Exploring nursing students' perspectives on preserving dignity in care: A mixed methods Q-methodology study

Rosemary F. Mullen

August 2018

A Thesis submitted in fulfilment of the requirements of
Edinburgh Napier University for the award of Doctor of Philosophy

Declaration

I declare that this thesis is the result of my own work and has not been submitted for any other academic award.

Rosemary F. Mullen

August 2018

Acknowledgments

I would like to thank the nursing students who participated in the study and gave their time so generously. Their depth of feeling on the importance of dignity in care and the role of nurses in preserving it has left a lasting and positive impression on me.

I am indebted to my Director of Studies, Professor Angela Kydd, and supervisors, Dr Laura McMillan and Dr Anne Fleming, for their indispensable and expert guidance. Without their diligence, patience, kindness and good-humour I would not have completed this thesis. Truly, 'We are ***SO*** Q'!

Thank you to Edinburgh Napier University (2015–2018) and to the University of the West of Scotland (2013–2015) for supporting me as a part-time research student. I am grateful to Professor Lis Neubeck of Edinburgh Napier University for being such a supportive and encouraging Independent Panel Chair. Many thanks also to my friends and colleagues at the University of the West of Scotland who supported me throughout my studies.

For forgiving messages unreturned, plans changed, meals missed, concerts unheard, films unseen and general grumpiness, I thank my family and friends, especially Brian.

I am deeply grateful to my sister Anne for her unstinting and invaluable personal and practical support. This thesis is dedicated to Anne and to my parents, Pat and Eddie.

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List of Publications

Papers

Mullen, R.F., Kydd, A., Fleming, A., & McMillan, L. (2017). Dignity in nursing care: What does it mean to nursing students? *Nursing Ethics, XX*(X), 1-15. doi:10.1177/0969733017720825 (Appendix 11.1)

Conference proceedings

Mullen, R.F., Kydd, A., Fleming, A. and McMillan, L. (2017). *Post-sort Interview in Q-methodology: Exploring nursing student perspectives on the role of the nurse in preserving dignity in care.* [Oral Presentation]. Paper presented at the 33rd Annual Q methodology Conference, Glasgow Caledonian University, Glasgow. (Appendix 11.2)

Mullen, R.F., Kydd, A., Fleming, A. and McMillan, L. (2016). *Student nurses' perceptions of dignity: An innovative use of photo-elicitation within a nominal group technique.* [Oral Presentation]. Paper presented at the 15th Qualitative Research Methods Conference, Glasgow. (Appendix 11.3)

Mullen, R.F., Kydd, A., Fleming, A. and McMillan, L. (2016). *Preserving dignity in care: Exploring nursing students' perceptions using Nominal Group Technique (NGT)* [Oral Presentation]. Paper presented at the Enhancing Nursing Through Educational Research (ENTER) Conference, Edinburgh Napier University, Edinburgh. (Appendix 11.4)

Mullen, R.F., Kydd, A., & McMillan, L. (2015). *Q-sample Development Using Nominal Group Technique* [Oral Presentation]. Paper presented at the 31st International Conference of the Society for the Scientific Study of Subjectivity, Ancona, Italy. (Appendix 11.5)

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Abstract

Background

A complex and contested concept, dignity is recognised as a significant factor in a person's experience of care. Variations in the provision of dignity in care are reported in the literature and in the media. Despite growing interest in the potential of nursing education to enhance dignity in nursing care, relatively little is known about what dignity means to nursing students.

Purpose

The purpose of the study was to explore perspectives on preserving dignity in care among nursing students and addressed the following research questions:

1. What meaning do nursing students attach to the term 'dignity in care'?
2. What are nursing students' perspectives on the personal and environmental influences on the preservation of dignity in care?
3. What are nursing students' perspectives on the nurse's role in preserving dignity in care?

Methods

The study adopted a two-strand mixed methods Q-methodology approach situated within a theoretical framework of pragmatism. Nursing students were recruited from a three-year undergraduate preregistration adult nursing programme in Scotland. A total of 31 nursing students participated in Strand 1 which employed photo-elicitation and Nominal Group Technique (NGT). Qualitative and quantitative content analysis were used to provide insight into perspectives on the meaning of dignity in care and influences on its preservation. A total of 21 nursing students participated in Strand 2 which used Q-methodology to reveal perspectives on the important aspects of the role of the nurse in preserving dignity in care.

Results

The concept of dignity was recognisable and meaningful for the participants. Participants' understanding of dignity in care and influences on it seem to be rooted in the nature of the nurse-patient relationship and interaction. Four distinct perspectives were identified: *Enabler, Caregiver, Companion* and *Defender.* Enabling

the role of the person in their own care was the most important aspect of the role of the nurse in preserving dignity in care for the *Enabler* while for the *Caregiver* it was the delivery of 'good' care. The *Companion* perspective attached the greatest importance to being with the person, while the *Defender* identified being courageous in the face of threats to dignity as most important.

Conclusion

This study provides insight into the under-researched area of nursing students' perspectives on dignity in care. Some consensus among participants was identified in relation to their perspectives on the meaning of dignity in care and the importance of the role of the nurse in preserving it. Four distinct perspectives were also identified, and these illuminated a perception among the participants that the 'good' nurse should be able to overcome context. A perception also existed among the participants that strategies to preserve dignity in care are 'just basic care' that does not require specific education or training. This contrasts strongly with the participants' limited reference to the physical environment of care as an important factor in the nurse's role in preserving dignity in care.

1 Chapter 1: Introduction

1.1 Introduction to Chapter 1

Chapter 1 introduces the background to the research study and provides an overview of the research design. To facilitate an understanding of the research design, a brief introduction to Q-methodology and some of its related terminology is also provided. Moreover, an outline of the structure and content of the thesis is provided to help readers navigate through it. In addition, Chapter 1 gives the rationale for decisions regarding the presentation of the thesis and defines key terms.

1.2 Motivation for the Study

I was motivated to conduct the current study in the first instance by reports of nurses' gross violations of dignity in care, ranging from discourtesy, thoughtlessness and indifference to incompetence, neglect and overt cruelty. These reports acted as a trigger for reflection on what I could do as a nurse and nurse educator in response. Around the same time, and in my role as a lecturer in a large School of Nursing, I became conscious that in practical and written assessments nursing students routinely stated something along the lines of, "I pulled the patient's curtains to protect their dignity". This was so standard a statement in hundreds of assessments that I felt compelled to consider whether this was really what dignity meant to nursing students and, indeed, what my own understanding of dignity was.

1.3 Background

> Good care is care that promotes the dignity of the human person … (Vanlaere and Gastmans, 2011, p. 172)

The Universal Declaration of Human Rights (United Nations General Assembly, 1948) and the subsequent European Convention on Human Rights (Council of Europe, 1950) identify respect for human dignity as the foundation of all human rights. Moreover, dignity is often identified as the basis of national constitutions and legislation (Baillie and Matiti, 2013; Misztal, 2013; Rothhaar, 2010). In relation to health care, the World Health Organisation's (WHO) Declaration of Patients' Rights – commonly referred to as the Amsterdam Declaration – reaffirms the significance of

dignity as the basis for human rights and as an objective for health care (World Health Organisation, 1994). Consequently, it seems reasonable for Baillie and Matiti (2013) to state that dignity is enshrined in patients' rights.

Initiatives designed to promote dignity in care in the United Kingdom (UK) reflect the priority placed upon it (Department of Health, Social Services and Public Health, 2006; NHS Wales, 2015; Scottish Government, 2013; Social Care Institute for Excellence, 2013). Dignity is identified as a key marker of safe and effective nursing care, both nationally and internationally (International Council of Nurses, 2012; Nursing and Midwifery Council, 2015). This priority is also reflected in a wide-ranging 'Dignity Survey' of over two thousand members of the Royal College of Nursing (RCN), which found a "high level of dignity awareness ... and a strong commitment to dignity in care" among those who completed the survey (Royal College of Nursing, 2008, p. 6).

Yet these aspirations for dignified care seem very much at odds with the reality portrayed in a range of reports citing a lack of dignity in care settings in the United Kingdom (Care Quality Commission, 2014; Department of Health, 2013a; Independent Commission on Dignity in Care, 2012; Mental Welfare Commission for Scotland, 2014; Older People's Commissioner for Wales, 2011; Patients' Association, 2011; Scottish Government, 2014).

Importantly, the Commission on Dignity in Care states that nursing students must have dignity "instilled into the way they think and act from their very first day" (Independent Commission on Dignity in Care, 2012, p. 35). This recognition of the importance of preparing future nurses, whose conduct is informed by concern for the dignity of those in their care, makes explicit a significant challenge for preregistration nurse education. Perhaps unsurprising then is the growing interest in the potential of preregistration undergraduate nursing education to enhance dignity in nursing care (Royal College of Nursing, 2012; Tadd and Dieppe, 2005; Vynckier et al., 2015), but realising this potential will not be without its challenges.

At the same time, this raises questions about the very nature of dignity, whether it is something that can be 'instilled' into people and, if so, how that might be achieved. Most particularly, it presupposes that nursing students "need to have dignity instilled" despite relatively little evidence in relation to the nursing students' perspectives on

dignity and its preservation in care. Moreover, it raises questions about the capacity of nursing students to effect change in care settings.

The tension between aspirations for dignified care and the reality of care for some has been identified as a source of stress for care providers in general (Jakobsen and Sørlie, 2010; Manthorpe et al., 2010; Stenbock-Hult and Sarvimäki, 2011). For nursing students, this tension has been associated with ethical dilemmas experienced while on placement (Comrie, 2012; Erdil and Korkmaz, 2009). Comrie (2012) suggests that student nurses who recognise ethical issues in practice may experience stress as a result of a conflict between their knowledge of what they 'should' do and their subsequent actions. Such conflict for nursing students is perhaps most likely in the "impoverished environments" described by Brown et al. (2008, p. 1218); characterised by inadequate care of older people and negative attitudes towards them. McCarthy and Deady (2008, p. 257) strike a more positive note when they assert that this may result in greater awareness and a commitment to "do better next time" when placed in a similarly 'impoverished' environment.

While this may be the case for some, it is far from guaranteed, given the diversity of care settings and the variable resilience of individual nursing students (Jackson et al., 2011; Thomas, Jack and Jinks, 2012). Significant organisational, professional, environmental and personal barriers to the promotion of dignity in nursing care have been identified by nursing students (Macaden et al., 2017; Munoz et al., 2017). Reports of the problems nursing students experience trying to overcome these barriers make difficult reading (Cassidy, 2009; Monrouxe et al., 2015; Monrouxe et al., 2014; Rees, Monrouxe and McDonald, 2015). It would be disingenuous to suggest that preregistration nursing education is the panacea for these problems, but it certainly has an important contribution to make (Rolfe, 2014).

In addition, while many theoretical (Nordenfelt and Edgar, 2005; Wainwright and Gallagher, 2008), organisational (Department of Health, 2013a; Independent Commission on Dignity in Care, 2012), professional (Baillie and Gallagher, 2011; Royal College of Nursing, 2008) and personal perspectives (Lohne et al., 2010; Nåden et al., 2013; Slettebø et al., 2009) on dignity have been described, the perspectives of nursing students have received relatively little specific attention. Understanding what dignity means to nursing students may help enhance learning and prepare future nurses who are more able to both preserve dignity and address situations in which dignity is

at risk of being violated. This has the potential to make a hugely significant difference to dignified care for all. Consequently, the purpose of this study was to explore nursing students' perspectives on dignity in care.

1.4 Chapter Outline

This section outlines the structure of the thesis by identifying the purpose and core content of each chapter. Some general points regarding the structure and presentation of the thesis require clarification at the outset.

First, consideration was given to integrating the methods and results for Strands 1 and 2 into combined 'Methods' and 'Results' chapters; however, they are presented in separate chapters. This decision was made because of the significant differences between each Strand in terms of the nature of the data collected and also in terms of the approaches to data collection and analysis. Separating them seemed to enhance the flow of the thesis and render their contents more readily accessible.

Second, Q-methodology has been described as a methodology in its own right (Ramlo and Newman, 2011; Watts and Stenner, 2012) and consideration was given to discussing it in Chapter 3 (Methodology). The defining characteristics of Q-methodology are, however, its methods of data collection and analysis. Consequently, discussing these in Chapters 6 and 7 as 'Methods' and 'Results' respectively seemed again to enhance the flow of the thesis and communicate the research process more effectively.

Third, to enhance clarity, consistent terms are used throughout the thesis and these are defined in Table 1-1.

Fourth, numbers between one and nine are written in words while numbers 10 and above are written in numerals. Exceptions are made when the number is part of a title – for example, Year 1, not Year One – or part of a heading – for example, Research Question 1, not Research Question One – or where the number is in a table presenting numeric information.

Fifth, a third-person narrative is used throughout, with the exception of Sections 1.2 and 9.2.2 in which the first person is used because these are the personal thoughts of the researcher.

Table 1-1 *Core terminology*

Term	Explanation
Carer	Person who gives care to a family member, partner or friend in need as a result of illness or disability (Lathlean, 2006)
Family	Persons the patient cares for and who care for them
Figure	Images or graphics
Patient	Person receiving care
Table	Numbers, images or text presented in rows and columns
The current study	The research undertaken for this thesis
The researcher	The author of this thesis

1.4.1 Chapter 2: Literature Review

The Literature Review chapter sets the current study in context and identifies the need to explore the perspectives of nursing students on dignity in care by:

- Outlining the search strategy and its results;
- Discussing theoretical perspectives on dignity with a particular focus on the typology of dignity developed by Nordenfelt (2004);
- Critiquing attempts to define dignity in terms of identity, merit or rational capacity, particularly in the context of care;
- Contrasting the use of concept analysis as a means of providing a more holistic understanding of dignity in care;
- Highlighting the role of relationship in preserving dignity in care via a relationship-centred framework developed by Jacobson (2009a); and
- Identifying themes present in the literature as the ambiguous nature of the concept and the personal and contextual influences on dignity in care and the nurse's role in its preservation.

1.4.2 Chapter 3: Methodology

The Methodology chapter provides the rationale for selecting pragmatism as the study's theoretical framework and mixed methods for its research design by:

- Evidencing the decision-making process around the selection of pragmatism as the paradigm in which to situate the research study;
- Discussing the rationale for describing the research study as a mixed methods and Q-methodology study; and
- Explaining the selection of a modified sequential mixed methods design with reference to the typology described by Teddlie and Tashakkori (2009).

1.4.3 Chapter 4: Methods – Strand 1

The Strand 1 Methods chapter explains the principles and practical application of the selected research methods for Strand 1 by:

- Outlining ethical considerations in relation to participants;
- Detailing the process of participant recruitment and resulting participant profile;
- Outlining data management processes;
- Summarising the principles and practical application of photo-elicitation and Nominal Group Technique (NGT) as data collection methods; and
- Discussing the use of qualitative and quantitative content analysis.

1.4.4 Chapter 5: Results – Strand 1

The Strand 1 Results chapter presents the results of Strand 1, including the development of the data collection tool for Strand 2 by:

- Outlining the principles and practical application of qualitative and quantitative content analysis to code and categorise the photo-elicitation and NGT data; and
- Evidencing the generation of the statements from which the data collection tool for Strand 2 was selected.

1.4.5 Chapter 6: Methods – Strand 2

The Strand 2 Methods chapter explains the principles and practical application of the selected research methods for Strand 2 by:

- Detailing the process of participant recruitment and resulting participant profile;
- Evidencing the decision-making process underpinning the selection of the data collection tool for Strand 2;
- Explaining the particular measures taken in Q-methodology to assure the rigour of the research process; and
- Summarising the principles and practical application of data collection in Q-methodology.

1.4.6 Chapter 7: Results – Strand 2

The Strand 2 Results chapter presents the results of Strand 2 by:

- Outlining the principles and practical application of by-person factor analysis to identify shared perspectives; and
- Summarising the participants' shared perspectives.

1.4.7 Chapter 8: Discussion

The Discussion chapter presents the findings in the context of the evidence-base and the study's contribution to knowledge by:

- Discussing the findings in relation to each research question in the context of the literature;
- Identifying the study's contribution to knowledge;
- Summarising strategies to ensure the trustworthiness of the findings; and
- Identifying the strengths and limitations of the study.

1.4.8 Chapter 9: Conclusion and Recommendations

This chapter concludes the thesis and makes recommendations for education, practice and research by:

- Providing an overview of the study and its findings;
- Making recommendations for education and practice;
- Suggesting areas for further research stemming from the study; and
- Providing a brief personal reflection on the study.

1.5 Overview of the Research Design

A modified version of the sequential exploratory mixed methods design described by Teddlie and Tashakkori (2009) was used. This consisted of two strands in which the findings from Strand 1 informed the development of the data collection tool used in Strand 2. The first strand of this study – Strand 1 – focused on research questions 1 and 2, while the second strand – Strand 2 – focused on research question 3. Figure 1-1 summarises the research design, which will be discussed in Chapter 3.

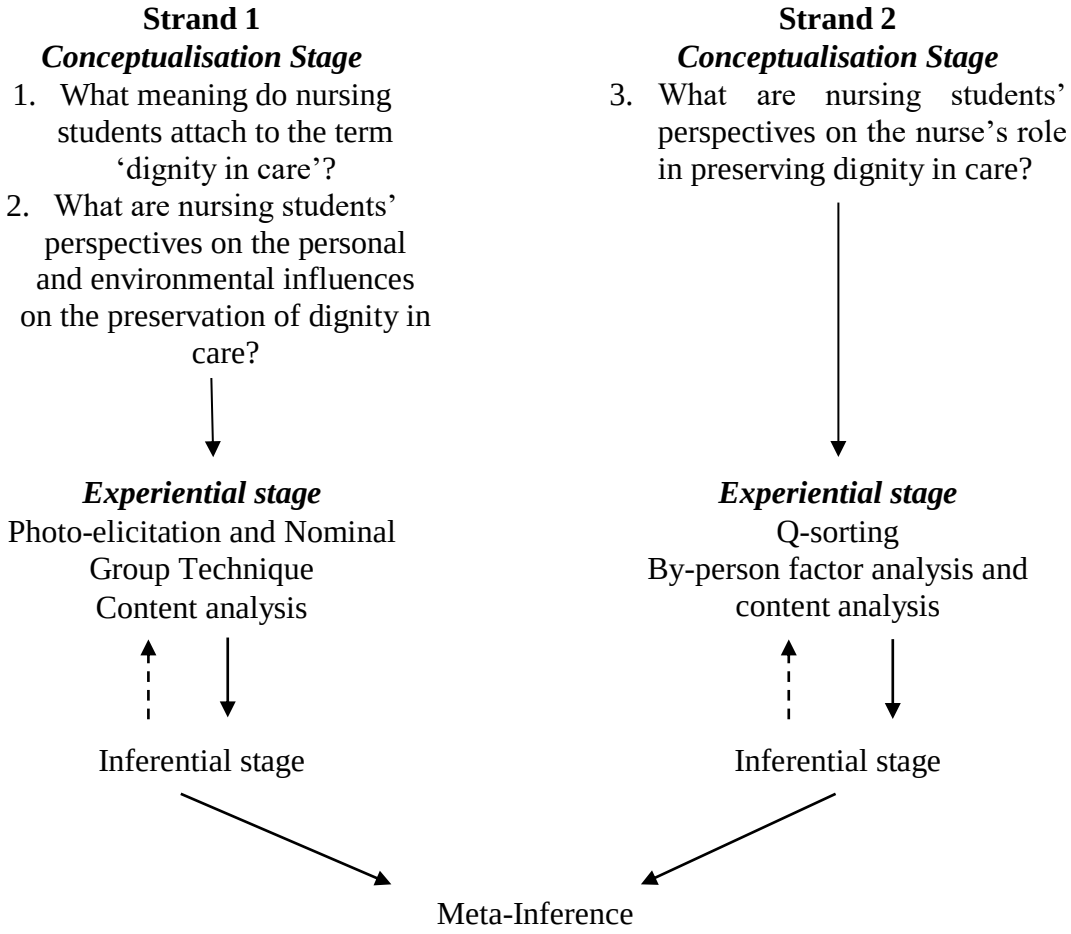


Figure 1-1 *Research design*

1.6 Chapter 1: Conclusion

Chapter 1 has provided the background to the current study and provides an overview of the research design. To facilitate an understanding of the research design, a brief introduction to Q-methodology and some of its related terminology is also provided. Moreover, an outline of the structure and content of the thesis was provided to help readers navigate through it. In addition, Chapter 1 has given the rationale for decisions regarding the presentation of the thesis and defines some key terms. Chapter 2 reviews

the literature to set the current study in its theoretical context and identifies a gap in the evidence-base.

2 Chapter 2: Literature Review

2.1 Chapter 2: Introduction

In a narrative review of the literature, Chapter 2 sets the current study in the context of theory and practice and identifies a gap in the evidence-base pertaining to nursing students' perceptions of dignity in nursing care. The chapter describes how literature was sourced through a combination of personal knowledge, 'snowballing' and protocol-driven search approaches. General strengths and limitations of the review are noted, and more specific detail is provided in Section 2.2.5. Three principal themes are identified:

1. The meaning of dignity is complex and contentious,
2. Dignity in nursing care is influenced by staff behaviour and patient characteristics, hereafter referred to as 'people' influences, and
3. Dignity in nursing care is influenced by local and social context, hereafter referred to as 'place' influences.

The discussion of the meaning of dignity begins with theoretical perspectives and is framed by a typology of dignity described by Nordenfelt (2004). Concept analysis of dignity is examined closely with the intention of bridging the gap between the purely theoretical and the meaning of dignity in nursing care. A framework of dignity in care developed by Jacobson (2009b) is used as a lens through which to view dignity in nursing care and the perspectives of patients, their relatives and healthcare staff. Staff behaviour – communication and dignifying care activities – and patient characteristics – vulnerability and resilience – are considered in relation to the preservation of dignity in care. In contrast, local and social context are considered in relation to the violation of dignity in care; focusing on the physical environment and culture of the care setting and the influence of target-setting and discrimination. The review also identifies some broad recommendations for education, person-centred care and leadership.

Chapter 2 concludes by identifying a lack of evidence in relation to nursing students as a distinct group in terms of what dignity in nursing care means to them and their perspectives of the role of the nurse in preserving dignity in nursing care. This provides the rationale for further research and lays the foundations for the methodological considerations presented in Chapter 3.

2.2 The Literature Search

Major influences on the search strategy for the current study were the research questions, the varying relevance of different types of literature – theoretical, research, practice and policy – for different aspects of the review, and the need for the search strategy to accommodate emerging interests.

A clear focus on the research purpose from the outset and throughout the current study was crucial to both the effectiveness of the literature search and the development of the research questions. Initially, exploring the literature helped the research questions to evolve. As the research questions evolved, so too did the search strategy. Once they were more established, the research questions were used to frame the search strategy more concretely. Returning to the research questions during the search process helped the search strategy remain focused but flexible enough to accommodate the evolving understanding. This flexibility was balanced by being mindful of the research purpose and what was reasonable and practicable within the resources of the current study.

The four broad types of literature described by Wallace and Wray (2016) – theoretical, research, practice and policy – all formed part of the literature review. Overlap exists between each type; for example, research, policy and practice literature refer to theoretical literature. Nevertheless, the relevance of each, and hence the search methods used, varied depending on the focus of individual searches. Theoretical literature is defined by Wallace and Wray (2016) as literature that seeks to explain or understand phenomena by developing theories of how they are or might be. Searching this type of literature was particularly helpful to the discussion of theoretical perspectives on dignity. Similarly, searching the research literature – literature that presents findings from primary studies involving data collection (Wallace and Wray, 2016) – was an important means of informing the discussion of personal and professional perspectives on dignity. Of course, in the context of health care, policy literature – such as reports and standards of care and education (Aveyard, 2014) – was another rich source; most especially in relation to the wider social and political context of the current study. Searching the practice literature – including expert opinion and discussion papers (Aveyard, 2014) – played an important role in clarifying key themes and debates in relation to dignity in nursing care.

Coughlan, Cronin and Ryan (2013) acknowledge that systematic literature reviews are most often conducted by teams of researchers due to the complexity and time-consuming nature of this process. Consequently, a narrative literature review was performed. Narrative and systematic literature reviews are often distinguished by the extent to which they adopt explicit and rigorous approaches to searching, analysing and synthesising the evidence (Aveyard, 2014; Bettany-Saltikov, 2012). Bettany-Saltikov (2012, p.11) notes that narrative literature reviews risk being "haphazard and biased". To counter this risk, the researcher adopted a combination of three methods of literature searching described by Greenhalgh and Peacock (2005): personal knowledge, snowballing and protocol-driven.

2.2.1 Personal knowledge

Personal knowledge is highlighted by Greenhalgh and Peacock (2005) as an important element of an effective search strategy. Certainly, this was the case in the current study. Originally, high profile reports of undignified care in the UK, such as inquiries into care in Mid-Staffordshire NHS Trust (Department of Health, 2010, 2013a) and elsewhere in the UK (Older People's Commissioner for Wales, 2011; Scottish Government, 2014), formed a key role in prompting the current research, but so too did professional networks and personal contacts.

One example is the work of Goffman (Goffman, 1968; Goffman, 1990), which was recommended by the researcher's Director of Studies. Also, via her Director of Studies, the researcher was invited to visit the Faculty of Health Sciences at Oslo and Akershus University College of Applied Sciences in 2015. While there, she met with several key authors in the field of caring sciences, such as Vibeke Lohne (Lohne et al., 2010; Lohne et al., 2016; Lohne et al., 2014) and Anne Heggestad (Heggestad et al., 2015; Heggestad, Nortvedt and Slettebø, 2013; Heggestad, Nortvedt and Slettebø, 2015). This raised the researcher's awareness of these authors' work and the 'Scandinavian Journal of Caring Sciences' so that these became part of her forward-tracking systems via citation and journal alerts.

In addition, Professor Ann Gallagher – Professor of Ethics and Care at the University of Surrey – was visiting the Faculty of Health Sciences in Oslo at the same time. This provided the researcher with a valuable opportunity to discuss the current study with her and this heightened the researcher's understanding of the study's broader ethical

context. Professor Gallagher also raised the researcher's awareness of authors MacIntyre (MacIntyre, 2007, 2009), Gastmans (Gastmans, 2013; Gastmans and De Lepeleire, 2010) and Sulmasy (Sulmasy, 2013) whose works would all go on to play a significant part in the discussion of dignity in nursing care and lead on to other authors via hand-searching reference lists.

Furthermore, the researcher was invited to attend a faculty staff seminar at which Professor Gallagher presented the 'Researching Interventions that Promote Ethics in Social Care' (RIPE) Project (Gallagher and Cox, 2015). This introduced the researcher to care ethics laboratories and, once again, to authors and topics influential in the current study such as Timmermans et al. (2015) and Vanlaere, Coucke and Gastmans (2010). Greenhalgh and Peacock (2005, p. 1064) also highlight the potential value of such "serendipitous discovery" of literature made through a chance contact or while searching for something else. The book 'Why Things Matter to People' (Sayer, 2011) – discovered while browsing in the library – is another good example of this process.

The researcher also had the opportunity to present preliminary findings from the photo-elicitation component of the current study at the same seminar. Feedback from those present was encouraging and the researcher was also encouraged to work towards publication and did so (Mullen et al., 2017a). Feedback from the publication's reviewers motivated the researcher to expand her discussion of the challenges of practice placements reported by nursing students (Levett-Jones and Lathlean, 2009; Monrouxe et al., 2015; Monrouxe et al., 2014; Rees, Monrouxe and McDonald, 2015).

2.2.2 Snowballing

Greenhalgh and Peacock (2005) describe 'snowballing' as a search that develops as a study develops by; for example, following references provided in reference lists, and tracking authors and journals that come to be of interest. This strategy was particularly useful in the current study because the researcher's knowledge of the field developed incrementally during the study and 'snowballing' allowed the search strategy to develop in tandem. Hand-searching references from reference lists helped to identify key authors and key themes.

To illustrate; following-up on references in the reference list of Baillie and Gallagher (2011) – sourced via the protocol-driven search – highlighted the significance of key

authors. For example, the 'Dignity and Older Europeans Project' (European Commission, 2005) highlighted the significance of the author, Win Tadd, who was then searched for in databases, revealing a rich seam of relevant and important work prior to the protocol-driven search. Reports with a specific focus on dignity in care were often sourced via reference lists and included particularly helpful sources, such as the 'Dignity Survey' (Royal College of Nursing, 2008), 'Dignity in Practice' (Tadd et al., 2011), the 'Delivering Dignity' report (Commission on Dignity in Care for Older People, 2012) and the Preventing Abuse and Neglect in the Care of Older Adults (PANICOA) Report (Lupton and Croft-White, 2013). Another illustration of 'snowballing' is provided in the discussion of concept analysis where some of the literature – such as Mairis (1994) and Jacelon et al. (2004) – would have otherwise fallen outside of the date limits of the protocol-driven search.

Similarly, using citation tracking in electronic databases was an efficient means of locating literature that cited work by an author of interest or in a field of interest. Journal alerts from especially relevant journals – such as Nursing Ethics – were also helpful in ensuring the search remained as current and comprehensive as possible. With 'snowballing', care was taken to minimise the risk of following references too far down avenues that were interesting but not entirely relevant.

2.2.3 Protocol-driven

A protocol driven method of literature searching is used when the search strategy is defined at the beginning of a study (Greenhalgh and Peacock, 2005). This systematic approach is recommended by Aveyard (2014) and involves maintaining a clear focus on the research purpose and careful consideration of the type of literature to be included. Identifying electronic databases, search terms and inclusion and exclusion criteria are all important to this approach (Bettany-Saltikov, 2012). This was the search method most commonly employed in the current study to source research literature.

The primary aims of the protocol-driven search were to identify the evidence-base regarding the meaning of dignity and nursing students' perspectives on dignity in care. The research questions were used to identify the keywords that formed the basis of individual searches within electronic databases. Identifying keywords, databases and inclusion and exclusion criteria also helped to ensure the search was effective; that is,

comprehensive, relevant and credible. The University of the West of Scotland (UWS) Library Catalogue, CINAHL Complete, ScienceDirect, SAGE Journals Online, Wiley Online Library and Taylor & Francis Online were the databases used. Other databases – Health Source: Nursing/Academic Edition, MEDLINE, PsycINFO, SocINDEX with Full Text – were searched contemporaneously with CINAHL Complete.

The 'Population Exposure Outcomes' (PEO) framework described by Bettany-Saltikov (2012) was used to help structure the search strategy. This is illustrated in Table 2-1 in relation to searches performed for nursing students' perceptions of dignity in nursing care.

Table 2-1 *Literature Review: PEO Illustration*

Population *Nursing Students*	Exposure *Dignity in Care*	Outcomes *Perceptions*
Nursing students in a pre-registration undergraduate adult nursing programme	Dignity in care in diverse placement settings in relation to ALL adults and place, e.g., older people, persons with dementia or mental health issues, those requiring nursing, residential acute, critical or community care	Perceptions, perspectives, attitudes, experiences, feelings, understandings, meanings, interpretations, views of dignity in care
Not	**No Exclusions**	**Not**
Nursing students in mental health or paediatric programmes, post-registration or post-qualification programmes Healthcare students in a programme of study leading to registration with the Health Professions Council Medical students, social work students, social care students		Perceptions, perspectives, attitudes, experiences, feelings, understandings, meanings, interpretations, views of: • Caring • Compassion • Compassionate care • Respect

Individual searches of the following keywords: 'dignity'; 'dignified care'; 'undignified care'; 'concept'; 'nursing students'; 'perceptions'; and 'meaning' – were used in different combinations. Truncation – such as 'nurs*' and 'digni*' – was used with Boolean operators such as 'and' to help ensure the retrieval of relevant data. Synonyms – such as 'view' and 'perception' for 'perspective' were also used for this purpose. The original inclusion and exclusion criteria are summarised in Table 2-2.

Table 2-2 *Original inclusion and exclusion criteria*

Inclusion Criteria		Rationale
Books	No date limits set for search	Scoping search using 'Dignity' as a keyword in the title retrieved 43 items only so dates limits were unnecessary
Journals:	2005–2015	Relevance to contemporary practice
Unpublished dissertations	No date limits set for search via EThOS	Scoping search using 'Dignity' as a keyword retrieved forty-five items only so dates limits were unnecessary
Specific to dignity and dignity in care		The focus of the review
English language		No resource for translation
Specific to: Adults, nurses and nursing students		Most relevant to participant group and study focus
Theoretical perspectives		To provide evidence of the theoretical underpinnings of the concept of dignity
Primary studies, theoretical papers and literature reviews		To provide findings from original work and avoid over-representation of a single study
Priority given to theoretical perspectives and primary studies with a UK and Ireland focus		Most relevant to the participant group and study focus
Exclusion Criteria		**Rationale**
Not anecdotal or opinion pieces or conference abstracts		Outwith the scope of the resources for the review
Not specific to related concepts such as care, caring, compassion, autonomy or vulnerability		The focus of the review was dignity and dignity in care
Not highly specific to a specialised field of adult nursing care		To help ensure that the focus was on dignity in care rather than on dignity in a highly specific field of practice or patient condition
Not about dignity in relation to developments in genetics e.g. transhumanism		Outwith the scope of this review and of limited relevance to the participant group of nursing students

For journal database searches, the date range from 2005 to 2015 was chosen because a scoping search indicated that sufficient relevant and credible evidence would be retrieved for the scope of the study. It also helped ensure relevance to contemporary nursing education and practice. No date range limit was applied to searches of the UWS Catalogue for books and ETHOS for unpublished dissertations. This was because scoping searches of these databases using 'dignity' as a keyword in the title retrieved relatively low numbers of items which were screened with ease.

More specifically, literature focused primarily on related concepts – such as autonomy, vulnerability and caring – was excluded from the protocol-driven search. The rationale for this was to ensure the analysis focused primarily on dignity and was directed towards core elements of the concept of dignity in care and not on the meaning of related concepts. No geographical limits were set, but only English language abstracts were included, and priority was also given to literature related to the UK because this was the context in which the participants lived and worked. All the original inclusion and exclusion criteria – accompanied by a rationale – are identified in Table 2-2.

One of the exclusion criteria – 'not highly specific to a specialised field of adult nursing care' – requires some further explanation, given the specialised nature of most adult nursing care. Indeed, much of the literature regarding dignity in care concerns dignity in the specialised care of persons with dementia or a diagnosis of cancer. Following reflection, a distinction was drawn between articles that provided an insight into dignity in care which was transferable to other adult care contexts and articles that provided insight into dignity in care which was highly specific to specialised care. For example; the findings of a metasynthesis of ten qualitative articles concerning dignity in dementia care by Tranvåg, Petersen and Nåden (2013) provides insight, among other things, into the prevention and management of dementia-related aggression and violence and the use of restraint. After careful consideration this article was excluded as being too specific to specialised dementia care settings while other articles, also involving the care of persons with dementia, were included. This was because the findings of the included studies were relevant to the care of other vulnerable persons in wider care settings. Similar decisions around transferability were made with regard to articles focused on dignity in multiple sclerosis (Lohne et al., 2010), head injury (Slettebø et al., 2009), heart failure (Bagheri et al., 2012), severe

physical disability associated with neurological disease or injury (Wadensten and Ahlström, 2009) and cancer (Johnston et al., 2015).

Appraisal tools were used primarily to help the researcher adopt a consistent and systematic approach to the appraisal of each article and documentation of the same. No article was included or excluded based on findings from the appraisal process. Each qualitative research article was appraised using the Critical Appraisal Skills Programme (CASP) Qualitative Research Checklist (Critical Appraisal Skills Programme, 2013a). Similarly, the CASP Systematic Review Checklist (Critical Appraisal Skills Programme, 2013b) was used to appraise each of the literature reviews. The researcher decided to use CASP criteria because of their established use in qualitative research appraisal (Hannes, Lockwood and Pearson, 2010) and her existing familiarity with the tools. The three articles reporting survey findings were appraised using the guidance provided by Parahoo (2014).

In summary, the search strategy encompassed all three of the methods described by Greenhalgh and Peacock (2005) and this enabled the search process to be focused and to accommodate newly acquired evidence. Moreover, searching different types of literature helped inform a broader discussion of theoretical, professional and personal perspectives on dignity in nursing care.

2.2.3.1 Findings from the protocol-driven search

Initial database searching resulted in the retrieval of 627 items of which 539 were excluded following review by title and abstract. The remaining 88 were screened by the application of the inclusion and exclusion criteria to leave a final sample of 51 articles, as shown in Figure 2-1. The broad characteristics of each of the 51 articles are summarised in Table 2-5.

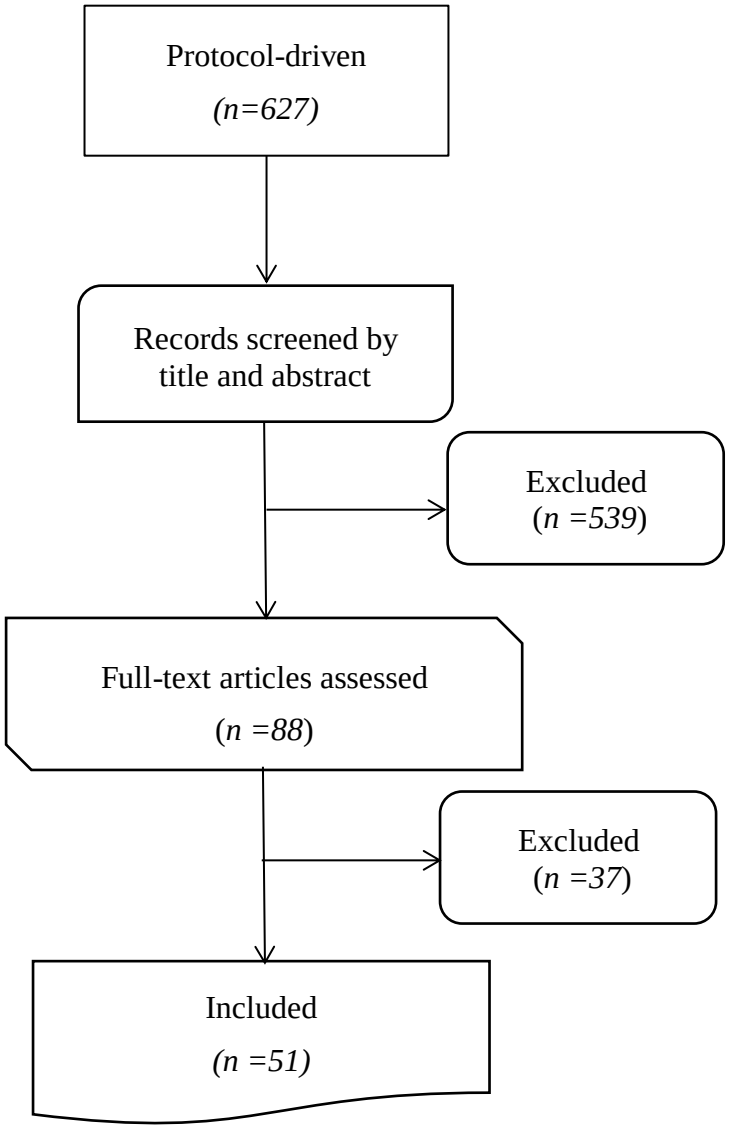


Figure 2-1: *Protocol-driven search*

2.2.4 Characteristics of the literature

The 51 articles retained from the protocol-driven search include eight theoretical papers, three literature reviews – two narrative and one systematic – and three reporting findings from concept analysis studies. Two other articles report findings from secondary analysis of data. Three articles report survey studies combining mainly descriptive statistics with qualitative data (Baillie et al., 2009; Cairns et al., 2013; Kinnear, Victor and Williams, 2015). The remainder describe findings from qualitative research studies. The majority of these are described as hermeneutic, explorative or descriptive in approach, although ethnography, grounded theory and

case study are also represented, as shown in Table 2-3. Each article is outlined in Table 2-5.

Table 2-3 *Articles by methodology*

Methodology	Number of Articles
Hermeneutic Approach	14
Qualitative – Descriptive or Explorative	11
Theoretical Papers	8
Literature Review	3
Concept Analysis	3
Qualitative Case Study	3
Survey	3
Grounded Theory	3
Ethnography	2
Total	51

2.2.4.1 Articles by country and/or region

The countries or regions where studies were conducted are shown in Table 2-4. The methodology category is split along country of origin lines, with all Scandinavian research adopting hermeneutic approaches. Most of the remainder describe the use of qualitative descriptive or explorative approaches. Particularly striking is the prevalence of research into dignity in care originating from Scandinavia and the UK countries of England and Wales. Equally striking is the absence of research from the other UK countries of Scotland and Northern Ireland and the limited volume of research from elsewhere in Europe and from the United States of America (USA).

The intention was always to give preference to primary work with a UK focus and only English language literature was retained. Nevertheless, the articles retained are dominated by Scandinavia and the UK. It is possible to speculate that this reflects relatively localised drivers, such as the high profile of caring science in Scandinavia and its significant influence on research described by Arman et al. (2015). Moreover,

Dougherty et al. (2011) highlight that, in Sweden, the route to achieving a doctorate is by publication, and this may also contribute to the prevalence of published work with a Scandinavian origin. While the public scandal of Mid-Staffordshire NHS Trust in the UK (Department of Health, 2013a) may reasonably be expected to have influenced research in the UK, the current literature review's date limit of 2005–2015 means that most of the literature pre-dates this. Awareness of undignified care had been identified earlier (Department of Health, 2006; Seedhouse and Gallagher, 2002), however. In a review of the research strategy of each country in the UK, Nursing Management (2005) notes the move towards more research focused on the patient experience and older person care.

Table 2-4 *Articles by country and/or region*

Country/Region	Number of Articles
UK	19
Scandinavia (Denmark, Norway, Sweden)	15
Spain, Slovakia, Ireland, Sweden, UK and France [from the 'Dignity and Older Europeans' Project (European Commission, 2005)]	4
Canada	4
Netherlands	3
Taiwan	4
Portugal	1
Republic of Ireland	1
United States of America	1
Total	51

Note: For theoretical papers, literature review and concept analysis, the country of origin reflects the address of the corresponding author.

2.2.5 Strengths and limitations of the literature

Significant features of the literature included in this review is the inclusion of multiple articles from single research projects or studies, the prevalence of qualitative methodologies and ethical considerations. The most notable feature of the research included in this review is the absence of literature specific to nursing students' perceptions of dignity in nursing care. Particular strengths of the literature reviewed is the rich detail provided by thick descriptions of participants' views and the depth of insight provided by the use of case study and ethnographic designs. Limitations relate to the lack of differentiation between staff groups which at times meant it was not possible to distinguish between; for example, nurses, nursing students, healthcare assistants and other healthcare workers. Despite the wide range of settings and countries, none of the literature was specific to the Scottish context.

It is worth noting that nine of the 51 articles report findings from larger commissioned studies. Four articles (Ariño-Blasco, Tadd and Boix-Ferrer, 2005; Bayer, Tadd and Krajcik, 2005; Stratton and Tadd, 2005; Woolhead et al., 2006) report findings drawn from the 'Dignity and Older Europeans Project' (European Commission, 2005). Another three (Cairns et al., 2013; Kinnear, Victor and Williams, 2015; Kinnear, Williams and Victor, 2014) report findings from a research project exploring the gap between policy and practice in relation to the dignified care of older people. A further two (Calnan et al., 2013; Tadd et al., 2012) report findings drawn from the 'Dignity in Practice' (Tadd et al., 2011) project. This project was commissioned and funded by the National Institute for Health Research and adopted by the Department of Health's PANICOA programme (Lupton and Croft-White, 2013).

Arguably, including more than one article reporting findings from a single research project may mean that its findings are over-represented in a literature review (Jackson et al., 2014). In response, however, it could also be argued that multiple articles from large-scale research projects such as these simply reflect the wealth of their findings. According to Jackson et al. (2014), the inclusion of multiple articles from single research projects may be warranted when each article reports on distinctly different aspects of the research problem and cross-references clearly to the other articles in the series. This was the case in the current literature review because of the range of methods, sites and participant groups involved, and so multiple articles were included.

Each of the four articles drawn from the 'Dignity and Older Europeans Project' (European Commission, 2005) has a distinct focus. Ariño-Blasco, Tadd and Boix-Ferrer (2005) focus on the perspectives of health care professionals, while Bayer, Tadd and Krajcik (2005) focus on the perspectives of older people. The focus for Stratton and Tadd (2005) is on the public view of dignity and ageing and the focus for Woolhead et al. (2006) is the impact on dignity of communication. Similarly, while both Cairns et al. (2013) and Kinnear, Victor and Williams (2015) report different aspects of the survey component of the larger research project, Kinnear, Williams and Victor (2014) reports on focus group and interview findings. Conversely, another article drawn from the 'Dignity in Practice' project (Tadd et al., 2011) – Hillman et al. (2013) – was not included in this review because it underlined rather than added to the other articles from the same project.

Other articles were retained because of their significant contribution to the development of the review themes. Three articles (Jacobson, 2009b, 2009a; Jacobson and Silva, 2010) report findings from a single study, but all were retained because each one focuses on a different aspect of the findings, and the framework the articles described proved so valuable in framing the discussion of influences on dignity in nursing care. Similarly, Baillie (2008) and Baillie (2009) report findings from a single case study described in a doctoral thesis (Baillie, 2007). Again, both articles were retained because one focuses exclusively on findings related to mixed-sex accommodation in hospital, while the other provides a much broader overview of the case study's findings. Similarly, other articles derived from single research studies – for example, Blomberg et al. (2015) and Willassen et al. (2015) – were also retained because each makes a distinctly different contribution to the area under investigation. Where articles have been drawn from a single research project this has been indicated in Section 2.2.6.

Most of the articles included in this review report on qualitative studies. In addition to descriptive and explorative approaches, grounded theory, case study and ethnography are all represented in this review. All are situated in the constructivist paradigm, which is characterised by the ontological assumption that reality is multiple and subjective (Nicholls, 2009a); not fixed but dynamic, and mentally constructed (Polit and Beck, 2014). This positioning is supported by Creswell and Plano Clark (2011), who note that these mental constructions of reality derive from an individual's

personal experience and social interactions. In order to understand these multiple and subjective realities, the researcher and those being researched need to be close, not separate (Polit and Beck, 2014). The use of the term 'participant' rather than 'subject' highlights the reciprocal nature of this relationship (Nicholls, 2009b). One of the potential benefits of adopting this stance is the potential to develop a holistic understanding of dignity in care.

The most prevalent methodology is hermeneutic inquiry. Walker (2011) explains that hermeneutic inquiry – also known as interpretive phenomenology – is concerned with meaning and understanding. It is one of the two main variants of phenomenology; the other being descriptive phenomenology (Polit and Beck, 2014). While descriptive phenomenology – developed by Husserl – seeks understanding through the description of the lived experience, interpretive phenomenology seeks understanding through interpretation of that experience (Whitehead, 2004). A crucial difference between descriptive and interpretive phenomenology is the role of the researcher. In the former, the researcher must recognise and remove their pre-existing knowledge and beliefs from the research process – a process known as 'bracketing' – so that they do not contaminate the data (Crist and Tanner, 2004). The researcher in the latter, however, regards such 'bracketing' of pre-existing knowledge and beliefs as unrealistic (Smythe et al., 2008). In a discussion of the lived experience of using the hermeneutic approach, Smythe et al. (2008, p. 1391) capture this in their statement that "As researchers of this methodology we are never outside our research" but present in it. Each of the articles reporting on studies using this methodology refers to the influence of Gadamer, one of Heidegger's students (Austgard, 2012). The hermeneutic approach developed by Gadamer hinges on the researcher being very much present in the situation and engaging in dialogue with text or with others (Austgard, 2012).

Hermeneutic methods are used in 14 articles retained for the current literature review to interpret and understand the lived experience of dignity in care. The trustworthiness of the findings is provided by all the articles in the rich detail they include in the form of participants' own words recorded during individual interviews. Austgard (2012) stresses that such rich detail is included in hermeneutic studies, not merely to enable a reader to enter a participant's world, but as a crucial means of enhancing the trustworthiness of the data. This is achieved by ensuring that the researchers'

interpretations of the text are transparent (Whitehead, 2004). According to Whitehead (2004), this transparency not only enhances the credibility of the findings but also their dependability by helping to clarify the rationale for decisions made regarding interpretation. This is also reflected in the other qualitative studies reported in this review.

Furthermore, Beck (2009) identifies authenticity as a key criterion for trustworthiness and the use of participants' own words in each of the articles enhances this. Similarly, all the articles describe the interpretive process in detail as an iterative process in which researchers worked in teams to interpret the data and reach a shared meaning. Crist and Tanner (2004) note that this team approach adds depth and insight to hermeneutic inquiry. This in turn enhances the confirmability of the findings. Many are specific to the Scandinavian context, but the level of detail provided enhances their potential transferability to the UK context.

While many of the participants are nurses or from a nursing background, several other staff groups are also represented in the literature, including nursing students and healthcare assistants. One of the limitations of the literature is that often findings do not distinguish between different staff groups. For example; the Royal College of Nursing (2008) 'Dignity Survey' of over 2000 nurses, nursing students and healthcare assistants does not differentiate between the different participant groups in its findings, and neither do a range of others, including Ariño-Blasco, Tadd and Boix-Ferrer (2005), Calnan et al. (2013) and Kinnear, Victor and Williams (2015). Restricting the literature search to nurses and nursing students would have excluded much of the literature retrieved. At times, a lack of clarity around recruitment and sampling procedures – for example; in Franklin, Ternestedt and Nordenfelt (2006), Hall and Høy (2012) and Calnan and Tadd (2005) – adds to this issue.

Ethical considerations are also noteworthy. All the articles noted standard ethical considerations, especially around participant informed consent (Øye, Sørensen and Glasdam, 2016; Royal College of Nursing, 2009). This was particularly well-described by Heggestad, Nortvedt and Slettebø (2013) and Heggestad et al. (2015) regarding persons with a diagnosis of dementia. Many of the articles describe violations of dignity and these are highlighted in Table 2-5. A remarkable feature of these studies; however, is the absence of any consideration by authors of their own

response to the ethical, professional and legal aspects of the conduct described. Consider; for example, the comment below from a nursing home resident:

> Needing to go to the toilet at night, one rings the bell and no one comes. Or the health personnel shout that you have to poop in the nappy. I have been shocked … that nights are like nightmares. (Nåden et al., 2013, p. 754)

Consider too the following comment from a nurse who reports:

> I was shocked when a colleague, in a very irritated way, took a patient's soiled clothes and went out. She left the patient naked in front of the other patients who were in the room. (Lindwall and von Post, 2014, p. 342)

Again, the authors make no comment on action considered or taken in relation to the care setting. Instead, they focus on the nurse participants being "forced to see what they did not want to see" and experiencing an "inner value conflict" (Lindwall and von Post, 2014, p. 341). This serves to make the absence of any comment on the authors' response to this or the other examples of violated dignity they describe even more conspicuous.

Houghton et al. (2010) discuss the challenges faced by nurse-researchers and the need to balance the benefits of the research against the obligation to do no harm. They offer a protocol for decision-making around intervening in patient care; advising nurse-researchers to intervene in situations, not only where there is a risk of physical harm but also when there is maltreatment or neglect (Houghton et al., 2010). The omission of any explicit consideration of grounds for intervention in the current literature review is striking. It seems extraordinary that all the articles concerned note the standard ethical considerations around potential harms but fail to mention ethical considerations related to some of the actual harms they report. A protocol is explicitly identified in the 'Dignity in Practice' project and includes grounds for direct intervention or referral to ward managers (Tadd et al., 2011). This offers a valuable template for other researchers gathering data in care settings where similar situations may arise.

In conclusion, much of the literature included in this review reports on qualitative research. The inclusion of multiple articles from single research projects or studies has been carefully considered and reflects the credibility and significant contribution to the development of themes. The prevalence of qualitative methodologies seems

appropriate, given the subjective and personal meanings attached to dignity, and enables participants' voices to be heard because of the rich detail provided. Ethical considerations raise questions around the role of the researcher, especially the nurse-researcher, and are worthy of further consideration. The most notable feature of the research included in this review is the absence of literature specific to nursing students' perceptions of dignity in nursing care. More specific detail regarding the findings, strengths and limitations of the articles included in this review are summarised in Table 2-5.

2.2.6 Summary of the literature

Table 2-5 *Summary of literature retained from protocol-driven search*

Source	Design and Method(s)	Participants/Setting	Findings Summary
1. Anderberg et al. (2007) *A concept analysis of preserving dignity in the care of older people*	Design: Concept analysis using Walker and Avant (2011) Method(s): Literature review	Search strategy described clearly Dates: 1990–2005 300 articles retrieved, 53 retained.	• Clear application of (Walker and Avant, 2011) framework • Uses cases as illustrations of the concept rather than as the evidence for the analysis (Risjord, 2009) • Key defining attributes include respect, empowerment, autonomy and communication – these are then further defined by other ambiguous terms (Paley, 1996)

2. Ariño-Blasco, Tadd and Boix-Ferrer (2005)
 	
Health and social care professionals' views on dignity in care
 	
See also Bayer, Tadd and Krajcik (2005); Stratton and Tadd (2005); Woolhead et al. (2006)
	Design: Qualitative
	
	Method(s): Focus groups and comparative analysis
		Purposive sampling
		
		424 participants range of ages, experience and roles
		
		Healthcare professionals in six European countries
		
		Spain, Slovakia, Ireland, Sweden, UK and France
			• Identifies influences on dignity in care
			  ○ Patient e.g., vulnerability, capacity
			  ○ Staff e.g., communication, identity
			• Recommendations for education and practice
			• Methods and findings clearly described
			• Rich detail, broad European sample and multiple sites
			• Lack of direct comparison between sample groups (wide variations in health and social care delivery in the various countries)
			• Sampling process based on pre-selection criteria unclear in this and in the methodology paper (Calnan and Tadd, 2005)

Source	Design and Method(s)	Participants/Setting	Findings Summary
3. Baillie (2008) *Impact of mixed-sex wards on patient dignity – views of patients and staff* See also Baillie (2009)	Design: Qualitative case study (single case) Method(s): Interview; participant observation; document examination	Purposive sampling Twenty-five patients, thirteen ward nurses and six senior nurses from a single ward District general hospital UK (England)	• Broad consensus between patients and staff that mixed-sex wards impact on dignity in care. • Clear discussion of method and findings • Rich detail provided by participant comments • Multiple methods used to triangulate data • No detail about sampling of senior nurses • Lack of direct comparisons between sample groups
4. Baillie (2009) *Meaning of dignity for patients, staff and senior nurses and views on influencing factors* See also Baillie (2008)	As for Baillie (2008)	As for Baillie (2008)	• Broad agreement between staff and patients about what is meant by dignity (expressed in terms of feelings, physical appearance and behaviour) • Summarised in a definition • Three categories of influences on dignity in care: patient factors, care environment and staff behaviour • Highlights differences between patients, and between patients and staff, and between staff

Source	Design and Method(s)	Participants/Setting	Findings Summary
5. Baillie et al. (2009) *Nurses' and care assistants' experiences of providing dignified care to older people*	Design: Survey (secondary analysis) Method(s): Online questionnaire	Secondary analysis of data from 1110 respondents (self-identified as working with older adults) All Royal College of Nursing members – around 70,000 registered nurses, nursing students and healthcare assistants – 2047 participated (Royal College of Nursing, 2008)	• Broad consensus around dignity and influence of physical environment, organisational issues and dignifying care activities • Diverse sample (including nursing students) • Rich detail • Low response rate • Approach to the analysis of qualitative data not described • Findings not distinguished by participant group i.e., for healthcare assistants, nurses or nursing students
6. Baillie and Gallagher (2011) *Nurses' strategies to respect dignity in care*	Design: Qualitative case study (multiple) Method(s): Semi-structured interview	51 nurses from three NHS hospitals, one NHS mental health hospital and two independent hospitals in the UK Nurses in local leadership roles related to the RCN dignity campaign (Royal College of Nursing, 2008)	• Five themes identified as related to vulnerability to loss of dignity, privacy, communication and relationships, care environment and attentive care even to the 'little things' • Rich detail provided by participant comments and multiple case study approach • Ease of transferability to other UK settings • Clarity of discussion in relation to findings and links with previous primary work • No discussion of what, if any, differences exist between the different hospitals • Approach to the analysis of qualitative data not described • Unclear if all four UK countries represented

Source	Design and Method(s)	Participants/Setting	Findings Summary
7. Baillie and Matiti (2013) *Impact of healthcare workers' discriminatory attitudes and behaviour on dignity in care*	Design: Theoretical paper Method(s): Review article	Not described	• Discriminatory behaviours by staff based on, e.g., age, disability or sexual orientation impact on dignity in care • Logical discussion drawing on a wide range of evidence • Explicit focus on a single factor • Recommendations: Education and person-centred practice • Focus on healthcare workers – no specific insight provided into nursing staff and students
8. Bayer, Tadd and Krajcik (2005) *Older people's views on dignity in care* See also Ariño-Blasco, Tadd and Boix-Ferrer (2005); Stratton and Tadd (2005); Woolhead et al. (2006)	Design: Qualitative Method(s): Focus groups, interviews and comparative analysis	Purposive sampling Older people (aged 60 to 80 years plus) in six European countries: Spain, Slovakia, Ireland, Sweden, UK and France 391 participants – range of age and backgrounds, 25% in residential or nursing homes	• Consensus around meaning and influencing factors • Influencing factors: Respect and recognition; participation and involvement and 3. Dignity in care activities • Highlights communication, privacy, personal identity and feelings of vulnerability • Rich detail • Findings related clearly to typology (Nordenfelt, 2004) • Lack of detail re differences between countries means that it is not possible to identify if any differences existed between sample groups – focus on what is similar
9. Blomberg et al. (2015) *Nurses' perspectives on preserving dignity in perioperative care*	Design: Hermeneutic approach Method(s): Textual analysis of written narratives	Convenience sampling 60 nurses – from Norway and Sweden – undertaking specialist training in Operating Department Nursing (ODN)	• Three themes related to acknowledging the patient, compassion and privacy • Rich detail provided by participant comments • Discussion of consistency with findings of other studies using different methods • Clear and detailed discussion of the hermeneutic approach • Specific to Norwegian/Swedish context and to postgraduate nursing students so less readily transferable to UK context

Source	Design and Method(s)	Participants/Setting	Findings Summary
10. Bridges, Flatley and Meyer (2010) *Older people's and relatives' views on dignity in acute care*	Design: Systematic review and synthesis Method(s): Databases, hand-searching	Search strategy described clearly (qualitative studies) Dates: 1998–2008 42 studies articles retrieved, one systematic review	• Procedural aspects of care less important to than interpersonal relationships with staff, sense of recognition and participation in care • Captures three influencing factors succinctly in descriptors: "Connect with me", "See me", "Include me" (Bridges, Flatley and Meyer, 2010, p. 93) • Clear and detailed search strategy, broad review • Did not explore dignity in acute care settings
11. Cairns et al. (2013) *The meaning of dignified care and its importance for health-care professionals* See also Kinnear, Victor and Williams (2015); Kinnear, Williams and Victor (2014)	Design: Survey Method(s): Questionnaire (print and online version), SPSS and content analysis	Purposive sampling UK (England): Health and social care workers in four English NHS trusts 192 completed questionnaires (31 completed online) Range of experience and roles, majority (57%) of nursing background	• Relational aspects of care ranked as more important than procedural proficiency • Contrasts importance attached by patients to fundamental care provision to findings elsewhere in the literature • Development of questionnaire and its face validity described but lack of clarity around the origins of the dimensions of dignified care ranked by participants • Readily transferable to other UK settings • Diverse sample and multiple sites provide an opportunity to make comparisons • Relatively low response rate (25%) • Any differences between participant groups not discussed

Source	Design and Method(s)	Participants/Setting	Findings Summary
12. Calnan et al. (2013) *Older people's experiences of dignity in acute care settings* See also Tadd et al. (2012)	Design: Ethnography Method(s): Semi-structured interview, non-participant observation and thematic analysis	Purposive sampling Four UK NHS hospitals in England and Wales 1. Patients discharged in previous four weeks. 2. Diverse group of clinical and non-clinical staff from four wards in each of the four hospitals	• Four themes: 1. Environment of care frenetic, confusing; 2. Skills and training focus on specialism; 3. Organisational context of recording, auditing, standardized checklists (reduced engagement and use of professional judgement) 4. Ward culture task-orientated and inconsistent • Methodology clear and data triangulated through multiple methods and sites • Compares patient, relative, staff (ward/managerial) perspectives clearly • Rich detail provided by participants' comments • Links made to political and economic issues • Readily transferable elsewhere in the UK • More comparison between different sample groups would have been worthwhile
13. Clark (2010) *A definition of dignity and a model to promote it in care*	Design: Theoretical paper Method: Not described	Not described	• Definition of dignity developed • Focus on how dignity is defined, its subjective/objective nature and self or other-regarding • Wide-ranging and interesting review • Model well-described with a practical focus on its relevance and application to health care • Search strategy not described

Source	Design and Method(s)	Participants/Setting	Findings Summary
14. Franklin, Ternestedt and Nordenfelt (2006) *Older people's views on dignity at the end of life*	Design: Hermeneutic approach Method(s): Semi-structured interviews, textual analysis	Purposive sampling 12 people aged 85 plus (10 women and two men) Older people in the early palliative phase aged 85 plus living in one of two nursing homes in a single Swedish town	• Three major themes: 1. Physical function; 2. Dependency and 3. Sense of being valued and respected • Communicated participants' stories clearly and sensitively personal and thoughtful participant accounts of • Detailed description of methods • Dependability enhanced by longitudinal study with interviews conducted over eighteen months (three to four interviews per participant). • Diverse sample • Specific to Scandinavian context so reduced transferability to UK context) • Unclear what guided decision-making around recruitment (recruited by nursing staff at the nursing homes)
15. Gallagher et al. (2008) *A narrative literature review exploring dignity in the care of older people*	Design: Narrative review Method(s): Electronic databases, hand-searching, personal/expert knowledge	Search strategy described clearly Dates: 1951–2007 342 studies articles retrieved, 49 retained and some books	• Discusses consensus around dignity as a core nursing value and the lack of consensus around what dignity means • Reviews influencing factors and identifies four themes: Environment of care; staff attitudes and behaviour; culture of care; and specific care activities. • Clear, concise and wide-ranging overview providing recommendations for education and practice • Clear links made between the findings and wider literature • Critique of some major themes in the wider literature such as typologies • Written before the Mid-Staffordshire Inquiry (Department of Health, 2013a) and before developments such as the Independent Commission on Dignity in Care (2012)

Source	Design and Method(s)	Participants/Setting	Findings Summary
16. Griffin-Heslin (2005) *A concept analysis of dignity*	Design: Concept analysis using Walker and Avant (2011) Method(s): Literature review	Not described	• Identifies defining attributes, antecedents, consequences and referents • Steps of model defined and followed in general • Absence of detail regarding search strategy • Cases as illustrations, not the evidence from which the defining attributes are derived (Risjord, 2009) • Identifies qualitative research as a means of determining the presence of dignity but not what would be explored • Key defining attributes include *respect*, *empowerment*, *autonomy* and *communication*. Illustrates Paley's comment that such analysis replaces one ambiguous term with another (Paley, 1996)

Source	Design and Method(s)	Participants/Setting	Findings Summary
17. Hall and Høy (2012) *Dignity and nurses' experiences of caring for older people*	Design: Hermeneutic approach (secondary analysis) Method(s): Textual analysis of interview data	Purposive sampling Nurses and care assistants working with older people in two wards (one described as medical, the other as geriatric) of a single hospital in Denmark 22 registered nurses and seven care assistants – range of ages, all female	• Equates caring with re-establishing dignity and identifies three themes related to: Acknowledging the person, facilitating independence, maintaining personal appearance • Clear and detailed discussion of methods and findings • Participant comments provide rich detail • Secondary analysis provides efficient use of resources and reduces burden on participants in terms of further research studies (Polit and Beck, 2014) but primary study concerned with health promotion, not dignity (or caring) • Authors note potential influence on interpretation of pre-existing familiarity with primary data • Lack of clarity around the rationale for group interviews • No detail around how what criteria guided recruitment • No distinction between registered nurses and care assistants • Based in Denmark so less readily transferable to UK

Source	Design and Method(s)	Participants/Setting	Findings Summary
18. Hall, Dodd and Higginson (2014) *Perspectives of care home residents, relatives and staff on maintaining dignity*	Design: Qualitative descriptive Method(s): Semi-structured interview and text analysis using descriptive methods (framework approach)	Random sampling of staff and convenience sampling of residents and relatives UK (England): Care home staff, residents and family members from 34 out of 38 care homes in two areas of London	• Eight themes: Independence, autonomy, choice and control being the most highly prevalent overall. Also, privacy, comfort, individuality; respect; communication; physical appearance; being human • Comparisons between participant groups (regarding physical appearance, individuality and being seen as human) • Themes defined and clearly explained • Methodological clarity around recruitment and sampling • Multiple sites provide a breadth of insight • High response rate from managers but low response rates from residents and families limits comparisons, other staff also relatively under-represented • Rich detail provided by participant comments
19. Heggestad, Nortvedt and Slettebø (2013) *Older people's experiences of dignity nursing homes* See also Heggestad, Nortvedt and Slettebø (2015)	Design: Hermeneutic approach Method(s): Participant observation, interview and textual analysis	Purposive sampling Eight Nursing Home residents and seven Special Care Unit residents In Norway (Special Care Unit for persons with dementia)	• Sense of the importance of being seen and heard and feelings of being in captivity and being homesick • Methodological clarity • Triangulation of data using interview and observation • Clear description of consent process for a vulnerable group • Rich detail provided by participant comments • Differences between nursing homes sampled makes comparisons more difficult • Based in Norway so less readily transferable to UK context

Source	Design and Method(s)	Participants/Setting	Findings Summary
20. Heggestad et al. (2015) *Experiences of dignity in nursing homes for persons with dementia* See also Nåden et al. (2013); Rehnsfeldt et al. (2014)	Design: Hermeneutic approach Method: Interview and textual analysis	Purposive sampling Residents in a total of six different nursing homes: • Three in Norway • Two in Sweden • One in Denmark A total of 28 residents from the six nursing homes	• Impact of dependency and organisational structures • Some rich detail provided by participant comments • Multiple sites enhance credibility • Relationship between autonomy, dependency and dignity discussed clearly • Not stated how many participated from each nursing home/country • Themes highlighted do not seem to capture the impact of staff behaviour described by residents as humiliating • No discussion of action taken in relation to reports of staff behaviour which humiliated patients
21. Heggestad, Nortvedt and Slettebø (2015) *Relatives' perspectives of dignity in nursing homes for persons with dementia*	Design: Hermeneutic approach Method: Participant observation, interview and text analysis	Purposive sampling Eight residents (Nursing Home), seven patients Special Care Unit for persons with dementia) and seven relatives Norway	• Dignity promoted by person-centred and relational care • Dignity threatened by task-centred care • Rich detail provided by participant comments • Combination of methods to triangulate results • Integration of participant observations with the participants' comments enhance credibility • Lack of detail around how participant observation was conducted • Less readily transferable to a UK context

Source	Design and Method(s)	Participants/Setting	Findings Summary
22. Heijkenskjöld, Ekstedt and Lindwall (2010) *Nurses' perspectives on patients' dignity in medical wards*	Design: Hermeneutic approach Method(s): Critical Incident Analysis and hermeneutic text interpretation	Purposive sampling Registered and enrolled nurses working in a total of three medical wards in three Swedish hospitals Twelve nurses – range of ages, qualifications and experience	• Dignity in care promoted when patients are enabled to speak about their life, participate in their own care and are given time • Dignity in care violated when nurses do not respect patients' choices or acknowledge them as adults and being of worth or value. • Use of critical incident technique enabled participants to reflect on their experience and learning • Methodology and methods described clearly in general but recruitment process unclear • Less readily transferable to UK context.
23. Høy, Wagner and Hall (2007) *Nurses' perspectives on the importance of older people's dignity in care*	Design: Hermeneutic approach Method(s): Focus groups, non-participant observation and text analysis	Purposive sampling Nurses and care assistants working in 'Geriatric' and medical units in Denmark A total of 29 nurses and care assistants in a single hospital in Denmark	• Three themes identified: Dignity of identity; dignity as autonomy and dignity as worthiness • Rich detail provided by participant comments • Detailed examples given in relation to each theme • Clear discussion of findings in relation to wider literature • Combination of methods to triangulate date • Less readily transferable to UK context • No distinctions drawn between registered nurses and care assistants so difficult to draw comparisons

Source	Design and Method(s)	Participants/Setting	Findings Summary
24. Jacobson (2007) *A review of the literature around the meaning of dignity in care*	Design: Theoretical paper Method(s): Not applicable	Not described	• Two types of dignity: Human and Social • Discusses lack of agreement on any definition of dignity • Reviews how the concept is used in philosophical literature, theology, the law, health and social care and bioethics and relevance to human rights • Clear, concise and wide-ranging overview of issues related to dignity in care • Clear links made between the findings and wider literature • Critique of some major themes in the wider literature such as typologies

Source	Design and Method(s)	Participants/Setting	Findings Summary
25. Jacobson (2009b) *A taxonomy of dignity* See also Jacobson (2009a); Jacobson and Silva (2010)	Design: Grounded Theory Method(s): Text in literature and data from semi-structured interviews	Recruited through informal procedures such as flyers and word of mouth in Toronto, Canada Total of 64 participants in three participant groups: Groups 1 and 2 convenience and Group 3 purposive sampling of persons: 1. With addiction or mental health issues and homeless persons 2. Who provide health and social care to the marginalized 3. Working in the field of health and human rights	• Taxonomy of dignity with three elements: Human interaction, setting and wider social order • Compares the conditions in each element that promote or violate dignity • Clear focus on the importance of the attitudes and behaviour of staff to the experience of dignity and the significance of this human interaction • Clear focus also on the importance of the setting in which the interaction occurs and the wider social order • Visual representations of the taxonomy help to clarify it • Some rich detail provided by participant comments • More participant comments would have enhanced the credibility of the findings • Less readily transferable to a UK context and to other care settings and people with other health issues
26. Jacobson (2009a) *Dignity violation in health care* See also Jacobson (2009b); Jacobson and Silva (2010)	As for Jacobson (2009b)	As for Jacobson (2009b)	• Three factors involved in dignity violation: Attitudes and behaviour – e.g., rudeness, condescension, indifference and discrimination; Setting – characterised by inadequate physical environments and excessive workload; and Social order – characterised by discrimination and injustice • Otherwise, as for Jacobson (2009b)

Source	Design and Method(s)	Participants/Setting	Findings Summary
27. Jacobson and Silva (2010) *Dignity promotion in health care* See also Jacobson (2009b, 2009a)	As for Jacobson (2009b)	As for Jacobson (2009b)	• Captures key feature of dignity promotion in term 'Dignity Work' – highlighting that promotion requires deliberate and purposeful action • Equates dignity promotion with beneficent action • Lies somewhere between reporting original findings and secondary analysis • Otherwise as for Jacobson (2009b)
28. Killmister (2010) *Understanding dignity in terms of autonomy*	Design: Theoretical paper Method(s): Not described	Not described	• Response to the "Dignity is a useless concept" debate (Macklin, 2003, p. 1420) • Argues that the concept of dignity can be useful in health care if it is defined in terms of rational capacity because this provides an objective criterion for its presence • Asserts that persons without rational capacity cannot be said to have dignity – that dignity in caring for a person with incapacity is that of the care-giver, not the care-receiver • Challenging and contentious argument logically and clearly presented • Greater exploration of counter-arguments would have provided greater balance

Source	Design and Method(s)	Participants/Setting	Findings Summary
29. Kinnear, Victor and Williams (2015) *Health and social care workers' perspectives on facilitators and barriers to dignified care* See also (Cairns et al., 2013); Kinnear, Williams and Victor (2014)	Design: Survey Methods(s): Questionnaire, descriptive statistics and content analysis	Convenience sampling 650 questionnaires distributed to health and social care professionals working in one of four NHS Trusts in UK (England) 192 returned (of these, 31 completed online) – 25% response rate Range of experience and roles although majority (57%) had nursing background	• Facilitators and barriers at individual (e.g., opportunity for reflection, meeting patient needs), ward (e.g., teamwork, staff attitudes, skill mix) and organisational (e.g., staffing, training and other resources) levels • Use of quantitative methods relatively unusual so potential to offer new insight • Methods clearly described in general enhancing credibility • Some rich detail provided by participant comments and linking these with descriptive statistics helps paint a broad and vivid picture of the findings in a concise way • Low response rate (25%) reduces credibility of findings • No distinction between different participant groups • Abstract refers to thematic analysis, text refers to content analysis

Source	Design and Method(s)	Participants/Setting	Findings Summary
30. Kinnear, Williams and Victor (2014) *Health and social care professionals' perspectives on the meaning of dignity in care* See also Cairns et al. (2013); (Kinnear, Victor and Williams, 2015)	Design: Qualitative descriptive Method(s): Focus groups and interviews	Purposive sampling Health and social care professionals in one of four NHS Trusts in UK (England). 33 participated in one of eight focus groups. 48 participated in interviews Majority female and nurses, broad range of ages with diverse group of other health and social care professionals	• Consensus around the importance of dignity, its complexity and its significance in 'little things' • Rich detail provided by participant comments • Clearly links findings and the literature • Diverse participant group provides an opportunity to explore difference • Transferability within a UK context • Some focus groups were small (less than four participants) • Some staff groups such as social care professionals under-represented • Lack of detail around any differences within such a diverse participant group
31. Lin, Tsai and Chen (2011) *Patients' perspectives on dignity in care*	Design: Qualitative descriptive Method(s): Semi-structured interview and content analysis	Purposive sampling 40 patients in a single Taiwanese teaching hospital. Range of ages, similar education and social backgrounds	• Six themes clearly described: Being respected as a person; avoidance of body exposure; sense of control and autonomy; prompt response to needs; confidentiality of disease information; nurses' caring behaviours • Rich description provided by participant comments • Focus on the patient experience • Links made between findings and existing literature • Methodological clarity and focus on trustworthiness • Less readily transferable to a UK context

Source	Design and Method(s)	Participants/Setting	Findings Summary
32. Lin and Tsai (2011) *Nurses' perspectives on maintaining dignity in care*	Design: Qualitative descriptive Method(s): Semi-structured interview and content analysis	Purposive sampling 30 nurses in a single Taiwanese teaching hospital (different length of experience, similar educational level and age)	• Five themes: Respect, protecting privacy, emotional support, fairness (treating all patients equally) and maintaining body image • Clear and detailed description of method • Specific focus on trustworthiness • Recommendations re education • Expressed findings in a model of dignity in care • Rich detail provided by participant comments • Most participants nurse practitioners rather than ward staff or other designations
33. Lin, Watson and Tsai (2013) *A narrative review of the literature related to dignity in care*	Design: Narrative literature review Method(s): Protocol-driven search of electronic databases.	Search strategy described clearly. Qualitative and quantitative literature written in English Dates: 2000–2010 37 articles retained for review (four review studies, 31 qualitative studies and two quantitative)	• Notes steady increase in the volume and international nature of studies of dignity in care • Notes that qualitative studies comprise the majority and growing interest in the factors influencing dignity in care • Four themes: Physical environment; staff attitude and behaviour; organisational culture; and independence and control • Clarity of method and explanation of the links made between different studies • Two quantitative studies mentioned in the article are not identified or discussed – from reference list these are likely to be the mixed qualitative and quantitative surveys conducted by the Department of Health (Department of Health, 2008) and Royal College of Nursing (Royal College of Nursing, 2008)

Source	Design and Method(s)	Participants/Setting	Findings Summary
34. Lindwall and von Post (2014) *Nurses' perspectives on dignity in care*	Design: Hermeneutic approach Method(s): Textual interpretation of written accounts using critical incident technique	Purposive sampling Total of 11 nurses (roughly equal mix of registered and enrolled nurses) working in medical wards in three hospitals in Sweden – 49 accounts analysed Range of ages and experience	• Dignity preserved when patients 'tell their story' and when nurses get close to the patient and are trusted by them • Dignity violated when nurses behaved rudely, failed to acknowledge patients' existence and humiliate them • Critical incident technique enabled participants to reflect on their experience and learning and methods described clearly • Participants recruited by a senior nurse in one of the wards, no detail, provided as to what guided decision-making • *No discussion of what, if any, action was taken in response to undignified care* • Less readily transferable to UK context
35. (Matiti and Trorey, 2008) *Patients' expectations of dignity in care*	Design: Hermeneutic approach Method(s): Interviews	Convenience sampling of patients from 3 hospitals in a single region of the UK (East Midlands of England) 102 participants (male and female represented equally)	• Six themes: Privacy; confidentiality; communication; control; respect and forms of address • Importance of expectations • Rich detail provided by participants' comments • Notes representation of minority groups limited but reflective of wider population in the area

Source	Design and Method(s)	Participants/Setting	Findings Summary
36. Nåden et al. (2013) *Relatives' perspectives on aspects of indignity for nursing home residents* See also Heggestad et al. (2015); Rehnsfeldt et al. (2014)	Design: Hermeneutic approach Method: Interview text interpretation	Purposive sampling 'Family caregivers' of nursing home residents in a total of six nursing homes • Three in Norway • Two in Sweden • One in Denmark 28 family caregivers (four to six per nursing home)	• Focus on the relatives' views on the factors which deprive persons of dignity in care • A sense of abandonment was the main theme identified • Six sub-themes: Belonging (related to changes to routines, physical environment); confirmation (lack of engagement with residents and indifference); and aspects of life (e.g., loss of activities previously enjoyed by residents such as listening to music); acts of omission (often fundamental care); physical humiliation; and psychological humiliation. • Rich detail provided by participant comments • Multiple sites and clarity regarding method • *No discussion of what, if any, action was taken regarding undignified care reported* • Less readily transferable to UK context • Danish participants relatively underrepresented
37. Nordenfelt and Edgar (2005) *A typology of dignity*	Design: Theoretical paper Method: Not described but developed out of 'Dignity and the Older European' project European Commission (2005)	Not described	• Describes four types of dignity: Dignity of merit (social rank); dignity of moral stature (moral conduct); dignity of identity (integrity of the body and mind); and dignity of Menschenwürde (human or intrinsic) • Provides a useful conceptual model of dignity and relates it clearly to health and social care • The typology ties dignity of identity to health and the attitudes and behaviours of others, neglects the role of the individual in constructing and maintaining their identity (Wainwright and Gallagher, 2008)

Source	Design and Method(s)	Participants/Setting	Findings Summary
38. Nunes, Rego and Nunes (2015) *Impact of economic recession on care and nurses' contribution to dignity in care*	Design: Theoretical paper Method(s): Not described	Not described	• Sets care in an economic context against a background of austerity in Portugal • Notes the burden of austerity on health and social care and access to it • Identifies role for nurses in monitoring and managing impact • Discusses ethical challenges for nurses in delivering dignified care in times of austerity • Rare, specific contribution around dignity and economics • A single European country so some specifics less transferable to a UK setting
39. Oosterveld-Vlug et al. (2014) *Residents' views on the factors influencing dignity in nursing homes* See also van Gennip et al. (2013); Oosterveld-Vlug et al. (2013)	Design: Qualitative descriptive Method(s): Interview and thematic analysis	Purposive sampling 30 residents recently admitted to one of four nursing homes in the Netherlands	• Three internal factors which threaten dignity: Individual self (identity, choice, faith); relational self (dependence and staff behaviour); societal self (excluded from society, ageism, mitigated by feeling part of a community) • Clear and detailed discussion of methods and findings • Rich detail provided by participant comments • Focus on patient factors rather than external factors • Transferability to the UK context • Participants selected with assistance of staff, but no detail provided as to the decision-making process

Source	Design and Method(s)	Participants/Setting	Findings Summary
40. Oosterveld-Vlug et al. (2013)	Design: Longitudinal qualitative study Method(s): Interview and thematic analysis	Purposive sampling 22 nursing home residents of the general medical wards of four nursing homes in the Netherlands	• Notes importance of both nurse and patient to dignity • Five themes help maintain or improve dignity: Coping strategies; familiarity with new environment; physical improvement; social activity; shared experience • Rich detail provided by participants' comments • Medical wards within nursing home suggests a significant difference from the UK arrangements so less readily transferable

Source	Design and Method(s)	Participants/Setting	Findings Summary
41. Rehnsfeldt et al. (2014) *The meaning of dignity for relatives of nursing home residents* See also Heggestad et al. (2015); Nåden et al. (2013)	Design: Hermeneutic approach Method(s): Interview and text analysis.	Purposive sampling 'Family caregivers' of nursing home residents in a total of six nursing homes • Three in Norway • Two in Sweden • One in Denmark 28 family caregivers (four to six per nursing home)	• Suggest that relatives perceive dignity in two ways; "Dignity as at-home-ness" (i.e., that their relative could feel 'at-home', was welcomed to a home that felt warm and safe) and; "Dignity as the little extra" (shaking hands, commenting on a resident's clothing, engaging in conversation) i.e., participants perceived that their relative was "really seen" (Rehnsfeldt et al., 2014, p. 507) • Stresses the importance of ethos and a caring culture within the nursing home • Some rich detail provided by participants' comments (more would have helped illustrate findings more effectively) • Multiple but broadly similar sites • Links drawn between findings and more abstract ideas about ethos and culture • Highlighting how little things may make a significant difference • Language of caring sciences and number of complex concepts introduced briefly in a relatively short article renders the article less accessible than it might have been • Less readily transferable to UK context

Source	Design and Method(s)	Participants/Setting	Findings Summary
42. Shu Lin and Shu Chen (2010) *A concept analysis of promoting dignity in long-term care*	Design: Concept analysis using Walker and Avant (2011) Method(s): Literature review	Databases and keywords identified No dates provided No other inclusion/exclusion criteria	• Four attributes of dignity in care identified as: Respect; individualised care; advocacy; listening • In general, a systematic application of stated approach to concept analysis – identifies defining attributes, antecedents, consequences and referents. • Rationale for 'preserving' logical • Search strategy not described • Illustrates view that this approach to concept analysis provides cases as illustrations, not the evidence from which the defining attributes are derived (Risjord, 2009) • Illustrates Paley's comment that such analysis replaces one ambiguous term with another (Paley, 1996) • A specific focus on long-term care is indicated in the title but not reflected in content

Source	Design and Method(s)	Participants/Setting	Findings Summary
43. Stratton and Tadd (2005) *Views of younger and middle-aged people on dignity, older people and ageing* See also Ariño-Blasco, Tadd and Boix-Ferrer (2005); Bayer, Tadd and Krajcik (2005)	Design: Qualitative explorative Method(s): Focus group and semi-structured interview	Purposive sampling Spain, Slovakia, Ireland, Sweden, UK and France 89 focus groups in six European countries 505 young and middle-aged adults	• Majority hold negative view of ageing, fearful • Criticism of "the state" for levels of care and support in older age (poor opinions and experiences of health and social care) • Notes the role of the family, caring burden on women, moral duty to care for older persons, older persons' role in caring for grandchildren • Increased vulnerability, positive media images, active ageing policies, increase pension • The importance of dignity for all ages but particular significance in older age • Broad European sample • Rich detail provided by participant comments • Distinguishes between different participant groups to allow comparisons • More detail around recruitment and sampling would have been helpful

Source	Design and Method(s)	Participants/Setting	Findings Summary
44. Sulmasy (2013) *Varieties of human dignity*	Design: Theoretical paper Method(s): Not described	Not described	• Adds another category to the usual intrinsic and attributed forms of dignity: *Inflorescent* dignity (the dignity attached to persons who demonstrate the virtues in their lives by consistently seeking human good) • Intrinsic (human) dignity is a prerequisite for attributed and inflorescent dignity • Counters argument that the claim to intrinsic dignity is inherently 'speciesist' and offers the 'natural kinds' theory as a justification • Convincing and systematic argument in support of intrinsic dignity and succinct explanation of 'natural kinds' • Further discussion of inflorescent dignity may have helped clarify this category further

Source	Design and Method(s)	Participants/Setting	Findings Summary
45. Tadd et al. (2012) *Dignified care for older people: Perspectives, behaviours and influencing factors* See also Calnan et al. (2013)	Design: Ethnography Method(s): Semi-structured interview and non-participant observation	Purposive sampling A total of four NHS hospitals in the UK (England and Wales) 16 wards Two sample groups: 1. Patients and relatives, 2. Ward staff and managers	• Risk avoidance and bed occupancy targets mean frequent moves and depersonalisation • Belief that older people not in the right place (despite older people being in the majority) and hospitals not designed for older people • Lack of training/continuing education in the care of older people • Ward ambience – frenetic activity, task-orientation, staff walk quickly, avoid eye contact, random quality of care • Methods and results clearly described • Rich detail provided by participant comments and excerpts from field notes • Wide-ranging discussion of relationship between care and the wider social order of targets • Refers to institutional ageism, individual responsibility, moral agency, marginalisation • Range of perspectives from diverse sample • Specific to England and Wales so transferability to Scotland and Northern Ireland requires some consideration

Source	Design and Method(s)	Participants/Setting	Findings Summary
46. Tranvåg, Petersen and Nåden (2015) *Perspectives of persons with dementia on the qualities of interactions which help preserve dignity in care*	Design: Hermeneutic approach Method(s): Semi-structured interviews and textual analysis	Purposive sample of eleven participants recruited from two Norwegian memory clinics Persons with a diagnosis of mild to moderate dementia, still living in their own homes in Norway	• Describes dignity-preserving interactions with friends and with healthcare practitioners • Qualities of relationships: feeling respected, listened to, taken seriously; kindness; gentleness; being empowered by through information and participation; treated fairly • Methodological clarity and discussion of ethical approach to a vulnerable research group • Rich detail provided by participant comments • Sample included range of ages and backgrounds, balanced male and female participants • Less readily transferable to the UK context • Lack of detail regarding location of clinics (not identified whether within same town or city or region) • Stated that medical staff identified potential participants but no detail about how this done (what guided decision-making)

Source	Design and Method(s)	Participants/Setting	Findings Summary
47. van Gennip et al. (2013) *A model of dignity in the care of the seriously ill* See also Oosterveld-Vlug et al. (2014); Oosterveld-Vlug et al. (2013)	Design: Qualitative descriptive Method(s): Interview and thematic analysis	Purposive sampling 34 patients in the Netherlands with a diagnosis of cancer, early stage dementia or severe chronic illness	• Three internal factors influence dignity: Individual self (shaped by experiences, personal values and beliefs); Relational self (shaped by interactions with others); Societal self (how the person is viewed by others) • Method clear and detailed – conceptual model described in Oosterveld-Vlug et al. (2014). • Detailed description of recruitment and sampling • Consideration of ethical issues involved • Rich detail provided by participant comments • Focus on intrinsic patient factors rather than external factors • Consistency of findings among diverse sample suggests consistent understandings of dignity • Less readily transferable to UK context • Lack of detail about any differences between different groups of persons

Source	Design and Method(s)	Participants/Setting	Findings Summary
48. Wainwright and Gallagher (2008) *A critique of Nordenfelt (2004)*	Design: Theoretical paper Method(s): Not described	Not described	• General theme of the critique is that insufficient attention is paid to some of the typology's ethical and practical challenges • Intrinsic (Human) Dignity: Insufficient attention paid to whether all human life has intrinsic dignity • Dignity of Merit: Unconvincing because it can be acquired by a person who seems worthy of it but whose private conduct is unworthy • Dignity of Moral Stature: Over-arching basis for human dignity rather than a sub-category • Dignity of identity: Overly-dependent on this and leads to conclusion that dignity loss inevitable with age/illness/disability • Clear and systematic examination of the typology relating the typology clearly to complex ethical principles and health care in an accessible way • Suggests that the four types are presented as 'equals' when Nordenfelt and Edgar (2005) makes it clear that they are different forms

Source	Design and Method(s)	Participants/Setting	Findings Summary
49. Webster and Bryan (2009) *Older people's views on dignity and its promotion in hospital care*	Design: Descriptive phenomenology Method(s): Semi-structured interviews, thematic analysis	Purposive sampling of patients in four medical assessment units in a single District General Hospital in UK (England) Ten participants aged 73–83, all unplanned admissions for a range of medical conditions and discharged to home	• Five dignity-promoting factors: Privacy (nurses' kindness and willingness to seek privacy more important than achieving it); Cleanliness; Respect for older age; Independence and control (again, how staff responded at least as important as what was said, hospital environment disabling) and Communication • Rich detail provided by participant comments • Methods, sampling and consent clearly described and interviewing participants at home may also have encouraged disclosure • Specific to England so less readily transferable to other countries in the UK • Observation of interactions may have enhanced the findings
50. Willassen et al. (2015) *Nurses' perspectives on undignified care in the perioperative setting* See also Blomberg et al. (2015)	Design: Hermeneutic approach Method(s): Critical incident technique (written narratives) analysed	Convenience sample of 60 post-registration nursing students from Norway and Sweden attending a training course in Operating Department Nursing (ODN)	• Unprofessional and humiliating actions by healthcare workers violate dignity in care • Rich detail provided by participant comments. Incidents vividly and clearly described • Clarity of method of hermeneutic textual analysis and critical incident technique • Discussion of findings linked clearly to wider literature • *No discussion of what, if any, action was taken to address some of the disturbing incidents described (either at the time or by the researchers subsequently)* • Transferability to UK context may be limited because specific to Norwegian/Swedish context

Source	Design and Method(s)	Participants/Setting	Findings Summary
51. Woolhead et al. (2006) *Dignity and communication with older people in health and social care settings* See also Ariño-Blasco, Tadd and Boix-Ferrer (2005); Bayer, Tadd and Krajcik (2005)	Design: Qualitative explorative Method(s): Focus group and semi-structured interview	Purposive sampling of older people and healthcare staff working with older people in six European countries 391 older people and 424 staff Spain, Slovakia, Ireland, Sweden, UK and France	• Broad consensus among older people and staff about aspects of communication that promote or threaten dignity: Forms of address; courtesy and privacy; listening to and engaging with patients; providing choice and enabling participation • Participants also highlighted barriers such as time, workload, general 'busy-ness' • Rich detail provided by participant comments. Use of multiple methods and multiple sites and multiple countries provides for cross-comparisons and enhances credibility of findings • Differences and similarities within and across countries discussed • Method clearly described enhancing credibility • More detail regarding how participants were recruited would have been helpful (large European study and this is described in Calnan and Tadd (2005)

2.2.7 Main themes of the literature

The main themes of interest identified via the protocol-driven search were that the meaning of dignity remains contentious and that influences on dignity in care may be understood broadly in terms of people and place. All the literature retained from the protocol-driven search contained elements of each theme. Literature was identified as contributing to the theme related to 'meaning' when it provided particular insight into how the meaning of dignity is understood; to 'people' when it provided particular insight into staff behaviour, patient characteristics or both; and to 'place' when it provided particular insight into the local context of care or its broader social context or both.

The most prevalent sub-theme in the literature concerned the impact of staff behaviour on the experience of dignity in care, while the least prevalent theme was the influence of patient characteristics. The relative prevalence of each theme is illustrated in Table 2-6. The contribution of individual articles to these themes is shown in Table 2-7 and reflects the finding that multiple themes were often present in any single article.

Table 2-6 *Number of articles contributing to each theme*

Theme		Number of articles contributing to each theme
1. Meaning		10
2. People	Staff behaviour	22
	Patient characteristics	11
3. Place	Local context	16
	Social context	16

Table 2-7 *Contribution made to themes by individual articles*

Theme	**1. Meaning**	**2. People**		**3. Place**	
Sub-theme	–	Staff Behaviour	Patient Characteristics	Local Setting	Social Context
Anderberg et al. (2007)	✓				
Ariño-Blasco, Tadd and Boix-Ferrer (2005)		✓			✓
Baillie (2008)				✓	
Baillie (2009)		✓	✓		
Baillie et al. (2009)		✓		✓	✓
Baillie and Gallagher (2011)		✓	✓		
Baillie and Matiti (2013)					✓
Bayer, Tadd and Krajcik (2005)					✓
Blomberg et al. (2015)		✓			
Bridges, Flatley and Meyer (2010)		✓	✓		
Cairns et al. (2013)		✓			
Calnan et al. (2013)				✓	✓

Theme	1. Meaning	2. People		3. Place	
Sub-theme	–	Staff Behaviour	Patient Characteristics	Local Setting	Social Context
Clark (2010)	✓				
Franklin, Ternestedt and Nordenfelt (2006)			✓		
Gallagher et al. (2008)	✓				
Griffin-Heslin (2005)	✓				
Hall and Høy (2012)		✓	✓	✓	
Hall, Dodd and Higginson (2014)		✓			
Heggestad et al. (2015)				✓	✓
Heggestad, Nortvedt and Slettebø (2013)				✓	
Heggestad, Nortvedt and Slettebø (2015)		✓		✓	
Heijkenskjöld, Ekstedt and Lindwall (2010)		✓		✓	
Høy, Wagner and Hall (2007)		✓			
Jacobson (2007)	✓				
Jacobson (2009b)		✓			✓

Theme	1. Meaning	2. People		3. Place	
Sub-theme	–	Staff Behaviour	Patient Characteristics	Local Setting	Social Context
Jacobson (2009a)					✓
Jacobson and Silva (2010)					✓
Killmister (2010)	✓				
Kinnear, Williams and Victor (2014)		✓			
Kinnear, Victor and Williams (2015)				✓	✓
Lin and Tsai (2011)		✓			✓
Lin, Tsai and Chen (2011)		✓			
Lin, Watson and Tsai (2013)			✓	✓	
Lindwall and von Post (2014)		✓			
Matiti and Trorey (2008)		✓	✓		
Nåden et al. (2013)				✓	
Nordenfelt and Edgar (2005)	✓				
Nunes, Rego and Nunes (2015)					✓

Theme	1. Meaning	2. People		3. Place	
Sub-theme	–	Staff Behaviour	Patient Characteristics	Local Setting	Social Context
Oosterveld-Vlug et al. (2014)			✓	✓	
Oosterveld-Vlug et al. (2013)			✓		✓
Rehnsfeldt et al. (2014)		✓			
Shu Lin and Shu Chen (2010)	✓				
Stratton and Tadd (2005)					✓
Sulmasy (2013)	✓				
Tadd et al. (2012)		✓		✓	✓
Tranvåg, Petersen and Nåden (2015)			✓		
van Gennip et al. (2013)			✓		
Wainwright and Gallagher (2008)	✓				
Webster and Bryan (2009)		✓		✓	
Willassen et al. (2015)				✓	
Woolhead et al. (2006)		✓		✓	✓

2.3 Theme 1: The Meaning of Dignity

> Dignity is a curious, elusive thing … it matters to all of us and is yearned for by those to whom it is denied … Although difficult to define it is something quite ordinary that we sense particularly when it is threatened. (Sayer, 2011, p. 189)

This description of dignity – as something most noticeable when absent, something special but, at the same time, ordinary – highlights a lack of consensus on what dignity is (Barclay, 2016; Gallagher, 2011b; Seedhouse and Gallagher, 2002). For Macklin (2003, p. 1420), this lack of consensus renders dignity a "hopelessly vague" and "useless concept"; a poor substitute for the more precise concept of autonomy.

Noting that the term has become increasingly popular, Sayer (2011) comments that this may be due, in part, to its vagueness. It is perhaps easier to appeal to a vague concept in statements such as 'I want to die with dignity' or 'At least I kept my dignity', than to something more closely defined such as autonomy (Sayer, 2011). Chapman (2015) asserts that this lack of clarity makes dignity problematic as a basis for human rights such as the right to health care. Schuklenk and Pacholczyk (2010) go further, arguing that it must be possible to do better in health care rather than rely on such a nebulous concept. This theoretical debate has been examined in the context of a typology of dignity described by Nordenfelt (2004) and insights gained from concept analysis.

2.3.1 Dignity as a typology

The typology described by Nordenfelt (2004) helps frame the discussion of theoretical perspectives on dignity. Developing out of the 'Dignity and Older Europeans Project' (European Commission, 2005), this typology is widely cited in the literature (Tadd, Vanlaere and Gastmans, 2010). Four distinct types of dignity are described and shown in Table 2-8: human dignity; dignity of merit; dignity of moral stature; and dignity of identity.

Human dignity – also known as intrinsic dignity – is often placed in a category of its own while the remaining three seem to belong in the category described variously in terms such as extrinsic or contingent (Gallagher, 2004) and social (Jacobson, 2007). In a discussion of the theoretical basis of dignity, Gallagher (2004, p. 588) notes that

human dignity has been described as "objective" and the other types as "subjective" because the latter rely on a person's feelings of self-respect and perceptions of the respect accorded to them by others. This "self-regarding" value of dignity is also compared with the "other-regarding" value of dignity associated with how a person is respected by others (Gallagher, 2004, p. 587). By way of example, self-regarding dignity is evidenced when a person perceives that they are of equal worth to others; other-regarding dignity is evidenced when a person is perceived by others as being of equal worth (Clark, 2010).

In her model of extrinsic dignity, Clark (2010) builds on this distinction between self and other-regarding dignity by identifying the former as being derived from a person's individual values and beliefs and the latter as being derived from a culture's shared values and beliefs. Clark (2010) comments that widespread agreement on what constitutes dignified care indicates that its meaning is often shared and held in-common within a culture. The importance of culture is underscored by Li et al. (2014) in a qualitative study exploring the concept of dignity in Taiwan among nine individuals with end-stage cancer and ten healthcare staff in an in-patient palliative care unit working in the same unit. Li et al. (2014) suggest that the Eastern conceptualisation of dignity differs from the Western one because the former attaches greater importance to existential feelings of peace and resignation.

Arguably, however, the differences identified are over-stated in that other studies involving persons receiving palliative care in the European context also identify existential concerns (Hall and Howard, 2008; Johnston et al., 2015). Likewise, Sayer (2011) asserts that, while some cultural variations exist, these are of limited significance. Nevertheless, for Li et al. (2014) and for Clark (2010) this is significant because it highlights the importance of exploring with a person their individual preferences. Moreover, it is important because – if a person is unable to communicate their preferences – then it should still be possible to deliver dignified care based on what is known of the accepted values and beliefs within their culture (Clark, 2010).

Nordenfelt (2004, p. 70) draws a helpful analogy between dignity and a "special dimension of value" measured on a scale. A person's human dignity cannot be created or destroyed and so remains on one unchanging point on the scale while the other types – such as dignity of identity – can vary along the scale as; for example, a person's self-esteem changes (Nordenfelt, 2004).

Table 2-8 *A typology of dignity (Nordenfelt, 2004)*

Intrinsic – Objective		Extrinsic – Subjective Self-regarding and Other-regarding	
Human Dignity	By virtue of being human	Dignity of:	
		• Merit	Acquired or inherited status
		• Moral stature	Morality of thoughts and actions
		• Identity	Self-respect and integrity

2.3.1.1 Human dignity

> There was a young woman in there who obviously was severely brain damaged and … She was only a young woman, but you had certain members of staff that were wonderful with her … gave her dignity … but others didn't, they never even pulled the curtains around … one of the elderly ladies who was next to her … she did actually shout a couple of times and say 'she's a person'. (Calnan et al., 2013, p. 479)

Recounted to Calnan et al. (2013) during an interview, the patient's observation above captures an understanding of dignity as something connected to being a person; being human. It also points to the 'commonplace' nature of this understanding in that it was articulated – indeed, shouted – by a fellow patient. This reflects the comment made by Sayer (2011, p. 189) that dignity is "something quite ordinary" that "matters to all of us".

Nordenfelt (2004, p. 70) uses the term "Menschenwürde" to describe this "abstract, universal quality of value" that all human beings have by virtue of their humanity (Jacobson, 2009b, p. 3). As such, human dignity is often regarded as being absolute and held by all human beings to the same degree (Jacobson, 2007). For Baertschi (2014), this special value is rooted in what it means to be a person; the possession of rational capacities such as autonomy. Conversely, Pullman (1999), cited in Gallagher et al. (2008), argues that, while autonomy is a significant aspect of dignity, it does not

constitute the whole. Also significant are relationships founded on shared human characteristics of vulnerability and dependence (Vanlaere and Gastmans, 2011).

Killmister (2010) summarises the arguments made for the claim that rational capacities such as autonomy are what make human beings worthy of claims to dignity. These arguments reject what is often described as a "speciesist" idea; that human beings are worthy of dignity simply on the grounds of being human (Sulmasy, 2013; Wainwright and Gallagher, 2008). Claiming that dignity "aligns … almost completely" with autonomy, Killmister (2010, p. 162) points to the different and often contradictory ways in which the term 'dignity' is used (such as its use on opposing sides of the euthanasia debate). For Killmister (2010), autonomy is the thread that sews all these contradictory ways together.

If autonomy is understood to be the defining characteristic of being human, then profound questions are raised about the human dignity of those whose autonomy is impaired (Allan and Davidson, 2013; Wainwright and Gallagher, 2008). Acknowledging that defining dignity in terms of autonomy means excluding those who lack capacity – commenting that "some" will find this "repugnant" – Killmister (2010, p.163) asserts that this is better than clinging to a concept so vague it lacks any real value. She goes on to argue that the dignity that is either preserved or violated in relation to those who lack capacity is the dignity of the individual providing care; the care-giver's dignity is preserved or violated and not the care-receiver's (Killmister, 2010). The logic of this argument, however, hinges on accepting that autonomy is the prerequisite of dignity.

It seems reasonable to assert that many, not just some, would find the argument presented by Killmister (2010) repugnant. It serves to illustrate the point that defining what it means to be a person in terms of rational capacities such as autonomy is profoundly problematic. This is especially the case for nurses and others who care for those who lack or have limited capacity. Pellegrino (2005) argues that stigma and discrimination are likely consequences of using autonomy as a measure of claims to human dignity. No longer classed as persons, human beings become mere objects (Pellegrino, 2005). Regarding the charge of being speciesist, Sulmasy (2013) retorts that proponents of this view make distinctions between biological kinds and are, themselves, therefore also speciesist.

Alternatives to relying on rationality are described by Sulmasy (2013) and Gastmans and De Lepeleire (2010) who reject the idea that the human dignity is dependent on rational capacities such as autonomy. Rather, their ideas reflect the helpful distinction drawn by Wainwright and Gallagher (2008, p. 53) between facts and moral values when they argue that human dignity is a "moral value" and, as such, questions about it "cannot be settled by reference only to facts".

According to Sulmasy (2013), human dignity is best considered from the perspective of the theory of natural kinds. It is the worth attached to human beings "simply by virtue of the fact that they are human" (Sulmasy, 2013, p. 938). He distinguishes human (intrinsic) dignity from other forms of dignity attributed by others such as those stemming from a person's conduct or skills or other merit (Sulmasy, 2013). Baertschi (2014) describes this view as the "natural kind conception"; the idea that human beings have human dignity because their natural kind possess rational capacities as standard. Sulmasy (2013) further explains that each natural kind has an intrinsic value and the nature of this value depends on the kind of thing it is. When the natural kind is humanity, then the nature of the intrinsic value is human dignity (Sulmasy, 2013). By way of example, he describes how racism is often described as an offence against the dignity of the person regardless of the person's capacity for rational thought (Sulmasy, 2013). For Sulmasy (2013), this evidences the fact that human dignity is not conferred by others; it exists independently of any human attribution.

Closely related to this perspective of natural kinds is the personalist approach to care (Gastmans and De Lepeleire, 2010). This approach is based on the idea that to be a person is to exist in relationship with others; all human beings exist in relationship with others, so all human beings are persons and all possess human dignity (Gastmans and De Lepeleire, 2010). Acknowledging the roots of these ideas in Christian theology, Gastmans et al. (2011) argue that they can stand alone because they are, fundamentally, ideas about what it is to be human and, as such, are relevant to people of all faiths and none. While noting the importance of autonomy, they argue that it is "neither the first or last word" in health care (Gastmans and De Lepeleire, 2010, p. 85). Indeed, autonomy is a significant element of their personalist approach but the focus is on relational autonomy (Gastmans and De Lepeleire, 2010).

Heggestad et al. (2015) describe relational autonomy as being focused on a person's interdependent existence within a web of relationships that are situated in a broader

social and cultural context. Describing this model of autonomy as being particularly valuable for care home residents, Heggestad et al. (2015) argue that it challenges conventional ideas about what threatens autonomy. They argue that autonomy is not threatened by frailty and dependence but by the nature of the relationships between staff and patients together with the characteristics of the care home context (Heggestad et al., 2015). Significantly, the personalist approach to care ethics embraces vulnerability and dependence as being part of human life (Tadd, Vanlaere and Gastmans, 2010; Vanlaere and Gastmans, 2005). Human beings are all – to differing degrees – vulnerable and dependent on each other, and the recognition and response to these qualities in each other forms the basis of good care (Vanlaere and Gastmans, 2005).

This echoes the work of MacIntyre (2009), who takes as his starting point the vulnerability of human beings to illness and injury and the resulting dependence on others at some points in a person's life or for all of that life. He notes a common presumption of disability as something that happens to other people; "not as we have been, sometimes are now and may well be in the future" (MacIntyre, 2009, p. 2). For MacIntyre (2009), all human beings are positioned somewhere on a scale of disability, all more or less disabled, all liable to find themselves suddenly or unexpectedly arriving at a different point on the scale. This disability renders all human beings dependent on others, albeit to varying degrees (MacIntyre, 2009).

MacIntyre (2009) identifies two principal virtues required to acknowledge dependence. One of these he explains as a mixture of justice and generosity – "just generosity" – that describes the generosity owed by persons to others and that others equally owe to them (MacIntyre, 2009, p. 126). A second virtue of acknowledged dependence is misericordia – experiencing sorrow when faced by the distress of another (presented in Latin to avoid the modern connotations of the English translation) – that prompts a person to act in the face of someone's else's suffering or distress (MacIntyre, 2009). Recalling the beginning of this section on human dignity and the patient's observation that some nurses preserved the young woman's dignity while others did not, it is tempting to speculate that the latter lacked insight into their own vulnerability and dependence.

In summary, the idea of human dignity raises profound questions about what it means to be human. It provokes debate around whether it is an unconditional quality

possessed by all human beings or depends on rational capacities such as autonomy or other characteristics such as a person's conduct or the respect shown to them by others. This leads the discussion on to consider the next two types of dignity described by Nordenfelt (2004): dignity of merit and dignity of moral stature conferred by others based on a person's perceived 'worthiness'.

2.3.1.2 Dignity of merit and moral stature

> "… they don't see what went before, and they don't necessarily have a vision of the whole person. They just see an old person in front of them, and I think that's part of the problem …" (Son of resident: CH30) (Hall, Dodd and Higginson, 2014, p. 58)

A sense of 'worthiness' is often associated with dignity and is apparent in the dignity of merit and as moral stature described by Nordenfelt and Edgar (2005). Dignity of merit is described as dignity related to a person's status acquired through life or bestowed at birth (Nordenfelt and Edgar, 2005). Founded on the morality of a person's thoughts and actions, dignity of moral stature is described as a "special kind" of dignity of merit (Nordenfelt and Edgar, 2005, p. 19).

Edgar (2003) explores this type of dignity in the work of the 17th Century artist Velázquez, arguing that this marks a turning-point in the conception of dignity as something divinely conferred to something derived from merit or moral stature. Prior to this time, Edgar argues, artists portrayed the dignity of a monarch simply by the presence of the monarch in the painting. From Velázquez on, monarchs are portrayed instead in such a way as to communicate their dignity in terms of perceived merit; for example, in terms of the physical representation and trappings of beauty, wealth or skills as a warrior or politician.

Wainwright and Gallagher (2008) assert that merit and moral stature make uneasy bedfellows. Consider, for example, a person who achieves high office but who accepts bribes in secret. The typology seems to indicate that the person could be worthy of dignity of merit on one hand but, on the other, judged unworthy of dignity of moral stature. Clearly questionable, moreover, is the appropriateness of dignity in nursing care being in any way dependent on good fortune at birth or during life or value judgements about what constitutes moral conduct and whether or not a given person's conduct is moral (Wainwright and Gallagher, 2008).

A sense of 'worthiness', therefore, may result more from the way in which personal clothing can bolster a person's sense of self and communicate this identity to others; no longer an anonymous patient but an individual person 'worthy' of dignity.

2.3.1.3 Dignity of identity

> Dressed in private clothes, it is not easy to have the sick role. The clothes change the role and thereby your sense of worthiness. When you have your own clothes on you can still be ill, but you become more self-confident. (Høy, Wagner and Hall, 2007, p. 162)

Nordenfelt (2004) highlights dignity of identity as the type most at risk in healthcare settings. Dignity of identity is related to a person's self-respect, integrity, autonomy and relationships with others and with their wider community (Nordenfelt and Edgar, 2005). This type perhaps most clearly reflects "how dignity exemplifies our deeply *social* being" (Sayer, 2011, p. 202), italics in the original. Dignity of identity aligns with the "self-regarding" – self-esteem – and "other-regarding" – respect accorded by others – value of dignity described by Gallagher (2004) and Clark (2010). Humiliation as a consequence of physical mistreatment, denial of rights enjoyed by others in the community and prejudice are all means of stripping the person of this dignity (Nordenfelt, 2009).

Scott (2015, p. 2) defines identity as a person's "set of integrated ideas about the self, the roles we play and the qualities that make us unique". She goes on to clarify that, while identity may be perceived as being relatively stable, it is dynamic and shaped by social context (Scott, 2015). A South African saying, cited by Sayer (2011, p. 120), captures this argument succinctly, as, "a person is a person through other persons". In other words, it is a person's relationships with others that develop their sense of self. With its focus on the agency of the actors involved in any social interaction and the importance of the setting for the interaction, the work of Goffman (1968, 1990) has been commended as being especially helpful in understanding the significance of the social context of care in relation to identity (Alabaster, 2006; Matiti and Baillie, 2011; Tranvåg, Synnes and McSherry, 2016).

To communicate his ideas around the nature of identity, Goffman (1990) draws an analogy between dramatic actors and social actors. Both portray different personas – such as mother, daughter, colleague or patient – in different settings and for different

audiences. Both use gestures, tone of voice, posture and facial expression to reinforce the persona. In addition, both rely on external 'props' to help ensure that the role being played is understood by the audience and elicits the appropriate response (Goffman, 1990). For the social actor in a care setting, the costume may be a nurse's uniform or a patient gown but, it is a costume all the same and serves the same purpose. A person may communicate their social identity when in the presence of strangers through their clothing and personal appearance but may lose these 'props' – and the perceived respect normally elicited – when admitted to a care setting as a patient.

Goffman (1968, p. 29) describes these 'props' as an "identity kit" and the stripping of them as a "personal defacement"; effectively disfiguring the person's sense of self and their capacity to communicate that self to others. The potential for loss of identity is heightened in care when these external signs are more likely to be coupled with physical disability or disfigurement, loss of independence, exclusion from decision-making, humiliating interactions and privacy violations. A participant in a qualitative study exploring how older persons managed the process of hospitalization captured this succinctly. She comments that her dignity had been adversely affected on admission because, "They took away everything, all my things", and that she felt at the "mercy" of the staff and that she "didn't count" (Jacelon et al., 2004, p. 552).

Moreover, just as the dramatic actor must interact with the rest of the cast and with the audience to portray a convincing character, so too does the social actor need to interact with others to portray a convincing social identity (Goffman, 1990). Goffman (1990, p. 85) emphasises that the success of the performance is not simply about an individual performance but about the performance of all others involved, too; the fellow actors and observers he identifies as the "performance team". Within this large team – consisting, for example, of everyone present in the setting of a hospital ward – smaller ones exist that are bound together by status or rank such as the 'the nurses' or 'the patients'. For Goffman (1990), the old maxim 'the show must go on' applies equally to the social setting in which these teams work together to 'stage' the performance. On stage, if a prop fails or a cast member forgets his or her lines then the rest of the cast will attempt to conceal or minimise the disruption to the performance; to sustain the "reality espoused by the team" (Goffman, 1990, p. 91). Similarly, social teams – such as 'the nurses' and 'the patients' – are each bound together by the team 'party-line' (Goffman, 1990).

This may help explain why healthcare workers sometimes tolerate failings in care; articulating beliefs – following the 'script' – that such failings are "the sort of thing that goes on in virtually all hospitals" (Department of Health, 2013b, p. 1367) Similarly, it may offer some interesting additional insight into why, at times, healthcare workers find it too difficult to speak out about such failings (Department of Health, 2013c; Francis, 2015); speaking out departs from the 'script' and is detrimental to the 'performance'. Furthermore, it may also help explain why those receiving care may tolerate and excuse failings in care. Given the scale of failings described in the Mid Staffordshire NHS Foundation Trust Public Inquiry, it is noteworthy that "the community in Stafford was reticent in raising concerns and accepting of poor care" (Department of Health, 2013c, p. 481) . Perhaps the same reluctance to depart from the script of the 'good patient' contributed to this reticence.

Returning to Edgar (2003), his discussion of visual representations of dignity in the work of Velázquez also sheds light on this idea of 'dignity of identity'. Edgar (2003) notes that dwarfs were employed in the 17th Century Spanish Court to entertain, often by behaving in undignified ways and because of their physical appearance. When portrayed in art, the dwarfs' undignified behaviour and physical appearance served to highlight the dignity and beauty of the Court (Edgar, 2003). In this sense, their 'dignity of identity' was determined externally by the values and beliefs of the Court at the time and excluded them from the Court community (Edgar, 2003). Importantly, Edgar (2003) argues that this parallels the way in which the values and beliefs of society today humiliate and exclude older people and those who are ill or disabled. In a similar way to the dwarfs of the 17th Century Spanish Court, the elderly, the ill and the disabled are stigmatised and humiliated by their 'outsider' status; excluded from meaningful participation in the wider community and in the determination of their own needs and wants (Edgar, 2003).

Wainwright and Gallagher (2008) note that respecting a person's preferences is required for individualised care – which they seem to equate with dignified nursing care – because such preferences reflect the person's unique identity. Nevertheless, they also identify some limitations of the idea of dignity of identity (Wainwright and Gallagher, 2008). Notably, they argue that dignity of identity does not explain how individuals can retain dignity in situations of appalling suffering (Wainwright and Gallagher, 2008). It is arguable; however, that it is the person's human dignity that is

retained in such circumstances when all else is lost. Wainwright and Gallagher (2008) also argue that the typology does not distinguish clearly enough between dignity of identity and other claims to dignity based on merit or moral stature. Certainly, perceptions of merit and moral stature do seem to fit within the definition of identity as encompassing a person's self-perception, roles and qualities (Scott, 2015). The relative's comment provided at the beginning of Section 2.3.1.2 – "they don't see what went before … They just see an old person" (Hall, Dodd and Higginson, 2014, p. 58) – illustrates the relationship between merit, worth and identity.

2.3.1.4 Summary

The typology described by Nordenfelt (2004) helps to frame discussion of the theoretical perspectives on dignity while also serving to highlight the lack of consensus surrounding the concept but is not without its limitations. This is particularly evident in the debate around intrinsic dignity. Rather than search for a "one size fits all" definition of dignity, Caldeira et al. (2017, p. 2) assert that attention would be focused more profitably on understanding what dignity is for each individual. Given the diverse theoretical perspectives on the meaning of dignity, it is perhaps unsurprising that there has been interest in exploring the meaning of dignity in a more holistic way through concept analysis.

2.3.2 Dignity as a concept

> Philosophers often say that, if you want to know the meaning of a word, don't ask for a definition. (Sayer, 2011, p. 192)

In nursing, concept analysis has been used as a means of moving away from definitions of dignity towards the meaning of dignity in the context of practice (Anderberg et al., 2007). Risjord (2009) explains that the aim of concept analysis is to make explicit any patterns in the way in which a concept is used in context. Concept analysis; therefore, seemed particularly relevant to the current study and its exploration of the meaning of dignity for nursing students. Findings from the five concept analyses of dignity retained for review share some key elements but vary in others. This might reflect the richness and complexity of the concept but seems also to reflect different approaches to concept analysis used in the various studies. This section will outline briefly the

Walker and Avant (2011) approach to concept analysis and examine the contribution made by concept analysis to the understanding of dignity in nursing care.

A concept is defined by Polit and Beck (2014, p. 376) as "an abstraction" developed from observations of how meaning is revealed in behaviour or communication. These abstractions allow researchers to describe observed phenomena effectively and to build theory (Duncan, Cloutier and Bailey, 2007). According to Risjord (2009, p. 688), concept analysis is the term used to describe the process of analysing concepts critically with a view to making "a pattern of use explicit"; that is, communicating how the concept is used in the 'real world'. By clarifying the meaning and use of a concept, concept analysis has been identified as a means of helping to ensure a concept is understood and used appropriately (Wilson, 1963). Risjord (2009) identifies three "major" approaches to concept analysis: Wilson (1963), Rodgers (1989), and Walker and Avant (2011).

The rich, complex and contested concept of dignity seems an obvious target for concept analysis and, indeed, this was reflected in the wealth of literature about its meaning retrieved from an individual literature search using the search terms 'Digni*' in combination with 'Concept Analysis' and by 'snowballing' from reference lists. To allow for clear comparison, only those which made explicit reference to a systematic approach to concept analysis – as described by Risjord (2009) – were assessed as full-text articles for their eligibility for inclusion. Of the seven articles retained, five apply the Walker and Avant (2011) process. The remaining two – Edlund et al. (2013) and Haddock (1996) – describe the use of systematic approaches developed by Eriksson (2010) and Chinn and Kramer (1991), cited in Haddock (1996), respectively. After some consideration, these were excluded on the grounds that a comparison would be more effective between analyses that adopted the same approach. The final five articles retained were: Mairis (1994); Jacelon et al. (2004); Griffin-Heslin (2005); Anderberg et al. (2007); and Shu Lin and Shu Chen (2010).

The concept analysis process developed by Walker and Avant (2011) consists of eight steps as outlined in Table 2-9 and the five articles retained were assessed against these steps.

Table 2-9 *Summary of Walker and Avant (2011)*

Step	Description
1. Select the concept	The concept should be an important one with contested or diverse meanings
2. Determine the purpose of the analysis	Various purposes exist include clarifying meaning and developing a definition
3. Identify uses of the concept	Uses may be theoretical, colloquial or a combination. Theoretical uses focus on how the concept is used in the literature while colloquial uses focus on how it is used by people and communities
4. Determine the defining attributes	These are the defining characteristics of the concept
5. Identify model case	This is a real-world example containing all the defining attributes
6. Identify additional cases	Borderline: contains some of the defining attributes Related: related to the concept but does not contain any of the defining attributes Contrary: does not contain the concept and is not related Invented: case which is not a real-world example Illegitimate: case in which the concept is incorrectly used
7. Identify antecedents and consequences	Antecedents: Prerequisites for the occurrence of the concept Consequences: Outcomes of the presence (or absence) of the concept
8. Define empirical referents	The observable phenomena that make the presence (or absence) of the concept evident

Table 2-10 *Steps of appraisal*

Step	Mairis (1994)	Jacelon et al. (2004)	Griffin-Heslin (2005)	Anderberg et al. (2007)	Shu Lin and Shu Chen (2010)
1. The concept *Is the concept of dignity important*?	Important in nursing care and in nurse education	Important in nursing care and in nurse education	A key element of nursing care	Recognised as a marker of quality nursing care, ageing population	Important in nursing care and nurse education
2. Analysis *Why is the analysis being performed?*	To explore meaning, clarify concept and advance nursing knowledge	To develop a definition	To clarify the meaning in the context of nursing and advance nursing knowledge	To explore the meaning of preserving dignity in care	To develop a conceptual model
3. Concept *In what ways is the concept used?*	Theoretical and colloquial. To convey worth, rank, honour, respect, rights	Theoretical and colloquial.	Theoretical. Attribute of respect, worth, advocacy, empathy, rank, merit, rights	Theoretical. To convey worth, rank, honour, respect, rights	Theoretical. To convey worth, rank, honour, respect, rights, trustworthiness
4. Defining Attributes *What are the recurring characteristics?*	Self-respect Self-esteem Uniqueness of the individual recognised	Respect Human characteristic Subjective Influenced by others	Respect Autonomy Empowerment Communication	Respect Individualised care Advocacy Restoring control Listening	Respect Individualised care Advocacy Listening

Step	Mairis (1994)	Jacelon et al. (2004)	Griffin-Heslin (2005)	Anderberg et al. (2007)	Shu Lin and Shu Chen (2010)
5. Model Case *What examples communicate these characteristics?*	Model	Contrary only	Model	None	None
6. Additional Cases *What examples communicate these characteristics?*	Contrary Borderline Invented	Contrary only	Contrary Borderline Related	None	None
7. Antecedents and Consequences *What are the prerequisites for the occurrence of the dignity?*	Being human Self-advocacy Expressing dignity e.g., in speech or dress Learning from experience	Learning from experience	Subjective Feeling competent and capable Expressing dignity e.g., in speech or dress Autonomy	Knowledge Accepting responsibility Reflecting on experience Non-hierarchical context	Sensitivity to culture considerations Creating new choices Supporting autonomy

Step	Mairis (1994)	Jacelon et al. (2004)	Griffin-Heslin (2005)	Anderberg et al. (2007)	Shu Lin and Shu Chen (2010)
(7 Cont'd.): *What outcomes are associated with the presence or absence of dignity?*	Dignity maintained: Positive self-image Feeling valued, confident, composed Dignity lost: Feeling humiliated, degraded, ashamed, distressed	Dignity is reciprocal; that is, if a person is treated with dignity then they will behave in a dignified manner and vice versa	Dignity maintained: Positive self-image Feeling valued, important Enhanced self-esteem and respect for self and others Dignity lost: Feeling degraded, dehumanised, not in control	Dignity preserved: Enhanced self-respect, feelings of coping successfully and of being useful and valuable	Dignity preserved: Enhanced self-respect, self-esteem, feeling of coping successfully
8. Empirical Referents *How can the presence or absence of dignity be measured?*	Physiological measurement of embarrassment or distress	Observation of behaviour	Identifies qualitative research as a means of determining the presence of dignity but not what this would explore or observe	Means of preserving dignity explicit in the person's care plan Actions associated with preserving dignity are documented in the person's record	Not described

Strengths of concept analysis in the retained articles are the application of a generally systematic approach, broad insight provided into the concept of dignity, and their focus on antecedents, consequences and measurement. Conversely, limitations relate to the rigour of the approach and the value of some of the findings.

All the articles, to a greater or lesser degree, follow the steps outlined in Table 2-10, and this helps to draw comparisons between the findings at each stage. The rationale for concept selection and the purpose of analysis are all broadly similar and reflect the wider literature; ranging from the lack of consensus around the meaning of dignity to its importance to a patient's experience of nursing care. The stated purposes of the articles include constructing a conceptual model of dignity (Shu Lin and Shu Chen, 2010), clarifying the meaning of the concept and advancing knowledge (Griffin-Heslin, 2005; Mairis, 1994), and developing a definition of dignity (Jacelon et al., 2004). While the purposes of the other articles are essentially no different to other published work directed towards exploring the meaning of dignity and the search for a definition, the purpose of Anderberg et al. (2007) is to clarify the types of activities that help preserve dignity. This specific and practical focus distinguished this article from the others and gave it a singularly 'practical' focus particularly relevant to the current study.

A little more variation between each of the articles is evident in their different approaches to exploring the uses of the concept. According to Risjord (2009), approaches to concept analysis differ depending on whether they explore the theoretical or colloquial ones, or both. Theoretical uses focus on how the concept is used in the literature, while colloquial uses focus on how it is used by people and communities (Risjord, 2009). Three of the five articles (Anderberg et al., 2007; Griffin-Heslin, 2005; Shu Lin and Shu Chen, 2010) focus solely on the concept's theoretical use, while two (Jacelon et al., 2004; Mairis, 1994) explore both its theoretical and colloquial use.

The theoretical approaches described provide a concise insight into how widely and diversely the concept of dignity is used. Tadd et al. (2011, p. 38) highlight the "broad, complex and rapidly evolving" nature of the literature concerned with dignity, both

within and across diverse disciplines. All the articles, to a greater or lesser degree, reflect this. Anderberg et al. (2007) analyse the concept's use in the theoretical literature between 1990 and 2005 – including 'grey' literature of reports and dissertations – to provide insight into dignity's deep historical and philosophical roots. In doing so, they identify how perspectives on dignity have developed over time to reflect changing ideas about what it means to be a person, the importance of social identity and individual creativity and preferences (Anderberg et al., 2007).

Risjord (2009) states that, despite their differences, theoretical and colloquial approaches can be combined effectively. Jacelon et al. (2004) and Mairis (1994) illustrate the potential power of this combination to enhance the analysis. Jacelon et al. (2004) combined nurses' views on dignity derived from literature review with older people's views on the same derived from focus groups. This enriched the resulting analysis and helped to set it in the context of care in the 'real world'. Similarly, Mairis (1994) combined literature review with written definitions of dignity provided by 12 nursing students. Again, this enriched the resulting analysis. Arguably, the use of a colloquial approach – alone or in combination – reflects the purpose of concept analysis to understand the use of concepts in the 'real world' (Risjord, 2009).

In addition, by articulating antecedents for dignity, the consequences of preserving or violating dignity and the potential for measuring dignity, the studies make a distinctive contribution to the debate around dignity in nursing care. Some particularly interesting antecedents for the preservation of dignity are the ability to learn from experience (Jacelon et al., 2004; Mairis, 1994) and sensitivity to culture (Shu Lin and Shu Chen, 2010). While identified elsewhere in the literature, such considerations are placed in sharp focus by concept analysis. This ability to highlight important aspects of dignity in nursing care is also evident in the clear identification of the consequences of preserving or violating a person's dignity for self-esteem and body image. To 'measure' dignity, empirical referents are highlighted as qualitative research (Griffin-Heslin, 2005) and documentation (Anderberg et al., 2007). While not described in any detail, this at least may stimulate further discussion.

Some of the limitations of the studies relate to rigour. Of the five studies, two Griffin-Heslin (2005) and Mairis (1994) refer to searching databases but provide no details of search parameters and databases. Consequently, the process on which the findings are based cannot be appraised (Aveyard, 2014; Smith and Noble, 2016). Tofthagen and Fagerstrom (2010) stress that the credibility of theoretical concept analysis hinges on the provision of explicit inclusion and exclusion criteria and the lack of such criteria in three of the five studies is, therefore, problematic. In particular, it lends weight to the argument that concept analysis is an arbitrary process (Paley, 1996).

More fundamentally, the drive to define abstract concepts such as dignity in objective terms is itself subject to criticism. Duncan, Cloutier and Bailey (2007) underline the importance of context to concept analysis and call into question attempts to reach definitions of concepts that transcend context. The potential for concept analysis to divorce the concept from the 'real world' is reflected in the suggestion that empirical referents for dignity could include physiological measurements of embarrassment and distress such as heat sensors placed on the skin to measure blushing (Mairis, 1994). Furthermore, Risjord (2009) argues that the Walker and Avant (2011) framework subverts the model it is based on (Wilson, 1963) by providing cases as illustrations of concepts, not the evidence from which the defining attributes are derived. Effectively, this removes the evidence for the defining attributes and exposes the approach once again to accusations of arbitrariness (Risjord, 2009).

In addition, the 'defining attributes' highlighted in the articles have much in common with each other and with the wider literature. This is particularly noticeable regarding 'respect' – self-respect and respect for and from others – and 'autonomy' as recurring characteristics of the concept. Wainwright and Gallagher (2008, p. 53) go so far as to suggest that respect might be a better term to use than dignity for two reasons; firstly, because respect does not rest on rationality as the defining characteristic of personhood, and, secondly, because "most people have a sense of what respect means". Arguably, however, the same could be said in relation to dignity. Indeed, this is acknowledged by Wainwright and Gallagher (2008), who note that the meaning

of respect also requires more discussion; highlighting the definition-defying nature of abstract concepts like dignity and respect. Furthermore, it raises questions about the value of a process in which ambiguous terms are defined by other ambiguous terms in ever-decreasing circles (Paley, 1996). This leads Paley (1996, p. 572) to dismiss concept analysis as a "vacuous exercise in semantics".

In conclusion, dignity seems to defy definition and concept analysis is arguably as limited as other approaches in attempting to define it. Nevertheless, the definition developed by Jacelon et al. (2004) through their concept analysis encapsulates the key themes of the literature considered so far:

> dignity is an inherent characteristic of being human, it can be felt as an attribute of the self and is made manifest through behaviour that demonstrates respect for self and others. (Jacelon et al., 2004, p. 81)

This definition of dignity as something characteristically human and intimately connected to respect; however, is only one of many. All are broadly similar, but none entirely satisfactory, as evidenced by the long search for a 'one size fits all' definition of dignity. Consensus on the meaning of dignity seems no closer now than it has ever been.

Arguably, it is time to welcome dignity's definition-defying nature and embrace it as something that is known but goes beyond what can be articulated fully. Perhaps it would be better to avoid trying to squeeze the meaning of dignity into the small, rigid spaces of types or definitions. It is possible that there is more to be gained from acknowledging its complexity and describing it in the looser terms of a framework such as the one developed by Jacobson (2009b).

2.3.3 Dignity as a human interaction

> Every human interaction holds the potential to be a dignity encounter. (Jacobson, 2009b, p. 3)

This understanding of dignity as a human interaction offers an interesting alternative to understanding it as a typology or defining it as a concept. Using grounded theory methods, Jacobson analysed literature alongside data from semi-structured interviews with persons marginalised by addiction, mental health issues or homelessness, their care providers and others working in the field of health and human rights (Jacobson, 2007; Jacobson, 2009b). From her findings, Jacobson (2009b) developed a theory of dignity as an encounter consisting of three elements: The actors; the setting; and the wider social order (Figure 2-2). While these elements have been described in other ways – for example, the micro, meso and macro aspects identified by Royal College of Nursing (2008) – and elsewhere (Calnan et al., 2013; Tadd et al., 2011), this singular focus on the interaction within and between them provides a particularly helpful lens through which to view dignity in nursing care.

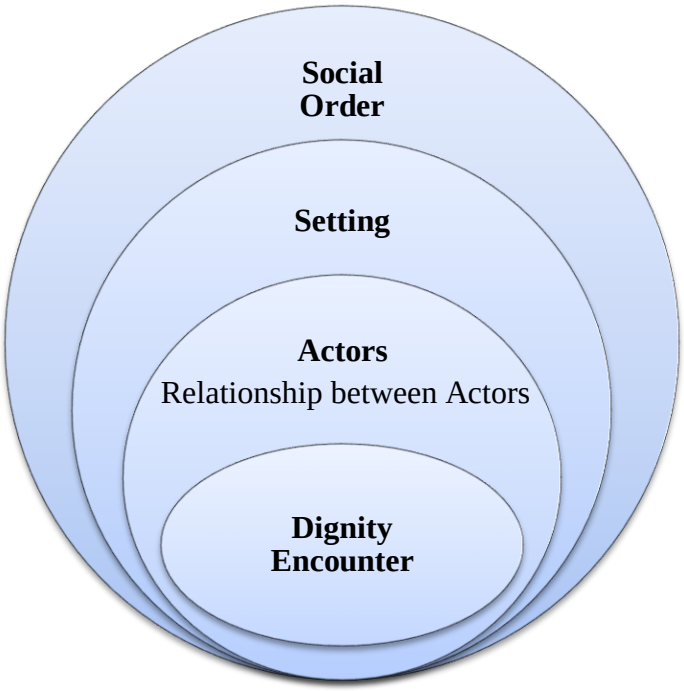


Figure 2-2 *The Dignity Encounter (Jacobson, 2009b, p. 4)*

The actors are the individuals or groups interacting and their interaction is characterised by their interpretation and response to what Jacobson (2009b, p. 3) refers to as "markers and gestures". Jacobson (2009b) identifies markers as being both physical – such as an actor's age – and social – such as an actor's dress – while gestures include eye contact, smiling, or lack thereof. Jacobson (2009b) notes two sets of conditions that influence actors: the position of the actors and the nature of their relationship. If one actor has a position of compassion and the other one of confidence, then dignity is more likely to be promoted. Conversely, dignity is more likely to be violated if one actor has a position of antipathy and the other actor one of vulnerability. Similarly, Jacobson (2009b) asserts that a relationship of solidarity between actors – characterised by empathy and trust – is more likely to promote dignity, while one of asymmetry – characterised by inequity in relation to power, knowledge or control – is more likely to violate it.

Setting refers to the local context in which the interaction occurs, for example, in a home or hospital ward environment. For Jacobson (2009b, p. 3), different settings are characterised by "customary patterns of behaviour" so that, for example, an actor's behaviour may differ if the interaction occurs in another actor's own home or in a hospital ward. Settings may be described as harsh or humane; the former characterised as rigid, hierarchical and obstructive environments, and the latter as calm, friendly and accessible ones (Jacobson, 2009b). In humane settings, dignity is more likely to be promoted, while it is more likely to be violated if the setting is harsh (Jacobson, 2009b).

The broader ethical, legal, economic and political factors in which the actors, the setting and the encounter are embedded constitute the social order (Jacobson, 2009b). This social order may be one of justice or inequality, depending on income, housing, health care and education (Jacobson, 2009b). Where the social order is one of justice, then the promotion of dignity is more likely, but where the social order is one of inequity, then its violation is more likely (Jacobson, 2009b). Figure 2-3 summarises the relationships between the dimensions and conditions and the promotion or violation of dignity.

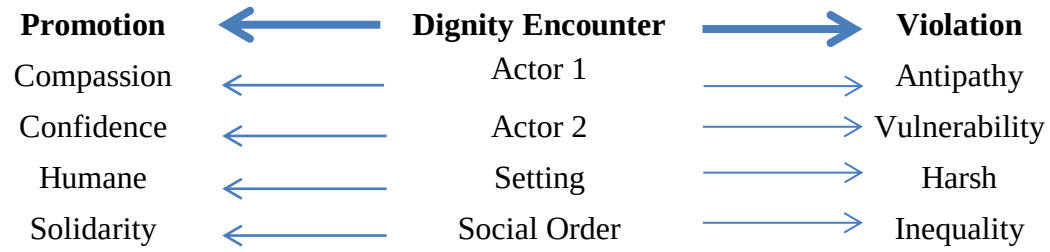


Figure 2-3 *Dignity promotion and violation (Jacobson, 2009b)*

Focused on a very specific group of persons marginalised by mental health and social issues and others working in a single Canadian city, it could be argued that the framework has limited transferability to the context of other care settings and other health issues. Its clear focus on the importance of the attitudes and behaviour of staff,

the setting and the wider social order, however, seems to resonate with the other themes identified in this literature review around the experience of dignity in nursing care. Moreover, its broad scope and flexibility also provide a useful, practical lens through which to view the wider literature.

2.4 Theme 2: The Influence of 'People' on Dignity in Care

Theme 2 focuses on the influence of 'people' influences on the preservation of dignity in care and has two sub-themes: staff behaviour; and patient characteristics. The 'people' are the staff and patients interacting in a care setting. In the context of the dignity encounter described by Jacobson (2009b), the 'people' are the 'actors'. The term 'staff' is used to describe anyone employed to deliver care and may include nurses and nursing students but also healthcare assistants, carers, medical staff and other healthcare workers. The term 'patients' is used to identify anyone receiving care, including service-users and clients. A deliberate effort has been made to focus on findings specific to the preservation of dignity.

2.4.1 Staff behaviour

> Brenda … returns from theatre … Carol, a staff nurse, is with her, checking her observations, asking if she has any pain. Again, the curtains are closed, Carol speaks in a quiet voice simply explaining what she is doing, what will happen next and when she can have a drink. (Observation: Elm Ward, Meadowfield Trust, Afternoon) (Tadd et al., 2011, p. 212)

The above observation illustrates some of the key aspects – providing privacy, communicating effectively and demonstrating respect – of the influence of staff behaviour on the preservation of dignity. Findings from this review suggest that staff behaviour is crucial to the preservation of dignity in care. This seems to be accomplished by staff behaving in a manner which demonstrates respect and helps build relationships with patients and their relatives. Aspects of staff behaviour of

greatest significance to the preservation of dignity in care appear to be verbal and non-verbal communication and the role of the nurse in dignifying care activities.

2.4.1.1 Verbal communication

The importance of verbal communication being polite and courteous is consistently noted (Blomberg et al., 2015; Bridges, Flatley and Meyer, 2010; Webster and Bryan, 2009). One aspect often raised by patients is the importance of being called their preferred name (Baillie et al., 2009; Cairns et al., 2013; Matiti and Trorey, 2008; Woolhead et al., 2006). Findings indicate that this is often not done. A patient's comment that, "I feel it is no longer me as a person they address" (Matiti and Trorey, 2008, p. 2715), suggests that using a preferred form of address acknowledges the patient as a person. Woolhead et al. (2006) note that many older people participating in their focus groups "particularly disliked" the use of first names without consent and 'pet names' such as 'love' or 'dear' because they felt humiliated or patronised by them. Another important aspect of verbal communication is providing explanation and information about care (Bridges, Flatley and Meyer, 2010; Heijkenskjöld, Ekstedt and Lindwall, 2010). This is seen as a requirement for person-centred care; enabling patients to participate in their own care (Bridges, Flatley and Meyer, 2010; Heijkenskjöld, Ekstedt and Lindwall, 2010; Lin, Tsai and Chen, 2011). Speaking softly is identified as important because it helps to protect confidentiality (Lin and Tsai, 2011). Speaking gently helps offer reassurance to patients and calm aggressive behaviour (Hall, Dodd and Higginson, 2014; Heggestad, Nortvedt and Slettebø, 2015). Related to these findings about the tone of speech is the avoidance of condescension – 'talking down' – to patients (Heggestad, Nortvedt and Slettebø, 2015; Woolhead et al., 2006).

Several authors note the importance of conversation between staff and patients and distinguish this from simply giving or receiving information (Baillie, 2009; Kinnear, Williams and Victor, 2014; Lin, Tsai and Chen, 2011; Lin and Tsai, 2011). Bridges, Flatley and Meyer (2010) suggest that conversation helps preserve dignity because it

enables patients and staff to connect with each other. For Blomberg et al. (2015, p. 680), this signals the importance of staff "getting to know and be known" by patients. Also important is that staff initiate conversation, because this acknowledges patients as persons (Baillie, 2009; Heijkenskjöld, Ekstedt and Lindwall, 2010; Kinnear, Williams and Victor, 2014; Lin, Tsai and Chen, 2011). Initiating conversation may be regarded as helping to level the balance of power in interactions between staff and patients, thus enhancing the conditions in which dignity is more likely may be promoted (Jacobson, 2009b).

2.4.1.2 Non-verbal communication

Findings from this review also highlight the importance of non-verbal communication to the preservation of dignity in care. Jacobson (2009b, p. 4) describes aspects of non-verbal communication as the "gestures that set the underlying tenor" of an interaction. Respect is demonstrated by staff paying attention to the patient and listening is frequently identified as important (Heggestad, Nortvedt and Slettebø, 2015; Kinnear, Victor and Williams, 2015; Lin, Tsai and Chen, 2011; Webster and Bryan, 2009). Similarly, eye contact (Lindwall and von Post, 2014; Matiti and Trorey, 2008; Woolhead et al., 2006), gentleness (Hall and Høy, 2012), kindness (Ariño-Blasco, Tadd and Boix-Ferrer, 2005), and appropriate touch (Blomberg et al., 2015; Woolhead et al., 2006) are all noted as being characteristic of dignity-preserving interactions. Seemingly 'little things', such as offering a coffee and a warm welcome, are also noted as being important (Rehnsfeldt et al., 2014). Several authors also identify the act of sitting down with patients to engage in conversation as dignifying (Ariño-Blasco, Tadd and Boix-Ferrer, 2005; Hall, Dodd and Higginson, 2014; Heggestad, Nortvedt and Slettebø, 2015; Heijkenskjöld, Ekstedt and Lindwall, 2010).

2.4.1.3 Dignifying care activities

Closely related to communication is the role of staff in managing dignity-threatening care activities. Such care activities are a necessary and unavoidable aspect of being a patient. How nurses and other staff manage them seems to help preserve dignity in

care. Important aspects relate to privacy, consent and maintaining identity. Privacy is consistently stressed by all groups of participants as being fundamental to dignity in care. Assisting patients with personal hygiene, elimination, eating and drinking and intimate care procedures such as urinary catheterisation are all identified as activities most likely to threaten dignity (Baillie, 2009; Baillie et al., 2009; Baillie and Gallagher, 2011).

Strategies to minimise this threat include closing curtains or screens and asking before entering (Hall, Dodd and Higginson, 2014; Webster and Bryan, 2009). Findings from this review include the importance attached to staff seeking consent before undertaking activities (Cairns et al., 2013; Hall, Dodd and Higginson, 2014; Kinnear, Williams and Victor, 2014). Closely related to this is enabling the patient to exert control over their situation by offering and respecting choice around activities; for example, when to dress and what to wear, when and what to eat (Baillie et al., 2009; Hall and Høy, 2012; Lin, Tsai and Chen, 2011; Lin and Tsai, 2011). Høy, Wagner and Hall (2007) relate choice and control to the need to respect autonomy and to further lessen the risk by facilitating their independence as much as possible. Bridges, Flatley and Meyer (2010) highlight the importance of enabling the patient to maintain their identity through, for example; personal belongings such as photographs, and assisting the patient to maintain their physical appearance (Baillie and Gallagher, 2011; Hall and Høy, 2012; Hall, Dodd and Higginson, 2014).

So far, the role of staff in preserving dignity has been discussed and the findings of this review highlight the importance of communication and dignifying care activities. One of the valuable aspects of Jacobson's framework is its focus on interaction and the importance attached to the role of all those involved (Jacobson, 2009b). In the context of care, this encourages consideration, not just of the staff involved but the patient, too.

2.4.2 Patient characteristics

Resilience

The response to such vulnerability has been related to another patient characteristic that influences the preservation of dignity in care: resilience. van Kessel (2013) notes that resilience is often defined as the ability to recover – to 'bounce-back' – in the face of adversity, such as hospitalisation or increasing dependency. This ability seems to be related to both personal and social resources (van Kessel, 2013). Personal resources may include a person's attitude and sense of purpose, while social ones seem to centre around relationships with others (MacLeod et al., 2016). These resources are reflected in findings from this review.

Franklin, Ternestedt and Nordenfelt (2006) describe personal resources as strategies to enhance self-esteem and identity, such as access to their personal belongings and reflecting on photographs of family or their role as a parent or grandparent. Maintaining physical appearance and as much independence as possible in self-care also seem to be important (Hall and Høy, 2012; Matiti and Trorey, 2008; Oosterveld-Vlug et al., 2014). Oosterveld-Vlug et al. (2014) also stress the importance of a person's ability to be assertive about their own care. In addition, being able to help others, recognise something positive in everyday life, and being of value also seem to contribute to a person's ability to preserve dignity (Franklin, Ternestedt and Nordenfelt, 2006; Tranvåg, Petersen and Nåden, 2015; van Gennip et al., 2013). The findings also stress the importance of spiritual belief, the ability to use humour to deal with threats to dignity and to adapt to or accept changes in functional capacity (Baillie, 2009; Oosterveld-Vlug et al., 2014; Oosterveld-Vlug et al., 2013; van Gennip et al., 2013).

Social resources are resources external to the person which seem to influence their resilience (van Kessel, 2013). A key social resource seems to be the opportunity to experience positive interactions (Tranvåg, Petersen and Nåden, 2015). Interactions with family are an opportunity to experience love and affection while those with a

wider social network may provide a sense of social inclusion (Tranvåg, Petersen and Nåden, 2015). The significance of family involvement is rarely discussed in the literature reviewed in Chapter 2, but is identified explicitly by Bridges, Flatley and Meyer (2010) and Baillie and Gallagher (2011). Warm, kind and gentle interactions with staff are identified as being crucial to a person's sense of recognition as a fellow human being (Tranvåg, Petersen and Nåden, 2015). This echoes the findings of Baillie (2009) about the importance attached by patients to their interactions with staff. Baillie (2009) also notes that only a few staff members attached importance to staff-patient interactions; suggesting staff place less importance on the quality of their interactions with patients. van Gennip et al. (2013) illustrate the impact of relationships on resilience with this participant's comment:

> they can still see me as the person I once was. Not Mrs So-and-So, not the patient, no, 'me'. (van Gennip et al., 2013, p. 1085)

In summary, findings from this review indicate that staff behaviour and patient characteristics exert a profound influence on a person's experience of dignity in care. Communication and dignifying care activities that are inherently threatening to a patient's dignity are highlighted as key aspects of staff behaviour. The patient's vulnerability and resilience are identified as key patient characteristics. Interacting with each other, these seem to help make it more or less likely that dignity in care will be preserved.

2.5 Theme 3: The Influence of 'Place' on Dignity in Care

Theme 3 focuses on the influence of 'place' on the experience of dignity in care and has two sub-themes: local and social context. In a sense, this discussion is moving on from the interaction of the actors in the dignity encounter to the setting and wider social order in which the dignity encounter is embedded (Jacobson, 2009b). Findings about the former centre on the physical environment and culture of the care setting, while the latter centre on the wider political and ethical context.

2.5.1 Local context

> It's just not the right place for them. (Interview with a Staff Nurse) (Tadd et al., 2012, p. 33)

While this comment refers to the care of older persons in acute settings, it raises interesting questions about the suitability of care settings more generally. There appears to be a general consensus in the literature that the design of a care setting plays a key role in the experience of dignity (Lin, Watson and Tsai, 2013).

2.5.1.1 Physical environment

This review suggests that the design of the physical environment of care may increase vulnerability and mitigate against resilience; making the preservation of dignity less likely. Mixed-sex areas (Baillie, 2008, 2009; Tadd et al., 2012), lack of cleanliness, and communal toilet facilities (Webster and Bryan, 2009) are associated with reduced privacy. Kinnear, Victor and Williams (2015) also note the absence of quiet rooms to discuss confidential matters. Uniformity, lack of signage and few clocks are identified as being confusing for older people in acute care; worsened by the frequency with which older people were moved from one area to another (Calnan et al., 2013; Tadd et al., 2012). Difficulties in navigating around cramped areas and equipment makes it less likely that patients will mobilise independently because of the perceived risk of falling (Calnan et al., 2013). It seems reasonable to suggest that these aspects of the care setting may increase vulnerability.

The ability to interact socially with others is hindered by the lack of day rooms or spaces other than the immediate bed-space (Calnan et al., 2013; Tadd et al., 2012). In long-term care settings, other restrictions are imposed by locked doors and the absence of a garden or other outside space (Nåden et al., 2013). The potential impact of being confined to a bed-space or small room is captured in a participant's comment that being in their nursing home was "like being in a prison without bars" (Heggestad, Nortvedt and Slettebø, 2013, p. 885). Another consequence of limited space noted is the restriction placed on personal belongings as a factor that reduces dignity in care

(Calnan et al., 2013; Nåden et al., 2013; Tadd et al., 2012). Once again, this could be regarded as restricting one of the key resources for resilience.

2.5.1.2 Culture of care

This review also found that two aspects of a care setting's culture – the model of care delivery and workload – seem to be associated strongly with dignity in care. Task-orientated rather than person-centred models of care delivery and lack of time are widely described in the literature reviewed as threats to dignity. This seems to be related to the impact on the quality of interaction between staff and patients.

There is consensus among the articles contributing to this theme that dignity is less likely to be preserved when the culture focuses on tasks; the "mechanistic aspects of care" (Woolhead et al., 2006, p. 367). Heggestad, Nortvedt and Slettebø (2015) assert that focusing on these aspects of care objectifies patients and represents a particularly serious threat to dignity. Heijkenskjöld, Ekstedt and Lindwall (2010, p. 318) agree; stating that "seeing patients as objects" represents the opposite of person-centred care. This focus on the task and not the person is reflected in numerous observations of staff in the acute care setting referring routinely to patients as bed numbers or conditions (Tadd et al., 2012; Woolhead et al., 2006). It is also reflected in reports and observations of undignifying personal care (Hall and Høy, 2012; Lindwall and von Post, 2014), perioperative care (Willassen et al., 2015) and assisting with eating (Heggestad, Nortvedt and Slettebø, 2015). The impact of seeing persons as tasks or objects is perfectly captured in the comment below:

> It's like you're a thing in a bed and I'm coming round. You have to have all these tablets whether you want them or not. (Mrs. V) (Baillie, 2009, p. 31)

In addition to task-orientation, lack of time – 'busyness' – is consistently identified as an influence on dignity in care (Baillie et al., 2009; Lin and Tsai, 2011). Lacking time to sit down with patients and engage in conversation is highlighted as a particular issue (Heggestad, Nortvedt and Slettebø, 2015; Woolhead et al., 2006). Jacobson and Silva

(2010) and Kinnear, Victor and Williams (2015) assert that 'taking time' is about being present to a patient; demonstrating that they are regarded by staff as being worthy of their time. Similarly, Oosterveld-Vlug et al. (2014) stress the importance of taking time to converse, to listen and to build a relationship with patients. Tadd et al. (2012, p. 34) describe the "intense busyness" of the care setting and the strategies – such as walking quickly and avoiding eye contact – used by nursing staff to reduce opportunities for patients to engage with them. They describe how:

> Often, patients or relatives would hover at the nurses' station trying to catch someone's eye, only to give up as staff rushed about, ignoring them. (Tadd et al., 2012, p. 35)

More worrying still is the apparent relationship between this 'busyness' and staff behaviour. Heijkenskjöld, Ekstedt and Lindwall (2010) describe nursing home residents being scolded and feeling embarrassed for requesting help at the 'wrong' time when the nurse was busy. Waiting for help (Heggestad et al., 2015) and grudging responses to request for help – "If I'm going to help you to go to bed, you have to do it now" (Nåden et al., 2013, p. 756) – also seem to be a consistent feature of the patient experience. Staff behaviour associated with 'busyness' ranges from discourtesy (Heggestad, Nortvedt and Slettebø, 2013) and indifference (Heijkenskjöld, Ekstedt and Lindwall, 2010) to neglect (Tadd et al., 2012) and abuse (Nåden et al., 2013).

In summary, findings from this review suggest that the local context of care influences dignity in care. Dignity seems less likely to be preserved when care settings are poorly designed and when the culture of care is characterised by task-orientation and lack of time or 'busyness'.

2.5.2 Social context

Reflecting on dignity as the human interaction described by Jacobson (2009b), this review has so far considered two of the three conditions – the actors and the setting – influencing whether dignity is promoted or violated. The third condition of a dignity encounter is the wider social order in which the actors and setting are embedded

(Jacobson, 2009b). This is discussed in relation to characteristics highlighted by the review: target-setting, and discrimination.

2.5.2.1 Target-setting

According to Calnan et al. (2013, p. 478), one of the consequences of setting targets around bed-occupancy, discharge and treatment times is the emphasis placed on "maximum throughput and minimum length of stay" rather than on the quality of the care delivered. This seems particularly relevant for those persons – such as older people – whose care needs are complicated by multiple co-morbidities and social circumstances (Calnan et al., 2013).

For Tadd et al. (2012), this focus on performance targets is what drives the frequent movement of older people around acute care settings that contribute to disorientation and threaten dignity. Jacobson (2009a, p. 1544) compares care governed by targets to a production line; asserting that discourtesy and other dignity-threatening aspects of staff behaviour are strategies used by staff to meet "production quotas". Nunes, Rego and Nunes (2015) note that this leads to a tension between the values of the institution and the espoused values of nursing. Stratton and Tadd (2005) argue that this commodification of care prioritises certain aspects of care not because they are valuable but because they can be quantified and measured with relative ease. In effect, what is measurable gains importance and what is unmeasurable loses it.

Related to the focus on targets in general is the focus on specific targets around the reduction of risk such as falls, hospital-acquired infection and pressure ulcers (Calnan et al., 2013). These are worthwhile goals in themselves, but their measurement has unintended consequences on the preservation of dignity in care (Calnan et al., 2013). It may be that focussing on single quantifiable issues as targets diverts attention from the holistic care of patients and leads to the fragmentation of care. It is also suggested that a culture of risk management influences the interaction between staff and patients and patient vulnerability and resilience (Tadd et al., 2012). The observation of patients

being advised by staff to use incontinence pads rather than be assisted to a toilet or commode because of perceived falls risk seems to support this (Tadd et al., 2012).

Confining patients to their bed or chair and removing personal belongings such as photographs from bed tables or lockers are other examples of unintended consequences of this risk aversion (Tadd et al., 2012). Tadd et al. (2012) also assert that increasing specialism contributes to the frequent and disorientating movement of older people from one area to another because they are more likely to have multiple health issues, which do not 'fit' in a single-speciality model of acute health care. Perhaps most important is the argument that a focus on single-issue targets and risk management alters staff perceptions around their own autonomy and their responsibility and accountability for a patient's holistic care (Tadd et al., 2012; Woolhead et al., 2006).

2.5.2.2 Discrimination

Discrimination has been defined as treating a person differently based on their perceived status or membership of a particular group (Jacobson, 2009a). Baillie and Matiti (2013) argue that dignity in care is threatened by discrimination against persons who are marginalised based on, for example, age, sexual orientation or disability. Findings from this review are that discrimination against older people affects dignity in care and reflects negative views on ageing.

Calnan et al. (2013, p. 482) highlight what they describe as an "inbuilt discrimination against the provision of high quality care for older people". According to Tadd et al. (2012, p. 35), this reflects as "underlying institutional ageism" within health care in the UK. The literature further suggests that scarce economic resources in health care contribute to this discrimination (Nunes, Rego and Nunes, 2015; Stratton and Tadd, 2005). It also seems reasonable to suggest that ageism in health care merely reflects ageism in wider society. Bayer, Tadd and Krajcik (2005) describe older people's perceptions of being viewed negatively by society as a homogenous group without useful purpose and dependent on others. In effect, the literature points to a view of

older people as "redundant, stigmatized and an economical burden to society" (Oosterveld-Vlug et al., 2013, p. 6). Similarly, Stratton and Tadd (2005) describe healthcare workers' views of older age as a time of physical and cognitive decline, financial insecurity and dependence. Unsurprising then is a perception that working with older people may be regarded as low status work compared to other specialities (Ariño-Blasco, Tadd and Boix-Ferrer, 2005).

Recommendations geared towards avoiding this discrimination relate to education, person-centred care and leadership. The literature points to education as one of the roots of such negative attitudes (Ariño-Blasco, Tadd and Boix-Ferrer, 2005; Tadd et al., 2012). Staff describe a lack of relevant education regarding dignity and the care of older people (Baillie et al., 2009; Calnan et al., 2013). Core issues are identified as dependency and vulnerability (Heggestad et al., 2015). It is argued that there is a "prejudice against dependency" when the real issue is the treatment of dependent and vulnerable persons (Heggestad et al., 2015, p. 44). Heggestad et al. (2015) also assert that negative views of dependency stem from a failure to understand or recognise that all persons are dependent on others to a greater or lesser degree.

Consequently, recommendations for education centre around ethics, vulnerability, communication and values clarification (Baillie and Matiti, 2013; Bayer, Tadd and Krajcik, 2005; Jacobson, 2009a; Nunes, Rego and Nunes, 2015). It is further recommended that care recognises and rejects task-orientated care and embraces person-centred care instead (Baillie and Matiti, 2013; Bayer, Tadd and Krajcik, 2005). Developing effective leadership at all levels is also identified as a means of preserving dignity in care (Nunes, Rego and Nunes, 2015; Tadd et al., 2012). Baillie and Gallagher (2011) provide an example of this when they describe how nurses' adjusted ward routine and updated their communication skills to facilitate local implementation of the RCN's 'Dignity Campaign' (Royal College of Nursing, 2008).

2.6 Chapter 2: Conclusion

According to Parahoo (2014), a literature review has four functions. It should provide a rationale for the current study, set the study in a broader theoretical context, review relevant research and provide the basis for decisions regarding the methodology chosen for the study.

This literature review has identified that research has explored the perspectives of patients, their relatives, and nurses on dignity in care. While nursing students have participated in relevant research, the review has established that their perspectives as a distinct group have not been described. As discussed in Section 1.2, the Commission on Dignity in Care states that nursing students must have dignity "instilled into the way they think and act from their very first day" (Independent Commission on Dignity in Care, 2012, p. 35). This presents a significant challenge to nursing students and pre-registration education. The dearth of evidence about nursing students' understanding and perceptions of dignity and dignity in nursing care identified by this literature review provides a sound justification for research in this area.

In terms of the theoretical context, this literature review identified that the meaning of dignity remains contested and contentious. This gave impetus to the current study to explore the meaning of dignity for nursing students. In addition, this literature review identified influences on dignity in care as being related to people (patients and staff) and place (local and wider social context). This was consistent with previous findings – such as Baillie (2009) and the Royal College of Nursing (2008) – and helped provide a useful framework for exploring nursing student perspectives.

3 Chapter 3: Methodology

3.1 Chapter 3: Introduction

The literature reviewed in Chapter 2 established a need to explore nursing students' perspectives on dignity in care. Specific areas of interest were identified as the meaning nursing students attach to the term "dignity in care", their perspectives on the 'people' and 'place' influences on dignity in care, and their perspectives on the role of the nurse in preserving dignity in care. Chapter 3 begins by considering this purpose in relation to paradigms and provides a rationale for the selection of pragmatism as the study's theoretical framework. The development of the research design and the choice of mixed methods are then discussed. The chapter concludes with a detailed explanation of the study's research design. Chapter 4 moves on to examine the study's ethical considerations and methods adopted.

3.2 Theoretical Framework

Morgan (2007) acknowledges that different versions of the paradigm concept exist but argues these are all characterised by a common understanding of them as shared beliefs influencing the type of knowledge deemed suitable for inquiry and how inquiry is conducted. It follows from this that paradigm selection is fundamental to both the development of the research questions and the methods used to answer them. For Mertens (2003, p. 139), a paradigm is a "worldview, complete with the assumptions that are associated with that view". Mertens (2010) goes on to explain that these assumptions are based on four belief systems: ontology; epistemology; axiology; and methodology.

Ontological assumptions concern the nature of reality while epistemological ones concern the nature of knowledge and the relationship between the researcher and those being researched (Creswell and Plano Clark, 2011). Teddlie and Tashakkori (2009) identify axiological assumptions as being concerned with the role of values in inquiry;

the extent to which the inquiry can be considered value-free or value-bound. Driven by these assumptions are those related to methodology; the broad approach to scientific inquiry (Welford, Murphy and Casey, 2011). Together, all of these assumptions contain the principles, language and methods that frame scientific inquiry (Weaver and Olson, 2006). Making the assumptions explicit, therefore, is required for the coherence and rigour of the inquiry (Houghton, Hunter and Meskell, 2012). Shannon-Baker (2015) supports this view, arguing that the paradigm selected by the researcher is less important than their ability to justify the choice and demonstrate its consistent application throughout the various stages of the research. The research purpose was considered in relation to the post-positivist, constructivist, transformative and pragmatism paradigms.

3.2.1 The post-positivist paradigm

According to Teddlie and Tashakkori (2009), positivist ontology assumes the existence of a single, external reality that is governed by natural laws and is directly observable in the physical world. While post-positivism is also characterised by this assumption, there is an acceptance that this reality, and the laws governing it, can never be fully known (Welford, Murphy and Casey, 2011). Initially, the selection of this paradigm to explore multiple and subjective perspectives on dignity in care seems to be at odds with this belief in a single and objective reality. However, its selection for the examination of subjectivity in nursing is evident in the study of such diverse phenomena as nursing students' learning styles (Fleming, McKee and Huntley-Moore, 2011) and empathy (Cunico et al., 2012). Perhaps most significantly, this paradigm is apparent in some studies investigating the closely related concept of caring (McCance, Slater and McCormack, 2009; Mlinar, 2010; Murphy, 2006; Papastavrou et al., 2012).

Epistemologically, the researcher and the subject are independent of each other and this helps ensure the objectivity of the knowledge gained (Teddlie and Tashakkori, 2009). The role of the researcher is to be a detached observer; controlling the context of inquiry so that valid and reliable findings can be generalised to the wider population

(Creswell and Plano Clark, 2011). However, this study is focused on the complex and subjective topic of nursing students' perspectives on dignity in care, and this appears to be at odds with such detachment. Similarly, the diverse nature of the nursing students' caring experience does not seem to lend itself to the degree of control required.

Closely related to this issue are axiological considerations. Potential challenges in this area are illustrated by the development of the Caring Dimensions Inventory developed from a literature review conducted by "authors who believed that it was possible to operationalize caring in this way" (Watson and Lea, 1997, p. 88). Arguably, it follows from this that the tool incorporates the values of the authors but explicitly excludes all others. In the context of this study, the process of developing or accepting a definition of dignity, what is meant by a student nurse's role in respecting it, and deciding what to observe would all involve value judgements about an already value-laden concept. Arguably, it would not be feasible to exert the required degree of control over values in this study because they seem integral both to the concept of dignity and the research process.

Methodology in the post-positivist paradigm is characterised by quantitative approaches such as descriptive and quasi-experimental research involving the use of deductive logic (Polit and Beck, 2014). Creswell and Plano Clark (2011) describe this as a top-down approach because it moves from theory to data with a view to testing or refining the theory. Associated methods involve the collection and statistical analysis of numerical data (Burns and Grove, 2007).

One benefit of this approach would have been the opportunity to consistently measure changes over time across a range of variables (Patterson and Morin, 2012). In addition, quantitative methodologies would have offered an opportunity to gain a broad insight into nursing students' perceptions due to the large sample sizes required. However, the primary problem triggering this research related to the need for greater insight into how nursing students perceive dignity in care and their role in promoting

it. The extent to which such perceptions can be represented accurately or sufficiently by numeric data is questionable (Nicholls, 2009a).

3.2.2 The constructivist paradigm

In contrast, the constructivist paradigm is characterised by the ontological assumption that reality is multiple and subjective (Nicholls, 2009a); not fixed, but dynamic and mentally constructed (Polit and Beck, 2014). This notion is supported by Creswell and Plano Clark (2011), who note that these mental constructions of reality derive from an individual's personal experience and social interactions. When studies located in this paradigm focus on social interactions, then it is also referred to as social constructionism (Robson, 2011). Flick (2015, p. 25) explains that realities studied in social constructionism are "social achievements" because they are constructed by interaction between individuals and groups in a social context. The assumption of multiple realities as being individually and socially constructed seems in keeping with the study of perceptions and is reflected in much of the literature related to dignity (Heggestad, Nortvedt and Slettebø, 2013; Oosterveld-Vlug et al., 2014; Rehnsfeldt et al., 2014). Therefore, situating the proposed study in this paradigm would have had the benefit of following a well-established route.

In order to understand these multiple and subjective realities, the researcher and those being researched need to be close, not separate (Polit and Beck, 2014). The use of the term 'participant' rather than 'subject' highlights the reciprocal nature of this relationship (Nicholls, 2009b). In addition, Polit and Beck (2014) note the flexibility of qualitative approaches in their ability to provide holistic understanding of the research problem as a particular strength. Given the relatively little evidence around nursing students' perspectives on dignity in care, flexibility to respond to emerging findings and the opportunity to arrive at a holistic understanding made this paradigm attractive in the context of the current study.

According to Polit and Beck (2010), values play an inevitable and desirable role in constructivist inquiry. This is echoed by Pratt (2012), who contends that, far from

limiting an inquiry, the values brought by a researcher to an inquiry are to be welcomed. What is important is that these values are made explicit (Creswell and Plano Clark, 2011) rather than remaining hidden. This seemed ideally suited to the focus of the study because of the value-laden nature of the concept being explored and the feasibility of removing values from the inquiry.

A range of qualitative methodologies applying inductive logic are characteristic of constructivist inquiry. The inductive process, described by Creswell and Plano Clark (2011) as moving from observation to theory, would suit the proposed study because of the flexibility required to respond to emerging questions. The use of such methodologies is again well-established in the study of dignity, and, therefore, suited to the topic of nursing students' perspectives on dignity in care. The current study's literature review reflects this range, including; grounded theory (Jacobson, 2009b, 2009a; Jacobson and Silva, 2010), qualitative case study (Baillie, 2008, 2009; Baillie and Gallagher, 2011), ethnography (Calnan et al., 2013; Tadd et al., 2012), and, in particular, hermeneutic approaches adopted in such studies as those presented by Franklin, Ternestedt and Nordenfelt (2006) and Heggestad, Nortvedt and Slettebø (2013). The wide range of methods associated with these methodologies – interviews, observation and documentary analysis to generate text (Nicholls, 2009c) – is also reflected in the literature reviewed in Chapter 2.

In the early stages of the current study, the researcher considered adopting this stance as a means of gaining a holistic understanding of nursing students' perspectives but did not do so for several reasons. One reason was that the literature review for the current study demonstrated that much of the evidence-base related to dignity in care was situated in the constructivist paradigm. This meant that the three survey studies retained for the literature review (Baillie et al., 2009; Cairns et al., 2013; Kinnear, Victor and Williams, 2015) were particularly conspicuous. This drew the researcher's attention, and the breadth of insight gained from the surveys encouraged her to consider a research design that might benefit from both the depth offered by qualitative approaches with the potential for breadth of findings. This was particularly interesting

to the researcher because of the under-researched nature of nursing students' perspectives. The researcher also wondered whether adopting an alternative approach might offer a new and different perspective.

3.2.3 The transformative paradigm

Inquiry situated in the transformative paradigm values human perspectives on reality but is based on the ontological assumption of a single reality – perceived in different ways by different people – shaped by social, political and cultural forces such as gender and race (Mertens, 2010). Uncovering the forces that privilege some and discriminate against others facilitates action and change (Mertens, 2003). Mertens (2010, p. 473) describes this paradigm as an "umbrella" for different types of inquiry that share a common interest in social justice and human rights. Situating the study in this paradigm may have helped gain an understanding of the broader political and organisational factors influencing dignity in care identified by the Royal College of Nursing (2008).

In contrast to the positivist and constructivist paradigms, objective separation and subjective interaction are both valued in the transformative paradigm, depending on the nature of the problem and the stage of inquiry (Teddlie and Tashakkori, 2009). Mertens (2010) emphasises the priority placed on interaction with the participants and the need to directly engage with them in all stages of the research process to ensure all viewpoints are represented and avoid discriminating against any individual or group. Combining these epistemological stances has the potential to mitigate some of the limitations discussed above in relation to the post-positivist and constructivist paradigms while building on their respective strengths.

Mertens (2010) also argues that axiological considerations of social justice and human rights are fundamental and underpin all the other assumptions of the transformative paradigm. This explicit focus on values may have been particularly helpful in illuminating the forces generating reported inconsistencies between professional values and care (Department of Health, 2013a).

In addition, Creswell and Plano Clark (2011) state that paradigms may be mixed within a mixed methods research design provided this is made explicit. Therefore, it would not be necessary to situate a mixed methodology study in only one paradigm. Both qualitative and quantitative methodologies are employed within the transformative framework (Teddlie and Tashakkori, 2009). Choices are not only driven by the nature of the problem and the stage of the process but, more importantly, by the need to ensure approaches are ethical and will result in equal representation of all the viewpoints of all the participants (Mertens, 2010). Sweetman, Badiee and Creswell (2010) identify the use of a wide range of methods in transformative mixed methods studies, including questionnaires, interviews and focus groups. While the focus on uncovering the cultural and other forces shaping reality was outwith the scope of this study, it seemed clear that combining methods associated with different methodologies offered numerous benefits (Östlund et al., 2011). Those particularly relevant to this study included the potential to paint a more complete picture of the nursing students' perceptions.

In the context of the current study; however, the research purpose was to explore nursing students' perspectives on dignity in care rather than investigate their origins or any tension between their perspectives on dignity in care and their actions. In addition, while Johnson, Onwuegbuzie and Turner (2007, p. 126) state that it is "possible and desirable" for researchers to move between different paradigms, they go on to state that learning to do so is challenging and beyond the reach of "many" researchers. Reflecting on this, the researcher was conscious that mixing paradigms would add a further level of complexity to the research design that she would prefer to avoid. Related to this and perhaps more fundamentally, Polit and Beck (2014) note that researchers are generally drawn to a paradigm that corresponds most closely to their own worldview. The transformative paradigm did not have any particular personal resonance for the researcher. Consequently, she was concerned that such commitment would restrict her ability to provide authentic rationale for decisions regarding the research design.

3.2.4 The pragmatism paradigm

One paradigm that did have personal resonance and would facilitate consistent decision-making in the research process was pragmatism. Teddlie and Tashakkori (2009, p. 74) assert that the pragmatism paradigm encompasses a wide range of views on the nature of reality but "prefers action to philosophizing" because debating this nature has little practical utility. Rorty (1982, p. xvi) summarises this view in his statement that pragmatists "would simply like to change the subject" from abstract philosophical debate to something more interesting and more practical.

Although a focus on 'what works' has come to define the paradigm, Morgan (2014, p. 1046) describes this as "a crude summary of pragmatism" that fails to acknowledge its value as a philosophical basis for inquiry. He goes on to argue that this is best-illustrated in the work of John Dewey, one of the founding fathers of pragmatism (Morgan, 2014). In a discussion of Dewey's work, Fricker (2005, non-paginated) comments that he dismissed the debate around the nature of reality as a "silly intellectual game". Dewey argued that there was a need for philosophy to move away from "dealing with the problems of philosophers" to "dealing with the problems of men" (Dewey, 1920 cited in Malachowski, 2010, p. 72). This is reflected in the view that pragmatism is "rooted in life itself" (Morgan, 2014, p. 1047). Creswell and Plano Clark (2011) describe this as being orientated to the real world and such an orientation seemed to fit well with this study's interest in nursing students' perspectives on dignity in care in their everyday practice. The potential appropriateness of this paradigm was underscored by the impact of Dewey's work on nursing education and contemporary ideas about reflection in nursing (Kinsella, 2010; Rolfe, 2014).

Epistemologically, there appears to be general agreement that the relationship between the researcher and the researched can be both objective and subjective, and that knowledge is concerned with practical understanding and application (Creswell and Plano Clark, 2011; Teddlie and Tashakkori, 2009). For Dewey, concern with the nature of knowledge is replaced by concern with the practices of inquiry because knowledge is "nothing more than the outcome of competent inquiry" (Fricker, 2005,

non-paginated). Morgan (2014) describes Dewey's concept of inquiry as a continuous, cyclical process of reflection on actions and beliefs, triggered by a situation perceived as problematic. Knowing cannot be separated from doing because beliefs depend on actions and actions depend on beliefs (Morgan, 2014). Once again, the central role of experience, reflection and learning was perceived to fit well with the focus of this study on nursing students in practice.

In the pragmatism paradigm, Houghton, Hunter and Meskell (2012) assert that values play a central role in decisions about what to study and how to do so. Similarly, Morgan (2007, p. 70) emphasises the importance of ethics and the extent to which values influence research, commenting that pragmatism embraces the idea that values "are always a part of who we are and how we act". Evans, Coon and Ume (2011) assert that pragmatism's practical focus on action and consequences is ideally suited to practice-based disciplines. Teddlie and Tashakkori (2009) add that, in this paradigm, decisions about what to study and how to do so are informed by the researcher's personal values, their feelings about what is important. This flows naturally from the central role of beliefs in Dewey's concept of inquiry and, again, seemed ideally suited to a study triggered by the researcher's professional values as a nurse and an educator.

According to Creswell and Plano Clark (2011), pragmatic choices about methodology are made on the basis of what will work best to answer the research questions and often result in the combination of quantitative and qualitative methodologies. Pragmatists reject the view that qualitative and quantitative methodologies are incompatible (Houghton, Hunter and Meskell, 2012; Morgan, 2014). Morgan (2007, p. 67) emphasises the need to consider the beliefs underpinning decisions about methods and their consequences for the "workability" of the inquiry. Qualitative and quantitative methods may be employed consistently within this paradigm; bringing with them their relative strengths and weaknesses (Teddlie and Tashakkori, 2009). This seemed to offer the opportunity to select the most effective methods from the

qualitative and quantitative traditions, providing their selection is justified clearly with reference to the selected paradigm (Shannon-Baker, 2015).

Johnson, Onwuegbuzie and Turner (2007) argue that mixed methods research design partners with pragmatism to produce more comprehensive and useful findings. Alise and Teddlie (2010, p. 106) also note that pragmatism forms the basis of the "compatibility thesis", which states that combining qualitative and quantitative approaches makes for good research. The partnership helps ensure that pragmatic choices about methodology are made on the basis of what will work best (Creswell and Plano Clark, 2011).

In conclusion, each of the paradigms discussed has strengths and limitations in the context of the proposed study. Strengths associated with the post-positivist paradigm included its well-established use to investigate the related concept of caring. The large sample sizes required would have helped to provide a breadth of insight. Moreover, the heightened anonymity of individual participants within a large sample might have encouraged them to more completely disclose their perceptions. However, limitations lay in its lack of flexibility, the feasibility of controlling values in the inquiry and of representing meaningful insights into subjective perceptions by numeric data generated by conventional quantitative methods.

Well-established in the study of dignity, situating the study in the constructivist paradigm would have avoided these limitations through its flexibility in accommodating emerging questions, the importance placed on the role of values and the depth of rich understanding provided. The researcher, however, was keen to explore the potential of combining methodologies offered by the transformative and pragmatist paradigms. This seemed to offer an opportunity to offset the limitations of each with the strengths of the other. While the former's focus on social justice would have facilitated an exploration of the forces shaping nursing students' perceptions, this seemed outwith the scope of the purpose of the study. Pragmatism's concern with the real world, and emphasis on experience and learning through reflection on beliefs and

actions, seemed to make it ideally suited to this study of nursing students' perspectives on dignity in care. In addition, pragmatism provided an opportunity to adopt both qualitative and quantitative methods in a consistent and coherent way. Therefore, pragmatism was selected as the theoretical framework to underpin decisions at each stage of the research process.

3.3 Research Design

3.3.1 Mixed methods: definition

Tashakkori and Creswell (2007a) stress that not all research questions will require, or benefit from, a mixed methods research approach. Understanding what is meant by the term 'mixed methods research' seems a logical first step in deciding to adopt such an approach. Unfortunately, this is not straightforward because of a lack of consensus in relation to what constitutes mixed methods research (Johnson, Onwuegbuzie and Turner, 2007). Some assert that mixed methods research can be characterised by a mix of different qualitative methods within a single study (Denzin, 2010; Morse, 2010). Others, more typically, argue that mixed methods research is characterised by its mix of qualitative and quantitative research methods or approaches (Johnson, Onwuegbuzie and Turner, 2007). This is reflected in the definition of mixed methods research as the use of both qualitative and quantitative approaches or methods in a single study to collect and analyse data, integrate findings and draw inferences (Tashakkori and Creswell, 2007b).

When and how such mixing takes place, however, is contested (Johnson, Onwuegbuzie and Turner, 2007). For example, Creswell and Plano Clark (2011, p. 172) argue that mixed methods research is defined by the "complete" use of each methodology, including their differential approaches to sampling, data collection and analysis. In contrast, Johnson, Onwuegbuzie and Turner (2007, p.123) argue that this "pure" mixed methods research is only one, central point on a qualitative-quantitative continuum that accommodates various types of mixed methods research. This is

reflected in their broad definition of mixed methods as research that combines elements of qualitative and quantitative approaches (Johnson, Onwuegbuzie and Turner, 2007). Similarly, Tashakkori and Creswell (2007b) are careful to define the concept of mixed methods broadly in order to be as inclusive as possible of the wide range of the many different ways in which qualitative and quantitative approaches are mixed. Their examples of mixed methods research include research utilising two types of sampling or two types of data collection, or, even more simply, two types of data (Tashakkori and Creswell, 2007b).

Teddlie and Tashakkori (2009) also rely on a qualitative-quantitative continuum to explain their understanding of mixed methods research and illustrate this diagrammatically, as shown in Figure 3-1. In their model, Zone A represents completely qualitative research, while Zones C and E represent completely mixed methods research and completely quantitative research, respectively (Teddlie and Tashakkori, 2009). The overlapping Zones, B and D, represent research that is either primarily qualitative with some quantitative components or primarily quantitative with some qualitative components (Teddlie and Tashakkori, 2009).

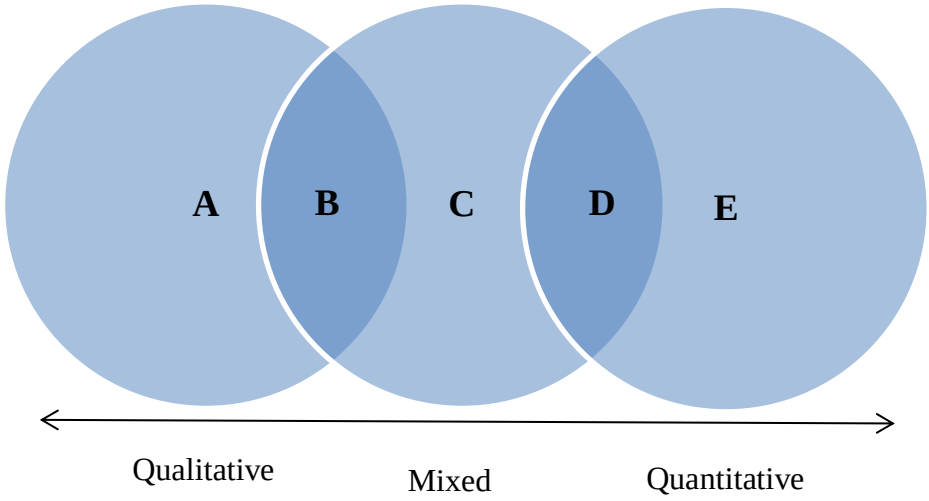


Figure 3-1 *Mixed methods continuum (Teddlie and Tashakkori, 2009)*

Teddlie and Tashakkori (2010, p. 5) expand on this broad definition with their concept of "methodological eclecticism", which they define as the selection and integration of "the most appropriate techniques" from across the continuum. Similarly, Bazeley (2010) also favours the concept of a methodological continuum, rejecting the need to separately define and include both qualitative and quantitative methodologies – in the "complete" form advocated by Creswell and Plano Clark (2011) – in a mixed methods study. What matters most to the selection of methods is the "centrality of the research question" and not any rigid adherence to "purist" ideas about qualitative, quantitative or mixed methods research (Niglas, 2010, p. 228). This broad understanding of mixed methods research underpinned the design of this study of nursing students' perceptions.

3.3.2 Mixed methods: rationale

In addition to the theoretical perspectives discussed in Section 3.2, Nastasi, Hitchcock and Brown (2010) identify research purpose as a key precursor to research design decisions. Similarly, Gorard (2010) stresses that the research purpose and questions

drive decisions about methodology. These decisions are perhaps best understood in the context of a research study's key stages, as described by Teddlie and Tashakkori (2009), and the general purposes of mixed methods research, as described by Greene, Caracelli and Graham (1989).

Teddlie and Tashakkori (2009) describe three key stages in a research study: conceptualisation; experiential; and inferential. Together, these three key stages constitute what Teddlie and Tashakkori (2009) identify as a "strand" of a study; strand being defined as any phase of a study that contains each of three stages. At the first stage – conceptualisation – the research purpose and questions, together with theoretical perspectives, are considered (Teddlie and Tashakkori, 2009). The second stage – experiential – concerns the study's methods of data collection and analysis (Teddlie and Tashakkori, 2009, p. 146). During the third and final stage – inferential – the findings are explained, and understanding is developed. In addition, in an exploratory sequential study of this type, the inferences of each strand will be integrated to generate a "meta-inference" (Teddlie and Tashakkori, 2009, p. 152).

As discussed in Section 3.2, this study's theoretical framework was pragmatism, and its purpose was to explore nursing students' perspectives on dignity in care. The research questions were:

1. What meaning do nursing students attach to the term 'dignity in care'?
2. What are nursing students' perspectives on the personal and environmental influences on the preservation of dignity in care?
3. What are nursing students' perspectives on the nurse's role in preserving dignity in care?

Regarding the conceptualisation stage of the current study, the research purpose and questions reflect the exploratory and inductive nature of the study, the researcher's qualitative orientation, and the gap existing around what is known of nursing students' perspectives on dignity in care. These considerations of orientation and available evidence are identified as reasons to choose an exploratory research design (Creswell

and Plano Clark, 2011). The methods identified at the experiential stage as the most appropriate to answer the research questions of this study were Nominal Group Technique (NGT) embedding photo-elicitation, and Q-methodology. These are detailed in Chapter 4, but, regarding the integration stage, both NGT and Q-methodology are characterised by their mixing of qualitative and quantitative techniques.

Carney, McIntosh and Worth (1996) and Gallagher et al. (1993) argue that, while NGT is essentially qualitative, its results can be presented quantitatively. This dual nature is underlined by Potter, Gordon and Hamer (2004), who describe NGT as a "mixed methods approach" because it provides both qualitative and quantitative information. NGT was used, in part, to develop the second, Q-methodology, strand of the study. Similarly, Q-methodology – which uses statistical analysis to reveal individual and collective viewpoints (Valaitis et al., 2011) – has also been described as both a qualitative and a mixed methods approach (Ernest, 2011; Newman and Ramlo, 2010; Watts and Stenner, 2012). The exploratory and inductive nature of the study, along with the use of these, arguably, mixed methods, situates the study in Zone B of the qualitative-quantitative continuum illustrated in Figure 3-1.

Greene, Caracelli and Graham (1989) identify the following reasons for choosing a mixed methods research design: triangulation; initiation; development; expansion; and complementarity. Relating the stages of the research study to these varied purposes helps provide the rationale for choosing a mixed methods research design, particularly in relation to the experiential and inferential stages.

One rationale for using a mixed methods design is triangulation (Creswell, 2014; Doyle, Brady and Byrne, 2009; Jick, 1979; Teddlie and Tashakkori, 2009). Archibald (2015, p. 2) explains that the "triangulation metaphor" has its origins in navigation and the use of two known points to locate a third unknown point. Similarly, Flick (2015, p. 218) describes triangulation as the use of "at least two vantage points" to scrutinise a research problem. These different vantage points are usually provided by the use of

multiple research methods (Flick, 2015), but may also be provided by the involvement of different researchers (Archibald, 2015; Teddlie and Tashakkori, 2009). Streubert and Carpenter (1999) argue that the latter is particularly important if a researcher lacks expertise in any of the methods being employed. Tracing its roots back to the ancient Greeks and Galileo, Maxwell (2015) disputes the view that ideas about triangulation began in the late 1950s with the growing recognition of mixed methods as a distinct research approach. Denzin (2012) also argues that contemporary ideas about triangulation are rooted in qualitative research; growing out of the combination of multiple qualitative approaches rather than the combination of qualitative and quantitative approaches.

Greene, Caracelli and Graham (1989) advocate the use of multiple research methods as a means of reducing variance and bias to enhance the validity of the findings. This stance is supported by Robson (2011), who comments that the use of multiple methods can improve the rigour of an inquiry. With reference to mixing qualitative methods only, Polit and Beck (2014) identify triangulation as a key strategy for enhancing the credibility and dependability of findings. In a similar way, Bryman (2006) identifies credibility as a reason for deciding to mix qualitative and quantitative methods in a single study. In the context of this study's location in Zone B of the qualitative-quantitative continuum, the use of triangulation to enhance credibility and dependability seemed most appropriate.

However, in an examination of over 200 mixed method research studies in social science, Bryman (2006) found that triangulation was not widely identified as a rationale for the use of mixed methods. In addition, Bryman (2007) argues that triangulation is much more than a means of confirming findings. Instead, the different methods should be "mutually informative" and integrated to generate a deeper understanding (Bryman, 2007, p. 21). The idea that the whole is greater than the sum of its parts is supported by Denzin (2012, p. 82), who argues that triangulation is "not a tool or a strategy of validation", but a means of enriching inquiry. Archibald (2015) agrees and suggests that viewing it only as a means of confirming findings is

"positivist" and limits its potential contribution to the enrichment of inquiry. This seems to be closely related to the remaining four other reasons identified by Greene, Caracelli and Graham (1989) for choosing a mixed methods design.

Firstly, one of these other reasons is initiation; a term used by Greene, Caracelli and Graham (1989, p. 127) to capture the use of mixed methods to enrich the "breadth and depth" of inquiry. This is achieved by seeking out and responding to contradictory or paradoxical findings (Bryman, 2006; Greene, Caracelli and Graham, 1989). Both consistent and divergent findings from the different methods are welcomed because of their potential to generate "fresh insights" (Greene, Caracelli and Graham, 1989, p. 128). To accommodate such insights, research questions are likely to evolve as the inquiry progresses (Bryman, 2006; Greene, Caracelli and Graham, 1989). Tashakkori and Creswell (2007a) identify this as a key approach to writing research questions for mixed methods studies. Therefore, the notion of initiation as a rationale for the use of mixed methods seemed relevant to this study because of the flexibility offered to respond to new or surprising insights emerging as the study progressed.

Secondly, development is another rationale, and this is defined by Greene, Caracelli and Graham (1989) as using mixed methods with the purpose of using one method to help develop the other. In this context, development refers to decisions about sampling as well as data collection and analysis (Greene, Caracelli and Graham, 1989). Bryman (2006) also highlights the use of mixed methods to facilitate sampling and develop instruments for data collection. As detailed in Chapter 3, the current study consisted of two strands, with the second being informed by the first.

Thirdly, 'expansion' is the term used by Greene, Caracelli and Graham (1989) to describe the selection of a mixed methods design because it allows for multiple components – such as processes and outcomes – to be incorporated into a single inquiry. This rationale is also highlighted by Bryman (2006), who notes that a decision to mix methods may be based on a desire to combine the quantitative study of structures with the qualitative study of the processes underpinning these structures.

Furthermore, expansion seems to correspond with the term 'completeness' used by Bryman (2006) to describe the use of mixed methods to enhance, explain and illustrate findings. In this way, it is argued that mixed methods will enrich findings, which is especially important in the study of complex problems (Creswell and Plano Clark, 2011; Doyle, Brady and Byrne, 2009; Muncey, 2009; Östlund et al., 2011). Again, this seemed especially appropriate to the study of perceptions and a complex concept such as dignity in care.

Fourthly, Greene, Caracelli and Graham (1989) also identify complementarity as a rationale. They explain that this term refers to the use of mixed methods as a means of remedying the limitations of one method with the strengths of another (Greene, Caracelli and Graham, 1989). This seems to correspond with what Bryman (2006, p. 106) refers to as the use of mixed methods to "offset" the strengths and weaknesses of qualitative and quantitative methods. It has been described as the most frequent rationale provided for the use of mixed methods (Bryman, 2006; Greene, Caracelli and Graham, 1989). It is argued that this enables findings to be elaborated, clarified and interpreted with greater ease and accuracy (Greene, Caracelli and Graham, 1989). These benefits were particularly relevant to this study of nursing students' perceptions because it was anticipated that enriching findings in this way would make them more amenable to analysis and more comprehensible, interesting, and accessible to others. It was anticipated that this in turn would aid the dissemination of the findings, especially to the student nurse participants and population. In addition, it seemed reasonable to suggest that this would improve the usefulness of the findings, especially in "applied" disciplines (Bryman, 2006, p. 106).

3.3.3 Mixed methods: challenges

Mixed methods research design, however, is not without its challenges. Among these, Creswell and Plano Clark (2011) identify the need for the researcher to be skilled, not only in qualitative and quantitative approaches, but also in mixed methods. Furthermore, they stress that mixed methods design has additional resource

implications because of the time involved in collecting, analysing and integrating multiple types of data (Creswell and Plano Clark, 2011). Strategies to overcome these challenges are identified as thorough preparation and working with, or being supported by, those with the requisite skills (Creswell, 2014). As a doctoral student, the researcher in this study worked with a supervisory team who provided this expert support and guidance.

Moreover, mixed methods design is not without criticism concerning what some regard as uncritical acceptance of its benefits, its masking of postpositivist thought and lack of clarity around its philosophical underpinnings. In a discussion of what he refers to as "clarion calls" for mixed methods in research, Silverman (2000) urges caution in viewing the combination of methods as necessarily providing a more holistic understanding. Giddings (2006, p. 196) provides a helpful summary of the criticism in her rejection of the notion that mixed methods design represents the "best of both worlds" in research. Instead, she describes mixed methods as post-positivism in disguise; a disguise that relegates qualitative approaches to a subordinate role (Giddings, 2006). Similarly, she comments that the use of the broad descriptor "qualitative" in mixed methods studies hides the diversity of qualitative approaches and diminishes their legitimacy as sources of knowledge (Giddings, 2006). Echoing these criticisms, Denzin (2010, p. 420) describes mixed methods research as consisting of a "community of postpositivist scholars" that has reduced qualitative inquiry to mere procedures.

Offering some support to this view is a review of the prevalence of mixed methods research in social and behavioural sciences conducted by Alise and Teddlie (2010). This review purposively sampled 150 mixed methods articles published in 2005 in "the most elite, prestigious journals" for two "pure" sciences – psychology and sociology – and two "applied" sciences – education and nursing (Alise and Teddlie, 2010, p. 109). One of the findings describes the dominance of post-positivism and quantitative approaches in sociology and, in particular, psychology (Alise and Teddlie, 2010). The authors argue that this reflects historical factors within the different

disciplines and contrast the historical roots of psychology in behaviourism with the emergence of mixed methods research in nursing and education (Alise and Teddlie, 2010). However, Alise and Teddlie (2010) point out more traditional research designs are perhaps to be expected in the most prestigious journals and advocate further research in this area. In this study of nursing students' perceptions, this issue was avoided because the more dominant approach was qualitative.

More fundamentally, Denzin (2010) states that mixed methods researchers modify paradigms to fit methods instead of fitting methods to paradigms. He goes on to query the feasibility of combining methods founded on radically different paradigms and the management of divergent findings (Denzin, 2010). Added to this, Giddings (2006) also asserts that mixed methods researchers not only fail to consistently define key terminology but also to identify the philosophical basis underpinning the research design and language used. Responding to these criticisms, Creswell and Plano Clark (2011) stress the need to explain the philosophical underpinning of any mixed methods study. With regard to this study of nursing students' perceptions, and as discussed in Chapter 3.2, the pragmatic paradigm seemed to provide a consistent and coherent theoretical framework and this helped to avoid the challenges presented by mixing paradigms. Moreover, Flick (2015) advocates careful consideration of a range of factors – such as the compatibility of the different methods – before embarking on a mixed methods study, and this will be discussed in Chapter 4.

3.3.4 Mixed methods: design

Creswell and Plano Clark (2011) accept that designing mixed methods research presents particular challenges and recommend that researchers consider carefully their design approach. They go on to advise those new to mixed methods to consider using a typology approach although others – such as dynamic approaches – are available (Creswell and Plano Clark, 2011).

A typology approach is characterised by the choice of a specific design from a range of options classified by factors such as the relative timing of the different methods and

where and how these methods are integrated (Plano Clark et al., 2014). Whichever typology is chosen, it can be adapted to suit the particular needs of the research concerned (Creswell and Plano Clark, 2011; Teddlie and Tashakkori, 2009). According to Teddlie and Tashakkori (2009), there are several reasons for adopting a typology-based approach to research design. Of these, most seem to be closely related to the relatively recent emergence of mixed methods as a distinct methodological approach. The reasons include helping to establish agreed terminology and formal structures specific to mixed methods methodology, distinguishing it from qualitative and quantitative approaches, and legitimising it as a methodology its own right (Teddlie and Tashakkori, 2009). Guest (2013) dismisses these reasons, highlighting the wide variations in both language and structure used in mixed methods research. However, Creswell and Plano Clark (2011) suggest that such variation is to be expected, given the emergent nature of mixed methods methodology.

For experienced mixed methods researchers seeking flexibility or dealing with particular complexity, dynamic approaches avoid these pre-defined options (Creswell and Plano Clark, 2011). Instead, researchers consider how qualitative and quantitative approaches interact with each other across each component of the design (Hall and Howard, 2008; Plano Clark et al., 2014). This approach offers greater flexibility for particularly complex research such as longitudinal studies (Plano Clark et al., 2014). In addition, Hall and Howard (2008) combined typological and dynamic approaches in their synergistic approach to manage the complexity of a randomised controlled trial. In this study of nursing students' perceptions, a typology approach was selected because – as advised by Creswell and Plano Clark (2011) – the researcher was new to mixed methods and welcomed the structure and clarity typologies provided.

Perhaps one of the most significant reasons for the use of a typology approach is that it provides researchers with a menu of "ideal design types" from which they can select the one best-suited to their study (Teddlie and Tashakkori, 2009, p. 139). This approach is supported by Plano Clark et al. (2014), who state that typologies are particularly useful for researchers new to mixed methods methodology and who need

to make decisions about research design. Once again, Guest (2013) rejects this idea, arguing that typologies are unnecessary because the successful combination of quantitative and qualitative methods pre-dates their use. However, it is perhaps worth highlighting that Teddlie and Tashakkori (2009, p. 139) do not state that typologies are necessary, only that they can "help" researchers make design decisions. This is underlined by Creswell and Plano Clark (2011), who state that a typology is not a recipe but a guiding framework.

3.3.5 Mixed methods: typology

Teddlie and Tashakkori (2009) provide a systematic approach to typology selection which – through a series of questions – prompts careful and explicit consideration of key decision points in research design. The decision points identified by the questions relate to two key design decisions: the number of methodological approaches required and the number and timing of strands in the study.

Identifying the number of methodological approaches in this study was problematic because NGT and Q-methodology do not "fit" completely into conventional "purist" ideas of qualitative or quantitative research. This is particularly true of Q-methodology because it combines qualitative and quantitative techniques in significant measure (Baker et al., 2014). Indeed, Q-methodology has been defined as a methodology in its own right and described as 'qualiquantological' (Newman and Ramlo, 2010; Watts and Stenner, 2005). Therefore, a modified version of the sequential mixed methods typology described by Teddlie and Tashakkori (2009) was adopted as a means of providing a clear and logical research design. Conventionally, this research design involves combining qualitative and quantitative data (Creswell, 2014). However, the study will combine primarily qualitative data from NGT with data obtained using a Q-methodology approach rather than a conventional quantitative approach.

This study of nursing students' perceptions contained two strands and was, therefore, categorised as a "multistrand" design (Teddlie and Tashakkori, 2009, p. 145). Teddlie

and Tashakkori (2009) advise researchers to determine which strand will focus on which research questions. The first strand of this study – Strand 1 – focused on all three research questions, while the second strand – Strand 2 – focused on the third research question. The rationale for this decision is detailed in Chapter 4. The next step for a multistrand design such as this one was to clarify whether the strands will be simultaneous or sequential (Teddlie and Tashakkori, 2009). In this study, a modified version of the sequential design described by Teddlie and Tashakkori (2009) was used. This consisted of two strands in which the findings from Strand 1 informed the design of Strand 2.

In a discussion of the strengths of exploratory sequential research designs Creswell and Plano Clark (2011) note that separating strands facilitates the description and implementation of studies. They also argue that including a quantitative strand "can make the qualitative approach more acceptable to quantitative-biased audiences" (Creswell and Plano Clark, 2011, p. 89). Interestingly, this same claim was made of a monostrand Q-methodology study (Merrick and Farrell, 2012), and this reflects the quantitative component of the approach, arguably lending further support to its use as the second strand of a sequential exploratory study. Creswell and Plano Clark (2011) also note that the exploratory sequential design is particularly valuable in developing new data collection instruments and this is true of this study in which Strand 1 informed data collection in Strand 2. In the context of this study of nursing students' perceptions, these strengths seemed to outweigh the challenges identified by Creswell and Plano Clark (2011), including the time required to implement each stage and to develop a data collection tool for the second strand. This study's exploratory sequential design is summarised in Figure 3-2.

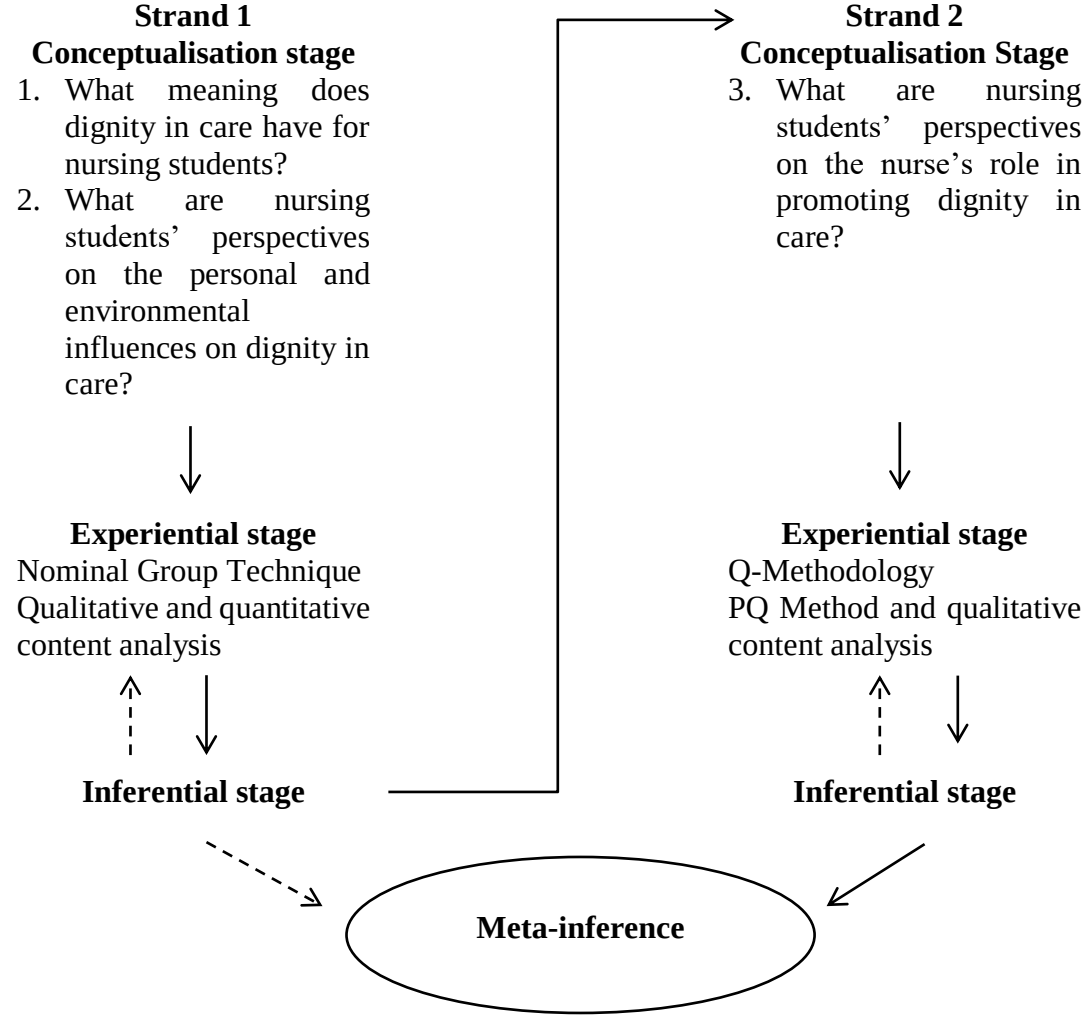


Figure 3-2 *Research design overview*

3.4 Chapter 3: Conclusion

Chapter 3 considered the focus of the current study in relation to post-positivist, constructivist and transformative paradigms. The rationale for the choice of the pragmatism paradigm as the theoretical framework for the current study was explained in terms of its resonance with the researcher and its flexibility. The development of the research design was also discussed. A typology of mixed methods research design was used to help the researcher make decisions around structure, methods and the integration of data. The selection of methods – NGT and Q-methodology – which are themselves 'mixed' – allowed the integration of data in each strand and offered the opportunity to triangulate results. A modified sequential exploratory research design was selected with the first strand informing the second. Chapter 4 moves on to examine the study's ethical considerations and methods adopted.

4 Chapter 4: Methods – Strand 1

4.1 Chapter 4: Introduction

Chapter 4 examines the ethical considerations for the whole study and the methods adopted in Strand 1 of the study. The methods used in Strand 2 of the study will be discussed in Chapter 6. This chapter also consider the methods of data analysis: qualitative and quantitative content analysis. The results for Strand 1 are presented in Chapter 5. Ethical approval for the current research study was provided by the School of Health Nursing and Midwifery Ethics Committee of the University of the West of Scotland. The confirmation letter is provided in Appendix 11.7.

4.2 Ethical Considerations

Polit and Beck (2014) highlight the need to address ethical considerations in research. These considerations concern not only the participants but also the researcher and the quality of the research itself. In the current study, a convenience sample for each strand was recruited from each year of a three-year undergraduate preregistration programme in the university where the researcher is employed as a nurse lecturer. The decision to recruit these students is perhaps best understood in terms of what Bradbury-Jones et al. (2011, p. 107) describe as a "balancing act" of risks and benefits. Cleary, Walter and Jackson (2014) advise that this balance is most effectively achieved by considering carefully the ethical principles of autonomy, non-maleficence, justice and beneficence.

4.2.1 Autonomy

Ferguson, Myrick and Yonge (2006) accept that nursing students are essential participants in most nurse education research but also stress the importance of recognising their vulnerability. This is especially important in relation to their right to make an autonomous decision about research participation; highlighted as a key ethical challenge for nurse lecturers considering recruiting nursing students from their

own university (Anderson, 2011; Bradbury-Jones, Sambrook and Irvine, 2007; Chen, 2011). Houghton et al. (2010, p. 18) go so far as to describe this as a "potentially exploitative relationship". Ridley (2009) warns against presuming that students will feel free to provide or refuse their informed consent to participate. Instead, students may think that declining or agreeing to participate will impact negatively or positively on their relationship with the researcher, future learning opportunities, or even their progression through the programme (Clark and McCann, 2005). Cleary, Walter and Jackson (2014) also note that a potential participant may experience peer pressure to decline or agree to participate. Regardless of whether coercion exists or is intended, Ferguson, Myrick and Yonge (2006) stress that it is the perception of coercion that matters.

To minimise the risk to autonomy, particular care was taken to ensure potential participants understood what participation involved and the voluntary nature of their participation (Anderson, 2011). This was also re-iterated in each interaction between the researcher and participants. As recommended by Ferguson, Myrick and Yonge (2006) and Cleary, Walter and Jackson (2014), the researcher did not recruit the students herself. Instead, students were approached on her behalf by three other lecturers in adult nursing – unconnected with the study – at the end of scheduled classes. As the nursing students were recruited from the adult nursing programme, the information sheets for each strand (Appendices 11.8 and 11.9) also provided the contact details of another nurse lecturer unconnected with the study and based in the mental health nursing programme. Providing students with a named person to contact who was unconnected with the research or their programme of study was directed towards alleviating any fears about the potential impact of raising concerns on their studies or progress.

In addition, the students all received the relevant forms – described in Section 4.3 – in an envelope and were asked to return them signed or unsigned in the same envelope. This meant that the staff member approaching the students, and other students, could not distinguish between those who declined and those who agreed to participate.

Consent forms and information sheets made it clear that nursing students were not obliged to take part, that participation was entirely voluntary, and that they were free to withdraw at any time without giving any reason and without their decision having any impact on their teaching and assessment. Following their initial expression of interest, potential participants had seven days to consider their participation to provide an opportunity for the student to re-consider (Polit and Beck, 2014).

Cleary, Walter and Jackson (2014) recommend that the researcher-lecturer should emphasise the role of researcher in contact with student participants. The researcher identified herself firstly as a student, secondly as a lecturer. She also provided her own student email address as her contact address and used this for correspondence. Similarly, the university ethics committee had advised the researcher not to use student email addresses because she had access to these only by virtue of her role as lecturer. Therefore, students who agreed to participate were asked to provide their preferred contact details and these were used for correspondence with them. This placed the onus on the student to provide their contact details with the aim of minimising any perceived coercion. In the initial contact, the researcher thanked students for their interest, invited them to a nominal group meeting and reminded them of their right to withdraw at any time. A day before the scheduled nominal group, a single reminder email was sent. This again re-stated the student's right to withdraw at any time. If the student did not respond or attend, no further contact was initiated to avoid any perception of coercion.

4.2.2 Non-maleficence

Risks to the student in relation to non-maleficence – the obligation to do no harm (Beauchamp and Childress, 2009) – focused on the potential for breaches in anonymity and confidentiality. Participants were identified by code only. Only basic demographic details were collected – age and gender – to help prevent breaches of anonymity. Bradbury-Jones, Sambrook and Irvine (2007) suggest researchers should refrain from collecting even these details because such defining characteristics could

reveal identity. However, the size of the cohorts at this university – 480 students – relative to the numbers who participated in Strand 1 – 31 students – reduced this risk. Only the researcher and members of the supervisory team had access to the codes used to identify participants. All identifying forms and data were kept in a locked filing cabinet and access to electronic data was by password only.

In a discussion of the researcher's responsibility to provide and maintain anonymity and confidentiality, Corbin and Strauss (2015) note that there is an obligation on the researcher to report behaviour that has the potential to harm others. This was particularly significant because the researcher – as a Registered Nurse – is accountable to the Nursing and Midwifery Council (Nursing and Midwifery Council, 2015). If a student nurse in the nominal group described a situation that raised questions regarding the professional conduct of the nursing student(s) and/or other individuals involved, then she would have needed to take further action (Bradbury-Jones and Alcock, 2010). Such action could have ranged from arranging support for the student(s) concerned to referral of the nursing student(s) to the Health, Nursing and Midwifery School's Fitness to Practise panel. Depending on the outcome of the panel, this could jeopardise a student's ongoing enrolment on the programme.

To mitigate the risk, students were reminded of this professional obligation on the consent form (Appendix 11.10). Participants were also reminded that the focus was on the promotion of dignity in care rather than its violation. A plan was made so that, if the discussion were to focus on circumstances in which dignity had been violated, then the researcher would offer the participant(s) the opportunity to discuss this after the group. Given the possibility that such a discussion might raise upsetting issues for the participants, they were debriefed by the researcher at the end of their participation in the nominal groups and debrief was also available in Strand 2.

Interestingly, Taylor and Bradbury-Jones (2011) highlight the risk of harm to the researcher caused by dealing with sensitive issues in research. However, the researcher is experienced and confident in working with nursing students. This work

often involves facilitating discussion around sensitive issues related to care and ensuring nursing students feel supported during such discussions.

4.2.3 Justice

Key considerations related to justice – the principle that equals ought to be treated equally (Beauchamp and Childress, 2009) – related to managing the perceived benefits and burdens of participation (Cleary, Walter and Jackson, 2014; Ridley, 2009). With regard to benefits, Beauchamp and Childress (2009, p. 255) explain that potential participants may perceive coercion when "undue inducement" is used. No monetary or similar inducements were offered in return for participation, although students were advised at the initial approach that during the nominal groups they would be offered light refreshments. Ridley (2009) also raises the possibility of students perceiving that participating in a research study related directly to assessed course content would result in improved grades. However, in this study, dignity in care does not form an assessed component of the programme, and so this risk was avoided.

Furthermore, Cleary, Walter and Jackson (2014) highlight the importance of groups not being burdened with research participation because of their availability. This was a significant consideration in this study because of the volume of research activity in the university and the frequency of requests for participation. The researcher managed this by seeking the approval of the Professional and Academic Lead for the School of Nursing – who was aware of any other requests for access – and timing her request for participation appropriately. In addition, the researcher's role as lecturer enabled her to identify the days and times when nominal groups would be most convenient for the students and this also helped reduce the burden on participants. Students were informed of the total expected duration of participation so that they could include this in their decision-making about whether or not to participate.

4.2.4 Beneficence

Ethical considerations in relation to beneficence – the obligation to do good (Beauchamp and Childress, 2009) – were primarily concerned with potential benefits for student learning and the enhancement of care and education. Chen (2011, p. 281) asserts that the "scales" of any risk-benefit analysis of student participation in research "appear tipped towards potential for benefit" because the risks are usually "minimal". Bradbury-Jones et al. (2011, p. 107) also warn that emphasis on risks can "obscure the possible benefits" of student participation.

Roberts and Allen (2013) conducted two online surveys of undergraduate psychology students in Australia – 68 students completed the first survey and 146 the second – to develop and validate a tool to measure student perceptions of research participation. They found a general consensus that participation provided educational benefits which outweighed perceived risks (Roberts and Allen, 2013). Similarly, in a study of 13 UK nursing students' experiences of being participants in a longitudinal research study, Bradbury-Jones et al. (2011) found that a key benefit identified by participants was the opportunity that participation provided to reflect on care. Enhanced knowledge of not only the subject being investigated but also the research process itself were also reported as benefits perceived by student participants in research (Bradbury-Jones et al., 2011). In addition, Bradbury-Jones et al. (2011) report that students perceived that participation enhanced their experiences in practice. For Winstone (2015), "conducting educational research 'with' and 'for' students rather than 'on' them" also allows researchers to learn from students and is more in keeping with the role of students as experts and partners.

4.3 Participant Recruitment

Five nominal groups – incorporating NGT with photo-elicitation – were recruited. All students in the September 2012, September 2013 and September 2014 cohorts (first-, second- and third-year nursing students, respectively) of the BSc Adult Nursing programme at one of four campuses were invited to participate (a total of 522 nursing

students) and provided with an information sheet (Appendix 11.8). In total, 89 nursing students completed and returned consent forms (Appendix 11.10) and contact sheets (Appendix 11.11). All nursing students who responded were thanked and invited – via their preferred contact details – to participate in a nominal group by the researcher using her student email address. A typical follow-up email is provided in Appendix 11.12. Nominal groups were arranged on dates and at times that corresponded with timetable commitments to minimise any potential inconvenience for the participants. Prior to each nominal group, several potential participants contacted the researcher because they were – for a variety of reasons – no longer able to participate as scheduled. The remaining 31 nursing students participated in one of five, cohort-specific, nominal groups, as summarised in Table 4-1.

Table 4-1 *NGT groups*

Year Group	Cohort	Group Name	Date	Number of Participants
Year 1	2014	14A	09.03.15	7
		14B	10.03.15	3
Year 2	2013	13	23.04.15	12
Year 3	2012	12A	18.12.14	6
		12B	11.02.15	3
Total Number of Participants				31

4.4 Participant Profile

Minimal demographic data – age and gender – were collected in order to provide a broad profile of the participants while protecting their anonymity. A summary of the participants' age and gender profile is provided in Table 4-2.

Table 4-2 *Participant profile: NGT*

	Age			Gender		
Group	20–29	30–39	40–49	Male	Female	Total
14A	3	2	2	0	5	7
14B	0	2	1	0	3	3
13	5	6	1	0	12	12
12A	3	2	1	2	4	6
12B	1	1	1	0	3	3
Total	12	13	6	2	29	31

4.5 Data Management

Potential participants were allocated a number based on their cohort – that is 12, 13 or 14 – and another number corresponding with the order in which their consent form was received. For example, a potential participant from the September 2012 cohort whose consent form was numbered 10 would be Participant 12.10. Group names also incorporated the relevant cohort and where two groups were drawn from the same cohort they were identified by A or B. For example, the first of the two groups involving participants from the September 2014 cohort was numbered 14A.

The photo-elicitation exercise used to begin the NGT used 'Envision' images (NHS Education for Scotland, 2012). These were pre-numbered at source and these numbers were used to identify them when responses to question one were transcribed. Once the statements generated via the Round Robin stage (see Section 4.6.1) were transcribed, they were allocated an identifying number. This number incorporated the following: the group in which the statement originated, the question the statement related to – question two or three – and the order in which it was listed during the Round Robin. For example, the statement listed first in response to question two during the Round Robin facilitated with Group 14A was numbered 14A.2.01.

Participants could be matched to their unique identifier in two places: on their consent form and in an electronic database of all those who returned consent forms. To protect the anonymity of all those involved, paper documentation was held securely in a locked filing cabinet in a locked office on campus or in a locked cabinet at the researcher's home. The electronic record matching participants with their unique identifier was held in a password protected database. Data generated during the nominal group was transcribed into electronic form and this was held securely in a password-protected laptop. Only the researcher and supervisory team had access to the paper and electronic documentation.

4.6 Data Collection in Principle

4.6.1 Nominal group technique (NGT)

Nominal Group Technique (NGT) may be defined as a highly structured approach used to explore areas of interest and develop consensus (McCance et al., 2012; Van De Ven and Delbecq, 1972). The process of NGT was developed by Van De Ven and Delbecq (1971) to assist in healthcare planning. Since then, the technique has been applied to problems in a wide range of settings; from nursing (Carney, McIntosh and Worth, 1996; Klim et al., 2013; McCance et al., 2012) to education (Colón-Emeric, Bowlby and Svetkey, 2012; Kennedy and Clinton, 2009; Kennedy and McKay, 2010; Shortt et al., 2010) and research (Gaskin, 2008; Kenkre et al., 2013). The adaptability and flexibility of the technique is illustrated by its use with a diverse range of participants, including those with intellectual disabilities and dementia (Dening, Jones and Sampson, 2013; Tuffrey-Wijne et al., 2007).

With its focus on problem exploration and group decision-making, it is perhaps unsurprising that NGT is "one of the most commonly used formal consensus development methods" (Harvey and Holmes, 2012, p. 188). Consequently, it seems reasonable to suggest that this will help provide an insight into participants' perspectives on the influences on dignity in care. The decision to use NGT was also

informed by the need to find a data collection tool for Strand 2 that represented participants' different views, and this is discussed in Section 6.4. The literature reflects a range of opinion about the relationship between focus groups and NGT and contains a wide range of recommendations regarding group size, process, and facilitation, and the recording and analysis of data.

4.6.1.1 NGT and focus groups

There are several similarities between focus groups and NGT and the use of both is established in Q-methodology (McKeown and Thomas, 2013; Valaitis et al., 2011). Each brings together small groups of similar participants in a relaxed and non-threatening environment with the purpose of exploring a particular topic (Doody, Slevin and Taggart, 2013; Harvey and Holmes, 2012; Kevern and Webb, 2001; Papastavrou and Andreou, 2012). Such groups seemed particularly appropriate to the sensitive subject of nursing students' perspectives on dignity in care. Moreover, in a discussion of focus group data, Massey (2011, p. 23) notes that the use of specific questions in focus groups can result in clearly articulated data. Porter (2012, p. 35) argues that NGT produces this same type of data and describes NGT as a "type of focus group". Similarly, Gaskin (2008, p. 12) describes NGT as a "focus group research method". These similarities have led some to argue that NGT can be used in the context of focus groups (Bamford and Warder, 2001; Cooke and Thackray, 2012; Harvey and Holmes, 2012; Hickey and Chambers, 2014; Iliffe et al., 2005; Massey, 2011; Sloan, 1999).

However, while there are many similarities between focus groups and NGT, it is also possible to argue that focus groups and NGT should not be conflated. Parker and Tritter (2006) stress that focus groups are more concerned with the dynamics between participants than with the participants' answers to questions and this seems to be very much at odds with the fundamental importance of questions to the NGT. Similarly, there is a widely held view that focus groups should not be used when the goal of the process is to reach consensus (Allen, Dyas and Jones, 2004; Krueger and Casey, 2000;

Redmond and Curtis, 2009). Therefore, as an "approach to building consensus" (McCance et al., 2012, p. 1147), it seems reasonable to suggest that NGT is significantly different from focus groups. Consequently, it is often distinguished explicitly from focus groups (Carney, McIntosh and Worth, 1996; Gallagher et al., 1993; Langford, 1994; MacPhail, 2001; Morgan, 1993; Potter, Gordon and Hamer, 2004).

4.6.1.2 NGT and process

The groups involved in NGT are characteristically small and have a particular interest or expertise in a specific problem area (Van De Ven and Delbecq, 1972). In general, group size ranges between a minimum of three (Miller, 2009) or five (Kennedy and Clinton, 2009; Potter, Gordon and Hamer, 2004) and a maximum of twelve (Allen, Dyas and Jones, 2004; Harvey and Holmes, 2012).

The NGT process is often discussed in relation to four key stages (Kennedy and Clinton, 2009) and the nominal groups in this study followed this structure. At the first stage, participants are introduced to the topic and invited to engage in a silent generation of ideas for around ten minutes (Van De Ven and Delbecq, 1972). Participants write their ideas down but there is no discussion at this stage between group members (Carney, McIntosh and Worth, 1996). Unusually, in their study of the involvement of service-users in developing education standards for students seeking registration with the Health Professions Council (HPC), Hickey and Chambers (2014) did not provide an opportunity for the silent generation of ideas, arguing instead that discussion and sharing of ideas would enhance group creativity. This may relate to the heterogeneous nature of their participant group – comprising service-users, students, academic and HPC staff. However, it could be argued that this could negate one of the key advantages of NGT; the avoidance of discussion being dominated by one or two groups members.

Next, at the second stage, each participant is invited, in turn, to share one of their ideas with the rest of the group in a "Round Robin" format (Bamford and Warder, 2001).

There may be clarification of ideas at this stage to allow them to be listed, but, again, there is no discussion (Harvey and Holmes, 2012). However, Bamford and Warder (2001, p. 318) identify "hitch hiking" – where participants record any new ideas triggered by the ideas of other members of the group – as a valuable feature of this stage. Each idea is recorded by a facilitator until all ideas have been listed or, where time is restricted, there has been an equal opportunity for each participant to express their ideas (Carney, McIntosh and Worth, 1996).

These ideas are then discussed at the third stage to identify any overlap or need for clarification with every effort made to ensure the discussion is 'value-neutral' (Harvey and Holmes, 2012). The fourth and final stage involves the participants in voting for and ranking their ideas (Dening, Jones and Sampson, 2013). This process is intended to ensure that all group members have an equal opportunity to participate and no one member dominates the discussion (Porter, 2012).

4.6.1.3 NGT and facilitation

The facilitation of groups in NGT varies in the literature. Some authors do not discuss it explicitly (Cooke and Thackray, 2012; Harvey and Holmes, 2012; Manthorpe et al., 2010; McCance et al., 2012; Sloan, 1999). Many, however, do discuss facilitation and there appears to be wide agreement that the facilitator should be a "neutral receiver of ideas" (Kennedy and Clinton, 2009; O'Neil and Jackson, 1983, p. 131; Porter, 2012). The need for the facilitator to have experience of managing group discussions is particularly highlighted by Allen, Dyas and Jones (2004). According to Potter, Gordon and Hamer (2004), the facilitator should also be an expert in the subject area. While O'Neil and Jackson (1983) state that the researcher should be a non-participant observer, Kennedy and Clinton (2009) and Dening, Jones and Sampson (2013) both state that the researcher can act as facilitator. Indeed, MacPhail (2001) states that the researcher is typically the facilitator.

4.6.1.4 NGT and analysis

There are also variations in the ways in which NGT is recorded and analysed. Field notes of the discussion stage are sometimes recommended (Bamford and Warder, 2001; Manthorpe et al., 2010). Audio-recording and transcription have also been described (Cooke and Thackray, 2012; Dening, Jones and Sampson, 2013; Potter, Gordon and Hamer, 2004). However, some authors do not discuss any recording methods other than the lists and rankings produced during the Round Robin and voting stages (Allen, Dyas and Jones, 2004; Harvey and Holmes, 2012; McCance et al., 2012; O'Neil and Jackson, 1983; Porter, 2012; Van De Ven and Delbecq, 1972). Indeed, MacPhail (2001) states that there is no need to make any other recordings and identifies this as one of the key advantages of NGT. Similarly, Kennedy and Clinton (2009) stress that there is no need to audio-record or transcribe discussion.

4.6.2 Photo-elicitation

Photo-elicitation was selected as a key component of the NGT process in this study for several reasons related to both the nature of dignity and the nature of the participants. In a comprehensive introduction to photo elicitation, Harper (2002) notes its origins in social sciences in the late 1950s and describes it as a technique involving the use of photographs in an interview setting. Since then, its popularity has grown, and it is increasingly used in a wide variety of research settings (Hibberd et al., 2009). Such uses include the needs of carers (Hibberd et al., 2009), student nurse strategies to manage stress (Woodhouse, 2012), and experiences of care in an acute in-patient setting (Dewar, 2012). Lorenz and Kolb (2009) distinguish photo elicitation from photovoice; the former more commonly used with individuals and involving pre-existing images, and the latter more commonly used with groups involving the creation and subsequent analysis of images.

One key reason for the use of photo elicitation in this study is the complex nature of the concept of dignity. In a discussion of the meaning of "compassionate care" Dewar (2012) notes that such complex concepts can be difficult for people to articulate in all

but the most general terms. It seems reasonable to assert that people would experience similar difficulties in articulating the meaning of dignity. To facilitate greater discussion, she recommends the use of creative methods such as photo elicitation (Dewar, 2012). Harper (2002, p. 13) argues that images can generate deeper responses than words alone. This is supported by Lorenz and Kolb (2009), who describe photo elicitation as a much more powerful means of revealing such responses than using words alone. For Banks (2007), this seems to be related to the idea that images have agency in so far as images can compel us to respond in a way that words cannot.

The nature of the participants was another reason why the use of photo elicitation in this study seemed appropriate. Lorenz and Kolb (2009) describe photo elicitation as a means of bridging the gap between what participants know and what they can articulate. They argue that this is particularly important for participants who "lack fluency with words" (Lorenz and Kolb, 2009, p. 263). Arguably, the student nurse participants in this study may have found it particularly difficult to articulate the meaning of dignity because of a perceived need to say the 'right' thing or to give the 'correct' answer. This would perhaps have been especially likely in the researcher's presence and that of their peers. Edgar (1999) suggests that photo elicitation may help such participants to respond more authentically by connecting with the unconscious to evoke a spontaneous response. For Banks (2007), this seems to be rooted in the power of images to stimulate memory and discussion.

This stimulation of broader discussion through photo elicitation is also identified by Dewar (2012) and was of particular interest to me – as a novice researcher – because I thought it might help to gain the nursing students' interest and encourage their active participation. In addition, Banks (2007, p. 65) makes the point that images can be a sort of "neutral third party" in an interview situation by giving those involved something to focus on, thereby reducing the "awkwardness" of the situation. In addition, Hansen-Ketchum and Myrick (2008) argue that photo elicitation does not simply provide more information; it provides different information. This seemed very appropriate because the researcher was keen to move beyond the narrow and standard

textbook definitions of dignity towards what it means for nursing students. Perhaps most importantly is the belief that visual methods such as photo elicitation can lead researchers into unconsidered and unanticipated areas (Banks, 2007).

In this study, pre-existing images were used from a suite of images, printed on cards, entitled "Envision" and published by NHS Education for Scotland (2012). Each card consists of a different image. This suite of images was developed over several years by Professor Belinda Dewar before being formalised in collaboration with NHS Education for Scotland (Personal Communication, Dewar, B. Meeting with the author, 20 May 2015). Banks (2007) criticises the use of such pre-existing images when they have no connection to either the researcher or the participant on the grounds that they tend to dominate the interview and make it less personal. However, Lorenz and Kolb (2009) argue that images can be drawn from a wide range of sources, including archived images and even advertisements. Reassuringly, Dewar (2012) used images from the same suite of cards in her study of compassionate care. Clark, Prosser and Wiles (2010) stress the need to consider copyright and NHS Education Scotland confirmed a licence to use the images was bought on their behalf by the production company that produced the cards.

4.7 Data Collection in Practice

Five nominal groups were held in spacious, quiet meeting rooms on campus. Each group lasted between one and one-and-one-half hours. Rooms were set up in the same way for each group, with a flip chart and the Envision (NHS Education for Scotland, 2012) images scattered along the meeting room table. On arrival, participants were welcomed and offered light refreshments. While waiting to begin, participants noticed the images, made some comments and asked questions about them. From the outset, the images acted as a conversation prompt, helping to 'break the ice', even before the nominal group began formally, and gain the participants' interest. Participants were invited to complete the response booklet shown in Appendix 11.13. Brief field notes

were made during the nominal group to facilitate the researcher's reflection on the process.

The first group – Group 12A (September 2012 cohort, 3rd Year nursing students) – was originally conducted as a pilot study but was then included in the main study. van Teijlingen and Hundley (2002, p. 35) note that the "contamination" of main study data with pilot study data is "less of a concern in qualitative research" than in quantitative research and is "often done". This approach was adopted because the changes made to the conduct of subsequent groups following the first group were minimal. These minor changes stemmed from the growing familiarity and confidence of the researcher with each group conducted rather than significant changes to process or content.

4.7.1 Step 1 – introduction

Participants tended to arrive at the venue at slightly different times and were welcomed as they arrived before being offered some refreshments. Once everyone had assembled, the researcher provided a more formal introduction to the process for between five and ten minutes. During the introduction, she thanked participants for their attendance and reminded them of the voluntary nature of participation and that they could withdraw at any time. Participants were also reminded that their anonymity would be protected and asked not to share with anyone else something another participant shared with the group. The researcher advised the participants that she would be available to them on an individual basis after the group to discuss any issues raised in more detail. The content of the introduction was modified following the first nominal group in response to questions raised by participants at the beginning of that group, and the researcher's reflection on it, as discussed below.

With regard to the photo-elicitation component, participants in the first group enquired whether more than one image could be selected, what to do if "their" image was chosen by another participant, and the relationship between the image and the word on its reverse. Consequently, in subsequent groups, participants were advised that they could select more than one image if they wanted to, that they could also share

images if an image was chosen by more than one participant, and that there was no relationship between the image and the word on its reverse. The researcher also advised participants that they would not be asked to share or discuss their chosen image because a key reason for selecting photo-elicitation was to reduce any embarrassment or awkwardness at the beginning of the group, as suggested by Banks (2007). The researcher felt this function would be enhanced by not asking participants to share their thoughts with others at the outset.

More generally, the introduction outlined briefly the process and the Response Booklet (Appendix 11.13). To help groups keep to time, participants were encouraged to use brief bullet points in the booklet and were advised that they could move through it at their own pace. The researcher also explained that silence was valued at the silent generation stage but there would be time for discussion at other stages. At the end of each introduction, questions were invited but rarely asked. The questions that were asked concerned the images; usually around where the images came from rather than the nominal group process.

4.7.2 Step 2 – silent generation of ideas

Lasting around thirty minutes, this stage was the longest one in the process. During this stage, participants were invited to respond to the three questions in the Response Booklet (Appendix 11.13) shown below:

Question 1 (Q1)

Please take a few moments and select an image that captures something of what dignity in care means to you. Jot down what it was about the image that captured something of that meaning for you:

Question 2 (Q2)

Please think about a situation you experienced while on placement in which dignity was promoted. Was there anything in particular about the people involved that helped promote it? Bullet point a list of your ideas below:

Question 3 (Q3)

Please think about a situation you experienced while on placement in which dignity was promoted. Was there anything in particular about the place that helped promote it? Bullet point a list of your ideas below:

Initially, the researcher was apprehensive that participants would struggle to respond to Q1 and to select an image, but that did not appear to be the case. Images seemed to be selected with ease, and responses to question one were completed within around fifteen minutes. Of the seventy images available in the Envision suite of cards (NHS Education for Scotland, 2012), a total of 32 images were selected. Of these, nine images were selected more than once (on between two and four occasions). The images and responses generated by Q1 one are provided in Table 5-11, and an example is provided below in Table 4-3.

Table 4-3 *Example of image selection and rationale*

Image 36A (NHS Education for Scotland, 2012) 	"I have chosen a set of keys, the reason for this is I feel a key is individual and every set is different. With regards to dignity in care, everyone is different. If someone gives you a key to their house/heart they must have a certain degree of trust and feel comfortable with you in their personal space. To keep a person's dignity we must have permission and always make them feel comfortable and not expose them to anything they feel is a danger or upsetting to them." Participant 14.01

4.7.3 Step 3 – round robin

This stage lasted around 15 minutes. The process was explained and all the participants, in turn, provided a single statement from their responses to Q1 and then Q2 until everyone had exhausted their lists. Each statement was numbered as the researcher recorded them on a flip chart (Appendix 11.14). Every effort was made to record the statements verbatim, although some were abbreviated or condensed in agreement with the participants who offered them. As flip chart pages became full, they were posted on the walls so that the participants could still see them.

On one occasion, the researcher was aware that two participants (12A.05 and 12A.15) were not offering the ideas as listed in their response booklets. Subsequent review of the responses in their booklets suggested that these participants had provided detail about their specific situations in the booklet rather than statements related to people or place. However, the detail of the situation had still enabled the participants to extract specific statements to add to the flip charts during this stage. The number of

statements – such as *'Involving families'*, *'Helping give back confidence'* and *'Remembering they're a person not a bunch of conditions'* – generated per group at this stage ranged from 24 to 31.

4.7.4 Step 4 – discussion

This stage was brief – lasting around five minutes – mainly because there seemed to be little overlap in the statements raised but also because of time constraints. Participants were invited to consider the statements recorded on the flip charts as follows and to identify any statements they did not understand, were unsure of, or needed to hear more about. Clarification was not sought on any of the statements by the group.

At times, generic statements were offered, such as *"A focus on quality improvement"* (statement number 12A.2.04) and *"Valuing the individual"* (statement number 12A.2.13). Some effort was made to clarify in practical terms what the participants meant by these by asking how these were made evident. However, the researcher was conscious of her role as a facilitator using NGT, described by O'Neil and Jackson (1983, p. 131) as a "neutral receiver of ideas". Similarly, Carney, McIntosh and Worth (1996, p. 1026) stress that the role of the facilitator is "not to lead the discussion but to ensure the smooth running of the group". This administrative function is also stressed by Kennedy and Clinton (2009) and Porter (2012). Therefore, clarification was not pursued if not immediately forthcoming. In any case, generic statements were relatively unusual, perhaps because of the emphasis placed during the introduction on identifying the practical ways in which dignity was promoted. Therefore, most statements listed on the flip chart remained largely unchanged for the next stage.

4.7.5 Step 5 – voting and ranking

This stage lasted around 15 minutes. Participants were invited to consider the flip chart lists and select the five statements that seemed most important to them. They were then asked to write the number of each of these statements down; each one on a

separate card (Appendix 11.14). Participants all appeared to select their 'Top 5' quickly in around 5 minutes. However, participants expressed more difficulty with ranking each of the five in order of priority – from one for the least important to five for the most important – and this took around ten minutes to complete.

The voting cards were then collected, and the scores recorded on the flip charts beside the relevant statements. The scores for each statement were then added together to give a total score for each statement. This enabled the participants in each group to identify their group's 'Top 5' priorities as reflected by the sum of scores. To illustrate this process, the number of votes, together with their scores and group rankings, for the 'Top 5' statements identified by Group 13 (2013 cohort, 2nd Year) are provided in Table 4-4. All 'Top 5' statements are shown in Appendix 11.15

Table 4-4 *Example of 'Top 5'*

Statement	Number of Votes	Scores	Sum of scores	Group ranking
Remembering they're a person, not a bunch of conditions	6	3, 4, 5, 5, 5, 5	27	1st
Treating as an individual	5	2, 3, 3, 5, 5	18	2nd
Genuine interest and listening	5	1, 3, 3, 3, 5	15	= 3rd
Being honest	5	1, 2, 3, 4, 5	15	= 3rd
Giving informed choices	4	1, 3, 4, 5	13	= 4th
Keeping covered as much as possible	4	2, 2, 4, 5	13	= 4th
Never leaving in a vulnerable position	3	4, 4, 4	12	5th

4.7.6 Step 6 – conclusion

This stage was brief and lasted no longer than five minutes. The participants and researcher viewed the statements receiving the most votes and the highest scoring

statements for the group. Each group indicated their agreement with the voting and ranking and expressed their interest in the results. The participants were thanked for their attendance and for their interesting and valuable contributions. They were also invited to contact the researcher if they wished to discuss any aspect of the process or any issues raised by the situations they had considered.

The day after the group participants were also emailed to thank them again and to remind them that the researcher was available to meet to discuss any aspect of the process or any issue arising from the discussion. One participant approached the researcher and arranged to discuss a situation that occurred on placement. At the subsequent meeting, the participant described a particularly challenging situation she had encountered on placement and which had left her feeling upset and guilty. The participant told the researcher that this had been uppermost in her mind during the nominal group. The situation was explored in terms of what happened, its implications, feelings of those involved, the events leading-up to it and what else could have been done. The participant was able to identify how she might deal with a similar situation in the future and expressed her gratitude for the opportunity to discuss it.

4.8 Data Analysis

The rationale for analysing nominal group data beyond the analysis performed by the participants themselves in the group setting was considered carefully. Different approaches to quantitative and qualitative analysis were considered and applied to the data before preferred options were selected. The data generated by the nominal groups were analysed quantitatively and qualitatively using content analysis.

One of the benefits of using NGT is the opportunity it offers participants to generate tangible outcomes within a relatively short space of time. Each group was able to identify their 'Top 5' priorities by votes awarded and by total score while still in the group setting. This is explained succinctly by Aveyard, Edwards and West (2005, p. 65) in their comment that "the process of data analysis takes place within the workshop itself". Participants often expressed a sense of satisfaction with this and an interest in

their findings. Similarly, the researcher was able to leave the group setting with much of the data analysed already and, perhaps most importantly, analysed by the participants themselves. For Porter (2012, p. 36), participants "code their own data" as part of the process of voting and ranking. Harvey and Holmes (2012) and McCance et al. (2012) each stress the importance of completing and sharing results with the group at the time.

The picture seems rather less clear when multiple groups are involved. McMillan et al. (2014) note that further analysis of large data sets generated by NGT involving multiple groups allows comparisons to be made between the different groups. While this seemed to be of limited relevance in this current study, given the relatively small number of participants involved, Gaskin (2008) comments on the need to standardise data derived from multiple nominal groups, even when the number of participants is relatively small. Illustrating this with reference to a study of 24 participants, it is worth noting that this still relates to the identification of the most important issues for participants. The use of NGT in Strand 1 was primarily directed towards identifying all the influences participants identified as being important for preserving dignified care; not which of these were the most important.

The Q-set could have been selected from the 141 statements generated through the nominal groups without further quantitative analysis so further analysis of the data generated could be regarded as unnecessary. In particular, quantitative analysis of rankings to take into consideration factors such as group size and identify priority themes or categories was unnecessary. However, the researcher was keen to enhance her familiarity with the data and further analysis seemed to be a useful means of doing that. The researcher felt that viewing the data in different ways would enable a more active engagement with the data and enhance her ability to compare and contrast differing perspectives identified by each group. Ascertaining any correspondence between the priorities identified through further analysis of rankings and the results of Strand 2 was also of interest.

4.8.1 Qualitative content analysis

Qualitative methods for analysis identified by authors of studies adopting NGT, range from thematic analysis (Cooke and Thackray, 2012; Kennedy and Clinton, 2009) to grounded theory coding (Iliffe et al., 2005; Sanderson et al., 2012) and content analysis (Dening, Jones and Sampson, 2013; Klim et al., 2013). In the published work reviewed, the practical application of these different methods lacks sufficient detail to allow for direct comparison of the strengths and limitations of each. In addition, the language used is, at times, ambiguous.

Kennedy and McKay (2010, p. 557) illustrate this when they state that data generated through NGT were "clustered thematically, analysed and coded". This language suggests that they conducted thematic analysis, but the process described seems to bear a stronger resemblance to content analysis. Similarly, Dening, Jones and Sampson (2013, p. 411) also describe "collating themes" which are then "scored" and this again seems to conflate aspects of thematic analysis with aspects of content analysis. Confusing terminology and lack of detail are highlighted by Braun and Clarke (2006) as reasons why researchers should identify clearly and describe in detail the rigorous application of the qualitative method chosen for analysis.

Initial consideration was given to the use of thematic analysis as a means of identifying patterns of beliefs in the data. However, Braun and Clarke (2006) highlight that content analysis is more appropriate when there is a particular interest in quantifying qualitative data. This fitted more closely with NGT as the principal method of data collection because the results of this essentially qualitative method are often presented quantitatively (Carney, McIntosh and Worth, 1996; Gallagher et al., 1993). This dual nature is underlined by Potter, Gordon and Hamer (2004), who describe NGT as a mixed method approach. Consequently, the nominal group data were analysed by qualitative and quantitative content analysis.

Flick (2015, p. 163) defines content analysis as a "procedure for analysing textual material". Robson (2011, p. 174) notes that this involves examining text for "recurrent instances" of a range of different "types", including words, phrases, categories or

themes. Quantitative content analysis provides frequency counts of the type of instance of interest while qualitative content analysis describes and illustrates findings through the integration of quotations into text (Robson, 2011). Content analysis has been used effectively with nursing students to explore sensitive issues (Vaismoradi, Salsali and Marck, 2011; Vaismoradi et al., 2013) and, therefore, it seemed appropriate for this study of nursing students' perspectives on dignity in care.

According to Flick (2015), content analysis is usually a deductive process in which pre-determined categories are applied to text. The researcher piloted the use of a deductive approach in which she applied categories provided by the conditions of the dignity dimension of an interaction described by Jacobson (2009b, p. 4). The categories and sub-categories identified by Jacobson (2009b) – of relationships between actors (positions of compassion and confidence, solidarity); setting (humane circumstances); and social order (an order of justice) – were used to develop a matrix which was then applied to the data from Group 12A.

This approach helped to familiarise the researcher with the data and the process of deductive coding, but the data did not seem to "fit" comfortably into the pre-defined categories. This is perhaps best illustrated by the category of "social order" described by (Jacobson, 2009b) as "an order of justice", characterised by equity of service provision and opportunity. When this category was applied to the data, four items were coded, but all four could reasonably have been accommodated in the categories of setting or relationship between actors. In addition, Elo and Kyngäs (2008) assert that inductive content analysis is the preferred approach when the existing knowledge of the phenomenon under investigation is limited or unclear. As this was the case in relation to nursing students' perspectives on dignity in care, an inductive approach was adopted.

4.8.1.1 Preparation stage

Elo and Kyngäs (2008) stress the importance of preparation as a key phase of content analysis. During the preparation phase, it is important to develop a "sense of the

whole" by becoming thoroughly familiar with the data being analysed (Vaismoradi, Turunen and Bondas, 2013). The researcher developed this sense by transcribing the text produced during the nominal groups and then reading and re-reading it, as recommended by Miles, Huberman and Saldaña (2014). While transcribing the data, the researcher jotted down preliminary ideas – an example drawn from the photo-elicitation component is shown in Table 4-5 below – to assist with code development at a later stage as recommended by Saldaña (2009).

Table 4-5 *Example of preliminary ideas*

Q1 - Image	**Participant comment**
Image 33A (NHS Education for Scotland, 2012) 	Participant 12A.01 "I chose the image of the handprint as I feel dignity is about being able to keep things which are personal to you and a handprint is a personal thing as no other person has the same one. I also think of dignity as being different for every person and handprints on each individual are different."
Preliminary thoughts	
"dignity is about … [keeping]… things which are personal to you" Suggests an understanding of dignity as something that is not restricted to a person's ability to maintain physical privacy (e.g. during personal care) but a broader understanding that takes into account private thoughts and feelings too. "dignity … different for every person". Reflects a view of dignity as something individual and unique to each person. Refers repeatedly to the person and the personal – suggests concern with person-centredness.	

The more formal preparation phase began with the selection of the unit of analysis (Elo and Kyngäs, 2008) for each component of Strand 1. For the photo-elicitation component, the unit of analysis consisted of the participants' written responses to question one in the response booklet. The images selected by the participants were

noted and used to further illustrate the participants' responses but were not in themselves analysed. This was because photo-elicitation was used primarily to help the participants to consider dignity in care and to articulate their ideas in the form of a written response. Furthermore, Saldaña (2009) advises that, while coding frameworks for visual data are available, the best approach is to analyse the language-based data associated with the visual data. In this study, the language-based data associated with the images was contained in the response booklet and so this formed the basis of the analysis for the photo elicitation component. For the NGT component, the unit of analysis consisted of the statements listed and ranked on the flip charts during the nominal groups in response to questions two and three in the response booklet.

4.8.1.2 Organisation stage

The next phase – the organisation stage – is concerned with coding and categorizing the data (Elo and Kyngäs, 2008). Miles, Huberman and Saldaña (2014) describe a wide range of coding methods for qualitative data, but the researcher in this study used values coding. Saldaña (2009) describes values coding as an affective coding method used to explore a participant's values, attitudes and beliefs. This seemed to make it eminently suitable for this study with its focus on the perspectives of nursing students.

Values coding involves coding qualitative data according to values, attitudes and beliefs (Saldaña, 2009). Saldaña (2009, p. 90) notes that the complex relationship between these concepts makes distinguishing between them a "slippery task" and that it is not necessary to code for all three or differentiate between them. The researcher initially attempted to code for all three but found significant overlap between them so that single words and phrases were coded as all three. In addition, reflection enabled the researcher to re-focus on the research purpose of exploring each nursing student's perceptions and her epistemological stance on the importance of beliefs. Therefore, the researcher focused on identifying beliefs; defined as the acceptance of the existence or truth of a person, object or idea (Masters, 2013, p. 94). For the purpose

of this content analysis, beliefs were identified when participants stated their perspectives as fact.

The next step at the organization stage is to categorize the data by gathering the preliminary codes on to a coding sheet and generating categories (Elo and Kyngäs, 2008). Explaining the process of moving from codes to categories, Saldaña (2009) stresses the importance of tacit as well as factual knowledge in deciding which codes belong together. The researcher initially grouped similar codes together under major headings. These headings were then used to generate tentative categories before these were refined by developing definitions for each (Saldaña, 2009, p. 9). For each component of Strand 1, the categories were initially generated by groups and by component. These individual group categories were then compared with each other and refined by revising the definitions for each and merging similar ones.

Elo and Kyngäs (2008, p. 111) advise naming these categories using "content-characteristic words". This was achieved by incorporating the statements generated during the round robin stages with the various groups that typified the contents of the category into the names. As an example, the category of statements in which the participant expresses the belief that dignity in care is promoted when practitioners protect the person's privacy or confidentiality was named "Promoting privacy", the statement generated during Group 14B's round robin (14B.2.03). The categories from each component were then compared with each other and further refined. This involved merging some categories with others; an example being the addition of privacy to the category concerned with vulnerability.

4.8.2 Quantitative content analysis

For the photo elicitation component, simple frequency analysis, as described by Flick (2015), was used to determine how often particular images and categories were identified by participants. For the NGT component, categories were ranked in order of frequency and importance. The purpose of doing this was to explore the frequency

with which different categories of statements were identified – that is, their popularity – and the strength of feeling among the participants about each category.

McMillan et al. (2014) argue that there is limited discussion in the literature regarding the management of data generated in NGT. One approach is to identify group priorities for each item generated in the Round Robin phase by the number of votes awarded in the voting phase (MacPhail, 2001). The more votes received, the greater the priority attached to the item by the group (MacPhail, 2001). However, the number of votes for each item does not completely reflect the priority attached to it by participants, because it does not take into consideration the ranking associated with each vote awarded (Harvey and Holmes, 2012). Another approach is to identify group priorities by the sum of the scores associated with each vote awarded. The higher the ranking awarded by each participant to each item, the greater the sum of the scores for each item; the greater the sum of the scores, the greater the priority attached by the group (Kennedy and Clinton, 2009).

A systematic approach described by van Breda (2005) provides an opportunity to analyse NGT categories in terms of both the strength of feeling and popularity. This involves a series of steps beginning with capturing the data in a spreadsheet to allow it to be manipulated and viewed easily in different ways. van Breda (2005) suggests that the strength of feeling about each category is reflected in the number of statements in each category placed in the 'Top 5' most important statements and by each category's average sum of scores. The popularity of each category is reflected in the number of statements each category contains (van Breda, 2005). van Breda (2005) suggests removing the statements that scored 0 from the analysis at this stage – presumably because if a statement receives no votes then it indicates it does not form part of the group consensus – but advises the researcher to use these statements to enrich understanding. In this study all statements were included in one worksheet of the spreadsheet (Appendix 11.16). All statements – even those scored zero – were included because the researcher was interested in all statements, not just the ones that

were ‘most important’. The next steps, identified by van Breda (2005) and adopted in a modified form for this study, are shown in Figure 4-1 below.

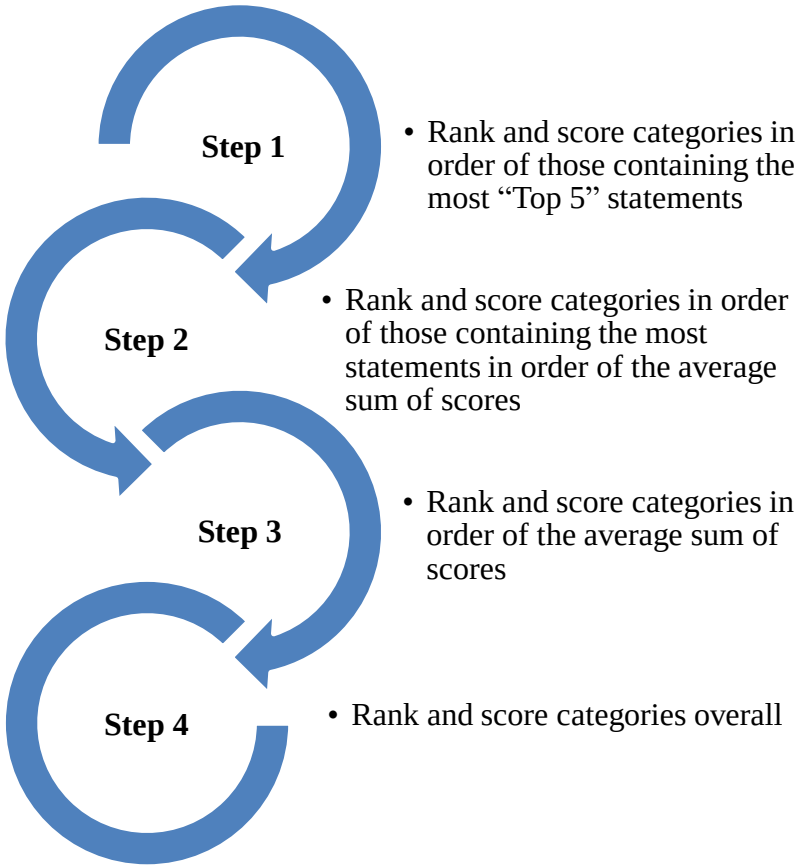


Figure 4-1 *Ranking and scoring in NGT*

4.9 Chapter 4: Conclusion

Chapter 4 examined ethical considerations in relation to the participants for the study as a whole before focusing on the methods of data collection and analysis adopted in Strand 1. The risks and benefits of participation in the current study were discussed with reference to the ethical principles of autonomy, beneficence, non-maleficence and justice. Practical measures – such as recruitment by someone unconnected with the current study and the availability of debriefing – to minimise risk to the participants were detailed. The recruitment of 31 nursing student participants using convenience sampling and the resulting participant profile were also summarised. The principles and practical application of the data collection methods of Nominal Group Technique (NGT) and photo-elicitation were discussed. Similarly, qualitative and quantitative content analysis were also discussed in principle and in practice. The results of Strand 1 are presented in Chapter 5.

5 Chapter 5: Results – Strand 1

5.1 Chapter 5: Introduction

This chapter presents the results of Strand 1. Chapter 5 discusses the use of qualitative and quantitative content analysis to code and categorise photo-elicitation and NGT data. This chapter details the insight provided into the meaning of dignity in care for participants that was provided by content analysis of the photo-elicitation data. Chapter 5 also details the process of analysing the data collected by NGT concerning participants' perspectives on the 'people' and 'place' influences on dignity in care. Related aims of Strand 1 were to explore the frequency with which different categories of statements were identified – that is, their popularity – and the strength of feeling among the participants about each category. The approach taken to exploring these aspects is explained in this chapter and the results summarised.

5.2 Qualitative Content Analysis

Values coding was used to analyse the qualitative data – the text written by participants – generated through photo-elicitation and NGT. For both photo-elicitation and NGT, data were first coded and then categorized by participant group. For each participant group, the photo-elicitation data were coded first, and the NGT data second. Preliminary codes and categories were revised during repeated reading of the data, codes and categories for each group.

5.2.1 Coding: photo-elicitation

The unit of analysis for this component was the participants' written responses to question one in the response booklet. A typical example of preliminary coding is shown in Table 5-1.

Table 5-1 *Example of preliminary coding*

Question 1	Comment	Preliminary codes
14B.09 Image 59A (NHS Education for Scotland, 2012) 	1. "This captured my attention because there is an issue of trust in the picture. 2. The small child is holding the adult's hand in trust 3. because they depend on the adult for their growth, development 4. and protection. 5. I feel that trust therefore is very important part of dignity, 6. especially if you are in a position of power/authority."	1. TRUST – RELATIONSHIP nurse in position of authority, power. 2. POWER – the power of the adult (nurse) compared to the child (person receiving care). AUTHORITY of the nurse. VULNERABILITY of the person. 3. DEPENDENCY or VULNERABILITY – growth and development – recovery. 4. VULNERABILITY and PROTECTION. 5. TRUST – again, power and authority of the nurse compared with the VULNERABILITY, POWERLESSNESS of the person receiving care.
Preliminary ideas		
Clear focus on the role of trust in dignified care – a relationship based on trust, recognition of the vulnerability of the person receiving care, their relative powerlessness and dependence on the nurse. The nurse must be deserving of that trust, the person's trust must not be misplaced/abused.		

After completing preliminary coding, the codes for each group were then listed on a coding sheet as shown in Table 5-2 for Group 14B:

Table 5-2 *Example of preliminary codes (Group 14B)*

Privacy	Protection	Feelings	Freedom
Caring	Dependency	Choice	Protection
Trust	Power	Loved Ones	Relationship
Vulnerability			

These preliminary codes were then considered again during repeated readings of the data. The process was repeated with the data generated by each group until no further codes were being identified, removed or modified. Similar codes were then grouped together, and definitions were developed. The developed codes – and the preliminary codes they replaced – for the photo-elicitation data from all groups are shown in Table 5-3.

Table 5-3 *Developed codes for photo-elicitation data (all groups)*

Developed Code	Preliminary Codes
Partnership	'Relationship' and 'Trust'
Choice	'Preferences'
Action	'Work'
Loved ones	'Family and Friends'
Patience	'Time'
Communication	'Touch' and 'Listening'
Personal	'Person' and 'Respect'
Caring	'Compassion'
Vulnerability	'Protection', 'Dependency', 'Power' and 'Privacy'
Feelings	'Feelings'

5.2.2 Coding: NGT

Preliminary codes and categories were revised during repeated readings of the data, codes and categories for each group. When no further changes were made on repeated readings of the data, the coding lists for the photo-elicitation and NGT data were then compared with each other and reduced further to identify shared codes.

The unit of analysis for this component was the statements listed on the flip charts (141 statements in total, Appendix 11.16). A typical example of preliminary coding of NGT data from Group 12B is shown in Table 5-4 below:

Table 5-4 *Example of preliminary NGT coding*

Participant	Statement listed on flip chart	Preliminary code
12B.06	Making light of an embarrassing situation, laughing with them	Feelings Relationship
12B.07	Respectful of an individual's choice	Choice Respect
12B.08	Before carrying out [care] discussing it with the patient and making sure [they are] happy	Choice Communication Feelings
12B.09	Letting patient do as much as they can for themselves	Power Independence
12B.10	Way they spoke to the patient – caring manner	Caring Communication

After completing preliminary coding, the codes were then listed on a coding sheet, as shown for Group 14B in Table 5-5.

Table 5-5 *Example of preliminary NGT codes*

Privacy Empathy Caring	Respect Consent Independence	Choice Communication Personal	Facilities Teamwork

These preliminary codes were then revised and modified through repeated reading of the data. This resulted in the developed codes shown in Table 5-6.

Table 5-6 *Developed codes for NGT data (all groups)*

Developed Code	Incorporated Preliminary Codes
Feelings	'Empathy' and 'Caring'
Choice	'Preferences'
Teamwork	'Team'
Patience	'Time'
Vulnerability	'Dependency' and 'Advocacy'
Communication	'Listening'
Loved ones	'Family', 'Friends' and 'People who Care'
Personal	'Person', 'Individual' and 'Respect'
Skilled	'Correct'
Environment	'Calm', 'Peace', 'Facilities' and 'Equipment'
Privacy	Not applicable

5.2.3 Coding: combined

To further refine the codes, the codes developed for each component – that is, the photo-elicitation and NGT components – were compared with each other to identify any similarities and differences. Shared codes were highlighted and checked again against the data for each component. Once shared codes were checked against context

and against each other, areas of overlap were identified and codes were merged or modified. Codes exclusive to photo-elicitation and those exclusive to NGT were also identified and checked again against the data for each component. This is illustrated in Table 5-7.

Table 5-7 *Comparison of developed codes*

Photo-elicitation	**NGT**
Feelings	Feelings
Choice	Choice
Vulnerability	Vulnerability
Loved Ones	Loved Ones
Patience	Patience
Communication	Communication
Personal	Personal
Partnership	Teamwork
Caring	
	Privacy
	Skilled
	Environment

Checking similar codes against context and against each other helped to identify overlap and merge or identify differences and modify codes. For example, 'Privacy' was identified as a separate code for the NGT data but incorporated into 'Vulnerability' for the photo-elicitation data. This prompted the researcher to review the application of this code again in both data sets. The code was retained as a separate code for each data set because it was highlighted specifically and frequently in each.

Similarly, ‘Caring’ was identified as a separate code for photo-elicitation data but incorporated into ‘Feeling’ for the NGT data. Once again, review of the application of these codes to the data confirmed that ‘Caring’ should be retained as a separate code for each data set.

Conversely, when consideration was given to the combination of ‘Teamwork’ and ‘Working in Partnership’, it was apparent that they were significantly different. ‘Teamwork’ was used to identify relationships between nurses, while ‘Working in Partnership’ was used to identify relationships between nurses and persons. Some codes generated by the NGT data – such as ‘Facilities’ and ‘Skilled’ – had no parallels with the photo-elicitation codes and were retained as separate ones. The thirteen developed codes for Photo-elicitation and NGT are shown in Table 5-8.

Table 5-8 *Final developed codes for photo-elicitation and NGT (all groups)*

Feelings	Loved Ones	Personal	Privacy
Choice	Patience	Partnership	Skilled
Vulnerability	Communication	Caring	Environment
Teamwork			

5.2.4 Categories: photo-elicitation

The number of categories initially generated through coding each of the five groups ranged from four to eleven. The final list consisted of ten categories is shown in Table 5-9. Participants’ statements and related images – all images NHS Education for Scotland (2012) – were used to name the categories (the number in brackets is the code of the participant whose statement was used to name the category).

Table 5-9 *Categories: Photo-elicitation*

Category		
Number	Name and Description	Defining image
Data coded and sorted into this category described the meaning of dignity in care in terms of:		
1	**Dignity in care is not having to worry about leaving it at the door** (Participant 13.05) Feelings involved such happiness, sadness, embarrassment, contentment, fear, anxiety, safety	Image 24A 
2	**Dignity in care is about being respectful of a person's individuality** (Participant 12A.01) Importance of the uniqueness of the individual and their perspective on what constitutes dignity in their own care.	Image 33A 
3	**Dignity in care is about doing whatever is possible to relieve anxiety** (Participant 13.02) Taking deliberate action to promote dignity in care or working to promote it.	Image 36A 
4	**Dignity in care is about protecting the vulnerable person** (Participant 13.03) The vulnerability of the person – experienced, for example, during personal care – together with the power of the practitioner.	Image 59A 

Category Number	Name and Description	Defining image
Data coded and sorted into this category described the meaning of dignity in care in terms of:		
5	**Dignity in care is about working together** (Participant 13.08) Patient-practitioner relationship	Image 12A 
6	**Dignity in care is about communicating with each other** (Participant 14A.06) Listening and communication	Image 28A 
7	**Dignity in care is about respecting the person's choices** (Participant 13.12) Supporting the person's right to make their own choices	Image 8A 
8	**Dignity in care is about showing that you care** (Participant 12B.07) Demonstrating care, compassion, a caring approach	Image 57A 
9	**Dignity in care is about giving people the time they need** (Participant 13.11) Taking or giving time, being patient	Image 37A 

Category Number	Name and Description	Defining image
Data coded and sorted into this category described the meaning of dignity in care in terms of:		
10	**Dignity in care is also about the person's loved ones** (Participant 13.04) Promoting the dignity of the person's family, friends or other loved ones.	Image 27A 

5.2.5 Categories: NGT

For the NGT component, ten to 14 categories were identified from the data gathered from each of the five groups. These were refined and named in the same way as the photo-elicitation categories by incorporating the language of the participants. The final 14 categories are shown in Table 5-10. Appendix 11.17 presents all 141 statements in their categories and identifies whether the statement was a response to Q2 ('people') or Q3 ('place') in the Response Booklet.

Table 5-10 *Categories: NGT*

Category Number, Name and Description
Data coded and sorted into this category suggested that dignity in care is influenced by:
1 *Promoting privacy* Practitioners protecting the person's privacy or confidentiality
2 *Not 'I'm the nurse and you're the patient'* Practitioners recognising and responding to the person's choice
3 *Not rushing the person – being patient* Practitioners taking or giving time to care and are patient
4 *Encouraging independence* Practitioners promoting the person's independence
5 *It's about the family's dignity too* Practitioners promoting the family's dignity
6 *Being 'in-tune' with the person* Practitioners demonstrating empathy or awareness of actual/potential feelings
7 *Genuine interest and listening* Practitioners demonstrating genuine interest in the person by listening
8 *Remembering they're a person* Practitioners recognising and responding to the patient as a unique person; a person with individual preferences and spiritual, social and emotional needs
9 *Taking everything into account* Practitioners being skilled such as being able to deliver holistic care, provide explanations and support, are prepared for all eventualities
10 *Protecting people who can't protect themselves* Practitioners protecting vulnerable patients, consider issues related to capacity, act as advocates

Category Number, Name and Description
Data coded and sorted into this category suggested that dignity in care is influenced by:
11 *Working as a team* Practitioners working in effective teams e.g. all team members feel part of the team, able to voice their opinions and to be listened to
12 *Being caring and positive* Practitioners demonstrating caring and positive attitudes towards others (staff and patients)
13 *Being in a calm and peaceful environment* When the environment is calm, peaceful and feels safe
14 *Having good facilities and equipment* When the environment has good facilities such as enough single rooms and resources

5.3 Quantitative Content Analysis

5.3.1 Quantifying: photo-elicitation

The unit of analysis for this component was the frequency with which certain images were selected. A total of 18 images were selected, and the results are shown in Table 5-11.

Table 5-11 *Frequency of image selection*

Image	Frequency of Selection	Participant(s)
 Image 28A	4	14A.05 14B.08 12A.05 12A.15
 Image 37A	3	14A.04 13.11 12A.06
 Image 59A	3	14A.03 14B.09 13.03
 Image 64A	3	14A.07 12A.16 12B.08

Image	Frequency of Selection	Participant(s)
 Image 12A	2	14A.06 13.08
 Image 32A	2	12A.18 13.10
 Image 36A	2	14A.01 13.07
 Image 41A	2	12B.09 13.06

Image	Frequency of Selection	Participant(s)
 Image 58A	2	12B.07 13.09
 Image 5A	1	13.12
 Image 6A	1	14B.09
 Image 8A	1	13.02

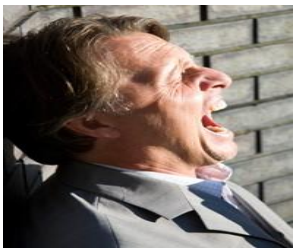
Image	Frequency of Selection	Participant(s)
 Image 17A	1	14A.02
 Image 22A	1	13.01
 Image 24A	1	13.05
 Image 27A	1	13.04

Image	Frequency of Selection	Participant(s)
 Image 33A	1	12A.01
 Image 38A	1	12A.18

It became apparent at an early stage that, while different individuals might choose the same image, they usually explained their choice in very different ways, and this is illustrated below with reference to the image most frequently selected: Image 28A.

Comparison of Rationales for Image 28A Selection

Participant 14A.05	Participant 14B.08
"To me dignity is about listening as well as many other things. I think it is important that people should be heard and treated equally. I feel communication is key in ensuring people received dignified care and as some people may be unable to communicate verbally so it's important to communicate in other ways i.e., body language, facial expressions."	*"... the meaning of that related to dignity in care is that if you want to have a conversation with someone you have to make sure it's only him or her that can hear. You don't have to make it louder so everybody can hear. For example, in hospital if you want to assist someone with personal care you have to put your voice down make sure nobody else is hearing it."*
Preliminary thoughts: Clear focus on communication – its importance and the need to overcome barriers to effective communication. Stresses listening. Awareness of the potential impact of disability/impairment – those most able most likely to experience dignified care – and the role of the nurse in overcoming such barriers to provide dignified care.	**Preliminary thoughts:** Clear focus on the protection of privacy. Repeats "if you want" – reinforces importance of privacy and the need to actively ensure it (does it also suggest that doing otherwise might be avoidance?)

Figure 5-1 Comp*arison of rationales for image 28A selection*

Simple frequency analysis as described by Flick (2015) was used to determine how often particular categories were identified by participants and this is summarised in Table 5-12.

Table 5-12 *Frequency of categories*

Category	Group 14A (*n*=7)	14B (*n*=3)	13 (*n*=12)	12A (*n*=6)	12B (*n*=3)	Total
Dignity in care is about:						
Not having to worry about leaving it at the door (13.05)	5	1	7	2	2	17
Being respectful of a person's individuality (12.05)	3	0	6	5	3	17
Doing whatever is possible (13.02)	4	0	5	4	2	15
Protecting the vulnerable person (13.03)	4	3	5	1	1	14
Working together (13.08)	2	1	6	1	2	12
Communicating with each other 14.06)	3	0	0	3	2	8
Respecting the person's wishes (14.03)	2	0	5	0	0	7
Showing that you care (12.07)	0	1	2	2	0	5
Giving people the time they need (13.11)	1	0	1	2	0	4
The people who care for the person too (13.04)	0	0	2	0	0	2

5.3.2 Quantifying: NGT

In total, 141 statements were generated by the five groups and are listed in Appendix 11.16. Of these, 93 were generated in response to question two and the remainder in response to question three. An overview of the number of statements provided in response to each question is provided below.

Table 5-13 *Number of statements in response to each question*

Group	Question 2 - People	Question 3 - Place	Total
14A	18	12	30
14B	18	7	25
13	20	11	31
12A	23	8	31
12B	14	10	24
Total	93	48	141

Further analysis was performed to explore the frequency with which different categories of statements were identified – that is, their popularity – and the strength of feeling among the participants about each category. As discussed in Section 4.8.2 quantitative analysis of the NGT data was performed using a modified van Breda (2005) approach to rank and score each category in order of:

- Step 1 – The most 'Top 5' statements (indicative of the strength of feeling associated with each category),
- Step 2 – The most statements (indicative of the frequency with which categories were identified; their popularity),
- Step 3 – Average sum of scores (again, indicative of the strength of feeling associated with each category), and
- Step 4 – Overall rank based on a combination of the first three steps.

Table 5-14 provides an example of the modified Van Breda (2005) approach applied to the statements in Category 1. Final rankings for all categories are shown in Table 5-15. The current study's data is presented in Appendix 11.16.

Table 5-14 *Example of modified van Breda (2005)*

Stat. #	Statement	Category	Sum of scores (z)	Number in group (*n*)	Average Score (z/*n*)	Group 'Top 5' (x)
14B.3.05	Confidentiality e.g., patient asked if OK to inform next-of-kin	1	6	3	2.0	X
14B.2.03	Promoted privacy, e.g., curtains pulled, single room at the end of life	1	5	3	1.7	X
12B.2.12	Discretion at handover – voices clear, not loud	1	5	3	1.7	X
12A.2.15	Making sure not too many staff/people around personal care	1	7	6	1.2	X
13.2.14	Covered as much as possible	1	13	12	1.1	X

Final ranked categories are shown in Table 5-15.

Table 5-15 *Ranked categories using modified*

Category	Number of statements in the category ranked as 'Top 5'	Total Number of statements in category	Average score for statements in category	Final Rank
Indicative of:	*'Strength of feeling'*	*'Popularity'*	*'Strength of feeling'*	
2: Not 'I'm the nurse, you're the patient'	9	13	1.4	1st
1: Promoting privacy	5	14	0.9	2nd
12: Being caring and positive	4	10	1.3	3rd
8: Remembering they're a person	4	8	1.2	4th
7: Genuine interest and listening	2	4	1.0	5th
4: Encouraging independence	2	4	0.9	6th
9: Being skilled	2	5	0.7	7th
6: Being in-tune with the patient	1	6	0.8	8th
5: It's about the family's dignity too	1	3	0.7	9th
10: Protecting people who can't protect themselves	1	3	0.7	10th
3: Taking time, not rushing	0	3	0.4	11th
13: Being in a peaceful and calm environment	0	2	0.2	12th

Category	Number of statements in the category ranked as 'Top 5'	Total Number of statements in category	Average score for statements in category	Final Rank
14. Having good facilities and equipment	0	2	0.1	13th
11: Working in a team	0	1	0.1	14th

The further analysis presented in Table 5-14 and Table 5-15 also helped the researcher to become more familiar with the data.

5.4 Chapter 5: Conclusion

Chapter 5 discussed the use of qualitative and quantitative content analysis to code and categorise photo-elicitation and NGT data and presented the results of Strand 1. Findings are identified in this conclusion and discussed in full in Chapter 8. The focus of Strand 1 was on Research Questions 1 and 2; respectively concerned with the meaning of dignity in care and perspectives on what influences it. Chapter 5 detailed the decision-making which led to the development of 10 categories of meaning and 14 categories of influences. All categories of meaning were concerned with interaction and relationship while 12 of the 14 categories of influences were concerned with 'people' rather than 'place' influences on dignity in care. Chapter 5 explained how the statements about the 'people' and 'place' influences on dignity in care were identified. In total, participants identified 141 statements concerning the personal and environmental influences on dignity in care. These 141 statements formed the basis of the data collection tool for Strand 2.

6 Chapter 6: Methods – Strand 2

6.1 Chapter 6: Introduction

Chapter 6 marks the transition from Strand 1 to Strand 2 of the current study. The first strand of this study – Strand 1 – focused on Research Questions 1 and 2: 1) What meaning does dignity in care have for nursing students? and 2) What are nursing students' perspectives on the personal and environmental influences on dignity in care? Strand 2 focused on Research Question 3: What are nursing students' perspectives on the important aspects of a nurse's role in preserving dignity in care? To answer this question, Strand 2 used Q-methodology, and Chapter 6 begins by introducing Q-methodology. Chapter 6 explains the decision-making around the selection of the data collection tool for Strand 2 from the 141 statements collected by NGT in Strand 1 (Chapter 5 and Appendices 11.16 and 11.17). This chapter also summarises participant recruitment for Strand 2 and data management. The methods of data collection and analysis used in Q-methodology are discussed and issues around rigour considered.

6.2 Introducing Q-methodology

> … a science for all that is subjective, comparable to that for all that is objective – for what is behind the eyes, as well as before them. (Stephenson, 1993, p. 3)

This science of subjectivity – Q-methodology – was first developed by physicist and psychologist William Stephenson in the 1930s (Watts and Stenner, 2012). It emerged from what Stephenson (1993) describes as his search for the meaning of consciousness, subjectivity and self. His search resulted in a rejection of the idea that subjectivity defies objective analysis (Stephenson, 1993). According to Brown (1996) – one of Q-methodology's key proponents – Q-methodology is founded on Stephenson's belief that subjective, first-person viewpoints are just as amenable to the application of the scientific method as overt behaviour (Brown, 1996).

Q-methodology makes no claims about the generalisability of findings, such as the distribution of perspectives in the wider population, or relationships between the participants' personal characteristics and the perspectives revealed (van Hooft et al., 2015). Q-methodology aims to provide a basis for "logical generalisations" from findings and, in this sense, resembles qualitative methodologies (van Exel et al., 2015, p. 129). Similarly, trustworthiness in Q-methodology may be regarded as hinging on credibility, transferability, confirmability and dependability, and these are discussed in Section 8.6.

For Cross (2005), the purpose of Q-methodology is to identify and describe participants' varying accounts of the subject under investigation. Participants – known as the P-set in Q-methodology – construct their accounts through a process known as Q-sorting. This involves rank-ordering statements that represent different views on the subject (Watts and Stenner, 2012). Typically, this rank-ordering is performed using a sorting grid similar to the one shown in Figure 6-1.

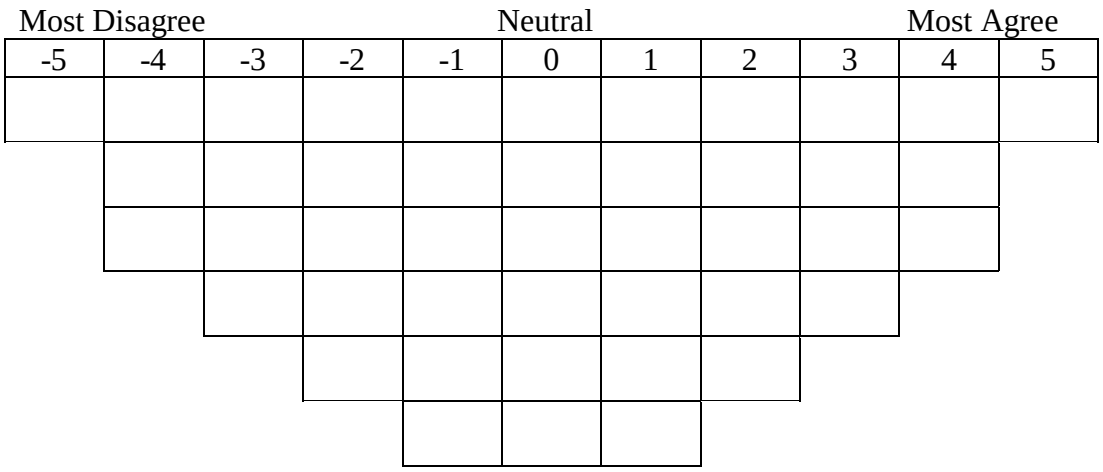


Figure 6-1 *Example sorting grid*

The statements that are rank-ordered comprise the Q-set (sometimes referred to as the Q-sample). Barker (2008, p.918) proposes that these viewpoints will be more accurately represented through Q-methodology because participants use the

statements to construct their own accounts, rather than relying entirely on a researcher's interpretation. Establishing the Q-set is crucial to the success of the approach because individuals will only be able to construct their accounts if it contains the statements they need in order to do so (Cross, 2005). The Q-set is sampled from a larger collection of statements known as the concourse; a "universe of statements" about the subject (Stephenson, 1986, p. 37). In Q-methodology, the term 'concourse' is used to describe all the statements made by people about a topic (Simons, 2013). Such is the importance of the concourse that Brown (1993, p. 97) describes it as the "raw materials" for Q-methodology. Authors of one of the core texts on Q-methodology, Watts and Stenner (2012), advise that the development of the concourse and Q-set will require much more time than its administration with participants.

Once the Q-sorting process is complete, the Q-sorts are analysed to reveal individual and collective viewpoints (Valaitis et al., 2011). Q-methodology data analysis is based on factor analysis; a means of data reduction that seeks to explain as much of the study variance as possible (Watts and Stenner, 2012). It does so by identifying "sizeable portions" of common variance (hereafter, variance) or shared meaning explaining the relationship between Q-sorts (Watts and Stenner, 2012). Factor analysis in Q-methodology is, therefore, described as being 'by-person' rather than 'by-trait' as in conventional factor analysis (Paige and Morin, 2014). Dedicated statistical software packages – such as PQMethod (Schmolck, 2012) and KenQ (Banasick, 2017) – are then used to perform a by-person factor analysis of the Q-sorts. This groups together participants who share similar perceptions (Akhtar-Danesh, Baumann and Cordingley, 2008). Watts and Stenner (2012) note that, typically, a factor with at least 2 significantly loading Q-sorts and an eigenvalue – a measure of the statistical strength of a factor – greater than one is considered significant. Watts and Stenner (2012) proceed, however, to stress that such objective criteria are best used as guides to decision-making rather than absolute rules.

During Strand 1, the concourse – from which the Q-set was derived – was developed through nominal groups with student nurses. A process of review involving domain

experts and pilot study condensed the concourse to form the Q-set by removing repetitive statements and clarifying ambiguous ones (Akhtar-Danesh et al., 2013; Valaitis et al., 2011).

A full glossary is provided in Appendix 11.6, but, for convenience, some key terms are defined in Table **6-1**.

Table 6-1 *Core terms in Q-methodology (1)*

Term	Definition
By-person factor analysis	Participants are correlated with each other based on the similarities and differences in how they configure their Q-sorts (Valenta and Wigger, 1997).
Concourse	The sum of all statements made or thought by people about the subject (Simons, 2013)
Factor	A representation of shared meaning (Watts and Stenner, 2012)
P-set	The participants (Simons, 2013)
Q-set	A representative subset of statements drawn from the concourse (Brown, 1993; Paige and Morin, 2014)
Q-sort	An individual's rank-ordered arrangement of the Q-set (Paige and Morin, 2014)
Q-sorting	The process of administering or performing a Q-sort (Watts and Stenner, 2012)

6.3 Participant Recruitment

As noted in Section 6.2, participants in Q-methodology are known as the P-set (Simons, 2013). The number of participants in the P-set matters less than the extent to which the P-set is representative of different viewpoints about the subject under investigation (Petit dit Dariel, Wharrad and Windle, 2010). Watts and Stenner (2012 p. 73) note that Q-methodology "positively embraces studies using smaller numbers".

This is supported by McKeown and Thomas (2013), who describe a P-set of 30 to 50 as typical but not essential.

All participants were recruited from a three-year undergraduate preregistration adult nursing programme as described in Chapter 4. All students in Years 1, 2 and 3 were invited to participate (a total of 534 adult nursing students). A total of 94 nursing students completed and returned consent forms (Appendix 11.10) and contact sheets (Appendix 11.11). All respondents were thanked and invited – via their preferred contact details – to complete a Q-sort. Respondents were invited to suggest some preferred dates and times to attend to minimise any potential inconvenience for the participants. Participants are summarised in below in Table **6-2**.

Table 6-2 *Strand 2: Participant profile*

Group Code	Cohort	Year Group	Number of Participants
14	September 2014	Year 3	5
15	September 2015	Year 2	9
16	September 2016	Year 1	7
		Total	21

6.4 Selecting the Q-set

For Cross (2005), the purpose of Q-methodology is to identify and describe individuals' accounts of the subject under investigation. Establishing the Q-set is crucial because individuals will only be able to construct their accounts if it contains the statements they need in order to do so (Cross, 2005). Also crucial is the need to balance comprehensiveness with the time required by participants to complete the Q-sort (Paige and Morin, 2014). This study used a four-step guide to the process of sampling described by Paige and Morin (2014) and summarised in Figure 6-2 to generate an unstructured Q-set using an inductive approach.

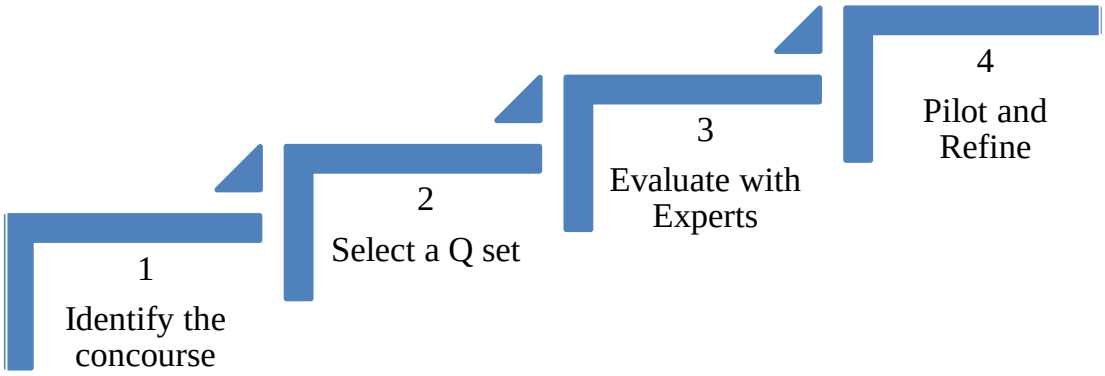


Figure 6-2 *Four-step approach to selecting the Q-set (Paige and Morin, 2014)*

The first step involves identifying a concourse that is representative of the participants' views and expressed in their own words (McKeown and Thomas, 2013). Selecting the Q-set from the concourse is the second step and is geared towards ensuring that a "broadly representative" Q-set of all the participants' views is selected (Watts and Stenner, 2012, p. 58). The third step is to evaluate, with subject and method "experts", the clarity and completeness of the preliminary Q-set. Pilot testing the content of the preliminary Q-set and establishing the procedure for its administration with potential participants is the fourth and final step.

6.4.1 Step 1: Identifying a representative concourse

As discussed in Chapter 5, the first step was accomplished by the use of NGT to identify participants' perspectives on the 'people' and 'place' influences on dignity in care. The resulting 141 statements constituted the concourse for the current study and the Q-set was selected from it. This helped meet the criteria for a concourse identified by the authors of another core text for Q-methodology – McKeown and Thomas (2013) – a concourse representative of the participants' views and expressed in their own words.

6.4.2 Step 2: Selecting the Q-set from the concourse

Sampling the Q-set from the concourse is the second step described by Paige and Morin (2014). This step is geared towards sampling a Q-set that was broadly representative of all the participants' views contained within the concourse (Brown, 1993; Watts and Stenner, 2012). Paige (2015, p. 76) reflects this in her description of the Q-set as "a representative subset of statements sampled from the concourse". A particularly helpful analogy is drawn by Watts (2008) between the items in a Q-set and individual carpet tiles; each item making a specific and individual contribution to the coverage provided. Q-set sampling from the concourse is crucial in Q-methodology (Baker et al., 2014). The number of statements in the Q-set can vary widely as long as it is representative of the concourse although around 30 to 50 statements in the Q-set is typical (Simons, 2013). Caution is required because, the more statements there are in the Q-set, the more complicated and time-consuming the process will be for the participants (Dziopa and Ahern, 2009). Q-set selection is one of the most challenging and contentious aspects of Q-methodology and different approaches are advocated.

Eden, Donaldson and Walker (2005, p. 416) describe their experience of selecting the Q-set as a "slow and argumentative process" and relate this to a perceived dearth of literature about how to perform it. Paige and Morin (2014, p. 2) also comment on this issue; describing the selection of the Q-set as a "critical, yet often overlooked and underdescribed process". Furthermore, Kampen and Tamás (2014, p. 3111) base some of their trenchant criticism of Q-methodology on what they describe as the "lack of clear prescriptions" for how to construct a representative Q-set. Robustly rejecting this view, Brown, Danielson and van Exel (2014) argue that clear guidance is readily available, citing Watts and Stenner (2012) and McKeown and Thomas (2013) among others. The debate seems to be partly related to the fact that no one type or approach to selecting the Q-set is recommended over another. In addition, published Q studies do not consistently label their approach to the process and this also contributes to a perceived lack of clarity around the process.

McKeown and Thomas (2013) identify two types of Q-sets; structured and unstructured. Watts and Stenner (2012) describe the structured approach as one that relies on a pre-existing theory or derived "simply through research or observation" (Watts and Stenner, 2012, p. 59). In comparison, an unstructured Q-set is one selected "without the use of explicit experimental design principles", particularly useful when the problem under investigation lacks an existing evidence-base (McKeown and Thomas, 2013, p. 23). Paige and Morin (2014) describe the structured approach to selecting the Q-set as deductive and the unstructured approach as inductive.

A combination of elements of each approach has also been used (Barker, 2008). For example, Barker (2008) uses both a pre-existing framework and inductive thematic analysis to identify the concourse and generate the Q-set. Similarly, several studies have used earlier concourses derived from a range of theoretical and experiential perspectives to generate Q-sets for subsequent studies (Killam et al., 2013; Montgomery et al., 2014; Montgomery, Mossey and Killam, 2013; Mossey et al., 2012). In the current study, consideration was given to adopting a structured approach before deciding on an inductive approach.

Brown (1993) illustrates a structured approach using a six-cell factorial design consisting of five components to categorise a concourse of views on the nature of Q-methodology. By selecting eight statements from each of the six cells, he generates a Q-set of forty-eight statements (Brown, 1993). Watts and Stenner (2012, p. 59) describe this type of balanced-block design as "the most formal rendering" of the structured approach to Q-sampling. Paige and Morin (2015) used a balanced-block design to select a Q-set from their concourse of student views about the use of simulation in nursing education. The concourse consisted of 392 statements derived from literature review, interviews and a national simulation framework (Paige and Morin, 2014). Their factorial design consisted of eight components; five derived from a national framework for simulation design and three from educational considerations revealed through interviews and literature review resulting in 15 cells (Paige and Morin, 2014). The authors categorised the statements of their concourse into the 15

cells and selected four statements from each cell to provide a Q-set of 60 statements (Paige and Morin, 2014).

Initially, the structured approach was considered because this seemed very much in keeping with the highly structured nature of the NGT. The concourse of 141 statements was already divided into 28 cells; 14 from the categories identified through content analysis and two from the literature – personal or 'people' and environmental or 'place' influences) (Appendix 11.14). Selecting items from each cell would have provided a preliminary Q-set; for example, selecting two items from each cell would have provided a Q-set of 56 items.

It became clear; however, that groups had identified similar statements in different ways. For example, Group 12A identified the statement "Letting patient do as much as they can for themselves" [12A.2.09] as a factor related to 'people', while Group 13 identified "Encouraged to do for as much as possible for themselves" [13.3.11] as a factor related to 'place'. Similarly, Group 14B identified "Good teamwork" [14B.2.16] as a factor related to 'people' while Group 12B identified "Staff working as a team" [12B.3.03] as a factor related to 'place'. Moreover, some cells – such as 'Place' in Category 3: 'Taking time, not rushing' and in Category 7: 'Genuine Interest and Listening' – were empty or contained only one item and this could have resulted in particular categories being under-sampled (Watts and Stenner, 2012). Therefore, an inductive approach to sampling was used to allow greater flexibility.

Watts and Stenner (2012, p. 60) describe this unstructured approach as "an overtly *crafty* strategy" (italics in the original) because it relies on the researcher's personal knowledge and expertise to select a representative Q-set. An inductive approach to Q-sampling does not rely on a pre-existing theoretical framework or hypothesis but relies instead on patterns identified through data analysis (McKeown and Thomas, 2013). Inductive approaches to Q-sampling are prevalent in the literature (Akhtar-Danesh et al., 2011; Baxter et al., 2009; Dziopa and Ahern, 2009; Ha, 2014; Valaitis et al., 2011; Work, Hensel and Decker, 2015).

Skorpen et al. (2015) used an inductive approach incorporating a balanced-block design to reduce their concourse of nearly 2000 statements to four main categories reflecting values, ideas of self, ethics and relationships and sampled between 11 and 12 statements from each of the four cells to give a Q-set of fifty-one statements. Another well-described example of an inductive approach to Q-sampling is provided by Akhtar-Danesh et al. (2013). In this study of perceptions of professionalism among nursing students, the authors employed thematic analysis to identify twelve themes from focus groups, interviews and literature and from these themes identified forty-five statements to include in their Q-set. Watts and Stenner (2012) are careful to note that the resulting representativeness of the Q-set using this approach hinges on the rigour with which the themes or categories were identified.

Through a process of reading and re-reading the statements in each category, a preliminary sample of 48 statements was selected; ensuring that each category was represented (as shown in Appendix 11.17). The selection of these statements was informed by considerations such as a statement's presence in a group's 'Top 5', the need to broadly represent statements related to 'people' and 'place' influences, and also statements generated by each year group. The number of statements from each category ranged from between one and six depending on the number of statements and their variety within each category. This helped to remove any repetition.

To ensure the "voice" of the participant was still present, only minor changes to wording were made. These changes were made to enhance "readability" and all statements were modified to become gerunds in order to suggest the nurse "doing" something; taking a particular action. An example of this is "Covered as much as possible" [13.2.14] which became "Keeping the person covered as much as possible". This not only enhanced the "readability" of each statement in the Q-set, but also facilitated the development of a straightforward but thought-provoking condition of instruction.

Care was also taken to remove statements such as “Person-centred care” [14B.2.17] and “Treating patients with respect” [14B.2.01] because their generic and unqualified nature would not provoke debate. Efforts were also made to ensure statements made in response to the both questions – ‘people’ and ‘place’ – were represented in the Q-set. Of the 94 statements generated in response to the ‘people’ question in the NGT, 25 were included in the preliminary Q-set. Furthermore, of the 48 statements generated in response to the ‘place’ question, 15 were included in the preliminary Q-set.

Similarly, care was taken to select statements generated by each year group, too. In the NGT, the Year 1 and Year 3 groups generated 55 statements each and, of these, contributed 20 and 14, respectively, to the preliminary Q-set. The remaining nine were contributed by the Year 2 group, which generated 31 statements in total during the NGT.

Some statements were removed from the Q-set because they were regarded as over-arching statements from which all other items could be seen to flow. Watts and Stenner (2012, p. 65) note the need for Q-set items to be “provocative”. For example, it seemed highly probable that all participants would agree with statements such as ‘Remembering they’re a person, not a bunch of conditions’ [13.2.18]. Rather than include this, therefore, other statements demonstrating how this attitude is evidenced by nurses in care – that it, what nurses do that reflects this attitude – were included instead. This was accomplished by returning to the data generated by the nominal group who listed this item in order to place it in context and identify related items. For example, in relation to the item ‘Remembering they’re a person, not a bunch of conditions’ this process led to the inclusion of item nineteen: ‘Speaking to the person as an individual’.

A discussion at the ‘T&Q Workshop’ at Birmingham University in January 2017 prompted the researcher to consider the need for statements to provoke a response in more detail. During the conversation it became apparent that some researchers

working with Q-methodology interpret the need for statements to be provocative and contentious. The researcher was conscious that all of the statements in the Q-set were expressed positively. This stemmed directly from the purpose of the research, which was to explore perspectives on the role of the nurse in preserving dignity in care. Expressing statements contentiously would be unlikely to provoke a response other than blank denial by all participants.

Consideration of the statement "Giving the person the information they need to make their own choices [13.2.05]" illustrates this point. The only way to re-work this to the opposite view would be "Not giving the person the information they need to make their own choices". It is entirely reasonable to assume that no participant would agree with this statement. Instead, participants were provoked by the sorting process itself to consider the relative importance of each statement. While the statements were not in themselves contentious, their relative importance was. Reviewing some Q-methodology studies again, the researcher noted that most did include contentious statements (Hensel, 2014; Montgomery et al., 2014; Petit dit Dariel, Wharrad and Windle, 2013). However, Brown (1993) does not refer to the need for contentious statements, just the need to be comprehensive. In addition, studies with a similar focus on professional issues also avoided contentious statements (Akhtar-Danesh et al., 2013; Dziopa and Ahern, 2009; Mossey et al., 2012).

According to Simons (2013) the number of statements in the Q-sort can vary widely, as long as it is representative of the concourse. However, some caution is required because the more statements there are in the Q-sort, the more complicated and time-consuming the process will be for the participants (Dziopa and Ahern, 2009). Through a process of review involving domain experts and pilot study, the concourse is condensed to form the Q-sort by removing repetitive statements and clarifying ambiguous ones (Landeen et al., 2015; Valaitis et al., 2011). For example, "If patient required time out – Church/Chapel available" [12B.3.03] and "Offer of support from Chaplain" [12B.3.06] were sufficiently similar to be combined in a single statement "Offering support for person's religious or spiritual needs" [12B.3.03 and 06].

6.4.3 Step 3: Evaluating the preliminary Q-set with experts

The preliminary Q-set was reviewed with the supervisory team, paying particular attention to what Watts and Stenner (2012, p. 62) refer to as "things to avoid". One of these – the avoidance of "double-barrelled" items – was particularly relevant (Watts and Stenner, 2012, p. 63). Many of the items identified during the NGTs were "double-barrelled"; for example, "Being in an environment that feels safe and warm" [14A.3.03]" and "Being genuine and interested" [13.2.06]. Such items could have resulted in confusion as a participant might have agreed that feeling safe and being genuine was important but not feeling warm or interested.

Consequently, these statements were reviewed through reflection on the sense of the statement as communicated and understood during the NGT and whether one of the two components was covered in other items. For example, the item "Genuine and interested" became "Being genuinely interested in the person [13.2.06] in order to remove the "double-barrelled" issue and provide a more accurate reflection of the NGT discussion. Similarly, discussion in the NGT around "Having time for the person" [14B.2.12] was focused on being able to take time because of sufficient staff and manageable workload rather than patience and so was revised to "Being able to take time with the person".

It was noted that in Category 1, statement 14A.3.06 – "Pulling curtains or screens around when the person's upset and during care" – contained two potentially contradictory propositions because a participant might agree that it was important to pull curtains around during care but not particularly important when the person is upset. The statement was, therefore, modified to reflect the discussion in the group more accurately while at the same time more clearly identifying what the participant would be asked to agree or disagree with. A few examples of the process are provided in Table **6-3** below.

Table 6-3 *Rationale for changes to statements in the final Q-set*

Category	Preliminary Q-set	Rationale for Change	Pilot Q-set
2	Discussing care with the person and making sure they're happy with it [12A.2.08]	*To avoid conflicting propositions.* *To provide a more accurate reflection of group discussion during NGT*	Making sure the person's happy with the care before it's carried out
3	Being patient, not rushing the person [14A.2.09]	*To enhance clarity by avoiding potential concerns around the potential need to rush in an emergency*	Being patient with the person
3	Having the time to take with the person [14B.2.12]	*To provide a more accurate reflection of group discussion during the nominal group when comments around this concerned workload and skill mix concerns*	Being able to take time with the person
8	Recognising the person's religious or spiritual needs [14B.2.19]	*To avoid repetition* *To avoid potentially conflicting propositions*	Offering support for the person's spiritual needs
8	Offering support from the Chaplaincy service [12B.3.06]	*Combined with above*	

6.4.4 Step 4: Piloting and refining the Q-set

The Q-set was piloted with three members of the researcher's supervisory team and a third-year nursing student. In accordance with Paige and Morin (2014), participants in the pilot were asked to comment on statement clarity and their experience of Q-sorting. Participants in the pilot were asked to identify statements they found difficult to score and anything missing from the Q-set. As a result, some minor changes were

made to the Q-set and the written guidance originally intended for participants was used by the researcher to guide her explanation to participants instead (Appendix 11.18). The final 44-item Q-set used in Strand 2 is provided in Table 6-4.

Table 6-4 *Final Q-set by category*

Category	Statement
1	Pulling curtains around when the person's upset
1	Keeping the person covered as much as possible during care
1	Being able to use single rooms when necessary
1	Ensuring there aren't too many people around during personal care
1	Speaking clearly but quietly to avoid being overheard
1	Asking if it's OK to pass information on to their next-of-kin
2	Giving the person the information they need to make their own choices
2	Finding out what the person wants
2	Asking the person what can be done to make things easier for them
2	Making sure the person's happy with the care before it's carried out
3	Being able to take time with the person
3	Being patient with the person
4	Encouraging the person to do as much as possible for themselves
5	Helping the person look their best before their loved ones come in

Category	Statement
5	Showing kindness to the person’s loved ones
6	Being in-tune with the person’s needs
6	Being able to tell how the person is feeling when they can't speak out
7	Listening to the person
7	Being genuinely interested in the person
8	Speaking to the person as an adult, not a child
8	Speaking to the person as an individual
8	Offering support for the person’s spiritual needs
8	Keeping the person’s belongings with them
9	Being well-prepared to deliver care
9	Responding promptly when the person reports pain
9	Helping the person with their personal hygiene
9	Keeping good records of care
9	Knowing how to move and handle the person well
10	Never leaving the person in a vulnerable position
10	Being courageous (not backing-off) if you need to protect dignity
11	Welcoming everyone’s ideas about care

Category	Statement
11	Working well with others in a team
11	Feeling confident enough to express opinions about care
12	Being passionate about care
12	Being approachable
12	Being honest with the person
12	Being able to build a relationship with the person
12	Not making assumptions about what the person needs
13	Caring for the person in an environment that feels safe
13	Being able to care for the person in a pleasant environment
14	Being able to access whatever equipment is needed
14	Being able to care for the person in a clean environment

6.5 Data Collection

6.5.1 Data management

Respondents were allocated a number based on their cohort – that is 14, 15 or 16 – and another number corresponding with the order in which their consent form was received. For example, a respondent from the September 2016 cohort whose consent form was numbered 4 was identified by the code 16.04. Participants could be matched to their unique identifier in two places: on their consent form and in an electronic database of all those who returned consent forms.

To protect the anonymity of all those involved, paper documentation was held securely in a locked filing cabinet in a locked office on campus or in a locked cabinet at the researcher's home. The electronic record matching participants with their unique identifier was held in a password protected database. Data generated were transcribed into electronic form and this was held securely in a laptop and back-up external drive. Only the researcher and supervisory team had access to the paper and electronic documentation.

6.5.2 Conditions of instruction

In Q-methodology, the conditions of instruction serve the purpose of guiding participants as they sort the Q-set statements along a continuum (McKeown and Thomas, 2013). The continuum most often ranges from 'most agree' to 'least agree' or 'most disagree' (Hensel, 2014; Landeen et al., 2015; van Hooft et al., 2015; Work, Hensel and Decker, 2015). However, this can vary depending on the nature of the study, to include 'most like' to 'most unlike' or 'least like', 'most characteristic' to 'least characteristic' (McKeown and Thomas, 2013). In the current study, the conditions of instruction were to rank the statements on the basis of how important each statement was with regard to the role of the nurse in preserving dignity in care.

6.5.3 Administration of the Q-sort

Q-sorts were administered by the researcher on a one-to-one basis in a spacious, quiet meeting room on-campus. The duration of each Q-sort was between forty minutes and one hour. Rooms were set up in the same way for each participant, with a Q-sort template – laminated and printed in A2 size (Figure 6-1) – and forty-four cards. Printed on each $6cm^2$ card was one of the Q-set items describing an aspect of the nurse's role in preserving dignity in care. On the reverse of each card was a random number to identify the item. On arrival, each participant was welcomed and offered light refreshment. While waiting to begin, participants noticed the template and cards, made some comments, and asked questions about them.

Participants were reminded by the researcher that, in this part of the study, she was interested in their thoughts about the role of the nurse in preserving dignity in care and confirmed consent verbally before they began the Q-sorting process. The process was explained to each participant following the "Helpful Hints to Sorting" provided by Watts and Stenner (2012, p. 191), and summarised in a guide for the researcher (Appendix 11.18). Participants were invited to read each card and then sort the cards into three piles; one for cards with items they most agreed were important, a second for those they least agreed with, and another for those they felt neutral about. Beginning with the cards in the 'most agree' pile, participants were asked to spread these out and to place the one they agreed with most in the +5 space, followed in descending order until the cards in the 'most agree' pile had been placed. This process was repeated with the cards in the 'least agree' pile, followed by those in the 'neutral' pile.

Brief field notes were made during the Q-sorting process to facilitate the researcher's reflection on the process. Once each participant completed their Q-sort, the researcher conducted a brief post-sort interview as described by Watts and Stenner (2012) using the schedule shown in Appendix 11.20. The participants were keen to talk about their experience of the process and it was more natural for the researcher to take down brief notes as they did, and thus enable them to talk more freely. The post-sort interview focused on the participants' thoughts in relation to the items they sorted into the plus and minus 5 and 4 positions in the sorting grid, which items, if any, they found difficult to rank, and whether they thought there was anything missing from the Q-set.

The researcher transcribed the numbers on the reverse of each card on to an A4 size blank paper Q-sort template. The participants were thanked for their attendance and for their interesting and valuable contributions. They were also invited to contact the researcher if they wished to discuss any aspect of the process or any issues raised for them by the process. Each participant was offered a mini-hand cream and a thank-you card. Participants were also emailed by the researcher to thank them again and to

remind them she was available to meet to discuss any aspect of the process or any issue arising from the discussion. No participant approached the researcher.

6.6 Chapter 6: Conclusion

Chapter 6 detailed a significant turning-point in the current study because it marked the beginning of Strand 2. The focus of Strand 2 was on Research Question 3) What are nursing students' perspectives on the important aspects of a nurse's role in preserving dignity in care? The current study employed Q-methodology to answer this question and Chapter 6 began with an introduction to this relatively rarely used approach and defined some of its key terminology. The origins and purpose of Q-methodology as a science of subjectivity was discussed. Moving on, the chapter highlighted the importance of Q-set selection and explained the decisions underpinning its selection from the concourse identified in Strand 1. Recruitment and methods of data collection in Q-methodology – Q-sorting and post-sort interview – were then discussed.

7 Chapter 7: Results – Strand 2

7.1 Chapter 7: Introduction

Chapter 7 discusses the process of analysing the data described in Chapter 6. The approaches taken to factor extraction and rotation will be justified and the associated statistical processes illustrated with reference to the data. These approaches are summarised in Section 7.2, but are presented in much greater detail in Sections 7.3 and 7.4. This further explanation is presented separately because the level of quantitative detail required to demonstrate the rigour of the analysis seemed to interrupt the flow of the results and place undue emphasis on numerical considerations. It is intended that the summary presented in Section 7.2 is sufficient to enable the reader to move from it directly to the key findings in Section 7.5. Chapter 7 concludes with summary information and commentaries on the four factors revealed: *Enabler* (Factor 1), *Caregiver* (Factor 2), *Companion* (Factor 3), and *Defender* (Factor 4). Each of these factors defines a different perspective on the important aspects of the role of the nurse in preserving dignity in care.

7.2 From Q-sorts to Factors: A Summary

> A little simple factor analysis is all that the operations demand: It will be the end of work in this domain if anyone thinks that its be-all and end-all is factor analysis. Stephenson (1986, p. 89)

Despite the integral role played by statistics in Q-methodology, Brown (1996) reminds researchers not to lose sight of the fact that Q-methodology has its roots in Stephenson's interest in subjectivity. Consequently, it is important to note that data analysis in Q-methodology was designed to reveal "life as lived from the standpoint of living it" and not "life measured by the pound" (Brown, 1996, pp.561-562). Accordingly, effective data analysis in Q-methodology requires both quantitative and qualitative procedures (Newman and Ramlo, 2010). Data in the current study were

analysed in the most widely used dedicated software package, PQMethod (Schmolck, 2012), but were also entered into another, recently developed one, Ken-Q (Banasick, 2017). The reason for doing this was to cross-check data entry and results, but also because the latter presents results in a more user-friendly way.

A holistic understanding of perspectives is made possible because, unusually, factor analysis in Q-methodology is completed by person rather than by variables or traits (Skorpen et al., 2015). It is the configuration of each Q-sort as a whole that is correlated with every other Q-sort and not the individual items in the Q-sort (Watts and Stenner, 2005). This means that participants are correlated with each other based on the similarities and differences in how they configure their Q-sorts (Valenta and Wigger, 1997). Factor analysis then enables these distinct groups of Q-sorts with similar configurations to be identified as factors; best understood in Q-methodology as representations of shared viewpoints (Akhtar-Danesh, Baumann and Cordingley, 2008).

Some of the terminology in this section may be unfamiliar in the context of Q-methodology. Terms will be defined in-text but a selection particularly relevant at this point are provided in Table 7-1. A full glossary is also provided in Appendix 11.6.

Table 7-1 *Core terms in Q-methodology (2)*

Term	Explanation
Factor array	A Q-sort representing a given factor which can be presented in a sorting grid (Paige, 2015)
Factor analysis	A statistical process aimed at identifying and representing distinct portions of shared meaning (Watts and Stenner, 2012)
Factor loading	A measure of the extent to which each Q-sort is typical of a given factor (McKeown and Thomas, 2013)
Factor rotation	A process to simplify structure and optimise factor loadings (Valenta and Wigger, 1997)

Q-sorts that load significantly onto a given factor are then used to construct a 'typical' or exemplar Q-sort representing the view captured by the factor. This is accomplished by calculating scores for each statement on each factor through weighted averaging (Akhtar-Danesh, Baumann and Cordingley, 2008). Representing the factors in this way is geared towards simplifying interpretation of the factors (McKeown and Thomas, 2013). Watts and Stenner (2012) describe data analysis in Q-methodology as a series of three key transitions; Q-sorts to factors, followed by factors to factor arrays, and, third, from factor arrays to factor interpretation. The process is summarised in Figure 7-1.

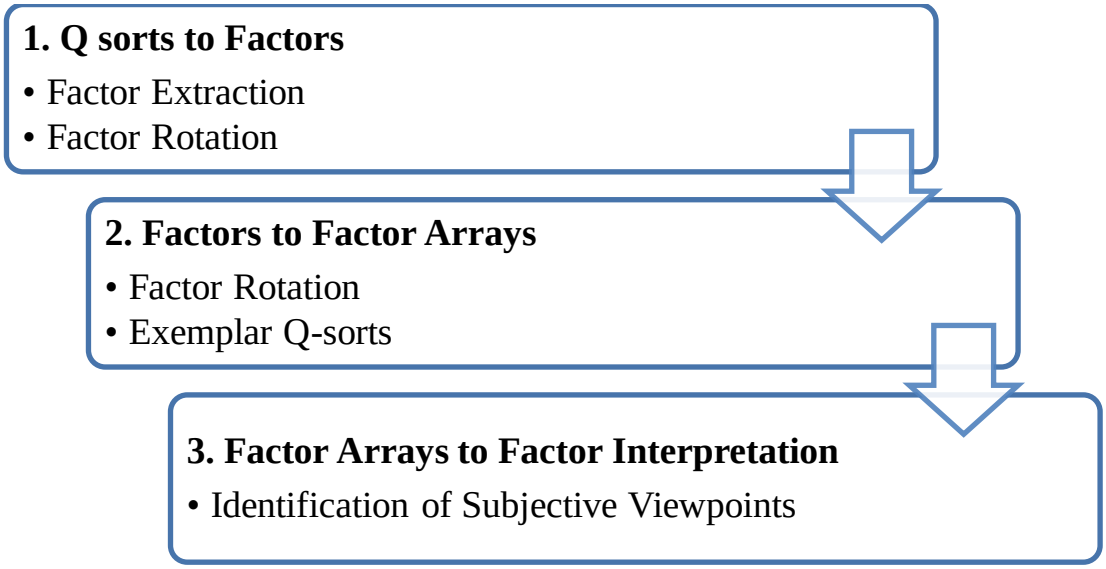


Figure 7-1 *From Q-sorts to factor interpretation*

7.3 From Q-sorts to Factors: Further Explanation

In Q-methodology, data analysis begins with the creation of a correlation matrix. Watts and Stenner (2012) stress that the correlation matrix represents all of the meaning and variability contained within the data set and that searching for patterns of similarity and difference within the matrix offers a means of engaging with the data in a meaningful way. The correlation matrix is derived from the intercorrelation of each sort with every other sort to provide a measure of the strength of their

relationship; that is, the similarities or differences between them. Table 7-2 illustrates the resulting correlation matrix for sorts 3, 7, 15, 16 and 19. The full correlation matrix is presented in Appendix 11.18.

Table 7-2 *Example correlation matrix*

Q-sort	3	7	15	16	19
3	100	21	8	14	26
7		100	3	4	15
15			100	67	72
16				100	50
19					100

The shaded areas highlight the relative strengths of the relationships between the selected Q-sorts. The areas shaded in blue highlight relatively strong correlations between Q-sorts 15, 16 and 19, while those shaded in pink highlight relatively weak correlations with Q-sorts 3 and 7. This indicates that the participants who completed Q-sorts 15, 16 and 19 sorted the items in similar ways to each other and differently from those participants who completed Q-sorts 3 and 7.

Watts and Stenner (2012) stress the importance of examining the correlation matrix for patterns, because these patterns provide insight into the relationships between all the Q-sorts and potential future factors. Indeed, Q-sorts 15, 16 and 19 all load significantly on one of the factors derived following the subsequent analysis discussed below. Q-sorts that correlate with each other significantly will be revealed through factor analysis.

Factor analysis is "fundamental to Q-methodology" because it is the means whereby Q-sorts are grouped together to reveal viewpoints (McKeown and Thomas, 2013). It is a statistical process aimed at identifying and representing distinct portions of shared meaning that seeks to explain as much of the study common variance (hereafter,

variance) as possible (Watts and Stenner, 2012). Explaining the process of factor analysis in Q-methodology, Watts and Stenner (2012) draw a helpful analogy between the process and a cake. In the same way different ingredients come together to make a cake, different Q-sorts come together to communicate a shared meaning or understanding.

Just as a cake can be divided in different ways, so too can the shared meaning or understanding contained within the completed Q-sorts. Each factor extracted from the Q-sorts equates with a slice of cake: a portion of the shared meaning or understanding extracted from the whole (Watts and Stenner, 2012). Continuing the cake analogy, Watts and Stenner (2012) explain that 'slices' of Q-sort data can be 'cut out' of the whole in many different ways using factor analysis. They advise researchers to conduct a factor analysis that supports a meaningful factor solution; one that accounts for as much as possible of the variance present in the study data (Watts and Stenner, 2012).

The first step in this process towards an effective factor solution is factor extraction. Two approaches to factor extraction are commonly referred to in the literature: Principal Component Analysis (PCA), and Centroid Factor Analysis (Paige and Morin, 2015). Both are offered as options for data extraction in PQMethod. The next step is factor rotation; commonly performed in Q-methodology by means of Varimax or 'by-hand' – also known as 'judgemental' – rotation. The current study used Centroid Factor Analysis with a Varimax rotation for the reasons discussed below.

7.3.1 Selecting an approach to factor extraction in Q-methodology

Watts and Stenner (2012) note the debate within Q-methodology regarding the strengths and limitations of each approach. They clarify that – while both approaches tend to produce similar results – PCA is not factor analysis and components identified by this process are not factors (Watts and Stenner, 2012). Watts and Stenner (2012, p. 99) further explain that, in extracting data, PCA seeks out the "single, mathematically *best* solution" (italics in the original). Noting that this may be an understandably

attractive option, they go on to argue that PCA limits the ability of the researcher to engage with the data in a meaningful way and as originally intended when Q-methodology was developed (Watts and Stenner, 2012). Consequently, Watts and Stenner (2012) advise the use of Centroid Factor Analysis in the first instance and, in particular, by novice Q-methodologists. Watts and Stenner (2012, p. 100) describe Centroid Factor Analysis is the "method of choice for Q methodologists" and, therefore, this was the method selected.

Using PQMethod, a traditional Centroid Factor Analysis of the data was performed. The default setting in PQMethod is to extract seven factors; however, Watts (2017) recommends – as a 'rule of thumb' – extracting one factor for every six sorts. Consequently, four factors were extracted initially.

7.3.2 Determining the number of factors to retain

Extracted factors are displayed by PQMethod as a table of unrotated factor loadings. Factor loadings are a measure of the extent to which a Q-sort is typical of a factor; in effect, how much a given Q-sort has in common with a factor (Watts and Stenner, 2012). Interpreting the table of unrotated factor loadings is a key step in determining how many factors to retain. An extract of the full table of unrotated factor loadings for the current study is shown below in Table 7-3 with factor loadings – rounded to two decimal points – for selected Q-sorts. Interpretation requires an understanding of: communality (h^2); factor loading; Eigenvalues (EVs) and variance. These will now be discussed and illustrated with reference to Table 7-3.

Table 7-3 *Example unrotated factor loadings*

Unrotated Factor Loadings						
Q-sorts	Factor 1	Factor 2	Factor 3	Factor 4	h^2	h^2 %
3	0.38	0.39	-0.18	0.03	0.33	33
7	0.32	0.01	0.52	-0.05	0.37	37
15	0.56	-0.58	-0.18	0.10	0.70	70
16	0.56	-0.33	-0.06	0.18	0.45	45
19	0.76	-0.30	-0.03	0.27	0.74	74
Eigenvalue	5.98	1.62	1.21	0.94		
Variance %	28	8	6	4		

Note: The eigenvalues and variances shown here have been calculated for all 21 Q-sorts and not just the five shown. The full table of unrotated factor loadings is shown in Appendix 11.22.

7.3.2.1 Communality

Communality (h^2) is a measure of the extent to which the extracted factors account for the variance of any given Q-sort (Watts and Stenner, 2012). Table 7-4 provides an illustration of communality calculation for Q-sort 3.

Table 7-4 *Communality*

h^2 (Q-sort 3)	
=	(Q-sort 3 loading on Factor 1)^2 + (Q-sort 3 loading on Factor 2)^2 + (Q-sort 3 loading on Factor 3)^2 + (Q-sort 3 loading on Factor 4)^2
=	$0.38^2 + 0.39^2 + -0.18^2 + 0.03^2$
=	0.14 + 0.15 + 0.03 + 0.00
=	0.32 (h^2 % = 32%)

Note: The discrepancy between this manually calculated figure of 0.32 and the automatically calculated figure of 0.33 is accounted for by rounding the factor loading to two decimal places.

This means that 32% of the variance in Q-sort 3 has been accounted for by the four extracted factors. In essence, 32% of the variance in Q-sort 3 is common variance that is; it is shared with all the other Q-sorts in the study. In comparison, the 74% communality score of Q-sort 19 in Table 7-3 highlights how much more Q-sort 19 has in common with all the other Q-sorts in the study, and how much more typical it is of the study group than Q-sort 3. Cumulative communalities for all 21 Q-sorts and all four factors are shown in Appendix 11.23. Table 7-5 shows the communalities in ascending order and illustrates that the communalities ranged widely between 14% (Q-sort 13) and 77% (Q-sort 5).

Table 7-5 *Communality range*

Number of Q-sort	h^2%
13	14
8	27
5	77

Watts and Stenner (2012) note that the Q-sorts with a lower communality are less likely to be significantly loaded on any particular factor because they do not have enough in common with any of the extracted factors. This was supported by the subsequent analysis detailed below, which found that Q-sorts 8 and 13 – with their relatively low communality scores (h^2%) of 27% and 14%, respectively – were non-significant; that is, they did not load significantly on any of the four factors extracted. Nevertheless, it is interesting to note that Q-sorts 8 and 13 were the only non-significant Q-sorts despite three other Q-sorts – Q-sorts 10, 11 and 20 – having similar or lower communality scores.

With regard to the nature of the correlations, consideration was given to the presence of positive and negative factor loadings because these are suggestive of the presence of opposing viewpoints (Watts and Stenner, 2012). This is illustrated in Table 7-3 by the relative factor loadings for the example Q-sorts on Factor 2. The positive and negative factor loadings on Factor 2 suggested that opposing viewpoints were present. Inspection of the unrotated factor loadings for each Q-sort in relation to each factor (Appendix 11.22) lent support to the existence of such opposing perspectives in relation to Factor 2 and Factors 3 and 4. No such opposing perspectives were evident in Factor 1. This indicated that the perspective captured by Factor 1 was one of consensus, while the other three factors seemed to capture perspectives incorporating some disagreement.

To identify the extent to which each Q-sort is typical of each factor, the unrotated factor loadings needed to be squared (Watts and Stenner, 2012). This can be illustrated with reference to Q-sorts 3 and 7 in Table 7-5. The unrotated factor loading for Q-sort 7 Factor 1 accounted for 14% (0.38 x 0.38) of the variance of Q-sort 7, but 57% (0.76 x 0.76) of the variance of Q-sort 19. This indicated that Q-sort 19 was more typical of and explained more about Factor 1 than did Q-sort 7. In essence, Q-sort 19 had more in common with Factor 1 than Q-sort 7.

7.3.2.2 Eigenvalues (EVs)

While communality provides information with regard to each Q-sort, EVs provide information with regard to each factor (Watts and Stenner, 2012). Typically, in Q-methodology, a factor with an EV greater than one is considered significant (Baxter et al., 2009). This is known as the Kaiser-Guttman criterion (Watts and Stenner, 2012).

EVs are automatically calculated by PQMethod but can be calculated manually by summing the squared factor loadings for each Q-sort on each factor (Brown, 1980). Manual calculation of a selection of EVs was performed to aid understanding and enhance engagement with the process. This is illustrated with reference to Factor 1 in Table 7-6 below.

Table 7-6 *Example calculation eigenvalue*

EV (Factor 1)	
=	(Q-sort 1 loading on Factor 1)^2 + (Q-sort 2 loading on Factor 1)^2 +… + (Q-sort 21 loading on Factor 1)^2
=	$0.54^2 + 0.36^2 + \ldots + 0.58^2$
=	$0.29 + 0.13 + \ldots + 0.34$
=	5.98

In Table 7-6 it is worth noting that, before rotation, Factor 1 had an EV of 5.98 and accounted for 31% of everything that the 21 Q-sorts held in common. Similarly, Factors 2 and 3 also had EVs in excess of one and so met this criterion, too. Conversely, the EV for Factor 4 was just under the threshold at 0.94. While Factor 4 did not meet this criterion, it came close, and this countered some of the doubts around whether this factor should be retained or not.

7.3.2.3 Factor Loadings

For a significant factor loading at the 0.01 level, Brown (1980) provides the equation shown in Table 7-7 below and illustrated with reference to the current study with forty-four items in the Q-set.

Table 7-7 *Example calculation significant factor loading*

Significant factor loading	= 2.58 × (1 ÷ √number of items in the Q-set)
	= 2.58 × (1 ÷ √44)
	= 2.58 × (1 ÷ 6.6332)
	= 2.58 × 0.1508
	= 0.3890 rounded-up to **0.39**

This significance level of 0.39 was then checked against the unrotated factor loadings provided in Appendix 11.22. This enabled the significant unrotated factor loadings on each factor to be identified. An example of this process is shown in Table 7-8 below, with the significant unrotated factor loadings highlighted in blue.

Table 7-8 *Example unrotated significant factor loadings*

	Unrotated Factor Loadings			
Q-sorts	Factor 1	Factor 2	Factor 3	Factor 4
1	0.7351	-0.1194	-0.1960	-0.0177
3	0.3776	0.3909	-0.1803	0.0272
7	0.3191	0.0133	0.5158	-0.0470
8	0.4019	0.1247	0.2371	-0.1971
12	0.3039	0.3163	-0.2845	-0.2735
20	0.2000	0.4459	0.0502	0.0232
21	0.2403	0.0754	-0.4614	-0.2198

When this process was completed for all Q-sorts and factors, Factors 1, 2 and 3 all had two or more significantly loading Q-sorts, but Factor 4 had none. This raised doubts about whether Factor 4 should be extracted for further analysis because no unrotated Q-sort loaded significantly on it.

7.3.2.4 Humphrey's Rule

Another guide to decision-making in this regard is Humphrey's Rule (Watts and Stenner, 2012). This states that a factor is significant if "the cross-product of the two highest loadings … exceeds twice the standard error" (Brown, 1980). The standard error was calculated using the equation provided by Brown (1980) for this 44-item study, as shown in Table 7-9.

Table 7-9 *Calculation unrotated standard error*

Standard error for study	= 1 ÷ (√number of items in the Q-set)
	= 1 ÷ (√44)
	= (1 ÷ 6.6332)
	= 0.1508 rounded-up to 0.15
Twice the standard error	= 0.30

Brown (1980) notes, however, that Humphrey's Rule can be applied less strictly so that it is satisfied by cross-products of highest loadings merely exceeding the standard error. This was calculated for all four factors and the results are shown below in Table 7-10 with the significant factors shaded in blue. Only Factor 1 satisfies the strictest application of Humphrey's Rule, but Factors 2 and 3 meet the criterion in its more relaxed form by exceeding 0.15. Once again, however, Factor 4 failed to meet this criterion and this raised doubts again about whether or not it should be retained.

Table 7-10 *Humphrey's Rule*

Factor	Humphrey's Rule	Exceeds 0.30?	Exceeds 0.15?
1	0.7798 × 0.7882 = 0.6146	Yes	Yes
2	0.5793 × 0.4459 = 0.2583	No	Yes
3	0.5158 × 0.4614 = 0.2780	No	Yes
4	0.3828 × 0.3637 = 0.1392	No	No

Table 7-11 summarises the application of these criteria in the current study.

Table 7-11 *Summary of extraction criteria*

Criteria	Factors			
	1	2	3	4
Eigenvalue > 1	Yes	Yes	Yes	No
Humphrey's Rule at 0.30	Yes	No	No	No
Humphrey's Rule at 0.15	Yes	Yes	Yes	No
Significant factor loadings > 2 Q-sorts	Yes	Yes	Yes	No

As shown, Factors 1, 2 and 3 all met criteria for retention. Factor 4 did not but its EV was borderline. Watts and Stenner (2012) remind researchers that EVs may well improve following rotation as discussed in Section 7.3. Indeed, this was the case for Factor 4 in the current study the EV of which increased to 1.05, meeting the criterion for retention. Watts and Stenner (2012) advise against abandoning factors too soon because significant perspective may be lost. Instead, they advocate retaining borderline factors for rotation and "taking a good look" at the result (Watts and Stenner, 2012, p. 110). The risk of abandoning Factor 4 prior to rotation – perhaps

missing a significant perspective – seemed to outweigh the risk of retaining too many factors. Consequently, Factor 4 was retained.

7.3.3 Rotating the factors

Valenta and Wigger (1997) describe factor rotation as a means of simplifying structure and optimising factor loadings with a view to enhancing the interpretability of the factors. This is achieved by rotating the factors about a central axis point (Watts and Stenner, 2012). In effect, the factor loadings are used – like coordinates in a map – to map the factors against each other in theoretical, multidimensional space (Watts and Stenner, 2012). In Q-methodology two approaches to rotation are commonly used: automated Varimax and/or manual 'by-hand' rotation (Akhtar-Danesh and Mirza, 2017). Factor loadings are crucial regardless of which approach or combination of approaches.

Varimax is an automatic procedure which rotates factors based on statistical criteria (Akhtar-Danesh and Mirza, 2017). It is available in a range of software packages including the PQMethod package used in the current study. Relying on statistical criteria, Akhtar-Danesh and Mirza (2017) describe Varimax as an objective means of conducting factor rotation. In contrast, 'by-hand' rotation – also referred to as theoretical or judgemental rotation – relies on researchers manually moving the factors based on their knowledge of the subject under investigation and the data (Watts and Stenner, 2012). Consequently, it is a subjective means of conducting factor rotation (Akhtar-Danesh and Mirza, 2017).

The approach to factor rotation is the subject of great debate within Q-methodology (Akhtar-Danesh and Mirza, 2017). Some argue that a 'by-hand' rotation is best because it is most in keeping with Stephenson's original vision and ideas about abduction and the discovery of surprising insights (McKeown and Thomas, 2013). Others argue that its very subjectivity renders it unreliable and impossible to reproduce (Akhtar-Danesh and Mirza, 2017; Kampen and Tamás, 2014). Watts and Stenner (2012, p. 122) take what seems to be a sensible middle road in the debate, arguing that

"there is no definitively right or wrong way of proceeding" and is dependent on preference, the data and the study purpose. They also note that manual rotation is an acquired skill and, as such, can be daunting for novice Q-researchers (Watts and Stenner, 2012). In addition, Watts and Stenner (2012) go on to suggest that Varimax may be preferred if a study is focused on the majority perspectives of the participants as was the in the current study. For these reasons, the current study used Varimax rotation. The final factor solution was a four-factor solution. Using PQMethod, a three-factor solution was also considered but it was noted that this lost the very distinctive perspective represented by Factor 4, which also had two Q-sorts loading significantly after rotation.

Regardless of whichever approach or combination of approaches is used, factor loadings are crucial to the process. PQMethod – and other dedicated programmes for Q-methodology such as Ken-Q (Banasick, 2017) – will automatically 'flag' Q-sorts with significant factor loadings. However, this was performed manually in the current study, in line with the recommendation of Watts and Stenner (2012). Doing so enabled the researcher to engage meaningfully with the data, develop her understanding of the process and to take control of the analysis process. This last point was particularly important because automatic flagging also flagged two confounded sorts and a sort that did not meet the significance level calculated for the current study. It was likely that the automatic process had adjusted the significance level in order to maximise the number of Q-sorts with significant factor loadings, but this was not explicit.

As shown in Table 7-12, 16 of the 21 participants who completed a Q-sort loaded significantly on to one of the four factors. These Q-sorts were 'flagged' as significant by this researcher in PQMethod and used to generate the factor estimates. The Q-sorts of four participants were confounded; that is, they loaded significantly on more than one factor. Watts and Stenner (2012) advise that these are not usually used to construct factor estimates because they do not represent a distinct perspective. They were not, therefore, used in the current study. The Q-sort of one participant did not load significantly on any factor.

Table 7-12 *Significant Q-sorts by factor*

Q-sort #	Factors				Comment
	1	2	3	4	
1	0.6195*				
2		0.7803*			
3		0.5226*			
4	0.6118*		0.4393*		Confounded
5	0.5482*	0.5721*			Confounded
6	0.6409*			0.4355*	Confounded
7			0.5455*		
8			0.4811*		
9	0.5598*		0.4661*		Confounded
10		0.4182*			
11	0.4729*				
12					
13	-0.0135	0.0967	-0.0128	-0.3599	Non-significant
14	0.5717*				
15	0.8191*				
16	0.6623*				
17			0.5211*		
18			0.5987*		
19	0.8105*				
20		0.3951*			
21				0.4939*	

Note: * = Significant factor loading > 0.39 (see Table 7-7 Example calculation significant factor loading). Confounded = Q-sort with significant loadings on more than one factor. Non-significant = Q-sort did not load significantly on to any factor.

Of the 21 completed Q-sorts, 16 were retained to generate the factor arrays. This is summarised with regard to specific Q-sorts below in Table 7-13.

Table 7-13 *Factors by Q-sort*

	Factors				Confounded	Non-significant	Total
	1	2	3	4			
Q-sort #	1, 11, 14, 15, 16, 19	2, 3, 10, 20	7, 8, 17, 18	12, 21	4, 5, 6, 9	13	
Total	6	4	4	2	4	1	21

Note: Q-sort # = Q-sort number

In the current study no claims are made about the significance of year group and perspective, but data were examined in case any broad differences were apparent. Table 7-14 below summarises results by year group.

Table 7-14 *Summary of factors by year*

Year Group	Factors				Confounded	Non-significant	Total
	1	2	3	4			
Year 1 #	3	1	2	1			7
Year 2 #	2	1	2	1	2	1	9
Year 3 #	1	2	0	0	2		5
Total	6	4	4	2	4	1	21

Note: Year # = Number of participants from year group. Confounded = Q-sorts that loaded significantly on to more than one factor. Non-significant = Q-sorts that did not load significantly on to any factor.

7.4 From Factors to Factor Arrays: Further Explanation

Based on the significant factor loadings flagged above, a factor array was prepared automatically for each factor by PQMethod (Schmolck, 2012). A factor array is an estimate of the perspective represented by the factor (Watts and Stenner, 2012). These are generated by means of a weighted average of the Q-sorts – called a z-score – that load significantly onto a given factor. Weighting for each Q-sort loading significantly on a factor is determined by its factor loading; the greater the factor loading, the greater the weighting. This means that, of the significant Q-sorts loading on to a factor, those with the highest factor loading will make the greatest contribution to the factor array (Watts and Stenner, 2012). Factor arrays are often presented in both tables and as an exemplar Q-sort in a sorting grid.

The factor arrays were then used to prepare "crib sheets", as recommended by Watts and Stenner (2012), detailing which items in each factor's array were ranked as -5 or +5 and those ranked higher or lower than in other factors. As recommended, the crib sheets were also used to detail the researcher's preliminary thoughts about the perspective captured in each factor array. Crib sheets for each of the four factors are shown in Appendix 11.25.

In addition, the relative ranking tables produced by PQMethod (Schmolck, 2012) provided a further guide to the similarities and differences existing between the different factors. Importantly, the factor arrays identify 'distinguishing statements'. Distinguishing statements are statements for each factor array with at least $p > 0.05$; that is, their ranking in a factor array is significantly different from other factors and indicate opposing perspectives (Newman and Ramlo, 2010). Consensus statements are statements that are not ranked significantly differently and so do not distinguish between factors and indicate agreement (Newman and Ramlo, 2010).

In the current study, these relative rankings were then cross-checked against the items highlighted in the crib sheets to identify any discrepancies. Relative ranking tables also augmented the crib sheets by providing a clear summary of where the factor was

positioned in relation to the other factors. The relative rankings and factor arrays for each factor and consensus statements are summarised in Section 7.5.1.

7.5 Factor Arrays to Factor Interpretation

Data analysis revealed four distinct nursing student perspectives on the relative importance of various aspects of the role of the nurse in preserving dignity in care. The four factors were named according to their primary focus as *Enabler* (Factor 1), *Caregiver* (Factor 2), *Companion* (Factor 3), and *Defender* (Factor 4). They are summarised below in Table 7-15.

Table 7-15 *The four factors*

Factor	Name	Primary Focus
1	*Enabler*	Enabling the person's role in their own care
2	*Caregiver*	Delivering 'good' care
3	*Companion*	Attending to feelings and relationships
4	*Defender*	Being courageous when dignity is threatened

First, *Enablers* (Factor 1) shared the view that enabling the role of the person in their own care was the most important aspect of the role of the nurse in preserving dignity in care. Second, *Caregivers* (Factor 2) were of the view that the delivery of 'good' care was the most important aspect of the nurse's role in preserving dignity. Third, *Companions* (Factor 3) attached the greatest importance to being with the person and attending to feelings and relationship. Fourth, *Defenders* (Factor 4) identified being courageous in the face of threats to dignity was most important.

Of the two presentation styles for factor interpretation described by Watts and Stenner (2012) – narrative and commentary – the current study used a narrative style because it seemed to flow more easily and was the style most commonly used in the published

literature. Statements incorporated to illustrate the factor interpretations are presented in brackets as the statement number and the ranking given in the factor array. For example, statement 28 with a ranking of -1 in the Factor 1 Array is presented as (28: -1). A selection of key terms particularly relevant at this point are provided in Table 7-16. A full glossary is also provided in Appendix 11.6.

Table 7-16 *Core terms in Q-methodology (3)*

Term	Explanation
Consensus Statement	A statement in the Q-set that does not distinguish between different factors indicating agreement (Newman and Ramlo, 2010)
Distinguishing Statement	A statement in the Q-set that distinguishes a factor from other factors at a significance level of $p > 0.05$ (Newman and Ramlo, 2010)

In Section 7.5, consensus statements are discussed first in Section 7.5.1, followed by each of the four factors. The current study also followed the recommendation to discuss each factor in turn, beginning with a brief summary of the relevant statistical information about the factor and the distinguishing statements (Watts and Stenner, 2012). Full factor arrays – both as relative ranking tables and in sorting grid form – are available after the commentary on each factor.

It is worth remembering that these are relative differences between the perspectives on the importance of certain aspects of the nurse's role. In other words, aspects of the role are more or less important than each other, not rejected as unimportant.

7.5.1 Consensus

Of the forty-four statements in the Q-set, four consensus statements were identified. These statements are shown below in Table 7-17. These reflect general agreement around the relative importance of these as aspects of nursing care which help to preserve dignity.

Table 7-17 *Consensus statements*

Stat. #	Statement	*	Factors 1	2	3	4
5	Never leaving the person in a vulnerable position		4	3	2	4
24	Being able to use single rooms when necessary	*	-4	-3	-4	-4
26	Being patient with the person	*	2	2	2	1
40	Helping loved ones to spend time with the person		0	-2	-1	-1

Note: Stat. # = Statement Number. All listed statements are non-significant at $p > 0.01$, and those flagged with * are also non-significant at $p > 0.05$.

The consensus around which aspects of care were relatively more important centre on the need to never leave the person in a vulnerable position (Stat. #5) and to be patient with the person (Stat. #26). Of these, the former was ranked more highly than the latter, as revealed by the rankings in Table 7-17 above. In the post-sort interview, Participant 15.05 explained that she had ranked this as most important (5: +5) because, "they're so vulnerable anyway". She expanded on this with an account of a placement experience when she acted to minimise a person's exposure during urinary catheterisation. Participant 16.04 explained her ranking of (5: +4) with the comment, "it's just basic care … you have to do that". Conversely, some participants used a similar justification for attaching a relatively low importance to the statement. During the sorting procedure, Participant 15.03 hesitated to place the statement and expressed the view that "it is important … just … need to do it" before deciding that "you do that anyway" and ranking it (5: -3). Interestingly, the same Participant (15.03) ranked as most important the need to be patient with the person (Stat. # 26) and explained this through an account of caring for an older relative recovering from a stroke. In common with Stat. #5 – never leaving the person in a vulnerable position – participants

who attached relatively low importance to this did so because it was perceived as something that was simply part of good care (Participants 15.02 and 15.05).

With regard to those aspects of care deemed relatively less important, consensus was reached on the use of single rooms (Stat. #24) and helping loved ones spend time with the person (Stat. #40). Being able to use single rooms (Stat. #24) was agreed to be one of the least important aspects of care. A real strength of feeling was evident to the researcher in relation to this statement even while data collection was ongoing because several participants commented on it while they completed their Q-sort. Comments centred on the lack of availability of single rooms, the risk of isolation and the need to "make the best" of what was available (Participant 16.02). Participant 14.01 awarded the highest ranking (24: +2) and, while not invited to explain this directly, she gave an account of caring for a person towards the end of his life in a single room that offered some insight into her rationale. There was also agreement around the relatively low importance attached to helping loved ones spend time with the person (Stat. #40). Participants variously described visitors as being potentially "tiring" for the person (Participant 16.06) and the need for "balance" (Participant 15.03) to protect rest and mealtimes.

In conclusion, consensus was found around the relative importance of four statements and for broadly the same reasons. Watts and Stenner (2012) note that consensus statements should not be ignored because they may point to areas that would benefit from improvement or the existence of learning needs. Participant comments in relation to the consensus statements were interesting and would benefit from further exploration, particularly around the use of single rooms and the role of loved ones in care.

7.5.2 *Enabler* (Factor 1)

7.5.2.1 Enabler (Factor 1): Summary

Following Varimax rotation, this factor had an EV of 4.41 and explained 21% of the study variance. Six participants loaded significantly on to this factor. They were all female nursing students and all three years of the programme were represented as shown below in Table 7-18.

Table 7-18 *Enabler (Factor 1) by year group and Q-sort*

Year Group	1	2	3	Total
Number of participants	3	2	1	6
Q-sort #	15, 16, 19	11, 14	1	

Note: Q-sort # = The number used to identify a given Q-sort that loads significantly on the factor (excluding confounded or non-significant Q-sorts).

Distinguishing statements for *Enablers* are shown in Table 7-19. Full details of the factor's relative rankings and the factor array are shown in Table 7-20 and Figure 7-2, respectively.

Table 7-19 *Enabler (Factor 1): Distinguishing statements*

		Factors				
Stat.#	Statements	**1**		2	3	4
Highest Ranking Statement						
15	Finding out what the person wants	**5**	D*	-1	0	-2
Statements Ranking Higher than in Other Factors						
8	Speaking to the person as an adult, not a child	**3**	D	0	1	0
21	Helping the person look their best before their loved ones come in	**2**	D	-4	-1	0
38	Asking if it's OK to pass information on to their next-of-kin	**1**	D	-1	-3	-4
Statements Ranking Lower than in Other Factors						
20	Being passionate about care	**-2**	D*	5	4	4
18	Keeping good records of care	**-3**	D*	2	-1	0
25	Knowing how to move and handle the person well	**-4**	D*	1	-1	3

Note: Stat.# – Statement Number; D – Distinguishing Statement $p > 0.05$, D* $p > 0.01$

Table 7-20 *Enabler (Factor 1): Relative rankings*

Stat.#	Statements	Factors 1		2	3	4
Highest Ranking Statement						
15	Finding out what the person wants	**5**	D*	-1	0	-2
Statements Ranking Higher than in Other Factors						
19	Speaking to the person as an individual	**4**		1	4	-1
5	Never leaving the person in a vulnerable position	**4**	C	3	2	4
17	Keeping the person covered as much as possible during care	**4**		3	0	2
7	Pulling curtains around when the person's upset	**3**		-1	0	3
9	Listening to the person	**3**		3	3	0
23	Being honest with the person	**3**		2	1	-2
8	Speaking to the person as an adult, not a child	**3**	D	0	1	0
26	Being patient with the person	**2**	C*	2	2	1
21	Helping the person look their best before their loved ones come in	**2**	D	-4	-1	0
38	Asking if it's OK to pass information on to their next-of-kin	**1**	D	-1	-3	-4
40	Helping loved ones to spend time with the person	**0**	C	-2	-1	-1
Statements Ranking Lower than in Other Factors						
6	Responding promptly when the person reports pain	**0**		2	0	2
43	Being approachable	**0**		2	3	1
16	Being genuinely interested in the person	**0**		1	5	1
28	Being in-tune with the person's needs	**-1**		-1	2	-1
27	Showing kindness to the person's loved ones	**-2**		0	1	-1
20	Being passionate about care	**-2**	D*	5	4	4
14	Working well with others in a team	**-2**		0	-2	-1
3	Being well-prepared to deliver care	**-2**		-2	0	2
30	Feeling confident enough to express opinions…care	**-3**		1	-2	3
18	Keeping good records of care	**-3**	D*	2	-1	0
24	Being able to use single rooms when necessary	**-4**	C*	-3	-4	-4
25	Knowing how to move and handle the person well	**-4**	D*	1	-1	3
41	Being specially trained in the type of care required	**-4**		-4	3	1
Lowest Ranking Statements						
12	Being able to access whatever equipment is needed	**-5**		0	-4	-4

Note: Stat.# - Statement Number; D – Distinguishing Statement $p > 0.05$, D* $p > 0.01$; C – Consensus Statement $p > 0.05$, C* $p > 0.01$

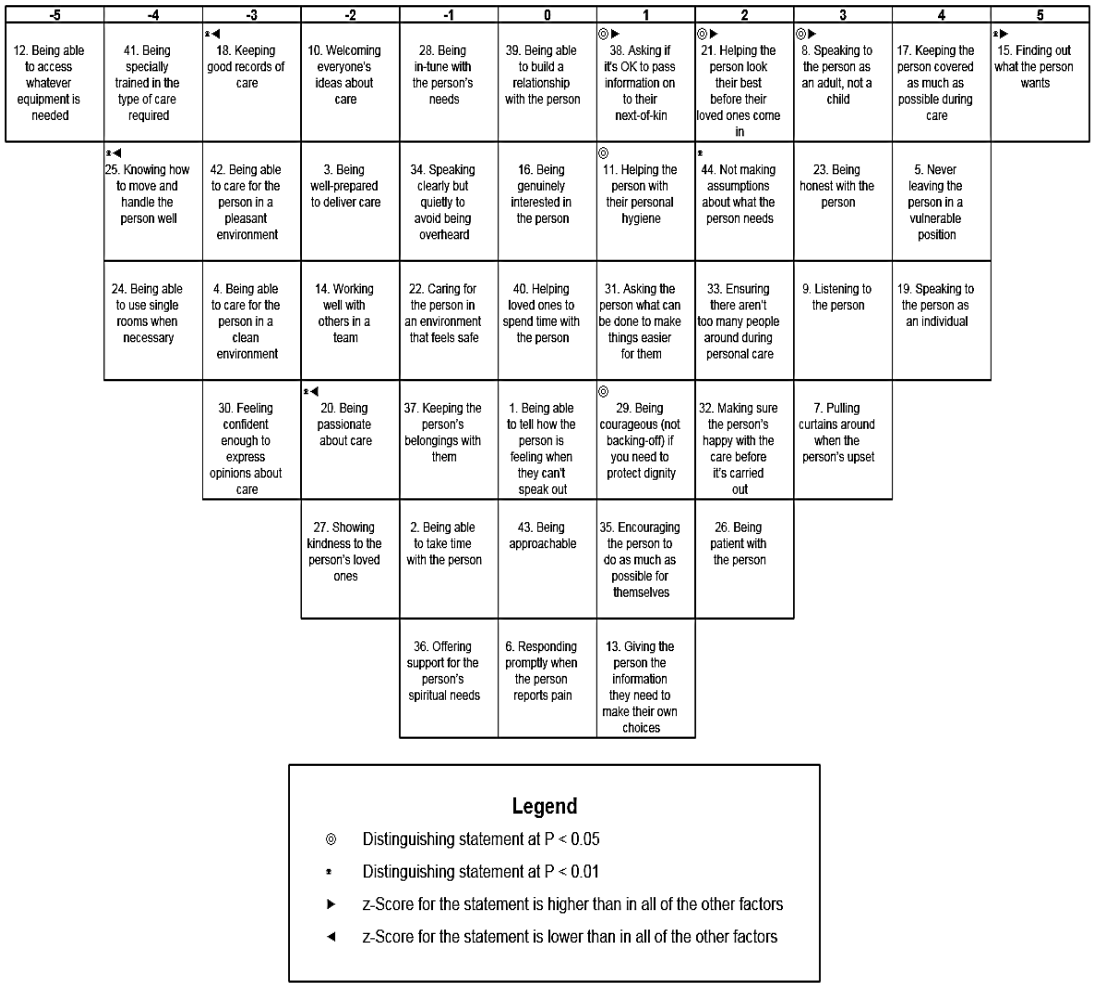


Figure 7-2 *Enabler (Factor 1): Factor array [from Ken-Q (Banasick, 2017)]*

7.5.2.2 Enabler (Factor 1): Commentary

Enabling the person's role in their own care is central to the *Enabler* perspective. This is reflected in the importance attached to finding out what the person wants (15: +5). When asked about this during the post-sort interview, Participant 16.01 summarised the reason for this in the comment, "They're in-charge of what happens to them". Closely related to this is the importance attached to preserving the person's privacy, both physical (17: +4) and emotional (7: +3). In addition to controlling what can be

seen by others, is it also important that the person can control what is known about them (38: +1). Participant 16.02 highlighted the importance of this is in an account of an incident experienced on placement when confidential information was inappropriately communicated. Similarly, control over the image presented to others extends in particular to how the person's loved ones perceive them (21: 2).

Communicating respect of the person is considered crucial (19: +3; 8: +3) because, "You should never talk-down to people" (Participant 16.05). An integral part of this communication is, of course, listening to the person (9: +3). To explain its importance, Participant 14.01 described a situation experienced while on placement in which the views of an older adult were not heard, resulting in a deterioration of the relationship between staff and family members. This concern for enabling the person's involvement in their care was further highlighted by Participant 16.02, who commented that honesty was important (23: +3) because, "patients have a right to know what's happening".

Less important aspects of care included those which related to the physical environment of care, education and skilled performance. With regard to availability of equipment (12: -5; 24: -4), Participant 16.02 explained that, "you have to work around" what is available. Also deemed less important was a nurse's skill in relation to level of education (41: -4). Describing dignity in care as "basic care", Participant 14.01 explained that this did not require specialist training because it was something everyone was able to do. The performance of tasks such as moving and handling (25: -4), pain management (6: 0), record-keeping (18: -3), and preparation (3: -2) were also regarded as being less important aspects of a nurse's role in preserving dignity in care. Participant 16.01 expressed the view that moving and handling was, again, "just basic care". With regard to pain management, Participant 15.09 explained that she had ranked this as least important because, "if you're doing everything else then you're doing this anyway". Interestingly, Participant 14.01 expressed a similar view in relation to record-keeping but also added that it sometimes "gets in the way" of care. Regarding being well-prepared to deliver care, Participant 15.09 simply stated that this

was not always possible – giving the example of urgent care situations – but it should always be possible to preserve dignity.

Other less important aspects of dignity in care were concerned with relationships with other healthcare workers (14: -2) and with the person's loved ones (27: -2). Participant 14.01 commented that teamwork was important but stated that she did not feel this was something she had much control over as a student on a relatively brief placement. With regard to loved ones, Participant 15.06 acknowledged that this relationship was important but that "they're [the person] the priority" and suggested that care of loved ones flowed naturally from "good basic care".

In addition, feelings such as being passionate about care (20: -2), being interested in the person (16: 0), and being approachable (43: 0) were, for Participant 15.09, quite simply also part of "good" care in the same way as moving and handling or record-keeping. Participant 16.02 explained that being in-tune with the person (28: -1) "isn't possible" because "you can't know what someone else is thinking". Feeling confident enough to express opinions (30: -3) proved particularly challenging for two participants: 15.09 and 16.01. Both participants demonstrated hesitation and voiced their reservations during the sorting procedure; commenting that "it's really important" (Participant 16.01) but might be inappropriate for them to do so as nursing students. Participant 15.09 also felt that it was important but that she lacked the knowledge required. When asked in the post-sort interview if that would also be the case for registered nurses, they both expressed the view that it would be easier for registered nurses to do so but that it would still "depend on the situation" (Participant 16.01). Interestingly, Participant 15.09 ranked 'being courageous … to protect dignity' at +4. This seems to reflect an acknowledgement of the need to be courageous alongside a need for this courage to be founded on knowledge and confidence.

In summary, *Enablers* were of the view that the most important aspect of the role of the nurse in preserving dignity in care was to enable the person's role in their own care. This was demonstrated by the importance they attached to aspects of nursing

care that placed the person at the centre of their care experience. For *Enablers*, the role of the nurse was, as far as possible, to enable the person to be involved in their own care, to control what others perceive about them and to communicate respectfully. What others – including the nurse – think and feel was less important than what the person thinks and feels. External aspects, such as the physical environment, training received, and the wider healthcare team, were all regarded as being less important. *Enablers* also highlighted perceived barriers to this in terms of knowledge and confidence.

7.5.3 *Caregiver* (Factor 2)

7.5.3.1 Caregiver (Factor 2): Summary

Following Varimax rotation, Factor 2 had an EV of 2.10 and explained 10% of the study variance. The Q-sorts of four participants loaded significantly on to this factor. Of the four, three were female one was male, and all three years of the programme were represented, as shown below in Table 7-21.

Table 7-21 *Caregiver (Factor 2) by year group and Q-sort*

Year Group	1	2	3	Total
Number of participants	1	1	2	4
Q-sort #	20	10	2, 3	

Note: # = The number used to identify a given Q-sort that loads significantly on the factor (excluding confounded or non-significant Q-sorts).

Relative rankings and the Factor Array for *Caregivers* (Factor 2) are shown in

Table 7-23 and Figure 7-3. Distinguishing statements for Factor 2 are shown in Table 7-22.

Table 7-22 *Caregiver (Factor 2): Distinguising statements*

Stat.#	Statements	Factors				
		2		1	3	4
Statements Ranked Higher than in Other Factors						
44	Not making assumptions about what the person needs	**4**	D*	2	-3	-1
12	Being able to access whatever equipment is needed	**0**	D*	-5	-4	-4
Statements Ranked Lower than in Other Factors						
21	Helping the person look their best before their loved ones come in	**-4**	D*	2	-1	0
Lowest Ranked Statement						
36	Offering support for the person's spiritual needs	-5	D*	-1	-1	-2

Note: Stat.# Statement Number, D Distinguishing Statement, $p > 0.05$, D* $p > 0.01$

Table 7-23 *Caregiver (Factor 2): Relative rankings*

Stat.#	Statements	Factors				
		2		1	3	4
Highest Ranked Statement						
20	Being passionate about care	**5**		-2	4	4
Statements Ranked Higher than in Other Factors						
44	Not making assumptions about…person needs	**4**	D*	2	-3	-1
13	Giving the person the information they need to make their own choices	**4**		1	3	1
32	Making sure the person's happy with the care before it's carried out	**4**		2	1	1
35	Encouraging the person to do as much as possible for themselves	**3**		1	-3	2
9	Listening to the person	**3**		3	3	0
26	Being patient with the person	**2**	C*	2	2	1
6	Responding promptly when…reports pain	**2**		0	0	2
18	Keeping good records of care	**2**		-3	-1	0
14	Working well with others in a team	**0**		-2	-2	-1
12	Being able to access whatever equipment is needed	**0**	D*	-5	-4	-4
Statements Ranked Lower than in Other Factors						
8	Speaking to the person as an adult, not a child	**0**		3	1	0
29	Being courageous…if you need to protect dignity	**0**		1	0	5
7	Pulling curtains around when the person's upset	**-1**		3	0	3
39	Being able to build a relationship with the person	**-1**		0	4	0
28	Being in-tune with the person's needs	**-1**		-1	2	-1
40	Helping loved ones to spend time with the person	**-2**	C	0	-1	-1
3	Being well-prepared to deliver care	**-2**		-2	0	2
2	Being able to take time with the person	**-2**		-1	1	-2
34	Speaking clearly but quietly to avoid being overheard	**-3**		-1	-1	-2
10	Welcoming everyone's ideas about care	**-3**		-2	-2	0
41	Being specially trained in the type of care required	**-4**		-4	3	1
21	Helping the person look their best before their loved ones come in	**-4**	D*	2	-1	0
Lowest Ranked Statements						
36	Offering support for the person's spiritual needs	**-5**	D*	-1	-1	-2

Note: Stat.# - Statement Number; D – Distinguishing Statement $p > 0.05$, D* $p > 0.01$; C – Consensus Statement $p > 0.05$, C* $p > 0.01$

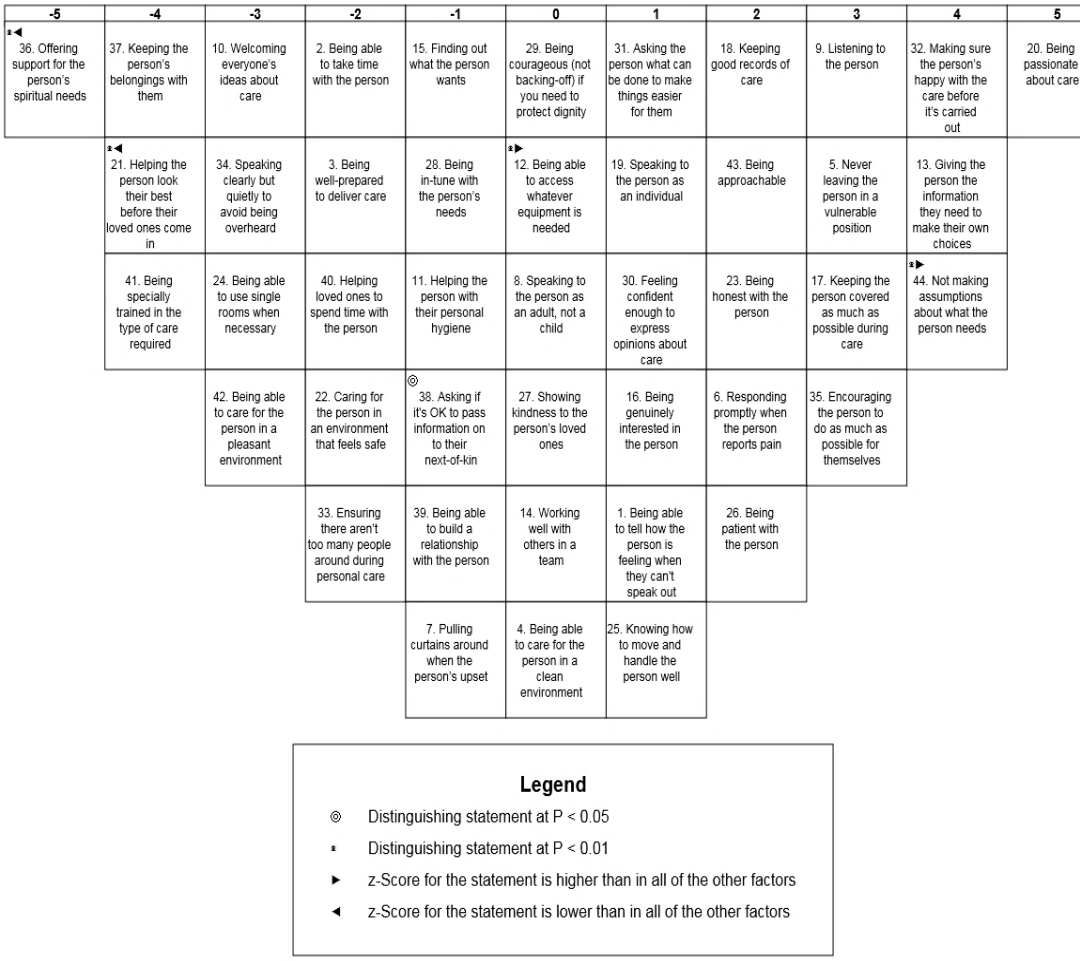


Figure 7-3 *Caregiver (Factor 2): Factor array [from Ken-Q (Banasick, 2017)]*

7.5.3.2 Caregiver (Factor 2): Commentary

Fundamental to the *Caregiver* perspective is the provision of 'good' care (20: +5). This was reflected in the importance attached to action in relation to care delivery. Whereas the *Enabler* perspective centred on the person, the perspective of the *Caregiver* was centred on the nurse and the provision of 'good' care. Participant 15.05 summarised this in her comment that preserving dignity is "just about good care".

For *Caregivers*, this 'good' care was delivered through effective communication when a nurse gives information that enables the person to make their own decisions about

their care (13: +4). Similarly, *Caregivers* attached particular importance to a nurse confirming with the person that they were "happy with the care" (32: +4). This was underlined by Participant 14.02, who stated, "If the patient's not happy then the care can't be good". Given that the nurse's role is to both give and seek information, it is perhaps unsurprising that listening (9: +3) was also important to *Caregivers*. Supporting the person's independence was seen as crucial to preserving dignity (35: +3); accomplished when the nurse is encouraging and patient with the person (26: +2). Participant 16.06 explained that she thought encouraging independence was key because "it's really important the person doesn't become dependent … need to get home". She went on to illustrate this by recounting how an older relative's mobility and continence had deteriorated following a hospital stay.

In addition to communication, skilled performance of procedures and related care were highly regarded by *Caregivers*. This is illustrated by the importance they attached to pain management (6: +2) and record-keeping (18: +2). Regarding the latter, Participant 14.03 expressed the view that "you need to keep … read notes … maybe off for a few days or someone's just come in". This participant also commented that, for the same reasons, nurses need to work well with others (14: 0); "need … to listen to other staff". The importance of procedural skills was underscored by Participant 15.05, who explained that, "you can't give good care if you don't have the right equipment" (12: 0).

Seemingly less important from the *Caregiver* perspective were the more abstract aspects of nursing care. This was particularly apparent in relation to the role of the nurse in supporting a person's spiritual needs (36: -5). Participant 14.02 stated that this was important if a person was "religious" but explained that "most people aren't", and it would, in any case, be "covered" by other aspects of care. Similarly, being in-tune with the person (28: -1), taking time with the person (2: -2), speaking to them as an adult (8: 0), and building a relationship with them (39: -1) were accorded relatively low priority by *Caregivers*. Perhaps further insight into this view is provided by Participant 15.03's comment – with reference to her placement in a "really busy"

surgical ward – that the "main things" were to admit and transfer people safely and perform post-operative observations. With regard to the importance attached to helping a person look their best for loved ones (21: -4), Participant 15.05 commented that this was because "it goes without saying" that the person should always look their best "regardless", and that this is how "you know that care's good".

Given the importance attached to the delivery of 'good' care, the relatively low priority given by *Caregivers* to specialist training (41: -4) and being well-prepared (3: -2) was surprising. Providing some insight into this, Participant 14.02 commented that "everyone's able to protect dignity [you] don't need to do a special course". These comments were echoed by Participant 14.03 and have much in common with those made by Participant 14.01 from the *Enabler* perspective. Participant 15.05 also commented that, just as it is not always possible to be prepared, it is not always possible to avoid being overheard (34: -3).

In summary, the *Caregiver* perspective was characterised by the importance attached to the provision of 'good' care for dignity. Above all else, this perspective was about the importance of action; what was important was what the nurse does to preserve dignity in care. What the person thinks and feels are important to dignity in care in so far as these are measures of how 'good' the care was. More abstract considerations were less important for dignity because these were regarded as resulting naturally from 'good' care rather than being amenable to more direct intervention.

7.5.4 *Companion* (Factor 3)

7.5.4.1 Companion (Factor 3): Summary

Following Varimax rotation the *Companion* perspective (Factor 3) had an EV of 2.10 and explained 10% of the study variance. The Q-sorts of four participants loaded significantly on to this factor. Of the four, all were female nursing students; two were in 2nd Year and two in 3rd Year, as shown below in Table 7-24.

Table 7-24 *Companion (Factor 3) by year group and Q-sort*

Year Group	1	2	3	Total
Number of participants	0	2	2	4
Q-sort #	-	7, 8	17, 18	

Note: Q-sort # = The number used to identify a given Q-sort that loads significantly on the factor (excluding confounded or non-significant Q-sorts).

Distinguishing statements for Factor 3 are shown below in .

Table 7-25.

Table 7-25 *Companion (Factor 3): Distinguishing statements*

				Factors		
Stat.#	Statements	**3**		1	2	4
Highest Ranked Statement						
16	Being genuinely interested in the person	**5**	D*	0	1	1
Statements Ranked Higher than in Other Factors						
39	Being able to build a relationship with the person	**4**	D*	0	-1	0
28	Being in-tune with the person's needs	**2**	D*	-1	-1	-1
2	Being able to take time with the person	**1**	D*	-1	-2	-2
22	Caring for the person in an environment that feels safe	**1**	D*	-1	-2	-3
Statements Ranked Lower than in Other Factors						
35	Encouraging the person to do as much as possible for themselves	**-3**	D*	1	3	2
Lowest Ranked Statement						
42	Being able to care for the person in a pleasant environment	**-5**	D*	-3	-3	-3

Note: Stat.# Statement Number; D –Distinguishing Statement $p > 0.05$, D* $p > 0.01$

Relative Rankings and Factor Array for *Companions* (Factor 3) are shown in and Table 7-26 and Figure 7-4, respectively.

Table 7-26 *Companion (Factor 3): Relative rankings*

Stat.#	Statements	Factors 3		1	2	4
Highest Ranked Statement						
16	Being genuinely interested in the person	**5**	D*	0	1	1
Statements Ranked Higher than in Other Factors						
19	Speaking to the person as an individual	**4**		4	1	-1
39	Being able to build a relationship with the person	**4**	D*	0	-1	0
43	Being approachable	**3**		0	2	1
9	Listening to the person	**3**		3	3	0
41	Being specially trained in the type of care required	**3**		-4	-4	1
1	Being able to tell how the person is feeling when they can't speak out	**2**		0	1	-3
31	Asking the person what can be done to make things easier for them	**2**		1	1	-3
26	Being patient with the person	**2**	C*	2	2	1
28	Being in-tune with the person's needs	**2**	D*	-1	-1	-1
27	Showing kindness to the person's loved ones	**1**		-2	0	-1
2	Being able to take time with the person	**1**	D*	-1	-2	-2
22	Caring for the person in an environment…safe	**1**	D*	-1	-2	-3
Statements Ranked Lower than in Other Factors						
17	Keeping the person covered as much as possible during care	**0**		4	3	2
6	Responding promptly when…reports pain	**0**		0	2	2
29	Being courageous (not backing-off) if you need to protect dignity	**0**		1	0	5
14	Working well with others in a team	**-2**		-2	0	-1
11	Helping the person with their personal hygiene	**-2**		1	-1	4
35	Encouraging the person to do as much as possible for themselves	**-3**	D*	1	3	2
33	Ensuring there aren't too many people around during personal care	**-3**		2	-2	3
24	Being able to use single rooms when necessary	**-4**	C*	-4	-3	-4
4	Being able to care for the person in a clean environment	**-4**		-3	0	2
Lowest Ranked Statement						
42	Being able to care for the person in a pleasant environment	**-5**	D*	-3	-3	-3

Note: Stat.# - Statement Number; D – Distinguishing Statement $p > 0.05$, D* $p > 0.01$; C – Consensus Statement $p > 0.05$, C* $p > 0.01$

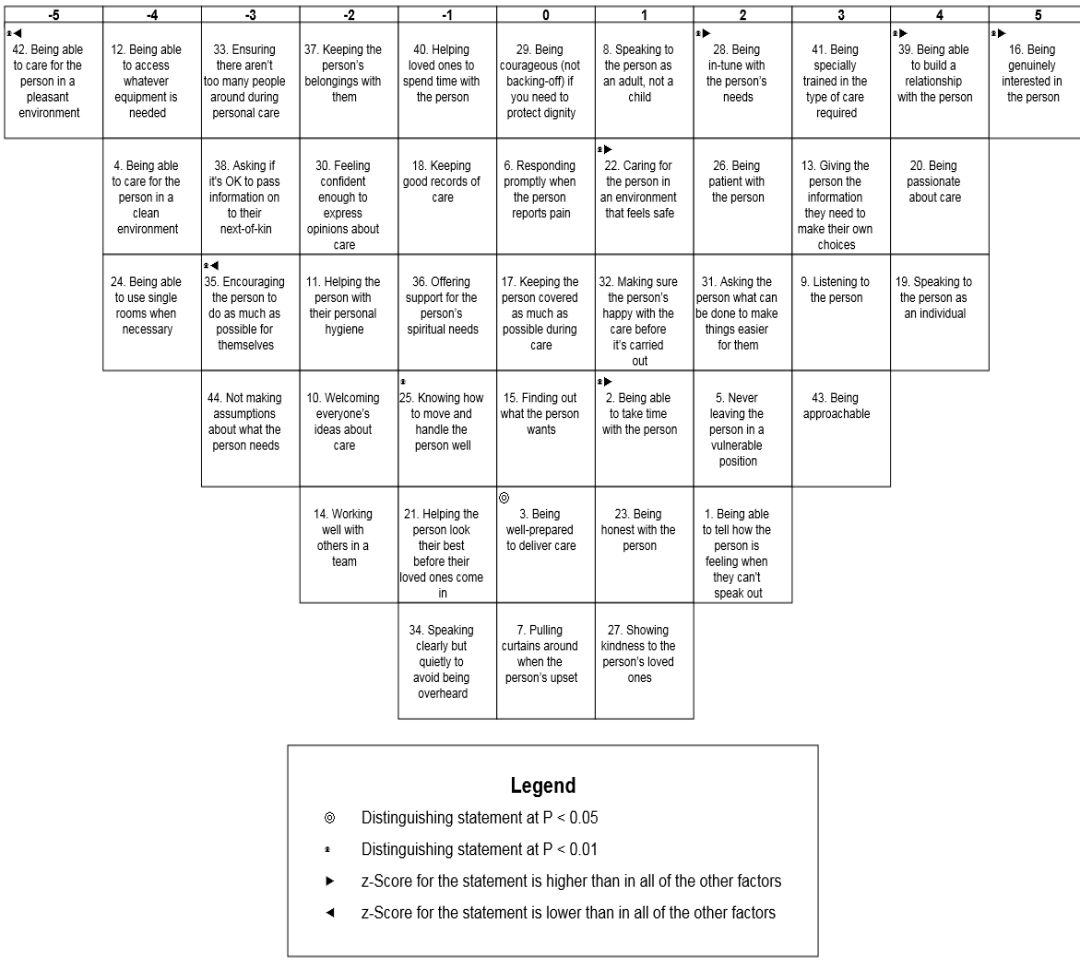


Figure 7-4 *Companion (Factor 3): Factor array [from Ken-Q (Banasick, 2017)]*

7.5.4.2 Companion (Factor 3): Commentary

In the same way as Factor 2 is all about the importance of 'doing for', Factor 3 is all about the importance of 'being with' the person and the feelings of those involved. The importance attached to 'being with' is reflected in the importance attached to being genuinely interested in the person (16: +5). During the post-sort interview, Participant 16.03 explained that her rationale for ranking this as most important (16:

+5) was that, "when someone's not [interested] patients can see it right away … [Staff] not bothered about them". This aligns closely with the importance attached to building a relationship with the person (39: +4) and being approachable (43: +3). Participant 15.03 used an account of her recent placement in a rehabilitation area to illustrate the value she placed on "really getting to know" people and their visitors. Taking time with the person (2: +1) was also ranked relatively highly and this was highlighted in a general comment by Participant 15.02 about how different placements could be in terms of the time available to spend with people "just getting to know them". Communication is seen as key to this relationship with relatively high importance being attached to speaking to the person as an individual (19: +4) and listening (9: +3).

Feelings were also at the heart of this relationship; both the feelings of the nurse and those of the person. From this perspective, it is important that nurses were able to use their intuition to gauge how a person is feeling when they cannot communicate this directly (1: +2) and be in-tune with the person's needs (28: +2). It is also important that nurses are kind (27: +1) and patient (26: +2). Rather than success being completion of tasks and other care activities, it is important that nurses establish what can be done to make things easier for the person (31: +2). This intuitive approach to care was illustrated by Participant 16.04 in an account of caring for persons with dementia when it was necessary to "use your imagination … sort of".

Interestingly, this perspective also attached a relatively high importance to being specially trained (41: +3) which seemed rather incongruous set against this context of relationship and feelings. During her post-sort interview, however, Participant 16.03 illustrated her comments on the general topic of dignity in care by reference to a placement where she had been impressed by the way in which staff were able to perform complex tasks while still being genuinely interested in the person and in-tune with their needs; "just talking … explaining all the time". It may be that this perspective recognises the value of specialised education and training to the development of expertise in a way the others did not. Interestingly, two of the confounded Q-sorts – from Participants 14.04 and 15.04 – both loaded significantly

onto Factors 1 and 3 and each ranked the intuitive aspects of care as most important for dignity, but the need for specialised education and training as least important. In each of their post-sort interviews, these participants were also adamant that specialised training was not required to preserve dignity.

Less important aspects of care for dignity include those which relate to the physical environment of care and basic personal care. More than any of the other factors, Factor 3 captures a perspective that places relatively little importance on environmental concerns. This is reflected in the low importance attached to being able to care for a person in a pleasant (42: -5) or clean (4: -4) environment or in a single room (24: -4). Each participant commented on these issues during the Q-sort, and Participant 16.04's comment that "you need to get on with it" is typical.

Initially surprising were the relatively low rankings attached to some aspects of basic care. With regard to basic care, this perspective attaches less importance to not making assumptions about what a person needs (44: -3) and encouraging a person to do as much as possible for themselves (35: -3). Participant 15.03 offered as a rationale for ranking these at the lower end of the spectrum the idea that "you need to find out what they like … need … some won't be able to do [what someone else is able to do] … need to help them". Helping a person with their personal hygiene (11: -2), keeping the person covered during such care (17: 0), responding promptly to reports of pain (6: 0), and ensuring that there were not too many people around (33: -3) were all regarded as less important for dignity. Insight is provided by comments made during the Q-sort by Participant 16.03, who stated that "you do these things anyway".

In summary, the perspective captured by Factor 3 – *Companion* – is grounded in the importance of 'being with' the person and the feeling of those involved. This is demonstrated by the importance attached to aspects of nursing care characterised by intuition and empathy. The role of the nurse is, as far as possible, to help preserve dignity by ensuring the person has a positive experience of care. External aspects such as the physical environment, were seen as less of a priority than this relationship.

7.5.5 *Defender* (Factor 4)

7.5.5.1 Defender (Factor 4): Summary

Following Varimax rotation, Factor 4 had an EV of 1.05 and explained 5% of the study variance. The Q-sorts of two participants loaded significantly on to this factor. Both were female nursing students; one in 1st Year, and one in 2nd Year, as shown below in Table 7-27.

Table 7-27 *Defender (Factor 4) by year group and Q-sort*

Year Group	1	2	3	Total
Number of participants	1	1	0	2
Q-sort #	21	12	-	

Note: # = The number used to identify a given Q-sort that loads significantly on the factor (excluding confounded or non-significant Q-sorts).

Distinguishing statements for Factor 4 are shown in Table 7-28. Relative rankings and the Factor Array for *Defenders* (Factor 4) are shown in Table 7-29 and Figure 7-5.

Table 7-28 *Defender (Factor 4): Distinguishing statements*

Stat.#	Statements	**4**		Factors 1	2	3
Highest Ranked Statement						
29	Being courageous (not backing-off) if you need to protect dignity	**5**	D*	1	0	0
Statements Ranked Higher than in Other Factors						
11	Helping the person with their personal hygiene	**4**	D	1	-1	-2
3	Being well-prepared to deliver care	**2**	D	-2	-2	0
Statements Ranked Lower than in Other Factors						
9	Listening to the person	**0**	D*	3	3	3
19	Speaking to the person as an individual	**-1**	D	4	1	4
23	Being honest with the person	**-2**	D*	3	2	1
1	Being able to tell how the person is feeling when they can't speak out	**-3**	D*	0	1	2
31	Asking the person what can be done to make things easier for them	**-3**	D*	1	1	2

Note: Stat.# = Statement Number; D-Distinguishing Statement $p > 0.05$, D* $p > 0.01$

Table 7-29 *Defender (Factor 4): Relative rankings*

Stat.#	Statements	Factors				
		4		1	2	3
Highest Ranked Statement						
29	Being courageous (not backing-off) if you need to protect dignity	**5**	D*	1	0	0
Statements Ranked Higher than in Other Factors						
5	Never leaving the person…vulnerable position	**4**	C	4	3	2
11	Helping the person with their personal hygiene	**4**	D	1	-1	-2
30	Feeling confident…express opinions about care	**3**		-3	1	-2
33	Ensuring there aren't too many people around during personal care	**3**		2	-2	-3
25	Knowing how to move and handle…well	**3**		-4	1	-1
7	Pulling curtains around when the person's upset	**3**		3	-1	0
3	Being well-prepared to deliver care	**2**	D	-2	-2	0
6	Responding promptly when...pain	**2**		0	2	0
4	Being able to care for the person in a clean environment	**2**		-3	0	-4
10	Welcoming everyone's ideas about care	**0**		-2	-3	-2
Statements Ranked Lower than in Other Factors						
8	Speaking to the person as an adult, not a child	**0**		3	0	1
9	Listening to the person	**0**	D*	3	3	3
19	Speaking to the person as an individual	**-1**	D	4	1	4
28	Being in-tune with the person's needs	**-1**		-1	-1	2
23	Being honest with the person	**-2**	D*	3	2	1
15	Finding out what the person wants	**-2**		5	-1	0
2	Being able to take time with the person	**-2**		-1	-2	1
31	Asking the person what can be done to make things easier for them	**-3**	D*	1	1	2
22	Caring for the person in an environment that feels safe	**-3**		-1	-2	1
38	Asking if it's OK to pass information on to their next-of-kin	**-4**		1	-1	-3
24	Being able to use single rooms when necessary	**-4**	C*	-4	-3	-4
Lowest Ranked Statement						
37	Keeping the person's belongings with them	**-5**		-1	-4	-2

Note: Stat.# - Statement Number; D – Distinguishing Statement $p > 0.05$, D* $p > 0.01$; C – Consensus Statement $p > 0.05$, C* $p > 0.01$

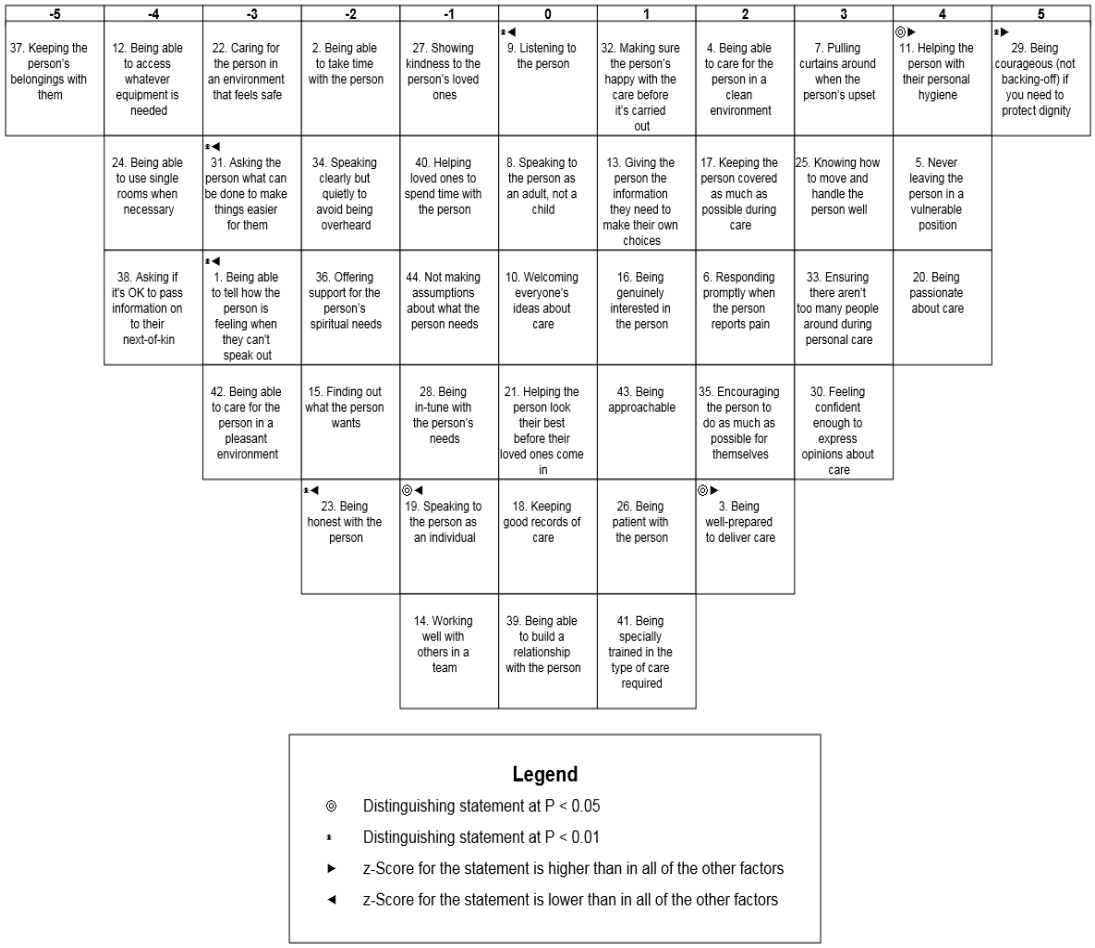


Figure 7-5 *Defender (Factor 4): Factor array [Ken-Q (Banasick, 2017)]*

7.5.5.2 Defender (Factor 4): Commentary

Factor 4 captures a perspective very much focused on the role of the nurse in protecting the person by being courageous and skilled. The thoughts and feelings of the person seem less important.

The importance this perspective attaches to being courageous in the protection of dignity (29: +5) is reflected in the importance of never leaving the person in a vulnerable position (5: +4) and feeling confident enough to express opinions about care (30: +3). Much of this courage and confidence is directed towards protecting the

physical privacy of the person, as illustrated by the priority given to ensuring that during personal care there are not too many people around (33: +3), and by pulling curtains around (7: +3). This is illustrated by Participant 16.07's account during the post-sort interview of staff in a recent placement pulling-back closed curtains and exposing patients on two occasions.

The importance of the physical aspects of care is also reflected in the concern for a clean environment in which to deliver this care (4: +2). From this perspective, skilled performance of basic care is crucial, and this is apparent in the value attached to helping the person with personal hygiene (11: +4) and being well-prepared to deliver such care (3: +2). Specific skills, such as knowing how to move and handle the person (25: +3) and responding promptly to reports of pain (6: +2), were also regarded as being important.

Of less importance were the feelings involved and the role of the person in their own care. Feelings of safety (22: -3), of being in-tune with the person (28: -1) and being able to tell how they are feeling (1: -3) were of lower priority. This is reflected in the importance attached to communication with the person. While this perspective welcomes others' ideas about care (10: 0), listening to the person seems less important (9: 0). The importance attached to protecting the person's confidential information (38: -4) is also in marked contrast to the perspective's concern with protecting the person's physical privacy. Asking what can be done to make things easier for them (31: -3) is similarly seen as being less important than the nurse's own skill in delivering care. Being honest with the person (23: -2), speaking to the person as an adult (8: 0) and as an individual (19: -1), and finding out what they want (15: -2) were all similarly seen as being less important. Together, these results suggest that relatively little importance is attached to the role of the person as a partner in their own care. Serving as a striking illustration of this is the comment by Participant 15.07 during Q-sorting that "it's not about what they want, it's what they need".

In summary, the perspective captured by Factor 4 – *'Defender'* – centres on ideas about the importance of the role of the nurse as a defender of dignity. The important aspects of a nurse's role in preserving dignity were closely aligned to assuring the person's privacy during personal care and the nurse's role as protector. The role of the person as a partner in their own care is less important.

7.6 Chapter 7: Conclusion

Each of the four factors identified by the current study represents a unique perspective on the relative importance of various aspects of the role of the nurse in preserving dignity in care. What are nursing students' perspectives on the important aspects of a nurse's role in preserving dignity in care?

Respect for the role of the person in their own care more than for the care itself characterises the *Enabler* perspective on the important aspects of the role of the nurse in preserving dignity in care. *Caregivers* share a perspective in which more nuanced considerations in care – such as the feelings of those involved – are accorded less priority in the preservation of dignity than the delivery of 'good' care. In contrast, the *Companion* perspective on the role of the nurse in preserving dignity in care is that the delivery of care is less important than the relationships and feelings which underpin it. For *Defenders,* the focus is very much on the role of the nurse in being courageous in defending dignity when it is threatened.

It is important to remember that the factors are the product of weighted scores and stress that all the participants expressed difficulties in ranking the statements because they all regarded all the statements as important. The perspectives captured by the factors reflect differences in the degree of importance attached by each perspective. This means that; for example, *Defenders* do not think a person's role as a partner in their own care is unimportant, only that it is less important than other aspects of care. The perspectives captured by each of the four factors are discussed in the context of the literature in Chapter 8.

8 Chapter 8: Discussion

8.1 Chapter 8: Introduction

This mixed methods study used photo-elicitation, Nominal Group Technique (NGT) and Q-methodology to explore nursing students' perspectives on the preservation of dignity in care. The study aimed to answer the following three research questions:

1. What meaning do nursing students attach to the term 'dignity in care'?
2. What are nursing students' perspectives on the personal and environmental influences on the preservation of dignity in care?
3. What are nursing students' perspectives on the nurse's role in preserving dignity in care?

Chapter 8 discusses each research question in the context of the literature reviewed in Chapter 2 and some recently published but directly relevant evidence. The current study's contribution to knowledge, its strengths and limitations and the trustworthiness of its findings are also discussed. Chapter 8 concludes with recommendations for education, practice and further research.

8.2 Research Question 1

What meaning do nursing students attach to the term 'dignity in care'?

8.2.1 Summary

This research question was answered by the photo-elicitation component of the NGT in Strand 1 of the study, which identified 10 categories of meaning, as illustrated in Table 5-9 (Mullen et al., 2017a). Approaches to understanding the meaning of dignity were discussed in Section 2.3 and the categories reflect several aspects of these. Categories also reflect findings discussed in Section 2.4 around the 'people' influences on dignity in care. None of the categories made any explicit reference to the 'place' influences discussed in Section 2.5. In particular, influences related to the wider social

context – such as policy, ethical principles or professional standards or guidance – were not identified. Nine of the categories describe dignity in care in terms of action; something that nurses played an active role in and made a difference to. What is most striking; however, is the participants' understanding of dignity in care as something located firmly in relationship and interaction, as illustrated in Figure 8-1.

Image 28A

(NHS Education for Scotland, 2012)

Dignity in care means to be respectful of a person's individuality. To listen to their needs and respond in a way that ensure their needs are met. [Participant 12A.05]

Figure 8-1 *Example of photo-elicitation and meaning*

8.2.2 Commentary

Findings in relation to this research question reflect several aspects of the literature reviewed in Chapter 2. In particular, they resonate strongly with the 'dignity of identity' and 'human dignity' identified in the typology described by Nordenfelt (2004) and discussed in Section 2.3.1. Dignity of identity is apparent in the participants' concerns around choice, communication and partnership and captured in five of the 10 categories (Categories 2, 5, 6, 7 and 10 in Table 8-1).

In contrast, the remaining five categories focus on feelings, recognising the unique person and vulnerability and, therefore, seem to have more in common with human dignity. Furthermore, the terms used by the participants to express their understanding are the same as, or very similar to, the defining attributes of dignity in care (Table 2.10) derived from concept analysis and discussed in Section 2.3.2. In addition, these findings reflect an understanding of dignity in care that is rooted in interaction and

relationship. This points to Jacobson's framework of dignity discussed in Section 2.3.3, where "every human interaction is a potential dignity encounter" (Jacobson, 2009b, p. 3). Notably, nine of the 10 categories of meaning attached to dignity by the participants centre on action. This resonates with Jacobson's idea of "Dignity work … a deliberate attitude, behaviour, or action" (Jacobson and Silva, 2010, p. 367). Consequently, it is perhaps unsurprising that the meaning expressed by participants also reflects the 'people' influences on dignity in care of staff behaviour and patient vulnerability from the literature reviewed in Section 2.4. Most significant are communication and the vulnerability of the patient.

A mixed methods study of nursing students at another University in Scotland also found that the participants expressed their understanding of dignity in care in terms of listening, enabling choice and promoting privacy (Macaden et al., 2017). A total of 111 nursing students completed an online questionnaire, and 35 attended one of three focus groups (Macaden et al., 2017). Different aspects of the same research project are presented by Kyle et al. (2017) and Munoz et al. (2017). Findings reported by Kyle et al. (2017), Macaden et al. (2017), and Munoz et al. (2017) are especially interesting in the context of the current study because of similarities between the two study populations of undergraduate preregistration nursing students based at a single Scottish University. Particular similarities are evident in the focus group component because of the similar sample sizes, the use of group interview methods, and of a "voting technique" to achieve consensus (Munoz et al., 2017, p. 3).

In Jacobson's framework (Jacobson, 2009b) discussed in Section 2.3.3, the actors are influenced by two sets of conditions: their 'position' relative to each other and the nature of their relationship. For the participants, these conditions seem to be where the meaning of dignity is found. Recalling Jacobson from Section 2.3.3, if one actor has a position of compassion and the other actor one of confidence then dignity is more likely to be promoted (Jacobson, 2009b). Conversely, dignity is more likely to be violated if one actor has a position of antipathy and the other actor one of vulnerability (Jacobson, 2009b). Categories primarily concerned with helping,

protecting, demonstrating care and giving time seem particularly relevant in terms of establishing a position of compassion and confidence (Table 8-1).

Similarly, Jacobson asserts that a relationship of solidarity between actors – characterised by empathy and trust – is more likely to promote dignity while a relationship of asymmetry – characterised by inequity in relation to power, knowledge or control – is more likely to violate it (Jacobson, 2009b). Categories primarily concerned with establishing a relationship based on respect for the individual and working in partnership with them and with their loved ones seem particularly relevant to this set of conditions (Table 8-1).

The highest-ranked category – 'Dignity in nursing care is not having to worry about leaving it at the door' – differs from the others because it does not focus on action but on outcome; the outcome being that persons receiving nursing care are not worried about their dignity being violated. When viewed in the light of Jacobson's theory (Jacobson, 2009b), it may be regarded as describing the consequences of establishing the conditions conducive to the promotion of dignity. The relationship between the categories and the conditions of a dignity encounter are illustrated in Table 8-1.

Table 8-1 *Categories and conditions of a dignity encounter*

Dignity in nursing care is not having to worry about leaving it at the door Image 24A (NHS Education for Scotland, 2012)	

Categories and Conditions for Dignity in Care

Category and Position		Category and Relationship	
3	Doing whatever is possible to help	2	Being respectful of a person's individuality
4	Protecting the vulnerable person	5	Working together
8	Showing that you care	6	Communicating with each other
9	Giving people the time they need	7	Respecting the person's choices
		10	Involving the person's loved ones

Differences between the literature and the findings in relation to this research question are also interesting and relate to Theme 3 of the literature review (Section 2.5). Category 9 – 'Giving people the time they need' – points to the 'place' factor of time but, otherwise, none of the categories make any explicit reference to the influence of 'place' – the local setting and wider social context – discussed in Section 2.5.

Regarding the wider social context, participants might have been expected to express their understanding with some reference to human rights and ethical principles because this approach underpins ethics education in their programme of study. Indeed, it has been reported that this approach characterises most ethics education in health care (Cannaerts, Gastmans and Casterlé, 2014; Monteverde, 2014). The language of human rights and ethical principles; however, formed no part of participants' expressed understanding. In particular, participants did not express their

understanding in terms of obligation – for example; the obligations of ethical principles – but in personal terms with an emphasis on the nature of the relationships and feelings involved. Participants may simply have found it easier to articulate their understanding in naturalistic language. This finding, however, seems to support other studies of qualified nurses in which personal values and the nature of the nurse-patient relationship were found to exert considerable influence on ethical decision-making (Gastmans, 2013; Goethals, de Casterle and Gastmans, 2013; Goethals, Dierckx de Casterlé and Gastmans, 2012).

Conversely, Macaden et al. (2017) found that participants did express their understanding in theoretical language; for example, one of the themes generated during focus groups with nursing students was "promoting autonomy". This difference may be related to differences in the methods used. The current study used photo-elicitation for the purpose of triggering a personal response, as discussed in Section 4.6.2. Responses were written down and there was no facilitated discussion. Had a focus group approach been used, it seems likely that participant responses would have been grouped together under headings such as autonomy or person-centred care. It may also be the case that the focus group participants employed the language of the classroom because they were in more of a classroom-type of situation and that was the natural language for that environment, especially in the presence of a facilitator.

As discussed in Mullen et al. (2017a), participants did not identify any prerequisites – such as autonomy – when they articulated their understanding of dignity. Much of the theoretical discussion of the meaning of dignity is around whether it is absolute and held by all human beings to the same degree "simply by virtue of the fact that they are human" (Sulmasy, 2013, p. 938) or whether it requires rational capacities such as autonomy to be present (Killmister, 2010). Arguably, only categories two and seven – 'Dignity in nursing care is about being respectful of a person's individuality' and 'Dignity in nursing care is about respecting the person's choices' – reference autonomy. The participants' understanding of dignity in care seems to reflect the view that autonomy is a significant aspect of dignity but not its defining characteristic

(Gallagher et al., 2008; Gastmans, 2013). Munoz et al. (2017, p. 3) also found that 'human dignity' (Section 2.3.1) formed part of the nursing student participants' conceptualisation of dignity.

Regarding the professional standards and guidance that frame ethics in a professional context in the UK, no explicit reference was made to The Code (Nursing and Midwifery Council, 2015), which obliges nurses to uphold the dignity of those in their care. While no explicit reference to The Code is made, the categories do seem to reflect some of the ways in which the Nursing and Midwifery Council identify that nurses should "prioritise people" by, for example, respecting diversity and choice, listening, and working in partnership (Nursing and Midwifery Council, 2015, p. 6). Again, this lends support to similar findings from a recent study of nursing students' perceptions of dignity in care (Macaden et al., 2017). Mullen et al. (2017a) also note that the common attributes of dignity – concepts such as respect that are frequently attached to dignity to describe it (Gallagher, 2011a) – are also reflected in the language of The Code and the participants.

Regardless of the ongoing debate around the utility of the concept of dignity in health care, the concept certainly seemed to resonate with participants. In stark contrast to the theoretical debate around the meaning of dignity, they showed no hesitation in selecting an image that captured something of the meaning of dignity in care for them and providing a confident rationale for their choice. This suggests that nursing students have a real sense of dignity as something with a distinct meaning; contrasting strongly with the claim that it is a "useless concept" (Killmister, 2010).

The meaning articulated reflects much of the literature reviewed in relation to dignity in care. This has implications for the education nursing students require in order for dignity to be "instilled into the way they think and act from their very first day" (Independent Commission on Dignity in Care, 2012, p. 35). Macaden et al. (2017) note that dignity in practice is more easily understood by nursing students than dignity in theory. One of the strengths of the approaches to understanding the meaning of

dignity discussed in Section 2.3 – dignity as typology, concept and human interaction – is that practice is part of the theoretical construct. This seems to support the work of Munoz et al. (2017, p. 3), who argue that nursing students understand dignity as something deeply personal, strongly felt and demonstrated through physical action: an "embodied practice". Arguably, the real issue in relation to nurse education seems not to be the understanding of what dignity in care means or its importance. Nursing students already seem to have a personal knowledge of the meaning of dignity in care which reflects much of the theoretical literature. Enabling nursing students to articulate and develop their personal understanding of dignity in care with others may be a more worthwhile focus of educational activity.

8.2.3 Key messages

Regarding the meaning of dignity in care for this small group of nursing students, findings suggest that:

1. Dignity in care is recognisable, has meaning and is important
2. The meaning of dignity in care is rooted in relationship and interaction
3. Understanding is founded on personal rather than factual knowledge

8.3 Research Question 2

> *What are nursing students' perspectives on the personal and environmental influences on the preservation of dignity in care?*

8.3.1 Summary

Research Question 2 was answered by the NGT component of Strand 1, which identified 14 categories of 'people' and 'place' influences on dignity in care. This section summarises findings, relates them to the literature reviewed in Chapter 2, and identifies key points.

In the nominal groups, participants were invited to consider an experience on placement when dignity was promoted and to respond in writing to two questions. The first question invited the participant to identify anything about the people involved that

helped promote dignity, while the second asked them to do the same in relation to the place (Appendix 11.13). The categories (Table **8-2**) derive from the content analysis of a total of 141 statements made and ranked by participants in the nominal groups as described in Section 4.7. Qualitative and quantitative content analysis, as described in Chapter 5 (Sections 5.22 and 5.2.5), was used to identify 14 categories listed in Table **8-2**. All 141 statements listed on flip charts during the nominal groups are provided in Appendix 11.14. This presents each statement in its category and identifies whether it was identified by the participant as a 'people' or a 'place' factor.

Table 8-2 *Category (NGT) number and name*

Category Number and Name	
1. Promoting privacy *(People)*	8. Remembering they're a person *(People)*
2. Not 'I'm the nurse and you're the patient' *(People)*	9. Taking everything into account *(People)*
3. Not rushing the person – being patient *(People)*	10. Protecting people who can't protect themselves *(People)*
4. Encouraging independence *(People)*	11. Working as a team *(People)*
5. It's about the family's dignity too *(People)*	12. Being caring and positive *(People)*
6. Being 'in-tune' with the person *(People)*	13. Being in a calm and peaceful environment *(Place)*
7. Genuine interest and listening *(People)*	14. Having good facilities and equipment *(Place)*

8.3.2 Commentary

Influences on the experience of dignity in care were discussed in Sections 2.4 and 2.5. Themes 2 and 3 of the literature reviewed – the influence of 'people' and 'place'

respectively – informed the questions asked during the nominal group so the similarity between the findings and the literature in those themes is unsurprising. Findings also have much in common with the those in relation to Research Question 1 because, once again, participants focus on interaction and relationship.

The categories again reflect a concern with communication, respect and vulnerability. All but two of the categories – categories 13 and 14 in Table **8-2** – are concerned with the influence of 'people' discussed in Theme 2 of the literature review (Section 2.4). None of the participants demonstrated any hesitation in noting the 'people' aspects they felt were important. Of the total 141 statements generated by the nominal groups, more than two-thirds were responses to the 'people' question. In addition, participants not only identified 'people' influences more frequently, but also ranked them more highly. This again lends support to similar findings around the significance of communication and respect in recent studies of nursing students' perceptions (Macaden et al., 2017; Munoz et al., 2017).

Perhaps more interesting is the lack of emphasis placed by participants on the influence of 'place' on dignity in care. Less than a third of the statements generated by the nominal groups relate to 'place'. Statements identified by the participants as being concerned with 'place' were not only identified less frequently but also ranked less highly. Observation of the participants during each nominal group also revealed that participants often seemed to struggle to think of aspects of the 'place' that influenced dignity in care in the situation they were reflecting on. Several voiced this as a difficulty and one commented that, with regard to the environment, "you just need to work around that" [the care setting] (Participant 12A.06).

Participants often expressed statements concerned with 'place' in terms that emphasised action on the part of the nurse. Statements made about single rooms; for example, were more often expressed in terms which emphasised the role of the nurse in promoting the patient's privacy, such as "Use available single rooms when needed" (Participant 14A.09) and "Remember to take them away – single room" for breaking

bad news or difficult conversations (Participant 13.01). Statements on 'place' such as the importance of it feeling calm, safe and warm related to the local culture of the setting rather than the physical environment. This seems to support findings in Section 2.5.1 around the detrimental impact of a 'place' dominated by task-orientation and frenetic 'busyness' described by Woolhead et al. (2006). The emphasis on the local culture points again to the importance attached to the nature of human interaction within the care setting. This perhaps illustrates the view that care settings and situations are not "people-free zones" because "WE are that culture, WE shape that context" (Darbyshire, 2014, p. 889).

It might have been anticipated that context would be especially significant for nursing students who, as learners, may occupy a particular place in the care setting's hierarchy – as 'just' a student – and more likely to feel disempowered and fearful (Levett-Jones and Lathlean, 2009; Monrouxe et al., 2014; Rees, Monrouxe and McDonald, 2015) when confronted by situations in which dignity is threatened (Monrouxe et al., 2014). Tension between the ideals of the classroom and the realities of practice in relation to dignity in care may further complicate the setting for nursing students (Curtis, Horton and Smith, 2012; Rees, Monrouxe and McDonald, 2015).

This perspective on the potential influence of 'place' on the experience of dignity in care may stem from the participants' role as nursing students; spending relatively little time in each placement before moving on to the next. The statement that "you just need to work around that" (Participant 12A.06) suggests this and reflects an ability to adapt and cope with changing environments. Certainly, this has been identified as a feature of resilience among nursing students (Thomas, Jack and Jinks, 2012). There is also a possibility, however, that the participants' limited focus on context reflects a sense of powerlessness and a punishing expectation that a 'good' nurse should always be able to work well around whatever barriers are in place. This contrasts with nursing students' reports elsewhere of the negative impact of the environment of care on their ability to dignify care and its resulting distress (Monrouxe et al., 2014). Participants in the current study seemed to focus almost exclusively on the role and responsibility

of the nurse, regardless of context, despite being asked explicitly about context. This was illustrated by the only participant who asked to meet with the researcher following a nominal group.

The participant told the researcher about a situation on placement when she felt that she had not delivered an acceptable standard of care. Further discussion provided the researcher with insight into what must have been a very challenging situation in which the availability of essential equipment, skill mix and ward culture all presented barriers to dignity in care. While the participant acknowledged these aspects of the situation, she was resolute in her opinion that she "should" have been able to overcome them. The need for strategies to enable nursing students to manage the distress resulting from this kind of tension between values, beliefs and behaviour has been highlighted elsewhere (McCarthy and Gastmans, 2015; Monrouxe et al., 2015; Monteverde, 2014). From this study it seems important that such strategies help nursing students to consider not only what else they might have done in a given situation, but also the context which influenced their actions. This may help reduce a sense of guilt or failure.

Findings in relation to Research Question 2 were especially interesting for the researcher because she anticipated at the outset of the current study that participants would focus on the impact of the care setting on their ability to preserve dignity. The findings described by Monrouxe et al. (2014) and Monrouxe et al. (2015) resonated with the researcher because of similar reports received from nursing students when she met with them to discuss challenges experienced on placement. The suggestion that some nursing students may place such a punishing expectation on themselves was surprising.

8.3.3 Key messages

Regarding influences on dignity in care for this small group of nursing students, the findings suggest:

1. Greater importance was attached by participants to 'people' than to 'place'.
2. The most important 'people' influences were the nature of the nurse-patient relationship and interaction.
3. The most important 'place' influences were related to the local culture of the care setting
4. A sense of powerlessness around their ability to influence the care setting

8.4 Research Question 3

> *What are nursing students' perspectives on the nurse's role in preserving dignity in care?*

8.4.1 Summary

This research question was answered by Q-methodology procedures in Strand 2, which identified consensus and four discrete perspectives on the nurse's role in preserving dignity in care.

Consensus among the participant group was found in relation to four statements in the Q-set (Table 7-17). Participants agreed on two statements as being important aspects of the role of the nurse: 'Never leave the person in a vulnerable position' (Stat. #5), and 'Being patient with the person' (Stat. #26). Conversely, consensus was also reached that 'Being able to use single rooms when necessary' (Stat. #24) and 'Helping loved ones spend time with the person' (Stat. #40) were less important aspects of the nurse's role.

Four different perspectives were identified through Q-methodology: *Enabler, Caregiver, Companion* and *Defender*. For *Enablers*, the most important aspect of the role of the nurse in preserving dignity in care is to enable the patient's role in their own care. The *Caregiver* perspective is characterised by the importance attached to

the provision of 'good' care. The *Companion* focus is grounded in the importance of 'being with' the person and the feeling of those involved. The *Defender* perspective is centred on the role of the nurse being courageous in defence of dignity in care. Participants' comments in relation to the consensus statements are interesting and would benefit from further exploration, particularly around the use of single rooms, personal belongings, and the role of the family in care. Figure 8-2 summarises these perspectives.

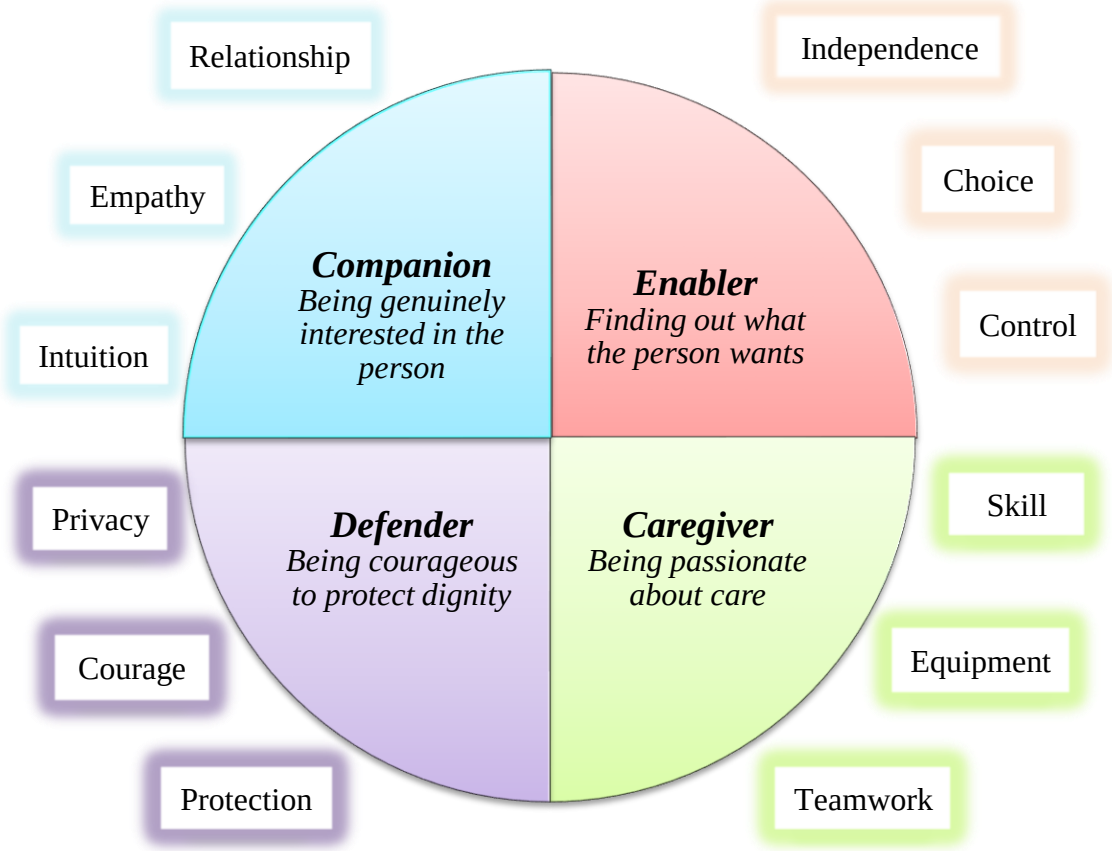


Figure 8-2 *Four perspectives*

8.4.2 Commentary

Findings from the NGT in Strand 1 provide valuable insight into the group's general perspectives on what influences dignity in care. The value added by Strand 2 is to focus explicitly on perspectives on the role of the nurse and, importantly, to distinguish specific perspectives within the participant group. This section considers the participants' perspectives on the role of the nurse in the context of the influences discussed in Sections 2.4 and 2.5 and the findings from the two previous research questions.

8.4.2.1 Consensus

The four consensus statements reveal shared perspectives on some aspects of the 'people' and 'place'. The importance attached to never leaving a person in a vulnerable position and being patient unites the four perspectives and reflects the participants' recognition and concern with the vulnerability of the patient (Sections 2.4, 8.2.1 and 8.2.2). Consensus on the use of single rooms lends support to the previous finding around the relatively low importance attached to the physical environment of care as an influencing factor on dignity in care. The participant group also demonstrate consensus in the relatively low priority given to involving relatives in care (Table 7-17). This emerges strongly in Strand 2 as an aspect of the nurse's role and merits further discussion.

A key patient characteristic noted as influencing dignity in care is resilience. Studies reviewed in Section 2.4 identified the involvement of family as a significant personal resource for resilience (Baillie, 2009; Bridges, Flatley and Meyer, 2010; Tranvåg, Petersen and Nåden, 2015). Family interaction may also reduce the vulnerability of the person by reinforcing their identity and self-esteem. One of the findings from the literature reviewed in Section 2.4 was that the significance of family involvement is rarely discussed. Similarly, the role of the family emerges in findings from Strand 1, but less frequently, and with less importance attached than to other aspects of dignity in care. Consequently, consensus among participants that facilitating family

involvement to preserve dignity in care is less important than many other aspects of the nurse's role is unsurprising. It seems reasonable to suggest that there may be a need to raise awareness among nursing students around the role of the nurse in helping patients involve family in their care if they wish to do so.

Moving on from areas of consensus to the differences between the four perspectives, it is important to stress that these are relative differences. Perspectives vary on the degree of importance attached to an aspect of the nurse's role and not on whether or not it is important. The following discussion focuses on the aspects of the nurse's role which distinguish each perspective. The discussion concludes with a reflection on participants' comments on education in relation to the nurse's role in preserving dignity in care and what is meant by 'just basic care'.

8.4.2.2 Enabler (Factor 1)

According to *Enablers,* the most important aspect of the role of the nurse in preserving dignity in care is enabling the patient's involvement in their own care and is captured in the perspective's distinguishing statement "Finding out what the person wants" (Stat. #15). This reflects the literature reviewed in Section 2.4.1 around dignifying care activities by optimising the patient's control through seeking consent and offering choice. The other perspectives attach a relatively low importance to this aspect of the nurse's role, exemplified in the *Defender* comment "It's not about what they [patients] want, it's about what they need" (Participant 15.07). This may reflect the participants' limited clinical experience and may also suggest a need to raise awareness of the significance of patient involvement in care among nursing students.

8.4.2.3 Caregiver (Factor 2)

The focus for *Caregivers* is the delivery of 'good' care. From the results around this perspective (Section 7.5.2), it seems reasonable to suggest that it equates 'good' care with promoting independence, information-giving and skilled performance of procedures. In Sections 2.4.1 and 2.4.2, the role of the nurse in preserving dignity through promoting independence is highlighted as a means of dignifying care

activities and enhancing resilience. Similarly, Section 2.4.1 identified information-giving as crucial to the delivery of person-centred care. Worth noting; however, is that Section 2.4.1 also highlights the importance of conversation in addition to task-related communication as a means of enhancing resilience.

Skilled performance is an interesting aspect of dignity in care because of apparent differences between staff and patient perspectives on its importance. From their literature review, Bridges, Flatley and Meyer (2010) comment that patients tend to take nurses' technical skills for granted, focusing instead on their interpersonal and communication skills. In their survey of nearly 200 healthcare professionals in England, Cairns et al. (2013) also found that physical aspects of care – such as assistance with eating and drinking and personal hygiene – were rated as being less important in relation to dignity than relational aspects of care such as communication.

In relation to its investigation of care provided by Mid-Staffordshire NHS Trust; however, the Department of Health (2010, p. 9) notes, "It was striking how many accounts related to basic nursing care". The accounts referred to focus on a *lack* of care – for example; lack of assistance with eating and drinking or with personal hygiene – rather than on *how* care was delivered. Similarly, the failures of nursing care described to the Vale of Leven Hospital Inquiry (Scottish Government, 2014) also often relate to a *lack* of care. It seems reasonable to suggest that while it is important for dignity in care to avoid the task-orientated and fragmented approaches so vividly described by Woolhead et al. (2006) and Tadd et al. (2012), there is also a need to avoid neglecting the significance of the nurse's role in delivering basic care.

8.4.2.4 Companion (Factor 3)

The *Caregiver* focus on the physical aspects of care is matched by the *Companion* focus on the more abstract aspects of the nurse's role in preserving dignity in care. Specifically, *Caregivers* attach great importance to the role of the nurse in establishing and developing a relationship with patients. This finding lends support to the literature reviewed around staff behaviour (Section 2.4.1) and resilience (Section 2.4.2) as key

influences on the preserving dignity in care. It also lends support to the importance of the culture of the local care setting (Section 2.5.1) in that participants who loaded onto this factor stressed the importance of being able to take time with participants and working in an environment that feels safe.

8.4.2.5 Advocate (Factor 4)

From the *Defender* perspective, the important aspects of the role of the nurse in preserving dignity in care relate to defending dignity. This points to awareness of situations in which patient dignity has been threatened or violated. Both participants who loaded onto this perspective recounted instances on placement when a patient's dignity was compromised by staff failing to respect their privacy. Interestingly, both indicated that they 'would have' said something and would say something in the future but the nurse they were working with did not. As noted in Section 8.2.2, nursing students may feel disempowered to act when confronted by situations in which dignity is threatened (Monrouxe et al., 2014). Action requires "moral courage" because of the potential detrimental consequences for nursing students who do so (Bickhoff, Levett-Jones and Sinclair, 2016, p. 35).

Related to this need to be courageous is the importance of 'Feeling confident enough to express opinions' (30: -3). As noted in Section 7.5.1, two participants who loaded onto the *Enabler* perspective acknowledged the importance of 'speaking up' but expressed concern about their ability to do so as 'just' a student. The need to enable nursing students to develop the ability to respond appropriately to such situations in practice is well-established in the literature (Bickhoff, Levett-Jones and Sinclair, 2016; Ion et al., 2016; Ion et al., 2015; Milligan et al., 2017) and is worthy of further exploration.

8.4.2.6 Education and 'just' basic care

Given the *Caregiver* focus on skilled performance, it is perhaps surprising that the perspective does not attach particular importance to 'Being specially trained in the care required' (Stat. # 41). Indeed, apart from *Companion*, none of the perspectives

attach particular importance to this aspect of the nurse's role (Appendix 11.23). During post-sort interviews, participants frequently expressed the view that education was not required for the nurse to preserve dignity in care. A typical justification of this view was that preserving dignity is "just about good care" (Participant 15.05) rather than something requiring education or training. This raises questions around the role of education and what is meant by 'just' basic care.

It is possible that participants may have been completing the Q-sorting procedure with formal education on dignity in mind. If so, then this is in-line with the finding that formal programmes have "relatively limited impact" on dignity in care (Royal College of Nursing, 2008, p. 15). Certainly, a greater impact of practice experience and role models on learning in relation to the compassionate care of older people has been described elsewhere (Brown, Nolan and Davies, 2008; Brown et al., 2008). Furthermore, the need for education about dignity in professional education has been identified elsewhere (Askham, 2005; Commission on Dignity in Care for Older People, 2012; Royal College of Nursing, 2012).

Recent research on nursing students' views on the role of formal education on dignity has found that nursing students have clear ideas about the importance of education on dignity in both the classroom and in practice (Kyle et al., 2017; Munoz et al., 2017). The current study did not ask participants directly about education for dignity and this seeming contradiction may relate to the participatory research approach used by these studies. This approach provided a valuable and novel opportunity for nursing students to engage directly with academic staff on the subject of dignity and its place within a nursing curriculum. It may also point to the type of educational approach which would be most valued by nursing students.

The notion of 'just' basic care is an interesting one. The researcher was left with a strong impression that there was a general feeling among participants that there was no need for specific education around dignity because it is an integral part of 'good' care. During the sorting procedure, Participant 15.03 explained the low ranking of,

‘Never leaving the person in a vulnerable position’ (Stat. #5) with the comment “you do that anyway”. Similarly, Participant 16.01 expressed the view that knowledge of moving and handling was, again, “just basic care”. This seems reminiscent of the impression discussed in Section 8.2.2 that the ‘good’ nurse will be able to work around barriers to dignity. In the same way, if a nurse is ‘just’ delivering good basic care, then dignity will be preserved. Once again, this hints at a limited understanding of the barriers to dignity in care which, in turn, may make it less likely that participants are prepared to recognise and manage these in practice.

In addition, it is tempting to speculate that the idea of ‘just’ basic care reflects the participants’ assimilation of what Darbyshire and McKenna (2013, p. 307) describe as the “devaluation and downgrading” of basic care. They argue that basic care has become something of an embarrassment to nursing in general and nursing education in particular. Consequently, it is routinely hidden from sight; its absence explained away with comments about it being ‘implicit’ in curricula or an ‘underpinning theme’ (Darbyshire and McKenna, 2013). In effect, dignity may be rendered invisible along with the ‘just’ basic care that the participants regard it to be part of. Furthermore, the increasing delegation of ‘just’ basic care to healthcare assistant staff may also contribute to a perception of dignity in care as something that requires no particular educational input (Tadd et al., 2011).

8.4.3 Key messages

Regarding the important aspects of the nurse's role in preserving dignity in care for this small group of nursing students, the findings suggest:

1. Consensus on the importance of the nurse's role in relation to patient vulnerability and nurse-patient interaction.
2. Consensus that the use of single rooms and involving relatives in care are less important aspects of the nurse's role.
3. The four distinct perspectives highlight the importance attached by the participants to the nurse's role in:
    - Involving persons in their own care,
    - Delivering 'good' care,
    - Being with the person, and
    - Defending dignity.
4. Little importance is attached by participants to education because of a perspective that preserving dignity is 'just basic care'.

8.5 Contribution to Knowledge

The current study answers the research questions and, in doing so, contributes to existing knowledge around dignity in care with specific reference to the under-explored area of nursing students' perspectives. This contribution is summarised below:

- The concept of dignity was recognisable and meaningful for the participants (Mullen et al., 2017a).
- Participants demonstrated no hesitation in identifying and considering situation experienced on placement in which dignity in care was preserved (Mullen et al., 2017a).
- Participants' understanding of dignity in care seemed to be based on personal rather than factual knowledge and this supports Munoz et al. (2017).

- Participants understood dignity as an integral part of practice and this supports Macaden et al. (2017).
- Participants' perspectives on the role of the nurse in preserving dignity in care were – in common with the meaning they attach to dignity in care – rooted in relationship and interaction. This also supports recent research (Macaden et al., 2017; Munoz et al., 2017).
- A perception existed among the participants that the 'good' nurse should be able to overcome context.
- Participants attached a relatively low importance to involving relatives as a means of preserving dignity in care.
- Different perspectives on the important aspects of the role of the nurse in preserving dignity in care were identified and concern patient involvement, the delivery of 'good' care, the nurse-patient relationship and defending dignity.
- Participants were not asked directly about education, but a perception existed that strategies to preserve dignity in care are 'just basic care' and do not require specific education. This contrasts with findings from studies in which nursing students were asked directly about education for dignity in care (Kyle et al., 2017; Munoz et al., 2017).

8.6 Trustworthiness

Strategies to help ensure the trustworthiness of the current study's findings are a significant element of the study's ethical underpinning. In this section, the strategies are discussed in relation to four criteria of quality: credibility, dependability, confirmability and transferability (Lincoln and Guba 1985, as cited in Houghton et al., 2013).

8.6.1 Credibility

Beck (2009, p. 543) describes credibility as a key marker of trustworthiness and defines it in terms of how believable the data is and how confident others can be in the

"truth" of the findings. Two main strategies were used to meet this criterion: triangulation and peer debriefing (Houghton et al., 2013).

Polit and Beck (2014) and (Flick, 2015) identify triangulation as a key strategy for enhancing trustworthiness. This was achieved by means of comparing and contrasting findings from the three methods of data collection used – photo-elicitation, NGT and Q-methodology – and across the different participant groups (Ryan-Nicholls and Will, 2009). Houghton et al. (2013) define peer debriefing as the independent checking of codes and categories by a colleague or expert in the field. The researcher's supervisory team performed this role by reviewing and discussing critically the content analysis process and results as described in Section 4.8. Following the thorough and systematic approach advocated by Elo et al. (2014) in relation to the content analysis process (Section 4.8) also enhanced the rigour of the study.

In addition, presentation of different aspects of the current research study at conferences (Mullen et al., 2016b; Mullen et al., 2016a; Mullen et al., 2017b; Mullen, Kydd and McMillan, 2015) enabled the researcher to learn from other researchers in the field and to gain feedback on the current study. The publication of a paper (Mullen et al., 2017a) provided a further opportunity for scrutiny. Feedback from reviewers was particularly helpful to the researcher because it developed her ideas around educational context (Section 2.2.1). The demonstration of credibility is also highlighted as being important (Polit and Beck, 2014), and this thesis aims to accomplish this through clear discussion of methods and decision-making.

8.6.2 Transferability

Polit and Beck (2014) define transferability as a measure of the extent to which findings can be transferred or applied to other settings or participant groups. The current study makes no claim to generalizability, but examples of raw data and participant demographics (Chapters 4, 5 and 7) – as recommended by (Houghton et al., 2013) – have been provided to enable a reader to develop their own interpretation and come to their own decision regarding transferability.

8.6.3 Confirmability

The confirmability of the findings is a measure of the extent to which they may be described as objective (Polit and Beck, 2014) or neutral (Ryan-Nicholls and Will, 2009). Ryan-Nicholls and Will (2009, p. 79) relate this to the "auditability" of the research process through the provision of clear descriptions of the research process and data. The current study has enhanced confirmability by detailing decision-making about the research process and providing examples of raw data such as coding memos (Table 5.1) and crib sheets (Appendix 11.25).

8.6.4 Dependability

Ryan-Nicholls and Will (2009) define dependability as a measure of the stability of data over time; that is, another researcher examining the data at a later date would be able to understand this researcher's interpretation. This has been related to the ability to audit the research process (Ryan-Nicholls and Will, 2009) and the current study has sought to provide a clear audit trail by detailing decision-making around the research process and providing examples of raw data and emerging interpretations (Chapters 4, 5 and 7).

8.7 Strengths and Limitations

8.7.1 Strengths

The current study's strengths relate to the methods employed. One of the key strengths of the current study was its use of active methods of data collection – photo-elicitation, NGT and Q-methodology – which were engaging and interesting for both the participant and the researcher. These are summarised below:

- Participants informed the researcher that they enjoyed participating in the research and this was observed in their non-verbal communication too.
- The methods were also efficient and effective means of collecting data and this helped minimise the burden of participation in terms of participants' time.

- The structure of the NGT – in which participants each have an equal opportunity to share their ideas – meant that each voice was heard.
- Moreover, both NGT and Q-methodology provided outcomes that were visible to the participant at the end of each nominal group or Q-sort. For example, NGT participants could observe the development of consensus as the data was being collected and participants could view and discuss their own Q-sort when they finished the Q-sorting procedure.
- Q-methodology also provided a unique and holistic insight into the different perspectives among participants on the nurse's role in preserving dignity in care.

8.7.2 Limitations

The limitations of the current study relate to methodological issues around sampling and methods and these are also summarised below:

- All participants were recruited from the same university on a single campus.
- The total number of participants across both strands of the study represents a very small proportion (less than one in 10) of the study population of around 600 nursing students.
- Participants were a self-selected group and, as such, may have had a particular interest in the topic and a particular view.
- The highly-structured nature of NGT placed a restriction on participants who perhaps wanted to 'tell their story'.
- The researcher under-estimated the power of photo-elicitation as a means of connecting participants with the subject matter and the depth and richness of the data that would be provided. The data served the purpose for which they were intended but could have been explored much further if time and other resources had allowed.

- Q-methodology is not very familiar to many outside what is a relatively small community of researchers using Q-methodology. Consequently, misconceptions exist around its nature and purpose (Kampen and Tamás, 2014) and divisions are also visible among Q-methodology researchers. These misconceptions and divisions tend to revolve around matters of statistical validity and reliability. This may act as a barrier to disseminating findings.

8.8 Chapter 8: Conclusion

Chapter 8 considered the findings in relation to each research question in the context of the literature reviewed in Chapter 2 and outlined the study's contribution to knowledge. The strengths and limitations of the study were also discussed, in addition to the trustworthiness of its findings. Chapter 9 moves on to the conclusion and recommendations of the study as a whole.

9 Conclusion and Recommendations

9.1 Chapter 9: Introduction

In this chapter, the methods, findings and contribution to knowledge are recalled, and recommendations made for education and practice. Chapter 9 concludes with suggestions for further research stemming from the current study.

9.2 Overview of methods and findings

The purpose of the study was to explore perspectives on preserving dignity in care among nursing students enrolled in a three-year preregistration undergraduate adult nursing programme. More specifically, the study addressed the following research questions:

1. What meaning do nursing students attach to the term 'dignity in care'?
2. What are nursing students' perspectives on the personal and environmental influences on the preservation of dignity in care?
3. What are nursing students' perspectives on the nurse's role in preserving dignity in care?

A two-strand sequential mixed methods Q-methodology research design was employed. Strand 1 informed the development of Strand 2 and the different methods used in each strand served to illustrate and enrich the findings of the other.

Photo-elicitation and Nominal Group Technique (NGT) were used to provide insight into the meaning of dignity in care for nursing students and the personal and environmental influences on nurses' preservation of dignity in care. Building on these findings, Strand 2 used the Q-methodology procedures of Q-sorting and by-person factor analysis to reveal distinct perspectives on the nurse's role in preserving dignity in care.

The current study's contribution to knowledge relates to the insight gained into the personal nature of nursing students' understanding of dignity in care as an integral part

of practice and the importance attached to interaction and relationship rather than to the physical environment of care. Different perspectives on the important aspects of the role of the nurse in preserving dignity in care were identified and concern patient involvement, the delivery of 'good' care, the nurse-patient relationship, and defending dignity. In addition, the findings indicate the existence of a perception that strategies to preserve dignity in care are 'just basic care' and do not require specific education or training.

9.3 Recommendations for education

> … professional education must do more than merely teach … it must educate for professional practical wisdom … (Sellman, 2011, p. 38)

This section considers the above statement in light of the findings from the current study and related literature and makes recommendations for undergraduate preregistration adult nursing education in the UK. In this section, 'Education' is the term used to refer to education within the higher education environment, while 'Practice' refers to the care setting and wider social order influencing it. Recommendations concern the purpose and content of education for dignity in the curriculum.

It seems reasonable to suggest that the purpose of nurse education for dignity is not to 'teach' nursing students what dignity is and why it is important. From the current study and other recent research (Macaden et al., 2017; Munoz et al., 2017), nursing students already seem to have a relatively sound grasp of this concept. In broad terms, nursing students seem to know what dignity means, know that it is important and know how it is preserved. Nevertheless, as discussed in Section 8.2.2, nursing students report witnessing violations of dignity in care and, for a variety of understandable reasons, not acting (Levett-Jones and Lathlean, 2009; Macaden et al., 2017; Monrouxe et al., 2015; Monrouxe et al., 2014). On that basis, educational activity may be more usefully directed towards building on nursing students' existing understanding to

develop the "professional practical wisdom" – professional phronesis – described by Sellman (2011, p. 38). According to Sellman (2012, p.127), professional phronesis is a core element of professional competence because it goes beyond 'knowing that' and 'knowing how' to include the aspiration of the practitioner to "do the right thing with (or to) the right person at the right time in the right way and for the right reason"; the 'right' reason neither being assessment nor observation, or feeling under an external obligation, but the 'right' reason being instead because they recognise the right thing to do and they want to do the right thing because it *is* the right thing. Arguably, this is the purpose of nurse education for dignity in care. Recommendations to achieve this purpose are outlined below.

9.3.1 Ensuring dignity is explicit within curricula

Making dignity explicit within the curriculum may be key to communicating to nursing students the value placed upon it by nurse education and has also been recommended by others (Kyle et al., 2017; Matiti, 2015; Munoz et al., 2017). This may help avoid nursing students perceiving it to be 'just' part of 'basic care'. Participants in the current study indicated that dignity in care did not need to be taught because it was 'just basic care'. This raises a question about the purpose of education in relation to dignity in care. It is worth noting again – as discussed in Section 0 – that other recent studies have found that nursing students *do* believe there is a place for education on dignity in care in nursing curricula (Kyle et al., 2017; Munoz et al., 2017). The new 'Standards of Proficiency for Registered Nurses' (Nursing and Midwifery Council, 2018a) certainly count as a proficiency the ability to "maintain dignity" in care so there should be scope to do so.

9.3.2 Educating nursing students to think

Regarding ethics education, Roberts and Ion (2014, p. 673) highlight a relationship between what they describe as nurses' "inability to think" and the violation of dignity reported in Mid-Staffordshire (Department of Health, 2013a). They argue that nurse education must focus on educating nursing students to think so that they are able to

avoid becoming habituated to poor practice and are also equipped to question practice. This resonates with what Brindle (2010, unpaginated) refers to as one of the unanswered questions about care in Mid-Staffordshire; "the role played, or not, by hundreds of student nurses" on placement and their lecturers. The more creative methods noted in Section 9.3.4 may go some way towards enhancing nursing students' ability to think. They may also be an ideal means of helping nursing students develop strategies to cope with the distress associated with witnessing poor practice (Monrouxe et al., 2015). So too might a move away from the rules-based approaches that characterise much of ethics education in health care (Cannaerts, Gastmans and Casterlé, 2014; Monteverde, 2014).

9.3.3 Enabling nursing students to reflect critically on care

Related to this move away from rules-based approaches, is enabling nursing students to reflect critically on care may help them to make a positive contribution to meeting ethical challenges in care settings as both nursing students and registered nurses (Goethals, Gastmans and de Casterlé, 2010; Vanlaere and Gastmans, 2007). The current study suggests that some nursing students may exclude barriers – such as the culture of the care setting and the wider social order – to their ability to preserve dignity in care. Critical reflection with peers and academic advisors may enable such nursing students to take a more holistic view of their experience; developing their ability to recognise and overcome such barriers in the future.

9.3.4 Adopting more creative approaches to learning about dignity

A range of creative approaches have been highlighted including the use of visual metaphors for dignity (Baillie and Gallagher, 2012) and creative writing (Draper, Wray and Burley, 2013). Workshops rather than didactic lecture approaches have been identified as being key to enabling nursing students to develop their understanding through reflection on practice with others (Devries and Timmins, 2016; Matiti, 2015). Preparing nursing students for the realities of practice is also highlighted in the growing use of approaches orientated more towards experiential learning (Chadwick,

2012; Crossan and Mathew, 2013; McLafferty, Dingwall and Halkett, 2010; Morgan, 2012; Tadd, Vanlaere and Gastmans, 2010; Timmermans et al., 2015; Vanlaere, Coucke and Gastmans, 2010; Willsher, 2013).

In summary, recommendations for education are made on the basis of the findings from the current study that nursing students already seem to have much of the 'that' and 'how' knowledge about preserving dignity in care. It is suggested, therefore, that nurse education focuses on building on this knowledge by making dignity explicit in curricula and adopting creative methods to facilitate reflective skills and provide nursing students with opportunities to develop their ability to respond to ethical challenges in practice.

9.4 Recommendations for practice

> … a massive 'get out of jail card' that will absolve poor or negligent practice from any hint of personal responsibility and accountability. "It wasn't me gov, it was the situation what made me do it". (Darbyshire, 2014, p. 888)

Darbyshire (2014) acknowledges the significance of the context of practice on the ability to preserve dignity in care but takes issue with nurse education, academics and practitioners using it to abdicate accountability for care. This section focuses on the current study's findings of a perception that the 'good' nurse 'should' be able to overcome context and that an important role of the nurse is to defend dignity.

Nursing students' experiences of poor practice involving gross breaches of patient dignity by nurses are well-documented (Monrouxe et al., 2015; Monrouxe et al., 2014; Rees, Monrouxe and McDonald, 2015). Also well-documented are the characteristics of the setting and wider social order discussed in Section 2.4 that act as barriers to the ability to preserve dignity in care (Baillie, 2008, 2009; Macaden et al., 2017; Tadd et al., 2012; Woolhead et al., 2006). In the researcher's experience, nursing students were likely to cite such barriers when describing situation in which the care they delivered did not meet their own or others' expectations. It was surprising, therefore,

that one of the findings from the current study was that some nursing students gave very limited consideration to the impact of context on their ability to preserve dignity in care.

9.4.1 Supporting nursing students in practice

The potential for reflective activity in the higher education setting as a means of helping nursing students consider practice experience more holistically has already been noted in Section 9.3. One of the recommendations for practice, therefore, is that such activity is also facilitated in practice. The provision of "critical companionship" by the registered nurse responsible for supporting the nursing student in practice is advocated by Vanlaere and Gastmans (2007, p. 763). By integrating reflective practice, role modelling, questioning, and constructive feedback, the critical companion may be able to help nursing students who struggle to do so recognise and acknowledge barriers to their ability to preserve dignity in care. It may also help those nursing students who do not recognise or acknowledge their own accountability for preserving dignity in care to do so.

9.4.2 Supporting learning in practice

Significant barriers exist to supporting learners in practice as the literature around mentorship reveals (Andrews et al., 2010; Duffy, McCallum and McGuinness, 2016). Moreover, this is a time of significant change for the support of nursing students in practice as the UK moves away from closely defined standards for mentorship (Nursing and Midwifery Council, 2008) to the far more loosely described standards for practice supervisors and assessors (Nursing and Midwifery Council, 2018b). During this transition period, effective nursing leadership in practice to support dignity in care is likely to be more important than ever (Baillie and Gallagher, 2011).

The new standards framework for nurse and midwifery education makes explicit the requirement for education providers and practice learning partners to provide a supportive learning environment in which nursing students are respected and protected

from the types of harm described in Section 8.4.2.5 (Nursing and Midwifery Council, 2018c). The emphasis placed upon student empowerment and the need to develop resilience (Nursing and Midwifery Council, 2018c) is interesting. These are worthy aims, of course, because, regardless of the support provided by learning environments, nursing students will be exposed frequently to the suffering of their fellow human beings. Nevertheless, this shift towards the role of the nursing students comes at the same time as what seems to be a shift away from the role of those charged with supporting the nursing student in practice in the new standards assessors (Nursing and Midwifery Council, 2018b). It is crucial that education providers and practice learning partners work together to ensure that the greater flexibility they now have in terms of how they support practice learning does not shift their responsibilities for it on to nursing students.

9.4.3 Enabling nursing students to escalate concerns

Related to the support of nursing students in practice is the question of their role in escalating concerns around poor practice. The *Defender* perspective on the role of the nurse as being courageous in defence of dignity, and the importance attached by *Enablers* to feeling confident enough to speak out, reflect an awareness of the challenges to reporting poor practice. Consequently, one of the recommendations of the current study is that nursing students are enabled to report such practice. Ion et al. (2016) propose that nursing students who do not report such practice do not regard it as a duty but an option. In effect, not reporting violations of dignity in care is excusable because they are 'only a student', vulnerable to the possible repercussions of reporting, and that responsibility lies with the care setting and university (Ion et al., 2016; Ion et al., 2015; Mansbach, Ziedenberg and Bachner, 2013).

Duffy et al. (2012) note that much is asked of nursing students and stresses the need for them to be well-prepared to escalate concerns by the provision of clear guidance and by the encouragement and support of registered nursing staff. Mansbach, Ziedenberg and Bachner (2013) suggest that integrating into curricula skills and

strategies for escalating concerns is one way of helping to ensure that this support is provided. Ion et al. (2016, p. 1061) go further; adding that nursing students must be made aware that escalating concerns are "not a case of personal choice" but an "expectation and professional requirement". The use of the creative methods described in Section 9.2 to support nursing students' critical reflection may help to explore challenges such as these in a safe environment. At the same time, education providers and practice learning partners must work together to try to address poor practice, neglect and abuse and their fundamental causes. Arguably, more emphasis could be placed on enabling nursing students to manage their exposure to unavoidable human suffering if there was less need to enable them to report situations in which such suffering is compounded by inadequate resources.

In summary, recommendation for practice are made on the basis of the findings of a perception that the 'good' nurse 'should' be able to overcome context and that an important role of the nurse is to defend dignity. The recommendations are that continued efforts must be made to develop effective support systems for nursing students in practice and to enable them to escalate concerns about violations of dignity in care.

9.5 Chapter 9: Conclusion

This chapter has recalled the methods, findings and contribution to knowledge and made recommendations made for education and practice. Chapter 9 concludes with suggestions for further research and a brief personal reflection.

9.5.1 Suggestions for further research

Suggestions for further research stemming from the current study are as follows:

- To explore nursing students' perspectives on preserving dignity in care with a more diverse sample.
- To explore nursing students' perception of dignity as 'just basic care'
- To evaluate education for dignity in the context of curricula based on the new Nursing and Midwifery Council standards for preregistration nurse education (Nursing and Midwifery Council, 2018d, 2018c, 2018b, 2018a)
- To explore threats to nursing students' own dignity and impact on retention.

9.5.2 Reflection on the study

My motivation for the current study stemmed primarily from the reports of appalling violations of dignity in care and curiosity about what dignity in care really meant to nursing students. I aimed to develop an understanding of what contribution I could make as a nurse and nurse educator to address the seeming erosion of nursing care.

When I began the study, I was pessimistic about the future of nursing and, now at the end, I am hopeful. The reason for this hope can be found in the nursing students who participated. This is best illustrated by the fact that, at the beginning, my greatest concern was that the nursing students would struggle to identify a situation they had experienced on placement in which dignity in care was promoted. The reality was that they had no difficulty whatsoever in identifying such a situation or in describing what it was about the situation that evidenced dignity in care to them. Their understanding of dignity was grounded in reality and deeply, personally felt. They communicated their enthusiasm for and commitment to preserving dignity in care powerfully and

authentically. I was the only pessimist in the room. Similarly, I expected the nursing students to focus on the context of the care setting and their own vulnerability. Instead, they focused on the vulnerability of those they care for and how their interactions could make them feel.

I am convinced of the need for education to build on the strengths of what nursing students already know to enable them to respond to the ethical challenges they assuredly face in practice.

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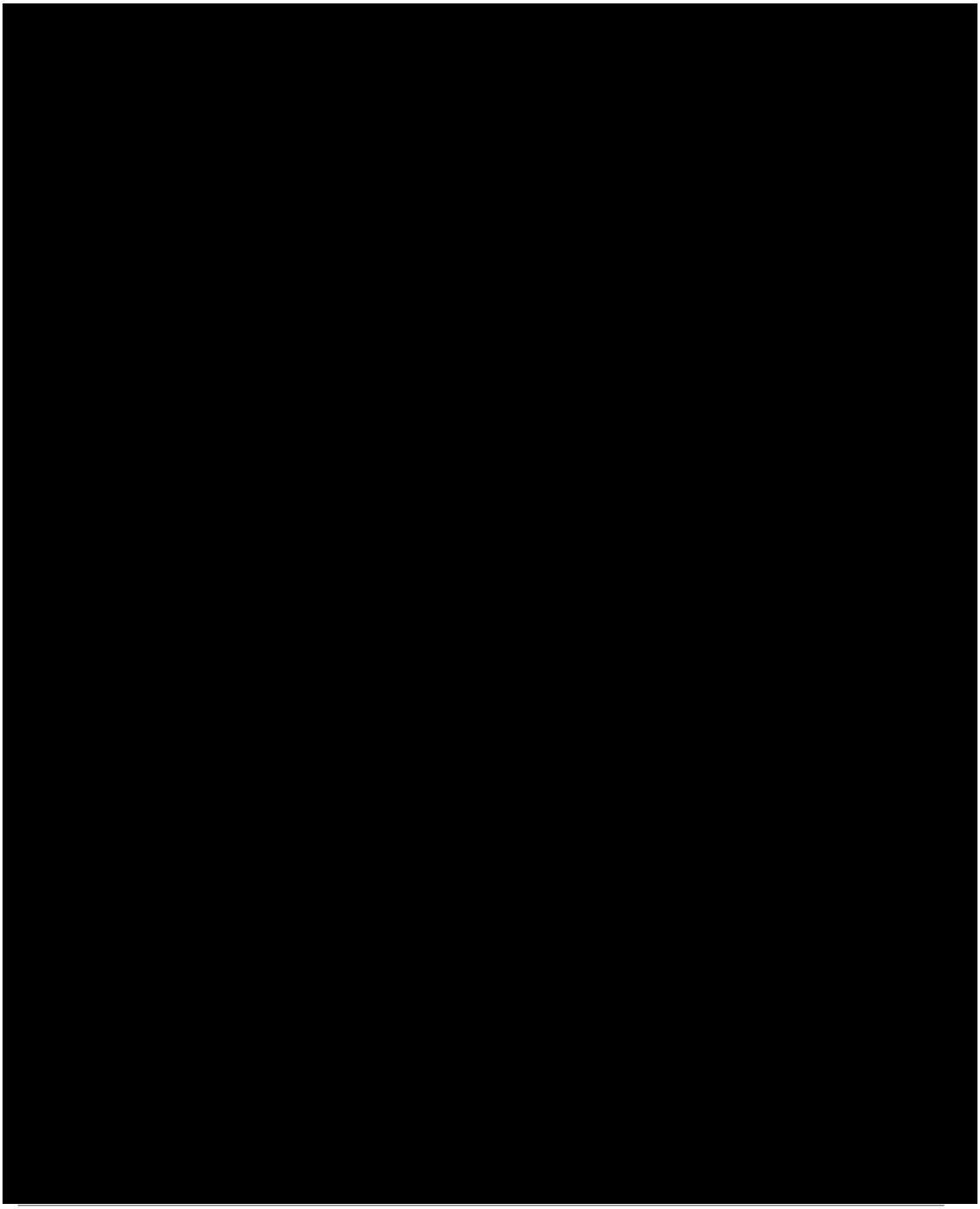
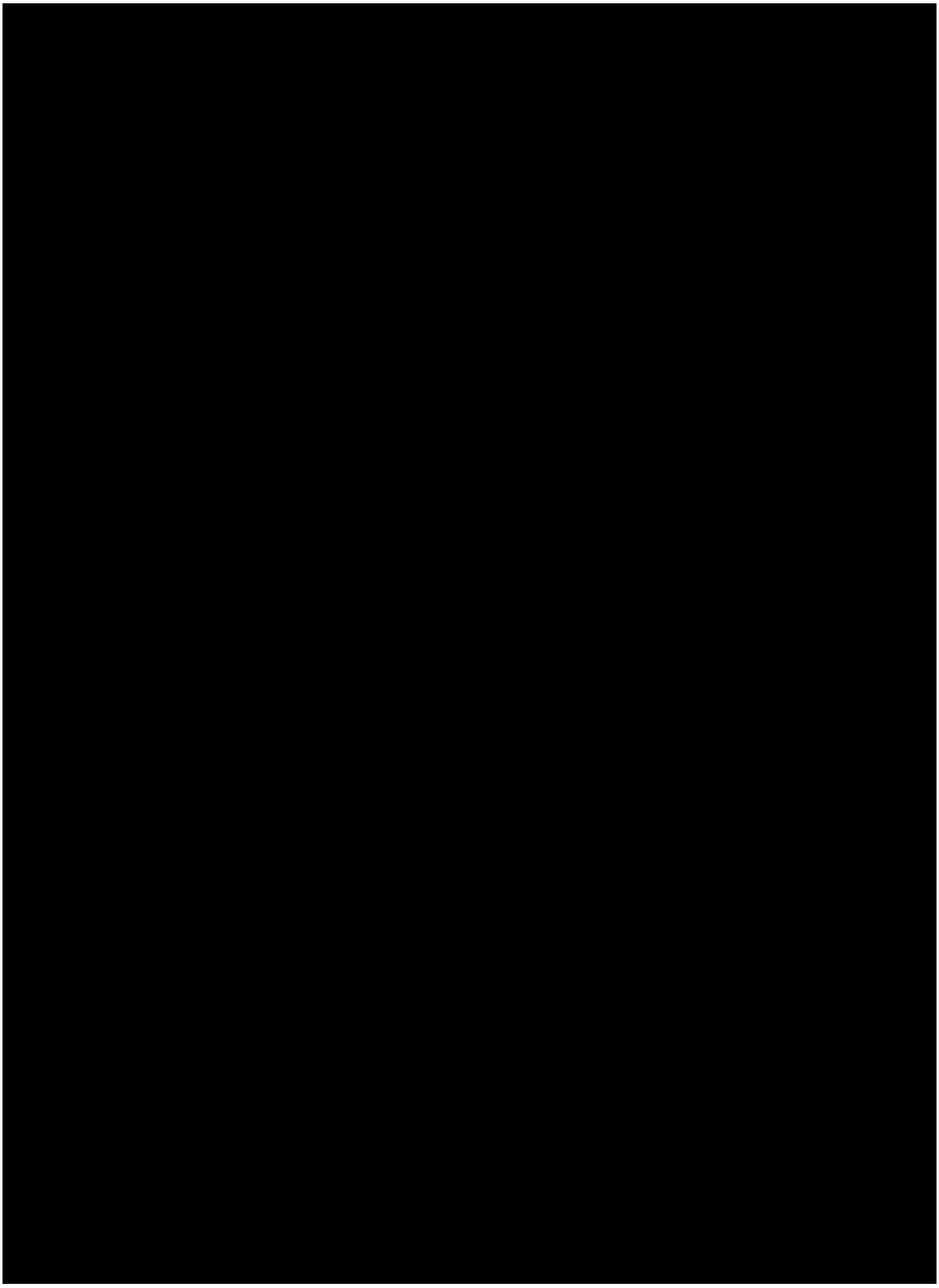
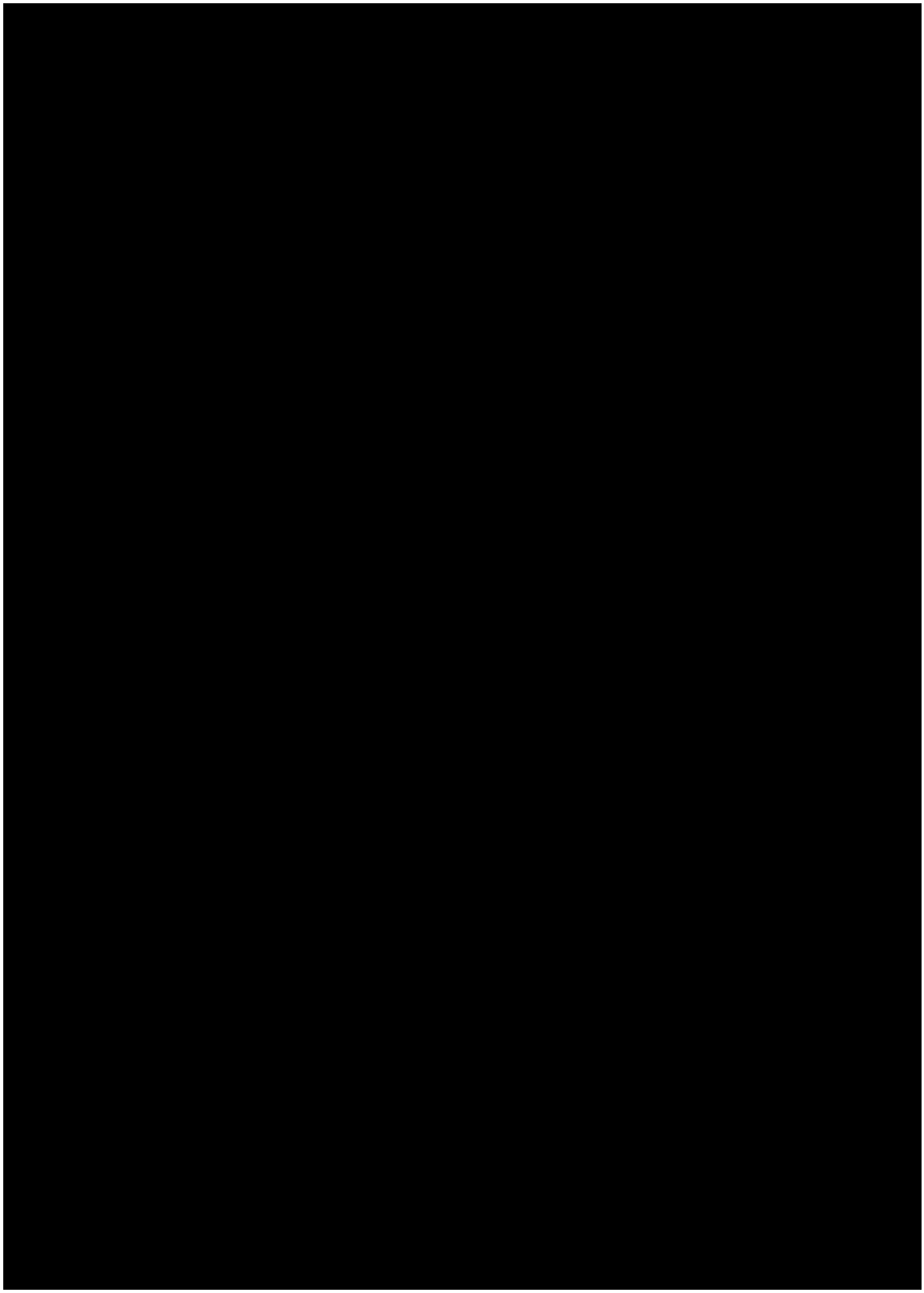
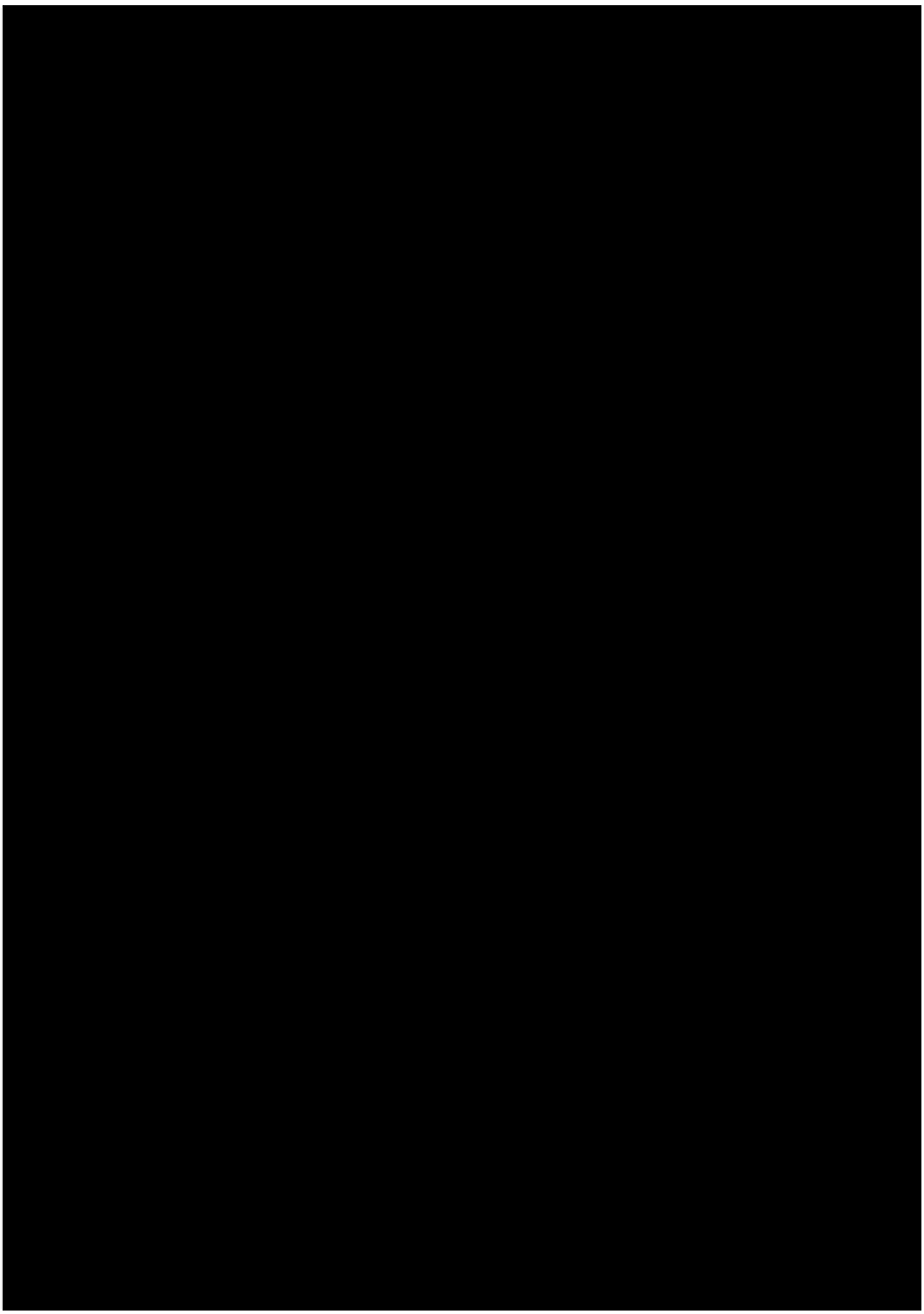
11 Appendices

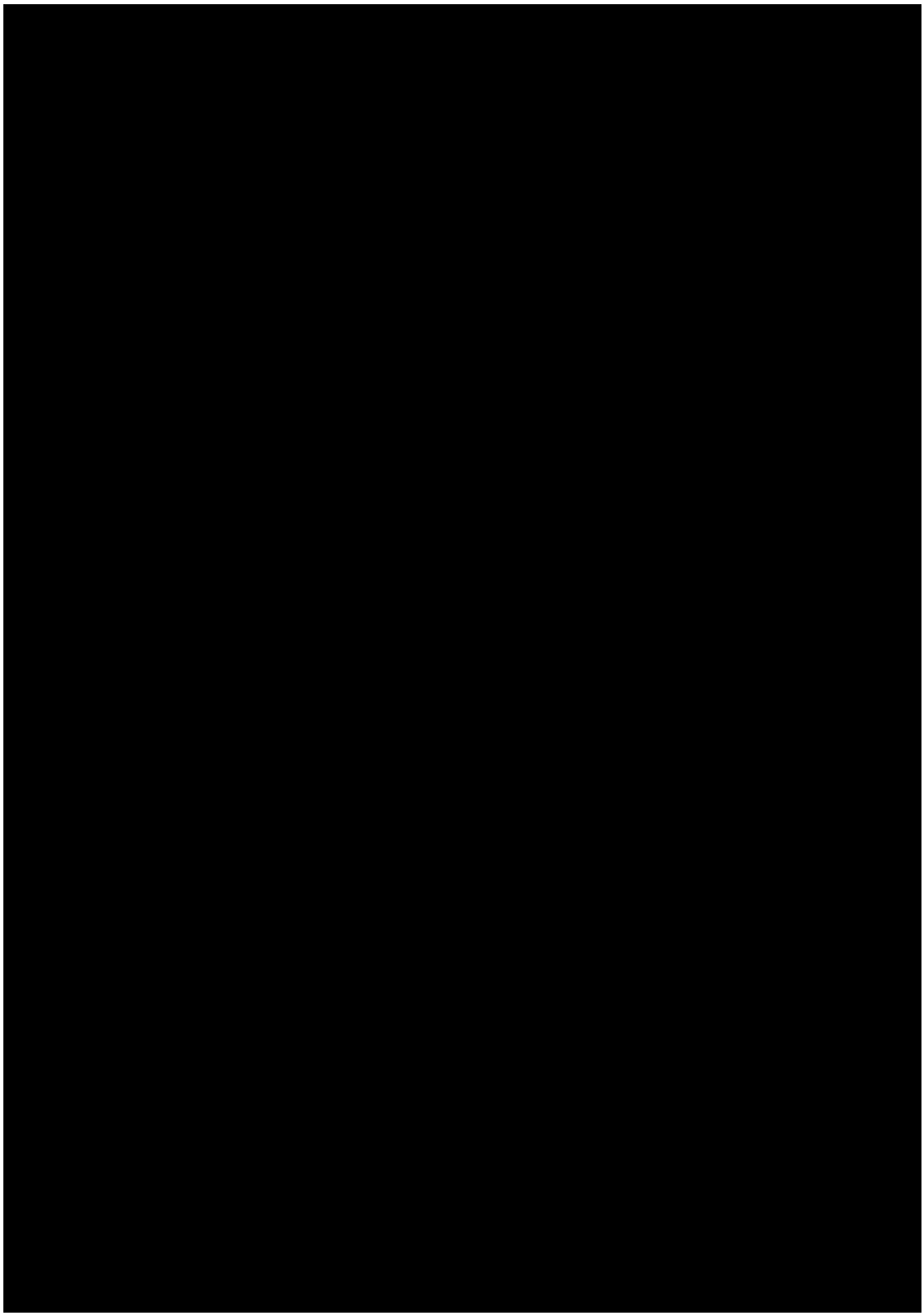
11.1 Paper (Mullen et al., 2017a)

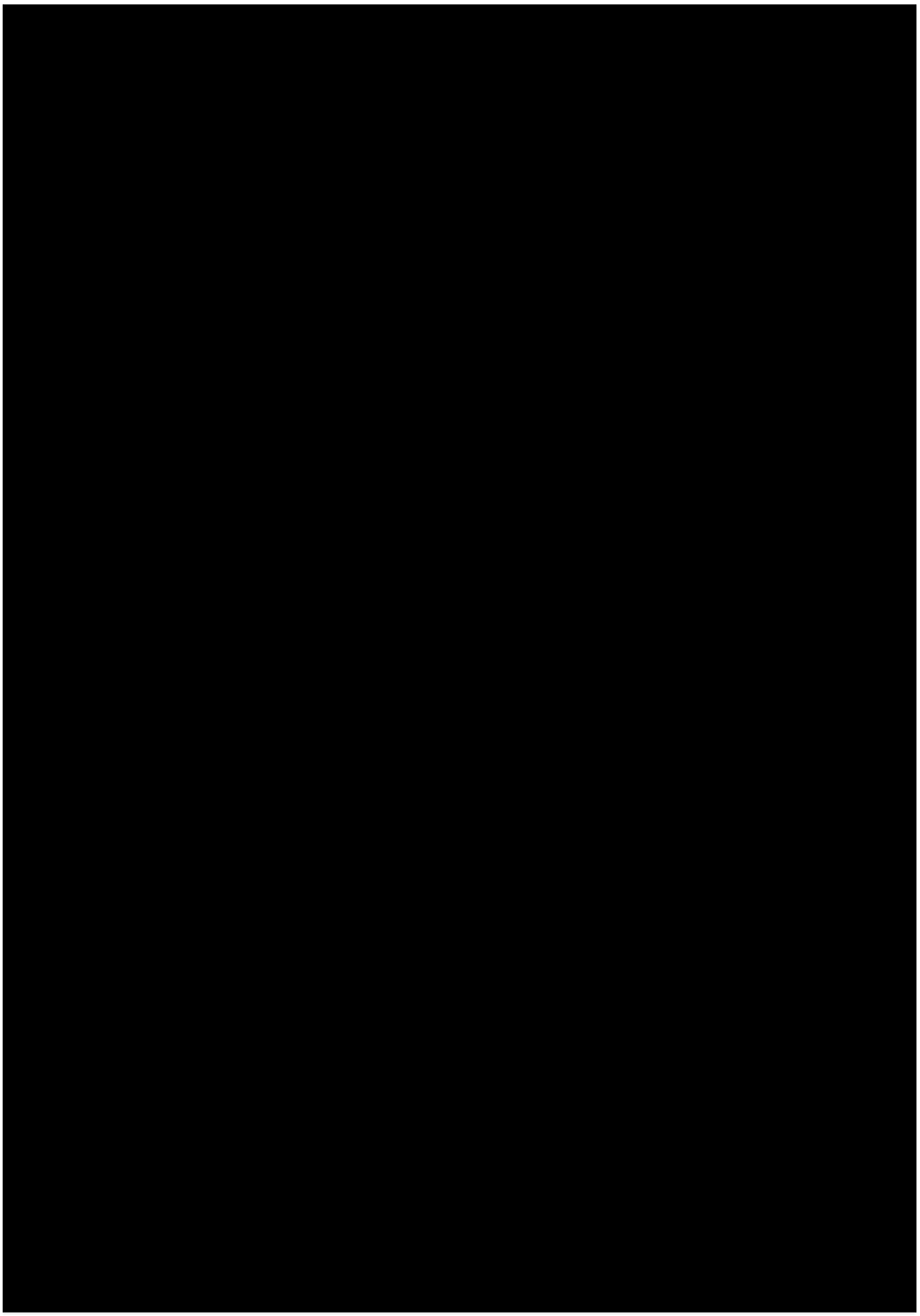


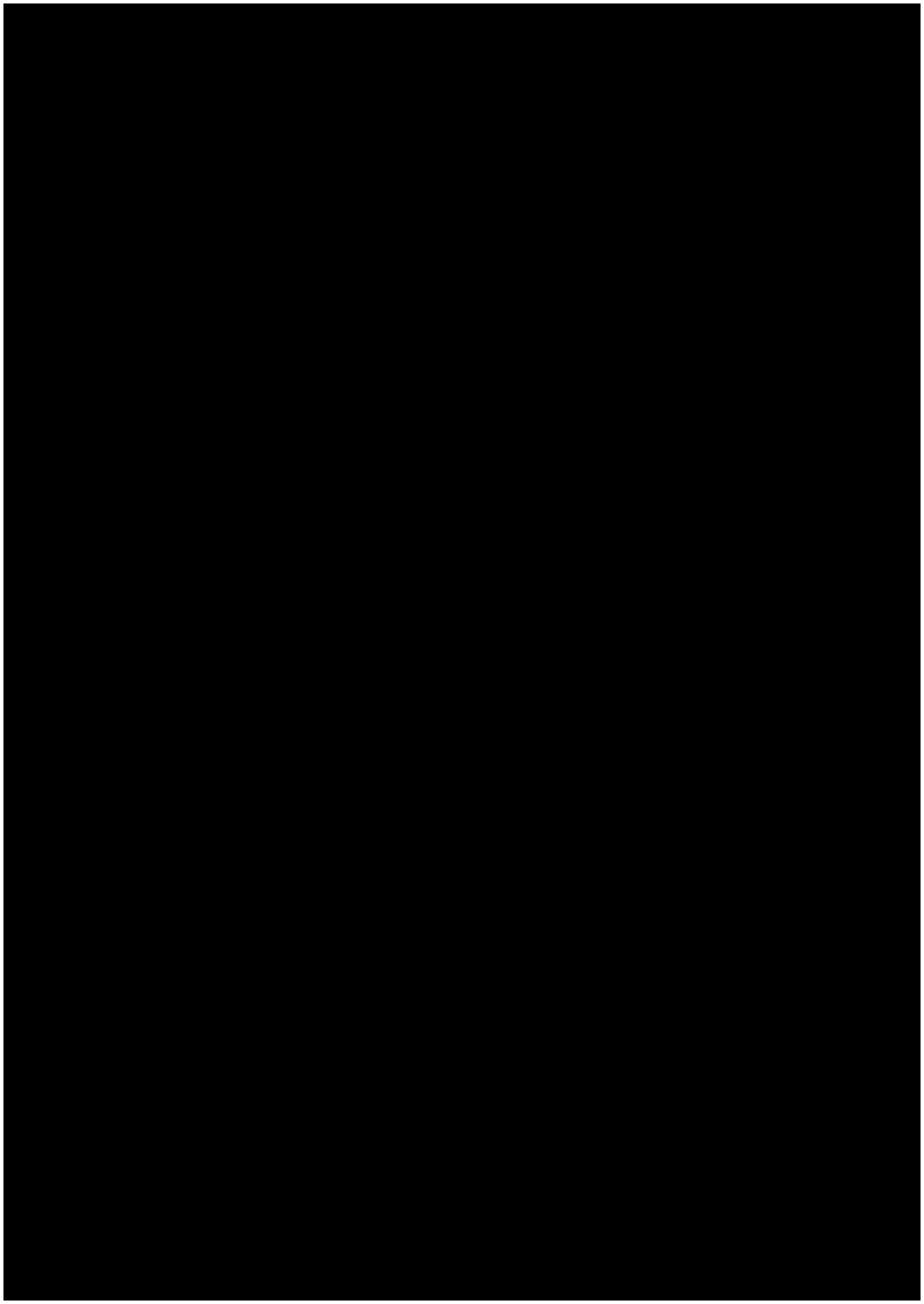


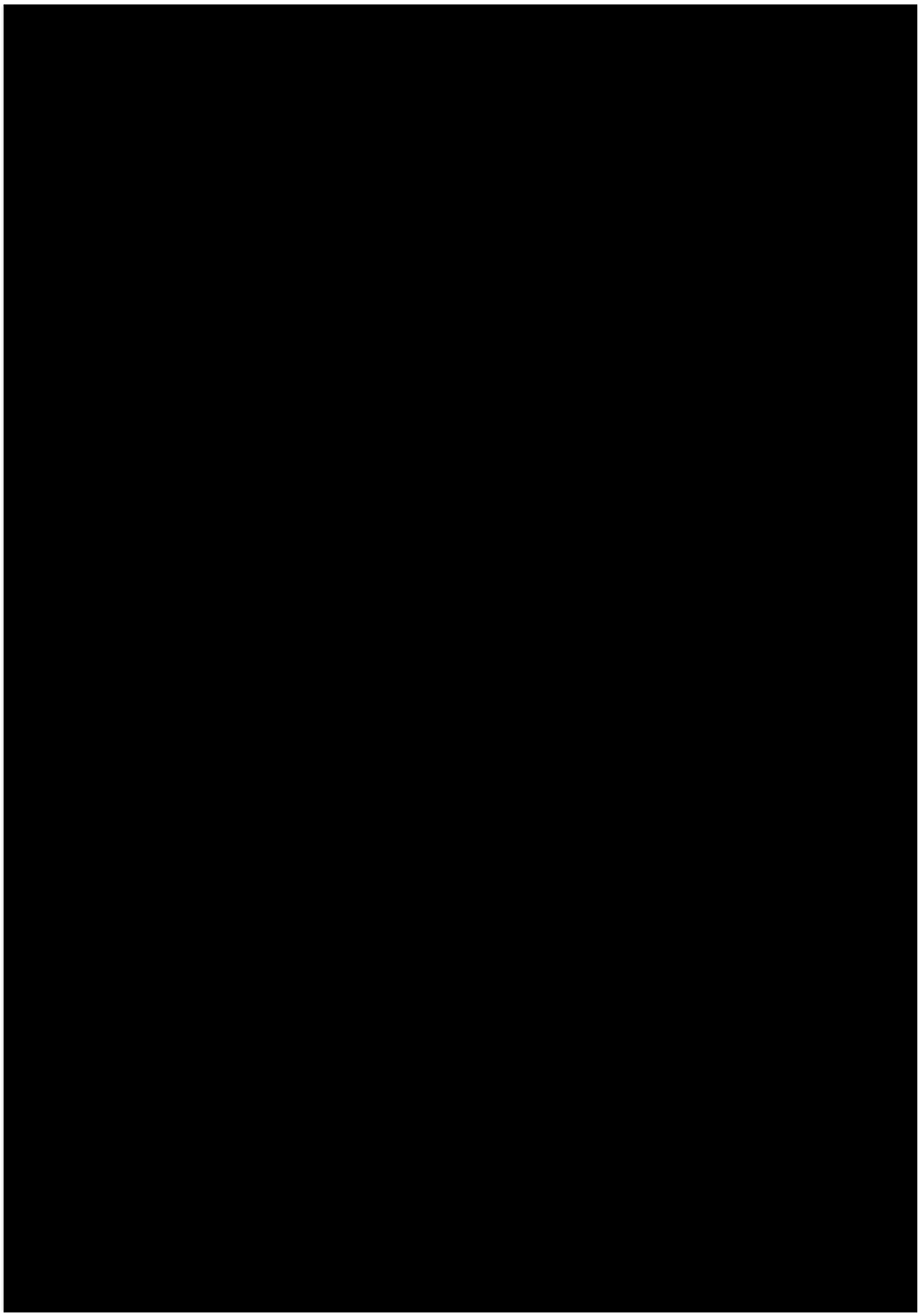


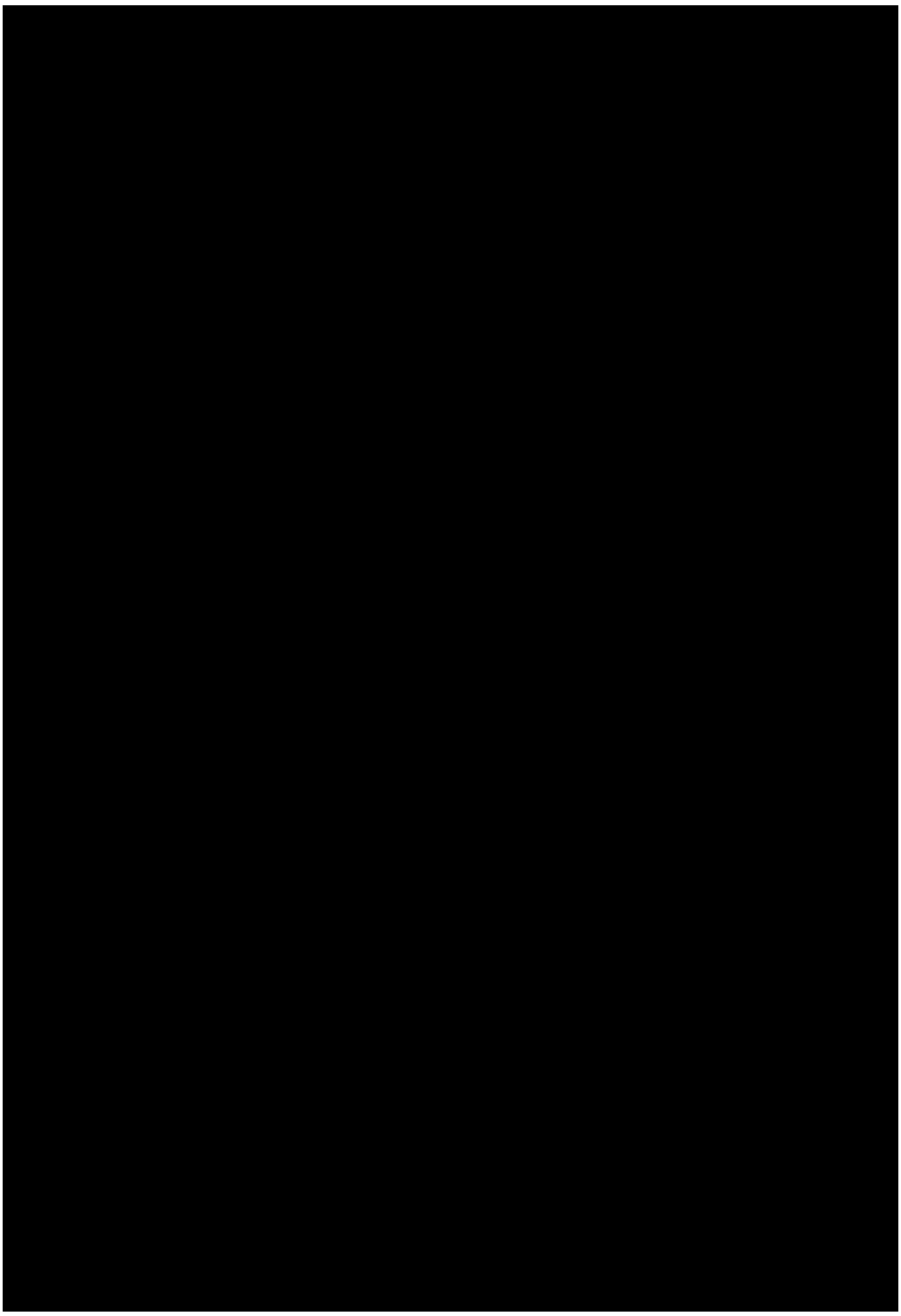


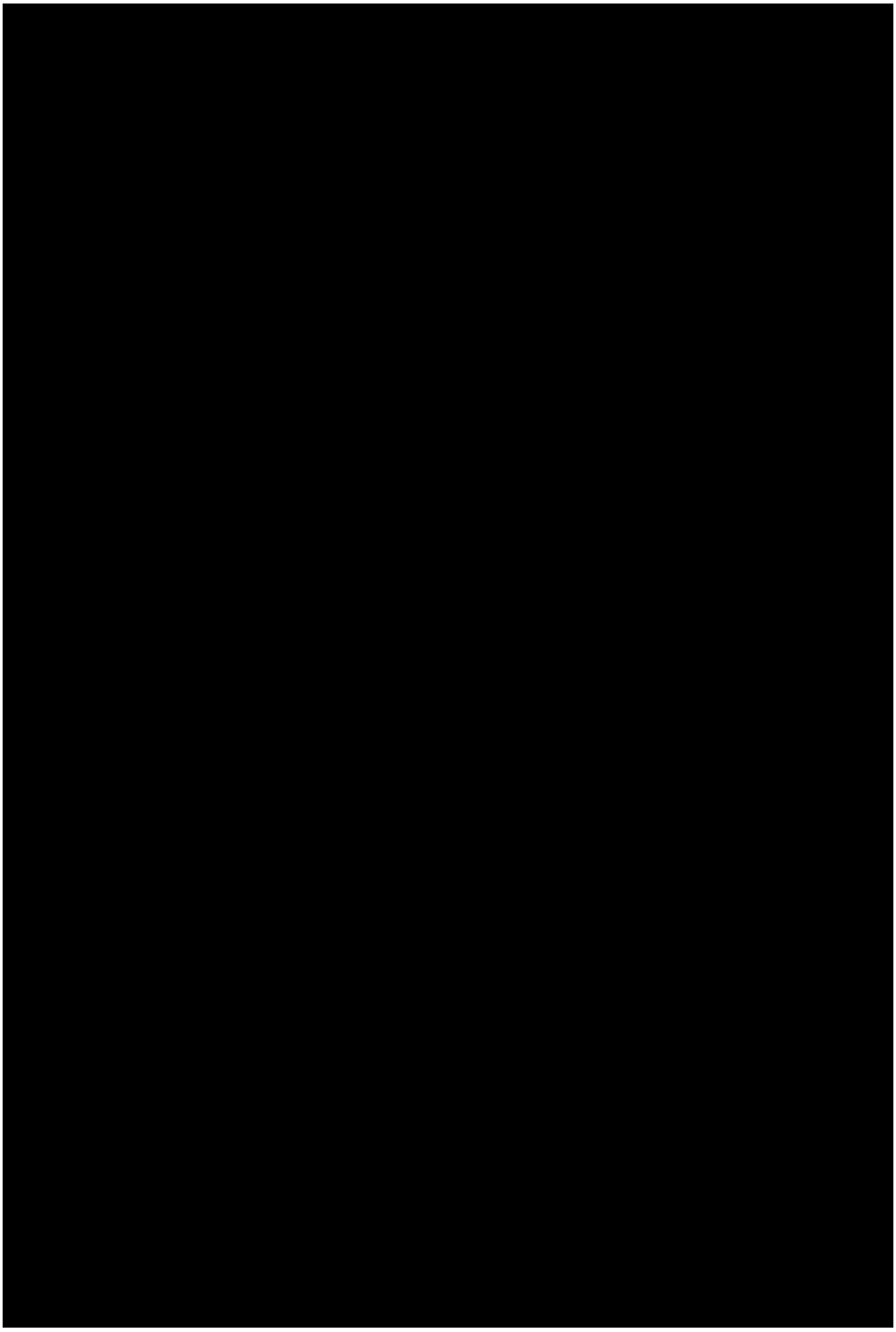


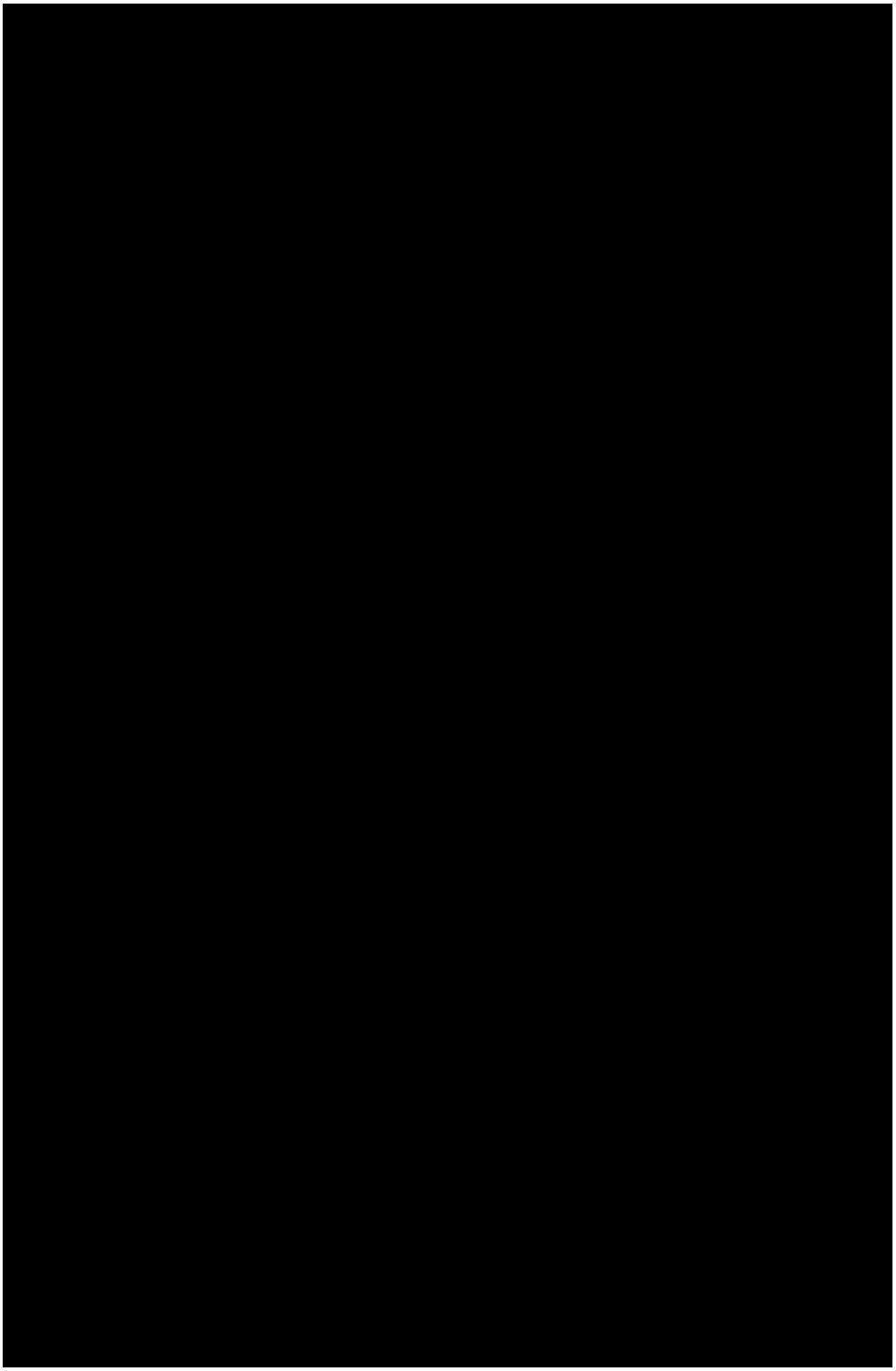


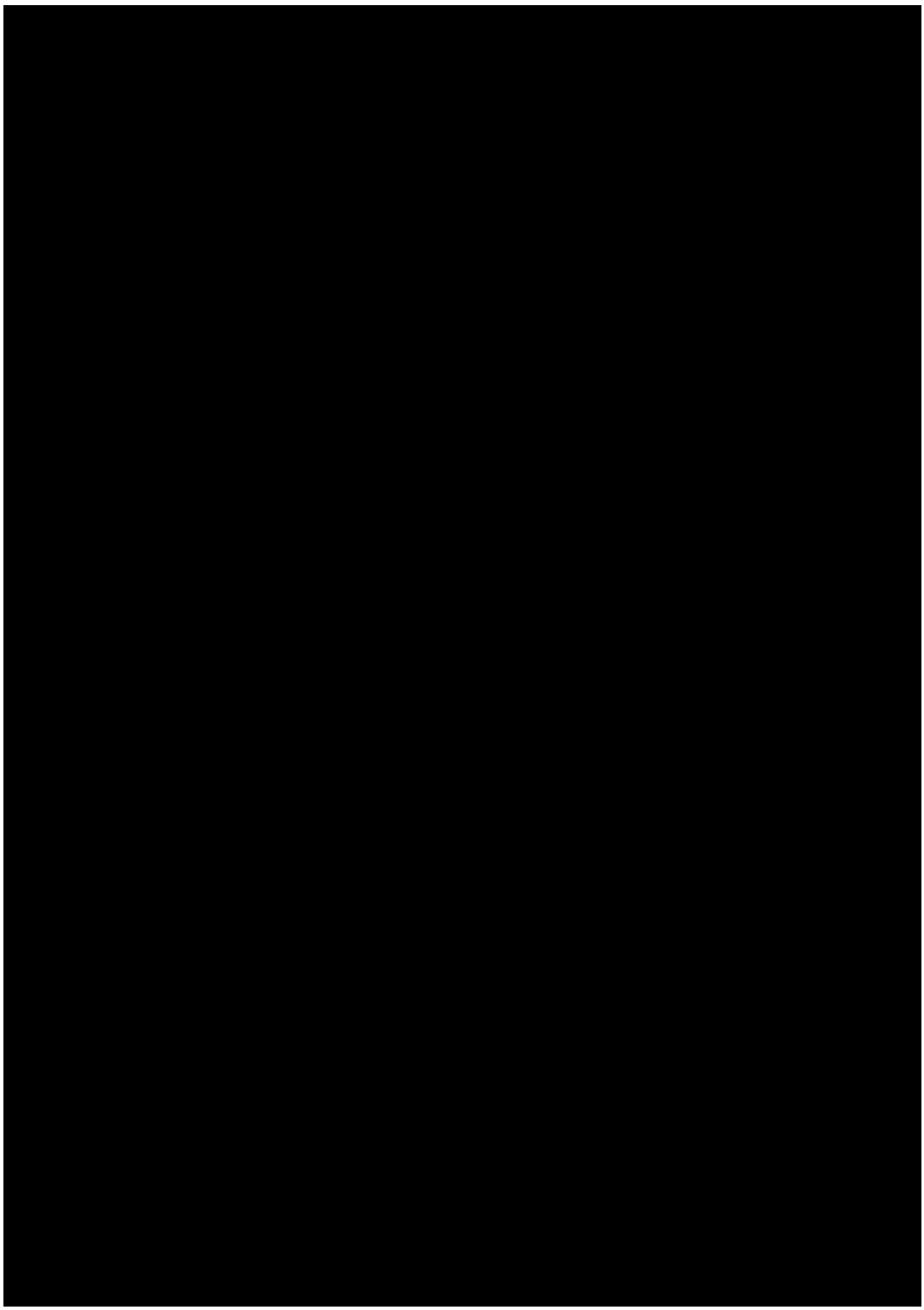


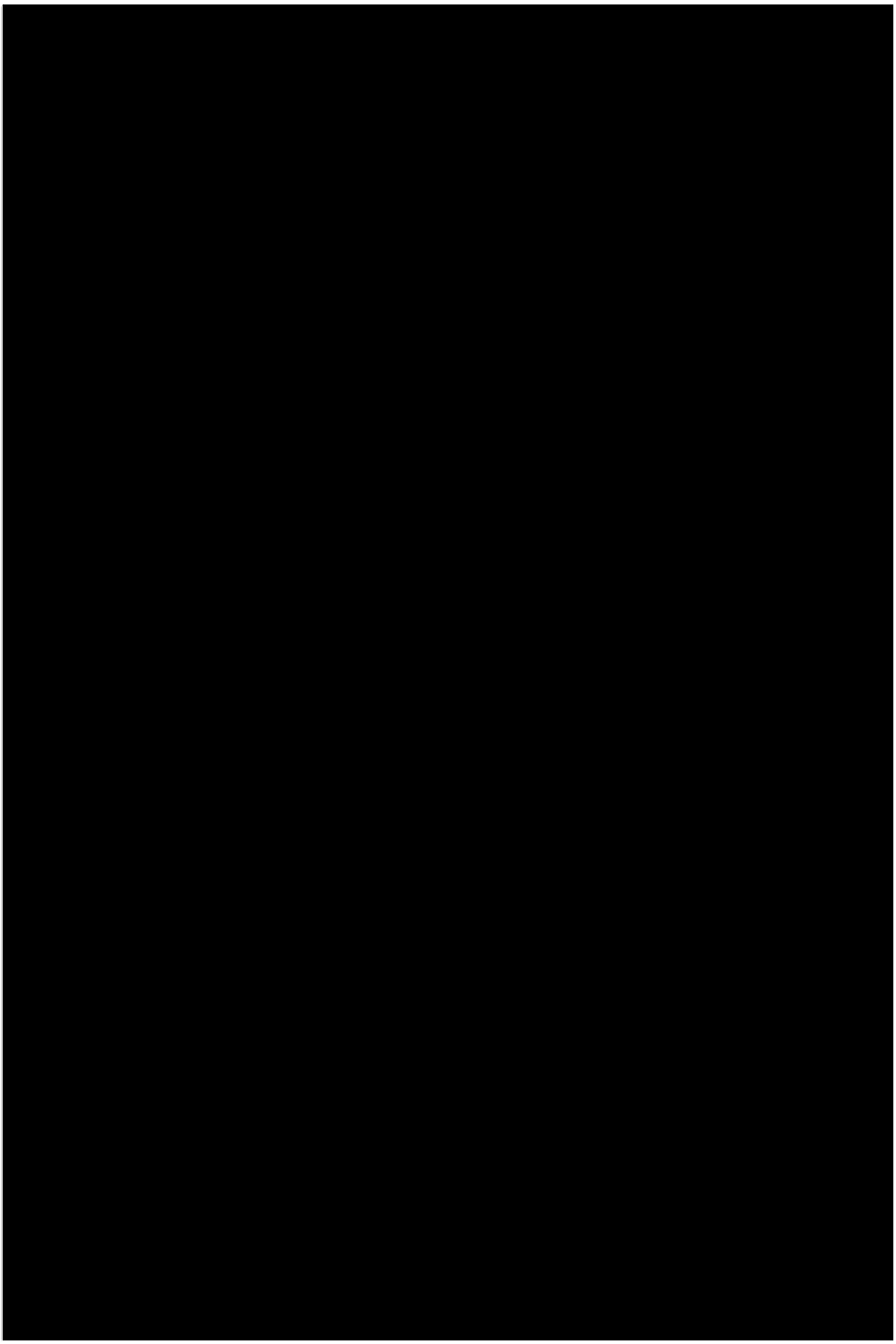


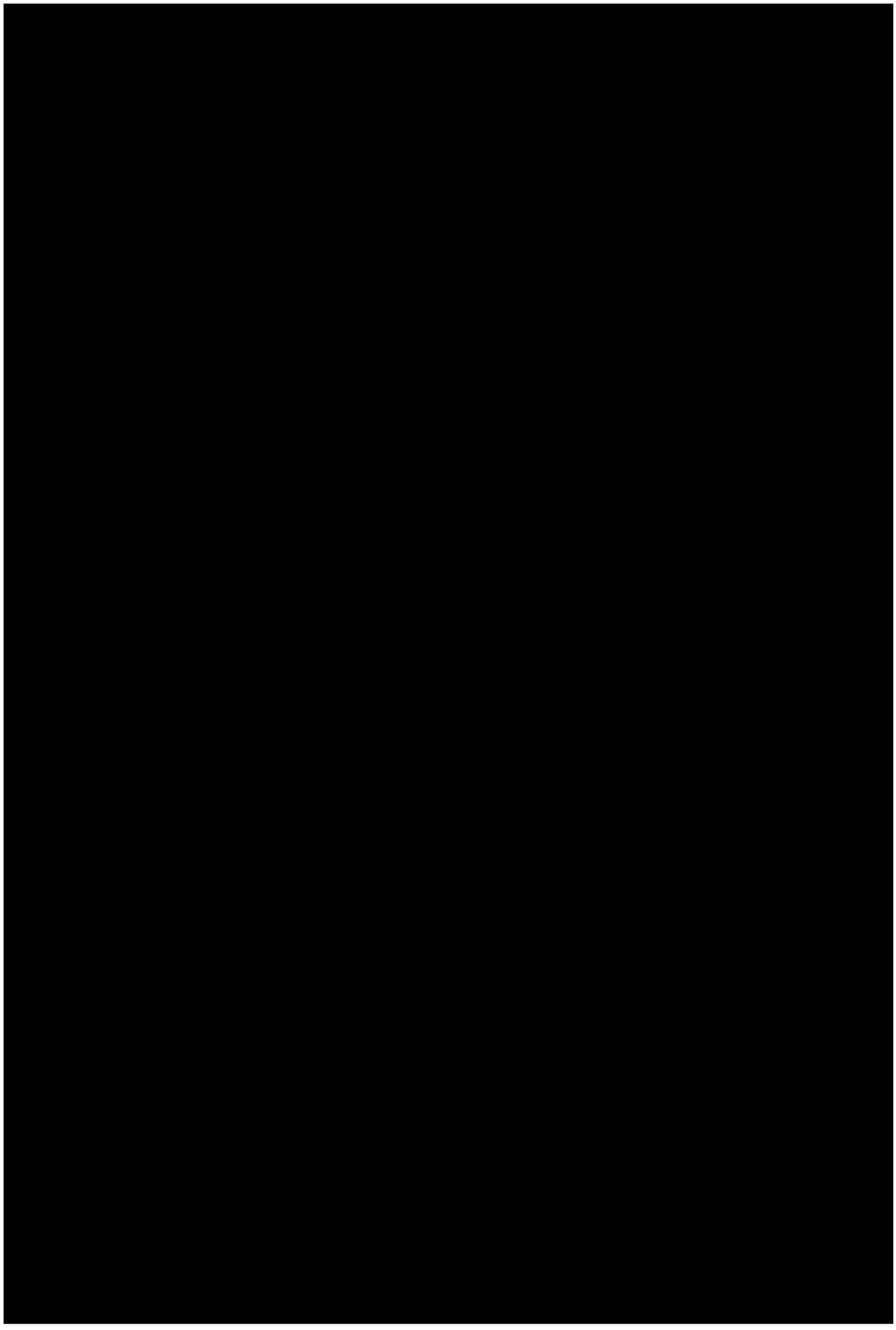


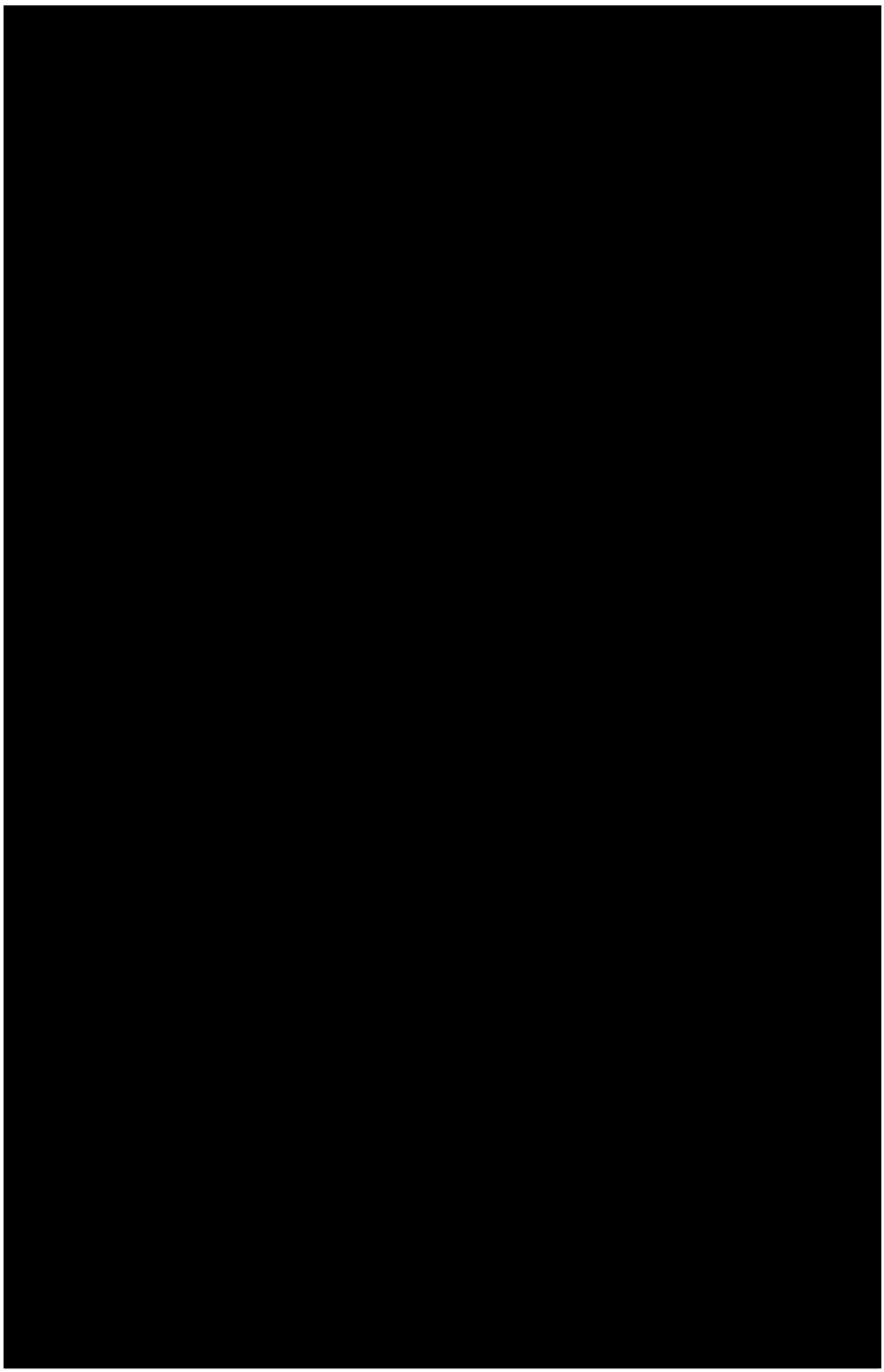












11.2 Conference - oral presentation (Mullen et al., 2017b)

Post-sort Interview in Q-methodology:
Exploring nursing students' perspectives on the role of the nurse in preserving dignity in care

Rosemary Mullen
Lecturer (Nursing), University of the West of Scotland
PhD Student, Edinburgh Napier University
[redacted]
Supervisors: Angela Kydd, Anne Fleming and Laura McMillan
33rd Annual Q Conference, Glasgow 2017

Edinburgh Napier

Content

- Background
- Data Collection and Analysis
- Key Findings
- Lessons Learned

Edinburgh Napier

Background: Research Question

What are nursing students' perspectives on the important aspects of the role of the nurse in preserving dignity in care?

Edinburgh Napier

Background: 4 Factors

Most important aspects of the nurse's role in preserving dignity?

1. Being respectful
2. Being passionate
3. Being genuinely interested
4. Being courageous

Edinburgh Napier

Background: Post-sort Interviews

- Ensure participant voice is heard
- Enliven data with subjectivity
- Inform factor interpretation
- Enhance rigour

Gallagher and Porock (2010); Gallagher et al. (2012); Stenner, Watts and Worrell (2008); Skorpen (2012)

Edinburgh Napier

Data Collection

- 21 nursing student participants
- Each sorted a 44-item Q-set
- All participated in a post-sort interview

Edinburgh Napier

Data Collection

Timing	• Immediately
Duration	• Few minutes to 10 minutes
Recording	• Field notes
Analysis	• Content analysis

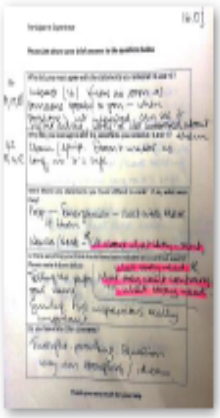
Gallagher and Porock (2010); Gallagher et al. (2012); Petit dit Dariel et al. (2013); van Hooft et al. (2015); Wolf (2012)

Data Collection

Why did you most /least agree with the statements you ranked at +4/+5 and -4/-5?

Were there any statements you found difficult to rank? If so, what were they?

Is there anything you think should have been included on a card but wasn't?



Why did you most agree with the statements you ranked at +4 and +5? e.g.

- #16: +5 *Being genuinely interested in the person*

"Know as soon as someone speaks to you...when someone's not interested patients can see it right away... [Staff] not bothered about them..."

Data Collection:

Statement-specific comments extracted

#15: *Finding out what the person wants*		
Participant	Rank	Comment
16.01	+4	"They're in-charge of what happens to them"
16.03	-4	"Not about what they want, what they need...what they want might be contrary to what they need"
16.05	+5	"Everyone's ideas of dignity are different"

Content Analysis

1. Statements
   - **Consensus**: interviews with participants who loaded on any Factors
   - **Distinguishing**: interviews with participants who loaded on a specific Factor
   - **Other**
2. General comments
3. Missing statements?

Key Findings:

Consensus Statements

#24: *Being able to use single rooms when necessary*	
Participant	Comment
16.02	"Need to 'make the best' of what's available"
14.05	"You just work-around that"

Key Findings:
Distinguishing Statements

#16: *Being genuinely interested in the person*	
Participant	**Comment**
16.03	"When someone's not [interested] patients can see it right away... [Staff] not bothered about them"
14.04	"...just really getting to know them"

Edinburgh Napier

Key Findings:
Factor Interpretation

	Factor 1	Factor 2	Factor 3	Factor 4
Eigenvalue	3.98	1.62	1.21	0.94
Q-sorts*	6	4	4	2
Variance %	28	8	6	4

Q-sorts* = Number of significantly loading Q-sorts on the factor
N.B. Confounded Q-sorts = 4; Non-significant Q-sorts = 1

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Key Findings:
Factor Interpretation
Shared Perspective on Partnership in Factors 2 and 4

The Role of the Nurse

The Role of the Person

Edinburgh Napier

Key Findings:
Factor Interpretation

#	Statement	Factors 4	2
29	Being courageous (not backing-off) if you need to protect dignity	5	0
9	Listening to the person	0	3
23	Being honest with the person	-2	2
1	Being able to tell how the person is feeling when they can't speak out	-3	1
31	Asking the person what can be done to make things easier for them	-3	1

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Key Findings:
Factor Interpretation

"Not about what they want...what they need...what they want might not be what they need..."

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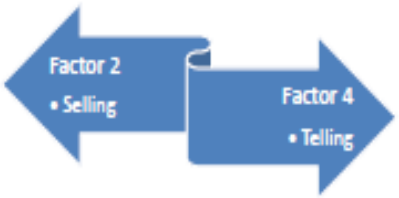
Key Findings:
Factor Interpretation
Divergent Perspective on Partnership in Factors 2 and 4



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Key Findings:
Missing Statements & General Comments

Missing

- Telling the person your name (16.03)
- Smiling (16.01)

General comments

- Question your own thoughts/ideas (16.03)
- Makes you think (16.04)
- Challenges you...puts you in the zone (16.05)

Edinburgh Napier

Lessons Learned

Efficient	• Time and other resources
Effective	• Factor interpretation
Collaborative	• Voice of the participant
Flexible	• Customised to 'fit'
Enjoyable	• Engagement

Edinburgh Napier

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Edinburgh Napier

Post-sort Interview in Q-methodology:
Exploring nursing students' perspectives on the role of the nurse in preserving dignity in care

Rosemary Mullen

Lecturer (Nursing), University of the West of Scotland

PhD Student, Edinburgh Napier University

[redacted]

Supervisors: Angela Kydd, Anne Fleming and Laura McMillan

33rd Annual Q Conference, Glasgow 2017

Edinburgh Napier

11.3 Conference (Mullen et al., 2016a)

Student nurses' perceptions of dignity:
An innovative use of photo-elicitation within a Nominal Group Technique (NGT)

R. Mullen, Dr A. Kydd, Dr L. McMillan and Dr A. Fleming

15th Qualitative Methods Conference
Glasgow, 2016

Content

- Why embed photo-elicitation in NGT?
- How were data collected and analysed?
- What were the key findings?
- What has been learned?

The research purpose

Dignity in care: Exploring the perceptions of student nurses enrolled in a three-year preregistration undergraduate adult nursing programme

- What meaning does dignity in care have for student nurses?
- What are student nurses' perceptions of the factors that promote dignity in care?

Nominal Group Technique

A highly structured technique used in group settings to explore areas of interest and develop consensus

Harvey and Holmes (2012); Porter (2012); Potter, Gordon and Hammer (2004); Van De Ven and Delbecq (1972)

Nominal Group Technique

A situation experienced on placement in which dignity was promoted

- an image capturing something of the meaning of dignity in care
- a list of anything about the people/place that helped promote dignity in care

Nominal Group Technique

Silent generation of ideas → **Round Robin** → **Discussion** → **Voting and ranking**

Kennedy and Clinton (2009)

Stage 1: Silent generation of ideas

Images (NES, 2012)

Response booklet

Please take a few moments to select an image that captures something of what **dignity in care** means to you. Jot down what it was about the image that captured something of that meaning for you.

Why embed photo-elicitation?

Image 5A (NES, 2012)

The nature of:

1. The concept
2. The participants

The nature of the concept

Image 45A (NES, 2012)

- Complex
- Value-laden

Banks (2007); Barton (2015); Dewar (2012); Harper (2002)

The nature of the participants

- Fluency
- Student voice

Banks (2007); Barton (2015); Edgar (1999); Lorenz and Kolb (2009); Richard and Lahman (2015)

Dignity in care

Image 37A (NES, 2012)

"Taking time to listen to a patient…Time spent when working with a patient while carrying out care…Do not rush a patient and make them feel like an inconvenience." (12A.06)

Data analysis

Braun and Clarke (2006); Flick (2015); Vaismoradi, Turunen & Bondas (2013)

Qualitative content analysis

- Gaining a sense of the whole
- Selecting the unit of analysis
- Coding the data
- Categorising the data

Elo and Kyngäs (2008); Miles, Huberman and Saldaña (2014); Saldaña (2009);

Values coding: Vulnerability

"...Dignity in care is about protecting the vulnerable person"

(13.03)

Image 50A (NES, 2012)

Dignity in care is not having to worry about leaving it at the door (13.05)

Image 24A (NES, 2012)

Dignity in care is about the <u>feelings</u> involved

e.g. happiness, sadness, embarrassment, contentment, fear, anxiety, safety

Dignity in care is being respectful of a person's individuality (12A.01)

Image 33A (NES, 2012)

Dignity in care is about <u>respecting individuality</u>

e.g. the importance of the uniqueness of the individual and their perspective on what constitutes dignity in their own care.

Quantitative content analysis

- How many images were selected
- How often were individual images selected
- How many statements were in each category

Flick (2015)

Frequency of image selection

Image 64A (NES, 2012)

Image 32A (NES, 2012)

One image, multiple meanings

Image 28A (NES, 2012)

- *"To me dignity is about listening as well as many other things… I think it's important that people should be heard"* [14A.05]
- *"…if you want to have a conversation with someone you have to make sure it's only him or her that can hear."* [14B.08]

Tensions

Counterbalance

Process

- Engaging
- Enjoyable
- Collaborative
- Rich

Practice

- Pre-existing images
- Ease of use
- Time-efficient
- Clear trigger question

Gong et al. (2012); Harris and Guillemin (2012); Linz (2011); Richard and Lahman (2015); Schwartz (1989)

Photo-elicitation…

"…mines deeper shafts into a different part of human consciousness than do words-alone interviews"

Harper (2002, p. 23)

Student nurses' perceptions of dignity:
An innovative use of photo-elicitation within a Nominal Group Technique (NGT)

R. Mullen, Dr A. Kydd, Dr L. McMillan and Dr A. Fleming

15th Qualitative Methods Conference
Glasgow, 2016

References

11.4 Conference (Mullen et al., 2016a)

Preserving dignity in care:

Exploring nursing students' perceptions using Nominal Group Technique (NGT)

Rosemary Mullen, PhD student (Napier)/Lecturer(UWS)

[redacted]

ENTER 2016

Edinburgh Napier University

Supervisors

- Dr Angela Kydd (Edinburgh Napier University)
- Dr Laura McMillan (University of the West of Scotland)
- Dr Anne Fleming (Independent Researcher)
- Dr Vibeke Lohne (Oslo and Akershus University)

Content

Why use Nominal Group Technique (NGT)?

What were the key findings?

What has been learned?

The research purpose

Preserving dignity in care: Exploring the perceptions of adult nursing students enrolled in a three-year preregistration undergraduate programme in Adult Nursing

- What meaning does dignity in care have for nursing students?
- What are nursing students' perceptions of the factors that preserve dignity in care?

Nursing students...

"...need to have dignity instilled into the way they think and act from their very first day"

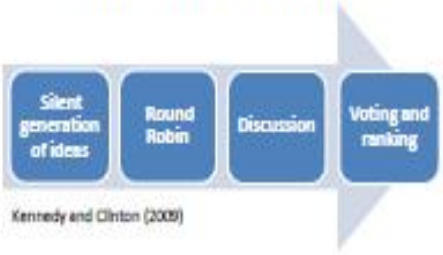
Commission on Dignity in Care for Older People (2012, p. 35)

Nominal Group Technique

A highly structured technique used in group settings to explore areas of interest and develop consensus

Harvey and Holmes (2012)

Nominal Group Technique



Kennedy and Clinton (2009)

Participants

- 5 nominal groups
  - Year 1 = 10
  - Year 2 = 12
  - Year 3 = 9

31 participants

Stage 1: Silent Generation of Ideas

List what it was about the people and place that helped preserve dignity

Stage 2: Round Robin

Each participant invited in-turn to state one item from their list

Stage 4: Voting and Ranking

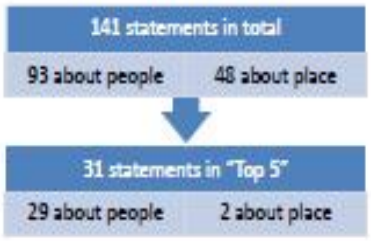
Each participant invited to:

i. select their 'Top 5' items from the flip charts

ii. rank each of their 'Top 5' item from 1 (least important) to 5 (most important)

Group 'Top 5'

Analysis of raw data



Content analysis

Remembering they're a person

Dignity in care is about respecting individuality

e.g. the importance of the uniqueness of the individual and their perspective on what constitutes dignity in their own care.

Image 33A (NES, 2012)

Making sure people don't have to worry about leaving it at the door

Dignity in care is about the feelings involved

e.g. happiness, sadness, embarrassment, contentment, fear, anxiety, safety

Image 24A (NES, 2012)

Protecting people who can't protect themselves

Dignity in care is about vulnerability

e.g. dependency, the power or authority of the practitioner

Image 59A (NES, 2012)

A dignity encounter

Jacobson (2009)

Relationships between actors

Educating for dignity

- Interprofessional workshops
  - Matiti (2015)
- Care ethics simulation laboratories
  - Timmermans et al. (2015)

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Preserving dignity in care:

Exploring nursing students' perceptions using Nominal Group Technique (NGT)

Rosemary Mullen, PhD student (Napier)/Lecturer(UWS)

[redacted]

ENTER 2016

Edinburgh Napier University

11.5 Conference (Mullen, Kydd and McMillan, 2015)

Q-sample development
Use of Nominal Group Technique

31st Q Conference
Ancona, Italy (2015)

Rosemary Mullen
Dr Angela Kydd
Dr Laura McMillan
Professor Austyn Snowden

Aim

- To outline the use of Nominal Group Technique in the development of a Q-sample
  - Sourcing the concourse
  - Selecting the Q-sample

The research purpose

Dignity in care: exploring the perceptions of student nurses enrolled in a three-year preregistration undergraduate adult nursing programme

"Student nurses...need to have dignity instilled into the way they think and act from their very first day."

Delivering Dignity (2012)

Research questions

1. What meaning does dignity in care have for student nurses?
2. What are student nurses' perceptions of the factors that promote dignity in care?

Dignity is about time

Image 37A (NES, 2012)

"Taking time to listen to a patient...Time spent when working with a patient while carrying out care...

Do not rush a patient and make them feel like an inconvenience." (A12.06)

Selecting the Q-sample

- Natural
  - In the language of the participants
- Comprehensive
  - In the representation of the subject

McKeown and Thomas (2013)

Nominal group technique

- A highly structured technique used in group settings to explore areas of interest and develop consensus
- Recommended for use in Q-methodology (Moseman, 2003; McKeown and Thomas, 2013)

Nominal group technique

Statements (Group 3, n = 6)	No. of votes	Individual scores	Sum of scores	Top 5
Remembering they're a person	6	3, 4, 5, 5, 5, 5	27	1st
Treat as an individual	5	2, 3, 3, 5, 5	18	2nd
Genuine interest and listening	5	1, 3, 3, 3, 5	15	3rd

Analysis of the raw data

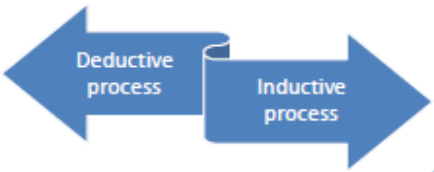
Qualitative content analysis

Values coding

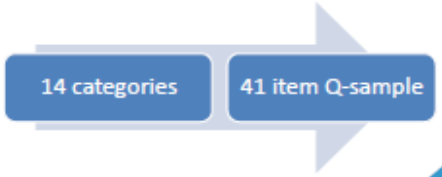
14 categories identified e.g.

- *Not, 'I'm the nurse and you're the patient'*
- *Remembering they're a person*
- *Protecting people who can't protect themselves*

Selecting the Q-sample



Selecting the Q-sample



Dignity in care is most likely to be promoted when the nurse:

Is genuine and honest with the patient
Takes care of the patient's family too
Feels they have time to care for the patient
Has access to whatever equipment is needed
Remembers the patient isn't just a bunch of conditions
Doesn't make the patient feel like an inconvenience

Q-sample development

Use of Nominal Group Technique

31st Q Conference
Ancona, Italy (2015)

11.6 Glossary of Q-methodology terminology

Term	Meaning in Q-methodology
Communality	A measure of the extent to which the extracted factors account for the variance of any given Q sort
Concourse	The sum of all statements made or thought by people about the subject (Simons, 2013)
Consensus Statement	A statement in the Q-set that does not distinguish between different factors indicating agreement (Newman and Ramlo, 2010)
Correlation	A measure of the relationship between two Q sorts or two factors
Distinguishing Statement	A statement in the Q-set that distinguishes a factor from other factors at a significance level of $p > 0.05$ (Newman and Ramlo, 2010)
Eigenvalue	A measure of the statistical strength of a factor (Valenta and Wigger, 1997)
Factor	A representation of shared meaning (Watts and Stenner, 2012)
Factor array	A Q sort representing a given factor which can be presented in a sorting grid (Paige, 2015)
Factor analysis	A statistical process aimed at identifying and representing distinct portions of shared meaning (Watts and Stenner, 2012)
Factor loading	A measure of the extent to which each Q sort is typical of a given factor (McKeown and Thomas, 2013)
Factor rotation	A process to simplify structure and optimise factor loadings (Valenta and Wigger, 1997)
Factor weight	A weighted average of the Q sorts that load significantly on a given factor (Watts and Stenner, 2012)
P-set	The participants (Simons, 2013)
Q-set	A representative subset of statements drawn from the concourse (Brown, 1993; Paige and Morin, 2014)

Term	Meaning in Q-methodology
Q-sorting	The process of administering or performing a Q-sort (Watts and Stenner, 2012)
Standard Deviation	A measure of the extent to which a set of scores vary: A descriptive statistic which can be thought of as the average distance of each data point from the mean (Maltby, Day and Williams, 2007).
Standard Error	A measure of the variability of a set of a set of scores around the mean: An inferential statistic (Maltby, Day and Williams, 2007)
Variance	A measure of the range of meaning and variability present in study data (Watts and Stenner, 2012)
Z score	A standardised factor score for each Q sort item (Watts and Stenner, 2012)

11.7 Ethical approval confirmation letter

UWS UNIVERSITY OF THE WEST of SCOTLAND

School of Health, Nursing and Midwifery
Hamilton Campus
Caird Building
HAMILTON
ML9 0QA
Tel +44 (0)1698 283100
Fax +44 (0)1698 282131

Ref: AS/ESB

2nd December, 2013

Rosemary Mullen
[redacted]

Dear Rosemary,

Outcome of School of Health Nursing and Midwifery Ethics Committee

Thank you for your recent submission to the Committee and for your attendance at the SEC on 27th November, 2013 to discuss your planned research.

I can confirm your submission was reviewed by the Committee where the outcome has been:

- **APPROVED (subject to recommended amendments)**

To support your research the Committee offer the following suggestions:-

1. Consider limitations of photos in regard to choice not allowing honesty

2. Avoid variation in verbal information where possible. Clarify (standardize) sharing of information with third party (academic member of staff outside team).

3. Avoid use of email with students unless approval from head of school has been granted (risk of blurring boundaries).

On behalf of the School Ethics Committee, I take this opportunity to wish you well with your study.

Yours sincerely

[redacted]

Chair
School of Health Nursing & Midwifery Ethics Committee

cc Dr Angela Kydd, Dr Laura McMillan

Faculty of Education, Health & Social Sciences
Dr Jeanne Keay, Vice-Principal (International) and Executive Dean of Faculty of Education, Health & Social Sciences

11.8 Participant information sheet for NGT

PARTICIPANT INFORMATION SHEET (A)
Student Nurses' Perceptions of Dignity in Care

UWS UNIVERSITY OF THE WEST of SCOTLAND

What is this study about?

We would like to find out what student nurses think about dignity in care and their role in promoting it. We are also interested in finding out if there any differences between first, second and third year student nurses in the way they think about dignity in care and their role in promoting it. Knowing what student nurses think will help us provide education that best suits their learning needs.

Who are we?

Rosemary Mullen – a Lecturer from the School of Health, Nursing and Midwifery at the University of the West of Scotland (UWS), Paisley Campus – is the principal researcher. She is conducting this study as part of a doctoral thesis. Dr Angela Kydd from UWS is the Director of Studies. The study is also being supervised by Professor Austyn Snowden (UWS), Dr Vibeke Lohne (Oslo and Akershus University College of Applied Sciences, Norway) and Dr Laura McMillan (UWS).

Why have I been asked to take part?

You have been asked because as a student nurse you will be learning – in theory and in practice – about dignity in care and your role in promoting it.

What will I have to do if I take part?

In this part of the study, discussion groups called "nominal groups" will be used to understand what dignity in care means to you. This will also help to develop a questionnaire that will be used later in the study. You will be invited to attend one nominal group with around 5 to 12 other student nurses from your own campus and cohort. It will last no longer than 1 hour and 15 minutes.

Do I have to take part?

No. Participation in this study is voluntary. Whether or not you choose to take part will not change your teaching or assessment. You can also withdraw from the study at any time without giving any reason. Withdrawal will not change your teaching or assessment either.

Will this information be confidential?

Yes. You will only be identified by number and your name will not be used in the study. The University of the West of Scotland is registered under the Data Protection Act and has an Information Security Policy to safeguard the collection, processing and storage of confidential information.

What if I want to find out more or have a complaint about the research?

If you want to find out more about this research or have a complaint about this research, please contact:

Principal Researcher
Rosemary Mullen,
Lecturer (Adult Health)
School of Health, Nursing & Midwifery
University of the West of Scotland
[redacted]
High Street, Paisley
PA1 2BE
e-mail: [redacted]
Tel: [redacted]

Director of Studies
Dr Angela Kydd
Senior Lecturer (Research)
School of Health, Nursing & Midwifery
University of the West of Scotland
[redacted]
Almada Street, Hamilton
ML3 0JB
e-mail: [redacted]
Tel: [redacted]

If you would like to discuss this research with someone unconnected with the study, please contact:

Dr Robert Boyd, Lecturer (Mental Health)
School of Health, Nursing & Midwifery, University of the West of Scotland
[redacted], High Street, Paisley. PA1 2BE.
e-mail: [redacted] / Tel: [redacted]

11.9 Participant information for Q-sorting procedure

PARTICIPANT INFORMATION SHEET (B)

Student Nurses' Perceptions of Dignity in Care

UWS UNIVERSITY OF THE WEST of SCOTLAND

What is this study about?

We would like to find out what student nurses think about dignity in care and their role in promoting it. We are also interested in finding out if there any differences between first, second and third year student nurses in the way they think about dignity in care and their role in promoting it. Knowing what student nurses think will help us provide education that best suits their learning needs.

Who are we?

Rosemary Mullen – a Lecturer from the School of Health, Nursing and Midwifery at the University of the West of Scotland (UWS), Paisley Campus – is the principal researcher. She is conducting this study as part of a doctoral thesis. Dr Angela Kydd from UWS is the Director of Studies. The study is also being supervised by Professor Austyn Snowden (UWS), Dr Vibeke Lohne (Oslo and Akershus University College of Applied Sciences, Norway) and Dr Laura McMillan (UWS).

Why have I been asked to take part?

You have been asked because as a student nurse you will be learning – in theory and in practice – about dignity in care and your role in promoting it.

What will I have to do if I take part?

In this part of the study you will be invited to complete a special type of questionnaire – called a "Q-sort" – once. This will take no longer than one hour.

Do I have to take part?

No. Participation in this study is voluntary. Whether or not you choose to take part will not change your teaching or assessment. You can also withdraw from the study at any time without giving any reason. Withdrawal will not change your teaching or assessment either.

Will this information be confidential?

Yes. You will only be identified by number and your name will not be used in the study. The University of the West of Scotland is registered under the Data Protection Act and has an Information Security Policy to safeguard the collection, processing and storage of confidential information.

What if I want to find out more or have a complaint about the research?

If you want to find out more about this research or have a complaint about this research, please contact:

Principal Researcher
Rosemary Mullen,
Lecturer (Adult Health)
School of Health, Nursing & Midwifery
University of the West of Scotland
[redacted]
High Street Paisley
PA1 2BE
e-mail: [redacted]
Tel: [redacted]

Director of Studies
Dr Angela Kydd
Senior Lecturer (Research)
School of Health, Nursing & Midwifery
University of the West of Scotland
[redacted]
Almada Street, Hamilton
ML3 0JB
e-mail: [redacted]
Tel: [redacted]

If you would like to discuss this research with someone unconnected with the study, please contact:

Dr Robert Boyd, Lecturer (Mental Health)
School of Health, Nursing & Midwifery
University of the West of Scotland
[redacted]
High Street
Paisley
PA1 2BE.
e-mail: [redacted]
Tel: [redacted]

This material is available in other formats on request.

11.10 Consent form

PARTICIPANT CONSENT FORM

UWS UNIVERSITY OF THE WEST of SCOTLAND

Participant Identification Number:

Title of Project:

Dignity in care: a mixed methods study of the perceptions of student nurses enrolled in a three-year pre-registration undergraduate adult nursing programme.

Name of Researcher: Rosemary F. Mullen (Lecturer, Adult Health)

Please initial box

1	I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.	☐
2	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my academic record being affected.	☐
3	I understand that if I describe an experience that raises questions about my conduct or the conduct of others then the researcher may need to take action.	☐
4	I agree to take part in the above study.	☐
5	I agree to be contacted by the researcher by email regarding arrangements. My preferred email address for contact is: _____@_____	☐

Name of participant:

Signature:

Date:

Name of person taking consent:

Signature:

Date:

1 copy for participant and 1 for researcher

This material is available in other formats on request.

11.11 Introduction and contact information

UWS UNIVERSITY OF THE WEST of SCOTLAND

LETTER OF INTRODUCTION

Dear Student Nurse,

Student nurses' perceptions of dignity in care: a research study

The purpose of the research study is to find out what student nurses think about dignity in care and if there any differences between the ways first, second and third year student nurses think about it. You have been invited to participate because you will be learning about dignity in theory and in practice during your programme.

More information is enclosed and I would be most grateful if you would take some time to read this. If you are interested in participating, please complete and return the consent form along with the tear-off slip below in the stamped addressed envelope provided.

Please note that your participation is entirely voluntary and you can also withdraw from the study at any time without giving any reason.

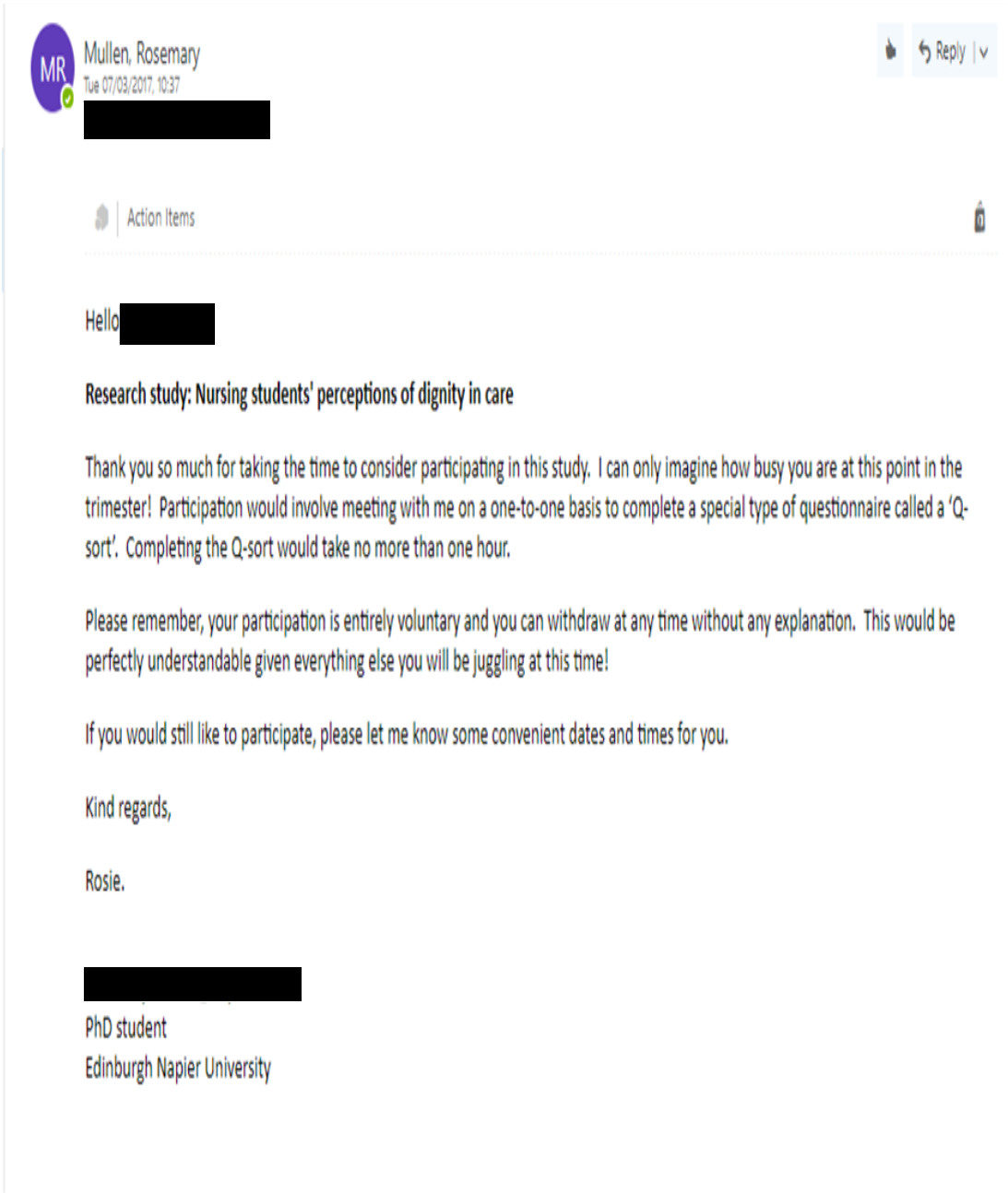
Thank you for taking the time to consider this.

Yours sincerely,

Rosemary F. Mullen (Principal Researcher)
PhD student/Lecturer (Adult Health)

Participant name (please print)	**Participant signature**
Preferred contact method Email ☐ or Phone ☐	
Email Please provide preferred address _____@_____ **Phone** Please provide preferred contact number _____	

11.12 Typical follow-up email to potential participants



Mullen, Rosemary
Tue 07/03/2017, 10:37
[redacted]

Reply

Action Items

Hello [redacted]

Research study: Nursing students' perceptions of dignity in care

Thank you so much for taking the time to consider participating in this study. I can only imagine how busy you are at this point in the trimester! Participation would involve meeting with me on a one-to-one basis to complete a special type of questionnaire called a 'Q-sort'. Completing the Q-sort would take no more than one hour.

Please remember, your participation is entirely voluntary and you can withdraw at any time without any explanation. This would be perfectly understandable given everything else you will be juggling at this time!

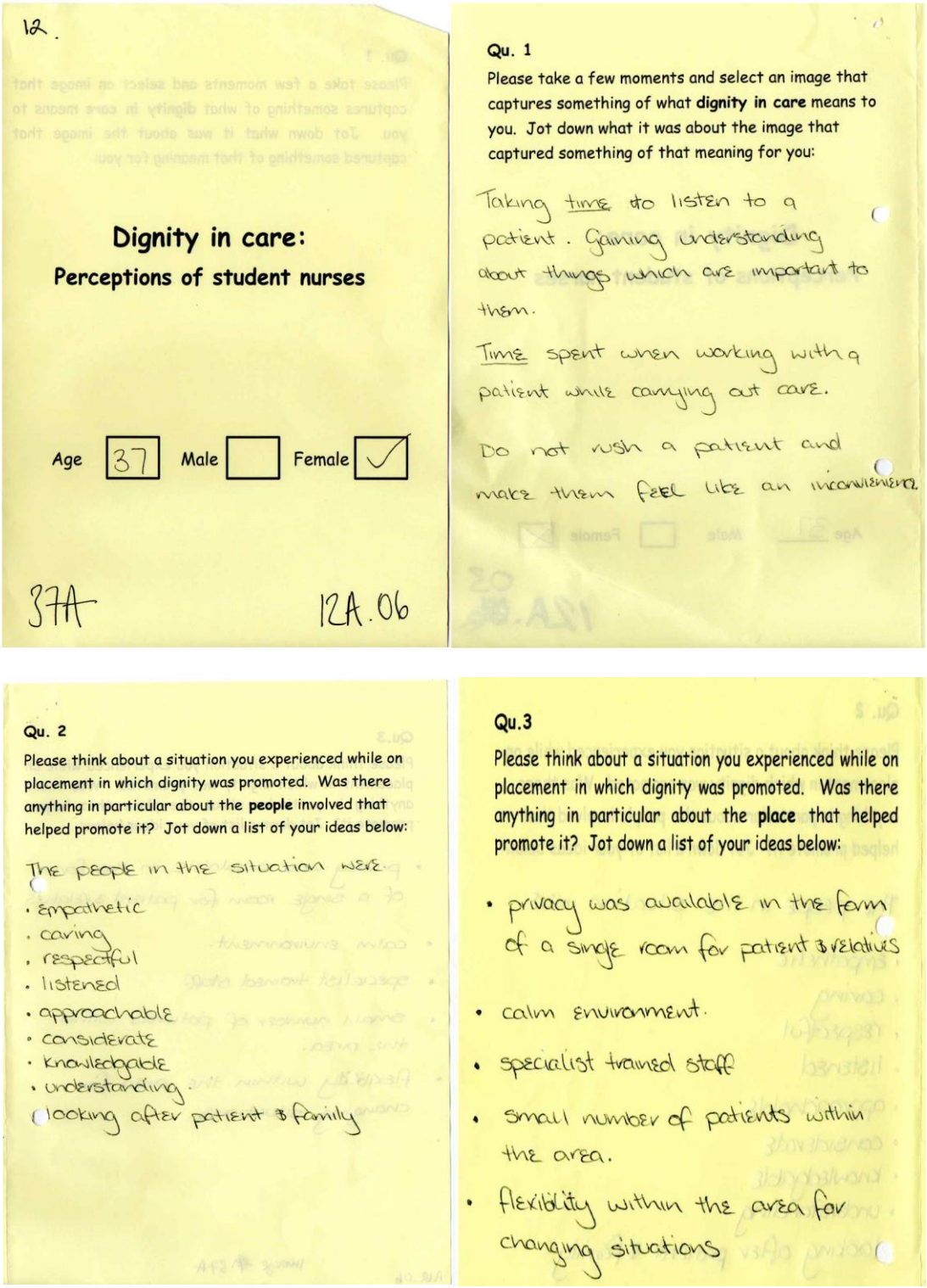
If you would still like to participate, please let me know some convenient dates and times for you.

Kind regards,

Rosie.

[redacted]
PhD student
Edinburgh Napier University

11.13 Response booklet used in the NGT



12.

Dignity in care:
Perceptions of student nurses

Age 37 Male ☐ Female ☑

37A 12A.06

Qu. 1

Please take a few moments and select an image that captures something of what **dignity in care** means to you. Jot down what it was about the image that captured something of that meaning for you:

Taking time to listen to a patient. Gaining understanding about things which are important to them.

Time spent when working with a patient while carrying out care.

Do not rush a patient and make them feel like an inconvenience

Qu. 2

Please think about a situation you experienced while on placement in which dignity was promoted. Was there anything in particular about the **people** involved that helped promote it? Jot down a list of your ideas below:

The people in the situation were:
- empathetic
- caring
- respectful
- listened
- approachable
- considerate
- knowledgable
- understanding.

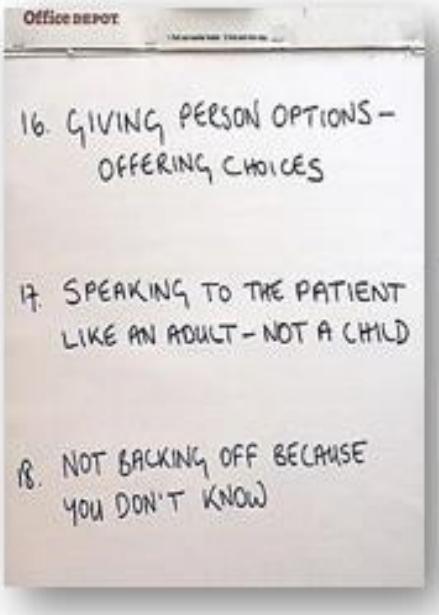
looking after patient & family

Qu.3

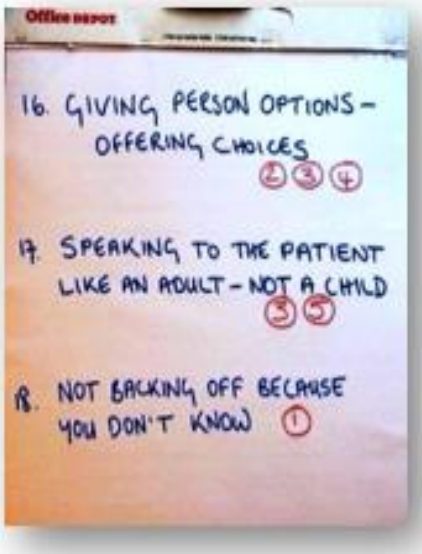
Please think about a situation you experienced while on placement in which dignity was promoted. Was there anything in particular about the **place** that helped promote it? Jot down a list of your ideas below:

- privacy was available in the form of a single room for patient & relatives
- calm environment.
- specialist trained staff
- small number of patients within the area.
- flexibility within the area for changing situations

11.14 Example of recording and ranking during NGT



- Each statement recorded on a flip chart.
- Each participant notes their 'Top 5' (on 5 separate cards, circled in green below).



- Each participant ranks each statement in their 'Top 5' between 1 and 5 (circled in red above)
- All ranks noted as scores on the flip chart.
- Scores added together to give a total score for each statement.
- The group's 'Top 5' statements are those with the greatest total scores.

11.15 'Top 5' statements identified by NGT

All Statements in Categories using modified (van Breda, 2005)

	A	B
1	Stat.#	Statement
2	14B.3.05	Confidentiality e.g. patient asked if OK to inform next-of-kin
3	14B.2.03	Promoted privacy e.g. curtains pulled, single room at the end of life
4	12B.2.12	Discretion at handover – voices clear, not loud
5	12A.2.15	Making sure not too many staff/people around personal care
6	13.2.14	Covered as much as possible
7	13.2.20	Never leave in a vulnerable position
8	14B.2.08	Asking consent
9	12B.2.01	Valued individual – what could we do to make it easier, personal preferences
10	12A.2.07	Respectful of an individual's choice
11	14A.2.16	Give person options, offer choices where possible
12	12A.2.08	Before carrying out [care] discussing it with the patient and making sure [they are] happy
13	13.2.12	Informed choices
14	14B.2.02	Encouraged independence
15	12A.2.09	Letting patient do as much as they can for themselves
16	14A.3.05	Single room so family could stay and come and go as they pleased

Summary | All statements | Gp. 1 statements

17	14A.2.14	Being able to empathise with the patient – treating them as you would like to be treated
18	12A.2.13	Listened
19	13.2.18	Remembering they're a person, not a bunch of symptoms
20	12A.2.21	Desire to make patients' experiences meaningful
21	13.2.17	Treat as an individual
22	12A.3.09	Personal belongings with them
23	14A.2.01	Taking everything into account e.g. person, place, processes (what you are doing)
24	12A.2.18	Staff making patient aware, supported and reassured
25	14A.2.02	Good communication
26	14B.2.14	Positive and caring staff attitudes
27	13.2.04	Genuine interest and listening
28	13.2.08	Honesty
29	12B.2.02	Acted in a caring manner
30		
31		

Summary | **All statements** | Gp. 1 statements

11.16 All statements provided by NGT

	A	B	C	D	E	F	G	H
1	Stat. #	Statement	Category	No. of votes	Sum of scores (z)	No. in group (n)	Average (z/n)	Top 5 (in group)
2	14B.3.05	Confidentiality e.g. patient asked if OK to inform next-of-kin	1	2	6	3	2.0	X
3	14B.2.03	Promoted privacy e.g. curtains pulled, single room at the end of life	1	2	5	3	1.7	X
4	12B.2.12	Discretion at handover – voices clear, not loud	1	1	5	3	1.7	X
5	12A.2.15	Making sure not too many staff/people around personal care	1	2	7	6	1.2	X
6	13.2.14	Covered as much as possible	1	4	13	12	1.1	X
7	14A.3.09	Use available single rooms when needed e.g. sensitive information	1	3	7	7	1.0	
8	13.2.20	Never leave in a vulnerable position	1	3	12	12	1.0	X
9	12A.2.01	Trying to keep information private, asking people to leave room without telling them why	1	3	6	6	1.0	
10	14A.3.06	Closing curtains and blinds when necessary (not just for e.g. getting dressed, when upset too)	1	2	6	7	0.9	
11	12A.2.11	Being mindful of the environment (speaking quietly)	1	2	5	6	0.8	
12	12A.3.06	Curtains provide visual privacy	1	1	4	6	0.7	
13	13.2.01	Remember to take them away – single room	1	1	5	12	0.4	
14	14A.2.13	Not discussing patients in other patients' hearing – privacy	1	1	2	7	0.3	
15	13.3.04	Door/curtains closed in ward	1	1	4	12	0.3	
16	13.3.08	Side room with door rather than curtain (privacy)	1	1	1	12	0.1	
17	14A.2.10	Ensuring patients can use the toilet privately and discretely	1	0	0	7	0.0	
18	14A.3.02	Knowledge of the importance of privacy	1	0	0	7	0.0	
19	14A.3.04	All single rooms, not just a curtain – door closed for privacy	1	0	0	7	0.0	
20	14A.3.07	Gender-specific rooms	1	0	0	7	0.0	
21	14A.3.08	Single rooms for privacy e.g. learning disabilities and end of life	1	0	0	7	0.0	

Summary | All statements | Gp. 1 statements | Gp. 2 statements | Gp. 3 statements | Gp. 4 stat ...

H8 X

	A	B	C	D	E	F	G	H
22	14A.3.10	Private area to discuss private/sensitive issues	1	0	0	7	0.0	
23	14A.3.12	Naming clinics/departments sensitively/discretely	1	0	0	7	0.0	
24	14B.2.04	Asking relatives/visitors to leave room if using commode	1	0	0	3	0.0	
25	14B.3.02	Private rooms used for discussions/information	1	0	0	3	0.0	
26	12B.3.04	Layout – separate bays with curtains	1	0	0	3	0.0	
27	12A.3.05	Single rooms would help	1	0	0	6	0.0	
28	12A.3.07	Flexibility – side rooms available for changing situations	1	0	0	6	0.0	
29	12A.3.01	Private, single room	1	0	0	6	0.0	
30	12A.2.07	Person-centred – what she wanted, make comfortable, time frame around her	2	3	9	6	3.0	X
31	14B.2.01	Treating patients with respect	2	2	7	3	2.3	X
32	14B.2.08	Asking consent	2	2	6	3	2.0	X
33	12B.2.01	Valued individual – what could we do to make it easier, personal preferences	2	3	6	3	2.0	X
34	12A.2.07	Respectful of an individual's choice	2	5	11	6	1.8	X
35	14A.2.16	Give person options, offer choices where possible	2	3	9	7	1.3	X
36	12A.2.08	Before carrying out [care] discussing it with the patient and making sure [they are] happy	2	4	8	6	1.3	X
37	13.2.12	Informed choices	2	4	13	12	1.1	X
38	14B.2.11	Informing patient of what you're going to do, give them a say	2	1	3	3	1.0	
39	12B.2.10	Respect in life and in death	2	1	3	3	1.0	X
40	13.2.05	Empowerment, giving information to make choice, take control	2	3	8	12	0.7	
41	12B.2.08	Showed respect – what the patient wanted, individual, not I'm the nurse, you're the patient	2	1	2	3	0.7	

Summary | All statements | Gp. 1 statements | Gp. 2 statements | Gp. 3 statements | Gp. 4 stat ...

42	12A.2.14	Being respectful – taking wishes into account	2	1	3	6	0.5	
43	14B.2.07	Giving patient choices	2	0	0	3	0.0	
44	14B.3.06	Capacity taken into consideration	2	0	0	3	0.0	
45	12B.2.03	Followed lead from the patient	2	0	0	3	0.0	
46	13.2.13	Patience	3	2	5	12	0.4	
47	13.2.07	Time	3	2	6	12	0.5	
48	14A.2.09	Not rushing the person – being patient	3	2	3	7	0.4	
49	14B.2.12	Having time for the patient	3	0	0	3	0.0	
50	12A.2.04	Not rushed, taking time	3	0	0	6	0.0	
51	14B.2.02	Encouraged independence	4	1	4	3	1.3	X
52	12A.2.09	Letting patient do as much as they can for themselves	4	2	8	6	1.3	X
53	13.3.11	Encouraged to do for as much as possible for themselves	4	2	6	12	0.5	
54	13.2.09	Maintaining independence	4	1	3	12	0.3	
55	14A.3.05	Single room so family could stay and come and go as they pleased	5	2	10	7	1.4	X
56	12A.2.11	Showed kindness not only to the patient but to the family as well	5	1	2	6	0.7	
57	13.2.15	Involving families	5	1	1	12	0.1	
58	14A.2.05	Checking with family about acceptability/comfort	5	0	0	7	0.0	
59	12B.2.22	Look after patient and family (family's dignity too)	5	0	0	3	0.0	
60	13.3.02	Relative nearby	5	0	0	12	0.0	
61	12B.2.02	Getting the person looking their best before relatives come back in	5	0	0	3	0.0	
62	14A.2.14	Being able to empathise with the patient – treating them as you would like to be treated	6	5	19	7	2.7	X
63	13.2.02	Sensitivity	6	4	11	12	0.9	
64	12A.2.12	Thought about how the patient was feeling	6	1	4	6	0.7	
65	13.2.19	Talking to them, less embarrassed	6	1	3	12	0.3	
66	14A.2.06	In-tune with the patient's needs e.g. quick to cover gaps in gowns etc.	6	1	1	7	0.1	
67	13.3.10	Toilet used rather than commode	6	1	1	12	0.1	
68	14A.2.15	Able to gauge how the person is feeling (might not feel able to speak	6	0	0	7	0.0	
69	12B.2.06	Making light of an embarrassing situation, laughing with them	6	0	0	3	0.0	
70	12B.2.19	Continually checking with the person, happy no concerns	6	0	0	3	0.0	
71	12A.2.05	Showed empathy – eye contact, touch, communication	6	0	0	6	0.0	
72	12A.2.13	Listened	7	1	5	6	1.7	X
73	12B.2.05	Listening to the patient, what they prefer, views into consideration	7	1	5	3	0.8	
74	13.2.06	Body language – interest - listening	7	3	3	12	0.3	
75	14B.2.13	Listening to the patient	7	0	0	3	0.0	
76	13.2.04	Genuine interest and listening	7	5	15	12	1.3	X
77	13.2.18	Remembering they're a person, not a bunch of symptoms	8	6	27	12	2.3	X
78	12A.2.21	Desire to make patients' experiences meaningful	8	3	12	6	2.0	X
79	13.2.17	Treat as an individual	8	5	18	12	1.5	X
80	12A.3.09	Personal belongings with them	8	1	4	6	1.3	X
81	14A.2.07	Respected patient – speaking to them as an adult, not a child	8	2	8	7	1.1	
82	14A.3.11	Multidisciplinary team meetings person-centred	8	0	0	7	0.0	
83	14B.2.10	Respect patient's belongings	8	0	0	3	0.0	

Summary | All statements | Gp. 1 statements | Gp. 2 statements | Gp. 3 statements | Gp. 4 stat ...

83	14B.2.10	Respect patient's belongings	8	0	0	3	0.0	
84	14B.2.17	Person-centred care	8	0	0	3	0.0	
85	13.3.09	No conversations with people outside the curtains	8	0	0	12	0.0	
86	12A.3.03	If patient required time out – Church/Chapel available	8	0	0	6	0.0	
87	12A.3.06	Offer of support from Chaplain	8	0	0	6	0.0	
88	14B.2.18	Treating people as individuals e.g. religion, dietary requirements	8	1	2	3	0.7	
89	12B.2.13	Valuing the individual	8	1	4	3	0.7	
90	14B.2.06	Patient addressed by first name	8	1	1	3	0.3	
91	12A.2.20	Using air freshener after someone has used commode	8	0	0	6	0.0	
92	14A.2.01	Taking everything into account e.g. person, place, processes (what you are doing)	9	2	9	7	1.3	X
93	12A.2.18	Staff making patient aware, supported and reassured	9	2	8	6	1.3	X
94	13.2.10	Explanation	9	2	5	12	0.4	
95	13.2.11	Being prepared (not bouncing in and out of the room)	9	1	4	12	0.3	
96	14B.2.05	Making sure pain-free, responded to promptly	9	0	0	3	0.0	
97	14B.3.03	Care plans used e.g. to prevent PUs	9	0	0	3	0.0	
98	14B.3.04	Good record-keeping	9	0	0	3	0.0	
99	13.2.03	Great knowledge of manual handling – giving suggestions (explained different ways)	9	0	0	12	0.0	
100	12B.2.03	Trying to put patients at ease, do the task as quickly as possible, make sure comfortable	9	0	0	3	0.0	
101	12A.3.08	Specialist trained staff	9	0	0	6	0.0	
102	13.2.16	Helping give back confidence	9	1	2	12	0.2	

Summary | All statements | Gp. 1 statements | Gp. 2 statements | Gp. 3 statements | Gp. 4 stat ...

	A	B	C	D	E	F	G	H
103	14B.2.09	Helping to maintain hygiene, clean and tidy	9	0	0	3	0.0	
104	12A.2.04	A focus on quality improvement improving patient care	9	0	0	6	0.0	
105	14B.2.15	Courage to be an advocate to protect dignity	10	1	3	3	1.0	
106	12A.2.16	The need to protect patients who can't protect themselves	10	1	1	6	0.2	
107	14A.2.18	Know when to get help not backing off because you don't know	10	0	0	7	0.0	
108	12B.2.23	Advocating for a person who was unconscious	10	0	0	3	0.0	
109	14A.2.08	Confident – express feelings/opinions as a student nurse (not just for qualified staff)	11	1	1	7	0.1	
110	14B.2.16	Good teamwork	11	0	0	3	0.0	
111	14B.3.07	Welcoming everyone's ideas	11	0	0	3	0.0	
112	12B.3.03	Staff working as a team	11	0	0	3	0.0	
113	12A.2.06	A caring team spirit	11	0	0	6	0.0	
114	13.3.03	Multidisciplinary team – more ideas	11	0	0	12	0.0	
115	14A.2.12	Including patient in conversations	12	3	7	7	1.0	
116	14A.2.03	Understanding each other	12	2	6	7	0.9	
117	14A.2.11	Letting patient know who you are, introducing yourself	12	2	6	7	0.9	
118	14A.2.17	Build up a relationship with patient – not too many different staff	12	0	0	7	0.0	
119	12A.2.09	Gaining understanding of need, not assuming	12	0	0	6	0.0	
120	12A.2.14	Company when required	12	0	0	6	0.0	
121	14A.2.02	Good communication	12	5	22	7	3.1	X
122	14B.2.14	Positive and caring staff attitudes	12	2	8	3	2.7	X
123	13.2.08	Honesty	12	5	15	12	1.3	X

	A	B	C	D	E	F	G	H
124	12B.2.02	Acted in a caring manner	12	1	3	3	1.0	X
125	12B.2.10	Way they spoke to the patient – caring manner	12	1	5	3	0.8	
126	14A.2.04	Staff passionate about what they are doing	12	1	5	7	0.7	
127	12A.3.08	You could see staff enjoyed surroundings	12	1	1	6	0.3	
128	12B.2.17	Staff were approachable and available	12	0	0	3	0.0	
129	14A.3.03	Environment felt safe and warm	13	1	2	7	0.3	
130	13.3.05	Calm environment	13	1	1	12	0.1	
131	12B.3.02	Calm environment	13	0	0	3	0.0	
132	12A.3.02	Peaceful and serene	13	0	0	6	0.0	
133	12A.3.10	Staff tried to keep place as quiet as possible	13	0	0	6	0.0	
134	14A.3.01	Cleanliness	14	0	0	7	0.0	
135	13.3.01	Small unit	14	1	1	12	0.1	
136	13.3.07	Equipment available (whatever needed)	14	1	1	12	0.1	
137	14B.3.01	Facilities e.g. curtains – no broken rails	14	0	0	3	0.0	
138	13.3.06	Toilet facilities near communal area	14	0	0	12	0.0	
139	12A.3.04	Facilities for audio books/music	14	0	0	6	0.0	
140	12A.3.05	Nice, bright furniture and pictures	14	0	0	6	0.0	
141	12A.3.07	Soft light, not too clinical	14	0	0	6	0.0	
142	12A.3.01	Staff – all female	14	0	0	6	0.0	

11.17 All statements by 'people', 'place' and category

People	Place
Category 1: Protecting privacy	
Promoted privacy e.g. curtains pulled, single room at the end of life 14B.2.03	Use available single rooms when needed e.g. sensitive information 14A.3.09
Discretion at handover – voices clear, not loud 12B.2.12	Closing curtains and blinds when necessary (not just for e.g. getting dressed, when upset too) 14A.3.06
Making sure not too many staff/people around personal care 12A.2.15	Confidentiality e.g. patient asked if OK to inform next-of-kin 14B.3.05
Covered as much as possible 13.2.14	Curtains provide visual privacy 12B.3.06
Trying to keep information private, asking people to leave room without telling them why 12A.2.01	Door/curtains closed in ward 13.3.04
Being mindful of the environment (speaking quietly) 12A.2.11	Side room with door rather than curtain (privacy) 13.3.08
Remember to take them away – single room 13.2.01	Knowledge of the importance of privacy 14A.3.02
Not discussing patients in other patients' hearing – privacy 14A.2.13	All single rooms, not just a curtain – door closed for privacy 14A.3.04
Ensuring patients can use the toilet privately and discretely 14A.2.10	Gender-specific rooms 14A.3.07
Asking relatives/visitors to leave room if using commode 14B.2.04	Single rooms for privacy e.g. learning disabilities and end of life 14A.3.08
	Private area to discuss private/sensitive issues 14A.3.10
	Naming clinics/departments sensitively/discretely 14A.3.12
	Private rooms used for discussions/information 14B.3.02
	Layout – separate bays with curtains 12B.3.04
	Single rooms would help 12B.3.05
	Flexibility – side rooms available for changing situations 12B.3.07
	Private, single room 12B.3.01
Category 2: Not 'I'm the nurse, you're the patient'	
Person-centred – what she wanted, make comfortable, time frame around her 12B.2.07	Capacity taken into consideration 14B.3.06

People	Place
(Category 2 continued)	
Treating patients with respect 14B.2.01	
Asking consent 14B.2.08	
Valued individual – what could we do to make it easier, personal preferences 12B.2.01	
Respectful of an individual's choice 12A.2.07	
Give person options, offer choices where possible 141.2.16	
Before carrying out [care] discussing it with the patient and making sure [they are] happy 12A.2.08	
Informed choices 13.2.12	
Informing patient of what you're going to do, give them a say 14B.2.11	
Respect in life and in death 12B.2.10	
Empowerment, giving information to make choice, take control 13.2.05	
Showed respect – what the patient wanted, individual, not I'm the nurse, you're the patient 12B.2.08	
Being respectful – taking wishes into account 12A.2.14	
Giving patient choices 14B.2.07	
Followed lead from the patient 12B.2.03	
Category 3: Taking time, not rushing	
Time 13.2.07	
Patience 13.2.13	
Not rushing the person – being patient 14A.2.09	
Having time for the patient 14B.2.12	
Not rushed, taking time 12B.2.04	

People	Place
Category 4: Encouraging independence	
Letting patient do as much as they can for themselves 12A.2.09	Encouraged to do for as much as possible for themselves 13.3.11
Encouraged independence 14B.2.02	
Maintaining independence 13.2.09	
Category 5: It's about the family's dignity too	
Showed kindness not only to the patient but to the family as well 12B.2.11	Single room so family could stay and come and go as they pleased 14A.3.05
Involving families 13.2.15	Relative nearby 13.3.02
Checking with family about acceptability/comfort 14A.2.05	
Look after patient and family (family's dignity too) 12A.2.22	
Getting the person looking their best before relatives come back in 12A.2.02	
Category 6: Being in-tune with the patient	
Being able to empathise with the patient – treating them as you would like to be treated 14A.2.14	Toilet used rather than commode 13.3.10
Sensitivity 13.2.02	
Thought about how the patient was feeling 12A.2.12	
Talking to them, less embarrassed 13.2.19	
In-tune with the patient's needs e.g. quick to cover gaps in gowns etc. 14A.2.06	
Able to gauge how the person is feeling (might not feel able to speak out) 14A.2.15	
Making light of an embarrassing situation, laughing with them 12A.2.06	
Continually checking with the person, happy no concerns 12A.2.19	
Showed empathy – eye contact, touch, communication 12B.2.05	

People	Place
Category 7: Genuine interest and listening	
Listened 12B.2.13 Genuine interest and listening 13.2.04 Listening to the patient, what they prefer, views into consideration 12A.2.05 Body language – interest - listening 13.2.06 Listening to the patient 14B.2.13	
Category 8: Remembering they're a person	
Remembering they're a person, not a bunch of symptoms 13.2.18 Desire to make patients' experiences meaningful 12A.2.21 Treat as an individual 13.2.17 Respected patient – speaking to them as an adult, not a child 14A.2.07 Treating people as individuals e.g. religion, dietary requirements 14B.2.18 Valuing the individual 12A.2.13 Patient addressed by first name 14B.2.06 Respect patient's belongings 14B.2.10 Person-centred care 14B.2.17 Treating people as individuals e.g. religion, dietary requirements 14B.2.18 Using air freshener after someone has used commode 12A.2.20	Personal belongings with them 12B.3.09 Multidisciplinary team meetings person-centred 14A.3.11 No conversations with people outside the curtains 13.3.09 If patient required time out – Church/Chapel available 12B.3.03 Offer of support from Chaplain 12B.3.06
Category 9: Being skilled	
Taking everything into account e.g. person, place, processes (what you are doing) 14A.2.01 Staff making patient aware, supported and reassured 12A.2.18 Explanation 13.2.10	Care plans used e.g. to prevent PUs 14.B.3.03 Good record-keeping 14B.3.04 Specialist trained staff 12B.3.08

People	Place
(Category 9 continued)	
Being prepared (not bouncing in and out of the room) 13.2.11	
Helping give back confidence 13.2.16	
Making sure pain-free, responded to promptly 14B.2.05	
Great knowledge of manual handling – giving suggestions (explained different ways) 13.2.03	
Trying to put patients at ease, do the task as quickly as possible, make sure comfortable 12A.2.03	
Helping to maintain hygiene, clean and tidy 14B.2.09	
A focus on quality improvement improving patient care 12A.2.04	
Category 10: Protecting people who can't protect themselves	
Never leave in a vulnerable position 13.2.20	
Courage to be an advocate to protect dignity 14B.2.15	
The need to protect patients who can't protect themselves 12A.2.16	
Know when to get help not backing off because you don't know 14A.2.18	
Advocating for a person who was unconscious 12A.2.23	
Category 11: Working in a team	
Confident express feelings/opinions as a student nurse (not just for qualified staff) 14A.2.08	Welcoming everyone's ideas 14B.3.07
Good teamwork14B.2.16	Staff working as a team 12B.3.03
A caring team spirit 12B.2.06	Multidisciplinary team – more ideas 13.3.03
Category 12: Being caring and positive	
Good communication 14A.2.02	You could see staff enjoyed surroundings 12B.3.08

People	Place
(Category 12 continued) Positive and caring staff attitudes 14B.2.14 Honesty 13.2.08 Including patient in conversations 14A.2.12 Acted in a caring manner 12B.2.02 Understanding each other 14A.2.03 Letting patient know who you are, introducing yourself 14A.2.11 Way they spoke to the patient – caring manner 12A.2.10 Staff passionate about what they are doing 14A.2.04 Build up a relationship with patient – not too many different staff 14A.2.17 Gaining understanding of need, not assuming 12B.2.09 Company when required 12B.2.14 Staff were approachable and available 12A.2.17	
Category 13: Being in a peaceful and calm environment	
	Environment felt safe and warm 14A.3.03 Calm environment 13.3.05 Calm environment 12B.3.02 Peaceful and serene 12B.3.02 Staff tried to keep place as quiet as possible 12B.3.10
Category 14: Having good facilities and equipment	
	Small unit 13.3.01 Equipment available 13.3.07 Cleanliness 14A.3.01 Facilities e.g. curtains – no broken rails 14B.3.01

People	Place
	(Category 14 continued) Toilet facilities near communal area 13.3.06 Facilities for audio books/music 12B.3.04 Nice, bright furniture and pictures 12B.3.05 Soft light, not too clinical 12B.3.07 Staff – all female 12B.3.01

11.18 Guide to Q-sorting

Guide to Q-sorting

I am interested in your thoughts about important aspects of the role of the nurse in preserving dignity in care.

You have been provided with:

- A set of 44 cards. Each card contains a statement describing an aspect of the nurse's role in promoting dignity in care. On the reverse of each card there is a number to identify the statement.
- A blank table ("sorting grid") consisting of 44 boxes and a scale running from +5 (most agree) to -5 (least agree).

Your task is to consider how much you agree with the statement on each card. You will then allocate each card to one of the boxes in the table according to ***how strongly you agree that the statement describes an important aspect of the nurse's role in promoting dignity in care.***

Step 1

Please read each card and then sort them into 3 piles as follows:

1. The cards containing the statements you **most agree** are important (put these in a single pile on your right- hand side)
2. The cards containing the statements you **least agree** are important (put these in a single pile on your left-hand side)
3. The cards containing statements you are **neutral** about or are unsure of (put these in a single pile directly in front of you)

There are no restrictions on how many cards you put in each pile.

Step 2

Take the pile of cards containing the statements you **most agree** with and move the other 2 piles to the side (making sure you keep them separate and know which is which!).

Spread these cards out in front of you so you can see them all at once.

Pick the card you agree with **most** strongly. This is the card containing the statement you think describes the most important aspect of the nurse's role in promoting dignity in care.

Place this card in the +5 box on the sorting grid, followed by the next 2 most agreeable cards in the +4 box. Continue to do this until you have placed all the cards in your **most agree** pile on the sorting grid.

- If you find it difficult to decide between 2 cards, read them again and try placing them in different positions on the sorting grid. This often helps people develop a better sense of which one they feel most strongly about.

Guide to Q-sorting

- Try not to spend too much time deciding about whether a card should be placed in a +4 or +3 box. I will be able to gain a general idea of your views whichever one you place in the lower position.
- There is no need to worry if the cards in your **most agree** pile cross over into the negative rankings (or if the cards in your **least agree** pile cross over into the positive rankings). When you place a card in the +2 box it just means that you agree with it slightly more than you agree with a card you place in the +1 box and slightly less than a card you placed in the +3 box.

Step 3

Repeat Step 2 but now with your **least agree** pile of cards.

Spread these cards out in front of you so you can see them all at once.

Pick the card you agree with **least** strongly. This is the card containing the statement you think describes the least important aspect of the nurse's role in promoting dignity in care.

Place this card in the -5 box on the sorting grid, followed by the next 2 most agreeable cards in the -4 box. Continue to do this until you have placed all the cards in your **least agree** pile on the sorting grid.

Step 4

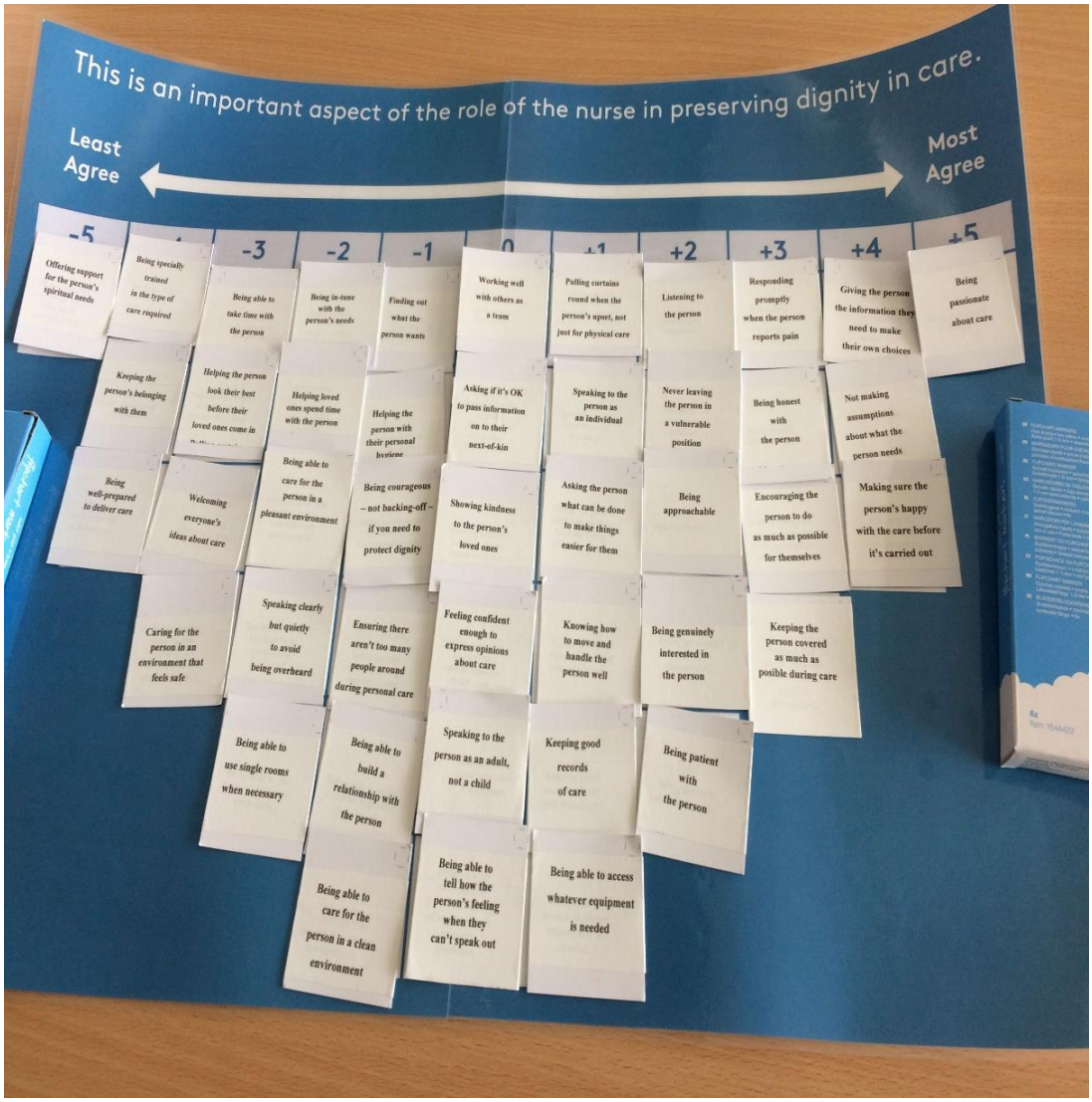
Repeat Step 2 with your **neutral** pile of cards.

Step 5

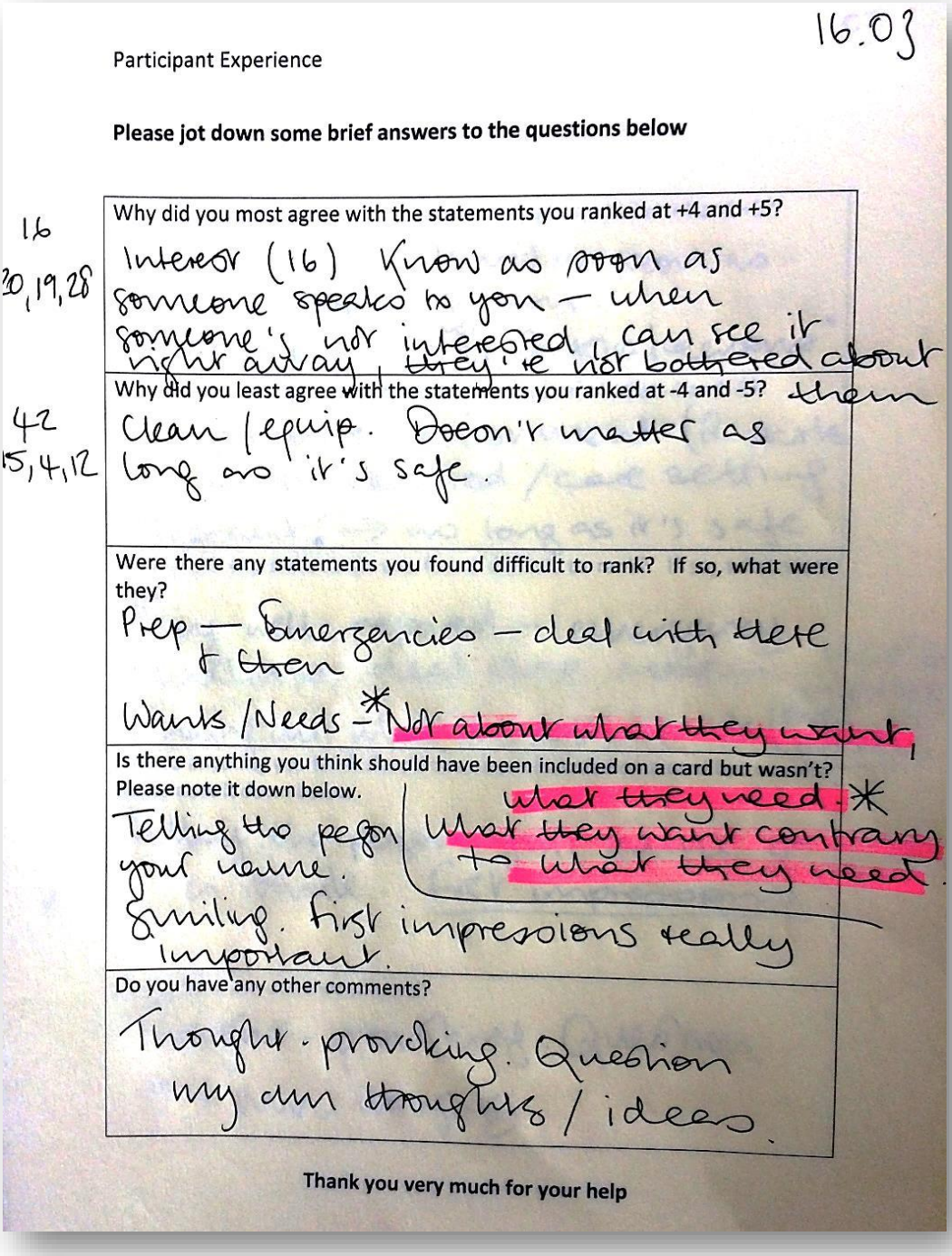
You will now have a completed sorting grid in front of you with every box containing a card. If you would like to adjust the ranking of any item, please do so now. Next, please write the number of each card in the relevant box.

Thank you

11.19 Example of a completed Q-sort



11.20 Example of completed post-sort interview schedule



16.03

Participant Experience

Please jot down some brief answers to the questions below

16
20, 19, 28

Why did you most agree with the statements you ranked at +4 and +5?

Interior (16) Know as soon as someone speaks to you – when someone's not interested, can see it right away, they're not bothered about them

42
15, 4, 12

Why did you least agree with the statements you ranked at -4 and -5?

Clean / equip. Doesn't matter as long as it's safe.

Were there any statements you found difficult to rank? If so, what were they?

Prep – Emergencies – deal with there & then

Wants / Needs – * Not about what they want, what they need. *

Is there anything you think should have been included on a card but wasn't? Please note it down below.

Telling the person your name.

Smiling. First impressions really important.

What they want contrary to what they need.

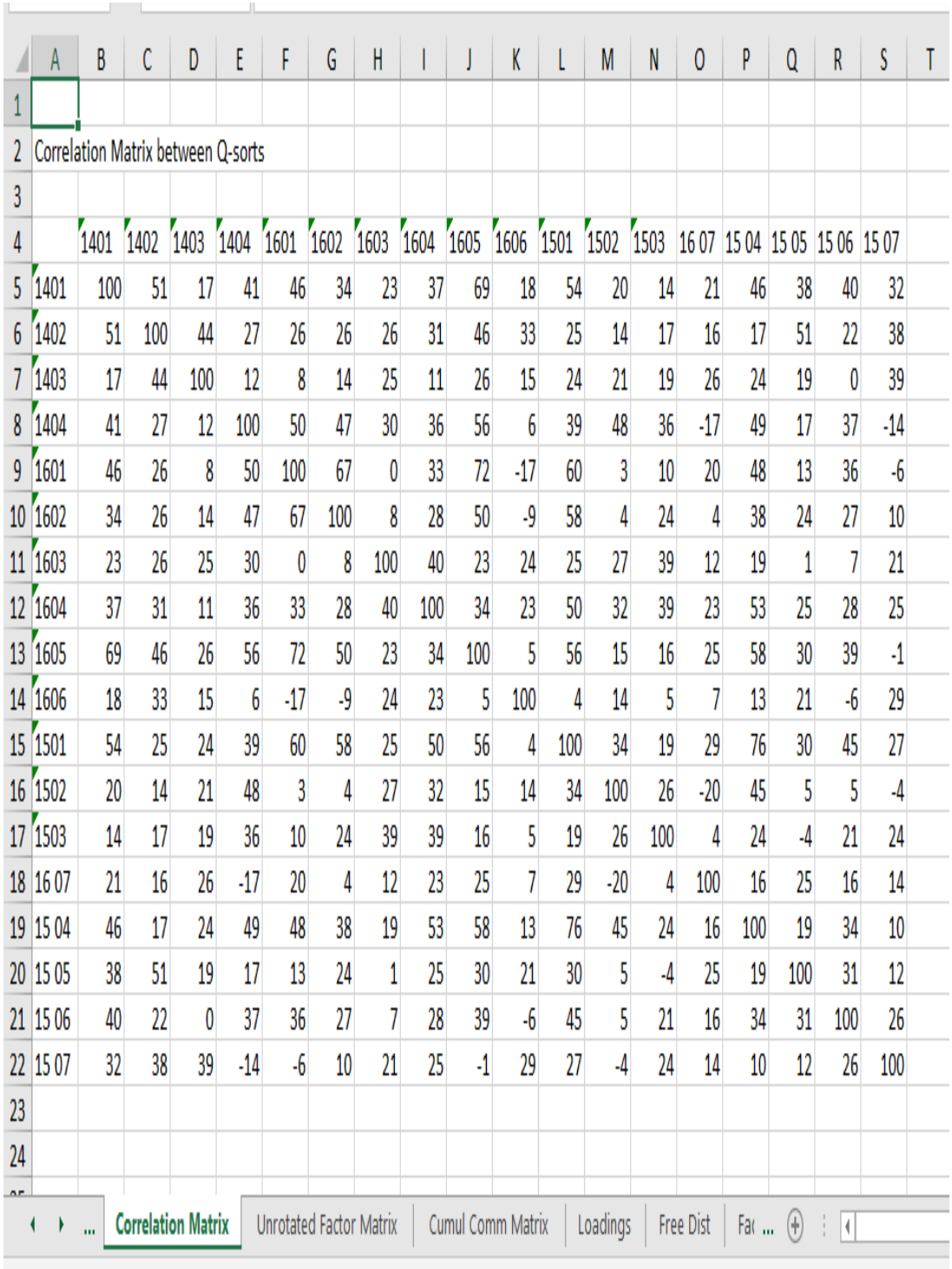
Do you have any other comments?

Thought-provoking. Question my own thoughts / ideas.

Thank you very much for your help

11.21 Complete correlation matrix

Correlation matrix printed from Ken-Q (Banasick, 2017)



Correlation Matrix between Q-sorts

	1401	1402	1403	1404	1601	1602	1603	1604	1605	1606	1501	1502	1503	16 07	15 04	15 05	15 06	15 07
1401	100	51	17	41	46	34	23	37	69	18	54	20	14	21	46	38	40	32
1402	51	100	44	27	26	26	26	31	46	33	25	14	17	16	17	51	22	38
1403	17	44	100	12	8	14	25	11	26	15	24	21	19	26	24	19	0	39
1404	41	27	12	100	50	47	30	36	56	6	39	48	36	-17	49	17	37	-14
1601	46	26	8	50	100	67	0	33	72	-17	60	3	10	20	48	13	36	-6
1602	34	26	14	47	67	100	8	28	50	-9	58	4	24	4	38	24	27	10
1603	23	26	25	30	0	8	100	40	23	24	25	27	39	12	19	1	7	21
1604	37	31	11	36	33	28	40	100	34	23	50	32	39	23	53	25	28	25
1605	69	46	26	56	72	50	23	34	100	5	56	15	16	25	58	30	39	-1
1606	18	33	15	6	-17	-9	24	23	5	100	4	14	5	7	13	21	-6	29
1501	54	25	24	39	60	58	25	50	56	4	100	34	19	29	76	30	45	27
1502	20	14	21	48	3	4	27	32	15	14	34	100	26	-20	45	5	5	-4
1503	14	17	19	36	10	24	39	39	16	5	19	26	100	4	24	-4	21	24
16 07	21	16	26	-17	20	4	12	23	25	7	29	-20	4	100	16	25	16	14
15 04	46	17	24	49	48	38	19	53	58	13	76	45	24	16	100	19	34	10
15 05	38	51	19	17	13	24	1	25	30	21	30	5	-4	25	19	100	31	12
15 06	40	22	0	37	36	27	7	28	39	-6	45	5	21	16	34	31	100	26
15 07	32	38	39	-14	-6	10	21	25	-1	29	27	-4	24	14	10	12	26	100

11.22 Complete table of unrotated factor loadings

Unrotated Factor Matrix presented in Ken-Q (Banasick, 2017)

	A	B	C	D	E	F
1						
2	Unrotated Factor Matrix					
3						
4	Respondent	Factor 1	Factor 2	Factor 3	Factor 4	
5	1401	0.7351	-0.1194	-0.196	-0.0177	
6	1402	0.5973	0.3627	-0.2739	0.3828	
7	1403	0.3776	0.3909	-0.1803	0.0272	
8	1404	0.6174	-0.2293	0.413	0.207	
9	1405	0.7798	0.1524	0.088	0.3636	
10	1501	0.7882	-0.2139	-0.0723	-0.2963	
11	1502	0.3191	0.0133	0.5158	-0.047	
12	1503	0.4019	0.1247	0.2371	-0.1971	
13	1504	0.7008	-0.1578	0.1626	-0.1467	
14	1505	0.4205	0.0888	-0.2154	0.2152	
15	1506	0.4822	-0.1962	-0.0182	-0.0132	
16	1507	0.3039	0.3163	-0.2845	-0.2735	
17	1508	-0.0473	0.0696	0.1681	0.3224	
18	1509	0.461	-0.3262	0.1226	0.1586	
19	1601	0.5643	-0.5793	-0.183	0.1027	
20	1602	0.5575	-0.3275	-0.0591	0.1821	
21	1603	0.3949	0.361	0.2571	-0.0929	
22	1604	0.6365	0.1855	0.2137	-0.204	
23	1605	0.7572	-0.3021	-0.0303	0.2733	
24	1606	0.2	0.4459	0.0502	0.0232	
25	1607	0.2403	0.0754	-0.4614	-0.2198	
26	Eigenvalues	5.9825	1.6219	1.2142	0.9409	
27	% Explained Variance	28	8	6	4	

... | Q-sorts | Correlation Matrix | **Unrotated Factor Matrix** | Cumul Com

11.23 Cumulative communalities matrix for four factors

Unrotated Factor Matrix presented in Ken-Q (Banasick, 2017)

	A	B	C	D	E
1					
2	Cumulative Communalities Matrix				
3					
4	Respondent	Factor 1	Factor 2	Factor 3	Factor 4
5	1401	0.5404	0.5547	0.5931	0.5934
6	1402	0.3567	0.4883	0.5633	0.7098
7	1403	0.1426	0.2954	0.3279	0.3286
8	1404	0.3812	0.4338	0.6044	0.6473
9	1405	0.608	0.6312	0.6389	0.7711
10	1501	0.6212	0.6669	0.6721	0.7599
11	1502	0.1018	0.102	0.368	0.3702
12	1503	0.1615	0.177	0.2332	0.2721
13	1504	0.4911	0.516	0.5424	0.5639
14	1505	0.1768	0.1847	0.2311	0.2774
15	1506	0.2325	0.271	0.2713	0.2715
16	1507	0.0924	0.1924	0.2734	0.3482
17	1508	0.0022	0.007	0.0352	0.1391
18	1509	0.2125	0.3189	0.3339	0.359
19	1601	0.3185	0.6541	0.6876	0.6982
20	1602	0.3108	0.418	0.4215	0.4547
21	1603	0.156	0.2864	0.3525	0.3611
22	1604	0.4051	0.4395	0.4852	0.5268
23	1605	0.5733	0.6646	0.6655	0.7402
24	1606	0.04	0.2389	0.2414	0.2419
25	1607	0.0577	0.0634	0.2763	0.3246
26	cumulative % explained variance	28	36	42	46
27					

... | Statements | Q-sorts | Correlation Matrix | Unrotated Factor Matrix | C

11.24 Overview of factor arrays

Overview of Factor Arrays provided by PQ Method (Schmolck, 2012)

Appendix Factor Q-sort Values for Each Statement - Notepad

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Factor Q-Sort Values for Each Statement

No.	Statement	No.	Factor Arrays 1	2	3	4
1	Being able to tell how the person is feeling when they can't	1	0	1	2	-3
2	Being able to take time with the person	2	-1	-2	1	-2
3	Being well-prepared to deliver care	3	-2	-2	0	2
4	Being able to care for the person in a clean environment	4	-3	0	-4	1
5	Never leaving the person in a vulnerable position	5	4	3	2	4
6	Responding promptly when the person reports pain	6	0	2	0	2
7	Pulling curtains around when the person's upset	7	3	-1	0	3
8	Speaking to the person as an adult, not a child	8	3	0	1	0
9	Listening to the person	9	3	3	3	0
10	Welcoming everyone's ideas about care	10	-2	-3	-2	0
11	Helping the person with their personal hygiene	11	1	-1	-2	4
12	Being able to access whatever equipment is needed	12	-5	0	-4	-4
13	Giving the person the information they need to make their ow	13	1	4	3	1
14	Working well with others in a team	14	-2	0	-2	-1
15	Finding out what the person wants	15	5	-1	0	-2
16	Being genuinely interested in the person	16	0	1	5	1
17	Keeping the person covered as much as possible during care	17	4	3	0	2
18	Keeping good records of care	18	-3	2	-1	0
19	Speaking to the person as an individual	19	4	1	4	-1
20	Being passionate about care	20	-2	5	4	4
21	Helping the person look their best before their loved ones c	21	2	-4	-1	0
22	Caring for the person in an environment that feels safe	22	-1	-2	1	-3
23	Being honest with the person	23	3	2	1	-2
24	Being able to use single rooms when necessary	24	-4	-3	-4	-4
25	Knowing how to move and handle the person well	25	-4	1	-1	3
26	Being patient with the person	26	2	2	2	1
27	Showing kindness to the person's loved ones	27	-2	0	1	-1
28	Being in-tune with the person's needs	28	-1	-1	2	-1
29	Being courageous (not backing-off) if you need to protect di	29	1	0	0	5
30	Feeling confident enough to express opinions about care	30	-3	1	-2	3
31	Asking the person what can be done to make things easier for	31	1	1	2	-3
32	Making sure the person's happy with the care before it's car	32	2	4	1	1
33	Ensuring there aren't too many people around during personal	33	2	-2	-3	3
34	Speaking clearly but quietly to avoid being overheard	34	-1	-3	-1	-2
35	Encouraging the person to do as much as possible for themsel	35	1	3	-3	2
36	Offering support for the person's spiritual needs	36	-1	-5	-1	-2
37	Keeping the person's belongings with them	37	-1	-4	-2	-5
38	Asking if it's OK to pass information on to their next-of-ki	38	1	-1	-3	-4
39	Being able to build a relationship with the person	39	0	-1	4	0
40	Helping loved ones to spend time with the person	40	0	-2	-1	-1
41	Being specially trained in the type of care required	41	-4	-4	3	1
42	Being able to care for the person in a pleasant environment	42	-3	-3	-5	-3
43	Being approachable	43	0	2	3	1
44	Not making assumptions about what the person needs	44	2	4	-3	-1

11.25 Crib Sheets

Crib Sheet Factor 1

	Stat. #	Statements
Item ranked at +5	15	Finding out what the person wants
Items ranked higher in Factor 1 than any other	19	Speaking to the person as an individual
	5	Never leaving the person in a vulnerable position
	17	Keeping the person covered as much as possible during care
	7	Pulling curtains around when the person's upset
	9	Listening to the person
	23	Being honest with the person
	8	Speaking to the person as an adult, not a child
	26	Being patient with the person
	21	Helping the person look their best before their loved ones come in
	38	Asking if it's OK to pass information on to their next-of-kin
	40	Helping loved ones to spend time with the person
Items ranked lower in Factor 1 than any other	6	Responding promptly when the person reports pain
	43	Being approachable
	16	Being genuinely interested in the person
	28	Being in-tune with the person's needs
	27	Showing kindness to the person's loved ones
	20	Being passionate about care
	14	Working well with others in a team
	3	Being well-prepared to deliver care
	30	Feeling confident enough to express opinions about care
	18	Keeping good records of care
	24	Being able to use single rooms when necessary
	25	Knowing how to move and handle the person well
	41	Being specially trained in the type of care required
Item ranked -5	12	Being able to access whatever equipment is needed

Person-centred/focused Initial thoughts – What's important: Respect – person-focused, focus on the person being cared for, communication with the person, what's important to the person. What's less important: Tasks (interesting re kindness to relatives – is this because the participants' concern is with the person in their care, not others? Is there an assumption that this follows naturally from care of the person? Are loved ones only important in so far as they are important to the person in their care?

Crib Sheet Factor 2

	Stat. #	Statements
Item ranked at +5	20	Being passionate about care
Items ranked higher in Factor 2 than any other	12	Being able to access whatever equipment is necessary
	13	Giving the person the information they need to make their own choices
	14	Working well with others in a team
	24	Being able to use single rooms when necessary
	32	Making sure the person's happy with the care before it's carried out
	35	Encouraging the person to do as much as possible for themselves
	44	Not making assumptions about what the person needs
Items ranked lower in Factor 2 than any other	7	Pulling curtains around when the person's upset, not just for physical care
	10	Welcoming everyone's ideas about care
	21	Helping the person look their best before their loved ones come in
	34	Speaking clearly but quietly to avoid being overheard
	39	Being able to build a relationship with the person
	40	Helping loved ones spend time with the person
Item ranked -5	36	Offering support for the person's spiritual needs

Initial thoughts – Care provision, 'I want to provide good care' – not as much focus on the person, seems to focus on keeping the personal and professional separate. Skills to provide good care. Quality-focused. What's less important: Spiritual, more abstract elements of care less important than this 'good care' that the participants want to deliver.

Crib Sheet Factor 3

	Stat. #	Statements
Item ranked at +5	16	Being genuinely interested in the person
Items ranked higher in Factor 3 than any other	1	Being able to tell how the person is feeling when they can't tell you
	2	Being able to take time with the person
	22	Caring for the person in an environment that feels safe
	27	Showing kindness to the person's loved ones
	28	Being in-tune with the person's needs
	31	Asking the person what can be done to make things easier for them
	34	Speaking clearly but quietly to avoid being overheard
	39	Being able to build a relationship with the person
	41	Being specially trained in the type of care required
	43	Being approachable
Items ranked lower in Factor 3 than any other	4	Being able to care for the person in a clean environment
	5	Never leaving the person in a vulnerable position
	11	Helping the person with their personal hygiene
	17	Keeping the person covered as much as possible during care
	33	Ensuring there aren't too many people around during personal
	35	Encouraging the person to do as much as possible for themselves
	44	Not making assumptions about what the person needs
Item ranked -5	42	Being able to care for the person in a pleasant environment

Initial thoughts – 'Personal intuitive care'. What's important: Compare with Factor 1 'Doing for': How the participant feels and thinks and how they sense the person's thoughts and feelings. Is this more 'Being with'? Sensing the person's needs, more emphasis on intuition and empathy? What's less important: Are these things participants thought would not happen if they got the other things right?

Crib Sheet Factor 4

	Stat. #	Statements
Item ranked at +5	29	Being courageous (not backing-off) if you need to protect dignity
Items ranked higher in Factor 4 than any other	3	Being well-prepared to deliver care
	4	Being able to care for the person in a clean environment
	10	Welcoming everyone's ideas about care
	11	Helping the person with their personal hygiene
	25	Knowing how to move and handle the person well
	30	Feeling confident enough to express opinions about care
	33	Ensuring there aren't too many people around during personal care
Items ranked lower in Factor 4 than any other	1	Being able to tell how the person is feeling when they can't tell you
	9	Listening to the person
	13	Giving the person the information they need to make their own decisions
	15	Finding out what the person wants
	19	Speaking to the person as an individual
	22	Caring for the person in an environment that feels safe
	23	Being honest with the person
	26	Being patient with the person
	31	Asking the person what can be done to make things easier for
	38	Asking if it's OK to pass information on to their next-of-kin
Item ranked -5	37	Keeping the person's belongings with them

Initial thoughts – 'Courageous leadership in care' So different (+5) from the other 3. What's important: Emphasis on managing care, focus on tasks, efficiency, organising and prioritising care. Being capable and confident. What's less important: non-physical aspects of care.