

ORIGINAL PAPER

DIGNITY OF ELDERLY ADULTS FROM THE PERSPECTIVE OF NURSES: A QUALITATIVE DESCRIPTIVE STUDY

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Abstract

Aim: The aim of this descriptive qualitative study was to analyze dignity in nursing care in institutionalised elderly adults from the perspective of nurses, and to identify factors affecting dignity. **Design:** A descriptive qualitative study. **Methods:** A descriptive qualitative study employing individual in-depth interviews. The sample comprised ten general nurses working in health and social institutions with round-the-clock care for elderly adults. A thematic analysis was used to analyze the data. **Results:** Six main themes have been identified in relation to dignity: Regarding elderly adults as unique human beings; Privacy and embarrassment; Quality of relationships; Communication; Quality of care; and Environment. The main themes were further broken down into 24 sub-themes and their mutual relationships. Among important determinants for dignity, nurses listed sufficient staff and funding, the necessity for health and social workers to cooperate, and family relationships. **Conclusion:** The resulting schema represents a description of nurses' experience of respecting dignity in primary nursing care for elderly adults. Nurses see dignity in open communication, room for privacy, securing quality individualised care, and preserving current family relationships. The schema may be used for a self-reflection by nurses in direct care for elderly adult, by the management of healthcare institutions and social care, and for students of nursing.

Keywords: dignity, elderly adults, interview, nurses, nursing care, thematic analysis.

Introduction

Dignity ranks as one of the essential undisputed human values stipulated in international agreements and declarations. The *Universal Declaration of Human Rights* (UN General Assembly, 1948) speaks of the need for “recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family”.

Due to recent demographic changes in the human population, the number of elderly adults has risen sharply on a world-wide scale. The aging of the population poses the challenge of giving elderly adults the chance to lead a meaningful and dignified life (Sander et al., 2015). Scientific literature in the field of healthcare offers several definitions of *dignity*. Nordenfelt (2004) divided dignity into four types: 1) dignity of merit; 2) dignity of moral stature; 3) dignity of identity; and 4) universal human dignity (*Menschenwürde*). Jacobson (2009)

interpreted the taxonomy of dignity on two levels: 1) human dignity; 2) social dignity.

Preserving patients' dignity is an important aspect of nursing care. It is the behavior of nurses and nursing staff that may influence the provision of dignified care (Baillie, Gallagher, 2012). Dignity in nursing has recently become a research topic for several authors, particularly in the United Kingdom (Gallagher, 2004; Woolhead et al., 2006; Baillie et al., 2009; Williams, Kinnear, Victor, 2016 and others) and Scandinavia (Jakobsen, Sørli, 2010; Hall, Høy, 2012; Hall, Dodd, Higginson, 2014). In their review focusing on Nordenfeld's exposition on four types of dignity in nursing care, Kane and de Vries (2017) claim that carers involved in long-term care often feel helpless in the face of organisational structure and institutional culture. Among the most frequent limitations to providing dignified care, nurses report lack of time, lack of financial resources, excessive workload, and burnout. There is a moral conflict between the care that nurses would like to provide and the care they are actually able to provide given their work

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environment and culture. Gallagher (2004) describes the relationship between how nurses respect patient dignity and their own personal and professional dignity (self-assessed dignity). In their empirical study, Williams, Kinnear, Victor (2016) identify the importance of the “little things” that promote patient dignity. They place emphasis on individualised care, similarly to Hall and Hoy (2012), who state that for dignity to be respected, it is necessary to “see the patient as a unique being”.

Dignity in nursing care is a frequently discussed issue. We need to identify how this concept is perceived by the nurses themselves, and to analyze their experience in the context of care for elderly adults, whose dignity is more precarious compared to the younger population (Webster, Bryan, 2009). Based on our literature review (Šaňáková, Čáp, 2018), we can state that the dignity of elderly adults (patients) in the context of nursing care is understood as a state of physical, emotional, social and spiritual well-being, while the unique identity and individuality of elderly adults are respected. Dignity is promoted when individuals utilize their full potential and coping strategies, keep control over their situation, can make decisions, feel involved in the decisions regarding their care, and have room for privacy and functional relationships with close friends and family and the nursing staff. Other important factors promoting dignity in nursing care are work culture and environment.

Aim

The aim of the qualitative descriptive study was to analyze nurses' experience of dignity in elderly adults in institutionalised care. We focused on how nurses interpret dignity in their nursing practice and

what factors affect dignity in nursing care for elderly adults. We formulated three research questions: How do nurses interpret the dignity of elderly adults? What factors may promote dignity from the perspective of nurses? What factors constitute threats to dignity in care for elderly adults?

Methods

Design

A cross-sectional descriptive qualitative study using in-depth semi-structured interviews and thematic analysis. The methodological background is based on *Generic qualitative research* (Caelli, Ray, Mill, 2003). The authors' methodological position is grounded between interpretivism and social constructivism. They are convinced that reality and its explanation are based on interpretation of human experience, and that this experience is always created through interaction with other people.

Sample

The sample was collected using a combination of purpose sampling in institutions, and snowball sampling. When searching for and addressing respondents, we used their links to a particular healthcare or social institution providing care for elderly adults. The following inclusion criteria were used: general nurse working independently without supervision; with currently at least one year of work experience in gerontology; and informed consent. The sample comprised ten nurses, aged 38–58, with an average work experience of 22.4 years and average length of current employment of 11.7 years (Table 1). Five nurses worked in two Long-term care facilities, five nurses in care homes with nursing.

Table 1 Sample characteristics

| Interview | Age | Education | Position | Work experience in years | Institution (work experience, years) |
|-----------|-----|-----------|---------------|--------------------------|--------------------------------------|
| 1 | 39 | U | nurse manager | 19 | LTC (8) |
| 2 | 38 | SS + MS | charge nurse | 20 | LTC (20) |
| 3 | 45 | SS | staff nurse | 20 | LTC (6) |
| 4 | 41 | SS | staff nurse | 8 | LTC (4) |
| 5 | 44 | SS | staff nurse | 25 | LTC (25) |
| 6 | 40 | U | nurse manager | 16 | HwN (12) |
| 7 | 52 | U | staff nurse | 29 | HwN (9) |
| 8 | 41 | U + GS | nurse manager | 23 | HwN (16) |
| 9 | 58 | SS + GS | staff nurse | 35 | HwN (19) |
| 10 | 47 | SS | staff nurse | 29 | HwN (8) |

GS – geriatric specialisation; MS – management specialisation; SS – secondary school; U – university degree; HwN – Care home with nursing; LTC – Long-term care facility

Data collection

Data were collected using in-depth semi-structured interviews. The interviews were conducted face-to-face in calm, safe environments at the health institutions where the nurses worked, in May and June 2016. Each interview was recorded and transcribed verbatim. Field notes were taken during the interviews, which complemented the process of reflexivity. In order to achieve increase the trustworthiness and credibility of the research in this phase, we used a unified structure for the interviews, triangulation of data sources, field notes, and the interview itself, making it possible to regard the data from multiple perspectives (Cohen, Crabtree, 2006; Hendl, 2008).

Data analysis

The interviews were analysed using thematic analysis by Braun and Clarke (2006). The analysis was performed in six stages: division of data into semantic units using direct quotations; the generation of initial sub-themes; the search for themes; the re-examination of the themes by comparing similarities and differences in content; the definition and labelling of themes; and the summarizing of results.

Semantic units were converted into MS Excel to facilitate data processing. Each step of the analysis

was meticulously recorded – *chain of evidence* (Yin, 2003). Six main themes were finally identified as characterizing the respondents' statements. Illustrative quotations from the recordings were added. The first author performed the thematic analysis, which was subsequently discussed with the second author – *peer debriefing* (Cohen, Crabtree, 2006). This method is known as *analytic triangulation* (Nguyen, 2008).

Results

The thematic analysis identified the following core themes affecting dignity: *Regarding elderly adults as unique human beings*; *Privacy and Embarrassment*; *Quality of Relationships*; *Communication*; *Quality of Care*; and *Environment*.

Each theme was broken down into sub-themes which specified in detail particular aspects of each theme. In order to visualise the results, we created a chart (Figure 1), and the sub-themes were substantiated with quotations from nurses' responses.

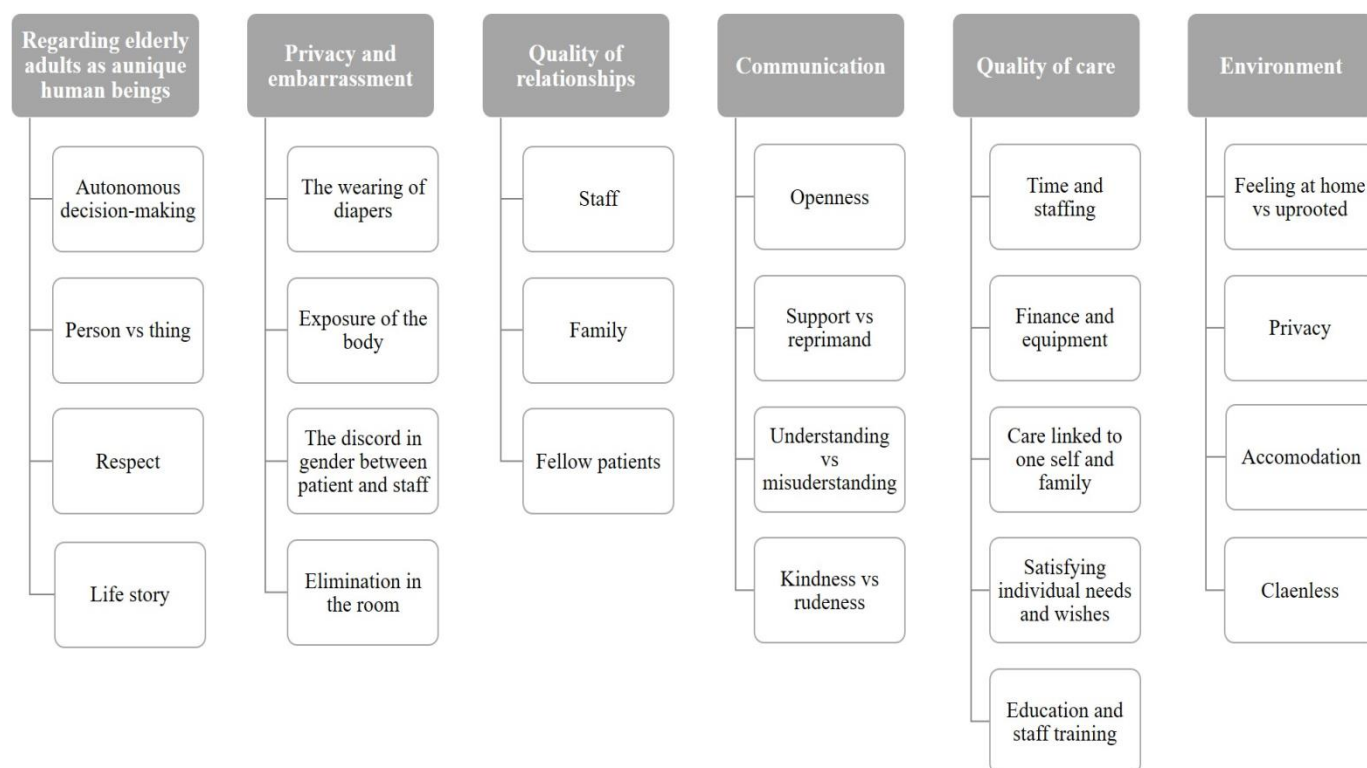


Figure 1 Results of the thematic analysis

Regarding elderly adults as unique human beings

Nurses semantically associated dignity with respect for human beings, autonomous decision-making, and regarding each person as an individual with their own life story. We called this thematic area *Regarding elderly adults as unique human beings*, and it consists of the sub-themes: *Autonomous decision-making; Person vs thing; Respect; and Life story*.

Nurses find it essential to preserve autonomy, and to allow elderly adults to make their own decisions in daily activities. Despite this fact, they admitted that it is not always possible to adjust operations to meet individual needs: *“It is dignified when our clients feel they can make decisions about the care they want, what the care should be like. Or what they would like the care to be, to let them make decisions... how they want things to be, not how we want it according to our norms”* (Nurse, 52, interview no. 7).

In connection with working against the clock and the need for efficient performance, nurses spoke of staff not regarding elderly adults as people: *“...to have everything in order and sometimes the person is lost in the middle of it.”* (Nurse Manager, 40, interview no. 6) *“It is like we work with machines, you work with people, we work with people”* (Nurse, 52, interview no. 7).

Respect was most often associated with esteem for a person: *“For me respect means esteem for the person ... in my entire career, I have tried not to demean the person, on the contrary, I have had respect for every person, for every patient, even those with low social status, even those who were demented”* (Charge nurse, 38, interview no. 2).

In the opinion of nurses, the dignity of an elderly adult is also preserved by knowing their life story and by working with their biography. One of the nurses described how she intentionally steers the interview with elderly adults back to their memories, and her interest boosts their self-confidence: *“When talking to an elderly person, I gather information about what they did in their life and so on. They go back in time, and by doing so, their self-confidence returns, their self-worth, and we are back in reality”* (Staff nurse, 44, interview no. 5).

Privacy and embarrassment

The theme privacy and embarrassment includes four sub-themes: *The Wearing of diapers; Exposure of the body; The discord in gender between patient and staff; and Elimination in the room*. The nurses interviewed agreed that observing privacy, and respecting the embarrassment of elderly adults is a precondition for preserving dignity. The factors that threaten dignity in elderly adults in this area include

incontinence and incontinence products, exposing patients' bodies and not respecting their embarrassment, elimination in a room with more beds, and the discord in gender between patients and staff.

Elimination, an intimate subject for every individual, is seen by nurses as a situation in which there is a great risk of loss of dignity, particularly in connection with diapers: *“Of course we do our best to preserve privacy during various procedures, because the mere fact that people wear diapers strips them of dignity as such”* (Nurse Manager, 41, interview no. 8).

In the opinion of nurses, elderly adults lose privacy when admitted into a healthcare institution. Nurses report that exposure of one's body is a serious threat to dignity: *“I realised, as I took the course (Basic stimulation course – author's note), that the person loses dignity, loses privacy in a healthcare institution. A doctor and I approach the patient, who has to undress in front of us. I can imagine it, the patient knows my name, has to get naked, then the examination comes – the patient is stark naked in front of us, then somebody enters the room...”* (Charge nurse, 38, interview no. 2). Two nurses in managerial positions noted that they deal with this matter repeatedly with their subordinates in direct care: *“She took her to the bathroom on a wheelchair again – this is covered, yes, fine, there is a pad, bedsheet, whatever, but the backside is out, isn't it...?”* (Nurse Manager, 41, interview no. 8).

The fact that the elderly adults and the staff are of different sexes poses another possible threat to dignity, particularly in the area of privacy. Nurses observe that elderly adults are quite sensitive to these differences: *“Then there was this problem that we are women and they are men, even though they are old. They are men, I can see that. Of course not all of them, the majority take us as nursing staff, but there are some where there really is this embarrassment...”* (Nurse manager, 40, interview no. 6).

The nurses interviewed realised that it is necessary to preserve dignity in a healthcare institution when it comes to elimination, at the very least by leaving the room to allow privacy. They clearly see that patients are robbed of dignity when they need to eliminate in front of other patients in a room with multiple beds: *“Now he needs to eliminate on a toilet chair, he has to wait there for a while, this is how he loses his dignity, exactly in this situation. He has to eliminate in a room with multiple beds”* (Charge nurse, 38, interview no. 2). To maintain elderly adults' dignity, nurses state they should allow patients some privacy, so that they feel more “at home”: *“Of course to*

observe privacy, if there are visitors, they are asked to leave the room, it's on the door, or when it comes to changing diapers or they want to use the toilet chair, so that they feel nobody is watching, they feel at home" (Nurse, 52, interview no. 7).

Quality of relationships

Dignity in nursing care depends on the quality of relationships which, in the opinion of nurses, affects the atmosphere in the workplace. The theme includes three sub-themes: *Staff*; *Family*, and *Fellow patients*.

Nurses realise that their attitude to elderly adults, and the quality of their relationships with them has a significant effect on dignity in the given facility. In care homes with nursing, care is provided by healthcare staff and social workers. Nurses regard cooperation between the two staff as a major factor in dignity: *"It is not going smoothly regarding indirect and direct care and activation. And no wonder. It is not only activation. If the basics are missing, there isn't any activation. Seems like something else is now in fashion, and it's not primary care"* (Nurse Manager, 41, interview no. 8). Nurses claim that work overload and personal problems contribute to care without dignity. One nurse stated that self-reflection and a subsequent apology are extremely important: *"It happened to me that I was unkind to one of the ladies. I had some problems... Then I calmed down and went back to the nurses' room because I was stressed, but then I went back to apologise to that lady. I said that I didn't mean it, that I had lost my temper, and I was sorry. She accepted that"* (Nurse, 47, interview no. 10).

Both staff nurses and charge nurses agree that cooperation with families, and maintaining functional relationships are essential to the preservation of dignity. Charge nurses, in particular, noted cases in which a family showed no interest or visited only out of profit-seeking motives: *"Some visitors come regularly, bring something, some only come on the 15th, collect the pension, or the rest of the pension, they do not let mother buy a bottle of water, or a pedicure or a haircut, nothing. We have cases like that. Absolutely horrendous"* (Nurse Manager, 41, interview no. 8). Nurses confirm that when a family shows no interest, elderly adults suffer, and their physical and psychological conditions deteriorate: *"The patient still cherishes hope... and says they promised to come on certain days. And then the family does not come, and there is this great disappointment which leads to a health decline, blood pressure goes up, patients cry, they need more care"* (Staff nurse, 45, interview no. 3).

Nurses also state that to maintain dignity in elderly adults, the person patients share a room with is important. Even though nurses try to meet patients' requirements regarding their fellow patients, it is not always possible to comply: *"No matter how we try, sometimes it happens that they meet in the room and there is nothing we can do about it. People who do not get on well with each other, they are totally different, two different worlds... And, quite logically, rifts occur... And this is terrible, the idea that at the end of life I have to learn to get on with somebody I would barely say hello to in my private life, and nothing more, and I'll be spending 24 hours a day with this person"* (Charge nurse, 40, interview no. 6).

Communication

According to nurses' responses, communication is the main tool for creating good social bonds in the adaptation process of elderly adults to a new environment. The theme *Communication* includes four sub-themes: *Openness*; *Support vs reprimand*; *Understanding vs misunderstanding*; and *Kindness vs rudeness*.

According to nurses, open communication lies in honest dialogue. In daily practice, they often face dilemmas in which the truth is withheld regarding elderly adults' health condition. These situations are considered undignified: *"We admitted a patient... , he thought his wife would be admitted to the other ward and that she would be visiting him, but the situation changed dramatically and the family explicitly wished us not to tell him anything"* (Staff nurse, 45, interview no. 3). Openness is essential not only in the contact between patients and staff, but also in the nursing team when they discuss their clients: *"In the moment when we sit in the morning, during shift handover, the nursing assistants come, we are planning the day, and we talk about our clients. This is during a regular daily meeting. Or we sit at lunchtime and lunch becomes something like a meeting and we talk about our job, we talk about our clients"* (Charge nurse, 40, interview no. 6).

Support of elderly adults, or lack thereof was mentioned in most of the interviews. The nurses repeatedly mention the need to find time for elderly adults, to adjust their tempo and speech to their abilities: *"Elderly people do not like rush and briskness. They prefer a slow pace, to take their time to understand things, to have things explained"* (Staff nurse, 58, interview no. 9). We established that an important aspect of communication and support of elderly adults is to hear them out, to praise and support them: *"I do so by always introducing myself, addressing them by their surname, asking them about their opinions, how they are, how things are. I praise*

them for doing something, or when a lady says 'I am clumsy, I am useless'... I say otherwise, I praise her" (Charge nurse, 38, interview no. 2). Nurses consider it undignified to reprimand elderly adults: *"When a patient fell over in a wheelchair and the nurse said 'I told you not to go there...'"* (Staff nurse, 44, interview no. 5).

For nurses, an important part of communication is understanding, i.e., comprehension of the specific needs of an elderly adult. Nurses are aware that an elderly person may understand some information differently: *"Or when an elderly person understands something else than what I mean. Some of them are quirky and you can take it personally"* (Charge nurse, 39, interview no. 1). The fact that the patient does not understand may result in an inappropriate reaction which threatens dignity. Understanding is also connected with the need to inform the patient/client about the institution, and care planning: *"Explain, explain, and explain. So that the person really understands the given problem, because otherwise he or she becomes sad, easily moved to tears, when he or she cannot do something as a young person would"* (Staff nurse, 45, interview no. 3).

In nurses' view, dignity was also frequently associated with kindness. According to their answers, kindness is rooted in a polite approach, addressing them by their full name and title: *"Kindness is also saying something loudly enough, clearly, without raising your voice"* (Staff nurse, 58, interview no. 9). For nurses, kindness and politeness are also demonstrated by using formal terms of address: *"We are not on first-name terms, we always ask during the admission how they wish to be addressed. It is always necessary, even though they say they want to be addressed with their first-name, such as Mrs. Věra or Mrs. Jaruška, but we use polite forms of address"* (in Czech, by using first names but with verbs in the polite form – author's note) (Charge nurse, 40, interview no. 6). And the opposite was expressed: *"Some members of staff addressed them as 'granny' or 'grandpa', these kinds of impolite terms, which I did not like"* (Staff nurse, 44, interview no. 5).

Quality of care

All respondents from all four institutions agree that dignity in nursing care is greatly influenced by the quality of care, particularly in connection with sufficient staff, equipment, and funding. Repeatedly, nurses linked dignity of care for elderly adults with care for oneself and family. The theme includes five sub-themes: *Time and staffing; Finance and equipment; Care linked to one self and family; Satisfying individual needs and wishes, and Education and staff training.*

Nurses acknowledge that for quality care it is necessary to have sufficient time and space. It is stressful to be aware of the conflict between the ideal of how care should be provided and how care actually is provided in the given conditions. One nurse stated: *"Clearly the stress, staff overload, of course (factors affecting dignified care – author's note). When I have enough time for the patient, I can attend to him. When there is not enough staff, when I know I am under time pressure, I am not very nice"* (Staff nurse, 45, interview no. 3). Charge nurses and Nurse Managers often talk of staff shortages and work overload, which enables them to provide only very basic care: *"There is a staff shortage, the girls are overwhelmed, they really only do the absolute basics so that the patients are fed, clean, washed, physically ok, but the girls are often like robots"* (Charge nurse, 40, interview no. 6). Some nurses said that the institutions are understaffed and that the age structure of patients has changed in recent years.

Some nurses expressed the view that patients' financial background, i.e., whether they can afford more services or better aids, also influences dignified care. A charge nurse (41, interview no. 8) commented: *"When they have money, they can buy additional diapers, more than the insurance covers. When they don't and when the family is not willing to pay, then there is a problem."* Some nurses claim that if the facility does not provide enough aids and products, it can result in lower quality of care: *"Bad equipment in the hospital or institution can threaten dignity, when they do not have enough means to guarantee privacy"* (Staff nurse, 41, interview no. 4). Dignified care is compared to care for oneself or one's family. It helps nurses to better understand elderly adults, and it increases their empathy and sensitivity: *"To stop, think for a while, what if she was your mother? How would I like her to be cared for? And at that moment, you think a little bit differently. Or what if I was lying in that bed?"* (Charge nurse, 40, interview no. 6). Charge nurses and Nurse Managers form the attitudes of the nursing staff by personifying their own family: *"So I always try to motivate my staff when they have had just about enough and complain: If you were in the person's place, you would not like that, would you? When we have meetings, I try to motivate them like this..."* (Charge nurse, 39, interview no. 1).

In connection with dignity, nurses speak of an individualized approach to elderly adults: *"We approach patients individually, we try to be emphatic. Of course we have to respect their wishes, their needs, which we must satisfy. We have to do so with regard to their individuality, not to harm*

anyone, because each person is an individual. We have to adjust our approach to each unique person, and, accordingly, direct the care to suit them” (Staff nurse, 35, interview no. 9). Nurses say it is important to respect elderly patients’ wishes, even if they are contrary to the wishes of the family: *“We enhance dignity by allowing them to decide about their spare time, so they don’t get bored. And if the clients wish not to participate, we do not force them...”* (Charge nurse, 40, interview no. 6).

Some nurses point to the fact that the ability to provide dignified care amongst the nursing staff stems from their upbringing and education: *“I think it might be in the upbringing or in the education whether the people are able to care for these elderly people”* (Charge nurse, 40, interview no. 6). One of the nurses said that it was a course in basic stimulation which helped her refine the nursing care she provides: *“As I started the course, I think I realised that they need something a bit different than just taking care of their bodies...”* (Charge nurse, 38, interview no. 2).

Environment

The interviewed nurses said that the environment in the institution, i.e., cleanliness, spaciousness of accommodation, privacy, and single or double bed rooms, significantly affects dignity of elderly adults. The environment determines whether elderly adults feel at home in the institution. The sub-themes identified were: *Feeling at home vs uprooted; Privacy; Accommodation and Cleanliness*.

Some nurses stated that in order to support the dignity of elderly adults, home care should be encouraged, and that elderly adults should be institutionalised only in severe cases. Nurses working in care homes with nursing claim that even though the nursing staff does its best to make the client feel at home, adaptation to a new environment is sometimes very difficult. A Nurse Manager in a care home with nursing (40, interview no. 6) recounts: *“We had a lady here, 95, who had lived in a house her entire life. During the first days after admission, she was very fine, easy-going, enjoyed conversation and so on. However, a few days later, as if she realised she would never return home, she suddenly started to miss her home. She became confused and died soon afterwards. The doctor on duty – a psychiatrist – described it as uprooting, as if you pull a tree out of the ground.”*

A significant threat to dignity mentioned by nurses was accommodation. They confirmed that the more beds to a room, the less privacy for elderly adults: *“The accommodation has changed significantly. It is nice here, but there are people who would like more*

privacy and they won’t find it here, although there are so many rooms. There is always this bustle and people keep coming and going” (Staff nurse, 47, interview no. 10). The institutions are usually located in old buildings and do not conform to current living standards: *“We have three beds in a room plus a bedside table, so you can barely move around. When we wash the patients and use a tub, we have to take all the tables out of the room. People in the room sometimes have no place to sit”* (Staff nurse, 47, interview no. 10).

According to nurses, dignity lies in making sure hygienic standards are met, that the clients are clean, and dressed in clean clothes: *“It is very important that the people are clean, washed. Then they feel much better”* (Charge nurse, 40, interview no. 6). There is, however, a discrepancy between what is best for the dignity of elderly adults – e.g., having their own clothes – and the reality of caring for patients in given institutions: *“When they are dressed in gowns, bedridden patients, disabled people, there’s no way around it. It’s not very good when they are in hospital for two weeks, but these people live here. The upside is that they are clean...”* (Charge nurse, 41, interview no. 8).

Discussion

This study describes nurses’ experience of patient dignity in nursing care, and identifies influencing factors. Dignity is a complex and multi-factorial concept, which lies in the centre of nursing care, yet patients are still at risk of losing their dignity (Baillie et al., 2009; Baillie, Gallagher 2012). The interpretation of dignity by nurses is represented in the theme *Regarding elderly adults as unique human beings*. Specifically, it means caring for elderly adults with respect, preserving their autonomy, with sensitivity to their life story. The content of this theme is similar to a study by Hall and Hoy (2012) in which the authors emphasize the importance of respecting patients’ individuality rather than seeing the patient only as a diagnosis. The nurses involved in our study emphasize the fact that elderly adults and their dignity and individuality become less important when they have to work “like machines” under pressure to carry out as many tasks as possible. Nursing care often involves routine tasks, and nurses are at risk of regarding patients as objects. Nurses are aware of this fact and try to devote some time to individual patients to get to know their life story. For nurses, preserving autonomy means allowing elderly adults to make their own decisions. Abma et al. (2012) point out that this autonomy is based on a traditional concept. Autonomy is not only

about making decisions without other's interference, but also about self-worth, and self-esteem gained through an interactive process. Institutionalisation of an elderly adult increases sensitivity to dignity (Jacelon, 2003). For this reason, the behavior of the nursing staff may threaten or enhance patients' sense of dignity.

The theme *Privacy and embarrassment* alludes to the preservation of dignity through respect for private body zones, and points to the violation of dignity during hygienic procedures or elimination, which would normally be carried out in privacy, without the assistance of others. Elderly adults outside their home setting become more vulnerable in situations which the nursing staff perceive to be routine. The nursing staff often becomes "blind" and no longer see a naked person as something unusual. This is in accordance with a study by Webster and Bryan (2009), who stress that bodily privacy is an important part of dignity. Walsh and Kowanko (2002) also focus on bodily privacy, and the body as an object.

The theme *Relationships* is closely linked to feelings of individual dignity, and is formed by dynamic interactions (Jacobson, 2012; Oosterveld-Vlug et al., 2014). Relationships with family, staff, and fellow patients play an important role in preserving dignity. Van Gennip (2013) stresses the importance of retaining the current social role of elderly adults, which helps maintain relationships with family and friends. Despite all efforts, nurses often face a family's unwillingness to cooperate, and their lack of respect for elderly adults. According to nurses, cooperation and openness of all members of the nursing, healthcare, and social worker team is essential. Nurses also pointed out the often contradictory individual plans for nursing and social care. Interpersonal relationships of the multidisciplinary team and their impact on professional conduct of nurses were the topics of a study by Stievano et al. (2012). However, it focuses more on the biomedical model, and the organisational hierarchy of doctors and nurses.

The degree of resilience varies throughout life. Supporting elderly adults through *communication* may significantly improve their adaptation to the institution and increase their sense of dignity. Quality, appropriate, and open communication with feedback may boost elderly adults' dignity. Walsh and Kowanko (2002) stress that even when the nursing staff is informed about how to communicate respectfully, the reality is far from ideal. Elderly adults may be robbed of dignity by the staff's poor communication, as nurses often witness. Communication is a breeding ground for

misunderstanding, with elderly adults in particular. Therefore, it is necessary to verify understanding and comprehension of what is being said.

Regarding the theme defined as *Quality of care*, dignity is determined by sufficient staff, equipment, and funding. Similarly to the findings of other studies (Jakobsen, Sørli 2010; Oosterveld-Vlug, 2014; Kane, de Vries, 2017), nurses are subjected to undignified situations and moral conflicts caused by work overload, ineffective time management, and increased administrative work. According to Oosterveld-Vlug (2014), nurses who retain their own dignity in the workplace are subsequently able to provide dignified care to patients. Stievano et al. (2012) claim that Italian nurses enhance their own dignity and respect through education and life-long learning. The nurses included in this study stated that life-long learning gives them the opportunity to learn new patterns and reflect on current care.

The Environment of institutions, which replace elderly adults' homes in long-term care, should comprise a clean setting, quality and spacious accommodation, and room for privacy. According to Hall, Dodd, Higginson (2014), a comfortable environment, care, and good physical appearance increase respect for individuality, and thus bolster dignity.

Conclusion

The study presents a description of nurses' views of dignity in nursing care for elderly adults. The results suggest that nurses perceive that elderly adults in institutionalised care are potentially at risk of losing their dignity. According to nurses, dignity lies in respecting the uniqueness of each elderly patient. This structured schema represents the multidimensional structure of human dignity and concrete factors affecting it, chiefly in the interaction of the nursing staff with elderly adults (communication, quality of care, quality of relationships). The environment of the facility and the management also play an important role, as the nurses' own dignity is reflected in the dignified care provided to elderly adults. The resulting schema of dignity may be used in educating trainee nurses. A particular situation in nursing practice may help them understand what the elusive and abstract term "dignity" means in reality, and may prevent care that reduces dignity in the future. The conclusions may also aid nurses in geriatric care and those in management of healthcare and social institutions to reflect on existing care, and possibly open a discussion on certain moral dilemmas.

The limitations of this study lie in the small sample, higher average age of nurses, and its focus on state institutions of the given region. Further research should be conducted amongst elderly adults in order to understand their perception of dignity. This may help provide a fuller picture of the issue and identify discrepancies between the providers and recipients of nursing care.

Ethical aspects and conflict of interest

The study was approved by the *Ethical Committee of the Faculty of Health Sciences at Palacký University Olomouc*. The authors were granted permission to conduct the research from the management of the institutions involved. Informed consent was given by the interviewees. The data gathered were anonymized and kept confidentially. The authors declare no conflict of interest.

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Authors' contribution

Concept and study design (ŠŠ, JČ), data collection (ŠŠ), analysis and interpretation (ŠŠ, JČ), manuscript (ŠŠ), manuscript revision (JČ), article finalisation (ŠŠ, JČ).

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