Geriatric Nursing 35 (2014) 55–60

Contents lists available at ScienceDirect

Geriatric Nursing

journal homepage: www.gnjournal.com

Feature Article

Maintaining dignity for residents of care homes: A qualitative study of the views of care home staff, community nurses, residents and their families

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ARTICLE INFO

Article history:
Received 14 May 2013
Received in revised form
9 October 2013
Accepted 14 October 2013
Available online 15 November 2013

Keywords:
Dignity
Nursing home
Qualitative

ABSTRACT

This study uses the Framework approach to qualitative analysis to explore and compare the views of residents in care homes for older people, their families and care providers on maintaining dignity. We interviewed 33 care home managers, 29 care assistants, 18 care home nurses, 10 community nurses, 16 residents and 15 members of residents' families. The most prevalent themes were: "independence," and "privacy"; followed by "comfort and care," "individuality," "respect," "communication," "physical appearance" and "being seen as human." Residents and their families sometimes described incidents where a resident's dignity had been compromised. How to help residents maintain dignity and focusing on fostering dignity, can be a starting point for improving the quality of care and quality of life of residents. It is, however, important to remove the gap between the rhetoric of dignity conserving care and the reality experienced by residents in these and other care settings.

In the UK, and in many other countries, older people are increasingly cared for in long-term care facilities such as care homes. These are collective institutional settings where care is provided for older people who live there, 24 hours a day, seven days a week, for an undefined period of time. The care provided includes on site provision of personal assistance with activities of daily living. Nursing and medical care may be provided by on-site nurses employed by the home (in nursing homes) and medical professionals working from an organization external to the setting.[1] Residents are often heavily reliant on staff for their care, which can erode their sense of dignity. Loss of dignity remains a major issue in the lives of older people in many countries.[2] Although dignity is an important aspect of quality of life for residents,[3] and a strong predictor of residents' satisfaction with their care,[4] concerns have been raised about loss of dignity in care settings.[5] Several qualitative studies have explored the construct of dignity from the perspective of care home residents,[6–8] however, there has been no comparison between the views of residents and those who provide their care in this setting.

Respect, including both respect from others and for oneself[9–11] and maintaining independence[12] are important for maintaining dignity in older people. A previous study exploring dignity in hospital settings found privacy and communication to also be important.[13] Additionally, qualitative studies have explored the views on dignity of older people in care homes. A German study showed that not being a burden was important to residents, and that their sense of dignity was threatened by illness and care needs.[7] A Swedish study described three main themes: the unrecognizable body (loss of function and control); fragility and dependency; and inner strength and a sense of coherence.[6] A study conducted in the UK[8] found support for three broad themes in Chochinov's dignity model[14]: illness-related concerns (level of independence and symptom distress); dignity conserving repertoire (perspectives and practices); and social aspects of the illness experience (social concerns or relationship dynamics which can erode or bolster a person's sense of dignity). Although these studies give some insight into aspects of care that residents feel could help them maintain dignity, the views of health care providers are of vital importance to understand which aspects of the care residents receive are likely to impact on their sense of dignity, since loss of dignity remains a major issue in the lives of older people in many European countries,[2] and concerns have been raised about loss of dignity in care settings.[5] The aim of this study is to explore and compare the views of care providers, residents and their families on dignity and how to maintain it.

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http://dx.doi.org/10.1016/j.gerinurse.2013.10.012

Methods

Study design

We used qualitative descriptive methods[15] to enable us to explore participants' views in depth.

Ethical approval

The study was approved by the Kings College Hospital Research Ethics Committee (REC Ref: 07/H0808/136; 07/Q0703/89) and met local research governance requirements.

Sampling and recruitment

Our sample was 34/38 of the care homes for older people in two areas of London UK (two homes were closing down, and two homes were too busy to take part). In each home we planned to recruit: the manager ($n = 34$), a care assistant ($n = 34$), a nurse in homes employing an on-site nurse ($n = 18$), community nurses who visited the care homes not providing on-site nursing ($n = 10$), care home residents ($n = 20$), and a family member who had regular contact with the resident ($n = 25$). We aimed to recruit five family members to represent residents with dementia who could not be interviewed. Care home managers are in day-to-day charge of the regulated services provided at the care home, nurses provide medical care and care assistants provide personal care under the guidance of qualified health care professionals. It was not feasible to ask managers to provide the details of their staff and residents needed for purposeful or maximum variation sampling, therefore, we used a random numbers table to select care assistants and nurses employed by homes from staff lists, and community nurses (from the centers where they worked). We recruited a convenience sample of residents and their families from eight care homes willing to help us with this aspect of the study. These homes varied on the following criteria: size, whether or not they were registered for nursing, and whether or not they were taking part in a national quality assurance program (Gold Standards Framework for Care Homes). We invited all residents whom managers felt were willing and able to take part, along with a close family member (if they had one).

Interviews

We conducted semi-structured interviews with participants in the home or facility based settings, depending on their work or living situation. Before commencing any interview, the interviewer checked participant's understanding of the study, answered any questions and obtained written informed consent. All participants were first asked "What does the word dignity mean to you?" followed by the following prompts: "What do you think supports a resident's sense of dignity?"; "What do you think undermines a resident's sense of dignity?"; and "What can you do to support a resident's sense of dignity?" Most interviews were audio-recorded and transcribed verbatim, however, four managers, two care assistants, and one community nurse preferred not to be recorded. In these cases the interviewer took detailed notes during the interview, which were sent to the participant for validation. Demographic characteristics of participants (gender, ethnicity and age) were collected for each participant from care home staff. All participants were compensated with a £20 gift voucher for their time.

Analysis

Our analysis was based on the Framework approach to qualitative analysis.[16] This comprehensive, dynamic, flexible approach to qualitative analysis can be used for studies which are more descriptive than interpretative, and is particularly suitable for comparing different groups. Both authors read the interview transcripts to familiarize themselves with the data and to identify recurrent themes. They compared and discussed themes, re-reading transcripts until they reached agreement. The themes were developed into a thematic framework, which included examples of text from the six participant groups. The transcripts were indexed (coded), using theme names and participant group. Sections of text relating to more than one theme were coded under each theme. The data were recorded in a chart so that the themes in each group could be counted and compared, and the range of responses within each theme described. The chart contained summaries of the indexed text. The data was analyzed independently and systematically by two authors and any discrepancies were resolved by discussion. Since we were interested in preserving participants' descriptions, we stayed close to the text, rather than transforming them into a more abstract interpretation of meanings, therefore, our analysis was more descriptive than interpretative.[15] We present the number of participants endorsing each theme to enable us to compare the views of the different groups in our study (Table 2).

Results

Response rates and demographics

Response rates were: 33/33 for managers (one managed two homes); 29/50 for care assistants; 18/28 for nurses employed by the homes; 10/20 for community nurses; 16/41 for residents; and 15/46 for residents' family members (eight representing residents with dementia). Denominators are the number of people invited to take part. Recruitment depended on help from busy care home managers and was slower than expected, consequently, we were unable to recruit care assistants in five of the homes, or the planned

Table 1
Characteristics of participants.

	Managers, $n = 33$	Care assistants, $n = 29$	Care home nurses, $n = 18$	Residents' family, $n = 15$	Residents, $n = 16$	Community nurses, $n = 10$
Sex (frequency)						
Female	27	27	17	12	11	9
Male	6	2	1	3	5	1
Ethnicity (frequency)						
White	10	6	4	12	15	1
Mixed	0	1	0	1	0	0
Asian/Asian British	1	1	3	0	0	3
Black/African/ Caribbean/Black British	17	20	10	2	1	5
Not given	5	1	1	4	0	1
Age (median (range))	56.0 (35–68)	41.0 (23–63)	47.0 (31–66)	60.0 (47–78)	80.5(56–93)	47.0 (34–59)