REGISTERED NURSES PROVIDING DIGNITY:

CARING FOR OLDER PERSONS LIVING IN RESIDENTIAL CARE

by

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Executive Summary

Older persons comprise an intricate component of society, and their rising numbers and complex care needs contribute to challenges within our health care system. Managing these care needs in a manner that demonstrates dignity, is an important element of nursing care. With limited literature describing how Registered Nurses (RNs) incorporate dignity when caring for older persons living in residential care, the purpose of this research study was to explore how RNs provide dignity for older persons living in residential care.

Eleven RNs working in a residential care facility were interviewed as part of this qualitative research study, in order to explore their understanding of dignity for older persons in residential care. Data analysis revealed three themes: 1) *Foundations That Support Dignity* included the sub-themes *caring for the whole person, respecting, encouraging independence* and *being remembered*; 2) *Dignity Care* incorporated *doing, value-giving care, building relationships,* and *balancing and negotiating;* and 3) *Structural Context for Dignity* comprised *time, nurse's voice, physical setting*, and *barriers created by policies/procedures.* Additionally, four important conclusions were derived from this study: 1) The RN participants described dignity as an important aspect of providing nursing care for the older population. The nurses explained how older people experienced numerous losses and that maintaining dignity was a priority; 2) The RN participants appeared to relate the meaning of dignity with that of *respecting* the older person. *Respecting* encompassed various forms including the *preservation of self-worth, maintenance of physical appearance, forms of addressing someone* and *proffering of choices*; 3) The RN participants helped the older person fill the void left by family and friends, through conversing with them and hearing their life stories, as a *foundation that supports dignity*. This linkage of self-identity and legacy to the concept of *foundations that support*

dignity for older persons, is a unique finding of this study; and 4) The structural contexts appeared to influence the RN participants' ability to provide dignity care to older persons in residential care. Structural contexts refers to insufficient time to provide care in an unhurried manner, insufficient nurses to provide person-centred care, and insufficient physical surroundings and policy/procedural support, which may lead to a reduction in promoting dignity care.

Recommendations derived from this research include the nursing areas of education, practice and research. Nursing education should focus on: 1) Promoting dignity care through initiating this focus of care from relevant influential organizations such as the Canadian Association of Schools of Nursing (CASN); 2) Focusing on *dignity care* throughout the nursing curriculum in order to permeate all patient populations, not simply limited to the older persons; and 3) Nurse educators creating a greater awareness of the specialized care needs required by older persons. Recommendations for nursing practice incorporate: 1) Integrating person-centred care into nursing practice in order to enhance the care of older persons living in residential care facility settings; and 2) Exploring how dignity care may best be integrated into nursing practice. Finally, recommendations for nursing research consist of: 1) Future research on dignity and older persons to involve other members and disciplines of the health care team including; care aides, licensed practical nurses, social workers, spiritual care practitioners, dieticians and pharmacists, within a comparison of facilities, to provide a broader perspective of their perceptions of providing dignity care for older persons in residential settings; 2) Further exploring the relationship between *being remembered* and dignity care for older persons in residential care; 3) Studying whether efficiency and safety within the healthcare system have removed the "care" out of caring, and whether there are any correlations between the effects of reduced hands-on

care and patient satisfaction; 4) Examining dignity care in relation to symptom management and the older person, in general, rather than simply at the end-of-life; and 5) Further exploring what the structure of the context should be for providing and promoting "optimal" dignity care? In conclusion, Registered Nurses (RNs) demonstrate various measures of providing dignity for older persons living in residential care that may contribute to improving the care of older people.

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Chapter One: Introduction and Background

Dignity is rated by patients as the second most important aspect of care (Valentine, Darby, & Bonsel, 2008). Similarly, Doyle, Reed, Woodcock and Bell (2010), noted an association between the importance to patients being treated with dignity and respect, to a positive overall rating of care received, and patients who were treated with dignity during their care, reported greater levels of satisfaction (Beach et al., 2005). As the population ages and the number of older people increase, so does the importance of providing dignified care for managing and maintaining health. The World Health Organization (WHO, 2012), for example, predicts that between the years 2000 and 2050, the number of people aged 60 years and over will double from 11% to 22% of the world's population. In Canada, the projection for the year 2036 is that there will be 10.9 million people over 65 years of age or up to 25% of the population (Stats Canada, 2012). Although the majority of older persons live in private homes, the total number of Canadians living in a residential care facility in 2009-10 was 7% or 247, 270 (Stats Canada, 2011). With dignity being considered an integral component of providing ethical nursing care, nursing must have sufficient understandings of how to incorporate this in their practice (International Council of Nurses' Code of Ethics, 2012). In the literature reviewed for this study, there was a dearth of information about how Registered Nurses (RNs) provide dignity when caring for the older persons in nursing practice. Therefore, the intention of this study was to discover how RNs incorporate dignity when caring for older persons living in residential care.

Background

There is strong agreement that treating the older person with dignity is an important aspect of providing good care (Anderberg, Lepp, Berglund, & Segesten, 2007; Hall & Hoy, 2012; Matiti & Trorey, 2008; Stone, 2011; Walsh & Kowanko, 2002; Woolhead, Calnan,

Dieppe, & Tadd, 2004). Anderberg (2007) et al. discussed how the five attributes of individualized care, control restored, respect, advocacy and sensitive listening, preserve dignity for the older adult through the development of an inner sense of freedom and ability to cope (p. 640). Similarly, nurses caring for older patients in hospital sought to re-establish dignity through seeing the patient as a unique individual, "getting rid of the bed" through patient mobilization and supporting patient appearance (Hall & Hoy, 2011, p. 289). Finally, patients and nurses have very clear expectations of factors which contribute to maintaining patients' dignity including: privacy; confidentiality; communication; choice/control/involvement in care; respect, forms of address; being seen as a person and having time to provide care and make decisions (Matiti & Trorey, 2008; Stone, 2011; Walsh & Kowanko, 2002; Woolhead, Calnan, Dieppe, & Tadd, 2004). Conversely, there are those who dispute even the use of the concept of dignity (Macklin, 2003; Sandman, 2002). From a medical ethics perspective for example, Macklin (2003) contends that dignity is "a useless concept" (p.1420) and that it does not have any greater meaning than that of "respect for persons or for their autonomy" (p. 1420). Philosophically, Sandman (2002) does not accept at face value that humans have dignity merely by being human. In relation to death and dying, Sandman (2002) further reasons that placing a high value on humans would mean that no death would be good because losing them at death, (based on this premise) would translate into losing something valuable and therefore never a good thing (p. 180). Sandman (2002) maintains that the concept of dignity (as it relates to human dignity) is not a useful concept for either palliative or other types of care. Irrespective of one's view, demonstrations of dignity in caring for the older person may be exemplified as using respectful forms of address; maintaining their hygiene and personal appearance; providing regular access to toileting; monitoring of pain management; fostering involvement in decision making; advocacy;

and lastly – treating them as individuals (Calnan, Badcott, & Woolhead, 2006; Gallagher, Li, Wainwright, Jones, & Lee, 2008; Hall & Hoy, 2012; Jeffrey, 2011; Ronch, 2011; Schirmaier, 2010).

From the patient perspective, maintaining dignity includes components such as being respected as a unique individual by endeavouring to understand their past and knowing what brings joy and meaning to their life; sustaining their self-esteem; developing a trusting relationship; ensuring privacy and confidentiality; good communication with the provision of information as required; allowing choices; preserving control and involvement in their care; autonomy; and the use of respectful forms of address (Holmberg, Valmari, & Lundgren, 2012; Matiti & Trorey, 2008; Randers, Olson, & Mattiasson, 2002; Woolhead et al., 2004). Moreover, factors that increase patient dignity include a physical environment that allows for privacy, support from other patients, and a respectful, caring atmosphere (Baillie, 2009; Baillie, Ford, Gallagher, & Wainwright, 2009; Jacelon, 2002; Potter, 2008). Conversely, components of care that may diminish dignity for the older person include a lack of privacy resulting in shame and humiliation, disrespectful communication including curt attitudes and authoritarian behaviour on the part of nurses and other staff, not being seen (or feel unheard), and loss of autonomy (Baillie, 2009; Baillie et al., 2009; Calnan et al., 2006; Gallagher et al., 2008; Randers & Mattiasson, 2004; Ronch, 2011; Tadd, 2006).

Dignity has also been shown to contribute to the enhancement of the work environment for Registered Nurses. When RNs, for example, are successful in respecting dignity toward patients, they experience satisfaction, self-respect and pleasure in their work (Soderberg, Gilje & Norberg, 1997, p.144). Yalden and McCormack (2010) noted the positive relationship between dignity and the quality of relationships with others. Additionally, Lawless and Moss (2007)

stated that dignity in the work-life of nurses may be a significant factor in developing and sustaining healthy workplaces. Lastly, Tadd et al. (2011) explained how the equally beneficial effect of dignity occurs when staff experiences a sense of dignity in their work environment; this enables them to provide dignity care to patients. These findings suggest that the provision of dignity results in mutually beneficial circumstances for both the patient and the caregiver. As people continue to live longer, there is an increasing demand for older persons requiring the 24-hour specialized care, found within residential care settings. Dignity care is an important component of this environment as it enables nurses to focus their care on the needs of the older person.

Definition of Terms

The following definitions define terms embedded within this study.

Older person. Over time, various labels or terms have been used to describe the demographic of the older population including; *elderly, senior citizen, and aged*. According to the Canadian Oxford Dictionary (2012), the term *elderly* is defined as "rather old; past middle age" (p. 2187), *senior citizen* is defined as "an elderly person, esp. a person over 65" (p. 6241), and finally, *aged* is defined as "having lived long; old" (p. 112). Although delineation of an older person is multifaceted encompassing physiological, societal and chronological aspects, there is currently no single established definition for this age group. In Canada, the Special Senate Committee on Aging (2009) suggests either *older person* or *senior* as the most appropriate term. As well, there is also no consensus for chronological age but, the UN agreed upon cut off for this age group is 60+ years (WHO, 2013). For the purposes of this study and in relation to a Canadian context, older person(s) or older people will be used to describe adults over the age of 65 years.

Dignity. This research focused on studying how RNs provide dignity when caring for older persons in a residential care facility, therefore a clear understanding of the term "dignity" is required. The Canadian Oxford Dictionary (2012) indicates that the word dignity originates from the Latin word *dignitas/dingus* meaning worthy, and is defined as "the state of being worthy of honour or respect" (p. 1915).

Origins of the concept of dignity may be traced back to ancient Greece with the musings of Aristotle who lists dignity as one of the 14 virtues of character in his work entitled *Eudemian Ethics* (Gallagher et al., 2008). Later, philosopher Immanuel Kant deliberates in his *Groundwork for the Metaphysics of Morals,* about how things in life have either value or dignity; things of value can be replaced by something of equivalent worth, whereas that which is above value has dignity, and therefore has no equivalent and is of an intrinsic worth (Wainwright & Gallagher, 2008). By nature of having an intrinsic worth, Wainwright and Gallagher (2008) suggest that Aristotle and Kant intimate that intrinsic worth is dependent on rationality and autonomy. Based on this reasoning then, is the implication that people lacking rationality and/or autonomy are also lacking dignity and intrinsic worth? On the contrary, Potter (2008) suggests that it is in fact those who are most vulnerable and with complex needs that are at the greatest risk of having their dignity compromised. Perhaps Gallagher (2004) states it even more succinctly "They have this dignity purely because they are human" (p. 590).

Other authors who also attribute dignity as having an intrinsic worth include Jacelon (2004), Nordenfelt (2004), and Calnan, Badcott, & Woolhead (2006). First, Jacelon (2004) links dignity to the concept of personal integrity and describes it as something that emerges as "a dynamic intrinsic quality of individuals" (p.552). Nordenfelt's (2004) work identifies four types of dignity: Dignity of *Menschenwurde* - a German word meaning the kind of dignity we all have

by nature of being human or intrinsic; Dignity as merit - people having rights based on merit or positions/roles that they hold; Dignity of moral stature - degrees of dignity that are based on person's actions or omissions; and Dignity of personal identity- dignity that is related to one's identity as a person and self-respect. The latter three types of dignity imply contingent worth (Wainwright & Gallagher, 2008). Finally, from their work exploring the meaning of dignity in later life for older people, Calnan, Badcott, and Woolhead (2006) explain dignity as an inherent trait to being human that is threatened simply by the disadvantages of older age. The authors also note that participants found it easier to denote what dignity *was not* (emphasis added) and when it was violated, as opposed to discussing the concept itself.

Another scholar, Chochinov (2002), has focused his early research on dignity at the end of life. His recent work describes a framework about a "dignity in care approach" that may be applicable in any clinical context (2010). In Chochinov's (2010) framework, he elucidates that the concept of dignity is derived from the core healthcare values of kindness, humanity and respect.

From a nursing perspective, there are various guidelines encompassing the concept of dignity. Beginning with Article 1 of the Universal Declaration of Human Rights, (UDHR), the UN (2013) clearly denotes dignity as a human right. Subsequently, embedded within the International Council of Nurses' (ICN) Code of Ethics (2012) is language which instructs nurses toward the provision of care that both respects human rights and promotes quality care. Finally, under preservation of dignity, Section D of the Canadian Nurses Association (CNA) Code of Ethics for Registered Nurses (2008) reads "Nurses recognize and respect the intrinsic worth of each person" (p. 13). Similarly, Section 5.8 from The Declaration on the Promotion of Patients' Rights in Europe (1994) serves as a reminder of the significance of dignity from the

patient perspective. It states: "Patients have the right to be treated with dignity in relation to their diagnosis, treatment and care, which should be rendered with respect for their culture and values." This document reminds us that dignity is an expectation of care and despite direction on the importance of provision of dignity in care, there is no unified meaning for this concept.

For this study, dignity will be used in the context of Gallagher (2004) who states: "People have this dignity or worth regardless of their levels of competence, consciousness or autonomy, or their ability to reciprocate in human relationships. They have this dignity purely because they are human" (p.590).

Residential Care. The varying contexts for providing care for the older person have taken on a variety of designations including extended care, intermediate care, long-term care (LTC), or residential care. The facility in which the research took place was designated as a residential care facility. The British Columbia Ministry of Health (2013) describes residential care as that which provides 24-hour professional care and supervision, in a protective, supportive environment, for people with complex care needs who are not able to live independently.

Project Description

Research Purpose and Objectives

The purpose of this study was to explore how Registered Nurses (RNs) provide dignity as they care for the older person living in residential care. The research questions for the study were as follows:

1) How do Registered Nurses (RNs) understand the meaning of dignity when caring for the older person?
2) What are the Registered Nurses (RNs) perceptions of how they provide dignity when caring for the older person?

Project Method

To answer these questions, a qualitative approach, interpretive description as described by Thorne (2008), was utilized. Data was collected through semi-structured interviews with RNs. Data was analyzed through transcription, coding and immersion with the data to ascertain meaning of the findings.

Relevance and Significance

Older persons comprise an intricate component of society, and their rising numbers and complex care needs contribute to challenges within our health care system. Managing these care needs in a manner that demonstrates dignity is an important element of nursing care. With limited literature describing how RNs incorporate dignity when caring for older persons living in residential care, this research study began addressing this gap.

Outline of Thesis

The thesis is organized into six chapters. Chapter One introduced the topic, purpose and method of the study. Chapter Two describes the search and retrieval strategies used for the literature review, as well as an overview of previous studies that are relevant to the study. Subsequently, Chapter Three explains the research method and includes information on sample selection, data collection and analysis, scientific quality and ethical considerations. The findings are reported in Chapter Four, whereas Chapter Five provides a discussion of the emerging analysis of the results in relation to relevant literature and a dignity framework. Chapter Six concludes with recommendations for nursing education, practice and research implications.

Chapter Two: Literature Review

This chapter describes the search and retrieval strategies for the literature review and presents the findings of the review. The literature review examined relevant literature pertaining to how RNs provide dignity to older persons living in residential care and to ascertain the perceived gaps within this research.

Search and Retrieval Strategies for Literature Review

The literature review was conducted in two phases: a preliminary and secondary search. The preliminary search was conducted using CINAHL, Medline, PsycINFO and Biomedical Reference Collection, and was comprised of four main key word searches. The first search entailed key words used to describe the older person and the terms "older people*", "elderly", "senior*", "geriatric*", older adult*" and "older patients" were used. Subsequently, the key words "registered nurse" and "registered nurs*" were added, followed by the third search of "dignity" and "dignity in care". Finally, the keywords for residential care were added and included "Residential care", "residential care facility", "long term care", and "nursing home". Due to the limited number of results encountered, successive searches included alternate care settings encompassing community, palliative care and hospital. These alternate settings were then added to the three initial search terms of; older person, registered nurse and dignity. Thus, keywords "community", "communit*" were substituted for the residential care keywords, followed by the key words for palliative care which included "palliative care", "palliative*", "hospice care", and "terminal care" in lieu of "residential care". Lastly, the location of hospital was used to replace the location of residential care and keywords included "hospital" and "acute care". The Boolean operators "AND" and "OR" were used in conjunction with the above stated keywords to further define the searches. Additionally, hand searching was done for some articles

found in article reference pages and others from articles/authors recommended by my supervisory committee (Refer to Appendix A).

The inclusion criteria included research articles that were published within the last ten years (2004-2014). A few exceptions included articles that were closely related to the topic of dignity and the older person but were published within the years of 2000-2004. Further inquiry occurred through reading the abstracts and related topics included integrity and personhood (Refer to Appendix B). The list of relevant articles expanded as the thesis project progressed. An ongoing and comprehensive secondary search was conducted as new themes emerged throughout the thesis process, from the literature, and through interviews with nurses. To ensure the most current literature was included, I continued to review the results from newer literature searches and modified key word searches as new terms and ideas unfolded during the qualitative research process.

In the preliminary literature review of registered nurses caring for older persons in a variety of settings, several themes emerged. The themes include the maintenance, re-establishing and promotion of dignity. The current research about dignity care for older persons in residential care has not specifically addressed the perceptions of the nurses caring for these patients and therefore, a gap currently exists in this area of knowledge.

The second literature search focused on emerging themes and ideas, and revisited previous concepts to identify newly published literature. The literature regarding personhood, person-centred care and dignity in dementia care was also explored. Similar to the first search, the secondary search utilized CINAHL, Medline, PsycINFO and Biomedical Reference Collection, with the inclusion of Google Scholar database, textbook resources, hand searching, and articles/authors recommended by my supervisory committee.

Literature Review

The following review provides an overview of literature related to the topic of dignity and the older person. The majority of the articles reviewed for this thesis used a qualitative approach as their method of exploring dignity. The study locations included acute care hospitals, residential care and homecare settings.

Assessment of Dignity

Various tools and frameworks have been developed to assess or measure dignity. Two examples of tools used to measure dignity include the Attributed Dignity Scale (2009) and the Cheshire Dignity Assessment Tool (2009). The former is a self-reported instrument designed to measure attributed dignity (value one accrues or loses based on life experience/accomplishments and how the meaning is related through behaviour) in cognitively intact older adults (Jacelon, Dixon, & Knafl, 2009, p. 203). Conversely, the Cheshire Dignity Assessment Tool (2009) was developed through input that was obtained from older persons, their families and caregivers, and includes a comprehensive and detailed outline of the process required to ensure dignity and respect in care. Furthermore, dignity frameworks are used to guide the provision of care. Bruton, Lipp, and McKenzie (2012), for example, described a newly developed program offered to newly registered nurses that was designed to enhance graduates knowledge and experience, build the nursing workforce, and increase their ability to deliver dignity-centred care to older patients in various hospital settings (p. 24). Finally, Potter (2008) explained how the six senses framework describes the characteristics of health and social environments that may be used as a guide for hospital staff, toward the maintenance of dignity for older hospitalized persons. The six senses used in maintaining dignity include: sense of security, sense of continuity, sense of belonging, sense of purpose, sense of achievement, and sense of significance.

Maintaining Dignity

Several of the articles retrieved focused on maintaining dignity from the patient perspective (Franklin, Ternestedt, & Nordenfelt, 2006; Holmberg, Valmari & Lundgren, 2012; Jacelon, 2003; Lin et al., 2013; Matiti & Trorey, 2008). These patient perspectives of maintaining dignity ranged from being seen and respected for who they are; respect for patient autonomy; defending one's privacy; having a positive attitude; communication and provision of information and; maintaining their body image. For example, a qualitative study by Jacelon (2004) who interviewed five hospitalized patients at least 75 years old, revealed that an older person's dignity is based on their sense of self. Jacelon (2004) further explained that an elder's dignity is strengthened when the combination of their behaviour, sense of their own value and confirmation of this worth by other people's actions are all in alignment (p. 552). Similarly, Franklin, Ternestedt, and Nordenfelt's (2006) qualitative study interviewed 12 elderly nursing home patients at the end of life and found that maintenance of dignity was enhanced by supportive staff and family attitudes that helped strengthen the older person's ability toward maintaining their dignity of identity (p. 140). Yet, in Lin et al's. (2013) narrative review of 37 studies (four review studies, 31 qualitative studies and two quantitative studies) reporting dignity in care of inpatients over the age of 18 years old, maintaining dignified care included protection of privacy, respect, and allowing them to be autonomous (p. 172). These findings are consistent with Matiti and Trorey's (2008) qualitative research involving 102 interviews with hospitalized patients over the age of 16 (the oldest being in their mid-eighties). Their study revealed six themes that contributed to maintaining a patient's dignity which included: privacy; confidentiality; communication and the need for information; choice, control and involvement in care; respect and; decency and forms of address. Additionally, Holmberg, Valmari and

Lundgren's study (2012) describing 21 patient interviews of participants ranging in age from 52-99 years whom were receiving homecare nursing care, reported a quandary in which older people find themselves. On one hand, patients found that having the choice of receiving nursing care in their home helped maintain their dignity, yet conversely, having to wait for the nurse's visit and accepting visits from unfamiliar nurses was irritating for them, thereby impacting their dignity (p. 710).

Other studies included both the patient and the nursing perspective for maintaining their dignity (Berg & Danielson, 2007; Hall, Dodd & Higginson, 2014). To illustrate the experiences of a caring hospital relationship, Berg and Danielson (2007) interviewed seven hospital patients between 51-75 years of age and six RNs. The results demonstrated that patients identified using their own competence, resources, awareness, values and images to form a caring relationship and; being cared for by the team, as approaches to maintaining their dignity (p. 502). Whereas nurses used their specific skills to form a caring relationship, which in turn decreased the patient's feeling of vulnerability and maintained their dignity (p. 504). Additionally, Hall, Dodd and Higginson's (2014) study of maintaining dignity for residents of care homes, compared the views of 16 residents (median age of 80.5 years) with those of 33 managers (median age of 56 years); 29 care assistants (median age of 41 years); 18 care home nurses (median age of 47 years); 15 resident family members (median age of 60 years) and 10 community nurses (median age of 47 years). The results of their study identified the themes of: independence, autonomy, choice and control; and privacy, as the most prevalent methods of maintaining dignity, followed by comfort and care; individuality; respect; communication; physical appearance and being seen as human, as less prevalent methods of maintaining dignity for this population (pp. 57-59).

Re-establishing Dignity

While maintaining dignity implies sustaining that which already exists, re-establishing dignity suggests that dignity has been lost and needs to be restored. The 29 nurses and nurse assistants in Hall & Hoy's (2012) qualitative study, described how being hospitalized increased the older patient's risk of losing their dignity and they felt that it was their responsibility to help the older patient re-establish their dignity. This study revealed that re-establishing dignity for the older hospital patient encompassed seeing the patient as a unique individual, helping "getting rid of the bed" or sick role by promoting mobility, and supporting patient appearance (p. 289).

Promotion of Dignity

Similar to maintaining dignity, are the concepts of promotion and/or the enhancement of dignity. Baillie's (2009) qualitative study using unstructured interviews from 24 hospitalized patients aged 34-92 years identified the environment, staff behaviour, and patient factors as having an impact on a patient's dignity. Environmental factors that promoted dignity included a physically conducive ward design, for example, single rooms versus shared rooms; a ward culture that demonstrated a caring and respectful approach toward patients and; the support of other patients. Staff behaviours that promoted dignity included the provision of privacy and interactions which enabled the patients to feel valued and in control. Conversely, staff behaviours that threatened patient dignity included: curt and authoritarian attitudes of staff and breaching of their privacy. Finally, Baillie (2009) found that patients promoted their own dignity through their attitudes, such as the use of humour and through the acceptance of a loss thereby allowing them to feel more comfortable; through the development of relationships with staff; and through the retention of control and ability (pp. 30-32). In comparison, Webster and Bryan's (2009) qualitative study of ten recently hospitalized patients aged 73- 83 years, described dignity

promoting factors as: privacy; cleanliness; effective communication, for example, staff who listened and were friendly and approachable; physical independence and; having control over what was happening to them (pp.1787-1790). Lastly, Heath's (2010) qualitative study explored the unique role of the RNs and care assistants (CAs) working with older people in nursing homes. The distinct outcomes of the work of RNs in caring for older people revealed an enhancement of the older person's dignity on various levels. Examples of dignity promoting behaviours included: the creation of a safe environment through the minimization of potential hazards; enhanced relationships through audiology assessments and subsequent use of a hearing aid; improved health and function for example, increased activity levels and effective pain management and; prevention of adverse problems/outcomes for example, early prevention of dehydration, and early detection of urinary retention (p. 122).

Personhood/Person-centred Care

Several authors have explored the concept of personhood and how it relates to older people. McCormack (2003) for example, developed a conceptual framework for person-centred practice with older people based on the relationship between the nurse and the patient and the expectations within the relationship. According to this framework, the factors that enable person-centredness to occur in practice include respect for what the patients value about their life and how they make sense about what is happening to them; the nurse's underlying values which allow the patient's values to take precedence and still contribute to the process of person-centredness, and the context of the care environment (p. 206). The latter is described as having the greatest influence on enhancing or limiting person-centred practice and may include systems of decision-making, staff relationships, power differentials, and the potential of the organization to tolerate innovative practices (p. 206). Further to this work, McCormack, Roberts, Meyer,

Morgan and Boscart (2012), conducted a review of three patient-centred models/frameworks to highlight the similarities and differences between existing models and to explore the implications of these for the role of the RN in LTC. The three models/frameworks represented culture change, person-centred practice, and relationship-centred care. They summarized the person-centred framework into four constructs: 1) *Prerequisites* that focus on the attributes of the nurse; 2) *The care environment* focusing on the context in which the care is delivered; 3) *Person-centred processes* focusing on the delivery of the care and; 4) *Outcomes*, which are the results of effective person-centred nursing (p.288). Although the authors acknowledged that the models and frameworks assist with understanding person-centred practices, they argue that looking for the ideal model or framework diminishes the focus of the evidence-based benefits of person-centred practice, specifically, how good relationships are a key to quality of life, quality of care, and quality of management (p. 292). Additionally, Siegel et al. (2012) highlighted the impact of contextual influences toward patient-centred care and explored four contexts that influence a RNs capacity to provide person-centred care in LTC. The four contexts included:
1) sociocultural; 2) policy/financing/regulation; 3) nursing/professional; and 4) organizational. Sociocultural contexts include societal and cultural beliefs about ageing and the care of older adults that may support or hinder personhood in LTC, for example, society's lower expectations of services for the older person such as, substandard food and shared rooms, which would be viewed as unacceptable by the younger generation (p. 297). Siegel et al. (2012) further suggest that RNs can integrate person-centredness into their practice by using this sociocultural knowledge to work with patients and families to identify ways of honouring each individual, and through role modelling the importance of meaningful relationships and demonstrations of respect for the older person. Policy/financing/regulation contexts related to privatization, funding and

regulation vary across countries; however, Siegel et al. (2012) propose that RNs can advocate for change through informing decision-makers and choosing careers that influence policy making. Nursing/professional contexts recognize the value of person-centred care yet the diverse licensing and certification standards create challenges related to translating this concept into practice. The authors urge RNs to have a strong working knowledge of their scope of practice and increased education/professional development in areas of gerontological nursing, leadership and supervision, as ways of handling these challenges (p.298). Organizational contexts that may influence the provision of person-centred care include work design and staffing practices. Personhood-focused care is less task-oriented, is often more time consuming, and may be viewed as less efficient. Staffing levels alone may not improve care, yet, factors such as nursing leadership and management practices; for example, communication, teamwork and staff empowerment likely contribute to staffing effectiveness. Siegel et al. (2012) encourage staff nurses and nurse mangers to use approaches that role model interpersonal behaviours that honour personhood. These approaches may include consistent assignments of staff, raising organizational awareness of how task-oriented behaviours undermine personhood, and developing business cases aimed at redesigning care processes (p.299).

Dignity Care for Patients with Dementia or Delirium

Another area examined in relation to the older person is dignified care for the older person with dementia and/or delirium. Simply having dementia or delirium gives rise to the older person being more vulnerable to a loss of dignity (Gastmans, 2013; Potter, 2008). Orulv and Nikku's (2007) qualitative study used video recordings and observation to identify coping strategies used by a staff of six assistant nurses, caring for seven elderly residents diagnosed with dementia. They described dignity work as maintaining the dignity of the residents on a daily

basis, despite the physical, cultural and social decline brought upon by the disease itself (p.509). Orluv and Nikku (2007) also explored how these coping strategies related to respecting and maintaining dignity in the daily life of the residents. For example, allowing residents to discover their own solutions and solve their own conflicts, demonstrated dignity work through respect for their autonomy (p. 520). Alternatively, Schofield, Tolson, and Fleming's (2012) qualitative study interviewed 15 RNs to explore how nurses cared for older people with delirium in the acute hospital setting. Schofield et al. (2012) discovered that nursing care became focused on either surveillance or containment. Surveillance care included watching and listening for a patient's movement within their bed or bed space, as well as visual appraisal, with a safety focus intended to prevent patient harm during hospitalization (p. 170). Containment care occurred during episodes of acute confusion and was initiated by nurses to keep patients safe and to prevent misunderstandings by onlookers (p. 170). Upon resolution of a patient's acute delirium episode in hospital, nurses maintained a patient's dignity and self-respect by not mentioning the episode unless the person specifically inquired about it (p.172). Finally, Kitwood's (1997) book presented a paradigm which hypothesised that good care practices, for example, intense personal interactions with people with dementia, may help slow down or reverse some of the deterioration typically seen with this disease.

Chapter Summary

This chapter provided a review of the relevant literature. Although it is suggested in the literature reviewed that there is an expansion of knowledge in the field of dignity, there were no articles that specifically addressed the perceptions of how RNs provided dignity in their care of the older person living in residential care and only one article that discussed how staff maintained dignity for residents of care homes. With the continuing rise in the older population

and consequently, the increasing demand for RNs in the delivery of care for older persons, it is important that RNs are able to respond to the specific care needs that this population requires. Based on this assertion, a research study to explore the RNs provision of dignity care to older persons was identified as an area of need. The next chapter will describe the research design, methodology and procedures used in this study.

Chapter Three: Research Design, Methodology and Procedures

This chapter describes the research process used to answer the research questions. It begins with a description of the research design, method, data collection and data analysis. Subsequent headings within this chapter include ethical considerations, scientific quality and limitations.

Research Design

To gain an understanding of what dignity means to RNs and how they incorporate dignity into their care of the older person in residential care, a qualitative research method was used. Specifically, the interpretive description methodology based on Thorne's (2008) work facilitated a deeper exploration of how RNs provide dignity for the older person, through the collection of rich narrative interviews and ongoing analysis. This method uses inductive reasoning, which begins with specific observations and moves toward broader generalizations that are developed through an open and exploratory manner (Thorne, 2008, p. 48). An inductive approach allowed for a thorough exploration of RN's understanding and practices in relation to foundations that support dignity and dignity care of the older person. Due to limited data found in my area of interest, the interpretive description method described by Thorne (2008) provided an ideal avenue for this novice researcher to generate new and meaningful knowledge within my own field, in effort to apply this data to my clinical practice.

Methods

Recruitment. Upon obtaining ethics approval from Trinity Western University (TWU) Research Ethics Board (REB) (Refer to Appendix C) and approval at the recruitment site (Refer to Appendix D), participants were recruited through advertisement at one residential care facility. The Assistant Director of Care (ADC) assisted with the recruitment process by placing the

recruitment posters in strategic locations throughout the residential care facility, such as at the nursing station and in lunch rooms. The posters included an explanation about the study and how to contact the researcher by phone or email for further information (Refer to Appendix E). Once RNs expressed interest in being in the study, they were asked to contact either the researcher or the ADC of the residential care facility. If interest in participation was expressed, an information letter (Refer to Appendix F) was provided to the participants by the ADC. Interested participants requested that the researcher contact them at their place of employment and the ADC provided the names and schedule information of when the interested RNs were available to be contacted. After the RN participants were contacted by the researcher, a mutually agreed upon interview date and time was confirmed.

Inclusion Criteria. The inclusion criteria included male or female RNs who currently were caring for older persons living in a 139 bed residential care facility, were English-speaking and were available to complete a face-to-face 45 minute interview. The exclusion criteria included any nurses who did not meet the inclusion criteria.

Sampling. Eleven RNs who met the inclusion criteria were interviewed for this study. The goal was to conduct interviews with six to twelve RNs from a single residential care facility. Six interviews were deemed the minimum number of interviews required to obtaining comparative data and the maximum number of twelve ensured project feasibility. Initially, eight RNs had consented to participate in the study, but upon review of the transcripts, it was agreed that if possible, additional interviews would further enhance the richness of the data.

Convenience sampling was the sampling method used in this study. This method was chosen because it allowed the researcher to choose both the setting and the individuals by virtue of their area of experience (Thorne, 2008). Although the researcher recognized that there is a

variety of staff working with the older persons in this residential care facility, due to the paucity of literature on this topic, it was decided to interview RNs first, by which to build a foundation of knowledge on this topic. In the future, other studies could be conducted with other health professionals who also work with the older persons in these residential care facilities, such as licensed practical nurses (LPNs), care aides (CAs), activity coordinators, or social workers.

Of the eleven RNs recruited for the study, there were one male and ten females. Age ranges included: one nurse between 21-30 years of age; two nurses between the ages of 41-50 years; five nurses between 51-60 years and; three nurses aged 61-70 years old. The highest educational level attained among the RNs interviewed included seven college/diplomas and four baccalaureate degrees. There was an average of 26.36 years of experience working as an RN, and within those years, there was an average of 19.6 years of experience caring for older persons. Five nurses identified their ethnic background as Caucasian (including Finnish, German, and Norwegian); three nurses as Pilipino; two as East Indian and one as Chinese. Countries of origin included Australia, Canada, Finland, Hong Kong, India and the Philippines.

Data Collection

Face-to-face semi-structured interviews were conducted with eleven RNs working in a 139-bed residential care facility for older people. All interviews occurred within the facility, at a mutually agreed upon date and time, and were approximately 30-45 minutes in length. The RNs were given permission from the ADC to participate in the interviews during a quieter work time, which was predetermined by each individual RN. With the exception of one interview which took place after work hours, the RNs brought a work phone in with them to the interview which was also connected to the call bell system. This enabled the RNs to be available to staff during this time if required. Although some interviews were temporarily interrupted due to

communication with other staff members, in each situation we were able to resume the interviews shortly thereafter.

Following initial introductions and an explanation of the study, an informed consent was obtained prior to the commencement of the interviews (Refer to Appendix G). Demographic information was collected from participants at the start of each interview using a demographic data sheet (Refer to Appendix H). An interview guide was developed in consultation with the thesis committee (See Appendix I). These questions were open-ended and began by asking for examples of a time when the RN participants helped an older person have dignity. Subsequently, the questions explored areas such as, what dignity meant to the RNs, what dignity might mean to older persons themselves and the significance of dignity to nursing care. Within the questions, there were also prompts which were designed to assist in eliciting more specific answers, for example, what dignity might look like to an older person in terms of their care or, in terms of their family life. Some participants cried during the interviews and sometimes we shared a laugh as they poignantly relived their stories. Interviews ended when the RNs appeared to have no further information to share. At this stage, the participants were asked if they had any questions and the debriefing questions were used to elicit their interview experience (Refer to Appendix J). Finally, participants were asked if they had anything else they would like to add. Some of the participants shared that they had been nervous about being interviewed, but that they were doing it because they felt that it was important to contribute to nursing research. Others were hoping to learn something about the older population and several participants showed a keen interest in receiving the study results. Additionally, one RN asked why the interview was not done in a written format as this had been her previous experience. At the conclusion of the interviews, a

few spoke well after the recorder had been turned off. A five dollar gift card was provided at the end of each interview as an honorarium.

After the completion of the first couple of interviews, the interview guide was re-evaluated and some of the questions were modified. Further modification was made with the interview guide after the sixth interview in consultation with the supervisor. Immediately following the completion of each audio-recorded interview, field notes were written and included a diagram of the room set-up, seating arrangements, body language of participants, notation of interruptions (if any) such as call bells, knocking on the door, and any details that may have provided greater understanding of the interview that were not captured on the recordings. This researcher transcribed the individual interviews verbatim from the audio recordings. Based upon the richness of the data collected by interviews with five more participants, no secondary interviews were conducted.

Data Analysis

Interpretive descriptive research is characterized by an analytical process whereby this researcher attempted to learn "to see beyond the obvious" in order to find meaning in the data (Thorne, 2008, p.142). This is an important aspect of qualitative data analysis as it enabled the researcher to go beyond the initial first impressions and see the data from a broader perspective. Full immersion of the data occurred through listening to the audio recordings, transcribing the transcripts, and re-listening to the recordings. Next, based on the interview questions, broad based coding was done as an initial method of sorting the data into smaller, more manageable sections. The code book was started following the initial two interviews, with constant refinement occurring during the analysis of the subsequent interviews with my Supervisor. Following the completion of the eleventh interview, the final code book (Refer to Appendix K)

was edited in consultation with my supervisor. Each interview was coded separately and compared to each other in order to reveal if there were any recurring patterns, themes or relationships therein. Once again, immersion of the data became an important process prior to writing up the findings and analysis of the data for the study.

During the coding process, I also created memos which were comprised of questions, potential emerging patterns and notes to consider at a later time. These memos allowed me to return to my data and develop a deeper perspective each time. Additionally, in order to not lose sight of the poignant quotes from the RN participants, I also created a section in which these "quotable quotes" (Thorne, 2008, p.148) were placed, with the intention of revisiting them at a time when they would not overshadow the coding and thematic analysis process.

Dr. Astle (thesis supervisor) reviewed the coding of the transcripts and provided guidance in development of themes and to ensure accuracy. Further discussion also involved Dr. Duggleby (thesis committee member) around key points in the analysis and emerging themes.

Once the themes emerged, a detailed thematic analysis was performed. Narratives from each RN participant were used to help illustrate each theme and sub-theme. To further enhance understanding of the analysis, an analytical model was developed.

Analysis of the data revealed the themes of: *Foundations that support dignity*, *dignity care* and *structural context for dignity.* Research findings were then organized to reveal relationships between the participant experiences. Further cohesion of the findings occurred through recurring data analysis; refer to Chapter 4.

Ethical Considerations

Ethics approval for this study was sought from the Trinity Western University (TWU) Research Ethics Board (REB) prior to recruitment of participants (Refer to Appendix C). As

well, a letter of approval was obtained from the Director of Care of the residential care facility where participants were recruited (Refer to Appendix D). The research purpose, interview process, and interview questions were discussed with the ADC prior to beginning recruitment and interviewing potential participants. The RNs were given the option to either contact the researcher directly or of advising the ADC if they were interested in participating in the study. Once participants expressed an interest in participating, an information letter (Refer to Appendix F) was provided and after they agreed to participate in the study, a mutually agreed time and place to be interviewed by the researcher was arranged. The purpose of the study was then explained to the participants, including the ability to withdraw at any time. Informed consent was obtained prior to the commencement of the interviews (Refer to Appendix G). Demographic information, audiotapes, transcribed interviews and field notes were assigned an identification code and pseudonym and kept in a locked filing cabinet. Any digital information was stored on a password-protected computer and will be kept for five years. Only my thesis supervisor and I had access to the transcribed raw data.

Scientific Quality

One of the major elements of qualitative research is the researcher as "instrument" (Thorne, 2008 p.69). Consequently, it was important that I acknowledge any biases that may influence the interpretation of data. My role as a RN and palliative care clinician, for example, in addition to my previous experience as a care aide and RN in LTC settings, may have biased me toward wanting to see only the positive outcomes the RNs portrayed or conversely, to be overly critical of the findings. Bias did not appear to have a negative effect on this study but rather provided a heightened awareness of RNs caring for older persons in residential care. However, to enhance the scientific integrity of the research findings, various strategies were implemented,

which included credibility, dependability, and confirmability (Polit & Beck, p. 584). Credibility refers to the confidence in the truth of the data and their interpretations of the findings in qualitative research. Quality of findings was ensured through an audit trail of reflexive notes which documented the researcher's decision-making and self- reflections, memoing and field notes. Furthermore, dependability, or the stability of data over time, was attained through a clearly delineated literature search and retrieval strategy followed by an analysis and interpretation that were confirmed with two separate members of my thesis committee for accuracy. Additionally, confirmability or data that reflects the participant's voice and not the researcher's biases, was demonstrated through asking participants if they were interested in providing their contact information as an opportunity to clarify and share research findings with them. All but one of the participants provided their contact information. Although a second interview was a possibility, the emerging themes did not need to be revisited due the richness of data. Finally, interpretive description research may be enhanced through quality of the interview themselves. Significant effort was made in creating a relaxed atmosphere, building rapport with which to elicit depth of discussion, clarification and elaboration of understandings as described by Thorne (2008, p. 129).

Limitations

Known limitations of this study included small sample size and the collection of data from only one institution. In relation to sample size, although interviewing eleven RNs met the recruitment requirements and encompassed 65% of the RNs in the residential care facility, the sample size remains small. Additionally, the collection of the data was only from one institution. This combination of a small sample size and recruitment from only one institution do not allow for generalizability. However, the intention of qualitative research is more about capturing a

deeper level of understanding of the participants' experiences, than trying to attain representation (Thorne, 2008, p. 89).

Another limitation of a study based on interviews alone includes an assumption of the researcher's own objectivity of the data. The inclusion of interviewing other stakeholders may have enhanced the confirmability of the findings.

Chapter Summary

This chapter described the research process used for this qualitative study. To understand how RNs provide dignity to older persons in residential care, interpretive description methodology was deemed the most appropriate research approach to answer the research questions. Once ethical approval had been granted, recruitment yielded eleven RNs who indicated interest in participating in this study. After the consents had been signed, interviews were conducted using semi-structured interviews. Based on the research questions, a code book was developed. The revised code book was applied to each interview resulting in themes and subthemes from which subsequent coding occurred. Scientific quality was maintained through an audit trail including the use of reflexive notes, field notes and memoing for self-reflection. Regular contact with my supervisor and second reader helped ensure that my biases and excitement as a novice researcher remained grounded. Although every effort was made to ensure scientific quality of the study, limitations included sample size, and representation from only one residential facility. The next chapter will discuss the findings from the eleven RN interviews.

Chapter Four: Findings

This chapter describes the findings from the eleven semi-structured interviews of RNs working in a residential care facility. A consistent element emerging from the RN participants was that dignity was an important component of nursing care. They described dignity as a basic necessity and essential to making life worth living. For example, one RN participant conveyed dignity as an enduring vestige of older persons; as expressed by the following example:

> Dignity is… probably all we have left. When we get to this age; there is not a lot we have left. We've taken, not t-a-k-e-n, but a resident has lost her home, has lost, usually their independence, has lost a car, has lost daily contact with friends and family, usually a telephone, there's nothing really left, they've given themselves to us, to care for, in a very trusting way. They have to trust that we have their best interests at heart. So we have to… we have to respect them as, what they are now because unfortunately they are not what they were. (01)

In addition, another participant intimated that without dignity, life isn't worth living; as depicted by the following excerpt: "Well… if you've got…dignity's all about… their life. Their life choices, their respect, their choice to do whatever. Um, their privacy …it's just…if you don't have any dignity, you might as well just lay [lie] down and die" (02).

Data analysis revealed the emergence of three primary themes: *Foundations That Support Dignity, Dignity Care* and *Structural Context for Dignity*. The first theme discusses various sub-themes of *supporting dignity* that may promote dignity of the older person including; *caring for the whole person*, *respecting, encouraging independence* and *being remembered*. Theme two explores the provision of *dignity care* comprising the sub-themes of *doing, value-giving care*, *building relationships* and *balancing/negotiating*. Finally, theme three reveals the *structural*

context for dignity for the nurses' ability to provide dignified care, and incorporates the sub-themes of *time, nurses' voice, physical setting* and *barriers created by policies/procedures* (*see Figure 1).*

Figure 1. Dignity Model of RNs Working with Older Persons in Residential Care

Theme One: Foundations That Support Dignity

Foundations That Support Dignity was a recurring theme that emerged throughout the data. This theme represents the motivations and beliefs of the RN participants supporting dignity for the older persons. Acknowledging someone as a person exemplifies this concept and is related by the following participant; "Every person deserves to be treated as who they are and what they are and not just like *Room 201* kind of thing, and that always bothers me". (11) The RN participants described this notion of caring for the older person with dignity through various ways which will be outlined as four sub-themes; *caring for the whole person, respecting, encouraging independence* and *being remembered*.

Caring for the whole person. The sub-theme of *caring for the whole person* was described as one aspect of providing dignity care that emerged from the RN participant interviews. Several of the RN participants suggested that some of the factors such as gender, culture, age, cognition, language and history, needed to be considered when assessing the whole

person. Taking time to get to know the older person was perceived as the beginning of the journey of caring for the older person but, as one nurse commented; remembering who the person was is also a key to understanding what and who a person really is:

> I like to look beyond what I see. I look into someone's history, what did they do? Where was their position in the world? And I look at for example, a university professor resident we had, who has since passed away. And I thought she was not always this frail, little woman in her bed, constantly on the bell, screaming, yelling. *Yes*, that can be quite disturbing at times, to other residents, it can be quite stressful to staff when they're really busy, but look to this person, she had a life; she's not just this little elderly person. I like to try and think of who they were, what they did, engage them in conversation. So you were a professor, what did you teach? I mean, how did you get into this? Would you have done this, were you happy with your role in life? Looking now would you have chosen something different? Try and engage them and talk. Ask them for their input. (01)

Likewise, another participant spoke about assessing the needs of the older person by seeing them as a person, not an illness, and incorporating this into their care:

> You know, don't talk to each other and not to the person. You know that's to me very important because otherwise you're an object. And you're just somebody …like part of a job duty instead of a person- the whole person. There's the disease, there's the person who was there before, there's the person that was a mother, a father a…teenager, you know and a grandparent. You have to think of all of those things, I believe. (09)

Additionally, several of the RN participants reflected upon the importance of appreciating the person rather than someone who is aging, as illustrated in the following excerpt:

> a lot of people forget…that these people were once your age; they were once you…they're not anybody different, they're just older. You know their body might not work as well as before, their mind not work as well…but you don't…you treat them still as a person. (02)

Respecting. Another element of *foundations that support dignity* revealed from the data was the sub-theme of *respecting*. A number of the RN participants mentioned the importance of providing avenues which empower the older person to have some control over their life. They further explained how older persons have suffered several losses such as the loss of their home, the loss of their health and the loss of family members, and presenting some choices may help retain a sense of dignity. The following nurse explained the significance of preserving their self-worth; "…as much as possible they have that feeling within themselves, that they're still worth, like …they still have worth" (04).

Another nurse expressed the importance of affording choices in their daily activities:

> You *have* to respect *their* feelings if they want to do it, do it, otherwise don't do it. So suppose …one of my residents said "I do not want to get up and have a bath". I said, "its okay she's 99 year[s] old, give her a sponge bath, maybe she doesn't feel like getting up now" …like suppose, as I told you, that if they want to eat-let them eat. If they don't want to eat [and] they say no, do not force them and whatever they like, try to provide later *that* thing[for them]. So sometimes they say "I don't like this meal". Provide something else. Sometimes they say "I don't want to wear this". Do not put that on. But especially if they don't like something- just put it away. I don't think you have [the] right to make them upset. (10)

Additionally, the significance of respecting choices and end-of-life decisions made by residents was illustrated by the following nurse:

> … There was another lady who had severe cardiac problems. And, she was really suffering, and then…she had an opportunity to go see a…a specialist. And the specialist offered her… [a] surgical intervention. And…she decided to…opt for that and we sat down and talk [ed] about it. She said you know [states her own name], the way I am, I have no quality of life and you know if I die on the table… [so] be it. She was very…she feel [felt] very strongly about it so we kind of talk [ed] about that, and I think the specialist explained everything to her, so she understood what she would be going through. And, so I think she just needed some support. So I said, "You know, I respect your decision to go through with it and you understand your quality of life is being zero, and that there's still a hope that you'll survive… Then you know you [may] improve your quality of life…and so basically, [I] give [gave] her support. And unfortunately she did die on the table. (07)

As well, for those residents with either cognitive impairments or dementia, choices may still be provided by using various approaches, as one nurse explained:

> Well, I think you can still break it down to *some* choices. Like what would you like to eat, eggs or cereal? You know like there's some –still some choices. Or, do you want to wear red today or do you want to wear blue? Like how do you feel? (09)

Gestures such as knocking prior to entering a room or calling someone by their preferred name were described throughout the data and the following excerpt illustrated this type of care, as one RN participant stated:

> I always knock on the door before I enter the room and when I enter I always say "Good morning" or whatever, I introduce myself and call them by Mr. or Mrs. whatever their name is and I always go gently [into the room], I don't just barge in. And if they're in the bathroom, I knock and I always say "Can I come in?" And I wait for permission. I don't just barge in like - I open the door, turn the lights on and say "Here's your meds!" Kind of like - you just don't walk in. Give them time to like wake up, especially in the morning when they're sleeping, turn the lights gently, kind of –"Mrs. Smith (she says this softly) are you awake, good morning?" You know wait for them, give them a chance and then… you know you give them the time to acknowledge that somebody is in there. (11)

Another RN participant admitted that she sometimes reverted to using terms of endearment as described by the following example:

> …it's hard sometimes even for myself, like usually I call them "Dear" or …like those terms (softly laughs).Which sometimes they don't…some of them…like most of them they so appreciate it…like they like it… but some of them, they don't, and it's kind of hard for me because usually I get…like I got used to it. So usually I try not to, and I call them by [their] names, and I try to…like make them decide for themselves what they wanna do. (04)

Further to addressing someone by their name, is the importance of actually asking them what they prefer to be called and not making the assumption, as this nurse stated:

> Yes, that's how I was raised that you show respect to your elders and you don't just- unless they give you permission- you don't call them by their name like they're your buddy. Unless they give you permission -that's a different thing. So you wait for that until the permission is given to you. You don't automatically *take* it. (11)

Finally, *respecting* also included the aspect of maintaining personal appearance. Several of the RN participants mentioned the importance of personal appearance as an element of *foundations that support dignity*; as explained by the following nurse: "I've learned that I can still provide dignity by, you know making sure they still look… presentable…Like they still look presentable, especially with [when] their family members [are] coming in" (04).

Encouraging Independence. Stemming from the sub-theme of *respecting* was the sub-theme of *encouraging independence. Encouraging independence* can be time consuming for nurses as they encouraged residents to do things for themselves. This seemed to be another key component in supporting their dignity as described by one nurse:

> And I remember here like we used to have a resident on the 6th floor- she used to change outfits for every- before every meal- and that was her thing and you want to continue to give her that freedom so she can maintain her independence. Or even if she needed a little bit of help- *provide* that. So she can maintain her independence and dignity so she knows that's who she is, that's how she's done it all her life. So if you take that away, because it takes us – like a few minutes extra right- because for three meals, we have to help her dress three times, but it goes a long way, to give her that little gesture you know. (11)

Being Remembered. The last attribute that will be discussed in relation to *foundations that support dignity* is the sub-theme of *being remembered.* This concept may evoke thoughts of leaving a legacy behind after someone dies (such as children or a work of art), but some RN participants emphasized the importance of remembering an older person while they were still living. Despite being in a facility that may provide for all their physical needs, sometimes the interpersonal needs may be forgotten as reflected by one nurse:

> So a lot of times…we act as their family. We, we talk to them and help them. Sometime[s] we don't have time, but we…some of us, try to make time. And that's the sad part, they do miss their family, and it is the truth that a lot of them, when they get older and get put in a facility…they're forgotten ...by their family *and* friends. (02)

In conclusion, what surfaced from the data was that *foundations that support dignity* involved taking time to get to know the person, seeing and appreciating them as a person who is not defined by age or illness. *Respecting* the older person included preserving their self-worth, providing choices, addressing them appropriately by their preferred name, and taking the time to attend to their personal appearance. Additionally, encouraging residents to do things for themselves in their own time, promoted *independence* and fostered a measure of control in their lives. Finally, we are reminded by RN participants in this study that an equally important element of *foundations that support dignity* is to encourage family and staff to not forget them as a person- *being remembered.*

Theme Two: Dignity Care

While theme one described the elements of *foundations that support dignity* for an older person, theme two illustrated those elements revealed in the data that actually encompassed *dignity care*. *Dignity care* incorporates the actions, qualities and techniques that help define this type of care. *Dignity care* is further subdivided into four sub-themes: *doing, value-giving care, building relationships* and *balancing/negotiating*.

Doing. The process of actually providing dignity care may look different for each individual but, some may be surprised at the simple courtesies that comprise this category. One may argue that providing this type of care should be a baseline of how residents should always be treated. The majority of RN participants mentioned the importance of maintaining an older

person's privacy whether it was during personal care, toileting or, upon entering their room, as described by one nurse:

> Like when you do care, you see to it that the doors are closed…we have some rooms that we share with another resident so…I make sure that they close the curtains, or if they're toileting, close the bathroom door. Because it's really important, even if they're that old, you know, they still have…still want their privacy. (03)

Several of the RN participants related care of the residents to that of treating them as they would their own parents. More than one nurse described the importance of offering explanations prior to implementing care but, perhaps even more significant in terms of *doing*, is the matter of actually ensuring permission from the residents (regardless of cognition status) prior to initiating any of these actions. Below is one example from a nurse seeking permission from a cognitively impaired resident and she very explicitly described how she uses a unique level of assessment for this type of resident:

> Yes, because you have to kind of get [the] okay from…anybody. [So if they] Understand, they will give it verbally or [an] other way if they are cognitively impaired, so then you have to kind of… *sense* it or feel it, or make them feel comfortable [and if they don't sort of give you that feeling that it's okay], Then it's no go (small laugh) until they…you somehow…make the connection and they feel that it's okay. (08)

Value-giving Care. Many people are able to provide physical care such as bathing and feeding to older persons but, it is the manner in which this care is provided that focuses on the essence of *value-giving care*. Some of the RN participants mentioned the importance of doing those little things that mattered such as using a gentle approach, a soft touch, or having an unhurried manner. However, *value-giving care* seems to go beyond the act of simply doing

something kind, it is treating them *with* care as one nurse explained; "It's not just putting them on the toilet cause they *have* to…it's you're providing care. It's because you care for them. Right like, you're doing it because you care for them" (04). Further to this, another nurse exemplified kindness and respect by taking the time to give gentle explanations prior to offering care as a measure of *value-giving care*:

> And you know like when we go to a resident, we want to…let's say change a diaper or a brief, and I see care aides sometimes go in, (she uses her hands to demonstrate the action of forcefully removing a blanket) and the resident could be asleep and just take the blanket off. Instead of (she gently taps the table)…calling their name, wake [waking] them up gently and [saying]…"I'm going to change your briefs, or I'm going to take the blanket off". (09)

Building Relationships. Spending time with an older person enables nurses to provide dignity for this population by developing an understanding of the nuances that may enhance their care. *Building relationships* includes getting to know their preferences and showing a measure of caring that may improve their quality of life, thereby increasing their comfort level. One nurse explained how seeing residents on a regular basis assists with building these relationships:

> I'm the one who can see them every day, like what they're like…and what they need, what they want like usually we are the ones to tell the family, she/he needs this…or she needs this, right, so…that allows me to provide or keep their dignity and if they need like they need new clothes…they need …dentures adjusted, right, it is part of my job…and I am part of their life and it means so much that as… I feel like I am keeping their…like, providing their dignity and keeping it…and as much as possible…I feel like… whenever, for example, I give their medications, and they…they just, like whenever they see my

> face they just take it, they never ask about, what am I taking or what is it? I feel like they trust me. (04)

Cultivating interactions with family members is another means of contributing to *dignity care* as it provides a broader perspective from which the nurses can draw from as one nurse explained:

> A lot of times too you know, some families, they're the ones who will tell [us]. It's like "Oh my dad wants- make sure you take him to the bingo, because he loves bingo! Because the families are the most important, you know, for you to coordinate with their activities right? Because they live with their parents all through [their lives] and then they come in here and they're the ones who will, you know like, fix everything for you because I mean, they know their parents. (06)

Although many family members know their relatives better than the nurses, illness such as dementia may shift this focus. It then becomes the role of the nurses to educate the families about their loved ones and to suggest new approaches for managing these changes, as one nurse elaborated:

> One resident she has dementia – like she's eating everything in sight and they keep bringing flowers and she eats flowers and dirt and to me it's like okay, at least you should be aware of what stage your mother *is*, right? Flowers aren't appropriate- I know it's a nice gesture like yes, Mother's Day or whatever the occasion is- she doesn't know, she doesn't understand what you're bringing. Even if you were to sit with her and hold her hand, that probably would be *more* meaningful than bringing her a bouquet of flowers and leaving them. Cause she doesn't know what they're for, what they're meant for. (11)

Balancing/Negotiating. Providing *dignity care* may not always be as straight forward

on the surface as it appears. Previous examples of courtesies such as addressing someone by their preferred name, providing privacy, and encouraging independence, may seem obvious examples of providing *dignity care* but what if a resident chooses not to have a bath on their designated bath day or, doesn't want to eat despite obvious weight loss? In situations such as this, that the participants described using a *balancing/negotiating* approach to *dignity care*. RN participants gave examples of negotiating aspects of care with older persons such as bath times, medication times and meal times. Specifically, deciding *when* to negotiate and with whom is an important aspect of this approach, as recalled by one nurse:

> …one of my residents[s] here he's bringing salt and pepper to [his] room. What is the use of salt and pepper? And another care aide is grabbing salt and pepper from him and he said "No, this is mine"! I said, "Could you please leave it with him? I'll take it later, don't worry. Let him take it- that's his". So, he took it and when he is in bed I brought it back. Simple right? Why would we fight? Why would we make *him* upset? Let them *have* it. (10)

Sometimes residents just require a little extra care and herein lay the balance in knowing who and what is appropriate for a particular person, as related by one nurse:

> Oh I think just on a daily basis, like I know just yesterday, there was a lady on fifth floor (I did day shift) and she was just kind of feeling a little bit…down, a little bit like -this is unusual for her, she's usually up and about and whatever - and she just didn't feel like coming to the dining room. So she needed *her* space and *her* privacy and she wanted to rest a little bit in between and so we brought her meals. Now, you know that might-it's a fine line- because somebody who is, you know who is bed-seeking you don't want to encourage that. But she - you know on a normal day - is bright and cheery and out in the

> dining room, you know. So what was going through her mind or she was just feeling a little under the weather...that's what we did. And then before we left she was like, sparkly and ready for the pig roast last evening. You know so, it seemed to help. It just gave her that individuality she needed. (09)

The selections above illustrated that *doing* incorporated maintaining privacy and seeking the older person's permission prior to care whereas; explanations and treating the older person with care, were examples of *value-giving care*. Additionally, *building relationships* included learning an older person's preferences and needs, in addition to cultivating family interactions. Finally, the art of knowing when to *balance/negotiate* aspects of care such as bath times, medication times and meal times and with whom, all seem to play a significant role in the delivery of *dignity care*.

Theme Three: Structural Context for Dignity

Although the second theme expanded on the delivery of *dignity care*, this third theme explored the concept of *structural context for dignity*. *Structural context for dignity* includes the elements of facility living that can either impede or enhance the delivery of dignity care. Data analysis from the RN participant interviews revealed four sub-themes of *structural context for dignity* including: *Time, Nurses' Voice, Physical Setting* and *Barriers Created by Policies/Procedures*.

Time. The first sub-theme of *structural context for dignity* that will be discussed is *time*. The majority of the RN participants spoke of the pressure they felt to complete care needs and yet, conversely, how lack of time prevented them from doing things either the way they felt it should be done or, in a manner which would accord job satisfaction. One nurse articulated this in the following quote; "I guess sometimes you know I regress a little bit because of time

constraint… I like to sit and talk and I like to sit and listen, but I just don't have that time. So that's the *frustrating* part" (07). Others struggled with the changes in the delivery of care models that took them away from the time spent with residents and required them do to more organizational work, as described by one nurse: "the way the healthcare system is now a days. I find…I don't have enough time to spend with my residents now because a lot of my work now is paperwork. I do 60-70% of my job is paperwork" (02).

One participant revealed that perhaps a key to providing dignity despite having a lack of time was to offer care in a manner that did not allow the residents to feel hurried:

> …like when you're thinking about the time… and how you're…like getting pressured about it because you need to do stuff like you know, very quickly and for elderly, they need you to at least, they need to see that you're not rushing… them and that when you are providing care, *it is care*, it's not just getting them dressed. (04)

Nurses' Voice. The second component of *structural context for dignity* unveiled from the data is *nurses' voice*. This sub-theme included advocacy for residents and their families, a sense of professional unity as well as aspects which elicit nurses' angst and cause moral dilemmas. There are some *structural contexts for dignity* which encourage nurses to voice their concerns while still others may in fact silence them. The following nurse eloquently expressed her concerns regarding the trend toward "mechanical" care and in particular, ceiling lifts:

> Well you know, our method of care now, because it's not really hands on, it's a lot of…mechanical. I find that very hard to provide dignity for them when they are suspended in a lift and given you know…um, personal care and I find that very, very, very hard to accept that- you know at that age- that they are so exposed. Even though it's

> helpful for the workers, but it's not a kindness, I don't think, to the residents mostly. You know, but then again, maybe it's more comfortable for them too. (05)

This next nurse described her attempts to point out discrepancies to those in authority that were able to help with possible solutions:

> But on a professional level we have to do the care or whatever's expected so sometime[s] it *is* taken away, the dignity is always rushed so I think that's when you have a meeting or some discussions, it's always better to point out that this is not appropriate or this *can* be done. (11)

Physical Setting. An additional sub-theme of *structural context for dignity* that may influence *dignity care* of the older person includes *physical setting*. There are various components within a *physical setting* that may promote or hinder the provision of *dignity care* such as, the temperature of the room or, the number of residents in a room, for example, a single room or semi-private rooms. Although many facilities are moving toward having mainly single room occupancy, those that still have double occupancy can present some challenges in caregiving as described by one nurse:

> And also too, sometimes we do have some double rooms, and it is occasionally difficult to perform care if you've got someone five feet away from you and the resident is aware of that. I don't want to do for example bathroom, toileting, I don't want to do this when there is someone in the room. It's uncomfortable for them, or it can be. (01)

Another attribute of the *physical setting* that may shape the provision of dignity is that of staffing or lack thereof. Simply having enough staff to deliver the necessary care is a basic factor that impacts both the nurses who provide the care and the residents who receive the care. The following nurse expressed the challenge this way; "You get super frustrated actually when you

wanna do, like for example, the care… and um… you have only two hands, right? And there's *so* many of them …." (06).

In addition, having adequate staff may also contribute to the provision of dignified care as explained by one nurse:

> We need more time or we need more staff. So if we have more staff we can take our time [and] give them the freedom or, the little bit of choice to do *some* part of their daily activities. Same thing like with feeding, you know. Because that's *also* a major thing, like it's their dignity like, to hold their independence if they can feed themselves. Instead because we're always in a rush at dinnertime we have to -or breakfast- we have to feed 20 people so let's do this and it's like a chain work like okay, feed residents and to me that *does* take some of their dignity and respect away. (11)

Barriers Created by Policies/Procedures. The final sub-theme of *structural context for dignity* to be discussed in relation to dignity and the older person is that of *barriers created by policies/procedures*. Policies and procedures are usually implemented in an institutional setting as a means of maintaining standards of care and providing clear, consistent direction to staff. Although guidelines are generally considered a good thing, a few of the RN participants intimated that sometimes policies may also be a stumbling block toward the provision of dignity. One nurse explained that maintaining confidentiality of the residents can depersonalize them as well:

> But to me its like- you know, first of all privacy is very important. If you want to talk about someone and nothing should be discussed openly and if you *are* discussing, the person's name should be mentioned- as long as it's in private. …Well, hinders in a way because you know there's always standards and policies we have to follow. Which is as I

> just mentioned that, you know, we're not supposed to be talking about them by their names because that identifies the person, right? So, we have to follow that but then on the other hand on one-to-one when I am talking with the individual, I always give them their respect and that's you call them by their given name. (11)

In summary, understanding the relationship between *structural context for dignity* and dignity may provide a key to the provision of quality care for older persons. Having adequate *time* and sufficient nursing staff to complete care allowed nurses to listen more intently to the needs of residents, offer them more choices and thereby promote independence. A *physical environment* that provides privacy and is conducive to adapting to the special care needs of each individual may also enhance this care. Although policies and procedures may offer guidelines toward the provision of various types of care for the older person, they do not acknowledge the emotional and psychosocial concerns of nurses and residents that are fundamental, in the delivery of dignified care for older persons.

Chapter Summary

The goal of this research was to discover how RNs provide dignity for older persons living in a residential care setting. The findings revealed that there are several facets that comprise dignity. Discovering who the person is through exploration of their past, seeing beyond their age and illness, as well as really listening to their needs and stories were aspects that were disclosed from the RN participant interviews. Incorporating individual traits of the whole person into their care and using this knowledge to guide decisions contributed to dignity in care that addressed both the physical and emotional needs of the residents. Moreover, the data revealed that promotion of dignity may be further enhanced with the provision of a *structural context for dignity* that identifies factors that reduce dignity, develops strategies to address these

matters, and provides a platform from which nurses are able to address the issues that reduce dignity. The next chapter will provide an in-depth discussion of the themes that emerged from the data analysis described in Chapter Four, and begins with a comparison of findings from previous research.

Chapter Five: Discussion

The themes that emerged from the data were *foundations that support dignity, dignity care* and *structural context for dignity,* and they described how the RN participants provided dignity for older persons living in residential care. Although these findings have some similarities with findings from other studies, they are unique in the fact that the findings from this study revealed that *foundations that support dignity*, *dignity care* and *structural context for dignity* were interrelated. In this chapter, the findings will be compared with relevant literature, as well as an end-of-life model, Chochinov's (2002) Model of Dignity in the Terminally Ill, which provided a conceptual framework to compare how dignity was perceived in this study. This model was chosen because although Chochinov's model focused on terminally ill persons, older persons living in long term care (LTC) with chronic and life-limiting illnesses, may also be nearing the end of their lives and therefore applicable within this context. The themes and sub-themes as described in Chapter Four, will be compared to Chochinov's (2002) Model of Dignity in the Terminally Ill.

Comparative Discussion

As previously stated, literature describing how RNs provide dignity to older persons living in residential care is sparse. Although many scholars differed in their definition of dignity, there was generally a consensus toward the importance of providing dignity care for this population.

In the findings of this study there were various elements from the themes of *foundations that support dignity, dignity care,* and *structural context for dignity* which supported the current literature in this area of research and supported answering the research questions. *Foundations that support dignity, dignity care* and *structural context for dignity* demonstrate interrelatedness

and become a possible framework toward understanding how RNs provide dignity for older persons in residential care.

Theme One: Foundations That Support Dignity

This section will discuss the sub-themes originating from the first theme, *foundations that support dignity,* and relate them to relevant literature. The sub-themes include: *respecting, caring for the whole person, encouraging independence* and *being remembered.*

In the initial theme, *foundations that support dignity*, the subtheme *respecting* was repeatedly expressed by the participants. Many of the RN participants used the word respect to describe dignity and some authors suggested that dignity promoting behaviours are measures of showing respect (Hall, Dodd, & Higginson, 2014). Several authors concurred that *respecting* also included taking into account a person's feelings and being aware of how one's actions may either positively or negatively influence demonstrations of respect (Baillie, 2009; Matiti & Trorey, 2008; Walsh & Kowanko, 2002). Furthermore, Thompson, McClement and Chochinov (2011) described respect and kindness at the end-of-life for nursing home residents as core principles of nursing practice. Thompson et al. (2011) further explained that respect was influenced by care providers knowing something about each individual (p. 111). The interconnection between dignity and respect may best be illustrated through the various participant expressions of *respecting* the older person which included: (1) preserving self-worth; (2) maintenance of one's physical appearance; (3) forms of addressing someone and; (4) proffering of choices. The subsequent passage will further describe the four aforementioned elements of respect.

Preservation of *self-worth* was described by some of the RN participants as a demonstration of respect and these results were comparable to several studies. Jacelon (2004)

explained self-worth as a component of personal integrity. Jacelon further elaborated that an older person's self-worth is based on an internal definition, developed over time and through past experience. This study demonstrated a positive relationship between dignity and self-worth as described by five older hospitalized persons; the stronger the sense of self-worth, the greater the self-dignity (p. 552). Furthermore, changes in bodily functions related to ageing were expressed by older adults living in residential care as a threat to their dignity and self-image and conversely, respect for these boundaries with reduced exposure, contributed to preserving their self-worth (Franklin, Ternestedt, & Nordenfelt, 2006). Additionally, retaining some control over oneself and the situation contributed to maintaining self-worth, and was consistently revealed in several studies (Anderberg, Lepp, Berglund, & Segesten, 2007; Holmberg, Valmari, & Lundgren, 2012; Walsh & Kowanko, 2002). Conversely, in Woolhead, Calnan, Dieppe and Tadd's (2004) study, they described how a loss of self-respect impacted an older person's self-identity and self-respect and examples included those who had "let themselves go" or "given up" on their self-care or, being excluded from conversations (p. 167) as measures of lost self-respect.

Closely tied to the maintenance of *self-worth* is the aspect of personal appearance. RN participants in the study spoke about how *respecting* included attention to the personal appearance of residents as a measure of *foundations that support dignity*. Various studies concur with this aspect and include cleanliness (Lin, Watson, & Tsai, 2013), "looking respectable" by ensuring clothing is not disheveled (Woolhead et al., 2004, p. 167), being dressed appropriately (Baillie, 2009; Hall & Hoy, 2012) and wearing their own clothing where possible (Matiti & Trorey, 2008), as examples of *foundations that support dignity* for this population.

Some RN participants stated that how the older person was addressed, for example, by first or last name, was an important aspect of providing respect for this population. This was

highlighted in Matiti and Trorey's (2008) study on hospital patients' expectations of maintaining their dignity, in which use of their first name was described by some patients as disrespectful, while others merely wanted to be asked their preferred name. Another RN participant in the study admitted that she sometimes used terms of endearment when addressing some of the residents and acknowledged that some residents did not prefer this form of address. Furthermore, Woolhead et al.'s (2007) study emphasized that casual manner or, use of the older person's Christian name without permission, may jeopardise their dignity as they felt patronized by this behaviour (p. 167).

Finally, offering choices, for example, what an older person would like to wear or eat, as a measure of respect, was frequently mentioned by the RN participants as being important. Matiti and Trorey (2008) explained how the option of choices contributed to patients' having a feeling of greater involvement in their care and control over what was happening to them (p. 2714). Moreover, choices in end-of-life decisions also added to the provision of dignity. Older people in Woolhead et al.'s (2004) study specifically emphasized the importance of having the right to choose how they lived and died. Many were in favour of *living wills* and having a choice of treatment options, and some felt that death had become too medicalised (p. 168). The significance of providing choices and supporting end of life decisions made by older people, was also illustrated by a RN participant in the study who supported a resident's decision to have a surgical intervention. Despite knowing the risks, the resident died during surgery with the hope of improving her quality of life. The nurse described how she and the resident had discussed the risks versus benefits and that the RN participant felt she had demonstrated respect by supporting the resident's decision to have the surgery. This study makes the distinction of putting all these aspects of respect (preserving self-worth; maintenance of one's physical appearance; forms of

addressing someone and; proffering of choices) together, as part of *foundations that support dignity.*

Within the second sub-theme, c*aring for the whole person* was described by some RN participants as incorporating aspects of their history, gender, culture and language into the care of an older person; remembering who they were; and seeing them as a person and not an illness. Older persons want to be respected as individuals (Randers, Olson, & Mattiasson, 2002). Walsh and Kowanko's (2002) study about nurses' and patients' perceptions of dignity also supported this perspective. These authors revealed that acknowledging the person as a human being and not as an object, helped promote dignity (p. 146). Also, nurses caring for older hospital patients expressed the importance of seeing the older person as a unique individual with their own beliefs, values, histories and capabilities, as a way to re-establish dignity (Hall & Hoy, 2012, p.290). Additionally, the importance of being treated with individuality was reaffirmed in Holmberg, Valmari and Lundgren's (2012) study of homecare patients seeking a balance between receiving care and maintaining their dignity. Finally, Anderberg, Lepp, Berglund, and Segesten's (2007) work on preserving dignity for the older person outlined how confirming individuality is accomplished through encouragement of self-care decisions, and by listening to people's life experiences (p.639).

The third sub-theme of *encouraging independence* was exemplified by some of the RN participants as assisting residents to choose their own clothing- even to the extent of changing their clothes prior to every meal, as a component of *foundations that support dignity.* These results were similar to Woolhead et al.'s (2004) study in which *encouraging independence* was related to the concept of autonomy. These authors explained that participants wanted to remain independent and have control over their lives for as long as possible, and that financial difficulty,

loss of a partner or children, reduced their independence (p. 168). Also, in Webster and Bryan's (2009) study, older persons cited the ability to exert control, for example, by walking off the ward to find privacy and going to the bathroom privately when they wished as expressions of independence (pp. 1789-90). This is a unique finding, however, that has not been found in other research on dignity.

Lastly, the final sub-theme of *foundations that support dignity* was *being remembered.* Although not a predominate sub-theme, this narrative about residents that were forgotten by their family and friends, and how nurses tried to fill this void by spending time with them and conversing about their lives, required further exploration. Previous research suggested that meeting this personal need through nurses spending intentional time of talking to them, may help reduce feelings of abandonment and lack of fullfilment for older residents living in nursing homes (Franklin et al., 2006). These authors explained that a lack of provision of these personal needs, contributed to older persons feeling "invisible", thereby increasing their dependency (p.139). Additionally, Westin and Danielson's (2007) study which interviewed 12 residents between the ages of 78-99 from three Swedish nursing homes revealed that residents felt a sense of community when they shared their life experiences with the nurses (p. 176). The opportunity to meet and talk to the nurses every day made their lives easier and contributed to their lives being more meaningful (p. 177). Conversely, residents felt that they were "nobody" when they did not have the opportunity to talk with nurses about their experiences in life (p. 178). Furthermore, Dwyer, Nordenfelt and Ternestedt's (2008) secondary analysis of three elderly women living in a nursing home revealed that being able to tell one's story and reveal one's life to one who actively listens, may contribute to their ability to maintain personal identity (p. 106). These authors state that staff members have an ethical responsibility to listen and engage in

dialogue with older persons in order to help them find meaning in their lives (p. 106). In a review of the literature to date, I have not found a study that describes the importance of linking self-identity and legacy to the concept of *foundations that support dignity* for older persons.

Theme Two: Dignity Care

In exploring the second theme of *dignity care,* the sub-themes of *doing* and *value-giving care* will be further elaborated upon and correlated to current literature.

Privacy, under the sub-theme of *doing,* was consistently mentioned within this research. A majority of the RN participants considered this an important aspect of providing *dignity care* and this was also found by other researchers. Lin's et al.'s (2012) narrative review of patients over 18 years old whose dignity was maintained or violated during hospitalisation, found that both patients and nurses consistently viewed privacy as a component of maintaining dignity. Furthermore, minimal exposure of the body was stated as one of the most important factors related to maintenance of dignity for older persons (Baillie, 2009; Matiti and Trorey, 2008; Walsh and Kowanko,2002; Webster and Bryan, 2009). Moreover, Woolhead et al. (2004) revealed that some older persons (especially in residential care) have become accustomed to and accepted these dignity- violating situations as the norm (p. 167).

In addition, positive interactions between patients and nurses help build relationships and may also contribute to the enhancement of an older person's dignity. This was reflected in this study and supported by previous research. The RN participants spoke about how *building relationships* with residents and their families helped enrich the care they provided and increased their personal work satisfaction. Residents in nursing homes described how supportive attitudes from staff and next-of-kin assisted in maintaining their dignity of identity (Franklin et al., 2006, p. 140), and hospital patients relayed how good relationships with staff helped promote their

dignity (Baillie, 2009, p. 23). In the community setting, nurses illustrated how they honoured residents' dignity by intimately knowing what was important to them and by providing physical, psychosocial and spiritual comfort (Touhy et al., 2005, p. 30). Similarly, some of the RNs participants within the study of how RNs provided dignity in residential care, mentioned the importance of developing trust with their residents. This significance of trust as an important component of a relationship was also found in a study of homecare nurses providing care to patients who explained that trust developed through continuity of care; that is, having consistent nursing staff with changes in nurses occurring as infrequently as possible (Holmberg et al., 2012, p. 709). As well in the study, another aspect of building positive relationships and development of trust included explanations, for example, providing explanations prior to carrying out treatments and procedures, following doctor's appointments, and when residents questioned when family members were coming to take them home. Matiti and Trorey (2008) supported the aforementioned findings and revealed that provision of explanations reduced patient embarrassment and helped to maintain dignity for patients in their study (p. 2714).

Lastly, *value-giving care* may be described as care that extends beyond the basic elements of care such as bathing, dressing and feeding. Some of the nurses in the study mentioned touch as an important demonstration of *value-giving care* and this is reaffirmed in the study by Brown et al. (2011) which identified touch as a care action that conserved dignity at the end of life (p. 243). In addition, unhurried care—that which allows residents to choose their own clothing, eat without feeling rushed, or provide time to bathe themselves—also contributed to dignity care, and is reflected in Baillie et al.'s (2009) study on nurses' views of dignity in care. Others have questioned whether the way in which the care is provided to an older person may be

perceived as more valuable. Webster and Bryan (2009) found that when care was provided in a kind and caring manner, this appeared to promote a feeling of dignity for older people (p. 1791).

Theme Three: Structural Context for Dignity

In the final theme, *structural context for dignity,* a further examination of the sub-themes *time* and *physical setting* will be explored within the pertinent literature.

Time emerged as an influencing factor toward supporting dignity for older persons in residential care. More than half of the nurses in the study cited lack of *time* as a hindrance to providing dignity care including the inability to perform care in an unhurried manner, inability to spend time with residents to listen to their stories and develop relationships, and the inability to allow residents to perform their own care needs in their own time. Conversely, Baillie et al. (2009) identified having plenty of time to allow clients to choose clothes, wash hair, use personal items such as lotions or, time to offer the option of having an electric versus manual shave, as measures of promoting dignity (p. 27). Furthermore, Walsh and Kowanko's study (2002) revealed that nurses viewed having time to carry out unhurried duties, explain procedures, and expose people to undignified situations for the least amount of time, as important aspects of patient dignity (p. 146). Similarly, the patients in Walsh and Kowanko's (2002) study also indicated that being rushed during care, not having time to make decisions, and being left alone too long, compromised their dignity (p. 148).

Also within this theme was the sub-theme *physical setting.* The RN participants in this study described the temperature of the room- particularly for those susceptible to cold, shared rooms, and insufficient staffing levels, as examples of *structural contexts for dignity* that impacted dignity care. Gallagher (2004) explained that the environment has the ability to make people feel either valued or devalued and included the example of dirty and shabby hospital

settings in the latter category (p. 596). Interestingly, some of the patients in Baillie's (2008) study of patient dignity within the hospital setting cited the physical layout of the hospital ward, (five-bedded bays with bathrooms), lacking privacy and thereby dignity, while others felt that the layout promoted privacy and therefore dignity (p. 30). In another study by Baillie et al. (2009), the authors described how mixed gender wards, lack of privacy due to inadequate space and overcrowding, hindered the ability to promote dignity care (p. 25). Additionally, insufficient or reduced staffing levels combined with increased workloads, contributed to reduced individualized care and attention that may promote dignity. Several authors supported the premise that staffing shortages and high workloads hindered nurses' ability to promote dignity with care. Teeri et al. (2008) identified staff shortages as an organizational factor which restricts the maintenance of patient integrity (p. 10). Nurses from Baillie et al.'s (2009) study noted that insufficient staff on wards with elderly patients meant incontinent patients were not being changed promptly, dementia patients were unable to wander without compromising the care of non-confused patients and that this lead to patients being treated as a task rather than as a person (p. 26).

Another example of how the *physical setting* influenced the nurses' provision of *dignity care* to the residents, was through their struggle with how to use patient lifts without the residents feeling that they were being exposed. Mechanical lifts are used to assist with mobility and transfers of residents for the provision of care, but one of the nurses spoke about how nursing had become more mechanical and less hands-on. There was an assumption that the personal aspects of care had become diminished due to the mechanical nature of these lifts, and residents may feel vulnerable and exposed during this component of care. Although patient lifts were developed to help reduce physical strain on nurses and to reduce injury (Collins, Wolf,

Bell, & Evanoff, 2004), there may be a disconnection between how such devices may actually result in hindering dignity care. For example, during the mechanical transfer, older adults are often minimally dressed, covered with blankets or sheets, suspended in the air, and subsequently wheeled to the desired destination. This illustrates the dichotomy of the mechanical lift: Use of the lift reduces strain and injury for the nurses, and conversely, the actual process of being transferred in a mechanical lift appears to reduce the dignity of the patient.

McGilton et al.'s (2012) study highlighted how current quality of life measures in long term care (LTC) focused on health outcomes such as falls, pressure ulcers and functional decline, rather than quality of life [such as foundations that support dignity], and well-being of residents. The authors suggested the person-centred care approach including mutual respect and the fostering and formation of relationships among care providers, as a way to meet the complex needs within the LTC setting (p. 306). Respecting and formation of relationships as suggested by McGilton et al. (2012) are consistent with the themes of *foundations that support dignity* and *dignity care* that were revealed in this study.

In summary, what has been revealed from comparing the findings of this study with previous studies is that there are several recurring sub-themes. Specifically, *respecting, caring for the whole person, encouraging independence, privacy, building relationships, value-giving care, time* and *physical setting*, were all consistently disclosed elements of providing dignity for the older person. Yet what arose from this research that was not consistent with previous studies was the concept of *being remembered* and how nurses try to fill the void that residents feel when they are "forgotten". Additionally, the question of whether or not safety and harm reduction measures (i.e., mechanical lifts) have been developed with the dignity of the resident in mind and

if not, would approaching these measures from a dignity perspective change either the appearance or the manner in which these measures are implemented?

Chochinov's Model of Dignity in the Terminally Ill (Dignity Model)

Background

In this section, to better understand and situate the findings found in this study, Chochinov's model of dignity (2002) (Refer to Appendix L) was chosen to assist with comparing and contrasting some of the similarities and differences that emerged. Chochinov's framework is referred to as both the Model of Dignity in the Terminally Ill" or the "Dignity Model", and for clarity I will refer to Chochinov's framework as the "Dignity Model" in this analysis.

The Dignity Model was developed from a study in which dying patients of varying ages were asked to explain their understanding of dignity. Within his work as a psychiatrist and researcher in palliative care, Chochinov (and colleagues) noted that those who expressed a wish for an earlier death were more likely to be depressed, experience considerable discomfort, have less social support, and that existential considerations, such as a loss of dignity, influenced their will to live (Chochinov, 2012, p. 4). Furthermore, patients who indicated a decreased sense of dignity, also reported an overall lower quality of life which included an increased perception of change in appearance, an increased feeling of being a burden to others, an increased dependency on others, an increased pain intensity, and an increased likelihood of being hospitalized (ibid, p.6). Although the older people in my study were not specifically identified as terminally ill, many had chronic life-limiting illnesses and based on this premise, it may be plausible to suggest that older persons living in residential care who are nearing the end of their lives may also at some point be terminally ill. In addition, it is important to make the distinction that the RN participants in the study were interviewed about dignity with the older persons in residential

care, as opposed to terminally-ill patients being interviewed about dignity. It is from this context, that the intricacies of the Dignity Model will be used to provide a comparison to the relevant findings, within the population being explored in the study and how the study findings contribute to the understanding of dignity.

Comparative Discussion with Model

Chochinov's Model of Dignity (2002) provided a framework to discuss a comparison of definitions of the themes that emerged from this study (see table 2). The Dignity Model is divided into three main categories: ***Illness-related concerns***, ***Dignity conserving repertoire,*** and ***Social dignity inventory.*** The majority of the themes from this study corresponded within the categories of ***Dignity Conserving Repertoire*** and ***Social Dignity Inventory,*** and one sub-theme (*encouraging independence*), corresponded within the category of ***Illness Related Concerns.***

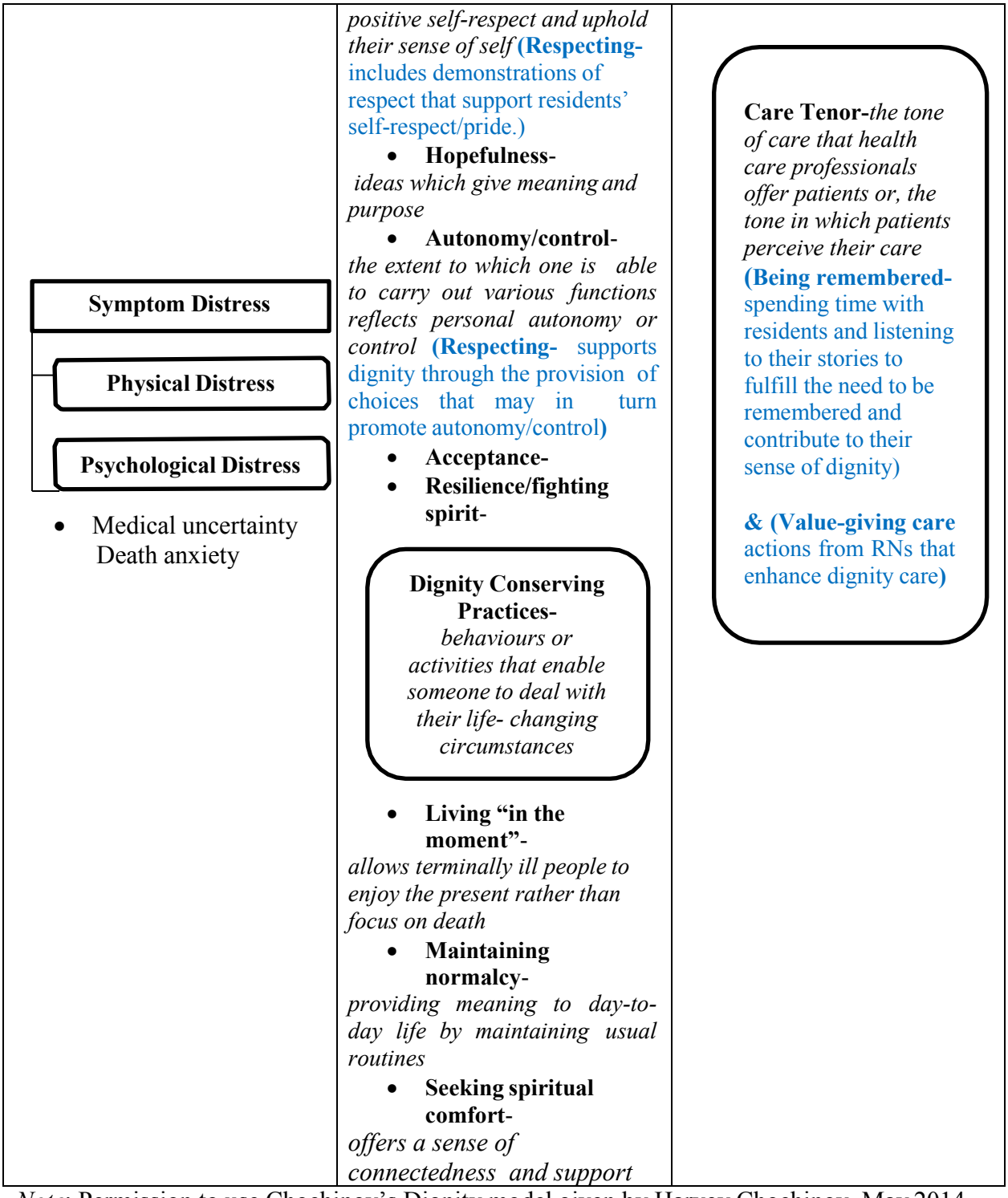
Chochinov's ***level of independence*** is a sub-theme of ***Illness-related concerns*** and is described as the degree to which one is able to avoid relying on others. In comparison, the sub-theme of *encouraging independence* from this study was described as a means of maintaining dignity and independence. The distinction between the study sub-themes may be explained as: ***level of independence*** illustrates the degree of one's ability to be independent, as opposed to *encouraging independence,* which described maximizing and maintaining existing abilities as a measure of *foundations that support dignity*.

Sub-themes within Chochinov's ***Dignity-conserving perspectives*** that corresponded with the study results included: 1) ***continuity of self***; 2) ***generativity/legacy;*** 3) ***maintenance of pride,*** and 4) ***autonomy/control. Continuity of self*** communicates how a person maintains their sense of self or personhood, in spite of changing health circumstances (Chochinov, 2012, p.14). In contrast, the sub-theme of *caring for the whole person*, incorporated looking beyond the illness

and seeing the person for who they are, as a method of *foundations that support dignity*. The former is more subjective in nature while the latter is more of an objective perspective of self.

Table 2: Comparison of Chochinov's Model with How RNs Provide Dignity in Residential Care

MAJOR DIGNITY CATEGORIES AND SUB-THEMES **(Blue highlighted areas indicate study results)**		
Illness Related Concerns *Factors that derive most directly from the illness itself, such as physical and psychological responses*	**Dignity Conserving Repertoire-** *the psychological and spiritual factors that may influence one's sense of dignity*	**Social Dignity Inventory-**"*the social issues or relationship dynamics that either enhance or detract from a patient's sense of dignity" (p. 27)*
Level of Independence - *the degree to which one is able to avoid relying on others* **(Encouraging independence-** as a means of maintaining dignity and independence**)** **Cognitive Acuity-** *one's ability to maintain mental clarity* **Functional Capacity-** *the ability to carry out personal tasks*	**Dignity Conserving Perspectives-** *a way of seeing the world that is shaped by the person who is ill rather than the illness itself* • **Continuity of self -** *how a person maintains their sense of self or personhood, in spite of changing health circumstance* **(Caring for the whole person-** looking beyond the illness and seeing the person for who they are**)** • **Role preservation-** *the way in which patients cling to their previously held roles as a means of preserving their identity* • **Generativity/legacy-** *arises from patients confronting the meaning of their own existence and wanting to share aspects of their life that they want others to know* **(Being remembered-** spending time with residents and listening to their stories to fulfill the need to be remembered and contribute to their sense of dignity**)**	**Privacy Boundaries** **(Respecting** privacy**)** **Social Support-** *encompasses social connectedness, physical presence and emotional support* **(Building relationships-** providing a social connection and developing a better understanding of their care needs, values and beliefs**)**
	• **Maintenance of pride-** *a patient's ability to maintain*	



Note: Permission to use Chochinov's Dignity model given by Harvey Chochinov, May 2014

Chochinov's ***generativity/legacy*** arises from patients confronting the meaning of their own existence and wanting to share aspects of their life that they want others to know (ibid, p. 16).

Similarly, the sub-theme of *being remembered* in this study of RNs caring for older persons in residential care, demonstrated how spending time with residents and listening to their stories helped fulfill the need to be remembered and contributed to their sense of dignity. Conversely, ***generativity/legacy*** may be described as being a patient initiated story, versus *being remembered,* which is a RN initiated conversation that supports/conserves dignity for the older person.

Chochinov's sub-theme ***maintenance of pride*** refers to a patient's ability to maintain positive self-respect and uphold their sense of self (Chochinov, 2012, p. 17). Comparatively within this study, the sub-theme of *respecting,* included forms of addressing the older person and attention to personal appearance, as measures which supported their dignity and thereby contribute to the maintenance of their pride. The former describes the patient's ability to maintain positive self-respect, whereas the latter illustrates how RNs demonstrated forms of respect that supported self-respect/pride.

Chochinov's sub-theme of ***autonomy/control*** describes the extent to which one is able to carry out various functions that reflect personal autonomy or control (p. 19). Chochinov (2012) further explained that ***autonomy/control*** differs from independence, in that the former is dependent on one's state of mind, rather than one's body or ability (p. 19). This sub-theme relates to the sub-theme of *respecting,* in which examples of proffering of choices included residents choosing not to get up for breakfast and nurses offering either alternative meal options or meal times. ***Autonomy/control*** describes the ability to be autonomous whereas *respecting,* supports dignity through the provision of choices that may in turn promote ***autonomy/control***.

Sub-themes within Chochinov's ***Social Dignity Inventory*** that corresponded with this study included: ***Privacy boundaries, social support*** and ***care tenor. Privacy boundaries*** become more challenging to balance with increasing illness and a violation of privacy is seen as

yet another loss which contributes to a further loss of control (p. 28). The significance of providing patients' privacy was clearly outlined in the literature and was illustrated in this study through the sub-theme of *respecting.* RN participants gave examples of; closing curtains/doors during personal care, knocking before entering, and maintaining confidentiality, as demonstrations of *respecting* privacy. A loss of dignity through violation of personal ***privacy boundaries*** may be countered through *respecting* privacy and thereby *foundations that support dignity*.

Chochinov's sub-theme of ***social support*** encompasses social connectedness, physical presence and emotional support. Patients' fear of becoming a burden is compounded by an underlying fear of abandonment, and Chochinov (2012) explained that simply being physically present conveys the message to patients that they are worthy of love and support and that they will not be abandoned (p. 29). In comparison, the sub-theme of *building relationships* within the study of older persons in residential care provided a social connection for residents, and revealed that when the nurses got to know residents better and developed a better understanding of their care needs, values and beliefs, this led to the enhancement of their *dignity care* through an individualized approach.

Subsequently, Chochinov's ***care tenor*** is the tone of care that health care professionals offer patients or the tone in which patients perceive their care (p. 29). The significance of this sub-theme is that the way in which patients feel they are perceived, has significant influence on their overall sense of dignity. Chochinov (2012) further clarified that the overarching message of ***care tenor*** is that "you matter" [patient], and therefore deserve honour, respect and esteem. Similarly, in this study, *being remembered* described how nurses help fill the void left by family and friends by spending time listening to their residents through the act of being a caring

presence. Restated, ***care tenor*** may be explained as caring that is based on the patient's rating of their perception of care, conversely, *being remembered,* supports dignity through expressing care by means of spending time and listening to residents. Additionally, demonstrations of ***care tenor*** may include the simple action of touch. Likewise, elements of *value-giving care* within the study included touch, using a gentle approach, unhurried care, and kindness. Both ***care tenor*** and *value-giving care* extend beyond the act of simply providing care, they are marked by the manner in which this care is provided. However, ***care tenor*** may be explained as an act of touch to meet the emotional needs of patients, versus *value-giving care* actions from RNs that enhance dignity care.

One area of the Dignity Model that did not emerge from the data within this study was the theme of ***symptom distress***. Although there was some discussion in the RN participant interviews about providing comfort measures for residents, this was mostly made in reference to their palliative patients and did not emerge as a general theme or sub-theme. It is interesting to note that Chochinov's Dignity Model (2002) illustrated the importance of symptom management and the provision of dignity for older people nearing the end-of-life, yet this may not be realized in the day-to-day care of older people in residential care with chronic, yet potentially life-limiting illnesses. Chochinov (2012) described symptoms as the "doorway to patienthood" (p. 12) and explained that is it often difficult to separate physical and emotional distress. The comparison of these models may help identify ***symptom distress*** as a further area to be explored in relation to dignity care and the older person, in general, rather than simply at the end-of-life**.**

In summary, a comparison of the definition of the themes/sub-themes from this study with Chochinov's Dignity Model (2002) provided a framework to discuss the findings. Within the theme, *foundations that support dignity,* the sub-themes which corresponded with

Chochinov's sub-themes included: ***level of independence*** *(encouraging independence)*, ***continuity of self*** *(caring for the whole person)*, ***generativity/legacy*** *(being remembered)*, ***maintenance of pride*** *(respecting)*, ***autonomy/control*** *(respecting)*, ***and privacy boundaries*** *(respecting)*. Subsequently, the corresponding sub-themes of *dignity care* were; ***social supports*** *(building relationships)* and ***care tenor*** *(being remembered & value-giving care)*. Although there were no sub-themes of *structural contexts for dignity* which directly corresponded to any of Chochinov's sub-themes, the subtle nuances of *structural contexts for dignity* seem to be imbedded within the Dignity Model (2002). For example, without *time* (sub-theme of *structural contexts for dignity),* it would be difficult to manage ***levels of independence***, ***symptom distress, privacy***, and elements of ***social support*** (sub-themes within Chochinov's Dignity Model). Additionally, these aforementioned sub-themes of Chochinov's Dignity Model would be equally challenging without the *physical setting* that supports this type of care. It is this type of connectedness that illustrates the comparison of the two models.

Chapter Summary

The purpose of this research was to examine how RNs provide dignity to older persons in residential care. The richness of the findings supported by current literature and concurrent comparisons made to Chochinov's Dignity Model (2002), revealed some distinct outcomes. Three unique findings were identified within the theme of *foundations that support dignity*. First, the research study demonstrated interrelatedness between *respecting* and dignity. This was illustrated in this study as four components of *respecting* that included: (1) preserving self-worth; (2) maintenance of one's physical appearance; (3) forms of addressing someone; and (4) proffering of choices. Similarly, the components of *respecting* corresponded with Chochinov's sub-themes of ***maintenance of pride***, ***autonomy/control*** and ***privacy boundaries***. Secondly, the

sub-theme *encouraging independence* revealed that expressions of residents having some control over their lives, for example, choosing which clothing to wear prior to every meal, contributed to supporting their dignity, and corresponded to Chochinov's sub-theme ***level of independence***. Lastly, the sub-theme *being remembered* identified a link between self-identity and legacy for older persons in residential care. The significance of nurses supporting residents forgotten by family and friends through listening to their stories and spending time with them, corresponded with Chochinov's sub-themes, ***generativity/legacy*** and ***care tenor*** and may merit further exploration**.**

Additionally, *structural context for dignity,* revealed interrelatedness whereby a lack of structural contexts which contribute to *foundations that support dignity* impacts the provision of *dignity care*. The sub-theme *physical setting* identified a dichotomy between mechanical lifts and dignity. Even though using mechanical lifts reduces strain and injuries for nurses, (Collins, Wolf, Bell, & Evanoff, 2004), the process of transferring older patients, appears to reduce the dignity of older patients.

All the participants in this study described the importance of *supporting dignity* in nursing practice and a few RN participants mentioned how lack of *time* reduced their ability to provide *dignity care*. One participant spoke about how the increasingly mechanical nature of nursing had reduced the hands-on approach while others expressed the positive impact of providing *value-giving care*. Despite limitations that may be experienced when there are reduced *structural contexts for dignity,* for example *time* and *physical setting*, the value of touch, kindness and a gentle approach may ameliorate *dignity care* for older persons. The final chapter will discuss conclusions and recommendations drawn from the research findings.

Chapter Six: Conclusions and Recommendations

The purpose of this project was to explore how RNs provide dignity for older persons living in residential care. In addition, discovering how RNs understand the meaning of dignity when caring for the older person and their perceptions of how they provide dignity when caring for older people was also examined. Chapter Six will summarize the study, present conclusions drawn from the findings, and discuss implications and recommendations for nursing education, nursing practice and nursing research.

Summary of the Study

Eleven RNs working in a residential care facility were interviewed as part of this qualitative research study, in order to explore their understanding of dignity for older persons in residential care. Data analysis revealed three themes: 1) *Foundations That Support Dignity* included the sub-themes; *caring for the whole person, respecting, encouraging independence* and *being remembered*, 2) *Dignity Care* incorporated; *doing, value-giving care, building relationships,* and *balancing and negotiating,* and 3) *Structural Context for dignity* comprised; *time, nurse's voice, physical setting*, and *barriers created by policies/procedures.*

Conclusions

The following conclusions were derived from this study:

1. The RN participants described dignity as an important aspect of providing nursing care for the older population. The nurses explained how older people experienced numerous losses and that maintaining dignity was an essential component of their care.
2. The RN participants appeared to relate the meaning of dignity with that of *respecting* the older person. *Respecting* encompassed various forms including; the *preservation*

of self-worth, maintenance of physical appearance, forms of addressing someone and *proffering of choices*.

3. RN participants helped the older person fill the void left by family and friends, through conversing with them and hearing their life stories, as a means of *foundations that support dignity*. This linkage of self-identity and legacy to the concept of supporting dignity for older persons, is a unique finding of this study.
4. The structural context appeared to influence the RN participants' ability to provide dignity care to older persons in residential care. Insufficient time to provide care in an unhurried manner, insufficient nurses to provide person-centred care, and insufficient physical surroundings and policy/procedural support, may lead to a reduction in providing dignity care for older people.

Implications and Recommendations

The recommendations below represent the three areas of the nursing domain that are most relevant to this study: education, practice and research. The recommendations characterize the findings in this research and are substantiated in previous literature.

Implications for Education. As previously discussed, dignity is integrated throughout various nursing documents. The UDHR (2013) denotes dignity as a human right, ICN code of ethics (2012) instructs nurses to provide respectful quality care, and the CNA code of ethics (2008) reminds nurses to respect the intrinsic worth of each individual. The Canadian Association of Schools of Nursing's (CASN) position statement for the Baccalaureate Education and Baccalaureate Programs posits that

> Baccalaureate programs prepare learners to identify, develop and incorporate professional values that respect and respond ethically and sensitively to social and cultural diversity…

> They foster an understanding of the role of nursing in promoting quality work environments that maximize patient safety. Programs prepare students to be aware of and respond to emerging themes such as new information technologies, and global citizenship. (2011)

The latter sentence which states "respond to emerging themes" leads to the first recommendation, for organizations such as CASN, to promote the importance of providing dignity care in nursing, in order to influence individual nursing programs, which in turn may have implications such as a positive impact on the care of the older person.

This research specifically inquired how RNs provide dignity to older persons living in residential care. One RN participant in this study indicated that dignity needed to start from the top [those in administration/management]. She then made the analogy of a waterfall effect; in essence, if staff were treated with dignity, this would have a ripple effect that would in turn promote dignity care within the entire facility. Jacelon et al. (2004) explained this reciprocal effect as a consequence of dignity and that an individual's dignity is affected by the treatment received from others (p. 80). Based on this premise, what would care of the older person look like if dignity based care started long before they entered LTC? To have this occur throughout the care continuum, dignity care would need to be integrated into the nursing curriculum. The second recommendation is for nurse educators to consider focusing on *dignity care* throughout the nursing curriculum.

CASN's Strategic Plan for 2014-2018 includes five strategic directions. The third strategic direction states, "Support nursing schools and educators to deliver high quality nursing education across the span of nursing" (2014). Acknowledging that older persons are currently being studied in Canadian nursing programs, the third recommendation is for nurse educators to

place further emphasis on providing *dignity care* for this population through developing a greater awareness of the specialized care needs required by older persons and through integrating a person-centred approach. Hirst and LeNavenec (2007) described a person-centred approach as one which acknowledges the person as an individual identifies behaviours that value the older person and recognizes the influence it may have on others (p. 6). This approach may provide a beneficial contribution to the nursing curriculum.

Implications for Nursing Practice. In the same way in which Chochinov's Dignity Model (2002) was derived exclusively from patient data in order to gain a better understanding of the patient perspective, similarly, it would seem logical to surmise that nursing practice derived from patient data would be more patient focused. Siegel et al. (2012) explained that current practices which use a standardized approach in order to meet regulations, ignores the individual needs of the older adult. The authors gave the example of care plan goals which are made within the context of the setting such as "walk once per day with assist", rather than goals that are in the older adult's best interest such as "walk with assist three times daily" (p. 298). Since the task-oriented approach of care is deemed more efficient, it results in residents being "objectified" (p. 299). Therefore, if patient focused data resulted in the Dignity Model, it would be interesting to note what the result of patient focused data might look like in relation to *dignity care*. The first recommendation is to consider integrating person-centred care into nursing practice in order to enhance the care of the older persons living in residential care facility settings.

The literature provided some understanding of what dignity means for older persons and how this may translate into their care. There is also some evidence to support that nurses concur with many of these aspects of providing *dignity care* to older persons, while striving to provide

this care in their nursing practice. Therefore, if both patients and nurses agree to common elements of dignity and therein *dignity care*, how can this be translated into a standard of nursing care? The second recommendation is to explore how *dignity care* may be integrated into nursing practice.

Implications for Research. One of the limitations of this study was the sample size. Although the sample size represented 65% of the RNs working in one residential care facility and included mixed gender and diverse cultural backgrounds, comparison to other residential care facilities both provincially and nationally, may have provided greater representation. Also, this research was limited to only RNs and used the Interpretive Description research methodology based on Thorne's work (2008). The first recommendation is for future research of dignity and older persons to involve other members and disciplines of the health care team including care aides, licensed practical nurses, social workers, spiritual care practitioners, dieticians and pharmacists, within a comparison of facilities, in order to provide a broader perspective of their perceptions of providing dignity care for older persons in residential settings. The second recommendation is for future research to use other methods of research, for example, observation or ethnography, to explore the residential care environment. Thirdly, to explore how dignity would be provided in a non-profit versus a for-profit setting. Additionally, the fourth recommendation is to explore the influence of staff cultural backgrounds on dignity care.

Also, within the theme of *being remembered*, there was reference made to residents that were "forgotten" by their family and friends. The RN participant in my study explained how nurses tried to fill this void by spending time with them and listening to their life stories. Chochinov (2004) asserted that spending time listening to dying patients gives meaning, bolsters hope and alters their perception of how they see themselves thereby affirming their sense of

dignity (p. 1339). Furthermore, Thompson et al. (2011) described respect and kindness for nursing home residents as interactions that include treating them as equals, listening and "being there" for them (p. 97). The fifth recommendation is to further explore the relationship between *being remembered* and dignity care for older persons in residential care.

Additionally, one of the participants identified patient lifts as a contributing factor to the reduction of hands-on nursing care approach. Kemp (1991) forewarned of this over twenty years ago stating: "technological development is a reality but ethics presupposes something beyond the technician, namely sensitive human beings" (p. 29, as cited in Söderberg, Gilje, & Norberg, 1997, p. 143). The sixth recommendation is for further research to explore whether efficiency and safety within the healthcare system have removed the "care" out of caring and whether there are any correlations between the effects of reduced hands-on care and patient satisfaction.

As mentioned in the previous chapter, Chochinov (2012) described the theme of ***symptom distress*** as the "doorway to patienthood" (p. 12). Chochinov (2012) further explained that physical and psychological symptoms are interrelated; for example, a person who is depressed may perceive pain from a chronic, life-limiting illness more acutely than someone who is not depressed. Conversely, someone living with a chronic life-limiting illness which has robbed them of some of their life pleasures may be more susceptible to emotional symptoms such as anxiety or depression. However, comparison of Chochinov's model with how RNs provide dignity in residential care revealed that symptom distress or symptom management in this study emerged specifically in relation to palliative residents only and not as a regular sub-theme for older persons in general. The significance of this finding is that older adults typically cope with symptoms related to normal age-related decline and co-morbid health problems that may produce multiple and chronic symptoms (Dawson et al., 2005). Additionally, both older

adults and health care providers often attribute these symptoms to older age which leads to reduced symptom management (Miaskowski, 2000). The seventh recommendation is for further research to explore dignity care in relation to symptom management and the older person, in general, rather than simply at the end-of-life. Additionally, the eighth recommendation is to explore how staff perceive the fragility of older persons in residential care, for example, at what point do staff consider residents of LTC facilities to be end-of-life and or palliative?

Finally, there is the interrelation between *structural context for dignity* and providing and promoting "optimal" dignity care. This study illustrated how sub-themes of *structural context for dignity;* for example, lack of *time* and insufficient nursing staff (*physical setting)*, may influence the RN participants ability to provide dignity care. The RN participants expressed how, without sufficient time to listen to the residents' stories or provide the individual care required for building relationships and delivering respectful nursing care, providing *dignity care* was challenging. What should the structural context be for providing and promoting dignity care and does leadership impact the provision of dignity care? Walsh and Shutes (2012) study described how caring relationships form an integral part of the structural contexts for quality care of older persons. Similarly, McGilton et al.'s (2012) study suggest a person-centred approach including mutual respect and the development of relationships. Additionally, Bicket et al. (2010) described how the physical environment of assisted living facilities that relate to greater resident dignity, appear to be associated with fewer neuropsychiatric symptoms and better quality of life in residents, particularly those without dementia (p. 1052). The ninth recommendation is to further explore what the structure of the context should be for providing and promoting "optimal" dignity care? The final recommendation is to explore how leadership impacts the provision of dignity care.

Chapter Summary

This study explored how RNs provide dignity for older persons living in residential care. The four conclusions were as follows: 1) The RN participants described dignity as an important aspect of providing nursing care for the older population; 2) The RN participants appeared to relate the meaning of dignity with that of respecting the older person and respecting encompassed the preservation of self-worth, maintenance of physical appearance, forms of addressing someone, and proffering of choices; 3) RN participants helped the older person fill the void left by family and friends, through conversing with them and hearing their life stories, as *foundations that support dignity* and; 4) Structural contexts appeared to influence the RN participants' ability to provide dignity care to older persons. The recommendations incorporated the nursing domains of, education, practice and research. Although the literature suggests that there is an expansion of knowledge in the field of dignity, there is minimum data on how RNs provide dignity in their care of the older person in residential care. The purpose of my research was to study this practice using a qualitative method in anticipation of developing a new understanding of dignity, particularly by the RNs providing nursing care in the residential setting.

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Appendix A: Literature Review Table

Date	Database	Key Words Used	Result
April 9, 2013	CINAHL	S1-Older people* OR older adult* OR senior* OR geriatric OR elderly,	98,357
		S2-Registered Nurse OR registered nurs*	27,647
		S3-Dignity OR "dignity in care"	3123
		S4-Residential care OR residential care facility OR long term care OR nursing home	70,299
		S1 AND S2 AND S3 AND S4	2
		S5- Community, communit*	129,436
		S1 AND S2 AND S3 AND S5	0
		S6-Palliative care OR palliative* OR hospice care OR terminal care	34,141
		S1 AND S2 AND S3 AND S6	0
		S7- Hospital OR acute care	221,025
		S1 AND S2 AND S3 AND S7	6
		7 articles selected for review	
	MEDLINE	S1- Older people* OR elderly OR senior* OR geriatric* OR older adult*	369,986
		S2- Registered nurse OR registered nurs*	9121
		S3- Dignity OR "dignity in care" OR personhood	7344
		S4- Residential care OR residential care facilit* OR Long term care OR nursing home	136,533
		S1 AND S2 AND S3 AND S4	3
		S5- Community OR communit*	402,619
		S1 AND S2 AND S3 AND S5	2
		S6- Palliative care OR palliative* OR hospice care OR terminal care	81,460
		S1 AND S2 AND S3 AND S6	1
		S7- Hospital OR acute care	2,701,887
		S1 AND S2 AND S3 AND S7	2
		2 articles selected for review	
April 12, 2013	Biomedical Reference Collection	S1- Older people* OR elderly OR senior* OR geriatric* OR older adult* Or older patients	80,149
		S2- Registered nurse OR registered nurs*	5097
		S3- Dignity OR "dignity in care"	5445
		S4- Residential care OR residential care facility* OR long term care OR nursing home	37,083
		S1 AND S2 AND S3 AND S4	3
		S5- Community OR communit*	103,837
		S1 AND S2 AND S3 AND S5	1

		S6- Palliative care OR palliative* OR hospice care OR terminal care	13,804
		S1 AND S2 AND S3 AND S6	0
		S7- Hospital OR acute care	388,847
		S1 AND S2 AND S3 AND S7	5
		1 article selected for review(duplicate)	
April 13, 2013	PsychINFO	S1- Older people* OR elderly OR senior* OR geriatric* OR older adult*	131,644
		S2- Registered nurse OR registered nurs*	3166
		S3- Dignity OR "dignity in care"	42,053
		S4- Residential care OR residential care facility OR long term care OR nursing home	40,540
		S1 AND S2 AND S3 AND S4	1
		S5- Community OR communit*	247,642
		S1 AND S2 AND S3 AND S5	1
		S6- Palliative care OR palliative* OR hospice care OR terminal care	19,951
		S1 AND S2 AND S3 AND S6	0
		S7- Hospital OR acute care	222,853
		S1 AND S2 AND S3 AND S7	3
		2 articles selected (duplicates)	
July 2013		Articles, books and textbooks	3 resources selected

Secondary Literature Review Table

Date	Database	Key Words Used	Result
February 10, 2014	CINAHL	S1- Older people* OR older adult* OR senior* OR geriatric OR elderly	103,543
		S2- Registered Nurse OR registered nurs*	28,835
		S3- Dignity OR "dignity in care"	3,303
		S4- Residential care OR residential care facility OR long term care OR nursing home	72,526
		S1 AND S2 AND S3 AND S4	2 (No new articles)
		S5- Community, communit*	135, 957
		S1 AND S2 AND S3 AND S6	0
		S6- Palliative care OR palliative* OR hospice care OR terminal care	35,969
		S1 AND S2 AND S3 AND S6	0
		S7- Hospital OR acute care	211,397
		S1 AND S2 AND S3 AND S7	6
February 10, 2014	MEDLINE	S1- Older people* OR older adult* OR senior* OR geriatric OR elderly	392,807
		S2- Registered Nurse OR registered nurs*	9,787
		S3- Dignity OR "dignity in care"	7,777
		S4- Residential care OR residential care facility OR long term care OR nursing home	143,261
		S1 AND S2 AND S3 AND S4	8
	MEDLINE	S5- Community, communit*	431,843
		S1 AND S2 AND S3 AND S6	4
		S6- Palliative care OR palliative* OR hospice care OR terminal care	85,867
		S1 AND S2 AND S3 AND S6	1
		S7- Hospital OR acute care	2,870,723
		S1 AND S2 AND S3 AND S7	2
February 10, 2014	Biomedical Reference Collection	S1- Older people* OR older adult* OR senior* OR geriatric OR elderly	85,155
		S2- Registered Nurse OR registered nurs*	5,388
		S3- Dignity OR "dignity in care"	5,686
		S4- Residential care OR residential care facility OR long term care OR nursing home	39,496

		S1 AND S2 AND S3 AND S4	4 (no new articles)
		S5- Community, communit*	112,697
		S1 AND S2 AND S3 AND S6	2
		S7- Palliative care OR palliative* OR hospice care OR terminal care	14,686
		S1 AND S2 AND S3 AND S7	0
		S7- Hospital OR acute care	416,817
		S1 AND S2 AND S3 AND S7	5
February 10, 2014	PsychINFO	S1- Older people* OR older adult* OR senior* OR geriatric OR elderly	133,614
		S2- Registered Nurse OR registered nurs*	3,367
		S3- Dignity OR "dignity in care"	41,598
		S4- Residential care OR residential care facility OR long term care OR nursing home	42,269
		S1 AND S2 AND S3 AND S4	1 (not a new article)
		S5- Community, communit*	256,255
		S1 AND S2 AND S3 AND S6	1 (not a new article)
		S7- Palliative care OR palliative* OR hospice care OR terminal care	21,181
		S1 AND S2 AND S3 AND S7	0
		S7- Hospital OR acute care	236,288
		S1 AND S2 AND S3 AND S7	5 (1 new but not applicable)
July 2014	Google Scholar	"dignity" AND "elderly" AND "registered nurses" AND "residential care"	826 1 article chosen

Appendix B

Relevant Articles

Author/APA Reference: Anderberg, P., Lepp, M., Berglund, A., & Segesten, K. (2007). Preserving dignity in caring for older adults: a concept analysis. *Journal of Advanced Nursing, 59*(6), 635-643. doi:10.1111/j.1365-2648.2007.04375.x **Research Method:** Qualitative study **Sample:** Older adults **Research Question:** Report of a concept analysis of the meaning of preserving dignity. **Relevant Findings:** The attributes of preserving dignity include: individualized care, control, respect, advocacy and sensitive listening. The consequences are strengthening life spirit, inner sense of freedom, self-respect and successful coping.
Author/APA Reference: Baillie, L., Ford, P., Gallagher, A., & Wainwright, P. (2009). Nurses' views on dignity in care. *Nursing Older People, 21*(8), 22-29. **Research Method:** Mixed method study **Sample:** Royal College of Nursing members **Research Question:** To gain the perspective of nurses, healthcare assistants and nursing students regarding the maintenance and promotions of dignity in everyday practice. **Relevant Findings:** Dignity of older people undergoing health care may be promoted through a conducive physical environment, a supportive organization and individual nursing actions.
Author/APA Reference: Baillie, L. (2009). Patient dignity in an acute hospital setting: a case study. *International Journal Of Nursing Studies, 46*(1), 23-36. doi:10.1016/j.ijnurstu.2008.08.003 **Research Method:** Qualitative study **Sample:** 24 patients (15 men and 9 women) 13 ward staff and 6 senior nurses **Research Question:** The meaning of patient dignity as well as how it is either threatened or promoted **Relevant Findings:** Patients are vulnerable to loss of dignity when in hospital and staff and hospital environment can have both a negative and positive effect on their dignity.
Author/APA Reference: Brown, H., Johnston, B., & Ostlund, U. (2011). Identifying care actions to conserve dignity in end-of-life care. *British Journal of Community Nursing, 16*(5), 238-245. **Research Method:** Qualitative study **Sample:** Six focus groups: two with community nurses, one with GPs, one with patients, one with carers and one with both patients and carers (family perspective). **Research Question:** How can community nurses best support participants through sensitive experiences? **Relevant Findings:** Actions that may help conserve dignity at the end-of-life include continuity of care, not treating patients as "sick persons", maintaining normalcy, development of therapeutic relationships with nurses and communication.
Author/APA Reference: Franklin, L., Ternestedt, B., & Nordenfelt, L. (2006). Views on Dignity of Elderly Nursing Home Residents. *Nursing Ethics, 13*(2), 130-146. doi:10.1191/0969733006ne851oa

Research Method: Qualitative study
Sample: 12 elderly people living in nursing homes in Sweden.
Research Question: To explore the views on dignity at the end of life.
Relevant Findings: Elderly persons described their views on dignity as: The unrecognizable body in which loss of bodily functions threatened their integrity; fragility and dependency which mean loss of control and reduced autonomy and; inner strength and sense of coherence that helped them deal with life in nursing homes.

Author/APA Reference:
Hall, E. O., & Hoy, B. (2012). Re-establishing dignity: nurses' experiences of caring for older hospital patients. *Scand J Caring Sci, 26*(2), 287-294. doi:10.1111/j.1471-6712.2011.00931.x
Research Method: Secondary analysis of qualitative interview data
Sample: 29 nurses and nurse assistants
Research Question: Exploration of Danish clinical nurses' experiences of caring for older hospital patients.
Relevant Findings: Caring includes re-establishing dignity through seeing the patient as a unique individual, assisting with 'removing the bed", and supporting patient appearance. Additionally, caring is shown through the creation of daily occurrences that enable patient dignity to flourish.

Author/APA Reference:
Hall, S., Dodd, R.H., & Higginson, I. (2014). Maintaining dignity for residents of care homes: A qualitative study of the views of care home staff, community nurses, residents and their families/ *Geriatric Nursing, 35*(1), 55-60. doi:10.1016/j.gerinurse.2013.10.012
Research Method: Qualitative study
Sample: 33 care home managers, 29 care assistants, 18 care home nurses, 10 community nurses, 16 residents and 15 members of residents' families
Research Question: Exploration and comparison of views of residents in care homes for older people, their families and care providers on maintaining dignity.
Relevant Findings: The most relevant themes were: "independence" and "privacy"; followed by "comfort and care", "individuality", " respect", "communication", "physical appearance" and "being seen as human". Fostering dignity may improve quality of care and quality of life of residents.

Author/APA Reference:
Heath, H. (2010). Outcomes from the work of registered nurses working with older people in UK care homes. *International Journal Of Older People Nursing, 5*(2), 116-127. doi:10.1111/j.1748-3743.2010.00217.x
Research Method: Qualitative study
Sample: Phase 1: 16 RNs and 18 CAs from care homes around the UK; Phase 2: 25 RNs (including Home Managers), 24 CAs, 3 physiotherapists, 1 general practitioner, 1 clinical psychologist, 1 Head of Residential Care, 4 relatives and 18 older residents.
Research Question: To illuminate the distinct contributions made by RNS and CAs to outcomes for older people in the UK nursing care homes and to identify the outcomes of their work.
Relevant Findings: Outcomes for residents from RN work included improved health and wellbeing, prevention of problems/adverse outcomes and enhanced quality of life (such as enhanced dignity through continence assessment).

Author/APA Reference: Holmberg, M., Valmari, G., & Lundgren, S. M. (2012). Patients' experiences of homecare nursing: balancing the duality between obtaining care and to maintain dignity and self-determination. *Scand J Caring Sci, 26*(4), 705-712. doi:10.1111/j.1471-6712.2012.0098.x **Research Method:** Qualitative study **Sample:** 21 patients receiving home care nursing **Research Question:** To describe patients' experiences and perceptions of receiving nursing care in their private homes. **Relevant Findings:** Eight subthemes emerged that described their experiences: 1) To be a person meant being respected as an unique individual, defending one's privacy and making choices, participating in care and social interactions. To maintain self-esteem included not surrendering their independence, not having to be a host to the visiting nurses and to have trust in the nurses and the care they received.
Author/APA Reference: Jacelon, C. S. (2002). Attitudes and behaviors of hospital staff toward elders in an acute care setting. *Applied Nursing Research, 15*(4), 227-234. **Research Method:** Qualitative study **Sample:** For each case interview with an elder (at least 75 years old) who had been admitted to hospital for medical care, a family member of the elder and a nurse(RN, or student nurse who had cared for the patient) for a total of 5 cases **Research Question:** The role of RNs, physicians, and assistive personnel in caring for hospitalized elderly patients and the relationship to their health, dignity and autonomy **Relevant Findings:** 1) Staff attitudes affected elder's dignity and autonomy and managing care impacted their health.
Author/APA Reference: Jacelon, C. S. (2003). The Dignity of Elders in an Acute Care Hospital. *Qualitative Health Research, 13*(4), 543-556. doi:10.1177/1049732302250762 **Research Method:** Qualitative study **Sample:** Five elderly hospitalized patients **Research Question:** The social processes engaged in by elderly individuals while hospitalized **Relevant Findings:** Two attributes of dignity: self-dignity (the individual's sense of self-worth) and; interpersonal dignity, which was attributed by others and was demonstrated in the respect they received.
Author/APA Reference: Jacelon, C. S. (2004). Managing personal integrity: the process of hospitalization for elders. *Journal Of Advanced Nursing, 46*(5), 549-557. **Research Method:** Qualitative study Sample: 5 elders over 75 years of age, 4 family members, 6 RNs **Research Question:** To observe behaviours of hospitalized elders over 75 years, discover meaning of their experience, and to develop a theory explaining the social processes that they use while in hospital **Relevant Findings:** Hospitalized elders choose their actions in order to manage their health, dignity and autonomy.
Author/APA Reference: Matiti, M. R., & Trorey, G. M. (2008). Patients' expectations of the maintenance of their dignity. *Journal of Clinical Nursing, 17*(20), 2709-2717. doi:10.1111/j.13652702.2008.02365.x

Research Method: Qualitative study **Sample:** 102 patients in three hospitals **Research Question:** To explore patients' views regarding the factors that contributes to the maintenance of their dignity while in hospital. **Relevant Findings:** Six themes that contribute to preservation of dignity include: privacy, confidentiality, communication, choice, control and involvement in care, respect and decency and forms of address.
Author/APA Reference: Randers, I., & Mattiasson, A-C. (2004). Autonomy and integrity: upholding older adult patients' dignity. *Journal of Advanced Nursing, 45*(1), 63-71. **Research Method:** Qualitative study **Sample:** 30 health care professionals including 7 RNs and 23 assistant nurses **Research Question:** To develop a deeper understanding of the relationship between autonomy and integrity secondary to interactions between patients and health care workers. **Relevant Findings:** Support of autonomy and integrity helps to maintain dignity of an older patient
Author/APA Reference: Tadd, W. (2006). Dignity and older Europeans. http://www.ccels.cf.ac.uk **Research Method:** Discussion paper **Sample:** Older Europeans **Relevant Findings:** Future research on dignity in relation to services for the care of the older person should also include the dignity of the carer as well as the cared for.
Author/APA Reference: Teeri, S., Välimäki, M., Katajisto, J., & Leino-Kilpi, H. (2008). Maintenance of patients' integrity in long-term institutional care. *Nursing Ethics, 15*(4), 523-535. doi:10.1177/0969733008090523 **Research Method:** Quantitative study **Sample:** 222 nurses and 213 relatives of older patients in 4 Finnish long term care institutions **Research Question:** Aim was to describe and compare factors restricting a patients' integrity in long term care. **Relevant Findings:** Social factors are the single most important factor that inhibits a patient's: integrity.
Author/APA Reference: Touhy, T., Brown, C., & Smith, C. (2005). Spiritual caring: end of life in a nursing home. *Journal Of Gerontological Nursing, 31*(9), 27-35. **Research Method:** Qualitative study **Sample:** 25 participants: 5 RNs, 5 LPNs, 6 CNAs 4 MDs and 5 APNs **Research Question:** To explore spiritual care for dying nursing home residents from a nursing staff and physician perspective **Relevant Findings:** 5 themes emerged through spiritual caring including: honoring dignity, intimate knowing, wanting to do more, personal knowing as a caregiver and struggles with end of life decisions. Suggest further education and research to develop tools to enhance this setting
Author/APA Reference: Walsh, K., & Kowanko, I. (2002). Nurses' and patients' perceptions of dignity. *International Journal of Nursing Practice, 8*(3), 143-151. **Research Method:** Qualitative study

Sample: Nurses and patients **Research Question:** To explore patients and nurses perceptions of dignity, formulate a definition of dignity based on these perceptions and identify nursing practices that maintain or compromised patient dignity **Relevant Findings:** Nurses associated respect, privacy, control, advocacy and time as elements of patient dignity. Patients associated the characteristics of respect, privacy, control, choice, humour and matter-of-factness with maintenance of dignity.
Author/APA Reference: Webster, C., & Bryan, K. (2009). Older people's views of dignity and how it can be promoted in a hospital environment. *Journal of Clinical Nursing, 18*(12), 1784-1792. doi:10.1111/j.1365-2702.2008.02674.x **Research Method:** Qualitative study **Sample:** Ten older patients who had been in hospital **Research Question:** To explore older patients (who had been in hospital) views on dignity and the factors which promote dignity. **Relevant Findings:** Independence and effective communication are central to older people maintaining dignity through attaining control of their situation. Communication from clinical staff that conveys empathy and values the individual is also an important factor in maintaining dignity.
Author/APA Reference: Woolhead, G., Calnan, M., Dieppe, P., & Tadd, W. (2004). Dignity in older age: what do older people in the United Kingdom think? *Age Ageing, 33*(2), 165-170. doi:10.1093/ageing/afh045 **Research Method:** Qualitative study **Sample:** 72 participants between the ages of 50-90 years in Europe **Research Question:** To explore the concept of dignity from the older person's perspective **Relevant Findings:** Older people identified the concept of dignity "identity" to include self-respect, self-esteem, pride, integrity, and trust. Negative interactions between staff and patients, lack of privacy, poor communication and general insensitivity to needs, challenged dignity. Finally, older people want to maintain their autonomy, be treated as equals and felt that government finances/policies did not appear to support their rights.

Appendix C: Research Ethics Board Certificate of Approval

TRINITY WESTERN UNIVERSITY

TRINITY WESTERN UNIVERSITY
Research Ethics Board (REB)
CERTIFICATE OF APPROVAL

Principal Investigator: Glenda King

Department: Master of Science in Nursing

Supervisor (if student research): Dr. Barbara Astle

Co-Investigators: None

Title: Registered Nurses Providing Dignity: Caring for Older Persons in Residential Care

REB File No.: 13G13

Start Date: July 15, 2013

End Date: December 31, 2013

Approval Date: July 8, 2013

Certification

This is to certify that Trinity Western University Research Ethics Board (REB) has examined the research proposal and concludes that, in all respects, the proposed research meets appropriate standards of ethics as outlined by the "Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans".

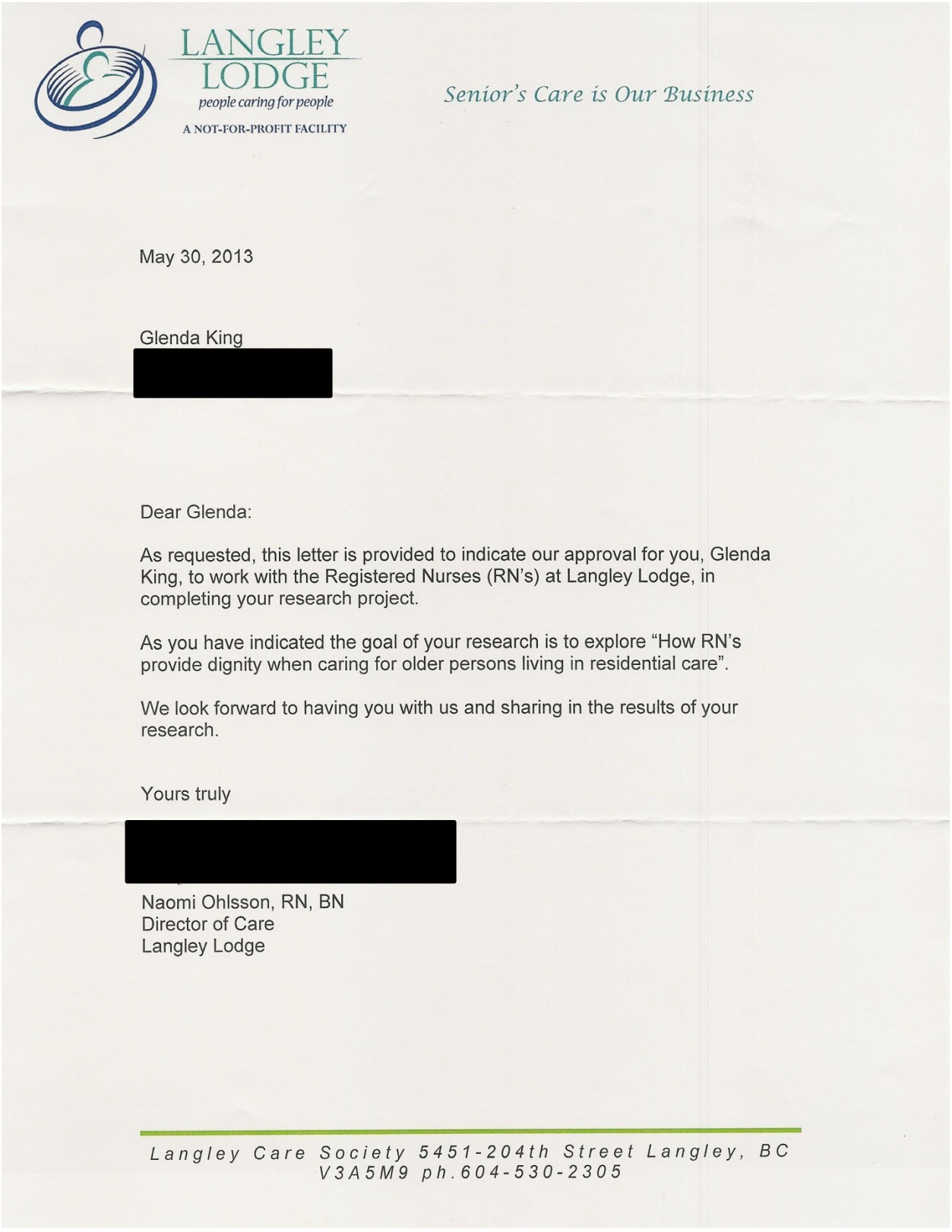
[redacted]

Sue Funk, B.A. for Bill Badke, M.Th., M.L.S.
REB Coordinator REB Chair

This Certificate of Approval is valid for one year and may be renewed.
The REB must be notified of *all* changes in protocol, procedures or consent forms.
A final project form must be submitted upon completion.

7600 Glover Rd., Langley, BC, Canada, V2Y 1Y1 Telephone (604) 888-7511, Fax (604) 513-2047

Appendix D: Approval Letter



LANGLEY LODGE
people caring for people
A NOT-FOR-PROFIT FACILITY

Senior's Care is Our Business

May 30, 2013

Glenda King
[redacted]

Dear Glenda:

As requested, this letter is provided to indicate our approval for you, Glenda King, to work with the Registered Nurses (RN's) at Langley Lodge, in completing your research project.

As you have indicated the goal of your research is to explore "How RN's provide dignity when caring for older persons living in residential care".

We look forward to having you with us and sharing in the results of your research.

Yours truly

[redacted]

Naomi Ohlsson, RN, BN
Director of Care
Langley Lodge

Langley Care Society 5451-204th Street Langley, BC V3A5M9 ph.604-530-2305

Appendix E: Recruitment Poster

Hello!

*We are recruiting **Registered Nurses** to volunteer for a research study on dignity and the older person.*

If you are you interested in participating in a short interview about your experiences please contact Glenda or Regina at the information below:

Primary Investigator: Glenda King, MSN student Trinity Western University
[redacted]
Assistant Director of Care: Regina Naing at local 4232

Study Supervisor: Dr. B.Astle, Assoc. Professor, TWU, (604) 513-2121 (ext. 3260)

Appendix F: Information Letter

Research title: Registered Nurses Providing Dignity: Caring for Older Persons Living in Residential Care

Information Letter for Registered Nurses (RNs) Working in Residential Care

Hello,

My name is Glenda King and I am a Master of Science and Nursing student at Trinity Western University. I am the Principal Investigator for a research study and I am interested in exploring how RNs working in residential care provide dignity when caring for older people. I am looking for RNs who would like to be part of this study.

If you volunteer as a participant in this study, you will be asked to share your experiences in a one-on-one interview with the Principle Investigator. The interviews will be approximately 45 minutes in length and will take place at a mutually agreed upon time and place. The interviews will be audio recorded and field notes will be written. All information collected is confidential and each person's identity will be kept anonymous.

This research may benefit how RNs provide dignity while caring for the older person and identifying nursing practices that will enhance the care of the older person.
If you are interested in participating, you can contact me at Glenda [redacted]

Appendix G: Consent Form

Consent Form

Registered Nurses Providing Dignity: Caring for Older Persons Living in Residential Care

Principal Investigator: Glenda King, Graduate Student, Masters of Science in Nursing, Trinity Western University. [redacted]

Supervisor: Dr. Barbara Astle, Associate Professor, School of Nursing, Trinity Western University Phone: 604-513-2121 Ext 3260; Email: barbara.astle@twu.ca

This research is part of a Capstone Project submitted in partial fulfillment of the requirements for the degree of Masters of Science in Nursing at Trinity Western University.

Purpose: The purpose of this research is to explore how Registered Nurses (RNs) provide dignity while caring for the older person living in residential care. I am interested in the following questions: 1) How do RNs understand the meaning of dignity when caring for the older person and 2) What are the RNs perceptions of how they provide dignity when caring for the older person?

Procedure: If you agree to participate, you will be interviewed for 45-60 minutes by the Principal Investigator at a mutually agreed upon time and location. The interview will be audio recorded. After the interview there will be a short debriefing session. You will receive a copy of the consent form to take home. A summary of research findings will be available to participants by contacting the Principal investigator.

Risks: There are no anticipated risks to the participants of this research study. If you feel at any point you need to withdraw from the study, please know you can do so.

Benefits: The benefit you may receive from participating in this study is knowledge to identify nursing practices that will enhance the care provided to the older person. There is no direct benefit, physical or monetary from participation in this study.

Confidentiality: Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Research materials will be identified by a participant number and kept in a secure digital file stored on a password-protected computer. A key code (linking participant names to participant numbers) will be stored in a separate secured electronic file, apart from the data. All hard copy documents will be stored in a locked filing cabinet. Research participants will not be identified by name in any reports of the completed project. Data recordings and

transcripts will be kept for five years after the project is completed in a password protected electronic file. After this time period, they will be destroyed. Hardcopies will be shredded after the completion of this project.

Remuneration/Compensation: A $5.00 coffee card will be provided as a "thank you" for participating in the study and you will receive it after the interview is completed. If you withdraw from the study at a later stage, you may keep the coffee card.

Contact information about the study: If you have any questions or desire further information with respect to this study, you may contact Glenda King (the Principal Investigator) at [redacted]

Contact information about the rights of participants: If you have any concerns about your treatment or rights as a research study participant, you may contact Ms. Sue Funk in the Office of Research, Trinity Western University at 604-513-2142 or at sue.funk@twu.ca.

Consent: Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without any negative outcomes to you; related to your work or this study. If you wish to withdraw at any time, please let the Principal Investigator know of your decision not to continue and your answers and information will be removed from the study and destroyed. Any written material will be shredded and recorded data destroyed. No information that you have given will be included in the study.

Signatures: Your signature indicates that you have had all questions about the study answered to your satisfaction and have received a copy of this consent form for your own records.

Your signature means that you consent to participate in this study and that your responses will be kept anonymous and destroyed after the completion of this study.

_____ _____

Research Participant Signature Date

_____

Printed Name of the Research Participant signing above

_____ _____

Researcher Signature Date

Glenda King

Appendix H: Demographic Information

Name: _____

Code: _____

Date of Interview: _____

1. Gender (circle): Male_____ Female _____

2. Age range: 21-30 years_____; 31-40 years_____; 41-50 years; _____

   51-60 years;_____; 61-70 years _____

3. Highest educational level attained:

   _____College/Diploma _____University (Bach)

   _____Graduate School

4. Occupation: _____

   Position: _____

   Years of Experience as an RN: _____

   Years of Experience working with the older person: _____

5. How do you describe your ethnic background? _____

   Country of Birth: _____

6. Mailing Address: (if interested in receiving a copy of results or for clarification of results)

   _____

   _____

Email Address: _____

Phone: _____

Appendix I: Interview Questions

1. Can you give an example of when you helped an older person have dignity?

   Prompt: What helped or hindered your ability to provide dignity in this case?

2. What does the word dignity mean to you when caring for an older person?

   Prompt: What words come to mind when you think of the word dignity when caring for an older person?

3. Can you describe how you might provide dignity to an older person in your care?

   Prompt: Are there things you say or do that provide dignity in the care you provide?

4. Can you think of any past experiences that may have influenced how you might understand dignity in the context of caring for an older person?

5. Do you think dignity is an important aspect of nursing care in caring for older persons? Why or why not?

   Prompt: Can you describe to me why you think dignity is an important aspect of nursing care?

   Prompt: Can you describe to me why you think dignity is not an important aspect of nursing care?

6. What do you think dignity means to an older person?

   Prompt: What might dignity look like to an older person in terms of their care?

   Prompt: What might dignity look like to an older person in terms of their daily activities?

   Prompt: What might dignity look like to an older person in terms of their family life?

7. What allows you in your nursing practice, to provide dignity when caring for the older person?

Appendix J: Debriefing Script

Thank you so much for your participation in this study.

Is there anything you would like to say about what it was like to participate in this interview?

What do you think you gained from this experience?

Your participation is very important to this study to help us understand how Registered Nurses provide dignity when caring for older people. My aim is that by developing a better understanding of dignity, we may enhance the care of older persons.

Do you have any other questions?

Appendix K: Code Book

1. Meaning of dignity

    a) Respecting
    b) Respect for the person
    c) Putting self or parents in their place and considering if this is appropriate care
    d) Making someone feel comfortable
    e) Trying to perform a task the way that person would do it if they were capable of doing it themselves
    f) Comfort zone
    g) Contentedness
    h) Self-respect (of resident)
    i) Listening
    j) Discovering *what* is important to them
    k) Provision of privacy
    l) Kindness/Tender loving care (TLC)
    m) Patience
    n) Giving information
    o) Giving choices
    p) Believing in the person
    q) Trust

2. Context of providing dignity

    a) Look at person as a whole (wholeness)
    b) Consider ethnicity, gender, age
    c) What would this look like if the older person was in their own home?
    d) Privacy/provision of personal space
    e) Simplicity in language, speech and tasks
    f) Look at ways to make them feel better and to feel complete (individuality)
    g) Ways of doing things the way they would do it if able
    h) May be hindered by language barrier, dementia or behavioural issues such as not wanting male staff to provide care or lack of privacy or discomfort, inexperienced or unfamiliar staff, lack of time, insufficient staff, personal care, bringing personal life to work may affect attitude at work, resident's rejection of care(or attitude), personality clash, standards and policies
    i) May be enhanced with experienced staff, enjoyment of job, feeling of trust and development of rapport, sufficient staff, resident's acceptance of care
    j) Choices
    k) Caring for and supporting the family
    l) Encourage independence
    m) Listening
    n) Support decisions
    o) Asking or ensuring permission prior to giving care
    p) Incorporating peer support(of resident)

q) Supporting and mentoring other care staff
r) Acceptance of life stages

3. Providing dignity

a) Explanation
b) Simplicity of language
c) Privacy
d) Simple considerations such as temperature of room, introductions, talking to them, discovering their likes/dislikes, touch, call them by their preferred name, smile, kindness, expressing interest in them, listening to them, not talking "over" them, spending time with them, knock before entering a room
e) Good grooming
f) Supervision of staff to ensure this is occurring/or lead by example
g) Respect as individuals including their wants/needs
h) Respect their values
i) Allow for time to "regroup"/ provide space
j) Use of humour
k) Approach
l) Confidentiality
m) Advocate for them

4. Influences of dignity

a) Looking beyond what is seen in the here and now
b) Older person's history, their past, cultural differences
c) Try to incorporate their history into their care and to engage them into conversation
d) Ask for their input/feedback(asking what they want)
e) Comfort level
f) Previous work experience (hospital, palliative care,) and education
g) Lack of time
h) Family culture of RN
i) Compassionate nature (of RN)
j) Work ethic of RN
k) Other colleagues

5. Relevancy of dignity to nursing care

a) All that remains after so many losses (i.e., loss of home, independence, contact with family and friends)
b) Have put their trust in nursing staff to provide the care required, "responsible for their happiness"
c) Need to respect them for who they are now
d) Dignity is about living
e) Builds their(resident) self-esteem/self-worth

f) Making connections
g) Entering someone's private space to do things that they used to do on their own
h) Reciprocal effect from management to staff and residents

6. Perceptions of the meaning of dignity

a) In terms of care

i. Me, look at me
ii. This is what I require
iii. Looking and listening to me
iv. Trying to accommodate the person I am now
v. Being heard and being listened to
vi. Having choices/provide space
vii. Privacy
viii. Preservation of self-respect
ix. Respecting their wants
x. Asking permission
xi. Unrushed care, including feeding at mealtimes
xii. To be loved and respected
xiii. TLC
xiv. To have value
xv. To be treated like a human being
xvi. Maintain independence

b) In terms of daily activities

i. Mutual consent
ii. Privacy
iii. Provide explanations
iv. Address by name
v. Know something about them as an individual
vi. Involve family members
vii. Personal hygiene
viii. Provide care with TLC
ix. Consider their schedule/wishes

c) In terms of family life

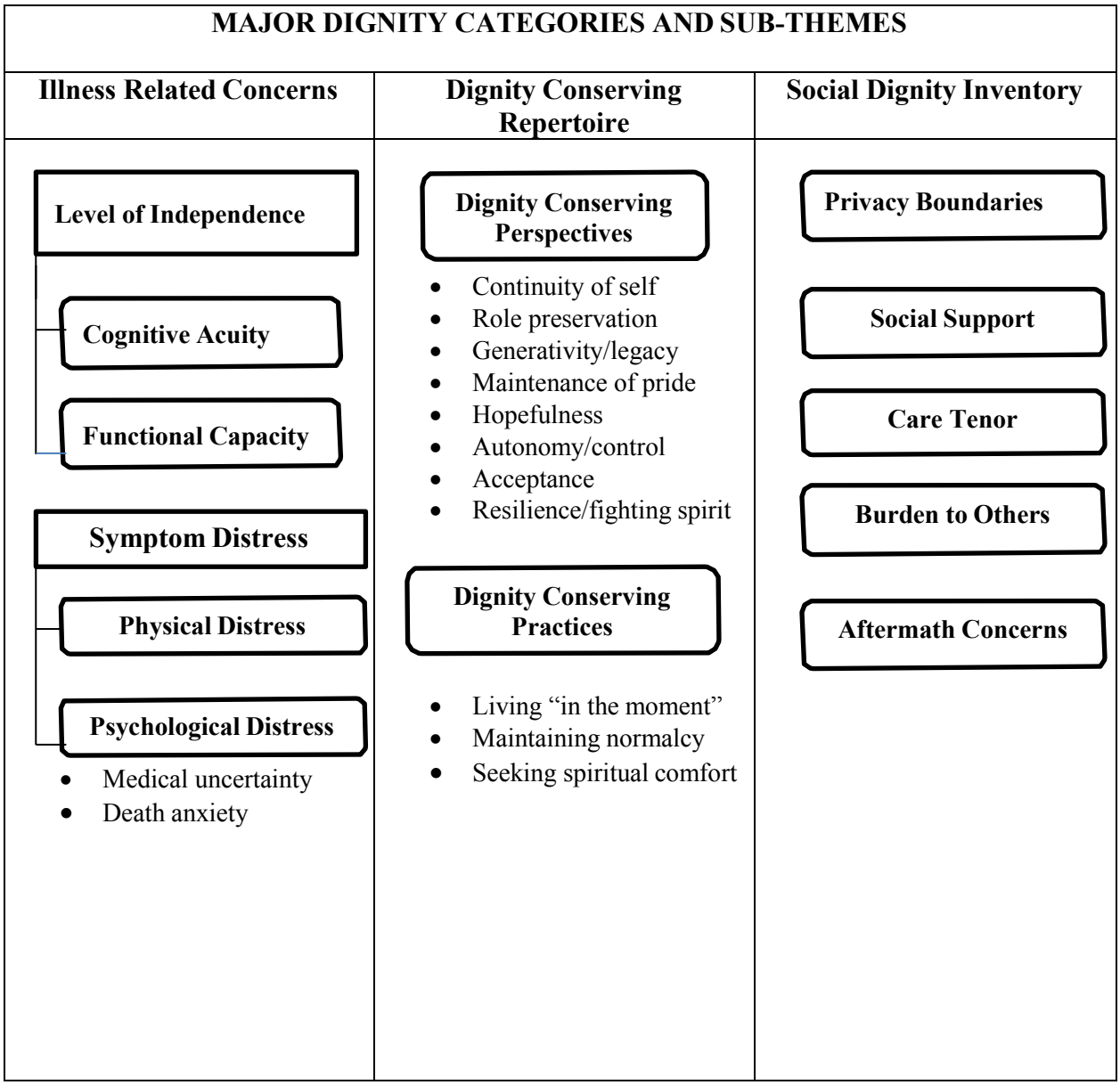
i. Not to be forgotten
ii. Activities with family members
iii. Respect of culture
iv. Know who is important to them (may include pets)
v. Treat them like a family member

vi. Consistent expectations of others: Either accepting of situations (low expectations) or demanding (high expectations)
vii. espect financial dynamics within families
viii. Distraction
ix. Include family in problem solving
x. Spend time together
xi. Educating the family(to increase awareness)

7. Recommendations

a) Don't "pigeon hole" everyone into the same box (treating them as individuals)
b) Consider various needs such as ethnicity, age groups, level of dementia
c) One type of care does not fit all needs- think outside the box
d) Use of humour
e) Going the extra mile for someone
f) Make life as comfortable as possible for as long as possible
g) Take pride in doing a job well
h) Respectfulness- as though they were your own family
i) Get to know who they are and what they require
j) Be interested in them
k) Listening to them
l) Ensure modern conveniences (i.e., mechanical lifts) factor in dignity
m) Personal beliefs/expectations of self "allow" provision of dignity in care
n) Follow up on issues of concern (get back to them)

Appendix L: Chochinov's Model of Dignity



Note: Permission to use Chochinov's Dignity model given by Harvey Chochinov, May 2014