“The little things count”: delivering dignified care

A study focused on the provision of “good” and dignified care, what health professionals perceive this to include and exactly what they need to do to provide it.

Improving the quality of healthcare has been a key policy goal of the last 20 years in the UK. The debate has focused on the technical aspects of care delivery – optimal therapeutic regimens, the delivery of guideline and evidence-based care – with an emphasis on targets as a mechanism for improving standards. Running in parallel with these initiatives has been the revelation of the lack of good-quality care and caring for vulnerable children and adults in a variety of settings, including acute hospital wards (Tadd et al, 2011) and long-term care homes (Manthorpe, 2014).

Such features are not unique to the modern healthcare context but the “failure” of health and social care staff to deliver care that is of good quality in terms of standard, evidence base and effectiveness, and dignified in how it respects the individual, has received considerable attention in the press. This has also been at the heart of several recent public inquiries in the UK – such as Winterbourne View and the Francis inquiry – and generated a stream of national and local policy initiatives, interventions and service developments to promote the delivery of dignified care.

Patients expect to receive individualised, patient-centred care delivered through a caring relationship between staff and patients that considers and incorporates the views of patients and their families (Woolhead et al, 2006; Attree, 2001). Research exploring professionals’ perspectives on dignity in care suggests maintaining dignity plays an important role in care provision (Cairns et al, 2013; Hall and Høy, 2012; Baillie, 2009; Ariño-Blasco et al, 2005). “Caring” has been described as being part of good care (Pearcey, 2010) and as has the delivery of dignified care (Anderberg et al, 2007; Attree, 2001).

Our understanding of health professionals’ thoughts on what constitutes “good” care and dignified care has improved but there is still a lack of research on how they enact this. This study therefore aimed to shed light on what constitutes “good” care from the perspectives of health professionals and how this may be enacted in practice.

Method
Participants were recruited from four NHS trusts, chosen to reflect the different contexts in which older patients experience ward-based care. They comprised:

- One community trust providing long-term care;
- One community trust providing specialist mental health care for older people;
- Two acute trusts providing specialist and acute care for older people.

Examples of good care and poor care
How aspects of care become “invisible”
How to ensure you deliver “good” care

Keywords: Dignified care/Patient experience/Care quality

In this article...

- Examples of good care and poor care
- How aspects of care become “invisible”
- How to ensure you deliver “good” care

5 key points
1 Improving the quality of care is a major focus in UK healthcare policy
2 Good-quality care must also be patient centred
3 Everyday aspects of care can become “invisible” to staff
4 Care must be “visible” to staff to be assessed, and continued or challenged as appropriate
5 Staff paying attention to the “little” things can make a big difference to patients

BOX 1. LITTLE THINGS MAKE A BIG DIFFERENCE

Staff gave examples of seemingly small actions they carried out that made a big difference to patients.

- Giving someone chocolates to cheer them up
- Talking to patients when providing personal care to make sure they felt at ease and comfortable
- Ensuring bath/washing water is at the right temperature and the care home is at a preferred temperature
- Introducing oneself by name when first meeting a patient
Findings
In total, 48 health professionals were interviewed. Forty-five were female and their age ranged from 20-56 (mean age 41) years. Jobs were categorised as a nursing role (n=16), occupational therapy or physiotherapy role (occupational therapists) (n=19), a management role (n=5) or other (n=8).

Two main themes were identified that related to providing dignified, good care:
» The “little things” that matter to both patients and staff;
» Making poor care visible to reflect, challenge and improve care.

The “little” things
Dignified care was revealed through the “little” things in staff–patient interactions (Box 1). Little things that were important to patients included personalised patient-centred care, empathy and attention to their needs and environment. But these seemingly little things often became the “big things” and although participants talked about initiatives trusts implemented to improve dignity in care (red pegs, coloured food trays etc), those things did not feature in stories of dignified care.

Making poor care visible
Some routines were so ingrained in daily work and surroundings they became “invisible” to staff and appeared to contribute to the acceptance of poor care. These included:
» Patients being routinely put in incontinence pads regardless of need;
» Staff talking over the patient;
» Staff carrying out clinical care without explanation.

These were not described as purposeful, poor or undignified care, but “unnoticed” care. Included were poor physical care settings that could lead to undignified care.

One story that was recounted focused on how a nurse consultant tried to raise staff awareness around meal times, as patients did not eat well, ate on their own and often had to wait for help. Meals were also taken in the same environment as personal hygiene tasks, something often mentioned in patient surveys. This issue was often raised in patient feedback and it was unclear why staff were reluctant to implement recent changes that required patients to be taken to a dining room to eat. The nurse consultant decided to film how staff behaved on a general acute ward that mainly admitted older people. The film was shown to ward staff; they were so shocked by the current running of the ward they decided to use the dining room so patients could share their meals at a large table away from their very clinical bed space that was often used for toileting and bathing.

On a more individual level, staff also explained how they made poor care visible to others by confronting ingrained and habituated behaviours in a non-threatening way (Table 1).

These stories highlighted the importance of making poor care visible at the grass roots – that is, where such care is happening rather than in discussions that are removed from the situation, such as senior meetings. Additionally, how such situations were approached was crucial, rather than making the involved colleagues feel challenged or criticised, situations were made visible in a respectful and non-judgmental way, with the aim of changing and improving practice, and educating staff, rather than blaming someone for poor care.

Conclusion
Caring and dignified care are elusive concepts, yet they are both central to good-quality healthcare, particularly in nursing where much of the care undertaken is hands on. Our findings clarify how health professionals can implement such care and highlights the importance of seemingly little things when delivering dignified care – these things not only allow staff to care for patients, but indicate that they care about patients. This also suggests that by providing the little things to patients, caring for and caring about become intrinsically interlinked rather than being two separate aspects of care. In that sense, the little things are the big things and should receive increased focus in nurse education, practice settings and organisational management.

We need to draw on theoretical and philosophical conceptualisations of caring and dignity to understand its theoretical basis and provide transferable definitions of these complex concepts, but it is also crucial that we give health professionals concrete examples of how they can improve their care and deliver dignified care in practice. This research shows that a focus on the little things can help professionals deliver such care and that, by making poor care visible, they can challenge ingrained and task-focused, rather than people-focused, care in a non-threatening way – this can be the catalyst for providing care that is caring and dignified.

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<th><strong>Table 1. Examples of Making Poor Care Visible</strong></th>
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<td>Patient transferred without appropriate clothing</td>
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<td>Patient left exposed during bed baths</td>
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<td>Meals eaten in unsuitable environment</td>
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References

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- Communication and the 6Cs: the patient experience
- Bit.ly/NTCommsPatientExp

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