplinary

team meetings (Chadwick, 2012; Webster et al., 2009). There have been no evaluations of the projects to date, although Matiti and Cotrel-Gibbons (2006) did state they planned to do so in the future.

Actions plans were also covered in the Royal College of Nursing (2009) dignity campaign, focusing on the role of the nurse leader. It acknowledged that nurse leaders, similar to staff nurses, may not know how to act for change within the hospital system. The campaign desired to provide leaders with the tools to initiate meaningful and sustainable change for dignity in nursing practice. It outlined a very detailed list of what leaders need to consider when implementing an action plan.

3.3.5.2 Pledges

Encouraging nurses to make a pledge for upholding patient dignity in their respective wards was noted on one occasion in the literature (Crow et al., 2006, 2007). The pledges were similar to the action plans and work-based projects, referring to a specific plan to create change. The main difference was that the pledges did not touch on acting for change as an empowering activity, but rather were more focused on reinforcing learning. The authors argued that the pledges would act as evidence of the classroom-based learnings, guiding the nurses in transferring their theoretical understandings into practice. Moreover, it was the authors' opinion that by having the participants make a written commitment to dignified care there would a greater likelihood that they would follow through on the pledges.

Pledges were focused on either the nurses' individual practice or directed at making a unit-based change. The pledges that were shared largely focused on the individual's practice, for example: getting to know the patient more and providing appropriate clothing for patients (Crow et al., 2007). Participants were asked to detail the timescale of the pledges as well as any support

that would be needed to fulfill their plans (Crow et al., 2006). However, feedback from the nurse participants found that regardless of the in-depth knowledge they had gained from the sessions and the pledges for change, they felt powerless to initiate and sustain projects fostering patient dignity in their clinical settings (Crow et al., 2006, 2007, 2010). This led to the creation of a Dignity and Respect Action Group within the hospital.

The Dignity and Respect Action Group was created as a safe environment for continuing education, discussion, support, and sharing of good practice. It was also a place to collaborate on projects and work together to have an impact on dignified care. It was arguably a group working on action plans together. However, working within organizational and cultural barriers has, according to the researchers, proven to be challenging. The facilitators reported that although the group completed a number of initiatives on patient dignity, the changes have largely held a technical focus (Crow et al., 2006). The changes, such as providing hospital guides for visitors and patients being allowed to wear their own clothing for day surgery, were described to be more in line with the acute care system's expectations of measurable outcomes (Crow et al., 2006, 2007). Even though the changes have positively impacted the patient experience, the authors state that the leaning toward these technical efforts has taken over the focus of the group to the point that reflection and working to influence attitudes and behaviours has been pushed to the wayside. The authors felt this was largely due to pressure from the institution to validate the group's existence. They expressed intent to make plans toward balancing the focus on action and measurable outcomes with the original focus on learning through reflection.

CHAPTER 4: DISCUSSION

This integrative review identified 12 highly relevant publications meeting all inclusion criteria. The analysis focused on strategies that intended to translate a conceptual understanding of patient dignity into a central role in daily acute care nursing practice. Five strategies emerged from this analysis: Training; Reflection and discussion; Imagining the patient perspective; Leadership; and Planning for action. These strategies will now be interpreted and discussed in light of current literature and implications for next steps will also be explored.

4.1 The Target of the Strategies

The strategies targeted three different levels, specifically focusing on an individual level, a relational level, and a structural level.

4.1.1 Individual

The registered nurse at the acute care bedside was the main focus of the strategies. Student nurses and new graduates were also identified in the literature; however, the individual nurse, their knowledge, beliefs, values, attitudes, and respective practice, was most often placed at centre stage.

Another target at the level of the individual was the nurse leaders themselves. Leadership was identified as a strategy; however, the nurse leaders were additionally observed to be a focus of the strategies due to the influence they can have on nursing and ward culture. Attention was specifically given to teaching leaders how to navigate the system when trying to work for change and how to have an impact. Their important role in creating the culture of a ward and setting expectations for good practice was also stressed.

4.1.2 Relational

Alongside targeting the individual, the strategies also focused on the relationships that nurses held with various groups. The first relationship observed was that between nursing

colleagues. The strategies targeted the connection between fellow staff nurses, encouraging nurses to share, learn from each other, and collaborate on possible solutions. This promoted peer support and a sense of nursing community.

The strategies also targeted the nurse-patient relationship. Through the involvement of service users, the use of storytelling, and encouraging nurses to examine care from the patient perspective, the nurses were brought closer to the patient experience, were reminded of their shared humanity, and helped to see the person behind the patient role. Focusing on this relationship, the strategies provided the opportunity for a deeper layer of learning to take place and a greater understanding of the special role nurses can play in meeting patient needs, wants, and values (Nisker, 2013).

The strategies furthermore targeted, albeit to a smaller degree, the nurse-nurse leader relationship. The importance of a strong and supportive relationship between nurses and nurse leaders was recognized and sought by a third party, the program facilitators. Although the facilitators did fulfill a leadership role for the participants, this role was only for the length of the program. Surprisingly, the unit-based nurse leaders were not responsible for any dignity-related projects or workshops. It was the facilitators who contacted nurse leaders, informing them of the purpose of the projects and seeking their support and involvement. The facilitators worked to develop the nurse-nurse leader relationship - most likely because they realized the great day-to-day impact leadership can have on bedside nurses and how critical their role is in setting the culture of a ward.

4.1.3 Structural

The final target of the strategies, the structural level, was much less evident in the publications compared to the individual and relational levels. Working toward structural change

was observed as nurses engaged in discussion about work environments and were encouraged to create plans for making an impact. A large part of this involved empowering the nurse participants to realize the impact they can have on those around them and the hospital system. Although this demonstrates a desire and intent to target the structural level, the strategies are arguably focusing on the individual level instead.

4.2 The Influence of the Strategies

The overall aim of the strategies was to improve nursing practice and the patient experience. More specifically, the strategies looked to reconnect the nursing profession with the important role of preserving and upholding patient dignity. In order to close this gap, translating a conceptual understanding into daily practice, the strategies had to exert various types of influence. The findings suggest that three types of influence were used: influence of a practical nature, influence of an emotional or cognitive nature, and the influence of power structures.

The influence at the practical level focused on skilled practices. It concentrated on everyday acute care nursing and providing nurses with tools to uphold patient dignity in care. Equipping nurses on how to challenge poor practice, reaffirming knowledge, developing interpersonal skills, exploring the work environment, and providing teaching on how to make an impact are examples of the strategies' practical influences.

The cognitive or emotional influence, on the other hand, focused on beliefs, values, and understandings. It worked to shape how nurses care and helped nurses make sense of the concept and its place in the nursing profession. In using this type of influence, the strategies focused on raising awareness, re-sensitizing nurses to the lived experience of hospitalization, strengthening empathy, reaffirming nursing values and attitudes, and emphasizing nursing's important role in preserving dignity in patient care.

The findings also suggested that the strategies aimed to close the nursing-patient dignity gap by influencing power structures. This type of influence involved empowering staff nurses and nurse leaders to take control of the nursing role and use their knowledge, skills, and voice to challenge existing practices as well as ward and hospital culture. This influence was most often demonstrated in the literature by the structure and guiding philosophy of program development initiatives. It was also observed through the use of action plans and work-based projects. It was hoped that the act of empowerment would strengthen participants' agency, helping them recognize their ability to create change, encouraging them to follow through on their goals, and in the end spread the dignity message.

The impact of leadership on nursing practice and ward culture was another means of influencing power structures. Leaders, through their presence and support, were identified as central to setting standards of care and developing high quality nursing practice. Their presence and support was also described as empowering for nurses. Based on this, good leadership appeared to encourage high quality care to be the norm, and strengthened nurses to challenge poor practice and question power structures that impinge on nursing care and patient dignity.

4.3 The Outcome of the Strategies

Moving on from discussing the strategies, their targets, and influencing style, the next step is to look at the outcomes. This prompts the question: Have the strategies translated a conceptual understanding of patient dignity into a central role in daily acute care nursing practice? The program development and campaign literature included evaluations of the various initiatives. As noted in the quality appraisal of the literature, these evaluations centered on the program itself or the nurse participants' experiences. The participant feedback focused on program structure, new understandings of patient dignity, and thoughts on creating change.

Nurses most often reported the initiatives to be a positive and empowering experience. They shared that the strategies made them consider the quality of their practice, reinforced proper attitudes, and heightened awareness of how to promote patient dignity. The programs and campaign were reported to create feelings of enthusiasm for upholding patient dignity and a desire to commit to fostering it in care. Finally, staff felt energized to spread the message and work for change in nursing practice.

Based on these findings, one might conclude that the strategies appropriately addressed the dignity issues in acute care nursing. The nurse participants reported a deeper understanding of the concept, an awareness of its importance, and a desire to make an impact on their work environments. Although this points to a closing of the theory-practice gap, it does not address whether this new understanding and appreciation for the concept of patient dignity was actually transferred into a central role in daily nursing care. The findings do not indicate whether the nurses followed through on their learning and if they did, whether their action had an impact on the nursing profession or patient experiences. The strategies presented in the expert opinion pieces and practice-based journal articles do not offer any further direction. This literature did not examine the outcomes of the strategies or offer examples of how they have been evaluated in practice.

Based on the above, it can be said that the strategies had an impact on the nurse participants, but beyond this point, the outcomes of the strategies are uncertain. It has been recognized that few initiatives working to reconnect nursing and patient dignity have been thoroughly evaluated, and furthermore, that it is difficult to assess changes in practice (Baillie & Gallagher, 2012). Nonetheless, it is a vital step to ensure the programs are an effective means of influencing the nursing profession, and, ultimately, the quality of patient and family care. If the

strategies are looking to bring patient dignity into daily nursing practice, then they must be evaluated in practice. This not only includes an evaluation of nurses in their places of work and overall acute care nursing culture, but the patient care experience as well. Moreover, assessing the benefits of the strategies must also take a long-term view, examining the sustainability of change once nurses complete a program and return to their workplaces.

4.4 The Importance of the Individual Nurse

To fully appreciate the strategies and their impact on the presence of dignity in acute care nursing, the findings of this review must also be examined in light of the original problem presented at the outset. Respect for patient dignity was argued to be an essential part of the nursing profession; however, growing concerns highlighted that nurses are failing to recognize and fulfill this special role and important responsibility. Examples of the dignity violations were varied and centered on how patients were treated in the physical environment, the fulfillment of the nursing role, nurse attitudes, and communication skills. The five strategies address a number of these issues, most prominently those directly related to frontline nursing. The strategies were shown, through self-report, to make an impact on the nurse participants by developing their knowledge, sensitivity, and sense of empowerment to upholding patient dignity in practice. The strategies also provided the potential for a greater impact on nursing culture with the use of action plans, work-based projects, and pledges, as well as through the development and involvement of leaders; however, this too was not evaluated in practice.

Although the planning for action strategy required the nurses to make separate and practical plans related to their own individual practice, these individual actions could still spread the dignity message and influence the overall nursing culture. Research supports the idea that through the process of sharing a message, an organizational culture of learning can be created.

This culture is one where the staff challenges the status quo and thinks creatively and strategically for solutions to problems – possibly engaging in this activity even before management has joined the work at hand (Austin, 2008). It is also suggested that sustainable change and improvements are more likely to occur when the change starts at a small scale, with individuals or groups, in comparison to large-scale organizational efforts.

The diffusion of innovation through individual efforts can indeed be powerful. The idea of creating change through individual actions strongly relates to the use of champions, a role that is becoming more widely used in nursing (Thompson, Estabrooks, & Degner, 2006). Research describes nurse champions as practitioners who are from within an organization, are highly enthusiastic about an area of work, and are able to influence their peers (Thompson et al., 2006; White, 2011). It has been described to be a good role to increase awareness and to change practice through the use of the individual, and has even been suggested to be a way to promote a more positive culture (Ploeg et al., 2010; Thompson et al., 2006; White, 2011). Research proposes that the nurse champion role is a strong means of closing knowledge-practice gaps as it relies on interpersonal contact for the diffusion of information – a method that aligns with nursing’s reported preferred way of learning (Estabrooks, Chong, Brigidear, & Profetto-McGrath, 2005; White, 2011).

Although the nurse champion term was observed in the initial search of the literature, it was not explicitly detailed as a strategy to reconnect nursing and patient dignity in the highly relevant findings. Nonetheless, parallels between nurse champions and the nurse participants in the program development initiatives, especially as they returned to their areas of work with plans to create change, can be easily drawn. As such, the nurse champion literature also supports the potential impact the nurse participants could have as individuals. This confirms, in addition to

the development of formal leadership support, that there is a need to develop and uphold individual nurses as informal leaders. Focusing on the individual nurse is a clear way to spread the dignity message, igniting interest in upholding dignity in care and working to shift the overall nursing culture.

4.5 The Importance of Considering the Context

The strategies provide helpful direction on how to reconnect nursing and the upholding of patient dignity. However, it must be noted that the strategies, in addition to not being evaluated in daily practice, do not take into account the overall complexity of the acute care arena. The findings are viewing the knowledge-practice gap to be mainly in the hands of nurses and are focusing on it as solely a nursing issue. Nurses must answer to their part in the failures to uphold dignity in acute care and are responsible for the quality of their practice. In addition, and as previously argued, individual efforts are a powerful means of effecting change. Yet, nurses do not practice in a vacuum. Nursing care is shaped by individual nurses, their actions, the actions and responses of others, and the context where they work (Hartrick Doane & Varcoe, 2013). Each of these layers must be addressed. Nurses need to reflect on their individual and collective actions, beliefs, and values; however, an examination of what is shaping and influencing their care is also necessary along with an assessment of what needs to be changed in light of these outside influences. The review findings only consider a few immediate layers of the dignity issue and do not take into account other possible factors affecting the upholding of patient dignity in acute care nursing. Looking at the background section of the review, the explanations nurses provided to justify the failings include a lack of time and resources, working in high-pressured environments with questionable staffing levels, and increasingly medically complex patients. Institutional culture, an absence of nursing leadership, and a lack of training were also said to be

reasons behind the insults to patient dignity. Based on the nurses' perspectives, the strategies only addressed the need for further training and touched on the role of nurse leaders. The strategies did not attend to all described factors. The acute care culture, including the focus on task-oriented mindsets, emphasis on performance measures, and drive for cost constraint, as well as the day-to-day challenges of acute care nursing, appeared to have had insufficient attention. This could leave nurses with a desire to create change in an unsupportive environment. Focusing on reconnecting nursing and patient dignity through individual efforts is certainly important; however, strategies must also look beyond the individual nurse to ways that structural issues can be impacted.

My review findings in this thesis concluded that the strategies may lead nurses to be more aware and knowledgeable, and more sensitive and empowered to exert an influence. They may even lead to better skills. However, nurses work within a larger organizational system that influences their practice and as such, any effort to make changes to nursing practice must also consider the influence of the system. A critical point that the strategies miss—one that will most definitely impact the strategies' overall and long-term effectiveness—is that the influence of the acute care system is not sufficiently acknowledged. Moreover, this acute care system is one that too often fails to uphold nursing values, belittles nursing concerns, and challenges nurses' ability to act as moral agents (Gallagher, 2011; Grob, Leng, & Gallagher, 2012; Hartrick Doane & Varcoe, 2013; Rodney et al., 2009; Storch et al., 2002; Varcoe et al., 2004; Varcoe et al., 2012). It is unlikely then, even with the best of intentions, that the new nursing awareness, knowledge, empowerment, and skills will be translated into lasting improvements in nursing practice unless the larger organization also takes measures to support such change (Henderson & Winch, 2008).

In other words, the new nursing awareness, knowledge, empowerment, and skills are necessary but not sufficient.

Looking at the insults to dignity from a contextual point of view, specifically a management and organizational perspective, provides a more nuanced picture of why nursing is not providing dignified care. The context shapes and affects how nurses work and also how they preserve patient dignity in daily practice (Hartrick Doane & Varcoe, 2013; Rodney & Varcoe, 2012). As the system upholds a business mindset, valuing tasks, performance measures, and cost constraint, nurses have been encouraged to adopt the system's values. They are being instructed to practice efficiently, keep cost in mind, and meet measureable outcomes (Rodney, Buckley, Street, Serrano, & Martin, 2013; Rodney & Varcoe, 2012; Rodney et al., 2009; Varcoe et al., 2004). As nurses work from this corporate mindset, they are not without agency, but it can be a challenge to uphold dignity in patient care. Even though there may still be a desire and attempts to provide dignified, quality care, the influence and unsupportive nature of the acute care context makes such efforts difficult.

4.6 A Next Step for Strategies

To make a lasting impact on nursing practice and the quality of patient care, strategies must continue to focus on frontline nurses, but also examine and target the relationship between nursing and the context. The program development literature and the high-profile campaign I cited earlier did show the organizations to be interested in reconnecting nursing with the upholding of patient dignity. Of these seven initiatives, four were instigated by the greater system, which included a local health board, a director of quality, hospital management, and a union. This demonstrates that even within the corporate ideology that has infiltrated the system, acute care leaders nonetheless acknowledge the importance of patient dignity, nursing's key role

in preserving it, and that something needs to be done. Although such organizations are taking steps to address the concerns of dignity in care, they are not addressing all factors, particularly the situation from nursing's perspective. The system is trying to improve the situation while not listening to nurses' understanding of the context and how it is limiting their ability to uphold patient dignity. The strategies must now dive deeper, aiming to support nurses as they work within the challenges of the acute care system and work to influence the surrounding power structures. Findings of this review suggest that empowerment and leadership are two areas that need additional attention to help nurses uphold patient dignity in daily practice.

Empowerment was identified in the findings as an important means of affecting structural issues. The guiding philosophies used by Matiti and Cotrel-Gibbons (2006) and Crow et al. (2006, 2007, 2010) both emphasized the need for nurses to be involved in a change process, stressing that the power to create change lies with nurses. Furthermore, the planning for action strategy helped guide the nurses toward having an impact on individual practice and hopefully ward culture as well. These steps reportedly empowered the nurse participants; however, the empowerment mainly occurred away from the acute care system. The only ward-based empowerment took place when facilitators provided follow-up support and liaised with ward managers. Both are important actions, but empowerment must also prepare nurses for the challenges they will return to and continue to face in their places of work. Empowerment can be used to strengthen nurses' voices so that they might be heard and also develop moral courage to persist with efforts to impact dignity in care.

Training in assertive communication and negotiation, which focuses on problem-solving, as well as a familiarity with ethical documents and ethical language to support arguments for dignified care, are steps that will empower nurses in the workplace (Hartrick Doane et al., 2009;

Lachman, 2010; LaSala & Bjarnason, 2010; Rodney et al., 2009). They will provide nurses with critical skills and knowledge for questioning and challenging structural influences that impinge on their ability to uphold patient dignity in daily practice. The strategies in the review findings aimed to develop nurses' moral reasoning skills and nurture an ethic of care, specifically focusing on patient dignity. Although this was mainly observed outside of the hospital, Crow et al.'s (2006, 2007, 2010) program, at the request of the nurse participants, continued such efforts in the work environment through the creation of a work group. Such groups need to be the norm. Working together as a group creates an environment of support as well as the opportunity for personal and professional development. It also provides the opportunity to enter into dialogue about how care can be improved (Gallagher, 2011; LaSala & Bjarnason, 2010). Working collectively is empowering and supports the development of a stronger, as well as louder, and ethically-minded nursing voice that can question the system more constructively.

An empowered voice can also be developed through the work of nurse leaders. The impact of leadership was clearly outlined in the review findings. Leadership presence and support were described as central to setting standards of care and the culture of a ward. However, a large part of the literature concentrated on program facilitators and preceptors, both having only temporary interactions with nurse participants, to fulfill leadership roles. Webster's (2007) expert opinion piece focused specifically on unit-based nurse leaders, describing them as crucial to high quality, dignified care. Webster was of the opinion that in order for staff nurses to deliver dignified care on a daily basis, they need to feel listened to and supported, and that unit leaders are key to enabling this to occur.

The great impact unit-based nurse leaders can have on a work environment, nurses, and patient outcomes is a topic that has been well-studied in the literature (Pearson et al., 2007;

Registered Nurses' Association of Ontario, 2013). Further attention needs to be given to these leaders as they help nurses bring dignity back into daily practice. Due to their close proximity to nurses and their influential role, they are in an ideal position to advocate for nurses as they work within the challenges of the acute care system and work to impact the surrounding power structures. To empower and strengthen the voice of nurses, these leaders must work to create supportive environments with a strong focus on listening to staff (Doody & Doody, 2012). Including frontline staff in decision-making, involving nurses on committees that affect practice, creating teams to respond to quality issues and nursing concerns, and regular team meetings are examples of how leaders can create an arena for nursing empowerment. These actions are also a way for nursing's voice to be heard and shared (Doody & Doody, 2012; LaSala & Bjarnason, 2010; Registered Nurses' Association of Ontario, 2013; Tomajan, 2012). An empowered nursing staff will then be stronger to follow through on plans to create change and uphold dignity in daily care, specifically within the challenging influence of the acute care system.

4.7 Implications for Practice, Leadership, Education, Research, and Policy

In summary, the review findings provide direction on what is needed to help reconnect acute care nurses with the important role of upholding and protecting the dignity of those in their care. The five strategies that were drawn from the data have implications for nursing practice, leadership, education, research, and policy.

4.7.1 Nursing Practice

Practising frontline nurses need organized opportunities for continuing training, reflection, discussion, and engagement with the concept of dignity. The structure of this time can vary – workshops, monthly in-services, and even mid-shift “time-outs” are a few possibilities. The important aspect is that it is time away from the demands of acute care work to develop

knowledge, skills, attitudes, and explore factors, both personal and structural, that may affect the presence of dignity in care (Matiti et al., 2007). It is recommended that the training take an exploratory and participatory format, and engage the nurses in the reality of the patient experience, offering further instruction on special populations, and empowering with the tools to create change.

Time for reflection is also required. This may be encouraged through diaries to record thoughts and feelings, the writing of reflective pieces, or the use of open-ended questions. Nurses need time to contemplate on their understanding of the concept of patient dignity, the place it holds in care, strengths and weaknesses, outside influences, and how changes can begin. Flowing from the reflection, time to discuss is critical to shed light on the considerations, share learnings, and encourage a greater depth of understanding in a group setting.

The opportunity to imagine the concept from the patient's perspective is a recommended strategy to help bring the upholding of dignity into daily nursing care. Possible ways to use this strategy include role play, theatre, written vignettes, or symbolic cues. The important aspect is that it directs practice, encouraging the development of empathy and sensitive nursing care.

The above-mentioned recommendations for shaping practice cannot stand alone. They require an empowering guidance on how to apply the new awareness, knowledge and understanding to practice. This was demonstrated in the findings through the use of action plans, work-based projects, and pledges. These strategies challenged and empowered nurses to take steps toward having an impact on individual care, other nurses, and ward culture.

4.7.2 Leadership

A second implication concerns nursing leadership. The review findings indicate that nurse leaders need to return to the bedside. The leaders' presence and support was shown to be

critical to the culture of a ward and empowering staff to provide high quality, dignified care. The difficulty with this is that this recommendation comes at a time when nursing leadership is absent from the wards. Nurse leaders are presently being pulled away from ward duties for other responsibilities, limiting their contact with staff nurses and patients (Morris, 2012). Their particularly important role in supporting staff nurses as they work within the acute care system and providing them with moral direction is missing (Storch, et al., 2002).

Nursing leadership's vital role in effecting high quality, dignified care needs to be highlighted. The high-profile dignity campaign in the United Kingdom clearly understood this and took great measures to develop the participating leaders, recognizing the influence of the role on staff nurses and patient outcomes (Royal College of Nursing, 2009). The revival of the matron role, also in the United Kingdom, is another example of steps being taken to empower staff nurses and support high quality care through a focus on leadership (Department of Health, 2002). The matron nurse leaders, termed modern matrons, are responsible for providing strong clinical leadership on wards, leading by example, motivating others, and ensuring excellence in patient care. The creation of this role was an investment by the Department of Health, one that has reportedly led to improvements in nursing practice and patient care. To promote a nursing culture that upholds patient dignity, hospitals need to similarly invest in their nurse leaders (Gallagher, 2011). Nurse leaders may also need to step out and, with courage, advocate for the importance of their presence and support, the significance of patient dignity, nursing concerns regarding their ability to uphold dignity in practice, and the value nursing brings to patient care (LaSala & Bjarnason, 2010; Storch et al., 2002). Doing so will be a proactive step towards supporting high quality care and the building of a moral community where the upholding of patient dignity is a standard part of nursing practice (Rodney et al., 2013; Storch et al., 2002).

4.7.3 Education

Training on patient dignity was presented as a necessary activity throughout nursing school education. Students need to be prompted to explore their important role in preserving dignity, developing an understanding of their own dignity, looking at how perceptions may differ, and possible cultural influences. It is also essential that students explore how they can apply the understanding of dignity in practice, including challenges they may face with other nurses, patients, families, the ward, and the system. Bruton et al.'s (2012) new graduate program connects the worlds of academia and practice, providing a safe environment for student nurses to transition to licensed work. Implementing such a program can soften what is often a difficult learning period and help transfer classroom learnings to daily practice, including the upholding of patient dignity in care.

4.7.4 Research

The strategies were reported as leading nurse participants to a deeper understanding of patient dignity, a greater awareness of its importance, and a desire to have an impact on the presence of dignity in acute care nursing. However, questions remain on whether the strategies went beyond a reported impact on individual nurses' knowledge and attitudes, to an actual change in nursing care and an improvement in the patient experience. Evaluative research is needed to examine the effect of the strategies in practice, assessing nurses as they work, the overall nursing culture, and the perspective of patients. This may include qualitative exploration of experiences and perspectives on practice and culture, from staff, leaders, and patients, as well quantitative measurements, such as through the use of tools to measure culture change (Baillie & Gallagher, 2012; Spence & Lau, 2006). Action research, which was used in one of the program development initiatives, is another means of evaluating the effect of the strategies. Action

research has been described as a good means of bridging a theory-practice gap (Munn-Giddings, et al., 2008; Rolfe, 1996). Its cyclical format of planning, implementation, data collection, analysis, and reflection leads to ongoing evaluation and working through an issue, in this case the presence of dignity in nursing care, until it is resolved (Crow et al., 2006; Rodney et al., 2013). The action research project by Crow et al. (2006, 2007, 2010) concentrated on the involvement of frontline nurses; however, the authors did comment that all health care professionals, in addition to service users, were invited to participate in the project and work group as well. Likewise, future action research projects will need to look beyond staff nurses to also include leaders, patients, and families to work toward changes in care. Evaluative research will also need a longitudinal approach to judge the long-term impact of the strategies and the sustainability of any changes.

A second research question to be addressed relates to how the reported new understanding, awareness, and desire for change fares in the corporate culture that has infiltrated the acute care system. The strategies focused on change through individual efforts, failing to account for the influence of context and how challenging it is for nurses to uphold nursing values in this culture. Without a consideration of the context, nursing attempts to create change could be exhausting and demoralizing (Rodney et al., 2013). Two program development initiatives included guiding philosophies centered on empowering nurses. Although this was argued to be a strength of the initiatives, it is unknown whether these two programs were better equipped to exert influence compared to the strategies solely directed at the level of the individual nurse and nurse relationships. Empowerment and leadership were also argued to be vital to helping nurses direct their voice at the system level. Additional research needs to evaluate efforts that support nurses as they work to influence the system. A closer examination of the contextual influences

on nursing care will offer new understanding of how dignified care is being limited and ideas of how to act more intentionally for change (Hartrick Doane & Varcoe, 2013; Rodney & Varcoe, 2012).

4.7.5 Policy

A final implication is the need for political action to address the constraining structures that are limiting nursing practice in the first place. Targeting the system will address foundational reasons nurses are at odds with the values of the profession, including the upholding of patient dignity. This larger focus will promote the long-term success of the review strategies and will also help stop the problem from continuing for years to come. In order to ensure high quality care at the bedside, organizational structures and policies are needed that support good care (Hartrick Doane et al., 2009). A first step to working toward this aim is by bringing individual dignity-related practice concerns together and, as a group, focusing on building a nursing community that desires to provide ethical and quality care (Hartrick Doane et al., 2009; Rodney & Varcoe, 2012). Collectively the concerns will have a greater impact and can be more easily labelled a professional ethical issue. Further strength will need to be added to the message through the support and involvement of nurse leaders, professional nursing associations, and unions (Rodney et al., 2013; Rodney & Varcoe, 2012). Nurses can then attempt to enter into dialogue with administrators, challenge the corporate ideology that is limiting their care, and fight for a say in decisions that affect nursing practice and patient care.

In questioning the dominate culture, it may be helpful to look to existing policy and research for support (Rodney et al., 2013). Nurses need to also work on the creation of policy – policy that will protect nursing concerns, such as nurse-patient ratios and the distribution of resources that are said to hinder the ability of nurses to uphold patient dignity in care.

4.8 Limitations

This integrative review provides an overview and critique of strategies that have been proposed, or implemented, to translate a conceptual understanding of patient dignity into a central role in daily acute care nursing practice. The findings have advanced understanding on reconnecting nursing and the upholding of patient dignity; offered practice, leadership, education, research, and policy implications; and shed light on gaps in research. However, this integrative review is nonetheless subject to some limitations.

A first limitation concerns data that was potentially missed as only English language databases were searched, only English language articles were considered, and due to time and resource constraints, manual searches of relevant journals were not completed. A second possible limitation surrounds the deemed relevancy of the publications. Due to the large number of articles retrieved in the initial searches and the scope of this Master's thesis, publications were evaluated to be of high, medium, or low relevance to the review question. Articles of low relevance were removed and those of medium relevance were broken down into matrices for reference, but not analyzed. Only literature of high relevance was analyzed and used to advance understandings on the issue. It is therefore possible that findings and further direction on the strategies were missed. It is important to note, though, that the literature of medium relevance was nonetheless skimmed. Reflection, discussion, role modelling, training, and leadership were frequently mentioned strategies throughout this literature and obviously quite similar to the strategies reported in the review. The literature of medium relevance also did not consider the context of the acute care system and the multiple influences shaping nursing care.

Finally, although not per se a limitation, it must be mentioned that eleven of the twelve highly relevant publications were based in the United Kingdom. This certainly creates a bias in

the findings; however, as discussed in the background section of the review, the upholding of patient dignity is a worldwide concern and many of the issues in the United Kingdom are also visible when examining nursing care in Canadian hospitals. It is also possible that Canadian literature on the topic exists, albeit under a different, but related concept. For example, in response to a recent report highlighting failures in care, Wales is focusing on safe and compassionate care while the rest of the United Kingdom centres on dignified care (Llywodraeth Cymru Welsh Government, 2013). The same care issues are being addressed although under different conceptual umbrellas.

4.9 Conclusion

Nurses have the honour and responsibility of promoting dignity during hospitalization, a vulnerable time in person's life. Upholding patient dignity has been argued to be an essential part of the nursing profession. However, governing bodies, nurse leaders, frontline staff, and the public report growing concerns that nurses are not taking steps to recognize and preserve patient dignity in practice. Violations are being reported in nursing's use of the physical environment—for example, bed curtains not being closed, the regular use of commode chairs, mixed gender accommodation, negative nursing attitudes, and negative nurse-patient communication. These violations are occurring at a time when the meaning of dignity has been well-examined in the literature and nurses are said to have an understanding of its importance in care. A gap clearly exists between discourse and practice. This integrative review set out to address this gap, developing an understanding of what is being done in response to the situation.

The research question stated: What strategies have been proposed, or implemented, to translate a conceptual understanding of patient dignity into a central role in daily acute care nursing practice? Addressing this question with an integrative review has provided practical

insight on what is needed to help nurses integrate patient dignity into daily practice and acts as a starting point to advance the understanding of the overall situation. Twelve publications were identified as highly relevant to the research question. The majority of the publications were assessed to be of high quality and organized into four subgroups of articles: program development initiatives, expert opinion pieces, practice-based journal articles, and a high-profile campaign. The following five strategies were drawn from the data: Training; Reflection and discussion; Imagining the patient perspective; Leadership; and Planning for action. These strategies were found, by self-report, to strengthen nurses' awareness and knowledge of patient dignity, and increase their desire to create change in their workplaces. A general weakness was a failure to evaluate the impact of the strategies on nurses as they work and the resulting patient experiences. As such, uncertainty surrounds whether the strategies truly led to change and whether they can be a recommended way to close the nursing-patient dignity gap. Further research is needed to ensure that the strategies are an effective means of influencing the nursing profession and also examine the long-term impact of any changes.

Moreover, the context of the acute care system must be considered along with how it influences daily nursing care. The strategies had a strong focus on the individual nurse and did not fully consider the power structures that challenge the upholding of patient dignity in practice. Although individual efforts were argued to be powerful, empowerment and leadership were put forward as two means of strengthening the voice of nurses as they work to effect surrounding structural influences. Other implications were offered for practice, leadership, education, research, and policy.

The preservation of dignity is critical for the emotional health and recovery of patients as well as their satisfaction with care received and adherence to treatment plans. It also impacts the

public's trust and confidence in nurses and the health care system. Furthermore, it affects the health and well-being of nurses, allowing them to enact the nursing role as desired and to the fullest measure. The upcoming challenges the Canadian health care system and nursing are likely to face will only add further strain to nurses' ability to uphold patient dignity in care. Proactive steps with empowering nurses and reclaiming nursing leadership's bedside role need to be taken now to address this issue, and reconnect nursing with the important responsibility of upholding and preserving patient dignity.

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