



Dignity in nursing care: What does it mean to nursing students?

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Abstract

Background: Despite growing interest in the potential of nursing education to enhance dignity in nursing care, relatively little is known about what dignity means to nursing students.

Research question: What meaning does dignity in nursing care have for nursing students?

Research design: Photo-elicitation was embedded within a Nominal Group Technique and responses were analysed by qualitative and quantitative content analysis.

Participants and research context: Participants were recruited from each year of a 3-year undergraduate preregistration adult nursing programme in Scotland. In total, 31 nursing students participated in the study.

Ethical considerations: The study was approved by the Ethics Committee of the School of Health, Nursing and Midwifery, University of the West of Scotland.

Findings: Participants articulated the meaning of dignity in nursing care in terms of the relationships and feelings involved. A total of 10 categories of meaning were identified.

Discussion: The significance of the nature of the nurse–patient interaction to preserving dignity in nursing care is highlighted.

Conclusion: Understanding the meaning of dignity for nursing students may help prepare future nurses more able to preserve dignity in nursing care.

Keywords

Content analysis, dignity in care, ethics education, nursing students, photo-elicitation, topic areas

Background

Dignity is a curious, elusive thing...it matters to all of us and is yearned for by those to whom it is denied...Although difficult to define it is something quite ordinary that we sense particularly when it is threatened (p. 189).¹

This description of dignity – as something most noticeable when absent, something special but, at the same time, ordinary – highlights a lack of consensus on what dignity is.^{2–4} For some, this lack of consensus renders dignity a ‘hopelessly vague’ and ‘useless concept’; a poor substitute for the more precise concept of autonomy (p. 1490).⁵ Some have even argued that it should be possible for healthcare ethics to avoid relying on such a nebulous concept.⁶ Conversely, it has also been argued that the concept of dignity offers something of singular importance to healthcare.³ As a result, it is often cited as a crucial factor in a person’s experience of care^{7,8} and a key marker of safe and effective nursing care both nationally and internationally.^{7–10} Initiatives designed to preserve dignity in care in the United Kingdom reflect the priority placed upon it.^{11–14} Yet these aspirations for dignity in care seem very much at odds with the reality portrayed in a range of reports citing a lack of dignity in care settings.^{15–21}

Many theoretical,^{22,23} organisational,^{15,20} professional^{24,25} and personal perspectives^{26–28} on dignity have been described, but the perspectives of nursing students have received relatively little specific attention. Significantly, the Commission on Dignity in Care states that nursing students must have dignity ‘instilled into the way they think and act from their very first day’ (p. 35).²⁰ Perhaps unsurprising then is the growing interest in the potential of preregistration undergraduate nursing education to enhance dignity in nursing care^{29–31} but realising this potential will not be without its challenges. Significant organisational, professional, environmental and personal barriers to the promotion of dignity in nursing care have been identified by nursing students.³² Reports of the problems nursing students experience trying to overcome these barriers make difficult reading.^{33–36} It would be disingenuous to suggest that preregistration nursing education is the panacea for these problems but it certainly has an important contribution to make.³⁷

It seems reasonable to suggest that understanding the meaning nursing students attach to dignity will help support the development of future nurses who are more able to preserve dignity and address situations in which dignity is at risk or being violated. This article provides insight into the meaning of dignity in nursing care for nursing students.

Research design

This article describes part of the first strand of a mixed-methods doctoral study exploring nursing students’ perceptions of factors involved in preserving dignity in nursing care. The purpose of the first qualitative strand using Nominal Group Technique (NGT) was to help develop a data collection tool for the second strand. NGT may be defined as a highly structured approach used to explore areas of interest and develop consensus.^{38,39}

The groups are ‘nominal’ because although participants work in a group setting, the emphasis is on gathering individual views with little interaction.^{40,41} This is to help ensure that all group members have an equal opportunity to participate and no one member dominates the discussion.⁴² The technique varies but is often discussed in relation to four key stages.⁴³ At the first stage, participants are introduced to the topic and invited to engage in a ‘Silent Generation of Ideas’ for around 10 minutes.³⁹ Next, at the second stage, each participant is invited, in-turn, to share one of their ideas with the rest of the group in a ‘Round Robin’ format.⁴⁴ There may be clarification of ideas at this stage to allow them to be listed but, again, there is no discussion.⁴⁵ Each idea is recorded and displayed – usually on flip chart paper – by a facilitator until all ideas have been listed.⁴⁶ These ideas are then discussed briefly at the third stage for the purpose of

Table 1. Participants.

Group name	Group year	Number
I4A	Year 1	7
I4B	Year 1	3
I3	Year 2	12
I2A	Year 3	6
I2B	Year 3	3
Total		31

clarification or removal of duplication.⁴⁵ The fourth and final stage involves the participants voting on and ranking the ideas listed by the group.⁴⁷ In this study, photo-elicitation was employed at the first stage: Silent Generation of Ideas as a ‘trigger’ for the subsequent stages in which group consensus was reached around the factors that help preserve dignity in nursing care.

Photo-elicitation is a technique that uses photographs or other images in an interview setting.⁴⁸ Recommended as a means of stimulating discussion of complex concepts^{49,50} and generating deeper responses than words alone,^{48,50,51} it is argued that photo-elicitation may help participants to respond more authentically because images connect with the unconscious to evoke a spontaneous response.^{52,53} Furthermore, photo-elicitation has been recommended for use in situations where participants might struggle to articulate their understanding.^{49,52}

A pre-existing collection of 70 images – photographs and abstract representations – ranging from people and animals to landscapes and objects⁵⁴ was used in this study. This eclectic collection has been used to study compassionate care,⁴⁹ the meaning of dignity for care home residents and staff⁵⁵ and in programme evaluation.⁵⁶ Each participant was invited to select an image from the 70 available that captured something of the meaning of dignity for them and to provide a written rationale for their choice in a response booklet. Participants were advised that they would not be asked to share or discuss their chosen image in order to reduce any potential embarrassment and avoid any discussion that might influence their individual response. The nursing student participants in this study may have experienced this difficulty because of a perceived need to say the ‘right’ thing or to give the ‘correct’ answer.

Participants and research context

Participants were invited to one of five groups which were specific to their year of study. The primary purpose of arranging year-specific groups was to facilitate a relaxed and non-threatening environment by bringing together similar participants^{45,57} rather than to detect differences between participants at different stages. Groups were arranged on dates and times to minimise any inconvenience to the participants. Attendance varied and group size ranged from between 3 and 11 (Table 1).

Ethical considerations

The study was approved by the Ethics Committee of the School of Health, Nursing and Midwifery, University of the West of Scotland. Participants were recruited from each year of a 3-year undergraduate preregistration programme in the university where the researcher is employed as a nurse lecturer. Acknowledging the particular need to protect participants from harm in this situation,⁵⁸ the decision to recruit these students is perhaps best understood in terms of what has been described as a careful balance of benefits and risks.^{59,60} Involving students as participants may be regarded as more in keeping with students as experts in

the research topic and partners⁶¹ while providing educational benefits for students⁶² and a valuable opportunity to reflect on nursing care.⁶⁰

To minimise risk, potential participants were recruited by a member of staff unconnected with the study and received detailed information about the study including what would be expected of them if they participated. Participation was entirely voluntary and participants could withdraw at any stage without giving any reason. All data were treated confidentially and anonymised. Minimal demographic data – age and gender – were collected in order to provide a broad profile of the participants while protecting their anonymity. Images within the set made available by NHS Education for Scotland were licensed for use from iStock (Getty Images) which requires model and property releases for all images supplied. Images were used with the permission of NHS Education for Scotland. Ethical issues related to the researcher and to the quality of the research were considered in the wider context of trustworthiness.

Findings

Responses were analysed qualitatively and quantitatively by content analysis following a systematic approach.⁶³ Qualitative inductive content analysis used values coding of participants' responses to identify 10 categories of meaning. Quantitative content analysis focused on the frequency with which certain images were selected and the number of coded units contained in each category. Content analysis has been used effectively with student nurses to explore sensitive issues,^{64,65} and, therefore, it seemed appropriate for this study of student nurses' perceptions of dignity in nursing care.

Qualitative content analysis


Content analysis is appropriate when there is a particular interest in quantifying qualitative data⁶⁶ and is usually a deductive process in which pre-determined categories are applied to text.⁶⁷ Inductive content analysis, however, is the preferred approach when the existing knowledge of the phenomenon under investigation is limited or unclear.⁶³ As relatively little is known about the meaning nursing students attach to dignity in nursing care, an inductive approach was adopted. Analysis followed a recommended three-phase approach of preparation, organisation and reporting.⁶³

During the first – preparation – phase, language-based data contained in the participants' written explanations of their image selections were selected as the unit of analysis. Saldaña⁶⁸ advises that while coding frameworks for visual data are available, the best approach is to analyse the language-based data associated with the visual data.

At the next – organisational – phase, values coding was used. Values coding involves coding qualitative data according to values, attitudes and beliefs.⁶⁸ The complex relationship between these concepts makes distinguishing between them particularly difficult and it is not necessary to code for all three or differentiate between them.⁶⁸ Analysis focused, therefore, on identifying the beliefs of the participants; beliefs are defined as the acceptance of the existence or truth of a person, object or idea.⁶⁹ For the purpose of this content analysis, beliefs were identified when participants stated their perspectives as fact (Table 2).

Generating categories of meaning formed the basis for the third and final stage: reporting. Similar codes were grouped together under major headings which were then used to generate tentative categories before these were refined by developing definitions for each.⁶⁸ These categories were then named using 'content characteristic words'.⁶³ Participants' statements and related images were used to name the categories. The number in brackets is the code of the participant whose statement was used to name the category. Categories were then compared with each other and further refined.


Table 2. Example of values coding.

Image	Participant's response	Preliminary codes
Participant A12.01 Image 33A ⁵⁴ 	<ol style="list-style-type: none"> 1. I chose the image of the handprint as I feel dignity is about being able to keep things which are personal to yourself 2. and a handprint is a personal thing 3. as no other person has the same one. 4. I also think of dignity as being different for every person and 5. handprints on each individual are different. 	<ol style="list-style-type: none"> 1. Dignity is about PRIVACY 2. Dignity is PERSONAL 3. Dignity is UNIQUE (to the person) 4. Dignity is UNIQUE (to the person) 5. Dignity is UNIQUE (to the person)

Preliminary ideas

Reflects a view of dignity as something *individual* and *unique* to each person. Refers repeatedly to the *person* and the *personal* – suggests concern with person-centredness. Suggests an understanding of dignity as something that is not restricted to a person's ability to maintain *physical privacy* (e.g. during personal care) but a broader understanding that takes into account private *thoughts* and *feelings* too.

Table 3. An example of differing rationales for image selection.






Image	Participant 14A.05	Participant 14B.08
	<i>To me dignity is about listening as well as many other things. I think it is important that people should be heard and treated equally. I feel communication is key in ensuring people received dignified care . . .</i>	<i>. . . the meaning related to dignity in care is that if you want to have a conversation with someone you have to make sure it's only him or her that can hear. You don't have to make it louder so everybody can hear . . .</i>

Quantitative content analysis

The units of analysis for this component were the frequency with which certain images were selected and the number of statements contained in each category. Each participant in each group selected one image from the seventy images available. In total, 18 images were selected, and of these, half were selected once and the remainder either two or three times. One image – Image 28A⁵⁴ – was selected four times but it became apparent at an early stage that while different individuals might choose the same image, they usually explained their choice in very different ways (Table 3).





Simple frequency analysis as described by Flick⁶⁷ was used to determine the number of coded units in each category as a means of reflecting something of the importance participants attached to each category. Categories 1 and 2 – 'Dignity in nursing care is not having to worry about leaving it at the door' and 'Dignity in nursing care is about being respectful of a person's individuality' – contained the most statements. Categories 9 and 10 – 'Dignity in nursing care is also about the person's loved ones' and 'Dignity in nursing care is about giving people the time they need' – contained the least. The final categories in order of this frequency analysis are presented in Table 4.

Table 4. Final categories in rank order.

Category	Defining Image
<p>1. <i>Dignity in nursing care is not having to worry about leaving it at the door</i> (Participant 13.05) The participant expresses a belief that dignity in nursing care is about feelings, for example, happiness, sadness, embarrassment, contentment, fear, anxiety and safety (Image 24A).⁵⁴</p>	
<p>2. <i>Dignity in nursing care is about being respectful of a person's individuality</i> (Participant 12A.01). The participant expresses a belief that dignity in nursing care is about the importance of the uniqueness of the individual and their perspective on what constitutes dignity in their own care (Image 33A).⁵⁴</p>	
<p>3. <i>Dignity in nursing care is about doing whatever is possible</i> (Participant 13.02) The participant expresses the belief that dignity in nursing care is about taking action to preserve dignity (Image 36A).⁵⁴</p>	
<p>4. <i>Dignity in nursing care is about protecting the vulnerable person</i> (Participant 13.03). The participant expresses a belief that dignity in nursing care is about the vulnerability of the person – for example, during personal care, clinical condition and procedure – their dependency, the power or authority of the practitioner (Image 59A).⁵⁴</p>	
<p>5. <i>Dignity in nursing care is about working together</i> (Participant 13.08) The participant expresses a belief that dignity in nursing care is about partnership; the relationship between the person and the practitioner (Image 12A).⁵⁴</p>	

(continued)

Table 4. (continued)

Category	Defining Image
<p>6. <i>Dignity in nursing care is about communicating with each other</i> (Participant 14A.06). The participant expresses a belief that dignity in nursing care is about communication (Image 28A).⁵⁴</p>	
<p>7. <i>Dignity in nursing care is about respecting the person's choices</i> (Participant 14.03) The participant expresses the belief that dignity in nursing care is about the person's right to make their own choices (Image 8A).⁵⁴</p>	
<p>8. <i>Dignity in nursing care is about showing that you care</i> (Participant 12B.07) The participant expresses a belief that dignity in nursing care is about demonstrating care and compassion (Image 74A).⁵⁴</p>	
<p>9. <i>Dignity in nursing care is about giving people the time they need</i> (Participant 13.11) The participant expresses a belief that dignity in nursing care is about taking or giving time, being patient. (Image 37A).⁵⁴</p>	
<p>10. <i>Dignity in nursing care is also about the person's loved ones</i> (Participant 13.04) The participant expresses a belief that dignity in nursing care includes promoting the dignity of the person's family, friends or other loved ones (Image 27A).⁵⁴</p>	

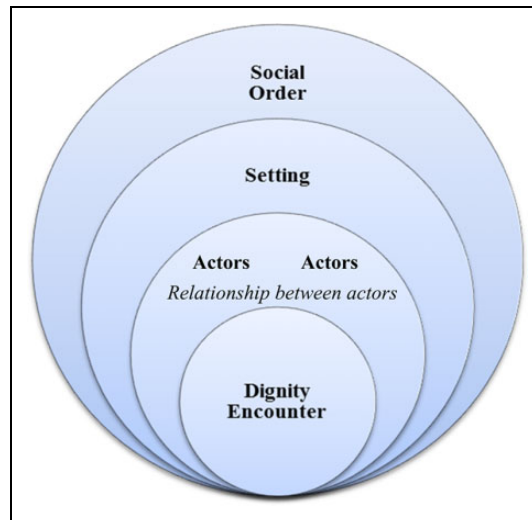


Figure 1. Elements of a dignity encounter.⁷⁰

Discussion

Philosophers often say that, if you want to know the meaning of a word, don't ask for a definition (p. 192).¹

Regardless of the ongoing debate around the utility of the concept of dignity in healthcare, the concept certainly seemed to resonate with participants in this study. In stark contrast to the theoretical debate around the meaning of dignity, none of the participants showed any hesitation in selecting an image that for them captured something of the meaning of dignity in nursing care and providing a confident rationale for their choice. Of the 10 categories, 9 describe dignity in nursing care in terms of action – something that nurses played an active role in and made a difference to. None of the participants made any explicit reference to policy, ethical principles or professional standards or guidance in their written responses. Instead, each of the 10 categories reflected a personal understanding of dignity in nursing care as something located firmly in the relationships and feelings involved.

A theory of dignity with a singular focus on the importance of these aspects of the participants' understanding has been developed by Jacobson and is founded on the idea that 'Every human interaction holds the potential to be a dignity encounter' (p. 3).⁷⁰ A 'dignity encounter' consists of three elements: the wider 'social order', the setting and the actors (Figure 1). While these elements have been described elsewhere,^{25,71,72} Jacobson's focus on the interaction within and between them provided a particularly helpful lens through which to view the findings.

The social order

The first element – the social order – is comprised of the broader ethical, legal, economic and political factors in which the actors, the setting and the encounter are embedded.⁷⁰ These broader issues – such as government health policy and the legal, ethical and economic factors influencing health – are also highlighted as significant influences on dignity elsewhere in the literature.^{2,25,71,73–75} This article's discussion of the broader social order focuses on the extent to which the meanings articulated by participants reflected ethical and professional understandings of dignity.

Primarily, participants might have been expected to express their understanding with some reference to human rights and ethical principles because this approach underpins ethics education in their programme of study. Indeed, it has been reported that this approach characterises most ethics education in healthcare.^{76,77} The language of human rights and ethical principles, however, formed no part of participants' expressed understanding. In particular, participants did not express their understanding in terms of obligation but in personal terms with an emphasis on the nature of the relationships and feelings involved.

Participants may simply have found it easier to articulate their understanding in naturalistic language; however, this finding seems to support the findings of studies of qualified nurses in which personal values and the nature of the nurse–patient relationship were found to exert considerable influence on ethical decision-making.^{78–80} An extensive literature review of nurses' ethical decision-making highlights the influence of personal and contextual factors on the process.⁸¹ It recommends that nurse education and its partners in healthcare enable nursing students to develop not only theoretical knowledge of ethics, but also the ability to reflect critically on care and to make a positive contribution to meeting ethical challenges in care settings.⁸¹ This seems to lend support to the growing use of approaches designed to facilitate nursing students' learning in relation to dignity that are orientated more towards personal values and experience.^{82–88}

Interestingly, participants did not identify any prerequisites – such as autonomy – when they articulated their understanding of dignity. Much of the theoretical discussion of the meaning of dignity is around whether or not it is absolute and held by all human beings to the same degree⁸⁹ 'simply by virtue of the fact that they are human'⁹⁰ or whether it requires rational capacities like autonomy to be present.^{91,92} This debate has profound implications for healthcare and persons with limited rational capacity.^{23,93} Arguably, only categories 2 and 7 – 'Dignity in nursing care is about being respectful of a person's individuality' and 'Dignity in nursing care is about respecting the person's choices' – clearly reference autonomy. It has been asserted that autonomy is a significant aspect of dignity but not its defining characteristic,^{79,94} and it is interesting that the participants' understanding seems to reflect this.


With regard to the professional standards and guidance that frame ethics in a professional context, no explicit reference was made to the Nursing and Midwifery Council's Code⁸ which obliges nurses to uphold the dignity of those in their care. There is some evidence suggesting that nurses often base their care decisions on experience and instinct rather than on the principles contained in such codes.^{95,96} This may lend support to arguments around the extent to which such codes are understood and have practical value for nurses,^{10,96} and it would be interesting to explore this further with nursing students. While no explicit reference to the code is made, however, the categories do seem to reflect some of the ways in which the Nursing and Midwifery Council identify nurses should 'prioritise people' by, for example, respecting diversity and choice, listening and working in partnership (p. 6).⁸ Moreover, the common attributes of dignity – concepts like respect that are frequently attached to dignity to describe it⁹⁷ – are also reflected in the language of both the code and that of the participants.

The setting

Setting is the second element in Jacobson's theory and refers to the local context in which the interaction occurs.⁷⁰ Jacobson characterises different settings as ranging between 'humane' and 'harsh'; the former characterised as calm, friendly and accessible and the latter as rigid, hierarchical and obstructive.⁷⁰

Once again, the importance of context – the culture and physical environment of a care setting – is highlighted in the literature.^{24,25,97–99} Context is likely to be especially significant for nursing students who, as learners, may occupy a particular place in the care setting's hierarchy – as 'just' a student – and feel disempowered to act when confronted by situations in which dignity is threatened.³⁴ Tension between the ideals of the classroom and the realities of practice may further complicate the setting for nursing students.^{33,100} Interestingly, participants made no reference to the physical environment of the care setting. In

Table 5. Categories and conditions.

<p>Dignity in nursing care is not having to worry about leaving it at the door (Image 24A).⁵⁴</p>	
	
Conditions	
Position	Relationship
<ul style="list-style-type: none"> • Dignity in nursing care is about doing whatever is possible to help • Dignity in nursing care is about protecting the vulnerable person • Dignity in nursing care is about showing that you care • Dignity in nursing care is about giving people the time they need 	<ul style="list-style-type: none"> • Dignity in nursing care is about being respectful of a person's individuality • Dignity in nursing care is about working together • Dignity in nursing care is about communicating with each other • Dignity in nursing care is about respecting the person's choices • Dignity in nursing care is also about the person's loved ones

the next stages of the NGT, however, participants did, when prompted, identify some aspects of the physical environment – for example, the availability of single rooms – as important.

The actors

The actors constitute the third and final element of Jacobson's theory and are the individuals or groups who are interacting and are influenced by two sets of conditions: their 'position' relative to each other and the nature of their relationship.⁷⁰ Arguably, for the participants, these conditions seem to be where the meaning of dignity is found.

For Jacobson, if one actor has a position of compassion and the other actor one of confidence, then dignity is more likely to be promoted.⁷⁰ Conversely, dignity is more likely to be violated if one actor has a position of antipathy and the other actor one of vulnerability.⁷⁰ Categories primarily concerned with helping, protecting, demonstrating care and giving time seem particularly relevant in terms of establishing a position of compassion and confidence (Table 5).

Similarly, Jacobson asserts that a relationship of solidarity between actors – characterised by empathy and trust – is more likely to promote dignity while a relationship of asymmetry – characterised by inequity in relation to power, knowledge or control – is more likely to violate it.⁷⁰ Categories primarily concerned with establishing a relationship based on respect for the individual and working in partnership with them and with their loved ones seem particularly relevant to this set of conditions (Table 5).

The highest-ranked category – 'Dignity in nursing care is not having to worry about leaving it at the door' – differs from the others because it does not focus on action but on outcome; the outcome being that persons

receiving nursing care are not worried about their dignity being violated. Consequently, when viewed in the light of Jacobson's theory, it may be regarded as describing the result of establishing the conditions conducive to the promotion of dignity.

Conclusion

This article provides insight into the richness and diversity of the meaning of dignity in nursing care for nursing students. Reflection on the findings and conduct of the study has identified a range of implications for future research.

Participants expressed their enjoyment of using the images and were clearly engaged in the process. The resulting fluency and immediacy of the participants' responses to the images they selected appeared strikingly authentic. Embedding photo-elicitation within the NGT worked well in the broader context of the larger study of which it was a small part. Nevertheless, it is worth noting that the nature of NGT does not offer individuals an opportunity to 'tell their story'. Exploring the meaning of dignity in nursing care for nursing students using photo-elicitation in an individual interview setting may help provide more detailed insight into nursing students' personal understanding. Similarly, the opportunity to utilise freely available and high-quality images was beneficial within the limits of the larger study too. Inviting participants, however, to capture something of the meaning of dignity in nursing care for them by taking their own photographs may help participants represent their perceptions even more powerfully.^{52,101} Moreover, it would be interesting to explore the meaning of dignity in nursing care with a more diverse sample of nursing students as this sample was self-selected from a single institution.

Understanding what dignity in nursing care means to nursing students may help develop nurses who are able to preserve dignity and to address situations when it is threatened. The meaning of dignity in nursing care for nursing students is articulated in terms of the relationships and feelings involved rather than in terms of the human rights and ethical principles that underpin conventional approaches to ethics education in preregistration nursing education. This lends support to the growing use of approaches that are orientated towards personal values and experience.

Conflict of interest

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References

1. Sayer A. *Why things matter to people: social Science, values and ethical life*. Cambridge: Cambridge University Press, 2011, pp. 189, 192.
2. Seedhouse D and Gallagher A. Undignifying institutions. *J Med Ethics* 2002; 28: 368–372.
3. Barclay L. In sickness and in dignity: a philosophical account of the meaning of dignity in health care. *Int J Nurs Stud* 2016; 61: 136–141.
4. Gallagher A. Editorial: what do we know about dignity in care? *Nurs Ethics* 2011; 18: 471–473.
5. Macklin R. Dignity is a useless concept. *BMJ* 2003; 327: 1419–1420.
6. Schuklenk UDO and Pacholczyk A. Dignity's woolly uplift. *Bioethics* 2010; 24: ii.
7. International Council of Nurses. The ICN code of ethics for nurses, http://www.icn.ch/images/stories/documents/about/icncode_english.pdf (2012, accessed 10 June 2015).

8. Nursing and Midwifery Council. The code. Professional standards for performance and behaviour, <http://www.nmc.org.uk/standards/code/read-the-code-online/> (2015, accessed 05 May 2016).
9. Healthcare Improvement Scotland. Care of older people in hospital, http://www.healthcareimprovementscotland.org/our_work/person-centred_care/resources/opah_standards.aspx (2015, accessed 10 October 2016).
10. Kangasniemi M, Pakkanen P and Korhonen A. Professional ethics in nursing: an integrative review. *J Adv Nurs* 2015; 71: 1744–1757.
11. Social Care Institute for Excellence. The dignity in care campaign, http://www.dignityincare.org.uk/About/Dignity_in_Care_campaign/ (2013, accessed 03 February 2015).
12. Scottish Government. Scotland's National Dementia Strategy: 2013–2016, <http://www.gov.scot/Resource/0042/00423472.pdf> (2013, accessed 10 March 2014).
13. Scottish Human Rights Commission. Chapter 1: Dignity and care. Getting it right? Human rights in Scotland, <http://hub.careinspectorate.com/media/255200/getting-it-right-human-rights-in-scotland.pdf> (2012, accessed 10 February 2016).
14. Scottish Government. National care standards. Care homes for older people, <http://hub.careinspectorate.com/media/109821/ncs-care-homes-for-older-people.pdf> (2007, accessed 22 May 2014).
15. Department of Health. Report of the Mid Staffordshire NHS Foundation Trust public inquiry. Executive summary (Chairman Robert Francis QC), <http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf> (2013, accessed 10 July 2013).
16. Scottish Government. The Vale of Leven Hospital inquiry report (Chairman Rt Hon Lord MacLean), <http://www.valeoflevenhospitalinquiry.org> (2014, accessed 05 May 2015).
17. Care Quality Commission. The state of health care and adult social care in England, <http://www.cqc.org.uk/sites/default/files/state-of-care-201314-full-report-1.1.pdf> (2014, accessed 05 May 2015).
18. Patients' Association. The lottery of dignified care, <http://www.patients-association.org.uk/wp-content/uploads/2014/07/Lottery-of-Dignified-Care.pdf> (2011, accessed 05 May 2015).
19. Mental Welfare Commission for Scotland. Dignity and respect: dementia continuing care visits, http://www.mwscot.org.uk/media/191892/dignity_and_respect_-_final_approved.pdf (2014, accessed 05 May 2015).
20. Independent Commission on Dignity in Care. Delivering dignity: securing dignity in care for older people in hospitals and care homes, <http://www.ageuk.org.uk/Global/Delivering%20Dignity%20Report.pdf?dtrk=true> (2012, accessed 15 May 2014).
21. Older People's Commissioner for Wales. 'Dignified care?' The experiences of older people in hospital in Wales, http://www.olderpeoplewales.com/Libraries/OPCW_Publications/Dignified_Care_Full_Report.sflb.ashx (2011, accessed 10 October 2016).
22. Nordenfelt L and Edgar A. The four notions of dignity. *Qual Ageing* 2005; 6: 17–21.
23. Wainwright P and Gallagher A. On different types of dignity in nursing care: a critique of Nordenfelt. *Nurs Philos* 2008; 9: 46–54.
24. Baillie L and Gallagher A. Respecting dignity in care in diverse care settings: strategies of UK nurses. *Int J Nurs Pract* 2011; 17: 336–341.
25. Royal College of Nursing. Defending dignity. Challenges and opportunities for nursing, <https://www.rcn.org.uk/professional-development/publications/pub-003257> (2008, accessed 22 February 2015).
26. Lohne V, Aasgaard T, Caspari S, et al. The lonely battle for dignity: individuals struggling with multiple sclerosis. *Nurs Ethics* 2010; 17: 301–311.
27. Slettebø A, Caspari S, Lohne V, et al. Dignity in the life of people with head injuries. *J Adv Nurs* 2009; 65: 2426–2433.
28. Nåden D, Rehnsfeldt A, Råholm M-B, et al. Aspects of indignity in nursing home residences as experienced by family caregivers. *Nurs Ethics* 2013; 20: 748–761.
29. Tadd W and Dieppe P. Educating for dignity. *Qual Ageing* 2005; 6: 4–9.

30. Vynckier T, Gastmans C, Cannaerts N, et al. Effectiveness of ethics education as perceived by nursing students: development and testing of a novel assessment instrument. *Nurs Ethics* 2017; 22: 287–306.
31. Royal College of Nursing. Quality with compassion: the future of nursing education. Report of the Willis Commission 2012 (Chairman: Lord Willis of Knaresborough), <https://www.nursingtimes.net/download?ac=1255026> (2012, accessed 05 May 2015).
32. Macaden L, Kyle RG, Medford W, et al. Student nurses' perceptions of dignity in the care of older people. *Br J Nurs* 2017; 26: 274–280.
33. Rees CE, Monrouxe LV and McDonald LA. 'My mentor kicked a dying woman's bed . . . ' Analysing UK nursing students' 'most memorable' professionalism dilemmas. *J Adv Nurs* 2015; 71: 169–180.
34. Monrouxe LV, Rees CE, Endacott R, et al. 'Even now it makes me angry': health care students' professionalism dilemma narratives. *Med Educ* 2014; 48: 502–517.
35. Monrouxe LV, Rees CE, Dennis I, et al. Professionalism dilemmas, moral distress and the healthcare student: insights from two online UK-wide questionnaire studies. *BMJ Open* 2015; 5: 1–13.
36. Levett-Jones T and Lathlean J. 'Don't rock the boat': nursing students' experiences of conformity and compliance. *Nurse Educ Today* 2009; 29: 342–349.
37. Rolfe G and Gardner LD. The compassion deficit and what to do about it: a response to Paley. *Nurs Philos* 2014; 15: 288–297.
38. McCance T, Telford L, Wilson J, et al. Identifying key performance indicators for nursing and midwifery care using a consensus approach. *J Clin Nurs* 2012; 21: 1145–1154.
39. Van De Ven AH and Delbecq AL. The Nominal Group as a Research Instrument for Exploratory Health Studies. *Am J Public Health* 1972; 62: 337–342.
40. MacPhail A. Nominal Group Technique: a useful method for working with young people. *Brit Educ Res J* 2001; 27: 161–170.
41. Milnes LJ, McGowan L, Campbell M, et al. Developing an intervention to promote young people's participation in asthma review consultations with practice nurses. *J Adv Nurs* 2013; 69: 91–101.
42. Porter J. Be careful how you ask! Using focus groups and nominal group technique to explore the barriers to learning. *Int J Res Meth Educ* 2012; 36: 33–51.
43. Kennedy A and Clinton C. Identifying the professional development needs of early career teachers in Scotland using nominal group technique. *Teach Dev* 2009; 13: 29–41.
44. Bamford M and Warder J. Occupational health nurses' perceptions of their education and training needs to meet the new public health agenda using the nominal group technique. *Int J Lifelong Educ* 2001; 20: 314–325.
45. Harvey N and Holmes CA. Nominal group technique: an effective method for obtaining group consensus. *Int J Nurs Pract* 2012; 18: 188–194.
46. Carney O, McIntosh J and Worth A. The use of the Nominal Group Technique in research with community nurses. *J Adv Nurs* 1996; 23: 1024–1029.
47. Denning KH, Jones L and Sampson EL. Preferences for end-of-life care: a nominal group study of people with dementia and their family carers. *Palliat Med* 2013; 27: 409–417.
48. Harper D. Talking about pictures: a case for photo elicitation. *Vis Stud* 2002; 17: 13–26.
49. Dewar B. Using creative methods in practice development to understand and develop compassionate care. *Int Pract Dev J* 2012; 2(1): 1–11.
50. Banks M. *Using visual data in qualitative research*. London: Sage, 2007.
51. Lorenz LS and Kolb B. Involving the public through participatory visual research methods. *Health Expect* 2009; 12: 262–274.
52. Barton KC. Elicitation techniques: getting people to talk about ideas they don't usually talk about. *Theory Res Soc Educ* 2015; 43: 179–205.
53. Edgar IR. The imagework method in health and social science research. *Qual Health Res* 1999; 9: 198–211.

54. NHS Education for Scotland. Envision, <http://nes.scot.nhs.uk/education-and-training/by-discipline/nursing-and-midwifery/resources/publications/valuing-feedback-envision-cards.aspx> (2012, accessed 20 November 2014).
55. Dewar B and MacBride T. Enhancing dignity through caring conversations, <https://www.qnis.org.uk/wp-content/uploads/2016/09/Enhancing-Dignity-through-Caring-Conversations-Report.pdf> (2014, accessed 15 March 2017).
56. Smith S, Gentleman M, Conway L, et al. Valuing feedback: an evaluation of a National Health Service programme to support compassionate care practice through hearing and responding to feedback. *J Res Nurs* 2017; 22: 112–127.
57. Doody O, Slevin E and Taggart L. Focus group interviews in nursing research: part 1. *Br J Nurs* 2013; 22: 16–19.
58. Ferguson LM, Myrick F and Yonge O. Ethically involving students in faculty research. *Nurse Educ Pract* 2006; 6: 397–403.
59. Bradbury-Jones C and Alcock J. Nursing students as research participants: a framework for ethical practice. *Nurse Educ Today* 2010; 30: 192–196.
60. Bradbury-Jones C, Stewart S, Irvine F, et al. Nursing students' experiences of being a research participant: findings from a longitudinal study. *Nurse Educ Today* 2011; 31: 107–111.
61. Winstone N. The role of students in pedagogical research projects: subjects, participants, partners, consultants? <https://www.heacademy.ac.uk/role-students-pedagogical-research-projects-subjects-participants-partners-consultants> (2015, accessed 17 June 2015).
62. Roberts LD and Allen PJ. A brief measure of student perceptions of the educational value of research participation. *Aust J Psychol* 2013; 65: 22–29.
63. Elo S and Kyngäs H. The qualitative content analysis process. *J Adv Nurs* 2008; 62: 107–115.
64. Vaismoradi M, Salsali M and Marck P. Patient safety: nursing students' perspectives and the role of nursing education to provide safe care. *Int Nurs Rev* 2011; 58: 434–442.
65. Vaismoradi M, Salsali M, Turunen H, et al. A qualitative study on Iranian nurses' experiences and perspectives on how to provide safe care in clinical practice. *J Res Nurs* 2013; 18: 351–365.
66. Braun V and Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006; 3: 77–101.
67. Flick U. *Introducing research methodology*. 2nd ed. London: Sage, 2015.
68. Saldaña J. *The coding manual for qualitative researchers*. London: Sage, 2009.
69. Masters K. *Role development in professional nursing practice*. 4th ed. London: Jones and Bartlett Publishers Inc., 2013.
70. Jacobson N. A taxonomy of dignity: a grounded theory study. *BMC Int Health Hum Rights* 2009; 9: 3–9.
71. Tadd W, Hillman A, Calnan S, et al. Dignity in practice: an exploration of the care of older adults in acute NHS Trusts, http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1819-218_V02.pdf (2011, accessed 10 July 2013).
72. Calnan M, Tadd W, Calnan S, et al. 'I often worry about the older person being in that system': exploring the key influences on the provision of dignified care for older people in acute hospitals. *Ageing Soc* 2013; 33: 465–485.
73. Tadd W, Hillman A, Calnan M, et al. From right place – wrong person, to right place – right person: dignified care for older people. *J Health Serv Res Policy* 2012; 17: 30–36.
74. Ariño-Blasco S, Tadd W and Boix-Ferrer JA. Dignity and older people: the voice of professionals. *Qual Ageing* 2005; 6: 30–36.
75. Nunes S, Rego G and Nunes R. The impact of economic recession on health-care and the contribution by nurses to promote individuals' dignity. *Nurs Inq* 2015; 22: 285–295.
76. Monteverde S. Undergraduate healthcare ethics education, moral resilience, and the role of ethical theories. *Nurs Ethics* 2014; 21: 385–401.

77. Cannaerts N, Gastmans C and Casterlé BDD. Contribution of ethics education to the ethical competence of nursing students: educators' and students' perceptions. *Nurs Ethics* 2017; 21: 861–878.
78. Goethals S, Dierckx de Casterlé B and Gastmans C. Nurses' decision-making in cases of physical restraint: a synthesis of qualitative evidence. *J Adv Nurs* 2012; 68: 1198–1210.
79. Gastmans C. Dignity-enhancing nursing care: a foundational ethical framework. *Nurs Ethics* 2013; 20: 142–149.
80. Goethals S, de Casterle BD and Gastmans C. Nurses' decision-making process in cases of physical restraint in acute elderly care: a qualitative study. *Int J Nurs Stud* 2013; 50: 603–612.
81. Goethals S, Gastmans C and de Casterlé BD. Nurses' ethical reasoning and behaviour: a literature review. *Int J Nurs Stud* 2010; 47: 635–650.
82. Timmermans O, Dale S-J, Holmes J, et al. Enhancing ethical practice and critical reflection by the sTimul experience in a care ethics lab: evaluation of the sTimul-experience. *J Nurs Educ Pract* 2015; 5: 65–75.
83. Tadd W, Vanlaere L and Gastmans C. Clarifying the concept of human dignity in the care of the elderly: a dialogue between empirical and philosophical approaches. *Ethical Perspect* 2010; 17: 253–281.
84. Vanlaere L, Coucke T and Gastmans C. Experiential learning of empathy in a care-ethics lab. *Nurs Ethics* 2010; 17: 325–336.
85. McLafferty E, Dingwall L and Halkett A. Using gaming workshops to prepare nursing students for caring for older people in clinical practice. *Int J Older People Nurs* 2010; 5: 51–60.
86. Willsher KA. The legacy of 'Joanna': the role of ethical debate in nurse preparation. *Nurse Educ Today* 2013; 33: 384–387.
87. Matiti MR. Learning to promote patient dignity: an inter-professional approach. *Nurse Educ Pract* 2015; 15: 108–110.
88. Morgan G. Interprofessional aspects of the dignity in care program in Wales. *J Interprof Care* 2012; 26: 511–513.
89. Jacobson N. Dignity and health: a review. *Soc Sci Med* 2007; 64: 292–302.
90. Sulmasy DP. The varieties of human dignity: a logical and conceptual analysis. *Med Health Care Philos* 2013; 16: 937–944.
91. Baertschi B. Human dignity as a component of a long-lasting and widespread conceptual construct. *J Bioeth Inq* 2014; 11: 201–211.
92. Killmister S. Dignity: not such a useless concept. *J Med Ethics* 2010; 36: 160–164.
93. Allan A and Davidson GR. Respect for the dignity of people: what does this principle mean in practice? *Aust Psychol* 2013; 48: 345–352.
94. Gallagher A, Li S, Wainwright P, et al. Dignity in the care of older people – a review of the theoretical and empirical literature. *BMC Nurs* 2008; 7(11): 1–12.
95. Sasso L, Stievano A, Gonzales Jurado MG, et al. Code of ethics and conduct for European nursing. *Nurs Ethics* 2008; 15: 821–836.
96. Tadd W, Clarke A and Lloyd L. The value of nurses' codes: European nurses' views. *Nurs Ethics* 2006; 13: 376–393.
97. Gallagher A. Care environments that support dignity in care. In: Matiti MR and Baillie L (eds) *Dignity in healthcare: a practical approach for nurses and midwives*. London: Radcliffe Publishing, 2011, pp. 52–61.
98. Willassen E, Blomberg A-C, von Post I, et al. Student nurses' experiences of undignified caring in perioperative practice – part II. *Nurs Ethics* 2015; 22: 688–699.
99. Brown J, Nolan M, Davies S, et al. Transforming students' views of gerontological nursing: realising the potential of 'enriched' environments of learning and care: a multi-method longitudinal study. *Int J Nurs Stud* 2008; 45: 1214–1232.
100. Curtis K, Horton K and Smith P. Student nurse socialisation in compassionate practice: a Grounded Theory study. *Nurse Educ Today* 2012; 32: 790–795.
101. Lorenz LS. A way into empathy: a 'case' of photo-elicitation in illness research. *Health* 2011; 15: 259–275.