Evaluation of the Royal College of Nursing’s ‘Dignity: at the heart of everything we do’ campaign: exploring challenges and enablers

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Abstract
Dignity in care has become a key policy, practice and political priority. This development has become more pressing as media, anecdotal and research reports have highlighted dignity deficits in care. In response to such reports and to concerns of the membership and general public, the Royal College of Nursing initiated a high-profile campaign (Dignity: at the heart of everything we do) involving engagement with stakeholders, a survey of members and the development and dissemination of educational and practice development materials. This article details findings from part of the evaluation of the Royal College of Nursing dignity campaign, which used a qualitative case study design across seven UK sites. The study used interviews with 51 staff members, direct observation of the physical care environment and document analysis, and data were analysed using thematic analysis. The article focuses on two areas: enablers (staff receptivity and creativity; organisational support and leadership; and campaign educational materials) and challenges (time constraints; and staff attitudes and insight).

Keywords
dignity, evaluation, case study, qualitative research, education, leadership, staff attitudes

Introduction
Dignity is central to quality care for patients and clients and has been increasingly emphasised in UK health policy over the past decade (Department of Health 2001a, b, 2006; Department of Health, Social Services and Public Safety, 2006; Scottish Government, 2006; Welsh...
Assembly Government, 2003, 2007). However, various reports have expressed concern about dignity being diminished in care settings (Healthcare Commission, 2007; Help the Aged, 2007; Mencap, 2007, Richards and Coulter, 2007) and the media regularly present examples of lack of dignity in health and social care. These reports and the government agenda on dignity formed the background to the launching of the Royal College of Nursing’s (RCN’s) ‘Dignity: at the heart of everything we do’ campaign in June 2008, which aimed ‘to provide support and direction to the UK’s nursing workforce, as they deliver care for patients and clients of any health status in every setting’ (see Royal College of Nursing, 2008a). The RCN’s online survey identified that while 98% of respondents considered that the dignity of their patients and clients was important to them, more than 8 out of 10 respondents reported always (10.9%) or sometimes (70.2%) feeling upset or distressed because they were unable to give the dignified care they knew they should (Royal College of Nursing, 2008b). The RCN’s dignity campaign resources (including an educational practice support pack) were developed collaboratively with practitioner reference groups and aimed to assist nurses in addressing this situation.

An evaluation was conducted at seven sites which were early adopters of the RCN campaign with the following overall aims:

(1) To establish current dignity practice, including any dignity practice developments prior to the RCN Dignity campaign launch.
(2) To examine factors affecting the implementation of the RCN Dignity campaign: enablers and challenges.
(3) To investigate how the RCN’s Dignity campaign products are being used in practice.
(4) To explore how the RCN’s Dignity campaign is impacting on practice.
(5) To consider how further evaluation might be conducted.

This paper focuses on the enablers and challenges encountered by staff leading the campaign’s implementation within the case study organisations. A full copy of the evaluation report, and further information about the evaluation, can be obtained from the RCN.

Background

Although the term ‘dignity’ is embedded in many documents and papers, it is rarely defined and has been described as vague (Shotton and Seedhouse, 1998) and elusive (Pullman, 2004). Concept analyses of dignity (Haddock, 1996; Mairis, 1994; Marley, 2005; Nordenfelt, 2003) have highlighted the complexity and multi-dimensional aspects of dignity. The commissioning of an anthology on human dignity and bioethics, by the President’s Council on Bioethics in the United States (2008), suggests the importance and challenging nature of the concept. In the Letter of Transmittal to the US President the Council’s Chairman, Edmund Pellegrino, writes:

‘These essays make it clear that there is no universal agreement on the term, human dignity. Some argue that human dignity has lost its traditional meaning. Others, by contrast, hold firmly to the view that dignity is an essential identifying and irreducible element of human nature. Still others take a more biological than philosophical or theological viewpoint on the question of the meaning of human dignity. An appreciation of the variety of these views is critical, if we are to understand the divergences in how we think and act in response to the challenges posed by contemporary bioethics.’

(President’s Council on Bioethics in the United States 2008, pp. xi–xii)
The philosophical challenges relating to dignity cannot be ignored and, indeed, need to be engaged with. However, the growing body of empirical research on dignity has helped to ground dignity in the everyday experiences of patients and professionals and to suggest how dignity in care might be operationalised. A literature review by Gallagher et al. (2008) identified four key and recurrent themes:

- **The environment of care** – this relates to physical features of the healthcare environment which had the potential to diminish or enhance dignity. Examples included access to bathroom and toilet facilities and mixed sex accommodation.
- **Staff attitudes and behaviour** – the way individuals respect the dignity of patients and others is evident in the language they use and in their actions. Examples such as the use of ‘endearments’ such as ‘sweetheart’, ‘darling’ and ‘poppet’ were described as patronising and infantilising. Offering choice to patients in everyday situations such as grooming and dressing was identified as respectful of dignity.
- **Culture of care** – the values and moral climate of the organisation was an important theme in the literature, for example, the ward philosophy and organisational priorities. A positive culture of care is supportive of patient and staff dignity whereas the prioritisation of managerial values and financial targets is likely to compromise dignity.
- **Specific care activities** – some care activities such as bathing, toileting, dressing and feeding render patients particularly vulnerable to dignity loss. Attention to individual preferences and sensitivity to the potential for embarrassment and humiliation helps maintain dignity.

The Royal College of Nursing (2008b) report *Defending dignity – challenges and opportunities for nursing* detailed findings from an online survey of over 2000 nurses, health care assistants and students. The survey generated similar themes to the literature review albeit from the perspective of staff. The findings suggested three areas that have the potential to enhance or diminish dignity in care:

- **people** – the attitudes and behaviour of staff and visitors;
- **place** – the physical environment and the culture of the employing organisation;
- **processes** – attention and sensitivity to the wide range of care activities which could threaten dignity.

The research team developed a working definition of dignity that underpinned the RCN Dignity campaign and sought to address the complex nature of dignity and to highlight the significance and scope of dignity (see Box 1).

**Methodology**

Clarke (2001) notes that evaluative research is practically orientated and applied and that process issues are best studied using a qualitative approach. Thus a multi-method qualitative case study design was used for the evaluation. Case studies are suitable for developing an understanding of a phenomenon in its real-life context (Yin, 2003) and they offer a holistic form of inquiry (Gangeness and Yurkovich, 2006). A case study design is especially suitable for developing understanding of the significance of particular factors within the context of the whole case (De Vaus, 2001) which, in this study, included organisational influences.
Using Yin’s (2003) framework, the design was multiple case (seven sites) with embedded units of analysis; these were staff with leadership roles relating to the campaign. De Vaus (2001) explains the benefits of cases being selected strategically because of their specific characteristics and the seven sites were all early adopters of the RCN Dignity campaign. Any appropriate range of data collection methods can be used in case study research and collecting data from multiple sources (data triangulation) enables corroboration of the same phenomenon thus strengthening the evidence for a particular conclusion (Yin, 2003). In this study the researchers used interviews, document analysis (including internet-based) and direct observation of the environment. The seven sites (identified here with the letters A–G) were purposively selected as they were UK-wide early adopters of the RCN Dignity campaign and included different types of care providers. Box 2 outlines the process for recruitment of participants and data collection.

An NHS Ethics Committee confirmed that the evaluation was considered to be a service evaluation. Information sheets were distributed to potential participants, consent was obtained and all data were treated confidentially and anonymised. The seven sites were situated across the UK: one in Scotland, one in Northern Ireland, one in Wales, one in the north of England and three in the south-east. The organisations were three independent care home providers, one NHS district general hospital, one NHS community trust and two city teaching hospital NHS trusts. One researcher conducted data collection at three sites and the other researcher at four sites.

The interviews (see Box 3 for general topic areas) followed an open-ended, guided conversation approach, of a style commonly used within case study designs (Stake, 1995; Yin, 2003). The interviewees signed written consent forms and all agreed to be audio-recorded, thus enabling the researchers to concentrate on the interviews (Gray, 2004). Between 5 and 9 staff members were interviewed at each site with a total of 51 staff members across the seven sites. The lead persons at the organisations included roles such as deputy chief nurse with a lead for dignity; the other interviewees’ roles were mainly matrons, ward or care home managers or staff with a practice education/development remit. On a few occasions, at the suggestion of these key staff, other practitioners (e.g., a staff nurse or allied

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**Box 1. Definition of dignity (Royal College of Nursing, 2008b)**

Dignity is concerned with how people feel, think and behave in relation to the worth or value of themselves and others. To treat someone with dignity is to treat them as being of worth, in a way that is respectful of them as valued individuals.

In care situations, dignity may be promoted or diminished by: the physical environment; organisational culture; by the attitudes and behaviour of nurses and others and by the way in which care activities are carried out. When dignity is present people feel in control, valued, confident, comfortable and able to make decisions for themselves. When dignity is absent people feel devalued, lacking control and comfort. They may lack confidence and be unable to make decisions for themselves. They may feel humiliated, embarrassed or ashamed.

Dignity applies equally to those who have capacity and to those who lack it. Everyone has equal worth as human beings and must be treated as if they are able to feel, think and behave in relation to their own worth or value.

Nurses should, therefore, treat all people in all settings and of any health status with dignity, and dignified care should continue after death.
health professional) who were supporting them with the campaign were interviewed – either separately or together with the key staff member. As well as conducting interviews, the researchers examined associated documentation and observed visual material. Copies of documents were obtained where possible (e.g., staff information, teaching materials) and photographs were taken of relevant visual material (e.g., noticeboards, care environment initiatives). The organisations’ websites were also scrutinised for material relating to dignity in care.

The interview audio-recordings were transcribed by a professional transcribing company. The researchers reviewed the transcripts and other data from the seven sites, initially analysing the data on a site-by-site basis. They were in regular contact throughout data collection and analysis, cross-checking processes and procedures to ensure a consistent approach. Thematic analysis was conducted by: reviewing all data for the site, applying codes to the data (these emerged from the data) and then developing categories under themes. The themes were developed from the main topic areas used for data collection:

- Dignity in the organisation prior to the RCN Dignity campaign launch.
- The RCN Dignity campaign: enablers and challenges.
- The impact of the RCN Dignity campaign.

**Box 2. Participant recruitment and data collection**

- Each organisation identified a dignity campaign lead person who liaised with the researchers, informed relevant departments as applicable and gained any locally required permission.
- The lead person selected the interviewees and drew up the interview schedule. The criteria for interviewee selection was that they must be in leadership positions and actively involved in the campaign, for example, using the practice support pack and/or other campaign resources with groups of staff.
- Each interviewee received an information letter about the evaluation prior to the interview.
- The researchers conducted individual interviews with the lead person and the other identified interviewees during March–May 2009, on the organisation’s premises.
- The interviewers also requested to see documents and any written or visual materials (including the care environment) related to the RCN Dignity campaign, taking copies and photos where possible.

**Box 3. Interview topic areas**

- Dignity in care developments prior to the RCN Dignity campaign launch in June 2008.
- Dignity in care in the organisation since the RCN Dignity campaign launch:
  - role and involvement in the RCN campaign;
  - campaign enablers;
  - campaign challenges;
  - campaign products: usage, responses;
  - impact on practice;
  - future plans.
- Suggestions for further evaluation of the campaign.
- Any other comments about the RCN Dignity campaign.
This paper focuses on the findings relating to the campaign enablers and challenges and draws on the interview data only.

Results

The campaign’s enablers are presented first, and then the challenges will be discussed, with quotations from the staff interviewed to illustrate these themes.

Campaign enablers

The main enablers to the dignity campaign were identified as:

- staff receptivity and creativity;
- organisational support and leadership;
- campaign educational materials.

Staff receptivity and creativity. There was clearly a strong commitment to dignity within local staff teams at some sites, which assisted the key staff in taking the campaign forward with their teams:

They [staff] have taken on board the privacy and dignity very, very strongly here. (Practice educator, Site A)

Some interviewees also considered that a cohesive team with staff who were receptive to practice improvements supported the dignity campaign, for example:

We’ve got a settled staff I have to say, there’s not a big turnover, you know they are very conscientious […] everybody’s really willing to just go that wee step further now and just keep going with it. There’s not really much negativity, there is a lot of positivity about the home you know and new challenges – they’re up for it. (Manager, Site C)

Interviewees referred to staff who liked ‘changing things for the better’, who were ‘very proactive and they want the best for their patients’ and who are ‘open to any changes’. The interviewees expressed their own commitment to their role in the campaign, as well as that of their colleagues:

It’s very high on my priority and it’s very high on my sisters’ priority as well. And my deputy matrons. Yes I’ve got commitment from all of them. (Matron, Site B)

Participants also shared examples of dignity initiatives that demonstrated a high level of creativity in some areas. On one site (F), staff had found a supplier for ‘dignifying aprons’ or clothes protectors to replace disposable ‘bibs’ that they considered infantilising. They also ordered door signs indicating ‘vacant’ or ‘occupied’ so that residents would have more privacy in bathrooms and toilets. They were responsive to resident requests to ensure that dinner plates were warm. Kitchen staff had been concerned about risks of burns and were persuaded to warm plates to a reasonable temperature. On Site E staff were aware that many of the less able residents were well groomed but often had shoes that were unpolished and, in some instances, were covered in talc. They arranged for a volunteer to shine shoes in...
the home. It was acknowledged repeatedly in interviews that it is the little or everyday things that make a difference to practice.

Organisational support and leadership. A strong enabler was the senior level commitment for staff to engage with the RCN campaign:

_There was a commitment from the Director of Nursing and the execs. That was a clear drive. He wanted it to happen. The assistant, the deputy director and I went to the launch. The support came from the exec team down._ (Education Director, Site A)

Site B’s interviewees referred to the organisation’s chief nurses as being ‘very driven’ and ‘passionate’ about the dignity campaign. Staff at several sites referred to the high profile of dignity in the organisation, with initiatives already in place, for example:

_I suppose the influence of like the matrons’ rounds and it being quite high profile and expected of us. I suppose that influences you in that it’s in your mind and it’s something that has to be done, something that has to be looked at._ (Senior Sister, Site A)

As in the RCN Dignity survey participants also emphasised the importance of role modelling in advancing the objectives of the dignity campaign:

_Well, I think we’re going to put the posters up and we’re going to have like a notice board as well [...] when our students come we’re going to, sort of, drum it into them I think, from the student’s level (laughs) because I think if you’ve got the manager, the role model, the sister implementing this, you’ve also got the students [...]_. (Senior Sister, Site E).

Interviewees at some sites expressed the view that the campaign ‘complemented what we were already doing’ (Practice development nurse, Site A), building on to the work already established, for example, sites in England had adopted the Department of Health (DH) Dignity campaign, with the 10-point dignity challenge and dignity champions already in place. Findings in Wales and Northern Ireland also suggested that the RCN Dignity campaign activities were compatible with other policy and practice initiatives and also were strengthened by senior staff acting as role models, for example:

_Because I think it’s about role models [...] and that’s what I like about the dignity campaign. You see for me and linking that to the ‘thousand lives’ campaign, this is all about training people to be champions for safer patient work. Well, that to me we’re all champions for safer patient work and it’s about making sure that the ward sister is the good role model’. (Practice Development Nurse, Site G).

Organisational support and senior nursing staff acting as role models are, therefore, enabling in supporting the RCN Dignity campaign objectives.

Campaign educational materials. At each organisation, there was a campaign launch event where the RCN Dignity campaign products were presented to key people in the organisation, so they could then use them in their own areas to develop dignity in care. The launch days had an important role in enthusing and orientating the staff to the package:

_I found the facilitator was absolutely fantastic really got the information over very clearly, made it very interesting and gave us lots of ideas for when we actually go out and deliver._ (Trainer, Site C)
The campaign materials provided were a practice support pack (DVD and facilitators’ guide), an influencing pack (to assist staff to facilitate change), dignity pocket cards, pens and posters; additional resources could be downloaded from the RCN website. There were many positive comments about the educational materials, particularly the DVD, which attracted comments such as: ‘those images just stay with me’, ‘it just captivates people’, ‘just brings it home just how it would feel’, ‘powerful’ and ‘thought-provoking’. The materials prompted reflection and self awareness:

*It stimulated quite active discussions about things and some people did hold their hand up and say you know ‘I didn’t always promote dignity and we know we should do’. So I think if you can get people to recognise that we’re not 1 hundred percent perfect and we do and have made mistakes in the past but let’s put things right now. You know like it says on the dignity training ‘it’s the small things that make the big difference’ and it is the small things that make the big difference.*

(Trainer, Site C)

*The very clear feedback that we’ve had is that it’s enabled staff to actually realise and have more insight into their own practice rather than having this ‘yes it’s dreadful that we’re having to talk about dignity of course we all do it and it happens here but it’s other places that it doesn’t’. It’s sort of the toilet in the lift is, is quite powerful and I think what that’s enabled people to do is yes we do just walk in and out of the curtains, we do sort of walk in and out of toilets and that kind of thing so I think it’s the visual impact of the little clips that have been really powerful.*

(Deputy Chief Nurse, Site B)

The facilitators used the resources flexibly in a way that worked best with their particular care setting and staff group. While they were developed by the RCN primarily for nurses, many interviewees were using them interprofessionally and had found them to be widely applicable. The facilitators’ own enthusiasm and commitment was evident, as they discussed how they engaged their colleagues:

*I used the actual package and the contents, but what I did, I got the staff while they were on a working shift, I could just get two or three staff to one side, and do short sessions with them in that way. Half hour sessions, and that’s how I did it[ . . . ] And I also got like a working party together, of six staff* (Senior Sister, Site A)

The impact of the educational materials was illustrated by the initiatives which had developed as a direct result of using them. A number of interviewees described how they were accessing material and environmental resources to enhance dignity. For example, negotiating with the laundry department to provide dressing gowns for patients walking to theatre (Site A) and, at Site B, a children’s ward team who were planning the development of a quiet room for breast-feeding mothers and private discussions, were optimistic that they could get access to funding. At Site F staff talked of how they had to be creative in budgeting for the ‘dignifying aprons’, the doorplates and also to pay for staff time to attend training. On Sites B, D and G staff shared how they invented their own curtain signs and pegs to emphasise patient dignity. One practice development nurse on Site G discussed the merits of ‘simple initiatives’. She was given £100 by the lead nurse for dignity in her trust and produced ‘do not disturb’ signs for bed curtains. Although she joked ‘you can tell I was brought up on Blue Peter’, this simple initiative was considered important in her trust. On Site D a clinical nurse leader had also invented a dignity sign for curtains albeit with a notice that could be seen on the inside and outside of the curtain.
Challenges

The interviewees identified some challenges they had encountered in initiating and maintaining the campaign but these were surprisingly few. The main constraints were described as:

- time – including staffing levels and pressure to fit in other mandatory training;
- staff attitudes and insight.

Time. Interviewees at several organisations referred to lack of time to meet with their teams and use the campaign materials:

‘I think again it’s going to be the challenge of people having time to sit a group of people down and play a DVD and talking through it and how that’s going to be done because there are millions of things here for us to do.’ (Matron, Site B)

However, others were sceptical about this type of response:

‘It’s almost a standard response for a lot of nurses now to say I haven’t got time to do that or I just want to come here to do my job do a good job and go home. And it’s very frustrating as a Ward Manager [...] How do we get people on board? Yes people [are] doing, you know they’re working long hours, they’re often doing extra shifts and cross covering at short notice but in some ways that’s always gone on [...] I do think we are up against that.’ (Clinical Manager, Site A)

Other interviewees’ comments indicated that while time was a barrier, with real commitment and creativity in approach, this could be overcome: ‘You have to make time and that’s what I’ve done’ (Matron, Site B). However, one facilitator highlighted that even attending mandatory training was problematic and indicated that it was only personal commitment that had enabled the training to occur: the challenges of combining the RCN dignity initiative with other training was echoed elsewhere:

‘I suppose really it’s the home managers getting the time now to deliver the training [...] there are so many different areas of mandatory training. It’s so difficult to get that fitted in. But, then again, we should see this [dignity training] as a mandatory training, and again, potentially it’s an organisational change of culture that it should be viewed as one of the mandatory subjects rather than an additional thing really.’ (Care Services Manager, Site F).

Nevertheless interviewees were often creative in finding ways that would work within their own environment, for example, some considered that a full day out for staff was the best solution, others found doing a series of short practice-based sessions worked best and others used existing forums, such as meetings or integrated the educational materials within existing training.

Staff attitudes and insight. As discussed earlier, there was high level organisational support for dignity in care and many staff groups were supportive and receptive to the campaign. However, some interviewees mentioned culture and staff attitude as being challenging, sometimes highlighting the differences even within the same organisation:

‘I think it will be a long process. For some homes are way ahead, they are just on a different league altogether, their care is dignified and you know they do have all the right kinds of attitudes.'
But obviously it’s bringing the poorer homes into the same mindset that’s probably more where I’m involved so I tend to see the worst kind of things.’ (Educational Manager, Site C)

The interviewees highlighted that certain ways of working can be ingrained in staff and they may be defensive, leading to unwillingness to engage with the dignity campaign. In such instances, the facilitator’s skills were crucial:

‘I think the barriers are people’s defensiveness about ‘you telling me I’m not treating people with dignity I’m always nice to my patients’ that kind of thing, getting around that, make them sit down and actually you know there are things we can all do better[...] there are always things we can get complacent about so it’s getting around the barriers, it’s getting around people’s perception about what the dignity campaign means[...] I think they’re the main barriers to people’s understanding of it, what it really means, feeling insulted by you even bringing up the thought that they are not like that[...] you’ve got to be very, very skilful around being able to bring up the campaign and drive it forward without insulting people.’ (Matron, Site B)

Nursing staff were keen to emphasise that the dignity campaign should not just target nurses. One home manager (Site F) said:

‘There was a chiropodist in the home the other day and he was doing people’s toenails in the lounge and I said to him “you know we should really be taking the patients to the treatment room to be doing that” and he said “but I shut the door” and I said “the doors are glass and I can see what you are doing through the doors [plus] there are other patients in the room”. He said “but they’re all getting their toenails done”. And I thought, you know, that’s not very dignified and then afterwards I wondered how he’d managed to take the residents stockings off.’

A matron in an intensive care unit (Site D) also pointed to the need for other professionals to take dignity seriously and to have training:

‘And I think one of the issues that constantly comes up is, there are groups of professionals who don’t have a lot of patient contact all of the time, but have to in intensive care, and dignity is not necessarily something that is high up on their agenda as part of their normal job’

later, in relation to the DVD, he said

‘What I’d really like to do is show it to our consultants. And some of the other allied professionals like the physiotherapists and the radiographers and the diabetics teams. So that’s my plans for the next year.’

On all sites, participants emphasised the importance of all staff (including porters, kitchen staff and other professionals) participating in the dignity training. It was also acknowledged that some members of staff might be experiencing campaign fatigue:

‘[...] staff are feeling a little campaigned out, because we’ve got lots of things going on at the moment.’ (Practice Development Nurse, Site G)

Although there were challenges in implementing the Dignity campaign these were not insurmountable; participants’ responses suggested, on all sites, that the enthusiasm and creativity of staff would overcome these.
Discussion

The evaluation was based at a small number of healthcare organisations which were early adopters of the RCN Dignity campaign and were at an early stage of piloting the educational resources. There is a question of the sustainability of the campaign and without reinforcement, change may be short-lived (Burnes, 2004). However, Gee (2009) reports that the DH Dignity campaign, launched in 2006, continues to gather momentum. This early evaluation’s findings illuminated enablers for a campaign to promote dignity, the challenges that may be encountered and how these might be overcome. The evaluation was based on the experiences of local campaign facilitators; further evaluation should include the views of patients, clients and their relatives about their perceptions of the campaign’s impact. A strength of the evaluation was the use of a qualitative approach capturing practitioners’ perspectives on factors that enabled the implementation of the RCN Dignity campaign and factors that made it difficult.

The findings indicated that the dignity campaign materials were well received and the way in which they were introduced in each organisation to key staff with responsibility for local delivery was an effective approach to a campaign delivery. These materials were developed collaboratively with groups of practitioners; it is likely that this strategy influenced the apparently accessible and practical package of campaign resources. The study findings indicated that the receptivity and creativity of staff, both the interviewees who were leading the campaign locally and the groups of staff who they were facilitating, were crucial to the campaign’s successful delivery at local level. The interviewees expressed that there was high-level support in their organisations and thus the importance of effective leadership, at both local and senior level in organisations, was highlighted. The importance of leadership in enhancing and diminishing dignity in care was a key finding in the Royal College of Nursing (2008b) survey. Work on nurse leadership, more generally, suggests the importance of clarity, commitment, self-image, pride and behaviour in effective leadership (Jooste, 2004). These components are also important in dignity campaign leadership: there needs to be a clear purpose, time frame and tasks; to take effective action those involved need to be committed to the campaign; participants need to have insight into what they can and can’t do (Jooste refers to this as ‘inner leadership’). There also needs to be an understanding of the cost and rewards of participating; and they need (as many of the evaluation participants had) to reflect on their own style of leadership and ability to role model dignifying practices.

Previous research has indicated that high workload impacts on patients’ dignity (Baillie, 2009; Royal College of Nursing, 2008b) and that staff shortages adversely affect dignity in care (Calnan et al., 2005; Health Advisory Service 2000, 1998; Matiti, 2002). This evaluative study indicated that it was challenging for some interviewees to find time to use the campaign materials with their groups of staff, despite the employing organisations being strongly committed to the campaign at senior level. However, the campaign resources were considered to be highly practical tools that could be used flexibly, and by taking a creative approach most facilitators were able to overcome time constraints in order to deliver the training. It was clear that there was considerable commitment and enthusiasm displayed by the staff leading the campaign, which helped to overcome time constraints and workload pressures encountered.

As a result of working with the campaign materials, staff sometimes identified dignity-promoting developments which required investment in the physical environment and resources. Most interviewees were optimistic that the necessary funding would
be available and some had already been able to instigate changes needed. The physical care environment has an important influence on patients’ dignity (Ariño-Blasco et al., 2005; Baillie 2009; Jacelon, 2003) and previous research has illuminated how inadequate resources can lead to lack of dignity in care (Enes, 2003; Health Advisory Service 2000, 1998; Royal College of Nursing, 2008b; Seedhouse and Gallagher, 2002). It is therefore important that staff wishing to enhance dignity for patients feel supported when they identify changes which have resource implications. Some Royal College of Nursing (2008b) survey respondents expressed considerable frustration about how care environment and resource issues impacted on their ability to deliver dignity in care.

Previous research has highlighted that staff attitudes impact on patients’ dignity (Walsh and Kowanko, 2002). The evaluation indicated that staff attitudes also affected openness to education about dignity in care, which is a crucial factor as without attitudinal change in practice are unlikely. However, this study’s findings were encouraging in that it appeared that the educational resources provided in this campaign were successful in triggering staff to critically reflect on their own practice and recognise improvements that were necessary. Further research would be needed to identify whether such insights led to sustained attitudinal change and impacted on actual care delivery on a long-term basis. McPhail (1997) remarks that change within the NHS is often met with resistance and is thus difficult to achieve. It must also be recognised that staff attitudes are likely to be affected by the culture within which they work. Previous research has indicated that a task-orientated culture can diminish dignity in care (Calnan et al., 2005) while some wards have a culture of respect for patients, which was strongly influenced by the ward manager’s leadership (Baillie, 2009; Health Advisory Service 2000, 1998). Furthermore, complacency and established work patterns can commonly hinder change but can be overcome through education, time, reinforcement and involving staff (Wright, 1998).

Key points

- Although the concept ‘dignity’ is contested there is a large body of empirical work which suggests how it might be respected or diminished in healthcare practice – the RCN Dignity campaign products were based on this evidence.
- The qualitative evaluation of the RCN Dignity campaign, which aimed to make a positive difference to practice, suggests that the campaign was supported and advanced by receptive and creative practitioners, supportive organisations and innovative teaching materials.
- The evaluation suggests that other demands on time and staff attitudes and behaviours may compromise the success of the dignity campaign.
- It is not claimed that the evaluation results are generalisable but rather that they suggest a commitment to taking the ‘small things’ seriously to promote dignity in care and that the success of the campaign relies on its being extended to other professionals and workers. Dignity is everybody’s business.
- It is also not claimed that the Dignity campaign brought about all of the positive changes evident in practice but rather that it complemented and developed other dignity-related initiatives.
Conclusion

Dignity in care is of central importance to nursing as a profession. The RCN Dignity campaign was launched at a time when there were continuing concerns about the dignity of patients and clients undergoing healthcare in the UK. The evaluation aimed to elicit responses from sites which were early campaign adopters; it is perhaps inevitable that these were organisations which had already started developing dignity-enhancing practices. However, the early messages from these sites about how a dignity campaign can be enabled and the challenges that nurses might encounter are likely to be applicable to other organisations which are aiming to develop practice to enhance dignity. The evaluation’s findings therefore provide insights for other organisations planning similar initiatives. The strategy of identifying local leaders to take the dignity campaign forward with groups of staff seemed to be an effective approach which encouraged local ownership and flexibility, thus helping to overcome constraints of time and workload. An interprofessional approach to dignity in care developments should be welcomed; and the evaluation indicated that nurses found this beneficial. Organisations wishing to take a dignity campaign forward need to support staff from a practical and material perspective; it is possibly more likely that staff will in turn be willing to invest their time and energies into the campaign despite over-pressing priorities. Finally, attitudes of staff are a key factor in developing dignity in care; the educational resource developed for this campaign appeared to stimulate self-reflection but needed to be combined with skilled facilitation by practitioners using the tool. In conclusion, there are early indications that the RCN Dignity campaign was well received and was already leading to practice developments. Further research would be necessary to consider the more long-term impacts of the campaign.

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References

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