

Original Article

Realising dignity in care home practice: an action research project

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ABSTRACT

Background: More than 400,000 older people reside in over 18,000 care homes in England. A recent social care survey found up to 50% of older people in care homes felt their dignity was undermined. Upholding the dignity of older people in care homes has implications for residents' experiences and the role of registered nurses.

Aims and Objectives: The study aimed to empower registered nurses to provide leadership regarding dignity in care homes through the development of a dignity toolkit.

Design: Action Research with groups of staff (registered nurses and non-registered care-givers) and groups of residents and relatives in 4 care homes in the south of England to contribute to the dignity toolkit development.

Methods: Action research groups were facilitated by 2 researchers to discuss dignity principles and experiences within care homes. These groups reviewed and developed a dignity toolkit over 6 cycles of activity (once a month for 6 months). The registered nurses were individually interviewed before and after the activity.

Results: Hard copy and online versions of a dignity toolkit, with bespoke versions for participating care homes, were developed. Registered nurses and care-givers identified positive impact of making time for discussion about dignity-related issues. Registered nurses identified on-going opportunities for using their toolkit to support all staff.

Conclusions: Nurses and care-givers expressed feelings of empowerment by the process of Action Research. The collaborative development of a dignity toolkit within each care home has the potential to enable ethical leadership by registered nurses that would support and sustain dignity in care homes.

Implications for Practice: Action Research empowers staff to maintain dignity for older people within the care home setting. Providing opportunities for care-givers to be involved in such initiatives may promote their dignity and sense of being valued.

The potential of bottom-up collaborative approaches to promote dignity in care therefore requires further research.

Key words. Dignity, Care homes, Action Research, Older people, Toolkit, Ethics

SUMMARY STATEMENT

What does this research add to existing knowledge in gerontology?

- Action research with registered nurses in residential care homes contributes to their empowerment in dignity promotion activities.
- The development of dignity toolkits through a process that enables time and space for dignity-related discussion among staff, residents and relatives provides opportunity for improvements in dignified care provision in residential settings.

What are the implications of this new knowledge for nursing care with older people?

- The study suggests the importance of providing opportunities for all staff within care homes to engage in research with a view to maintaining and improving nursing care and leadership of care are required.
- Enabling collaborative research that encourages discussion between and within staff and resident/relative groups can maximise a sense of dignity among all participants that promotes an environment for dignifying care.

How could the findings be used to influence policy or practice or research or education?

- Findings suggest the value of care home managers recognising the importance of making time and space for dignity-related discussions within residential care settings.
- The collaborative development of toolkits with the potential to promote ethical practice requires further exploration, particularly regarding collaborators' sense of being valued for their participation and the potential for empowerment to change practice.

Introduction

In the face of concerns raised about the quality of care, dignity has emerged as a key concept that underpins good care. Previous research on dignity in care homes has highlighted the importance of trusting and respectful relationships (Dwyer et al 2009) and of independence, privacy, comfort and care and 'being seen as human' (Hall et al 2014). Registered nurses can play a key role in providing ethical leadership that promotes and sustains dignity in care homes. However, they require support and resources to do this well. There is still little research regarding the facilitators and tools for developing sustainable and dignifying care within residential care settings. The *Empowering Nurses to Provide Ethical Leadership in Care homes supported by a Dignity Toolkit* (ENACT) project was developed in response to a research call from the Burdett Trust for Nursing (2013). The call related to 'Delivering dignity through empowered leadership'. The ENACT project was designed to build on the experience of registered nurses to provide ethical leadership using action research to develop a dignity toolkit that is appropriate to the context of individual care homes, and over which the staff take ownership and realise the sustainability of dignifying care. This paper reports details of the project toolkit development and project evaluation findings from qualitative interviews with registered nurses.

Background

The concept of dignity has received a good deal of attention from practitioners, researchers, philosophers and theologians in recent years (Naden et al 2013, Chochinov 2012, Matiti and Baillie 2011, Kateb 2011). Much international attention has focused on dignity within the care of older people specifically (Franklin et al 2006, Gallagher et al 2008, Nordenfelt 2009, Naden et al 2013, Tranvåg et al 2015, Lohne et al 2016). The *Delivering Dignity* report estimated that 17% per cent of the UK population were aged 65 and over (10.3 million people), with 1.4 million of them aged 85 and over and that in England, more than 400,000 people aged over 65 are living in over 18,000 care homes (Commission on Dignity in Care, 2012). This report also emphasised the important role of care homes in taking responsibility for safeguarding vulnerable older adults and providing dignified care. Despite this, a recent survey by Ross (2013) found that up to 50% of older people in care homes feared abuse and many felt their dignity was undermined. *In Defence of Dignity* from The Northern Ireland Human Rights Commission (2012) provided further detail on specific areas that render older people in care homes vulnerable to indignity; specifically in relation to their personal care, eating and drinking, medication and restraint. There have been too many reports of neglect and abuse in care homes (BBC 2014a, 2014b).

Dignity remains a contested concept in bioethics (Macklin 2003; Pinker 2008) while research into the ethics of care has provided a good understanding of the meaning and importance of dignity for older people (Franklin et al 2006). Research has found that what is important to older people is the preservation of self-identity and confirmation of their value as persons, regardless of their capability (Stabell & Naden 2006). Other research highlights the importance of working in care contexts with a good organisational culture, one that supports nurses and nursing values (Gallagher et al., 2008). There are many definitions and philosophical frameworks relating to dignity (Gallagher 2004; Nordenfelt 2009). Perhaps most helpfully for our purposes

here, the Royal College of Nursing (RCN) *Defending Dignity in Care* report definition (Baillie, Gallagher & Wainwright 2008 p.8) states that:

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.

The RCN definition of dignity continues:

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.

The nursing team should, therefore, treat all people in all settings and of any health status with dignity, and dignified care should continue after death.

The Nursing and Midwifery Council (NMC) responsible for the regulation of the UK nursing profession requires nurses to 'treat people as individuals and uphold their dignity' (NMC 2015). A report commissioned by the Royal College of Nursing found that dignity within care settings may be promoted or diminished by: the physical environment; organisational culture; the attitudes and behaviour of nurses and others; and in the way care activities are carried out (Baillie, Gallagher & Wainwright 2008 p.8). Previous research on dignity in care homes highlighted the importance of care home residents needing to be seen, respected and having their identity maintained (Franklin et al 2006). Findings from a UK qualitative study by Hall et al (2014) reported themes of independence, privacy, comfort and care, communication and 'being seen as human' (Hall 2014).

Whilst dignity has gained traction as a concept through which professionals can improve the quality of the care they provide to patients and other service users, there is a dearth of academic study or other forms of evidence on how best to translate the concept of dignity into practical implications for care delivery. In this sense, 'dignity' as a concept is short of 'real-world' detail. As a report from the Picker Institute states 'It is easier to make pronouncements about dignity than to ensure that dignified care happens' (Magee et al 2009 p.9). It is then uncertain precisely how care practices that are dignifying can be established, fostered, and disseminated within care settings. Professional bodies have sought to close this gap between concept and practice, with the RCN introducing a 'dignity toolkit' and Skills for Care launching a 'dignity guide', both of which are built around core principles and case studies. Again, however, it is not precisely clear how practitioners ought to instigate these principles in practice, and how the case studies (and other aspects of the training materials such as presentations and animations), can be best used to reform the delivery of everyday care in ways that respect dignity to the greatest extent possible. In response to the Francis reports that identified leadership failings in care, the King's Fund (2013) leadership survey found that 'leadership development should give priority to supporting leaders at all levels to be patient-centred [...]' Nurses play a key role in providing ethical leadership that puts service users at the centre of care and safeguards vulnerable adults. There is some evidence that ethics-related toolkits have potential to impact positively on care practice (see Ramage et al 2015).

While some Registered Nurses (RNs) have formal leadership roles, all RNs are expected to take responsibility for influencing dignity in care and as such might be understood to be 'ethical leaders'. Whether or not RNs have formal leadership responsibilities, ethical leadership can be understood to have a number of facets and incorporate different leadership styles (Bjarnson & LaSala 2011). Gallagher and Tschudin (2010) suggest that ethical leadership aspires to promotion of good ends at the same time as paying attention to how those ends are reached. Ethical leadership is also concerned with influencing others to behave ethically, for example, through role modelling (Sama & Shoaf 2007). The concepts of leadership and empowerment are closely related. Influence is itself a form of power (Rao 2012) and leadership requires both formal and informal power (Gallagher 2011). Furthermore, Koukkanen et al. (2002) provide insight within their model of the qualities of an empowered nurse, such as the importance of moral principles and personal integrity. An empowered nurse is someone who acts ethically, in a way that is honest and just, and treats others with respect (Koukkanen, Leino-Kilpi & Katajisto 2002). Finally, just as nurse empowerment is understood in the context of the individual, the organisation and socio-cultural conditions, so too does leadership extend into each of these domains, operating at the micro-, meso- and macro-levels (Baillie, Gallagher & Wainwright 2008).

The ENACT project was developed in order to address two key aims: 1) to ascertain how dignity, as a key concept identified by service users, practitioners and policy makers to underpin good care, should be enacted in a care home environment; and 2) to establish how RNs could utilise a dignity toolkit and reflective process to support ethical leadership to translate dignity into care home practice. Given the lack of evidence about which strategies could be best used to meet these aims, it was judged that a research approach that connected real-world changes with the ongoing evaluation of these changes, would be most appropriate. Thus, the ENACT project adopted an action research methodology to develop a dignity toolkit centred on specific care interventions that were tailored to the context of individual care homes, introduced and disseminated by RNs, and refined and evaluated over the course of the project. This paper reports details of the toolkit development and project evaluation findings from the action research activities and additional qualitative interviews with registered nurses.

The theoretical framework underpinning this project has three components: the recognised contribution of action research to practice development (Dewar and Sharp 2013); dignity scholarship and research (Gallagher 2011); and pedagogic insights regarding ethics education and reflective practice (Hart and Cooper 2015).

Method

Action research is research 'with' participants rather than 'on' them (Williamson, Bellman & Webster 2012) so that changes in practice can be achieved (McLeod 2011). The participants or action researchers in this project are the residential care home staff (RNs and care workers), with contributions from resident and relative participants, and action research support and facilitation from pairs of academic researchers. The action research process is cyclical and consists of planning, action, monitoring and reflection, with on-going evaluation; bringing together action and reflection to find solutions to practical concerns while enabling the flourishing of participants in the process (Williamson, Bellman & Webster 2012). The project was

supported by an expert Advisory Group. The Advisory Group brought different areas of expertise to the project. Primarily the Advisory Group worked with the Research Team to develop and refine the Toolkit. The process was iterative and the Toolkit activities tried out with the Action Research Groups in the care homes and feedback then brought back to the Advisory Group and the Toolkit refined further. **Setting**

The ENACT project recruited volunteers from 4 care homes located in the South of England. The four care homes were approached following recommendations from members of the Advisory Group. Initial contact was made following a favourable ethical opinion of the project from the University Research Ethics Committee and site participation was achieved through direct requests to the care home managers. The 4 care homes that took part varied in terms of size and organisation; one being an independent care home specialising in mental health and dementia care, and three belonging to large national care home companies. Bed numbers in each home varied from 46 to 97.

Sampling and Recruitment

Project researchers recruited volunteer RNs and care workers to an Action Research Group (ARG) within each home, and recruited volunteer residents and relatives to a Residents & Relatives Group (RRG) in each home in order that they could contribute to the toolkit development activities within their home. Potential participants of the ARGs and RRGs were provided with participant information sheets and invited to participate, with time to consider the information and ask questions. All participants provided fully informed consent and principles of ethical research were upheld such as respect for anonymity and confidentiality. Recruitment to the 4 ARGs ranged from 6 to 9 participants, including 1 or 2 RNs in each ARG, with an average of 7 people in attendance at each of the 6 ARG meetings held in each home. Recruitment to the 4 RRGs ranged from 1 to 5 residents plus 1 to 4 relatives in each RRG, with an average of 4 people in attendance at each of the 6 RRG meetings. Dates for the 6 meetings were identified with the ARGs and RRGs at the start of the project to maximise attendance and each ARG and RRG meeting lasted approximately one hour with refreshments provided. Two academic researchers were present to facilitate and support the ARG and RRG activity at each of the monthly meetings.

Data collection

The project engaged with the RNs in particular, encouraging them to be leaders of their ARG with the care-worker participants who were employed in the same care home, creating a toolkit that promoted dignity for their residents. Qualitative data were collected through digital recordings of ARG and RRG discussions at each home and each meeting, and through notes taken by pairs of academic researchers who facilitated the meetings. Further data were collected through individual interviews with 2 RNs at each home (n=8), once at the start of the project and once at the end. Data were also collected through final reflections of the academic researchers who facilitated the ARGs and RRGs. Following an initial RN interview where their views on dignity, their role in promoting dignified care and their confidence in working with colleagues to promote dignity were discussed, the final RN interview enabled exploration of the process of leading the ARG and development of their dignity toolkit. **Figure 1** illustrate the action research process.

Within an action research design, data can be collected and analysed using a range of methods. Interview data were analysed using Braun and Clarke's (2006) approach to thematic analysis as this was appropriate for these data. This is a six-phase process as follows:

1. Familiarising yourself with the data
2. Generating initial codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the report

Results

Findings from the ENACT project evaluation are divided into: the development of the dignity toolkit through action research; and the themes arising from RN interviews.

The Development of the ENACT project Dignity Toolkit

As action research is participatory and the RNs were facilitated to lead the activity, the development and refinement of the toolkit was the focus for the majority of the project. In order to enable a baseline for the initial Action Research Group (ARG) activity in each home, the ENACT project team and an advisory group of experts in the field of care, developed a selection of suggested activities based upon the Skills for Care 7 'common core principles' relating to dignity (Skills for Care 2012). These common core principles were stated in the initial version of the Dignity Toolkit and reduced as the iterative action research process progressed.

The Action Research process involved monthly meetings with ARGs and RRGs to discuss topics from the baseline version of the toolkit. Sections were then amended, added to and refined as the action research process progressed, through the 6 repeating cycles of implementation of activities, evaluation and redevelopment. The RRGs discussed the suggested activities and toolkit information as it was developed and contributed to the 5 sections within the toolkit. The Action Research process within the care homes comprised a topic area relating to each of the 6 sessions as follows.

Session 1 – The focus of this session was on 'understanding dignity' and on participants' views of the meaning of dignity and views of what increases and challenges dignity in care. Regarding 'what dignity means?' members of the ARGs identified: respect, seeing each other as an individual, taking the person as a whole, being discreet, treating as I would like to be treated, setting people up for success, not using patronising language, using your body language to show you care e.g. use of touch and smiling. Members of the RRGs referred to giving time, getting to know the individual, showing human warmth, consider as a family, having fun and a joke and being aware of responses e.g. asking 'what can I do for you?' rather than 'what do you want' and acknowledging residents:

We'll walk down the corridor, it doesn't matter if you see them 65 times that morning, you know, you say 'hello', you acknowledge them as a person, you

know they might choose to walk past you, they might choose to talk to you, and it's little things like letting them come along with you to make a bed, or just follow you and be with you. But you don't ignore them as a person, acknowledge them.

Session 2 – By the time of the second session, a draft toolkit had been prepared with the first section including responses from the Session 1 group discussions demonstrating the value of these contributions. This second session focused on participants' experience and views of 'the potential of a dignity toolkit'. There was a view that a toolkit should be 'direct and simple' and that it should include examples and exercises. Following the session 1 discussion and consultation with the Advisory Group, it was proposed that the 7 principles of dignity from the Skills for Care dignity resource principles that were included in the initial version of the Dignity Toolkit, should be reduced to 4. These are: support and care for me in ways that value who I am; communicate with me so that I am understood and my needs are met; work together to provide care that is safe and respectful of my feelings and to create an environment where I can feel at home; and be prepared to speak up on my behalf and on behalf of others, in order to protect and promote everybody's dignity.

Session 3 – This focused on 'communication and dignity' and participants in the ARGs had the opportunity to try out and give feedback on the 4 exercises in section 3 of the draft toolkit. These were viewed positively although there were different opinions about 'role play' exercises with some saying this could be very effective and others saying they did not like role play. The discussion at the RRGs highlighted the importance of an empathic approach, politeness and of non-verbal communication such as smiling. Members of both the ARGs and the RRGs were invited to share 'top tips for communicating dignity'. Some of these are published in Section 3 of the toolkit and include: refer to resident and relative by preferred name; speak to people with 'one voice' not many people giving instructions; give people time to respond; and give the person your whole, undivided attention when you are talking with them. Here, paying and giving attention to residents and their families was seen as important to dignifying care:

It doesn't matter how far you think the dementia's gone if you actually take the time to get to know somebody. Even if they can't verbally communicate with words, they could just communicate with voices, you can see that they understand because they respond to your voice if you take the time and trouble to know them. And you can see in their eyes when you get to know your resident the different responses and the changes to different things, different stimuli, different questions and things like that

Session 4 – A potential dignity promotion strategy suggested in team and Advisory Group discussions focused on the value of staff members having time and space for 'dignity group conversations' (section 4 of the toolkit). A framework was developed and applied to examples shared by ARG and RRG members. One topic area related to truth-telling. ARG members shared dilemmas relating to truth-telling and dementia care, for example, what should you do when a person experiencing dementia repeatedly asks for her husband who staff know is deceased? In one of the RRGs a relative shared an example of withholding information from a resident who had severe dementia. He had not told his wife of the wedding of their daughter because,

he said, she would say 'can I come?' Such examples were used for reflective discussions.

Session 5 – The penultimate ARG and RRG focused on 'ethical leadership'. This section of the toolkit had not been developed and was drafted after session 5. Group members shared many examples of individual, organisational and external factors that impacted on dignity in care: the importance of role modelling and leading by example; the provision of training and induction; supporting staff and attending to their welfare; and organisational culture that acknowledged dignifying care saying 'well done'. A relative talked of the importance of leaders making the 'atmosphere light and pleasant' and of being 'gentle'.

Session 6 – The final session comprised a summary of previous sessions and an invitation to evaluate the toolkit and the overall action research process. The discussion was generally positive with comments on the value of specific elements of the toolkit, for example. 'I like the family bit and "what can I do for you?"' section. When asked about the development of the toolkit there were some different views with some ARGs favouring a 'durable pocket guide' and others posters ('you can look at it while you are having a cup of tea').

After the final ARG and RRG meetings, the academic researchers transferred the dignity toolkit into the ARG's/RRG's requested format/s (online version, dignity pocket guide and/or poster) specific to each care home, and then provided each care home manager with these versions of their dignity toolkit in a final meeting to thank them for their participation. Any on-going development and utilisation of the dignity toolkit was handed over to each care home with an understanding that it was to be led by RNs and involve contributions from care workers, residents and relatives.

The 'bespoking' of the Toolkit for each home also included adding ARG and RRG responses on their understanding of dignity and dignified care, and included their '10 Top Tips' for communication that promotes dignity within their care home.

The ARGs identified their preferred format for their dignity toolkit and this ranged from a laminated pocket guide to a workbook and poster. All 4 care homes were given access to an online version of their toolkit so that they could own and manage any further developments (See <http://dignitytoolkitsurrey.org/abouttheproject.html>).

Qualitative Data from RN Interviews

Transcriptions of audio data from the individual interviews with RNs at the beginning and end of the project were also analysed for common themes, which were: *Leading dignified care*; and *Ethical leadership and empowerment*.

Leading dignified care describes participants' views on and experiences of leading dignified care. It includes the sub-themes: the leadership role and the practice of leadership. In talking about their leadership role, the RNs acknowledged the responsibility that goes with having a leadership role within their care homes:

[When] I'm in charge of the shift, and if someone phones up sick I need to find staff. I mean there is pressure to be in charge of a shift'

They also described the extent to which they had confidence in their own and others' leadership, with confidence coming from experience and lack of confidence coming from perceived lack of experience:

I think [I'm] very confident. I'm older than obviously a lot, I tend to be the old school nursing – we were talking about that this morning ... you are people-orientated from the word go [CH3RN1]

Trust, and sometimes lack of trust in their staff was also referred to:

I have a fairly small team, but we're all working towards a common goal ... We're lucky to have found them ... I rely on them very much

Finally, having a leadership role was understood in the context of being part of the team, so that while the responsibility of the leadership role was seen as sometimes separating them from other team members, the importance of being prepared to work alongside care staff was also emphasised.

'*Ethical leadership and empowerment*' was a recognised outcome from engagement in the ENACT project. RNs were asked about their experiences of developing a Dignity Toolkit through the Action Research process. One of the positive experiences reported was the opportunity to share experiences. This had led to a broadening and deepening of their understanding of dignity:

...it's all been beneficial because it's good to hear specially within the group discussions other people's thoughts and ideas, which they maybe wouldn't express on the unit or in unit meeting'

At the same time, this opportunity had been experienced as valuable in itself, with RNs appreciating the chance for themselves and their colleagues to be heard and to have their views taken seriously:

For me the positive thing was we could say what we want to say and [the researchers] ... didn't tell us [their] point of view ... we could be really honest without judgement'

RNs were also asked about their understanding of ethical leadership, and their own role as an ethical leader. For some participants, ethical leadership was understood in terms of ethical decision making:

It's about managing things like the mental capacity of people to make sure that you're making those decisions correctly and supporting people in those decisions and that you're doing things for the right reasons

Overall, the participants felt that they were empowered, by virtue of their position and responsibilities, and the support and expectations of their managers. One participant reflected on the relationship between care for the individual resident and the wider context in which that care is provided:

No it was really nice actually, really really nice, this project. And hopefully I think we will see and act with this, because it's so important. I'm terrified sometimes when I see - I don't want to see more problems [on] TV and all of that about nursing homes ... because I've got this kind of passion for elderly (people), and I just want all of them to be happy [...] And if I could change, even if it was a little bit, change [someone's] life and make them feel useful because they are useful, it will make all the difference for me at least and ... even if it's just for one person if I can change the way people, society look to persons in nursing homes, I would be really really happy. And I will use all the resources I've got and this [toolkit], everything what I can use to change that, I will do it for sure

Discussion

The project data suggest that the outcomes of the ENACT project were realised through the design of dignity toolkits specific to the 4 care homes participating in the project. Alongside this, the qualitative data collected provided some insight into the value of dignity promoting initiatives within residential care settings for older people; namely:

- the positive impact of making time and space in care homes for discussion about dignity-related issues for staff, as this is valued highly by staff, residents and relatives,
- that the project process is as important as project outputs, as Action Research enables staff to be listened to and to have one's views considered important was highly valued by participants, and
- the value and potential of using bottom-up collaborative approaches to promote dignity in care homes.

The overall ENACT project evaluation and feedback from the action research group participants suggest that an outcome of engagement in action research was a sense of being valued and having dignity enhanced through involvement. Having a voice and being listened to with respect to activities and experiences that are important to individuals may contribute to empowerment. . For the RNs, this sense of being valued and empowered emphasised their responsibility as leaders of ethical care; an aspiration to promote good quality care (*Gallagher and Tschudin 2010*) and added to the effectiveness of their leadership through enabling them to role model dignity in care during the action research cycles (*Sama & Shoaf 2007*). Project findings suggest that empowerment exerts a positive influence in terms of self-identity, sense of purpose, supportive relationships, finding a voice, and social and self-awareness (*Coser et al., 2014*). Creating a 'partnership' between carers and care recipients is recognised as empowering and beneficial (*Latimer, 2014*), particularly with disempowered groups such as older people and care home residents. Providing opportunity for older people living in care homes and all those staff that provide care for them to contribute to ethical approaches in care and changes to improve ethical practice requires further consideration in terms of residential care environments. Attention to staff dignity in care homes is also worthy of future research attention building on work conducted in the acute sector (*Khademi 2012, Sabatino et al 2012, Sturm & Dellert 2015*).

The ENACT project findings suggest that empowerment through involvement promotes the dignity of the residents, relatives and staff due to an improved sense of personal worth in having their voices heard and their opinions utilised in the development of change (the dignity toolkit). Findings from this study suggest the value of care home management and the RNs leading care to make time and space to listen to staff and to the residents and their relatives, and thereby encourage collaborative working and change that meets the needs of all. If change is seen as a collaborative venture with alignment between needs and developments, the benefits are visible to all involved in determining that change, then the change is much more likely to be adopted and sustained (Grant et al. 2010). Using a 'bottom up' approach to improve ethical practice within care homes provides opportunity for improvements in dignified care provision in residential settings.

Alongside the improved sense of general self-worth, the registered nurses (RNs) involved in the ENACT project developed their understanding of their role in ethical leadership within the care home. Authentic leadership significantly and positively influences nurses' empowerment, which in turn increases job satisfaction (Wong & Laschinger, 2013). The ENACT RNs expressed a sense of achievement from being involved in developing and evaluating the toolkit and its activities with their care workers. Although they had not described their involvement as 'ethical leadership', they were able to articulate that as RNs they had a responsibility to role model 'doing the right thing' in terms of promoting dignity and supporting care workers in providing dignified care to residents. Although some RNs expressed uncertainty in defining 'ethical leadership', a concept that exists at different levels and is recognised as complex (Gallagher & Tschudin 2010), they could clearly identify their responsibilities for leading teams of care workers in ways that promoted respectful and compassionate care.

Empowerment of participants through action research is not a new phenomenon (Jones & Gelling 2013). Despite this empowerment, care home staff are vulnerable to the ethical environment within which they work and commitment from managers to the ENACT project provided support to the RNs and care workers during the duration of the project. However, the on-going environmental support following completion was not assessed. It is also important to consider the ethical leadership potential of RNs beyond that of their immediate care teams and both these areas are ripe for further research.

Finally, the ENACT project aimed to support registered nurses in leading dignified care within residential care homes, through development of a dignity toolkit specific to their care home. This aim was achieved within each of the 4 participating care homes. However, on-going utilisation of the toolkit was not evaluated during the subsequent months following completion of the ENACT project and so its sustainability was not tested. Further research to explore the value of toolkits developed by staff for their work would enhance understanding of the best means to enact change for improved ethical practice. The limitations of the study relate to the limited number of care homes (X 4) involved and the fact that they were in one geographical area.

Conclusions

Dignity is an important factor in ethical care practice and promotion of dignity is a recognised responsibility of registered nurses working in care homes. The project has highlighted the value of making time and space in care homes for dignity discussions between staff and between staff and the residents and/or their relatives. Providing opportunities for discussion of complex concepts such as dignity not only empowers those taking part and adds to their sense of self-worth, it also enables collaboration that in turn can effect change for the better.

A collaborative, action research approach empowers registered nurses to lead on care improvements, and specifically dignity, for older people within care home settings. Action research leads to active engagement of staff, residents and families, enables their voices to be heard and promotes bottom-up changes to improve care. The collaborative development of interventions to improve care, such as the dignity toolkit in this project, appears to promote satisfaction and dignity and a sense of being valued for those involved. The dignity toolkit that was developed collaboratively for this project is freely available and could be used by other care homes.

The fact that there was a good deal of enthusiasm for the project and the toolkit suggests that the dual aims of the project have been met to some extent. However, we do not know whether insights gained will endure over the longer term. Further research is necessary to revisit the research sites to investigate what, if any change, has endured from the perspectives of staff, residents and relatives. There is also a need to use quantitative methodology to measure change resulting from education interventions in care homes. A current project by members of the research team (Gallagher and Cox) is investigating the impact of 3 different ethics education interventions using 4 scales to measure moral sensitivity, empathy, moral stress and ethical leadership. There is also scope to investigate more systematically, and using mixed methods the impact of toolkits on practitioners and care practice.

Overall, the ENACT project provided new insights regarding the importance of empowering care home staff, residents and relatives through their involvement in an action research project. It is important to promote on-going research relationships amongst care home staff, residents, relatives and academics with expertise in ethics research in order to further the understanding of how to improve ethical practice such as dignity in care

No conflict of interest has been declared by the authors.

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FIGURE 1

the ENACT action research process within each of the 4 care homes

