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The Patient Dignity Project

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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Abstract

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MS, Grand Canyon University, 2017

BS, Pennsylvania College of Technology, 2009

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

The delivery of patient-centered care is central to many healthcare initiatives. However, the national nursing shortage and the task-oriented nature of the nursing process can make the delivery of this type of care difficult. Nursing as a caring science *requires* nurses to have an in-depth understanding of how the care they provide impacts patient dignity. Although the Patient Dignity Question is effective as a dignity-preserving intervention, the project facility offered no orientation or educational opportunities that specifically related to patient dignity. This project was a multimodal educational intervention on protecting patient dignity with pre- and posteducation survey assessments. The practice-focused question asked if nurses were more likely to incorporate strategies to address patient dignity in patient care after the education than before. For this project, Lewin's model for planned change was used. Thirteen nurses completed a multi-modal education program over the course of two weeks. Comparative inferential analysis of the data revealed a few items that were of statistical significance between the pre-/post education survey results and a few others with larger differences in means and moderately low *p*-values, that though close, were not considered to be statistically significant. Upon completion of the multi-modal education program there was a shift in perspective that allowed nurses to reflect on the factors they felt most impacted the delivery of dignity-preserving care. This project has promoted positive social change by broadening the focus of patient dignity to encompass all patients within the acute care setting rather than only those receiving palliative or hospice care services.

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Dedication

To my wife and daughter who stood patiently by as I successfully navigated and completed the doctoral program in addition to being a wife and mother and working full time hours. To my mentor Juliann, who took the time to review my doctoral work and provide constructive feedback, going above and beyond her duties as the Director of Magnet. Lastly, the unit director and staff of the Progressive Care Unit for taking the time to provide their insight and helping to bring patient dignity to the forefront of patient care.

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Section 1: Nature of the Project

Introduction

Delivering individualized, patient-centered care is a crucial element of the overall patient experience. The competing demands of the acute care setting such as nurse-to-patient ratio and patient acuity can present a challenge. Despite this, it is important for nurses to deliver care that embraces the concept of human dignity, a patient's sense of human worth and value (Albers et al., 2011). There are multiple factors that may impact an individual's sense of dignity, including disease, disability, aging, and physical suffering.

A holistic, patient-centered approach to care can help identify specific areas of concern for the patient. According to Johnston, Gaffney, et al., (2015), dignity-preserving interventions like the Patient Dignity Question (PDQ) were developed based on research of patients' perceptions of their dignity at end-of-life to assist healthcare providers in getting to know their patients on a personal level and helping the nurses look beyond the patient's symptoms or disease process. This project assisted nurses in recognizing the importance of providing care that reflects both the patient's values and preferences as part of an experience that is meant to enhance rather than diminish their sense of self-worth.

Care that incorporates patient dignity has the potential to positively impact total patient care and the overall patient experience. This project is in line with Walden University's mission to help promote positive social change by advocating for greater

attention to assessment and recognition of patient values and person-centered care strategies.

Problem Statement

The provision of personal, individualized care is a necessary component of effective healthcare and is central to many policies. Patient experience has become a metric to measure payment systems for quality as reimbursement and performance policies become more prescriptive (Berkowitz, 2016). Because of this, healthcare providers are called upon to provide care that embraces a patient's sense of worth. This includes preserving human dignity, a concept central to nursing practice (Parandeh et al., 2016). Preservation of dignity is the most cited reason for drafting an advanced directive (Albers et al., 2011). This allows patients an element of control as their age progresses and their health begins to decline. One dignity-preserving intervention, the PDQ, originated from research that examined patient perception of dignity at end-of-life (Johnston, Gaffney, et al., 2015). Its use has assisted healthcare providers to better understand the patient as a person and not by their illness (Johnston, Pringle, et al., 2015). Dignity-preserving interventions like the PDQ set the stage for nurses and other healthcare providers to be able to provide total patient-centered care. The problem addressed in this project is that the study site facility offers no orientation or educational opportunities that specifically relate to patient dignity.

Purpose Statement

The practice-focused question was as follows:

PFQ: Are nurses who are educated on the importance of patient dignity in the overall patient experience as well as strategies to address patient dignity in patient care more likely to incorporate these actions into their practice than before they were educated?

The purpose of this project was to assist nurses to provide care that is reflective of the patient's values and preferences and to enhance their sense of self-worth.

The Patient Dignity Project helped to promote social change by providing nurses insight into the importance of patient dignity through the development and implementation of an educational program highlighting these points. Incorporation of dignity-preserving behaviors into the nurses' workflow has the potential to positively impact total patient care and the overall patient experience. This project is in line with Walden University's mission topromote positive social change by strengthening awareness and improving the nurses' attention to assessment and recognition of patient values and person-centered care strategies.

Nature of the Doctoral Project

Sources of evidence for this project were drawn from the existing literature. For the review of the literature, Thoreau at Walden Library and Google Scholar were utilized in the search for resources. Key words included *patient dignity question* and *patient dignity in acute care*. Only full text, peer-reviewed scholarly articles were reviewed. Another source of evidence was the data that was collected pre- and posteducation at the project site.

I used the Walden *Manual for Staff Education* (Walden University, 2019) as a guide for this project. The project was developed in steps. First, I obtained baseline data. A pre-education survey was administered to nurses working on the Progressive Care Unit to assess their attitudes on patient dignity and how often they feel they take patient dignity into account when providing care. Next, a multimodal education program was developed highlighting the impact of taking patient dignity into account on both patient outcomes and the overall patient experience.

According to Sharma (2017), a multimodal educational approach has proven most effective, as not all individuals learn in the same way. I also incorporated emotional influence into this educational experience to help maximize learner engagement and improve learning and long-term retention of the material. Emotion is well-documented as having a substantial influence on cognitive processes. These influences include perception, attention, learning, memory, reasoning, and problem-solving (Tyng et al., 2017). According to Tyng et al. (2017), "Emotion has a particularly strong influence on attention, especially modulating the selectivity of attention as well as motivating action and behavior" (para. 1). The third step in the development of this project was implementation of the education program.

Education was provided over 2 weeks to allow ample time for staff to review and receive clarification as needed. After the 2-week period, a posteducation survey was administered to assess whether the education provided had impacted the nurses' attitudes on patient dignity and whether they were more mindful about taking patient dignity into account when providing care. The purpose of this project was to support nurses in

providing care that reflects the patient's values and preferences and enhances the patient's sense of self-worth. Tapping into the emotional aspect of patient dignity helped close this knowledge gap and provide nurses the understanding of how meaningful patient dignity is to overall patient care.

Significance

Nurses are considered caring and compassionate individuals, and patients and their families often seek their encouragement and support when experiencing physical, emotional, and spiritual distress. However, nursing shortages are on the rise and nurses are feeling pressured to do more with less. These factors make it more easily understood how nurses go about their day checking off tasks without fully seeing the person in front of them (Harris & Quinn, 2015). Dignity-preserving interventions like the PDQ can be used to improve patient/family communication by allowing the nurse to get to know the patient as a person (Johnston, Pringle, et al., 2015). Nurses using dignity-preserving interventions like the PDQ would have the opportunity to assess the impact on routine clinical care through daily nurse leader rounding and continuous feedback.

To fully grasp the impact of dignity-preserving behaviors on routine clinical care, nursing education was required. In addition to the nurses, the director of nursing, the director of nursing education, and the director of the Progressive Care Unit were also key stakeholders in this project, as their approval was required to proceed. Once education is provided and the process of incorporating dignity-preserving interventions into the daily plan of care is hardwired and rolled out to all inpatient units, it is suggested that all direct care providers be educated on the importance of dignity in practice. While nurses were

the focus of this quality improvement project, there are others who will benefit from its efforts. This includes the patients and their families, as they will be most impacted by this change as the organization continues its shift toward a more patient-centered approach to care.

Summary

Many factors can influence patient dignity including age, illness, and the related disability or physical suffering. The Patient Dignity Project was born out of the need to address these issues for patients in the acute care setting so that healthcare providers could get to know more about the patient than just their diagnosis. This project helped promote a social change on the Progressive Care Unit through the evaluation of how often nurses feel they are taking patient dignity into account and the development and implementation of a comprehensive educational program and posteducation survey. Incorporation of dignity-preserving interventions into the nurses' workflow can have a positive impact not only on total patient care but the overall patient experience.

Section 2: Background and Context

Introduction

The purpose of this project was to educate nurses to provide care that reflects the patient's values and preferences and enhance patients' sense of self-worth. This project provided nurses valuable insight into the importance of patient dignity and how it influences the care they provide. Factors that impact dignity are as unique as the individual. Physical suffering and loss of control of bodily functions can impact a patient's sense of dignity, making them feel like they no longer control their own body. A patient may feel so desperate to preserve their dignity that they contemplate extreme efforts to make that happen. According to Johnston, Gaffney, et al., 2015, patients have gone as far as discussing physician-assisted suicide in an effort to preserve their dignity and maintain a sense of control over a body that they feel has betrayed them. Much of the research on patient dignity has its origin in end-of-life care. Positive feedback from the literature review indicated that integration of dignity-preserving interventions like the PDQ could benefit all patients in the acute care setting, making acknowledgement of patient dignity more relevant to everyday practice.

Concepts, Models, and Theories

For this project, Lewin's (Wojciechowski et al., 2016) model for planned change was used as a theoretical framework. Lewin's theory suggests that there are restraining forces that counter the driving forces of change to maintain the status quo. The tension that is created when the driving forces meet restraint creates an equilibrium. Lewin's

three-step model can be used to help redefine a new status quo (Wojciechowski et al., 2016).

The first step of the model is unfreezing, which is meant to create awareness of an issue (Wojciechowski et al., 2016). . In order to create awareness on the importance of patient dignity to the overall patient experience, a dialog and baseline knowledge were established. I began speaking to nurses on the Progressive Care Unit prior to implementation of my DNP capstone project regarding their perceptions of how they felt they incorporated patient dignity into the care that they provided. It was revealed that many of them believed that they always took patient dignity into account through actions such as providing for patient privacy during toileting or bathing. When asked about patient interaction and whether nurses inquired how the patient would prefer to be addressed or whether they asked patient permission before touching them, it was revealed that very few took this into consideration. When I inquired about their reasoning, a variation of the same answer was given. Nurses feel as if they are running on autopilot, and they just "do." They have the same routine for every patient they see. The provision of total patient care requires a holistic approach. Nurses get so involved in their tasks that there is a need to remind them that they are providing treatment for a person and not just treating a diagnosis.

The second step of the model is changing/moving. This step demonstrates the benefit(s) of change and aims to decrease the impact of restraining forces (Wojciechowski et al., 2016). . To demonstrate the benefits of addressing patient dignity

as part of the overall patient experience, I designed a thoughtful, evidence-based, multimodal education experience with the "busy nurse" in mind.

The goal of this education was to reintroduce the importance of nursing theory to bedside practice. Appealing to their emotions through education helped remind these nurses why they went into nursing—to care for patients and their families in their time of need. The director of nursing once mentioned during a conversation related to the development of education that "if you appeal to human emotion, they will remember." According to Tyng et al. (2017), there is much evidence to support that emotional influence in education can maximize learner engagement and improve learning and long-term retention of the material. Experiences evoking emotion are often recalled more accurately and remembered more vividly.

The third and final step of this model is refreezing. This is the phase where validation occurs (Wojciechowski et al., 2016). During this step, a posteducation survey was administered to nurses to assess whether the education provided had impacted their attitudes on patient dignity and whether they are mindful about taking patient dignity into account when providing care.

Relevance to Nursing Practice

The literature acknowledges the importance of providing patient-centered care in the acute care setting; however, there is a lack of evidence showing that this is carried out consistently in everyday practice (Johnston, Pringle, et al., 2015). The findings from Johnston, Gaffney et al.'s (2015) feasibility study, which examined both the feasibility and acceptability of the PDQ as a patient-centered intervention for patients with palliative

needs in the acute care setting, emphasized the importance of valuing the patient as a person. Patients in this study perceived better relationships and communication with their care team. The results of this study suggested that the PDQ as a dignity-preserving intervention can enhance communication between patients and healthcare providers by providing an awareness of the patient as an individual. To achieve results such as this, staff must be aware of a patient's individual experiences, struggles, and goals (Johnston, Pringle, et al. 2015). Only then can nurses provide the kind of care that enhances patient dignity.

Dignity-preserving interventions like the PDQ were designed to assist healthcare providers to look beyond the patient's condition and see them as a person (Johnston, Gaffney, et al., 2015). Sadly, dignity-preserving interventions like the PDQ are often only considered when patients require palliative care services (Johnston, Pringle, et al., 2015). With patient-centered care at the forefront of many organizations, nurses need to understand the importance of patient dignity, and what it means to every patient (Albers et al., 2011). The promotion of dignity-preserving interventions aligns with the values and mission of the project facility, which emphasizes the importance of placing patients and their families first.

Local Background and Context

Short-staffing, high patient acuity, and organizational expectations to do more with less enable nurses on the Progressive Care Unit to perform only the bare minimum to complete their tasks. Situations like this make it easy to understand how nurses may go about their day without actually seeing the person in front of them (Harris & Quinn,

2015). With new graduate nurses, orientation has been condensed and the number of hours reduced, so the focus has shifted to completing tasks such as focused physical assessments and safe medication administration. While these are important, and in some cases life-saving tasks, they are often completed without regard for patient dignity. Nurses become fixated on diagnoses and treatments, vital signs, and laboratory results but may be unaware of a single personal detail related to the patient. Nurse residency programs aim to help nurses think "big picture." According to the Davood (n.d.), nurse residency programs were developed to help increase decision-making confidence and competence, as well as enhance critical thinking skills. Nurse residency programs can improve the quality and safety of patient care and positively impact the overall patient experience. The Vizient nurse residency program was developed by Vizient and the American Association of Colleges of Nursing (AACN) to help nurses transition into their professional role. The Pennsylvania Action Coalition has partnered with Vizient, Inc. to increase the number healthcare institutions with nurse residency programs in Pennsylvania (Davood, n.d). A nurse residency program was introduced at the project facility in 2017 to help support new nurses. However, the feedback from these programs has been less than desirable. As a facilitator of the nurse residency program, I can attest to its underwhelming results. While the organization and Vizient prescribe the monthly topics, each individual institution is encouraged to make the program their own, which is an evolving process. Incorporation of my education project throughout this program has the potential to address and reinforce the importance of dignity-preserving interventions to the nursing process.

Nurses as front-line staff are in an ideal position to implement dignity-preserving interventions like the PDQ. However, there are no systematic processes or support for the bedside staff nurse in the project facility that specifically address patient dignity. The setting for this project was a 24-bed progressive care department, a critical care step-down unit located in a regional medical center in Northcentral Pennsylvania. The primary patient population served includes patients with various cardiovascular and pulmonary conditions.

Role of the Doctor of Nursing Practice Student

As the educator of the Progressive Care Unit, I must actively participate in both departmental and practice-specific quality improvement initiatives. As a DNP student, I have been provided the knowledge and the tools to identify opportunities for quality improvement and present those findings to members of the leadership team. According to the AACN (2006), DNP-prepared nurses must be proficient in quality improvement strategies at the organizational level, impacting changes that are sustainable, effective, and realistic at the point of care.

This project began in 2016 as my master's thesis. It has always been my intention to see this project through to the end, and I am honored to not only be part of the process, but to be leading this change. In my first few years of nursing, I was convinced that theory had no place at the bedside. I could not have been more wrong. As I have progressed in my academic journey, I have gotten to experience just how important theory is. Reintroduction to the importance of nursing theory to practice has ensured that every patient I come in contact with knows that I am there to care for them, mind, body,

and spirit. Dignity-preserving interventions like the PDQ can help nurses provide more individualized and patient-centered care.

For this project, I provided a pre-education survey to obtain baseline data related the nurses' perception of the importance of patient dignity to their practice and how often they feel they take patient dignity into account when providing care. From there, I developed a multimodal education program to present to the nurses working on the Progressive Care Unit. The director of nursing once said to me that if you want to make an impact, appeal to human emotion so the nurses will remember an education or training. According to Tyng et al., (2017), emotion has a strong impact on attention and can motivate actions and behavior. Once the nurses completed their education, a posteducation survey was administered to again assess the nurses' perceptions of the importance of patient dignity to their practice and if they have been more inclined to include what they have learned into their daily practice.

Potential biases for this project related to the way the data was collected. Rather than using my normal survey strategies, I needed to ensure anonymity of the nurses participating. I was also reminded that completion of these surveys is voluntary, whereas all the education and evaluations I have sent out as part of my job as the unit educator are mandatory completions. I was cognizant of not pressuring staff to review the education or complete the pre-and postevaluations so as to not influence the integrity of the data being collected.

Summary

The purpose of this project was to provide nurses with the tools necessary to provide dignity-enhancing, patient-centered care. To help facilitate these changes, Lewin's (Wojciechowski et al., 2016) model for planned change was used. This theory was chosen for application to this project for its acknowledgement and consideration of "restraining forces" and how to address them for successful implementation.

Dignity-preserving interventions like the PDQ stand to complement and even enhance a patient-centered approach to care. Findings of the Johnston, Gaffney et al., (2015) initial feasibility study suggest that patients perceived better relationships and improved communication with those providing care. Barriers to providing this type of care relate to the task-oriented mindset of the nurse and a lack of critical thinking. Nurses know and even sometimes refer to their patients by diagnosis.

The Patient Dignity Project began as a master's thesis. To see this project through, I administered a pre-education survey to gauge nurses' perception of the importance of patient dignity to the care they provide. Next, a multimodal education program was developed and administered to nursing staff. The final leg of the project was the administration of a posteducation survey to assess the likelihood that the nurses would include what they have learned into their daily practice. Potential biases have been identified and addressed for this project.

Studies addressing patient dignity and dignity-preserving interventions like the PDQ have only been performed with nurses serving a select group of patients, those prescribed palliative care services. However, the positive feedback gleaned from patients

and families who participated in these studies suggests that all patients could benefit from the inclusion of dignity-preserving interventions like the PDQ in practice, and its application would cause little to no disruption to workflow. The following review of the evidence provides more specific details related to patient/family and staff feedback.

Section 3: Collection and Analysis of Evidence

Introduction

Individualized, person-centered care is an essential element of effective and efficient healthcare. Care that is provided should help to enhance a patient's sense of worth and value. Patients cite preservation of their dignity as the most common reason for drafting a living will, as this provides them a sense of control as they age and their health begins to decline (Albers et al., 2011). The preservation of human dignity is central to nursing practice (Parandeh et al., 2016). Dignity-preserving strategies like the PDQ can help nurses attain a better understanding of the patients they care for. Including these interventions as part of the nurse's workflow allows the nurse to examine the patient much more closely, setting the stage for a holistic plan of care. The evidence supports that the healthcare provider can also benefit from use of dignity-preserving interventions in practice because they experience more compassion and increased job satisfaction. In turn, their patients receive more responsive and compassionate care.

The PDQ as a dignity-preserving intervention originated from research that examined patient perceptions of dignity at end-of-life. Its use has assisted in helping healthcare providers better understand the patient as a person and not by their illness (Johnston, Pringle, et al., 2015). Incorporation of dignity-preserving strategies like the PDQ set the stage for nurses to provide more patient-centered care.

Amidst frightening and uncertain situations, nurses are often looked upon to provide support and encouragement. Patient acuity and high census place a strain on resources already experiencing challenges related to staffing shortages and organizational

expectations to do more with less. These circumstances make it easier to understand how nurses go about their day without truly seeing the person in front of them (Harris & Quinn, 2015). Nurses on the front-line staff are in an ideal position to implement dignity-preserving interventions like the PDQ. However, there are no systematic processes or support that specifically address patient dignity at the project site.

Practice-Focused Question

Organizational focus at the site is aimed at "hardwiring" the bedside shift report process and "key words at key times," which are helping to create a more patient-centered environment. However, these initiatives do not address patient dignity specifically. With this project I aimed to address this gap. The practice-focused question was as follows:

PFQ: Are nurses who are educated on the importance of patient dignity to the overall patient experience as well as strategies to address patient dignity in patient care more likely to incorporate these actions into their practice than before they were educated?

Sources of Evidence

Patient dignity is an essential component of patient-centered care. It is important for the nurse to understand how a patient's illness can affect their dignity. The PDQ as a dignity-preserving intervention is a way of providing more empathetic, patient-centered care by inquiring as to what the nurse needs to know to provide the best possible care. For the review of the literature, I utilized Thoreau at Walden Library and Google Scholar to search for resources. Key words included *patient dignity question* and *patient dignity*

in acute care. Only full text, peer-reviewed scholarly articles were reviewed. Using the phrase *patient dignity question* as a search term yielded six completed studies related to use of the PDQ as a dignity-preserving intervention, Johnson, Gaffney et al., 2015, Johnston, Pringle, et al. (2015), McDermott (2019), Hadler et al. (2020), Burkeen et al. (2018), and Meier et al. (2019). There was one study that only had preliminary results available from the beginning of year 2020, which was not included in this review. These studies have centered on patients receiving palliative or hospice services or patients with diagnoses that would qualify them for these types of services. Studies specific to acute care were found lacking. There is ample evidence from the literature to apply to the development of nursing education. While I would prefer to evaluate sources within the last 5 years, it was imperative to this project to review all studies using the PDQ as a dignity-preserving intervention. The goal of the literature review is to emphasize how the positive feedback from these studies suggests that integration of the dignity-preserving interventions like PDQ could benefit all patients in the acute care setting.

Another source of evidence was data collected from the evaluation conducted for the development and implementation of the education at the project site. A pre-education survey was administered to nurses to assess how often they take patient dignity into account when providing patient care. Once education was provided, the same test was administered again to evaluate whether the nurse was more likely to incorporate what they learned into their practice. The goal of the education was to reintroduce the importance of nursing theory to bedside practice. Appealing to their emotions through

education helped these nurses rediscover why they went into nursing, to care for patients and their families in their time of need.

The first study to use the PDQ was a mixed methods feasibility study performed to determine whether the use of the PDQ was both feasible and acceptable in the acute care setting. Nine patients receiving palliative services and five healthcare providers were purposively chosen to participate in the study on an acute care ward in Scotland, United Kingdom. A person-centered climate questionnaire (PCQ-P) was used in the assessment of responses to the PDQ. Feasibility and acceptability were evident in the responses to the feedback questionnaire as the PCQ-P was able to determine a patient-centered climate (Johnston, Gaffney, et al., 2015. These findings indicate that the PDQ can help enhance the patient experience. Because of the nature of this study, there was no predata available for comparison and no postdata was collected, making it impossible to know whether the PDQ was the sole reason for the shift to a more patient-centered climate. Limitations included the population of primarily female participants. The small sample size is not considered a limitation due to the nature of the study. The same researchers to perform the feasibility study were the researchers involved in the second pilot study.

The second study served as a follow-up to the feasibility study. This study evaluated the effectiveness of the PDQ on an acute care ward in Scotland, United Kingdom, and aimed to prove that the PDQ can be used to enhance the care of palliative care patients (Johnston, Pringle, et al., 2015). This study utilized a mixed methods approach to test the hypothesis that the PDQ can create a patient/family-centered environment for those patients receiving palliative care services in the acute care setting

and provide evidence of its acceptance. The PCQ-P and the Consultation and Relational Empathy were used as pre- and postoutcome measures. As with the feasibility study, feedback questionnaires were used postintervention for all participants, as well as qualitative interviews. A total of 13 patients, four family members, and 17 healthcare providers participated in the study. A positive correlation between higher PCQ-P and the Consultation and Relational Empathy scores indicated positive improvements can occur with the use of the PDQ, including an improved patient-centered environment and a perceived increase in the level of empathy. The qualitative findings indicated a marked appreciation of staff, that patients wanted the staff to know them as a person and develop a plan of care specific to them (Johnston, Pringle, et al., 2015). The results of this study demonstrate that the PDQ positively impacts patients' and their families' perceptions of care and the attitudes of healthcare providers. Further research is needed geographically with more diverse settings that should include patients not receiving palliative services.

The third study performed by McDermott (2019), was a prospective study performed to investigate the feasibility of the use of the PDQ in a small rural hospice setting at Algonquin Grace Hospice in Huntsville, Ontario. Study participants included 19 individuals admitted to hospice between September, 2015, and December, 2016, who scored 30% or higher on the Palliative Performance Scale who were able to read and write in English and were not cognitively impaired. Study participants completed the Patient Dignity Inventory and modified versions of the Edmonton Symptom Assessment Scale and Integrated Palliative Care Outcome Scale both before and after the PDQ interviews.

The responses to each of the 19 PDQ interviews were unique. However, there were consistencies noted in the patients' stories regarding accomplishments, hopes, and fears, and the hospice staff found the information from the PDQ interviews to be very valuable to understanding their patients- in fact at the conclusion of the study, both staff and patients collectively wanted the program to continue. The PDQ interview documents also provided family with something very unexpected, a documented intervention that served as a legacy left behind for the patients' family and loved ones providing a very meaningful last gift (McDermott, 2019). Limitations of this study included a small sample size and a relatively short amount of time. Patients included in this study were very ill and/or near death, which could have affected the way the questions were answered. Not only did the PDQ provide a dignity-preserving intervention for the staff to assist them in better understanding the needs of the patients, it truly gave the patients a voice to let their caregivers know exactly what was most important. Interventions such as use of the PDQ should not be exclusive to the dying patient. Person-centered care requires the healthcare provider to understand what is most important for every patient, and the PDQ is a tool that can help them achieve this with every patient every time.

The fourth study was performed in an outpatient psycho-oncology clinic. The PDQ was administered as a routine part of clinical care. The sample included 66 patients who were referred for psychotherapy to treat their depression/anxiety after being diagnosed with cancer. The PDQ was asked after a thorough history was gathered at the initial psychology consult and was worded in a way that did not require prompting. Patients' responses were analyzed to determine common themes, which included

reference to individual characteristics and personality traits, how patients' lives have been impacted since their cancer diagnosis, and goals they wish to achieve both in life and in therapy (McDermott, 2019). This study demonstrated the ease of incorporating the PDQ into the workflow and gave the providers more insight into the unique person in the patient. Further studies are needed to evaluate whether answers to the PDQ would be different in other healthcare settings.

The fifth study took place at Memorial Sloan-Kettering Cancer Center from 2015-2017 and involved incorporating the PDQ into a routine palliative care consultation (Hadler et al., 2020). The researchers performed a literature review to categorize responses to the PDQ. Three separate investigators performed coding until they achieved thematic saturation. From there, descriptive analysis was deployed to determine feasibility of the PDQ and explore themes of those who responded. Association between specific patient characteristics and their responses to the PDQ were established using multivariable, multinomial regression. Unique responses were elicited in 2,051 of the 5,200 total palliative care consultations performed during the study. Three themes were identified: concerns related to illness, interpersonal relationships, and individual perspectives. It was found that patients of different age groups experienced very distinct stressors and priorities. This study yielded a large sample size and addressed patient-specific characteristics and how they related to patient response to the PDQ. However, the focus continues to be on patients requiring palliative services further emphasizing the gap that exists.

The sixth study was set in an oncology clinic. The PDQ was assessed for all patients who were presenting for initial consultation between March 2016 and December 2017. The question was presented as a voluntary form, offered in two languages (English and Spanish). Once answered, the form was provided to the physician for review prior to meeting with the patient. Responses were analyzed for common words/phrases and then again for frequency and prevalence of recurring themes. Press Ganey reports were also analyzed. A total of one hundred forty patients participated in this study. Of this total, sixty one percent of patients were being treated for primary disease, ten percent for recurrent disease, and twenty nine percent for metastatic disease. This is the only study using the PDQ to be performed in a radiation oncology clinic. Data generated from this study highlighted common themes that occurred among patients just prior to starting treatment. This data led to significant improvement in patient satisfaction related to their attending physician (Burkeen et al., 2018). The participants in this study were not revealed to have been prescribed palliative services. However, an oncology diagnosis would certainly qualify a patient for these services, further reiterating the use of the PDQ in only a very select patient population. The PDQ was also presented and utilized in a much different way than in previous studies. However, like other studies, improved patient satisfaction was reported further emphasizing the need to expand its use.

Evidence Generated for the Doctoral Project

Participants

Recruiting participants for research is an essential component of the research process. It does not matter how ground-breaking the topic might be, if the researcher is

unable to recruit participants, the study will fail and the potential impact on the field will be lost (Joseph et al., 2016). There are many individuals who contributed evidence to support the practice-focused question. For this project, all registered nurses on the Progressive Care Unit were counted as potential participants. This includes the Unit Director and Clinicians (supervisors) as they can fill in for bedside RNs as needed, for a total of twenty-nine nurses. Their participation in this doctoral project was essential since beside nurses spend more time with the patient than any other healthcare provider thus putting them in an extraordinary position to affect such positive change.

Procedures

For this project, the *Manual for Staff Education* (Walden University, 2019) was used as a guide. This project was developed and rolled out in a stepwise manner. Initial, baseline information was voluntarily collected from registered nurses on the Progressive Care Unit through the administration of a pre-education survey to assess nurses' attitudes on patient dignity and how often they feel they take patient dignity into account when providing care. Once nurses were voluntarily surveyed, an educational program was developed and implemented. According to Sharma (2017), a multi-modal education program has been proven most effective to ensure reaching a broad range of learners. Use of an electronic presentation as well as QR codes for short podcast episodes were combined with in-person in-servicing and story boards to help increase awareness of the importance of patient dignity to patient care practices. This took place over a two-week period and occurred on multiple shifts to allow ample time for staff review and to receive clarification as needed. This education reintroduced the importance of nursing theory to

bedside practice. Once the education was completed, a post-education survey was administered to the nurses to assess whether the education provided had impacted their attitudes on patient dignity and whether they have been more mindful about taking patient dignity into account when providing care.

The DNP-prepared nurse must be competent in the development of quality improvement strategies and how they will meet the needs of the patient population where they practice. Graduates of a DNP program are set apart by their ability to conceptualize care delivery models that are based in nursing science (AACN, 2006). Understanding the importance of dignity can help nurses identify and understand what is most important to the patient in the provision of patient-centered care, thereby enhancing the overall patient experience.

Ethical Protections of Human Subjects

For this project, neither the partnering organization nor any of its participants were identified. Because this is a nursing education initiative there was no direct patient contact. This project provided protection of the participants through survey anonymity. Participation in the training as part of this project was voluntary. Consent was received following the guidelines in the DNP *Manual for Staff Education* (Walden University, 2019). Data from the training was collected from the project site with permission as deidentified data (anonymous). Pre- and post-surveys were administered and allowed for anonymous answers to be provided. Staff was be made aware that they could withdraw their participation from the project at any time. The IRB application was completed using

Form A and an agency site agreement was obtained from the project site. No ethical issues were identified.

Analysis and Synthesis

The pre-education survey was administered to the nurses on the Progressive Care Unit and was done via RedCap to allow for anonymous completion. Computer-based education review and completion was done through Microsoft Sway. Story boards highlighting the importance of patient dignity were placed on the unit and reviewed at daily huddles and staff were encouraged to listen to the brief podcast episodes that I produced that summarized this information. During the two-week educational period, I was accessible to all staff, all shifts, including weekends. Comparative inferential analysis was performed to compare nurses' responses before and after education was reviewed.

Summary

There is an abundance of evidence to suggest that both patients and healthcare providers stand to benefit from placing greater emphasis on the importance of incorporating dignity-preserving interventions into everyday practice. This project aimed to address the gap within the acute care setting, as evidence in acute care was found lacking and there are no processes currently in place at the project facility that emphasize the importance of patient dignity. The practice-focused question is as follows: Are nurses who are educated on the importance of patient dignity to the overall patient experience as well as strategies to address patient dignity in patient care more likely to incorporate these actions into their practice than before they were educated?

Section 4: Findings and Recommendations

Introduction

Person-centered care is an essential component of effective, efficient healthcare. Patients should feel that what is important to them *matters* to those caring for them. Preservation of patient dignity is central to nursing practice and nurses have an obligation to incorporate dignity-preserving interventions like the PDQ into their workflow so that they are better able to create a more holistic plan of care for the patient.

The practice-focused question for this project was as follows:

PFQ: Are nurses who are educated on the importance of patient dignity to the overall patient experience as well as strategies to address patient dignity in patient care more likely to incorporate these actions into their practice than before they were educated?

The purpose of this project was to educate nurses on the importance of patient dignity to the overall patient experience and provide examples of the interventions that could be incorporated into their workflow that would assist them in providing care that reflected patients' values and preferences and would enhance the patients' sense of self-worth.

Sources of evidence included a pre-education survey, which was administered to nurses to assess how often they take patient dignity into account when providing patient care as well as their perceived barriers to providing this care. A multimodal education program was deployed over 2 weeks. The same survey was administered again to evaluate whether the nurses were more likely to incorporate what they learned into their practice. I performed an inferential comparative analysis to compare pre- and

posteducation survey responses. While there were a few items that showed statistical significance between pre- and posteducation survey results, I recommend repeating the study with a larger sample to further validate these results.

Findings and Recommendations

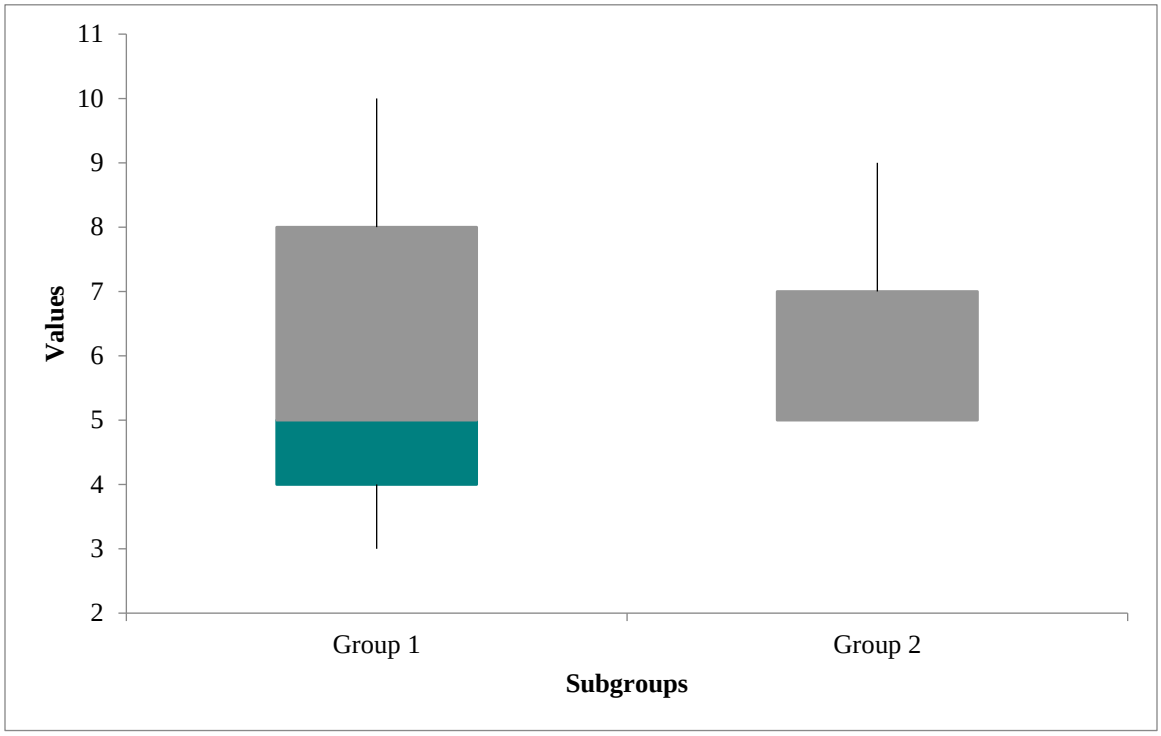
The pre-/posteducation survey consisted of 35 items. The first section consisted of ranking 10 aspects of patient care from most important to the nurse's individual practice to least important to the nurse's individual practice (1= most important, 10 = least important). I used a two-sample *t* test ($p = 0.05$) to analyze the rankings of each statement. Staff communicated some confusion for this first section, stating to me that they had not thoroughly read the instructions because of completing the survey during working hours and in addition to their clinical duties. This confusion resulted in them initially not ranking all aspects of care before continuing to the next section. These instructions were clarified for staff via email, social media, and in person. For future studies, I recommend performing the same study with a larger sample to further validate these results.

The first aspect ($n = 16$ presurvey, $n = 13$ postsurvey), undertaking clinical treatments (e.g., making clinical observations, performing clinical interventions, administration of medicines), showed an increase in the mean ranking from 3.625 to 4.469. However, there was no statistically significant change in the pre-/postsurvey results, with the *p*-value equaling 0.404. These figures indicate that there was no significant change to the way nurses ranked this aspect of patient care even after the multimodal education was provided.

The second aspect (n = 15 presurvey, n = 13 postsurvey), ensuring that all documentation is up to date, also showed an increase in the mean ranking from 5.866 to 8.307. This increase was statistically significant, with a p-value equaling 0.036. These findings suggest that there was a shift in perspective on how important RNs feel this particular aspect of patient care is to the overall patient care experience after the multimodal education was reviewed. With COVID impacting hospital visitation and the influx of patient family and caregiver presence at the bedside significantly decreased, the multimodal education likely brought the importance of dignity-preserving interventions to the forefront, thereby decreasing the significance of this task-oriented intervention. This data can be visualized in the chart below, Figure 1.

Figure 1

PTTESTV Data1-2



The third aspect (*n* = 15 presurvey, *n* = 13 postsurvey), addressing patients/caregivers by their preferred name and engaging in meaningful conversation/active listening, revealed a slight increase in the mean ranking from 5.933 to 6.153. However, there was no statistically significant change in the pre-/postsurvey results, with a *p*-value equaling 0.768. These figures indicate that there was no significant change to the way nurses ranked this aspect of patient care even after the multimodal education was provided.

The fourth aspect (*n* = 17 presurvey, *n* = 13 postsurvey), ensuring that patients receive care tailored to their individual needs, revealed an increase in the mean ranking from 3.764 to 5.307. However, there was no statistically significant change in the pre-

/postsurvey results, with a *p*-value equaling 0.090. These figures indicate that, though close, there was no significant change to the way nurses ranked this aspect of patient care even after the multimodal education was provided.

The fifth aspect (*n* = 17 presurvey, *n* = 12 postsurvey), ensuring that patients have been provided with meals on time and have helped with eating and drinking as appropriate, showed a slight increase in mean ranking from 5.647 to 6.666. There was no statistically significant change in the pre-/postsurvey results, with a *p*-value equaling 0.356. These figures indicate that there was no significant change to the way nurses ranked this aspect of patient care even after the multimodal education was provided.

The sixth aspect (*n* = 16 presurvey, *n* = 13 postsurvey), ensuring that patients have been given the opportunity to receive help with washing, dressing and toileting all while maintaining patient privacy, showed a slight increase in mean ranking from 5.812 to 6.307. There was no statistically significant change in the pre-/postsurvey results, with a *p*-value equaling 0.572. These figures indicate that there was no significant change to the way nurses ranked this aspect of patient care even after the multimodal education was provided.

The seventh aspect (*n* = 18 presurvey, *n* = 13 postsurvey), ensuring that patients are safe and made as comfortable as possible by responding promptly and professionally when they ask for assistance, displayed a decrease in the mean ranking from 5.166 to 3.769. Though the mean ranking decreased by 1.397, there is no statistically significant change in the pre-/postsurvey results, with a *p*-value equaling 0.212. These figures

indicate that there was no significant change to the way nurses ranked this aspect of patient care even after the multimodal education was provided.

The eighth aspect (n = 18 presurvey, n = 13 postsurvey), development of a care plan that are reflective of the patient's sexual identity/gender and use of appropriate pronouns (e.g., she/her, he/him, they/them), also revealed a decrease in the mean ranking from 6 to 4.846. Though the mean ranking decreased by 1.154, there is no statistically significant change in the pre-/post survey results, with a p-value equaling 0.264. These figures indicate that there was no significant change to the way nurses ranked this aspect of patient care even after the multimodal education was provided.

The ninth aspect (n = 17 presurvey, n = 12 postsurvey), ensuring confidentiality and privacy of patient data, revealed a decrease in the mean ranking from 5.411 to 3.833. Though the mean ranking decreased by 1.578, there is no statistically significant change in the pre-/post survey results, with a p-value equaling 0.143. These figures indicate that there was no significant change to the way nurses ranked this aspect of patient care even after the multimodal education was provided.

The 10th aspect (n = 19 presurvey, n = 13 postsurvey), good communication and collaboration with the patient and the multidisciplinary team when planning for discharge, is the final item in this section. As with the previous two aspects, there was a decrease in the mean ranking from 6.578 to 5.384. Though the mean ranking decreased by 1.194 there is no statistically significant change in the pre-/postsurvey results, with a p-value equaling 0.228. These figures indicate that there was no significant change to the

way nurses ranked this aspect of patient care even after the multi modal education was provided.

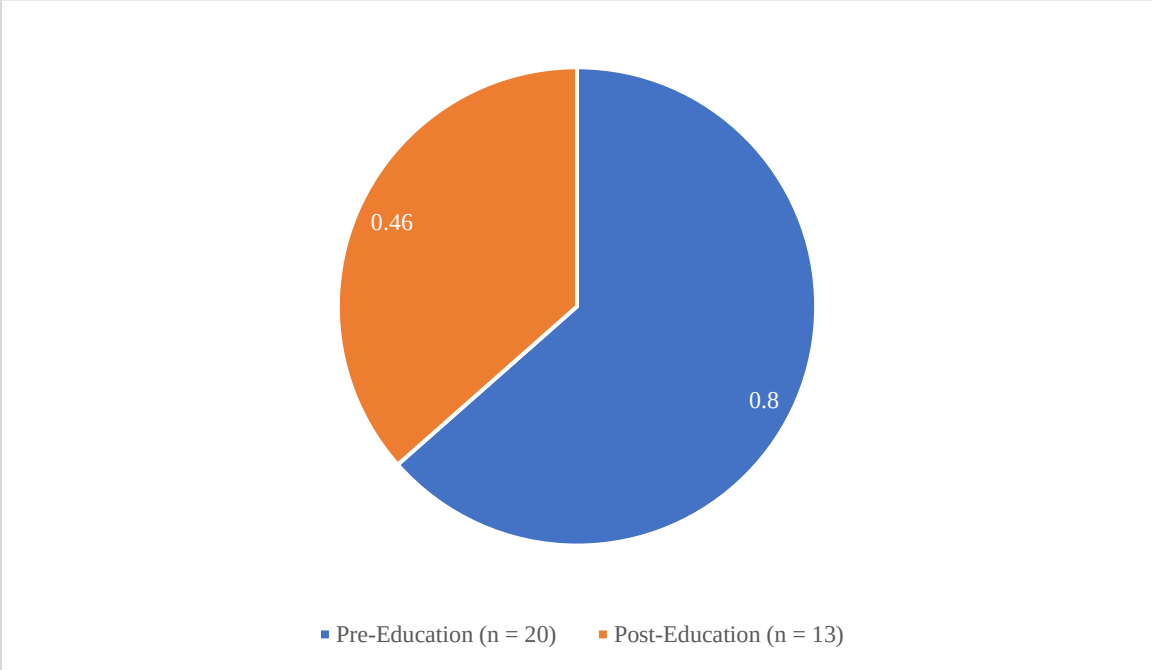
I used a Mann-Whitney test ($p = 0.05$) to analyze Section 2, Item 11 ($n = 19$ presurvey, $n = 13$ postsurvey), during an average work week, how often do you estimate you are able to deliver dignified care daily. The choice of responses included the following: sometimes (2), never (1), about half the time (3), most of the time (4), and all of the time (5). The median rank of 4.00 (most of the time) was the same pre-/postsurvey, and a *p*-value of 0.49 indicates no statistically significant change in the pre-/postsurvey responses for this item.

The third section included Items 12 and 13. Item 12 asked, What things in your work area can you identify that help to maintain and promote dignified care? The nurses were instructed to select all that apply from the following: private rooms/privacy curtains, adequate number of staff, a clean/comfortable environment, and a quiet environment that promotes healing and rest. A two-tailed proportion test was used to analyze Item 12. Two of the four choices displayed statistical significance: adequate number of staff and a clean/comfortable environment. Only one of these selections is significant to this project. In the pre-education survey ($n = 20$), 80% ($n = 16$) felt that there was an adequate number of staff to maintain and promote dignified care. The posteducation survey ($n = 13$) revealed that only about 46% ($n = 6$) felt there was an adequate number of staff to maintain and promote dignified care ($p = 0.020$). This finding indicates that upon review of the multimodal education, nurses reflected on the information provided and realized that given the current state of healthcare postpandemic, they were not as well-staffed as

originally thought. This data can be visualized in the chart below, Figure 2. As with the first and second sections, a larger sample is necessary to further validate these results.

Figure 2

Percentage of Staff Who Felt There Was an Adequate Number of Staff to Maintain and Promote Dignified Care



Item 13 asked, Which of the following do you feel inhibit the promotion of dignified care? The nurses were instructed to select all that apply from the following: lack of privacy, staffing ratios, specific things within the physical environment, lack of knowledge pertaining to patient dignity. The fourth selection, lack of knowledge pertaining to patient dignity, when analyzed using a two-tailed proportion test, the p-value equaled 0.087 indicating that while it was close, there was no statistical significance between samples (n = 20 pre-survey, n = 13 post-survey). However, when analyzed using a one-tailed proportion test, the p-value equaled 0.044, indicating

statistical significance. Pre-education survey data shows that of the total number surveyed (n = 20), only 25% (n = 5) felt that a lack of knowledge inhibited the promotion of dignified care. After review of the multi-modal education, approximately 54% (n = 7) of the total number surveyed (n = 13) felt that a lack of knowledge did in fact inhibit the promotion of dignified care. This finding indicates that upon review of the multi-modal education, nurses reflected on the information provided and realized that a knowledge gap did in fact exist and that ongoing education was necessary. As with previous sections, a larger sample is necessary to further validate these results.

The fourth section included Items 14 through 23: How easy do you find it to deliver the following aspects of dignified care at your workplace?:

- maintaining privacy when providing personal care,
- providing help with meals, access to talk to patients in privacy,
- providing individualized spaces/furniture for all patients (such as lockable carts),
- provision of clean care environment,
- having time to talk to patients and actively listen to patients when delivering care,
- providing adequate information to patients about their care,
- being able to involve patients in decisions about their care,
- ability to always respect the patient's personal needs and care preferences, and
- ability to promote patient autonomy and right to make independent choices.

The nurses were instructed to select easy (1), neither easy nor difficult (2), or difficult (3). A Mann-Whitney test ($p = 0.05$) was used to analyze these items. There were no statistical differences between pre-/post-survey responses for this entire section. Data for each of these items can be compared in *Table 1*, *Section Four Mean Comparison*.

Table 1

Section Four Mean Comparison

Item number	Presurvey result	Presurvey *n*	Postsurvey result	Postsurvey *n*
14	1.000	17	1.00	13
15	2.000	16	3.00	13
16	1.000	17	1.00	13
17	2.000	16	3.00	13
18	2.000	17	2.00	13
19	2.000	17	3.00	13
20	2.000	17	2.00	13
21	1.000	17	1.00	13
22	1.500	16	1.00	13
23	1.000	17	1.00	13

The fifth section included Items 24 through 30, Does your employer support you in delivering dignified care in the following ways?:

- our workplace philosophy specifically mentions dignity in care,
- the importance of providing dignified care is included in new staff induction,
- we have internal development events that include training on dignified care,
- we have good staffing levels,
- I can discuss difficult issues of dignity with my colleagues,
- I can include dignity in care when teaching/working with students/new staff, and

- I feel able to report breaches of dignity in care in confidence to my manager/employer.

The nurses were instructed to select from the following: yes (1), somewhat (2), no (3), don't know (4). A Mann-Whitney test ($p = 0.05$) was used to analyze these items. There were no statistical differences between pre-/postsurvey responses for this entire section. Data for each of these items can be compared in *Table 2, Section Five Mean Comparison.*

Table 2

Section Five Mean Comparison

Item Number	Pre-Survey Result	Pre-Survey *n*	Post-Survey Result	Post-Survey *n*
24	1.000	17	3.000	13
25	1.000	17	3.000	13
26	2.000	17	3.000	13
27	3.000	17	3.000	13
28	2.000	17	2.000	13
29	1.000	16	1.000	13
30	2.000	17	2.000	13

Section six of the survey included Items 31 through 34, How would you rate the standard of provision of dignified care to patients by: your organization, your unit, your colleagues, yourself?. The nurses were instructed to select from the following: excellent (1), good (2), fair (3), poor (4). As with the previous section, a Mann-Whitney test ($p = 0.05$) was used to analyze these items. There were no statistical differences between pre-/postsurvey responses for this entire section. Data for each of these items can be compare in *Table 3, Section Six Mean Comparison*.

Table 3

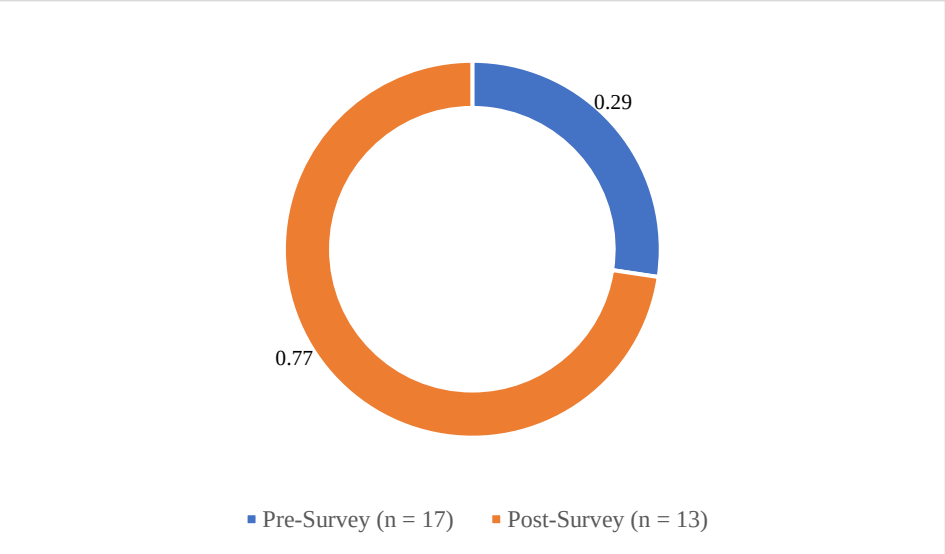
Section Six Mean Comparison

Item number	Presurvey result	Presurvey *n*	Postsurvey result	Postsurvey *n*
31	3.000	17	4.000	13
32	2.000	17	2.000	13
33	2.000	16	2.000	13
34	2.000	17	2.00	13

The final section of the survey included Item 35, Which of the following would help you maintain and improve your ability to provide dignified care? Please select only three aspects from the list below. The nurses were instructed to select from the following: education, peer support, support from your managers/organization, better staffing, less work pressures, more time, better work environment (e.g., equipment, cleanliness, space), and integration into work philosophy. A two-tailed proportion test ($p = 0.05$) was used to analyze Item 35. Only two of the eight selections were of statistical significance, of which only one was of any real significance to project. For the third selection, support from your manager/organization, only about 29% ($n = 5$) of the presurvey sample ($n = 17$) communicated that they felt that support from their manager/organization was helpful in maintaining/improving their ability to provide dignified care. The postsurvey data indicates that approximately 77% ($n = 10$) of the post-survey sample ($n = 13$) feels that support from their manager/organization would be helpful in maintaining/improving their ability to provide dignified care ($p = 0.003$). This data can be visualized displayed in the chart below, Figure 3.

Figure 3

Percentage of Staff Who Believe Manager/Organizational Support Would Help Improve/Maintain Ability to Provide Dignified Care



The nursing leadership model for the project facility changed during the time of project roll-out, decreasing the number of clinicians (supervisors) for each unit, while creating a new position, administrator-on-duty (AOD). The AOD serves as a charge nurse for the entire facility. Unfortunately, not all the positions for this new role had been filled prior to the implementation of this change, so nurse leaders were “farmed out” to cover this new role, creating a decreased presence on their own units, including the Progressive Care Unit. These changes coupled with the multi-modal education accounts for the statistically significance in the pre-/post-education data. This finding indicates that upon review of the multi-modal education, nurses reflected on the information provided and realized that manager/organizational support is in fact important in the promotion of dignified care. Manager/organizational support is a broad description that could relate to

a variety of supportive means including but not limited to, funding for educational opportunities, incorporation of the importance of patient dignity into organizationally funded programs such as professional nurse orientation, nurse residency, improved staffing, and increased leadership presence on the inpatient units. I suggest revision of the data collection tool to further investigate staff definition of management/organizational support. As with previous sections, a larger sample is necessary to further validate these results.

Strengths and Limitations of the Project

For this project, a web-based survey was used. A hyperlink was generated from the Redcap program, which was then embedded in an email and on nursing's closed social media page. Use of this program allowed for complete anonymity during survey completion. According to Nayak & Narayan (2019), web surveys have gained in popularity largely due to their simplicity and cost-effectiveness. Another benefit of using a web-based survey as part of the data collection process is the speed of responses. Most modern online survey tools include three components. Questionnaire design, distribution, and reporting. These online questionnaires allow for various formats including text boxes, multiple choice, checkboxes, scales, and grids. Web-based surveys also offer the convenience of charting the results and even exporting them to a spreadsheet for analysis (Nayak & Narayan, 2019). I was able to avoid sampling bias that is common with web-based surveys as the link was only sent to the registered nurse email group and only visible to registered nurses on the closed social media page. I did not have a choice in survey platforms and was permitted by the organization to utilize only Redcap, ensuring

the security and anonymity of survey responses, and eliminating any ethical concerns related to data storage and confidentiality. Staff were asked to participate voluntarily as time allowed. Despite ease of distribution and survey anonymity, this project was faced with two very challenging and unanticipated limitations.

First, was the timing of the roll-out of this quality improvement initiative. Before the pandemic, the project facility had multiple ongoing quality improvement initiatives that were focused on enhancing the overall patient experience. These included "hardwiring" the bedside shift report process and introduction of the "Commit to Sit" initiative, which focused on medication education and side effects. These initiatives were helping to streamline care delivery throughout the various departments within the facility and the facility was reaping the benefit of these programs in the form of improved patient satisfaction scores.

However, when the pandemic began, most active efforts came to a screeching halt. The focus shifted to educating staff to provide safe care for COVID-19-infected patients. This meant restructuring care processes to mitigate risks to both patients and staff. Processes changed rapidly as more details on the virus emerged. Not only did this affect quality improvement initiatives, but most mandatory education, including competency-based learning, ceased. And while the number of COVID patients declined during the time of this quality improvement initiative, the nurses' workload on the Progressive Care Unit did not due to both caring for those individuals who chose not to seek treatment of their chronic illness during the pandemic out of fear and/or uncertainty, as well as the COVID "long-haulers". At the start of presurvey deployment, staff reported

some initial confusion to me related to the first section of the survey, stating they had not thoroughly read the instructions prior to survey completion because they were completing it during working hours and in addition to their clinical duties. This confusion resulted in them initially not ranking all aspects of care before continuing to the next section. These instructions were clarified for staff via email and social media, as well as in person. This confusion resulted in omission of responses in the first section which accounts for the inconsistent *n*-values seen in the pre-education survey results.

During this time, my unit (and facility) also experienced a mass exit of nurses leaving the bedside, completely burnt out. The expected number of participants in this project during the planning phases was projected to include over forty nurses. At the time of the pre-education survey deployment, only twenty-nine remained. For this initial survey, of the twenty-nine nurses, a little less than half participated. With mandatory education on topics associated with action plans left untouched, I was fully aware of the challenges of putting out surveys that did not require mandatory completion. Face-to-face interactions with staff, as well as social media and email reminders were used to remind staff of the survey and encouraged voluntary participation at their convenience.

Section 5: Dissemination Plan

According to Brownson et al. (2018), a gap related to ineffective dissemination strategies exists between discovery of pertinent knowledge in healthcare and its application. I aimed to narrow this gap through the implementation of a strategic plan for dissemination of project findings as well as recommendations for future projects. To disseminate the project findings I intend to use more unconventional" methods to reach the target audience. Brownson et al. (2018) stated that effective dissemination can be achieved by framing messages in a way that will resonate with the intended audience. Rather than relying solely on journal articles, alternative outlets such as social media, live podcasting, and live webinars/seminars will be considered.

The Patient Dignity Project will be presented to members of nursing administration as well as the nursing professional development team. I will review the specific details of the findings, discussing strengths and limitations, and will suggest running the study again for all inpatient units within the hospital to attain a larger sample size to further validate findings. I also suggest further condensing the data collection tool, decreasing the likelihood that staff will omit responses or choose not to participate due to expected length of time to complete. Repetition of the project could be easily achieved by eliciting the assistance of all members of the inpatient education team to send out pre-education surveys to their staff, as well as the electronic and audio education. To maintain consistency for in-person education, I can perform "roving rounds" and arrange to perform an in-service with staff on all inpatient units on all shifts, including weekends. Upon completion of education, I would again request that the inpatient unit educators

send out the posteducation surveys. Completed survey data would then be sent back to me for analysis.

I will also present my findings as a poster project at the 2022 Nurse's Week Celebration as this is tradition for all quality improvement and research projects completed by nursing in the previous year. I will also request permission to present project findings at either the Spring 2022 or Fall 2022 Nursing Symposiums. Another area of interest for use in dissemination of findings is through the facility's multiple social media outlets. These options have gained in popularity and use since the start of the pandemic and are widely accessible to all stakeholders. I will consider publication and presentation to scholarly forums and incorporation into regional programs such as Nurse Residency once the study is repeated and the results validated with a larger sample size.

Analysis of Self

Dignity is a core ethical value that must be acknowledged as a standard of care in nursing practice (Asmaningrum & Tsai, 2018). Through the development and provision of a thoughtful, stimulating, and evidence-based education program, nurses on my unit were provided with the information needed to establish relationships with patients using therapeutic communication and an understanding of the importance of dignity to person-centered care. This education emphasized a holistic approach to nursing care, drawing from ethical and psychosocial sciences to empower nurses to advocate for healthcare delivery that is safe, equitable, and that addresses the patient as an individual being.

These actions were performed in accordance with the guidelines set forth by the AACN (2006), and are in fulfillment of DNP Essential I.

DNP-prepared nurses must understand practice management and conceptualize practical strategies that balance productivity and quality of care (AACN, 2006). The use of a multimodal education approach enabled me to communicate project information effectively and efficiently through a variety of educational tools. I strategically combined emotional influence with innovative methods to deliver education information, creating an experience that maximized learner engagement and improved the likelihood of long-term retention of the material at the point of care. These strategies were performed in accordance with the guidelines set forth by the AACN (2006) and are in fulfillment of DNP Essential II.

The DNP-prepared nurse must be able to design, direct, and evaluate quality improvement initiatives to promote safe, efficient, patient-centered care and develop a plan to disseminate project findings (AACN, 2006). Despite limitations imposed by a global pandemic, I was able to strategically plan, execute, and evaluate the effectiveness of a thoughtful and meaningful nursing education program. Because of the knowledge and insight that I have gained throughout her academic journey, I was able to identify the need to repeat the study to further validate the findings, thereby contributing to the overall the success of her project. These strategies were performed in accordance with the guidelines set forth by the AACN (2006) and are in fulfillment of DNP Essential III.

The AACN (2006), states that graduates of a DNP program must display competence in the use of information systems/technology to provide education and

evaluate care systems to improve patient care. I used a web-based survey program deemed appropriate by the partnering organization in collection of pre-/posteducation survey data and successfully exported the raw data for analysis. I also used an electronic presentation and online podcast platform to communicate pertinent information to project participants. These strategies were performed in accordance with the guidelines set forth by the AACN (2006) and are in fulfillment of DNP Essential IV.

The Patient Dignity Project was born out of the need to consider patient dignity as an essential component of the overall patient experience and not just something to be pondered at end of life. Staff on the Progressive Care Unit have been educated on the importance of incorporating dignity-preserving interventions into their workflow. This project will serve as a catalyst in changing the way patient experience is defined and evaluated by proposing required initial and ongoing education on the topic of patient dignity for all nursing staff onboarded to the acute care setting in the project facility. According to the AACN (2006), DNP-prepared nurses must develop, lead, and advocate for ethical and equitable delivery of healthcare. These strategies were performed in accordance with the guidelines set forth by the AACN (2006) and are in fulfillment of DNP Essential V.

Effective communication and collaboration among an interprofessional team is a core competency of the DNP-prepared nurse (AACN, 2006). I researched and presented my topic to various members of nursing executive leadership and with their approval, led process to carry out the requirements of the project in a diverse and demanding work

environment. These strategies were performed in accordance with the guidelines set forth by the AACN (2006) and are in fulfillment of DNP Essential VI.

DNP-prepared nurses have an obligation to practice and promote evidence-based care for a culturally diverse population (AACN, 2006). My project broadened the focus of patient dignity to encompass all patients within the acute care setting and not just those receiving palliative or hospice care services. This was achieved through research, education, and evaluation of findings for application to all individuals who make up the inpatient population at the project facility. These strategies were performed in accordance with the guidelines set forth by the AACN (2006) and are in fulfillment of both DNP Essential VII and DNP Essential VIII.

Despite multiple challenges faced as a result of the COVID pandemic, I was able to gather valuable information on how staff view different aspects of care as well as the challenges that diminish their ability to perform these aspects. I suggest repeating this project on all inpatient units in the facility to obtain a larger sample to further validate her project findings. I also suggest further modification of the survey tool, if possible, to mitigate any barriers that might impact staff participation.

I ventured out of my comfort zone when preparing this education program. I produced a podcast miniseries that allowed staff to listen to the information contained within the electronic presentation and visual story boards. As a result of the positive feedback I have received, I have incorporated the production of various podcasts into my current professional role and will seek opportunities to speak as a nursing education expert on regional, state, and nationally recognized podcast platforms.

Summary

Dignity-preserving interventions play an integral role in provision of patient-centered care and are vital components of effective, efficient healthcare. All patients seeking healthcare deserve to be cared for in a way that best reflects what really matters to their physical, mental, and emotional health and should not be reserved for patients of a particular population. Preservation of patient dignity is central to nursing as a caring science and practice. Healthcare providers have an obligation to incorporate dignity-preserving interventions like the PDQ into their workflow so that they are better able to create a more holistic plan of care for the patient.

The practice-focused question for this quality improvement initiative was as follows:

PFQ: Are nurses who are educated on the importance of patient dignity to the overall patient experience as well as strategies to address patient dignity in patient care more likely to incorporate these actions into their practice than before they were educated?

The purpose of this project was to educate nurses on the importance of patient dignity to the overall patient experience and provide examples of dignity-preserving interventions that could easily be incorporated into their workflow that would assist them in providing care that is reflective of patients' values and preferences and would enhance the patients' sense of self-worth.

Despite the challenges faced as a result of the COVID pandemic, I was able to implement a multimodal education program and evaluate its effectiveness. And while

there were only a few items that showed statistical significance between pre-/posteducation survey results, I recognize the importance of repeating the study with a larger sample to further validate these findings.

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Appendix A: Pre-/Posteducation Surveys

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Patient Dignity Pre-Survey

The purpose of this survey is to assess your knowledge and attitude related to patient dignity and how you feel you incorporate this concept into your daily practice. This survey should take approximately15 minutes to complete and you are able to save it in progress and return to it later if needed. There are no "wrong" answers and your voluntary participation is appreciated!

-Jenn Flick

Please complete the survey below.

Thank you!

*This survey is a modified version utilized in the cited study below and permission has been granted for its use in this project.

Kinnear, D., Victor, C., & Williams, V. (2015). What facilitates the delivery of dignified care to older people? A survey of health care professionals. BMC research notes, 8, 826. https://doi.org/10.1186/s13104-015-1801-9

Section One

Please review each aspect of patient care listed below and rank them from most important to your individual practice to least important to your individual practice (1= most important, 10 = least important). PLEASE DO NOT RANK ANY OF THE STATEMENTS THE SAME

		1	2	3	4	5	6	7	8	9	10
1)	Undertaking clinical treatments (e.g., making clinical observations, performing clinical interventions, administration of medicines)	○	○	○	○	○	○	○	○	○	○
2)											

	Ensuring that all documentation is up to date	○	○	○	○	○	○	○	○	○	○
3)	Addressing patients/caregivers by their preferred name and engaging in meaningful conversation/active listening	○	○	○	○	○	○	○	○	○	○
4)	Ensuring that patients receive care tailored to their individual needs	○	○	○	○	○	○	○	○	○	○
5)	Ensuring that patients have been provided with meals on time and have helped with eating and drinking as appropriate	○	○	○	○	○	○	○	○	○	○
6)	Ensuring that patients have been given the opportunity to receive help with washing, dressing and toileting all while maintaining patient privacy	○	○	○	○	○	○	○	○	○	○
7)	Ensuring that patients are safe and made as comfortable as possible by responding promptly and professionally when they ask for assistance	○	○	○	○	○	○	○	○	○	○
8)	Development of a care plan that are reflective of the patient's sexual identity/gender and use of appropriate pronouns: e.g., she/her, he/him, they/them	○	○	○	○	○	○	○	○	○	○
9)	Ensuring confidentiality and privacy of patient data	○	○	○	○	○	○	○	○	○	○
10)	Good communication and collaboration with the patient and the multi-disciplinary team when planning for discharge	○	○	○	○	○	○	○	○	○	○

11) During an average work week, how often do you estimate that you are able to deliver dignified care daily?

- ○ Never
- ○ Sometimes
- ○ About half of the time
- ○ Most of the time
- ○ All of the time

12) What things in your work environment help to maintain and promote dignified care? (select all that apply):

- ☐ Private rooms/privacy curtains
- ☐ Adequate number of staff
- ☐ A clean, comfortable environment
- ☐ A quiet environment that promotes healing and rest

13)	Which of the following do you feel inhibit the promotion of dignified care (select all that apply):	☐ Lack of privacy ☐ Staffing ratios ☐ Specific things within the physical environment ☐ Lack of knowledge pertaining to patient dignity

Section Four

How easy do you find it to deliver the following aspects of dignified care at your workplace:

		Easy	Neither easy nor difficult	Difficult
14)	Maintaining privacy when providing personal care:	○	○	○
15)	Providing help with meals:	○	○	○
16)	Access to spaces to talk to patients in privacy:	○	○	○
17)	Providing individualized spaces/ furniture for all patients (such as lockable carts):	○	○	○
18)	Provision of a clean care environment:	○	○	○
19)	Having time to talk and actively listen to patients when delivering care:	○	○	○
20)	Providing adequate information to patients about their care:	○	○	○
21)	Being able to involve patients in decisions about their care:	○	○	○
22)	Ability to always respect the patient's personal needs and care preferences:	○	○	○
23)	Ability to promote patient autonomy and right to make independent choices:	○	○	○

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Section Five

Does your employer support you in delivering dignified care in the following ways?

		Yes	Somewhat	No	Don't know
24)	Our workplace philosophy specifically mentions dignity in care	○	○	○	○
25)	The importance of providing dignified care is included in new staff induction	○	○	○	○
26)	We have internal development events that include training on dignified care	○	○	○	○
27)	We have good staffing levels	○	○	○	○
28)	I can discuss difficult issues of dignity with my colleagues	○	○	○	○
29)	I can include dignity in care when teaching/ working with students/ new staff	○	○	○	○
30)	I feel able to report breaches of dignity in care in confidence to my manager/ employer	○	○	○	○

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Section Six

How would you rate the standard of provision of dignified care to patients by?

		Excellent	Good	Fair	Poor
31)	Your organization:	○	○	○	○
32)	Your unit:	○	○	○	○
33)	Your colleagues:	○	○	○	○
34)	Yourself:	○	○	○	○

35) Section Seven

Which of these would help you to maintain and improve your ability to provide dignified care?

Please select only the THREE MOST IMPORTANT aspects from the list below.

- ☐ Education
- ☐ Peer support
- ☐ Support from your managers/ organization
- ☐ Better staffing
- ☐ Less work pressures
- ☐ More time
- ☐ Better work environment (e.g., equipment, cleanliness, space)
- ☐ Integration of dignity into work philosophy

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Patient Dignity Post-Survey

The purpose of this survey is to assess your knowledge and attitude related to patient dignity and how you feel you incorporate this concept into your daily practice after reviewing the multi-modal nursing education. This post-education survey should take approximately 15 minutes to complete and you are able to save it in progress and return to it later if needed. There are no "wrong" answers and your voluntary participation is appreciated!

-Jenn Flick

Please complete the survey below.

Thank you!

*This survey is a modified version utilized in the cited study below and permission has been granted for its use in this project.

Kinnear, D., Victor, C., & Williams, V. (2015). What facilitates the delivery of dignified care to older people? A survey of health care professionals. BMC research notes, 8, 826. https://doi.org/10.1186/s13104-015-1801-9

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Section One

****Multi-modal education included: interactions with staff, a story board displayed on the unit, a Sway presentation distributed via email, PowerPoint slides uploaded to the unit FB page, and podcasts made available to staff in a variety of ways**

After review of the multi-modal nursing education provided, please review each aspect of patient care listed below and rank them from most important to your individual practice to least important to your individual practice (1= most important, 10 = least important). PLEASE DO NOT RANK ANY OF THE STATEMENTS THE SAME

		1	2	3	4	5	6	7	8	9	10
1)	Undertaking clinical treatments (e.g., making clinical observations, performing clinical interventions, administration of medicines)	○	○	○	○	○	○	○	○	○	○
2)	Ensuring that all documentation is up to date	○	○	○	○	○	○	○	○	○	○
3)	Addressing patients/caregivers by their preferred name and engaging in meaningful conversation/active listening	○	○	○	○	○	○	○	○	○	○
4)	Ensuring that patients receive care tailored to their individual needs	○	○	○	○	○	○	○	○	○	○
5)	Ensuring that patients have been provided with meals on time and have helped with eating and drinking as appropriate	○	○	○	○	○	○	○	○	○	○
6)	Ensuring that patients have been given the opportunity to receive help with washing, dressing and toileting all while maintaining patient privacy	○	○	○	○	○	○	○	○	○	○
7)	Ensuring that patients are safe and made as comfortable as possible by responding promptly and professionally when they ask for assistance	○	○	○	○	○	○	○	○	○	○
8)											

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	Development of a care plan that are reflective of the patient's sexual identity/gender and use of appropriate pronouns: e.g., she/her, he/him, they/them	○	○	○	○	○	○	○	○	○	○
9)	Ensuring confidentiality and privacy of patient data	○	○	○	○	○	○	○	○	○	○
10)	Good communication and collaboration with the patient and the multi-disciplinary team when planning for discharge	○	○	○	○	○	○	○	○	○	○

11) After review of the multi-modal nursing education, during an average work week, how often do you estimate that you are able to deliver dignified care daily?

- ○ Never
- ○ Sometimes
- ○ About half the time
- ○ Most of the time
- ○ All of the time

12) After reviewing the multi-modal nursing education, what things in your work area can you identify that help to maintain and promote dignified care?

- ☐ Private rooms, privacy curtains
- ☐ Adequate number of staff
- ☐ A clean, comfortable environment
- ☐ A quiet environment that promotes healing and rest

13) After reviewing the multi-modal nursing education which, of the following do you feel inhibit the promotion of dignified care?

- ☐ Lack of privacy
- ☐ Staffing ratios
- ☐ Specific things within the physical environment
- ☐ Lack of knowledge pertaining to patient dignity

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Section Four

After review of the multi-modal nursing education provided, how easy do you think it will be to deliver the following aspects of dignified care at your workplace?

		Easy	Neither easy nor difficult	Difficult
14)	Maintaining privacy when providing personal care:	○	○	○
15)	Providing help with meals:	○	○	○
16)	Access to spaces to talk to patients in privacy:	○	○	○
17)	Providing individualized spaces/ furniture for all patients (such as lockable carts):	○	○	○
18)	Provision of a clean care environment:	○	○	○
19)	Having time to talk and actively listen to patients when delivering care:	○	○	○
20)	Providing adequate information to patients about their care:	○	○	○
21)	Being able to involve patients in decisions about their care:	○	○	○
22)	Ability to always respect the patient's personal needs and care preferences:	○	○	○
23)	Ability to promote patient autonomy and right to make independent choices:	○	○	○

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Section Five

After review of the multi-modal nursing education, do you feel your employer supports you in delivering dignified care in the following ways:

		Yes	Somewhat	No	Don't know
24)	Our workplace philosophy specifically mentions dignity in care	○	○	○	○
25)	The importance of providing dignified care is included in new staff induction	○	○	○	○
26)	We have internal development events that include training on dignified care	○	○	○	○
27)	We have good staffing levels	○	○	○	○
28)	I can discuss difficult issues of dignity with my colleagues	○	○	○	○
29)	I can include dignity in care when teaching/ working with students/ new staff	○	○	○	○
30)	I feel able to report breaches of dignity in care in confidence to my manager/ employer	○	○	○	○

Section Six

After review of the multi-modal nursing education, how would you rate the standard of provision of dignified care to patients by:

		Excellent	Good	Fair	Poor
31)	Your organization:	○	○	○	○
32)	Your unit:	○	○	○	○
33)	Your colleagues:	○	○	○	○
34)	Yourself:	○	○	○	○

35) Section Seven

After review of the multi-modal nursing education, which of the following would help you improve and maintain your ability to provide dignified care?

Please select only the THREE MOST IMPORTANT aspects from the list below.

- ☐ Education
- ☐ Peer Support
- ☐ Support from your managers/organization
- ☐ Better staffing
- ☐ Less work pressures
- ☐ More time
- ☐ Better work environment (e.g., equipment, cleanliness, space)
- ☐ Integration of dignity into work philosophy

Appendix B: Staff Educational

LEARNING OBJECTIVES

- To improve care and preserve the dignity of patients by increasing the awareness of barriers.
- Evaluate patient care practices andmprove these practicesbased on constant self-evaluation and a commitment to lifelong learning.
- Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
- Demonstrate respect, compassion, integrity and responsiveness to the needs of patients through the promotion of patient privacy and autonomy and a commitment to excellence and on-going professional development.

"A" is for Attitude

- Examine your own attitudes/assumptions
- Understand that your perceptions are subjective and may not reflect the reality of the patient
- Recognize that these perceptions can have a profound effect on how care is provided
- Your personal attitude is dependent on how you have been conditioned to think about or react toward a particular situation

Points to Ponder

- How would you feel if you were in the patient's situation?
- What is leading you to draw those conclusions?
- Have you assessed whether these assumptions were accurate?
- How is your attitude toward the patient affecting him/her?
- Is your attitude toward the patient based on a personal experience, anxiety, or fear?
- Does your attitude toward the patient help or hinder your ability to treat the patient with care, openness, and respect?

“B” is for Behavior

Simple gestures can make a patient feel more like a person that is worthy of attention and respect and less like something to be poked and prodded, or an obstacle to be worked around.

Small acts of kindness and respect can enhance trust and connection between the patient and the nurse.

You may be comfortable in the hospital environment, but the patient may not.

Physical exams and other intimacies of care can be upsetting to some

Always act and speak with respect and kindness!

- Getting a patient/family member a glass of water
- Helping a patient get dressed
- Getting the person’s glasses or hearing aid
- Adjusting a pillow or bed sheets
- Acknowledging a photograph, greeting card or flowers

“C” is for Compassion

- Compassion is a feeling or deep awareness regarding the suffering of another and desire to relieve it
- Compassion is an essential component quality of patient care
- People can gain compassion through various experiences
  - Natural disposition
  - Life experience
  - Clinical practice and a vulnerability to life’s uncertainties

Simple ways to show compassion…

- An understanding look
- A gentle touch to the hand, arm, or shoulder
- Communication either spoken or unspoken, acknowledging the patient as a person and their challenges related to thei r illness

"D" is for Dialogue

- Quality, patient-centered healthcare relies on the constant exchange of information
- Healthcare providers need to gather accurate details about the person as a holistic being, and not just the illness
- Dialogue with patients must acknowledge the person beyond the affliction, and the emotional impact that accompanies illness

Ways to improve communication…

- Provide the patient/family your full attention
- Involve patient's family/caregivers in the plan of care
- Provide for patient's privacy
- Position yourself at eye -level
- Realize that illness and changing health status can be overwhelming and you may need to offer patients/families repeated explanations
- Use plain language
- Always ask whether the patient has any further questions and assure them that there will be other opportunities to ask questions as they arise

When communicating…

- Ask the patient for permission to touch them
- Ask for the patient's permission to include students or orientees in the examination
- Put the patient at ease and acknowledge that what you are about to do may cause them discomfort:
  - "I know this might feel a bit uncomfortable…"
  - "I'm sorry that we have to do this to you…"
  - "I know this is an inconvenience…"
  - "This should only hurt for a moment…"
  - "Let me know if you feel we need to stop for any reason…"
  - "This part of the conversation is necessary because…"
- Limit conversation during an examination (aside from providing instruction or encouragement) until the patient has dressed or been covered appropriately

Examples of how a person's life circumstances could affect the response to the illness…

- A person with severe arthritis who is also an avid pianist
- A person with terminal cancer who is the single parent of young children
- A person with limited mobility who doesn't know anyone in the community

The Patient Dignity Question (PDQ) can yield valuable information to improve patient care. Here are some answers that people have provided:

"I'm frightened of authority."

"I think people might not think I'm smart enough or important enough to deserve answers."

"I don't want to die alone."

Tune in…

Intro to the ABCDs of Patient Dignity

Episode 1: "A" is for Attitude

Episode 2: "B" is for Behavior

Episode 3: "C" is for Compassion

Episode 4: "D" is for Dialogue

Episode 5: Final Thoughts

References

The ABCDs of Dignity in Care. (2016). Retrieved from https://www.dignityincare.ca/en/theabcds-of-dignity-in-care.html#attitude