emerald PUBLISHING

The Journal of Adult Prot

"Just because people are old, just because they're ill..." Dignity matters in district nursing

Journal:	*The Journal of Adult Protection*
Manuscript ID	JAP-07-2021-0024.R2
Manuscript Type:	Research Paper
Keywords:	district nursing, dignity, Safeguarding, home, older adults, temporality, time, space

"Just because people are old, just because they're ill…" Dignity matters in district nursing

Abstract

Purpose:

This paper explores the concept, and practice, of dignity as understood and experienced by older adults and district nursing staff. The paper adds a new, nuanced, understanding of safeguarding possibilities in the context of district nursing care delivered in the home.

Methodology:

The research employed an ethnographic methodology involving observations of care between community district nursing clinicians and patients (n=62) and semi-structured interviews with nursing staff (n=11) and older adult recipients of district nursing care (n=11) in England.

Findings:

Abuse is less likely to occur when clinicians are maintaining the dignity of their patients. The themes of time and space are used to demonstrate some fundamental ways in which dignity manifests. The absence of dignity offers opportunities for abuse and neglect to thrive; therefore, both time and space are essential safeguarding considerations. Dignity is influenced by time and how it is experienced temporally, but nurses are not allocated time to 'do dignity', an arguably essential component of the caregiving role, yet one that can become marginalised. The 'home-clinic' exists as a clinical space requiring careful management to ensure it is also an 'environment of dignity' that can safeguard older adults.

Practical Implications

District nurses have both a proactive and reactive role in ensuring their patients remain safeguarded. By ensuring care is delivered with dignity and taking appropriate action if they suspect abuse or neglect, district nurses can safeguard their patients.

Originality:

This paper begins to address an omission in existing empirical research regarding the role of district nursing teams in delivering dignified care and how this can safeguard older adults.

Key words: district nursing, dignity, safeguarding, abuse, home, time, temporality, space, older adults

Article classification: Research paper

Introduction

District nurses deliver nursing care to patients in their homes, a space in which there are endless opportunities for, and threats to, safeguarding. District nursing care and its relevance to safeguarding have, for example, previously been conceptualised in relation to whether pressure ulcers are a safeguarding concern (Ousey *et al*., 2015; Drennan *et al*., 2017; Manthorpe and Martineau, 2017; and McGraw, 2018) and, within the safeguarding umbrella, considerations for district nursing care practices have also been discussed in terms of the Mental Capacity Act (Griffiths and Tengnah, 2008a, 2008b); deprivations of liberty (Griffiths, 2014); female genital mutilation (Griffith and Tengnah, 2009); the role of district nurses in safeguarding through advocacy (Pettitt, 2000) and adhering to the Nursing and Midwifery Council professional code of practice (Griffith and Tengnah, 2015). There are, however, no current empirical explorations into how the delivery of high-quality district nursing care can safeguard patients by reinforcing and upholding their dignity.

In this paper, the 'home-clinic' is conceptualised as an important, dual-use, space in which district nurses work; it is simultaneously home and clinic. Primarily, this space functions as a home, however, at specific times (often in the presence of a nurse), the same space assumes a clinical purpose. The 'home-clinic' is important because this is the space in which dignity is likely to (de)manifest during clinical interventions. Moreover, this is adaptable over time and subjective experiences of temporality, thus it assumes a crucial role in the construction of dignity in the home.

Definitions of dignity are varied, and, at times contradictory (Rosen, 2012; Tranvåg *et al*., 2016). In this paper, concepts of dignity are grounded in Immanuel Kant's philosophy of the inherent worth of human beings. Nordenfelt (2004, 2009) later described this as *Menschenwürde*, a universal dignity that all humans hold. Crucially, this paper adopts the view that district nursing care offers the possibility for dignity to manifest, and importantly, abuse is less likely to occur when clinicians are maintaining the dignity of their patients. When care is delivered in the home, if nurses and patients can co-create an 'environment of dignity', older adults retain control and influence over their care,

implicitly ensuring they experience increased empowerment and autonomy, which contributes to preventative approaches to safeguarding.

In this paper, routine dignity-enhancing district nursing care is framed as a safeguarding practice that ensures older adults remain empowered and protected in their homes. There are micro-moments and micro-opportunities where dignity can be reinforced or contravened as community district nursing practises can underpin or undermine safeguarding when dignified care is viewed as part of a wider commitment to safeguarding.

'Behind closed doors': The context of district nursing

There is an increasingly blurred distinction between health and social care (Argyle *et al*., 2017) and this is an important context for the delivery of district nursing care in which both clinical and social elements of care can provide opportunities for dignity to manifest. Within district nursing, 'demand is rising faster than funding' (Charles *et al.,* 2014: 26), yet, at a national level, relatively little data on community health services is collected, compared with care delivered in hospitals. Maybin *et al*. (2016) and Black and Dobbs (2014) also note the lack of research into dignity experienced by community-based older adults. Empirical studies that address fundamental dignity concerns primarily focus on people's experiences in acute hospital services (Høy, 2007; Matiti and Trorey, 2008; Baillie, 2009). Holmberg *et al*. (2012) recognise that it is individual expectations that govern professional/patient interactions, and maintaining dignity involves nurses demonstrating respect for patients' autonomy and integrity; but, perhaps most importantly, it is clear that when dignity is not present, abuse is more likely to occur (Michael, 2014).

The home is a private space, hidden from outsiders' gaze, but district nurses gain entry to this world: 'to receive care within the home is thus to negotiate boundaries of privacy and intimacy' (Conradson, 2003: 452). When nurses visit the home, public and private intersect, and potential tensions arise when the home is dually purposed as both 'home' and 'workplace' where the boundaries between private and public become blurred (Milligan, 2000). This contrasts with the dominant discourse relating to the home, which is based on assumptions that it is spatially distinct from the workplace (Seymour, 2007). This duality means there are times when nurses must negotiate through complex workplace/ home dilemmas with their patients. Private spaces, such as the home, are 'owned' and occupied by people who have power over the place (Peter, 2002; Liaschenko and Peter, 2004; Öresland *et al.*, 2009). Places of care are important, as patients can be expected to

experience security and control of their home situation (Carolan *et al.*, 2006). Older adults can experience increased confidence and autonomy over decisions relating to their nursing care when it is received in the home, yet complex power relations within nurse-patient relationships can hinder empowerment in practice (McGarry, 2003).

In contrast to hospital-based care, professional power and control may be reduced in patients' homes where district nurses often practise in isolation from other colleagues. As a result, care delivery may vary more widely in patients' homes than in hospital wards, where nurses have continual contact with each other to informally supervise, guide and modify their own and others' practice. When care is delivered on wards, nurses are continually exposed to a group culture, in contrast to the lone-worker culture of district nursing, making district nursing an area of care delivery that is not widely subjected to the scrutiny of others, and, in a research context, a fieldwork location that remains under-explored. In safeguarding terms, because district nurses have reduced opportunities to co-work, there is greater potential for problems in individual practice to remain unobserved and unreported. The provision of care within the home is open to less scrutiny than institutional settings in which care is routinely observed by others; therefore, the home presents increased opportunities for certain types of abuse and neglect by family members, carers and indeed, district and community nurses.

Methods

This study received ethical approvals from the University of Hull, Faculty of Arts and Social Sciences (23/6/16) and Yorkshire and the Humber – South Yorkshire NHS Research Ethics Committee (Ref: 17/YH/0009. IRAS ID: 21677).

As an ethnographic study, fieldwork was undertaken between July and October 2017 in which the ethnographer was located within an urban community district nursing team in the north of England. At the time fieldwork was undertaken, the ethnographer was also employed in the host organisation as a safeguarding adult specialist and therefore her positionality was a regular element of critical reflection. Two methods were utilised: non-participant observations of clinical interactions between 13 clinical staff (all female) and 40 patients (male and female, aged over 60) and interviews with staff and patients (n=22; 11 clinicians and 11 older adult patients) – all transcribed verbatim. Observation and fieldwork notes were handwritten contemporaneously and later typed. This process assisted with the reflexivity that is necessary for a trustworthy qualitative study. All data was analysed thematically

on QSR NVivo in line with Braun and Clarke (2006, 2013) and trustworthiness was assessed by considering credibility, transferability, dependability and confirmability (Guba, 1981).

Staff members were recruited following a presentation to the team and via the distribution of a Participant Information Leaflet (PIL). All clinical staff within the team were eligible for the study, but this was an opt-in study and they self-selected – therefore participants ranged from health care assistants (unregistered clinicians) to community staff nurses and senior nurses (including district nurses). Once staff-participants had signed a consent form, they acted as gatekeepers to older adults, whereby they distributed PILs to eligible patients that met the inclusion criteria, which were: aged over 60, living in their own homes, capacity to consent and English-speaking. Once older adults gave their clinician verbal consent to participate, the ethnographer was invited to attend the next appointment. On the first visit, the ethnographer ensured informed consent was given before seeking written consent and verbal consent was sought on every subsequent visit. Participants could withdraw from the study at any anytime and no incentives or rewards were offered.

Limitations

In accordance with the ethical approvals, the ethnographer was not permitted to make initial contact with any patients. Therefore, as clinical staff were required to be gatekeepers, the sample of older adults selected for inclusion was not directly under the researcher's control. Additionally, the study purposefully excluded people living in residential care homes, those aged under 60 and non-English speakers, therefore the experiences of these district nursing consumers were not considered. Finally, fieldwork occurred within a community nursing team in which all clinicians were female, which ensured there was no opportunity to recruit any male nurse-participants and thus, the voices of male nurses remain unheard.

Findings

Space

The sole criterion to access the district nursing service was for the older adult to be unable to access care at a health centre or GP practice, therefore, nurses described their patients as "housebound". As older adults under the care of district nurses cannot actively enter and fully participate in the outside world, their home becomes representative of the wider world.

> **Nurse-Denise**: "It's the best job ever. It's better than any hospital. Cos you're going into their home…they're letting you into their world and it's an absolute privilege."

Denise recognised her privileged position meant gaining entry not just into patients' homes but also into their worlds. There are many safeguarding risks and opportunities when external environments are no longer accessible making the home the older adult's world. In this context, there is a danger that any abuse remains unobserved by others and, therefore, opportunities to safeguard are reduced, yet the private-residential setting affords some protection against elements of institutional abuse, which is inherently more noticeable in settings such as care homes and hospitals. Clinicians recognised the importance of the home in their delivery of dignified care.

> **Nurse-Anya**: **"**Dignity… just respect that you're in someone's house, it's their house… respect it, they've invited you in."

To demonstrate respect for the patient and their home, Nurse-Victoria explained her personal code of operation when arriving at a house for the first time.

Nurse-Victoria: "You don't just walk into the [patient's] house, you'd wait to be invited."

Nurse-Victoria was implicitly describing a 'house-rule', which offers behavioural expectations within the home, and nurses are expected to comply with these, even though they are not formally inducted to the ways in which these rules customarily operate. One 'house-rule' that was consistent across all older adults' homes was that nurses were not given unrestricted access, their movement typically being limited to the specific areas in which care was delivered – the 'home-clinic'. Insights into how (in)dignity manifests can also be achieved by considering how the 'home-clinic' operates through the organisation of the home, and how this adapts in the context of illness. In this paper, an 'environment of dignity' is conceptualised as a space in the home that offers a safe and dignified area. However, ensuring the 'home-clinic' operates as an 'environment of dignity' can be challenging, particularly when nursing/clinical artefacts are introduced into this space, often denoting and highlighting the evident decline of the functioning of the body. In the next quote, Michelle, referring to her commode, illustrates the existential dilemmas that can arise when the personal meets the clinical.

> **Michelle (86)**: **"**I thought, 'Ooooh – disgusting', but by crikey… I'm pleased with that commode…I wouldn't be without it now."

Offering older adults' commodes is a routine occurrence for nurses, but, for many patients, the use of a commode is neither routine nor regular; symbolising, as it does for Michelle above, a body which

is unable to abide by usual, and taken for granted, conventions – a body that, perhaps, can no longer be fully controlled.

Indeed, commodes present a particularly good example of the intrusions into the home space that are demanded by clinical activity. They are difficult to conceal or gentrify and this may be a step too far for older adults who have not come to terms with changes around their declining health needs alongside increasing desires for dignity. This was the scenario encountered when observing Betty and Nurse-Nieca. Betty had mobility limitations and had been prescribed Frusemide, a diuretic that can increase the need to urinate. Betty's bathroom was upstairs, a significant distance from where she sat downstairs during the day, and it had proved difficult for her to get to the toilet in time.

Nieca stated, "I thought if you were having difficulties, we could look at getting you a commode, but I know you're a proud woman".

Betty swiftly declined this offer and the vehemence of her rejection indicated displeasure and disgust. Betty's refusal was an automatic and honest reaction to being offered equipment that she did not associate with her sense of self or her home environment. It challenged her identity, threatened her dignity and therefore could not protect her from the potential consequences of continence challenges. Even though in practical terms, a commode may have made Betty's ability to self-manage her continence easier, this benefit was outweighed by the dignity-reducing messages inherent in accepting, accommodating, and using, the artefact. Betty's refusal of a commode also ensured that visible signs of illness remained absent in her house – a commode is an obvious indicator of illness, a key example of an artefact that holds both power and stigma. Interestingly, Betty had only recently been discharged from hospital, where she admitted she regularly used a commode. Hence, for Betty, whilst it was acceptable to use a commode in hospital, this was unacceptable at home, where dignity would be jeopardised by its introduction into this space, no longer making it an 'environment of dignity'.

Some of the differences in between hospital and community based nursing care were also recognised by the nurses.

> **Nurse-Nieca**: "There's a big difference in the community with dignity than there is in hospital, I think patients' perception of dignity is very different as well. I think people expect to lose their dignity when they're going into hospital, but I think when they're at home, they expect to be able to maintain their dignity."

Alison, aged 82, certainly expected to be able to maintain her dignity in her own home and this involved careful consideration of who was permitted into her 'home-clinic' at specific times during clinical interventions. Alison was under the care of the nurses for bilateral leg dressings, and, although her husband was not allowed to enter the 'home-clinic' during the unwrapping of her legs, once they were unveiled, she would instruct the nurse to bring her husband into the room to offer his views on the nature of her leg ulcers. Alison was blind, and she described her husband as "my eyes". The feedback he offered on the progression of her legs was preferable to any observational comments from the nurses. During her interview Alison was asked about the use of her bedroom as the 'home-clinic', and, when asked about dignity, Alison offered an interesting insight into why she preferred her care to be delivered in a private bedroom away from her husband's view.

> **Alison (82)**: **"**Erm, dignity. I don't mind at all if it's females, with me being female but if it comes to a man, even my husband, I don't like him to look at my body, er, if I've got anything wrong with it and if I say, 'is that a bit scurfy down there?' Things like that I don't like."

Alison thus maintained control of her dignity within the clinical situation by only permitting her husband to view her body through a similar clinical lens to that adopted by the nurses at the specific time she indicated was appropriate.

Time

Another important factor identified in the data analysis was the impact of Time. Older adults receiving district nursing care were aware that their nurses were busy and therefore tried not to delay them, which became apparent during observations in this study. As a result, many older adults would undertake advance preparations. For example, before every visit, Warren's partner ensured his dressings were laid out prior to the nurse's arrival to "save time". This was not to save *their* time, but to save the nurses' time, which they identified as important because they empathised with the number of patients the nurses were required to visit each day. Warren also assisted the nurses as much as possible in doing his bilateral leg dressings. Whilst his partner laid out all the dressings, Warren would unzip his outer bandage and prepare pieces of microporous tape to hand to the nurse, which he indicated quickened the process. At her interview, one of his nurses, Sapphire, said:

> **Nurse-Sapphire**: "We haven't got enough time in the day to give to our patients and that is what it boils down to."

Insufficient time to undertake caring duties might be considered indicative of potential institutional abuse and can lead to elements of neglect. Reinforcing dignity also requires time, and this was

recognised by other nurses, who felt the community setting offered them "more time" to do this than hospital-based care.

> **Nurse-Daisy**: "I think time is massive like for showing dignity. In the community, there's more time I think, than on the wards. I will stay with that patient as long as I need to, because I know I can hand it over to someone, or I can do it later or… so I feel in the community it is more… able, you are more able to care better… with time."

Each week, the senior nurses evaluated how much time would be necessary for each visit before allocating tasks to staff members in their teams, but their time assessments were not always popular with the junior nurses.

> **Nurse-Anya**: "I'm telling you I haven't got capacity to do it. It's not fair… when I can see that [nurses] are sat there on two visits and we're sat there on eighteen visits. How is that a fair representation?"

The senior nurses assessed the time required for each visit and therefore junior clinicians (such as Anya) could be allocated many "light" visits (15-18 per day), a few "heavy" visits (3 or 4 per day), or, more commonly, a combination of both. When undertaking allocations, the senior nurses described their workload reviews as "weighting" the visits to ensure equitability across staffing teams and they explained it was not appropriate to compare administering an insulin injection (which could take as little as a few minutes) to a bilateral leg dressing in which legs in water-retention could require substantial physical effort and time from the nurse. The nurses described bilateral leg dressings as "heavy visits", which corresponded with their overall process of "weighting visits", in which time was measured by weight ("heavy visit" = slow, "light visit" = fast). As an example, delivering care to Warren (who required bilateral leg dressings, but also had a range of complex co-morbidities) was considered a "heavy visit", so nurses were allocated more time to undertake his care.

Some of the nurses recognised the flaws in the system which led to care being evaluated in terms of time rather than quality, and many nurses recognised time and quality as independent concepts that were often in direct opposition to each other.

Nurse-Ella: "It's not about the quantity of visits, it's about the quality."

Nurse-Denise: "Sometimes it's not the quality, it's the quantity we do. And we've got to get back to the quality […] It's that quick in, quick out, quick in, quick out and that's not quality."

Although nurses are working to clock-time, issues of temporality may be more important to their older adult patients where their subjective experiences of the passage of time are crucial in experiencing care delivered with dignity.

> **Michelle (86)**: "Just because people are old, just because they're ill…it doesn't mean you can, erm…how would you say… 'slaphappy' always comes to my mind."

Michelle evoked the term "slaphappy" to describe her current team of community nurses who she felt rushed her care more than a previous team. Her words are symptomatic of much broader systemic issues in healthcare, where there are increasing pressures placed on clinicians to spend less time with patients, whereby, as Levy and Banaji (2002) argue, discrimination against the elderly is likely to increase. This also poses issues of how time (an objective measurement) and temporality (subjective experiences) impact dignity. The manifestation of dignity within the nursing relationship may be dependent on differing expectations of time and the ability for nurses to manage the temporal aspects of patients' dignity remains a challenge, because, although nurses are 'time-poor', many older adult patients are 'time-rich'.

> **Nurse-Daisy**: "I know nurses do just go in and out, they don't always ask how they are and… I hope not_ that it doesn't happen often, but you see it everywhere, like on the wards as well, you just_ it's just quick, quickly you know… do what they need to do quickly and rush off but… you know, these patients are vulnerable and I think they need to be cared for with dignity."

Implicit in Daisy's quote is a belief that a slower pace of work could result in dignity-enhancing care. Despite their temporal coexistence, nurses may lack time in a way that older adults do not, and thus there is the potential for a paradoxical mismatch in the expectations of the 'time-rich' patient and 'time-poor' nurse. Time is required to deliver care with dignity, and, by extension, potential safeguarding issues are more likely to arise (or remain unnoticed) if insufficient time is allowed to support dignity.

> **Nurse-Sheila**: "We are so busy and a Doppler [ultrasound] takes like an hour to do, and sometimes… we just sort of push it to the side, and we think, 'oh we are busy'. Like for example, if somebody rings in sick, the Doppler can wait till next week."

Sheila's comment illustrates Walshe *et al.*'s (2012) finding that, although 'caring in the moment' is important, this has implications for future care, as current care needs become prioritised more highly than advanced care planning. As Sheila explains, if time is limited, certain tasks are postponed. When Dopplers are delayed, this saves time in the short term which can be transferred to other (more immediately pressing) tasks. However, delaying Dopplers also means a delay in maximising effective

treatments, resulting in patients remaining on nursing caseloads for longer, and therefore any time saved in the short-term is in fact 'borrowed' from the future. In this context, time is a currency that can be loaned, but it may be a false economy, as patients not only remain on caseloads longer, but they remain in ill-health for longer, and this can lead to other co-morbidities, as well as possibly increasing patient complaints, and indeed potentially leading to safeguarding allegations of abuse or neglect.

Discussion

Space and time are relevant in the delivery of dignified district nursing care. Domestic spaces and spaces of formal service provision merge when care is delivered in the home as the same space adapts to serve assorted functions at different times. These factors contribute to the complexity and nuance of manifesting dignity in district nursing care.

People modify their standards and expectations according to the differing environments in which care is given and received, therefore, older adults' acceptance of care within the home is based on different behavioural standards to those they adopt when care is received in institutions. Hospitals are littered with clinical artefacts, and patients are accepting of them, but, introducing clinical equipment into the home is a different matter, as they fundamentally depersonalise the space, whilst simultaneously rendering it a more familiar space for the nurse. In this context, the understanding and experience of dignity between nurses and patients might, thus, differ significantly.

Respect for the home is arguably related to respect for patients' dignity where social obligations and cultural scripts shape people's expectations of behaviours in the home. These codes of operation manifest in terms of informal 'house-rules' which provide socially and culturally constructed norms within the household. Many 'house-rules' are not universal, yet they fundamentally underpin patients' dignity as clinicians are expected to conform to these established codes of social behaviour, even though they have not been formally introduced to the individual idiosyncrasies of each household. Therefore, to show dignity and respect, nurses must navigate their way through complex cultural scripts where there may be wide variations across different households and transgressing these codes may cause disruptions to dignity.

The 'home-clinic' is the primary significant space within which power, agency, and control are operationalised. It is the key location within the home where patient and nurse must collaborate to

ensure dignity manifests. There are certain areas of the home where it is implicitly preferable for nursing care to occur. The lounge, for example, was the home space where older adults preferred to situate 'home-clinic', possibly because other spaces (such as kitchens) have a designated purpose that is less acceptably contravened, though a small number of participants made use of the bedroom as the 'home-clinic'.

Certain areas of the home are more public than others and nurses' spatial freedom is restricted when working in patients' homes. As previously noted, lounges were commonly used as the 'home-clinic' and, during fieldwork observations, it was noted that objects that rendered this space identifiable as a lounge (such as a television and a sofa), were often displayed alongside clinical equipment (such as commodes and oxygen cylinders). At times, profiling hospital beds dominated communal living areas, making the 'home-clinic' an unconcealable feature of a lounge. When home spaces such as the lounge are transformed into a triple-purpose space (lounge, bedroom and 'home-clinic'), it becomes a hybrid area defined by the need to compromise, thus rendering it an unsatisfactory space for all, as the overall purpose of the space has become difficult to identify. The actual use of the area differs from its intended function, making it unboundaried; an aesthetic disruption to the home. In the nurse's presence, the room has meaning and purpose as the 'home-clinic', but in the absence of clinicians, the space becomes a 'nonplace' (Augé, 1995) or a 'noplace' (Lawton, 1998), as functional boundaries are blurred, resulting in an environment in which it is difficult for dignity to flourish. Illness (and the ensuing clinical paraphernalia) can cause disruptions to the home environment as there is the continual threat that the functions of daily home life become usurped by illness in the household. Thus, for dignity to thrive, spatial disruptions require careful management, and although older adults may initially refuse aids and adaptations, nurses must recognise that in future, patients may become more accepting of them, and being able to advise patients on how to gentrify clinical artefacts may also assist in maintaining an 'environment of dignity'.

Spatial disruptions were evident particularly in observational visits, where a lounge also served as a bedroom and 'home-clinic'. In these scenarios, despite being daytime, curtains or blinds were drawn, preventing daylight from entering and ensuring rooms remained in a perpetual state of twilight. Windows obscured by curtains ensured that the older adult was unable to witness symbolic indicators of day and night, seasonal changes and the movement of time. In these contexts, time was suspended, as the relevance of clock-time held no importance when eternal twilight prevailed. The sad irony is that, for district nursing patients at the end of life, the significance of time is potentially even greater,

as they do not have enough of it, and yet they are inhabiting a space in which time is effectively suspended by the absence of markers of its passing.

The influence of time is also apparent when considering how caring activities undertaken by the district nursing team were influenced by time assessments made by the senior nurses when they undertook their visit allocations. The approach they adopted considered 'process time' (defined by Davies, 1994) which ensured appointments were allocated to ensure that specific clinical tasks (such as administering insulin, catheter-care, changing dressings) were allocated sufficient time. Davies (1994) recognises, although caring activities can be structured by clock time, it may raise issues of quality, and the allocations did not consider wider elements of nursing care that require embedding such as the 6Cs (DH, 2012a) - care, compassion, courage, communication, commitment and competence, which all contribute to quality patient care, along with the seventh C, curiosity, which is particularly important in a safeguarding context. There is a danger that dignity can become marginalised if these broader elements of care are not considered in the allocation of (process) time. Consequently, if dignity remains on the periphery of care, there is a danger that conditions are created in which abuse is more likely to occur, as has been shown from high profiles failures such as at Mid-Staffordshire Hospitals Trust and Winterbourne View (Mid Staffordshire Inquiry 2010, 2013; DH, 2012b).

Nurse-participants emphasised how "quality and not quantity" was most important to deliver care with dignity, and indeed, 'time-rich' patients appreciate slower approaches to care, where their care is personalised, they are recognised as a person and are not viewed as a task. Thus, genuine movement away from task-centred care to person-centred care requires an acknowledgement that 'all dressings are not equal' and that, although nurses may be undertaking the same task with multiple patients, certain individuals may require more time than others to ensure they experience dignity. Although time was of significance to nurses, perhaps it was temporality that was of greater significance to their patients, where their subjective experience of caring in time, related to their experience of dignity. Despite this, many patients were observed to be keen to ensure they did not delay the nurses (for example by laying out any equipment in advance) which this may be reflective of Twigg's (2000) view, that as many care recipients do not directly pay for their care, their moral claim on carers' time is weakened.

Practical Implications

Older adults value their relationships with their nurses, and, thus, although individual patients are only one of many patients a nurse encounters during the day, nurses must remain mindful that this may be the only contact the patient has for the day (or week, or even longer). This provides a vital opportunity to reduce social isolation, and, reinforce patients' dignity. Through demonstrating the 7Cs in their practice, individual nurses can take a proactive approach to ensure their patients receive care with dignity. Every contact with a patient has the potential to be a 'dignity encounter' (Stevens, *et al*., 2021), and through the delivery of dignified care, nurses can ensure their patients remain protected because abuse and neglect can thrive in the space in which dignity is not present.

District nurses also have a role in identifying abuse and neglect and acting if it is suspected as well as ensuring their practice prevents safeguarding issues. They have some oversight of what else is occurring in the home, and therefore may be able to identify safeguarding concerns arising from informal or paid carers, as well as noticing indicators of domestic abuse. Therefore, it is important that all nurses receive regular safeguarding training and that they are familiar with their local policies and procedures, and receive appropriate supervision, so that they understand what action to take if they have any safeguarding concerns.

Further research

Further research into a broader range of people giving and receiving care within the home could contribute to the growing evidence base around safeguarding practice. Older adults, like other patient groups, are not homogenous, and thus future research could offer insights into perspectives of a wider range of people with populations that were excluded from this study. For example, participants who lacked capacity to consent to their care were excluded, and these may be the people that are particularly vulnerable to dignity violations as they are less likely to be able to complain or advocate for themselves. Similarly, the study could be replicated with other professional groups that deliver care within the home, such as domiciliary carers or other community care staff such as social workers or community mental health and learning disability nurses.

Conclusion

District nurses' practice within the home, and this involves interacting with their patients across both time and space. Complex dynamics come into play when someone's home becomes another

person's workplace. Boundaries of what is public and what is private begin to merge as the private space of home becomes a public workplace. Certain areas of the home are more public than others and nurses' spatial freedom is restricted when working in patients' homes, unlike hospital settings where it is patients that have greater spatial restrictions than nurses. People live in a diverse range of social conditions, and community nurses adapt to undertake their work in a variety of environments. Although there are opportunities to create 'environments of dignity' when people become unwell, health issues dominate their world and clinical artefacts may begin to consume, or dominate the home space, making an 'environment of dignity' more difficult to achieve.

To some people, 'home' may be a place of comfort, safety and security. However, for others, it may be a place of danger, imprisonment or violence. When people require nursing treatment in the home, domestic space and spaces of formal service provision merge. Older adults may receive nursing care in the same location within the home in which they sustained the injury requiring nursing input, which is particularly relevant for people that have fallen in their home and receive nursing care as a result. In these situations, the site of the 'accident' later becomes the 'home-clinic', in which nurses deliver their care, and importantly, the domestic space may also be the location of abuse and a site of safeguarding concerns. This space may, therefore, hold multiple meanings for patients – as both a site of harm and healing.

This paper explored how delivering nursing care within the home has important dignity and considerations and potential safeguarding implications. As district nursing is undertaken 'behind closed doors', care recipients are potentially vulnerable to abuse from lone-workers operating free from the gaze of other professionals. This potentially increases the likelihood of unwitnessed delivery of poor care or abuse; yet simultaneously, district nurses are in a unique position to identify abuse or neglect within the home and take action to safeguard their patients. By delivering care in the home, district nursing teams are in a unique and privileged position. At the micro-level of community nursing relationships, in everyday spaces and through geographies of care within the home, delivering care with dignity has the potential to safeguard adults living in their own homes.

References

Argyle, E., Kelly, T., Gladman. & Jones, R. (2017) The effective ingredients of social support at home for people with dementia: a literature review. *Journal of Integrated Care*, **25**(2), pp110-119.

Augé, M. (1995) *Non-places: Introduction to an anthropology of supermodernity*. London: Verso.

Baillie, L. (2009) Patient dignity in an acute hospital setting: A case study. *International Journal of Nursing Studies,* **46**(1), pp23–37.

Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, **3**, pp77–101.

Braun, V. and Clarke, V. (2013) *Successful qualitative research: a practical guide for beginners.* London: Sage.

Carolan, M., Andrews, G.J., Hodnett, E. (2006) Writing place: a comparison of nursing research and health geography. *Nursing Inquiry,* **13**(3), 203–219.

Conradson, D. (2003) Geographies of care: spaces, practices, experiences. *Social & Cultural Geography*, **4**(4), pp451–454.

Davies, K. (1994) The tensions between process time and clock time in care-work *Time & Society*, **3**(3), pp277–303.

DH (2012a) *Compassion in practice*. Available online: https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf [Accessed 29/06/21].

DH (2012b) *Transforming care: A national response to Winterbourne View hospital – final report.* Available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf [Accessed 29/06/21].

Drennan, V.M, Manthorpe, J. & Ilifffe, S. (2017) Meeting the needs of older people living at home with dementia who have problems with continence. *Quality in Ageing an Older Adults* **18**(4), pp246-253.

Griffith, R. (2014) District nurses' crucial role in identifying unlawful deprivation of liberty. *British Journal of Community Nursing*, 19(5), pp239-243.

Griffith and Tengnah (2008a) Mental Capacity Act: determining best interests. *British Journal of Community Nursing*, **13(**7), pp335-341.

Griffith R, Tengnah C. (2008b) Mental Capacity Act 2005: advanced decisions to refuse treatment. *British Journal of Community Nursing*, **13**(8), pp391-394.

Griffith R, Tengnah C. (2009) The Female Genital Mutilation Act 2003: an overview for district nurses. *British Journal of Community Nursing*, **14**(2), pp86-89.

Griffith R. (2015) Understanding the Code: safeguarding vulnerable adults. *British Journal of Community Nursing*, **20**(11), pp564-566.

Guba, E.G. (1981) Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Communication and Technology*, **29**(2), 75–91.

Holmberg, M., Valmari, G., & Lundgren, S. M. (2012). Patients′ experiences of homecare nursing: Balancing the duality between obtaining care and to maintain dignity and self-determination. *Scandinavian Journal of Caring Sciences*, **26**(4), pp705–712.

Høy, B., Wagner, L. & Hall, E. (2007) The elderly patient's dignity: The core value of health. *International Journal of Qualitative Studies on Health and Well-Being,* **2**(3), pp160–168.

Lawton, J. (1998) Contemporary hospice care: the sequestration of the unbounded body and 'dirty dying'. *Sociology and Health and Illness***, 20**(2), pp121–143.

Levy, B.R & Banaji, M.R (2002) 'Implicit Ageism'. In T.D. Nelson (ed.) *Ageism: stereotyping and prejudice against older persons*. Cambridge, MA: MIT Press.

Liaschenko, J. & Peter, E. (2004) Nursing ethics and conceptualizations of nursing: profession, practice and work. *Journal of Advanced Nursing,* **46**(5), pp488–495.

Manthorpe, J. & Martineau, S. (2017) Home pressures: failures of care and pressure ulcer problems in the community – the findings of serious case reviews. *The Journal of Adult Protection,* **19**(6), pp345-356.

Matiti, M. R. & Trorey, G. M. (2008) Patients' expectations of the maintenance of their dignity. *Journal of Clinical Nursing,* **17**(20), pp2709–2717.

Maybin, J., Charles, A. & Honeyman, M. (2016) *Understanding quality in district nursing services: Learning from patients, carers and staff.* Available online: http://www.kingsfund.org.uk/publications/quality-district-nursing [Accessed 29/12/2020].

McGarry, J. (2003) The essence of 'community' within community nursing: a district nursing perspective. *Health Soc Care Community,* **11**(5), pp423–430.

McGraw, C. (2018) Nurses' perceptions of the root causes of community-acquired pressure ulcers: Application of the model for examining safety and quality concerns in home healthcare. Journal of Clinical Nursing, **28**(3-4), pp575-588.

Michael, L. (2014) Defining dignity and its place in human rights. *The New Bioethics,* **20**(1), pp12–34.

Mid-Staffordshire NHS Foundation Trust Inquiry (2010) *Independent inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005-March 2009 Volume 1.* London: Crown Copyright. Available online: http: //webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113018 [Accessed 14/11/21].

Mid-Staffordshire NHS Foundation Trust (2013) *Report of the Mid Staffordshire NHS Trust Foundation Trust public inquiry.* London: Crown Copyright. Available online: http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/report [Accessed 14/11/21].

Milligan, C. (2000), 'Bearing the burden': towards a restructured geography of caring. *Area*, **32**(1), pp49–58.

Nordenfelt, L. (2004) The varieties of dignity. *Healthcare Analysis,* **12**(2), pp69–81.

Nordenfelt, L. (2009) *Dignity in care for older people.* Ames, Iowa: Wiley-Blackwell (an imprint of John Wiley & Sons Ltd).

Öresland, S., Määttä, S., Norberg, A. & Lützén, K. (2009) Patients as 'safeguard' and nurses as 'substitute' in home health care. *Nursing Ethics*, **16**(2), pp219-230)

Ousey, K., Kaye, V., McCormick, K. & Stephenson, J. (2015) Pressure ulcers: are they a safeguarding issue in care and nursing homes? *Wounds UK*, **11**(3), pp14-17.

Peter E. (2002) The history of nursing in the home: revealing the significance of place in the expression of moral agency. *Nursing Inquiry,* **9**(2), pp65–72.

Pettitt, K. (2000) The district nurses role as patient advocate: case study. British Journal of Community Nursing, **5**(1), pp14-19.

Rosen, M. (2012) *Dignity: Its History and Meaning*. Cambridge, MA: Harvard University Press

Seymour, J. (2007) Treating the Hotel Like a Home: The Contribution of Studying the Single Location Home/Workplace. *Sociology,* **41**(6), pp1097–1114.

Stevens, E., Price, E. & Walker, E. (2021) Making the mundane remarkable: an ethnography of the 'dignity encounter' in community district nursing. *Ageing & Society* (Early Access)
DOI: https://doi.org/10.1017/S0144686X21000738

Tranvåg, O., Synnes, O. & McSherry, W. (eds) (2016) *Stories of dignity within healthcare: research, narratives and theories.* Keswick: M & K Publishing.

Twigg, J. (2000) *Bathing – the body and community care*. London: Routledge.

Walshe, C., Payne S. & Luker K (2012) Observing district nurses roles in palliative care: an understanding of aims and actions. *BMJ Supportive & Palliative Care,* **2**(1), A2–A3.