



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

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5 **“Just because people are old, just because they're ill...” Dignity matters in district nursing**  
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9 **Abstract**  
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12 **Purpose:**

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

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

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

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

56 This paper begins to address an omission in existing empirical research regarding the role of district  
57 nursing teams in delivering dignified care and how this can safeguard older adults.  
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4 Key words: district nursing, dignity, safeguarding, abuse, home, time, temporality, space, older adults  
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7 Article classification: Research paper  
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## 10 **Introduction**

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12 District nurses deliver nursing care to patients in their homes, a space in which there are endless  
13 opportunities for, and threats to, safeguarding. District nursing care and its relevance to safeguarding  
14 have, for example, previously been conceptualised in relation to whether pressure ulcers are a  
15 safeguarding concern (Ousey *et al.*, 2015; Drennan *et al.*, 2017; Manthorpe and Martineau, 2017; and  
16 McGraw, 2018) and, within the safeguarding umbrella, considerations for district nursing care  
17 practices have also been discussed in terms of the Mental Capacity Act (Griffiths and Tengnah, 2008a,  
18 2008b); deprivations of liberty (Griffiths, 2014); female genital mutilation (Griffith and Tengnah,  
19 2009); the role of district nurses in safeguarding through advocacy (Pettitt, 2000) and adhering to the  
20 Nursing and Midwifery Council professional code of practice (Griffith and Tengnah, 2015). There  
21 are, however, no current empirical explorations into how the delivery of high-quality district nursing  
22 care can safeguard patients by reinforcing and upholding their dignity.  
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33 In this paper, the ‘home-clinic’ is conceptualised as an important, dual-use, space in which district  
34 nurses work; it is simultaneously home and clinic. Primarily, this space functions as a home, however,  
35 at specific times (often in the presence of a nurse), the same space assumes a clinical purpose. The  
36 ‘home-clinic’ is important because this is the space in which dignity is likely to (de)manifest during  
37 clinical interventions. Moreover, this is adaptable over time and subjective experiences of temporality,  
38 thus it assumes a crucial role in the construction of dignity in the home.  
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45 Definitions of dignity are varied, and, at times contradictory (Rosen, 2012; Tranvåg *et al.*, 2016).  
46 In this paper, concepts of dignity are grounded in Immanuel Kant’s philosophy of the inherent worth  
47 of human beings. Nordenfelt (2004, 2009) later described this as *Menschenwürde*, a universal dignity  
48 that all humans hold. Crucially, this paper adopts the view that district nursing care offers the  
49 possibility for dignity to manifest, and importantly, abuse is less likely to occur when clinicians are  
50 maintaining the dignity of their patients. When care is delivered in the home, if nurses and patients  
51 can co-create an ‘environment of dignity’, older adults retain control and influence over their care,  
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2 implicitly ensuring they experience increased empowerment and autonomy, which contributes to  
3 preventative approaches to safeguarding.  
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7 In this paper, routine dignity-enhancing district nursing care is framed as a safeguarding practice  
8 that ensures older adults remain empowered and protected in their homes. There are micro-moments  
9 and micro-opportunities where dignity can be reinforced or contravened as community district  
10 nursing practises can underpin or undermine safeguarding when dignified care is viewed as part of a  
11 wider commitment to safeguarding.  
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### 16 17 **‘Behind closed doors’: The context of district nursing** 18

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20 There is an increasingly blurred distinction between health and social care (Argyle *et al.*, 2017)  
21 and this is an important context for the delivery of district nursing care in which both clinical and  
22 social elements of care can provide opportunities for dignity to manifest. Within district nursing,  
23 ‘demand is rising faster than funding’ (Charles *et al.*, 2014: 26), yet, at a national level, relatively  
24 little data on community health services is collected, compared with care delivered in hospitals.  
25 Maybin *et al.* (2016) and Black and Dobbs (2014) also note the lack of research into dignity  
26 experienced by community-based older adults. Empirical studies that address fundamental dignity  
27 concerns primarily focus on people’s experiences in acute hospital services (Høy, 2007; Matiti and  
28 Trorey, 2008; Baillie, 2009). Holmberg *et al.* (2012) recognise that it is individual expectations that  
29 govern professional/patient interactions, and maintaining dignity involves nurses demonstrating  
30 respect for patients’ autonomy and integrity; but, perhaps most importantly, it is clear that when  
31 dignity is not present, abuse is more likely to occur (Michael, 2014).  
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43 The home is a private space, hidden from outsiders’ gaze, but district nurses gain entry to this  
44 world: ‘to receive care within the home is thus to negotiate boundaries of privacy and intimacy’  
45 (Conradson, 2003: 452). When nurses visit the home, public and private intersect, and potential  
46 tensions arise when the home is dually purposed as both ‘home’ and ‘workplace’ where the  
47 boundaries between private and public become blurred (Milligan, 2000). This contrasts with the  
48 dominant discourse relating to the home, which is based on assumptions that it is spatially distinct  
49 from the workplace (Seymour, 2007). This duality means there are times when nurses must negotiate  
50 through complex workplace/ home dilemmas with their patients. Private spaces, such as the home,  
51 are ‘owned’ and occupied by people who have power over the place (Peter, 2002; Liaschenko and  
52 Peter, 2004; Öresland *et al.*, 2009). Places of care are important, as patients can be expected to  
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2 experience security and control of their home situation (Carolan *et al.*, 2006). Older adults can  
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4 experience increased confidence and autonomy over decisions relating to their nursing care when it  
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6 is received in the home, yet complex power relations within nurse-patient relationships can hinder  
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8 empowerment in practice (McGarry, 2003).  
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11 In contrast to hospital-based care, professional power and control may be reduced in patients'  
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13 homes where district nurses often practise in isolation from other colleagues. As a result, care delivery  
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15 may vary more widely in patients' homes than in hospital wards, where nurses have continual contact  
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17 with each other to informally supervise, guide and modify their own and others' practice. When care  
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19 is delivered on wards, nurses are continually exposed to a group culture, in contrast to the lone-worker  
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21 culture of district nursing, making district nursing an area of care delivery that is not widely subjected  
22  
23 to the scrutiny of others, and, in a research context, a fieldwork location that remains under-explored.  
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25 In safeguarding terms, because district nurses have reduced opportunities to co-work, there is greater  
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27 potential for problems in individual practice to remain unobserved and unreported. The provision of  
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29 care within the home is open to less scrutiny than institutional settings in which care is routinely  
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31 observed by others; therefore, the home presents increased opportunities for certain types of abuse  
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33 and neglect by family members, carers and indeed, district and community nurses.

## 33 **Methods**

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36 This study received ethical approvals from the University of Hull, Faculty of Arts and Social  
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38 Sciences (23/6/16) and Yorkshire and the Humber – South Yorkshire NHS Research Ethics  
39  
40 Committee (Ref: 17/YH/0009. IRAS ID: 21677).  
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43 As an ethnographic study, fieldwork was undertaken between July and October 2017 in which the  
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45 ethnographer was located within an urban community district nursing team in the north of England.  
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47 At the time fieldwork was undertaken, the ethnographer was also employed in the host organisation  
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49 as a safeguarding adult specialist and therefore her positionality was a regular element of critical  
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51 reflection. Two methods were utilised: non-participant observations of clinical interactions between  
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53 13 clinical staff (all female) and 40 patients (male and female, aged over 60) and interviews with staff  
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55 and patients (n=22; 11 clinicians and 11 older adult patients) – all transcribed verbatim. Observation  
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57 and fieldwork notes were handwritten contemporaneously and later typed. This process assisted with  
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59 the reflexivity that is necessary for a trustworthy qualitative study. All data was analysed thematically  
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2 on QSR NVivo in line with Braun and Clarke (2006, 2013) and trustworthiness was assessed by  
3 considering credibility, transferability, dependability and confirmability (Guba, 1981).  
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7 Staff members were recruited following a presentation to the team and via the distribution of a  
8 Participant Information Leaflet (PIL). All clinical staff within the team were eligible for the study,  
9 but this was an opt-in study and they self-selected – therefore participants ranged from health care  
10 assistants (unregistered clinicians) to community staff nurses and senior nurses (including district  
11 nurses). Once staff-participants had signed a consent form, they acted as gatekeepers to older adults,  
12 whereby they distributed PILs to eligible patients that met the inclusion criteria, which were: aged  
13 over 60, living in their own homes, capacity to consent and English-speaking. Once older adults gave  
14 their clinician verbal consent to participate, the ethnographer was invited to attend the next  
15 appointment. On the first visit, the ethnographer ensured informed consent was given before seeking  
16 written consent and verbal consent was sought on every subsequent visit. Participants could withdraw  
17 from the study at any anytime and no incentives or rewards were offered.  
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## 28 **Limitations**

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

### 47 *Space*

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49 The sole criterion to access the district nursing service was for the older adult to be unable to access  
50 care at a health centre or GP practice, therefore, nurses described their patients as “housebound”. As  
51 older adults under the care of district nurses cannot actively enter and fully participate in the outside  
52 world, their home becomes representative of the wider world.  
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2 **Nurse-Denise:** "It's the best job ever. It's better than any hospital. Cos you're  
3 going into their home...they're letting you into their world and it's an absolute  
4 privilege."  
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6 Denise recognised her privileged position meant gaining entry not just into patients' homes but also  
7 into their worlds. There are many safeguarding risks and opportunities when external environments  
8 are no longer accessible making the home the older adult's world. In this context, there is a danger  
9 that any abuse remains unobserved by others and, therefore, opportunities to safeguard are reduced,  
10 yet the private-residential setting affords some protection against elements of institutional abuse,  
11 which is inherently more noticeable in settings such as care homes and hospitals. Clinicians  
12 recognised the importance of the home in their delivery of dignified care.  
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18 **Nurse-Anya:** "Dignity... just respect that you're in someone's house, it's their  
19 house... respect it, they've invited you in."  
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22 To demonstrate respect for the patient and their home, Nurse-Victoria explained her personal code  
23 of operation when arriving at a house for the first time.  
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26 **Nurse-Victoria:** "You don't just walk into the [patient's] house, you'd wait to be invited."  
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29 Nurse-Victoria was implicitly describing a 'house-rule', which offers behavioural expectations  
30 within the home, and nurses are expected to comply with these, even though they are not formally  
31 inducted to the ways in which these rules customarily operate. One 'house-rule' that was consistent  
32 across all older adults' homes was that nurses were not given unrestricted access, their movement  
33 typically being limited to the specific areas in which care was delivered – the 'home-clinic'. Insights  
34 into how (in)dignity manifests can also be achieved by considering how the 'home-clinic' operates  
35 through the organisation of the home, and how this adapts in the context of illness. In this paper, an  
36 'environment of dignity' is conceptualised as a space in the home that offers a safe and dignified area.  
37 However, ensuring the 'home-clinic' operates as an 'environment of dignity' can be challenging,  
38 particularly when nursing/clinical artefacts are introduced into this space, often denoting and  
39 highlighting the evident decline of the functioning of the body. In the next quote, Michelle, referring  
40 to her commode, illustrates the existential dilemmas that can arise when the personal meets the  
41 clinical.  
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51 **Michelle (86):** "I thought, 'Ooooh – disgusting', but by crikey... I'm pleased  
52 with that commode...I wouldn't be without it now."  
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56 Offering older adults' commodes is a routine occurrence for nurses, but, for many patients, the use  
57 of a commode is neither routine nor regular; symbolising, as it does for Michelle above, a body which  
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2 is unable to abide by usual, and taken for granted, conventions – a body that, perhaps, can no longer  
3 be fully controlled.  
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7 Indeed, commodes present a particularly good example of the intrusions into the home space that  
8 are demanded by clinical activity. They are difficult to conceal or gentrify and this may be a step too  
9 far for older adults who have not come to terms with changes around their declining health needs  
10 alongside increasing desires for dignity. This was the scenario encountered when observing Betty and  
11 Nurse-Nieca. Betty had mobility limitations and had been prescribed Frusemide, a diuretic that can  
12 increase the need to urinate. Betty's bathroom was upstairs, a significant distance from where she sat  
13 downstairs during the day, and it had proved difficult for her to get to the toilet in time.  
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19 Nieca stated, "I thought if you were having difficulties, we could look at getting you a commode,  
20 but I know you're a proud woman".  
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23 Betty swiftly declined this offer and the vehemence of her rejection indicated displeasure and  
24 disgust. Betty's refusal was an automatic and honest reaction to being offered equipment that she did  
25 not associate with her sense of self or her home environment. It challenged her identity, threatened  
26 her dignity and therefore could not protect her from the potential consequences of continence  
27 challenges. Even though in practical terms, a commode may have made Betty's ability to self-manage  
28 her continence easier, this benefit was outweighed by the dignity-reducing messages inherent in  
29 accepting, accommodating, and using, the artefact. Betty's refusal of a commode also ensured that  
30 visible signs of illness remained absent in her house – a commode is an obvious indicator of illness,  
31 a key example of an artefact that holds both power and stigma. Interestingly, Betty had only recently  
32 been discharged from hospital, where she admitted she regularly used a commode. Hence, for Betty,  
33 whilst it was acceptable to use a commode in hospital, this was unacceptable at home, where dignity  
34 would be jeopardised by its introduction into this space, no longer making it an 'environment of  
35 dignity'.  
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47 Some of the differences in between hospital and community based nursing care were also  
48 recognised by the nurses.  
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51 **Nurse-Nieca:** "There's a big difference in the community with dignity than  
52 there is in hospital, I think patients' perception of dignity is very different as  
53 well. I think people expect to lose their dignity when they're going into hospital,  
54 but I think when they're at home, they expect to be able to maintain their  
55 dignity."  
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2 Alison, aged 82, certainly expected to be able to maintain her dignity in her own home and this  
3 involved careful consideration of who was permitted into her 'home-clinic' at specific times during  
4 clinical interventions. Alison was under the care of the nurses for bilateral leg dressings, and, although  
5 her husband was not allowed to enter the 'home-clinic' during the unwrapping of her legs, once they  
6 were unveiled, she would instruct the nurse to bring her husband into the room to offer his views on  
7 the nature of her leg ulcers. Alison was blind, and she described her husband as "my eyes". The  
8 feedback he offered on the progression of her legs was preferable to any observational comments  
9 from the nurses. During her interview Alison was asked about the use of her bedroom as the 'home-  
10 clinic', and, when asked about dignity, Alison offered an interesting insight into why she preferred  
11 her care to be delivered in a private bedroom away from her husband's view.

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19 **Alison (82):** "Erm, dignity. I don't mind at all if it's females, with me being  
20 female but if it comes to a man, even my husband, I don't like him to look at  
21 my body, er, if I've got anything wrong with it and if I say, 'is that a bit scurfy  
22 down there?' Things like that I don't like."  
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25 Alison thus maintained control of her dignity within the clinical situation by only permitting her  
26 husband to view her body through a similar clinical lens to that adopted by the nurses at the specific  
27 time she indicated was appropriate.  
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### 30 31 32 *Time*

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

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52 **Nurse-Sapphire:** "We haven't got enough time in the day to give to our patients  
53 and that is what it boils down to."  
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56 Insufficient time to undertake caring duties might be considered indicative of potential institutional  
57 abuse and can lead to elements of neglect. Reinforcing dignity also requires time, and this was  
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2 recognised by other nurses, who felt the community setting offered them “more time” to do this than  
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4 hospital-based care.  
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7 **Nurse-Daisy:** "I think time is massive like for showing dignity. In the community, there's more  
8 time I think, than on the wards. I will stay with that patient as long as I need to, because I know  
9 I can hand it over to someone, or I can do it later or... so I feel in the community it is more...  
10 able, you are more able to care better... with time."  
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14 Each week, the senior nurses evaluated how much time would be necessary for each visit before  
15 allocating tasks to staff members in their teams, but their time assessments were not always popular  
16 with the junior nurses.  
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19 **Nurse-Anya:** "I'm telling you I haven't got capacity to do it. It's not fair...  
20 when I can see that [nurses] are sat there on two visits and we're sat there on  
21 eighteen visits. How is that a fair representation?"  
22  
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24 The senior nurses assessed the time required for each visit and therefore junior clinicians (such as  
25 Anya) could be allocated many “light” visits (15-18 per day), a few “heavy” visits (3 or 4 per day),  
26 or, more commonly, a combination of both. When undertaking allocations, the senior nurses  
27 described their workload reviews as “weighting” the visits to ensure equitability across staffing teams  
28 and they explained it was not appropriate to compare administering an insulin injection (which could  
29 take as little as a few minutes) to a bilateral leg dressing in which legs in water-retention could require  
30 substantial physical effort and time from the nurse. The nurses described bilateral leg dressings as  
31 “heavy visits”, which corresponded with their overall process of “weighting visits”, in which time  
32 was measured by weight (“heavy visit” = slow, “light visit” = fast). As an example, delivering care  
33 to Warren (who required bilateral leg dressings, but also had a range of complex co-morbidities) was  
34 considered a “heavy visit”, so nurses were allocated more time to undertake his care.  
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45 Some of the nurses recognised the flaws in the system which led to care being evaluated in terms  
46 of time rather than quality, and many nurses recognised time and quality as independent concepts that  
47 were often in direct opposition to each other.  
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50 **Nurse-Ella:** "It's not about the quantity of visits, it's about the quality."  
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52 **Nurse-Denise:** "Sometimes it's not the quality, it's the quantity we do. And we've got to get back  
53 to the quality [...] It's that quick in, quick out, quick in, quick out and that's not quality."  
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2 Although nurses are working to clock-time, issues of temporality may be more important to  
3 their older adult patients where their subjective experiences of the passage of time are crucial in  
4 experiencing care delivered with dignity.  
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7 **Michelle (86):** "Just because people are old, just because they're ill...it doesn't  
8 mean you can, erm...how would you say... 'slaphappy' always comes to my  
9 mind."  
10

11 Michelle evoked the term "slaphappy" to describe her current team of community nurses who she  
12 felt rushed her care more than a previous team. Her words are symptomatic of much broader systemic  
13 issues in healthcare, where there are increasing pressures placed on clinicians to spend less time with  
14 patients, whereby, as Levy and Banaji (2002) argue, discrimination against the elderly is likely to  
15 increase. This also poses issues of how time (an objective measurement) and temporality (subjective  
16 experiences) impact dignity. The manifestation of dignity within the nursing relationship may be  
17 dependent on differing expectations of time and the ability for nurses to manage the temporal aspects  
18 of patients' dignity remains a challenge, because, although nurses are 'time-poor', many older adult  
19 patients are 'time-rich'.  
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23 **Nurse-Daisy:** "I know nurses do just go in and out, they don't always ask how  
24 they are and... I hope not\_ that it doesn't happen often, but you see it  
25 everywhere, like on the wards as well, you just\_ it's just quick, quickly you  
26 know... do what they need to do quickly and rush off but... you know, these  
27 patients are vulnerable and I think they need to be cared for with dignity."  
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35 Implicit in Daisy's quote is a belief that a slower pace of work could result in dignity-enhancing care.  
36 Despite their temporal coexistence, nurses may lack time in a way that older adults do not, and thus  
37 there is the potential for a paradoxical mismatch in the expectations of the 'time-rich' patient and  
38 'time-poor' nurse. Time is required to deliver care with dignity, and, by extension, potential  
39 safeguarding issues are more likely to arise (or remain unnoticed) if insufficient time is allowed to  
40 support dignity.  
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45 **Nurse-Sheila:** "We are so busy and a Doppler [ultrasound] takes like an hour  
46 to do, and sometimes... we just sort of push it to the side, and we think, 'oh we  
47 are busy'. Like for example, if somebody rings in sick, the Doppler can wait till  
48 next week."  
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51 Sheila's comment illustrates Walshe *et al.*'s (2012) finding that, although 'caring in the moment' is  
52 important, this has implications for future care, as current care needs become prioritised more highly  
53 than advanced care planning. As Sheila explains, if time is limited, certain tasks are postponed. When  
54 Dopplers are delayed, this saves time in the short term which can be transferred to other (more  
55 immediately pressing) tasks. However, delaying Dopplers also means a delay in maximising effective  
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2 treatments, resulting in patients remaining on nursing caseloads for longer, and therefore any time  
3 saved in the short-term is in fact 'borrowed' from the future. In this context, time is a currency that  
4 can be loaned, but it may be a false economy, as patients not only remain on caseloads longer, but  
5 they remain in ill-health for longer, and this can lead to other co-morbidities, as well as possibly  
6 increasing patient complaints, and indeed potentially leading to safeguarding allegations of abuse or  
7 neglect.  
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## 14 **Discussion**

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16 Space and time are relevant in the delivery of dignified district nursing care. Domestic spaces and  
17 spaces of formal service provision merge when care is delivered in the home as the same space adapts  
18 to serve assorted functions at different times. These factors contribute to the complexity and nuance  
19 of manifesting dignity in district nursing care.  
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25 People modify their standards and expectations according to the differing environments in which  
26 care is given and received, therefore, older adults' acceptance of care within the home is based on  
27 different behavioural standards to those they adopt when care is received in institutions. Hospitals are  
28 littered with clinical artefacts, and patients are accepting of them, but, introducing clinical equipment  
29 into the home is a different matter, as they fundamentally depersonalise the space, whilst  
30 simultaneously rendering it a more familiar space for the nurse. In this context, the understanding and  
31 experience of dignity between nurses and patients might, thus, differ significantly.  
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39 Respect for the home is arguably related to respect for patients' dignity where social obligations  
40 and cultural scripts shape people's expectations of behaviours in the home. These codes of operation  
41 manifest in terms of informal 'house-rules' which provide socially and culturally constructed norms  
42 within the household. Many 'house-rules' are not universal, yet they fundamentally underpin patients'  
43 dignity as clinicians are expected to conform to these established codes of social behaviour, even  
44 though they have not been formally introduced to the individual idiosyncrasies of each household.  
45 Therefore, to show dignity and respect, nurses must navigate their way through complex cultural  
46 scripts where there may be wide variations across different households and transgressing these codes  
47 may cause disruptions to dignity.  
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56 The 'home-clinic' is the primary significant space within which power, agency, and control are  
57 operationalised. It is the key location within the home where patient and nurse must collaborate to  
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2 ensure dignity manifests. There are certain areas of the home where it is implicitly preferable for  
3 nursing care to occur. The lounge, for example, was the home space where older adults preferred to  
4 situate 'home-clinic', possibly because other spaces (such as kitchens) have a designated purpose that  
5 is less acceptably contravened, though a small number of participants made use of the bedroom as  
6 the 'home-clinic'.  
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12 Certain areas of the home are more public than others and nurses' spatial freedom is restricted  
13 when working in patients' homes. As previously noted, lounges were commonly used as the 'home-  
14 clinic' and, during fieldwork observations, it was noted that objects that rendered this space  
15 identifiable as a lounge (such as a television and a sofa), were often displayed alongside clinical  
16 equipment (such as commodes and oxygen cylinders). At times, profiling hospital beds dominated  
17 communal living areas, making the 'home-clinic' an unconcealable feature of a lounge. When home  
18 spaces such as the lounge are transformed into a triple-purpose space (lounge, bedroom and 'home-  
19 clinic'), it becomes a hybrid area defined by the need to compromise, thus rendering it an  
20 unsatisfactory space for all, as the overall purpose of the space has become difficult to identify. The  
21 actual use of the area differs from its intended function, making it unboundaried; an aesthetic  
22 disruption to the home. In the nurse's presence, the room has meaning and purpose as the 'home-  
23 clinic', but in the absence of clinicians, the space becomes a 'nonplace' (Augé, 1995) or a 'noplacé'  
24 (Lawton, 1998), as functional boundaries are blurred, resulting in an environment in which it is  
25 difficult for dignity to flourish. Illness (and the ensuing clinical paraphernalia) can cause disruptions  
26 to the home environment as there is the continual threat that the functions of daily home life become  
27 usurped by illness in the household. Thus, for dignity to thrive, spatial disruptions require careful  
28 management, and although older adults may initially refuse aids and adaptations, nurses must  
29 recognise that in future, patients may become more accepting of them, and being able to advise  
30 patients on how to gentrify clinical artefacts may also assist in maintaining an 'environment of  
31 dignity'.  
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49 Spatial disruptions were evident particularly in observational visits, where a lounge also served as  
50 a bedroom and 'home-clinic'. In these scenarios, despite being daytime, curtains or blinds were drawn,  
51 preventing daylight from entering and ensuring rooms remained in a perpetual state of twilight.  
52 Windows obscured by curtains ensured that the older adult was unable to witness symbolic indicators  
53 of day and night, seasonal changes and the movement of time. In these contexts, time was suspended,  
54 as the relevance of clock-time held no importance when eternal twilight prevailed. The sad irony is  
55 that, for district nursing patients at the end of life, the significance of time is potentially even greater,  
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2 as they do not have enough of it, and yet they are inhabiting a space in which time is effectively  
3 suspended by the absence of markers of its passing.  
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7 The influence of time is also apparent when considering how caring activities undertaken by the  
8 district nursing team were influenced by time assessments made by the senior nurses when they  
9 undertook their visit allocations. The approach they adopted considered 'process time' (defined by  
10 Davies, 1994) which ensured appointments were allocated to ensure that specific clinical tasks (such  
11 as administering insulin, catheter-care, changing dressings) were allocated sufficient time. Davies  
12 (1994) recognises, although caring activities can be structured by clock time, it may raise issues of  
13 quality, and the allocations did not consider wider elements of nursing care that require embedding  
14 such as the 6Cs (DH, 2012a) - care, compassion, courage, communication, commitment and  
15 competence, which all contribute to quality patient care, along with the seventh C, curiosity, which  
16 is particularly important in a safeguarding context. There is a danger that dignity can become  
17 marginalised if these broader elements of care are not considered in the allocation of (process) time.  
18 Consequently, if dignity remains on the periphery of care, there is a danger that conditions are created  
19 in which abuse is more likely to occur, as has been shown from high profiles failures such as at Mid-  
20 Staffordshire Hospitals Trust and Winterbourne View (Mid Staffordshire Inquiry 2010, 2013; DH,  
21 2012b).  
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34 Nurse-participants emphasised how "quality and not quantity" was most important to deliver care  
35 with dignity, and indeed, 'time-rich' patients appreciate slower approaches to care, where their care  
36 is personalised, they are recognised as a person and are not viewed as a task. Thus, genuine movement  
37 away from task-centred care to person-centred care requires an acknowledgement that 'all dressings  
38 are not equal' and that, although nurses may be undertaking the same task with multiple patients,  
39 certain individuals may require more time than others to ensure they experience dignity. Although  
40 time was of significance to nurses, perhaps it was temporality that was of greater significance to their  
41 patients, where their subjective experience of caring in time, related to their experience of dignity.  
42 Despite this, many patients were observed to be keen to ensure they did not delay the nurses (for  
43 example by laying out any equipment in advance) which this may be reflective of Twigg's (2000)  
44 view, that as many care recipients do not directly pay for their care, their moral claim on carers' time  
45 is weakened.  
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## 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



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2 person's workplace. Boundaries of what is public and what is private begin to merge as the private  
3 space of home becomes a public workplace. Certain areas of the home are more public than others  
4 and nurses' spatial freedom is restricted when working in patients' homes, unlike hospital settings  
5 where it is patients that have greater spatial restrictions than nurses. People live in a diverse range of  
6 social conditions, and community nurses adapt to undertake their work in a variety of environments.  
7 Although there are opportunities to create 'environments of dignity' when people become unwell,  
8 health issues dominate their world and clinical artefacts may begin to consume, or dominate the home  
9 space, making an 'environment of dignity' more difficult to achieve.  
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17 To some people, 'home' may be a place of comfort, safety and security. However, for others, it  
18 may be a place of danger, imprisonment or violence. When people require nursing treatment in the  
19 home, domestic space and spaces of formal service provision merge. Older adults may receive nursing  
20 care in the same location within the home in which they sustained the injury requiring nursing input,  
21 which is particularly relevant for people that have fallen in their home and receive nursing care as a  
22 result. In these situations, the site of the 'accident' later becomes the 'home-clinic', in which nurses  
23 deliver their care, and importantly, the domestic space may also be the location of abuse and a site of  
24 safeguarding concerns. This space may, therefore, hold multiple meanings for patients – as both a site  
25 of harm and healing.  
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34 This paper explored how delivering nursing care within the home has important dignity and  
35 considerations and potential safeguarding implications. As district nursing is undertaken 'behind  
36 closed doors', care recipients are potentially vulnerable to abuse from lone-workers operating free  
37 from the gaze of other professionals. This potentially increases the likelihood of unwitnessed delivery  
38 of poor care or abuse; yet simultaneously, district nurses are in a unique position to identify abuse or  
39 neglect within the home and take action to safeguard their patients. By delivering care in the home,  
40 district nursing teams are in a unique and privileged position. At the micro-level of community  
41 nursing relationships, in everyday spaces and through geographies of care within the home, delivering  
42 care with dignity has the potential to safeguard adults living in their own homes.  
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