

Small changes make a big difference:  
how you can influence to deliver dignified care



Supported by an unrestricted  
educational grant from



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## Acknowledgements

We would like to thank the Influencing Resource Practitioner Group for their guidance, critique and support (see Section 4: Additional resources).

We would also like to thank the following personnel for their comments and support in the preparation of this second edition:

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Second edition: March 2009

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Published by the Royal College of Nursing, 20 Cavendish Square, London W1G 0RN

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## Introduction

Providing dignified care is at the very heart of nursing and is the responsibility of everyone that works within a nursing team, regardless of their role, grade or discipline. Dignity is, effectively, everybody's business and everyone can influence for dignity in care.

In February 2008, the RCN conducted a membership survey to investigate nurses' awareness of dignity and the barriers which prevented dignified care being given to patients and clients in a wide range of health care environments. More than 2,000 nurses, nursing students and health care assistants took part.

The 2008 survey found a high level of awareness of dignity and sensitivity to dignity issues among nursing teams – more than 98% of respondents stated that the dignity of their patients and clients is important to them – combined with a strong commitment to dignified care, and concern in relation to factors that diminish dignity in care.

While there are many opportunities for nurses to promote dignified care, there are also challenges. Survey respondents identified a variety of issues relating to three chief factors that maintain or diminish dignity in care: the physical environment and culture of the organisation (place), the attitudes and behaviour of staff and others (people) and the nature and conduct of care activities (process). The survey also revealed that nursing teams were willing to respond creatively and practically to the challenges they face in providing dignified care.

A number of formal and informal standards, metrics, benchmarks and audit descriptors are now in use across the UK, and it is clear that dignity and compassion are very much a key focus of both policy and practice, affording the nursing workforce numerous opportunities to influence. For example, if a team leader wishes to

secure new equipment to enable more dignified care to be given, then linking this to organisational requirements on meeting targets or demonstrating the achievement of formally audited metrics/benchmarks on dignity will strengthen the argument considerably.

Developed for unit, ward or team leaders and managers, this resource is designed to help you and your team identify the potential and actual obstacles to dignity in your area of practice, and take the first steps to influence change for dignified care delivery. It contains tools to help you get to the heart of your dignity issue, and to support you in the development of strategies to effect change. The guide is divided into the following sections:

### **Section 1: Influencing for dignity**

This section provides a brief introduction to dignity and identifies some of the specific issues that may impact dignified care in your area. Simple steps, including approaches, tools and templates you might find useful, are suggested to enable you to identify and scope your dignity issue, and prepare your influencing strategy for action.

### **Section 2: Examples of good practice**

These case studies outline examples of good influencing practice and demonstrate the techniques and approaches used by practitioners working to improve dignified care.

### **Section 3: Tools to support you in influencing for dignified care**

Here you'll find tools and templates, together with instructions on how to use them, to scope your dignity issue, identify key stakeholders, and plan your influencing strategy.

### **Section 4: Additional resources**

This final section points you towards other sources and resources you might find useful.



## Influencing for dignity – a step by step guide

**STEP 1** In preparation, we recommend you first visit the RCN website at [www.rcn.org.uk](http://www.rcn.org.uk) to identify, review, and work through all available learning resources relating to dignity.

**STEP 2** Do you have a clear understanding of the issues that affect you and your team's ability to provide dignified care?

**Yes**  
Go to Step 4

### STEP 3

**No**  
Investigate, using data gathering techniques such as Observations of care, contained in Section 3.2 of this guide

### STEP 4

Having defined and scoped your dignity issue(s) you are now well positioned to:

- use themes (**place, people** and **process**) to get a clear picture of what the issue is
- clarify the focus of your work, using the *Circle of Concern/Circle of Influence* tool (see Section 3.5 of this guide)
- discover your preferred influencing style using the *Influencing style audit* tool (see Section 3.1 of this guide)
  - identify stakeholders and levers for change using the *Stakeholder analysis* tool (see Section 3.3 of this guide)
- develop an action plan using the *Action plan* template (see Section 3.4 of this guide).

## Section 1: Influencing for dignity

The RCN believes that every member of the nursing workforce should prioritise dignity, placing it at the heart of everything that we do. When dignity is absent from care, people feel devalued, lacking in control and comfort. They may also lack confidence, be unable to make decisions for themselves, and feel humiliated, embarrassed and ashamed.

The RCN's (2008) comprehensive definition of dignity highlights a number of key factors:

1. Dignity is concerned with how people feel, think and behave in relation to the worth or value they feel for themselves and others. By 'people' we mean patients/clients, carers, colleagues, students and others in practice settings.
2. Dignified care, or the lack of it, can have a profound and long-lasting effect on patients/clients and contribute to or diminish their wellbeing. In addition to focusing on the meaning of dignity in care, it is important to consider the meaning or consequences of lack of dignity. This will help you to influence more effectively.
3. Dignity applies equally to everyone, and the nursing team needs to influence others so that the dignity of both those who have, and those who lack, capacity is respected.

The full RCN definition can be downloaded from the RCN website at [www.rcn.org.uk](http://www.rcn.org.uk).

4. Dignity can be promoted or diminished by:
  - the physical environment (**place**)
  - the attitudes and behaviour of nurses and others, and organisational culture (**people**)
  - the way in which care activities (**process**) are carried out.

The RCN research report (RCN 2008) detailed the views of



members of the nursing force on challenges and opportunities in relation to these three areas. Influencing to improve dignity requires you consider all three aspects – **place, people** and **process** – in your practice area.

### 1.1 What does ‘influencing’ for dignity mean?

You don’t have to be a ‘person of influence’ to be influential. If you reflect on the people who have influenced you in relation to dignity in care it’s possible that it’s not who you’d expect (for example, senior managers and professionals). Nursing colleagues, health care assistants, student nurses, and the wider health and social care team can all influence to maintain and improve dignified care. What’s more, patients/clients, their relatives and carers can also influence for dignity.

If you are a manager you might, in collaborating with other managers, influence senior management to ensure protected mealtimes or provide resources for dignity training.

Each of these influencing activities requires a range of approaches and skills, for example:

- role modelling
- giving feedback
- gathering and presenting a business case at a finance meeting
- finding time to talk with multidisciplinary colleagues
- persuading people to make changes they don’t understand and don’t want to make.

There are a number of different influencing styles and approaches. For example, some people might have a more goal-setting style, others might focus more on educating colleagues, while some might be more ‘visioning’ types, enabling colleagues to imagine and work towards a more positive future.

## Section 1: Influencing for dignity

Your ability to influence successfully may be affected or enhanced by your approach. Developed through the RCN Political Leadership Programme, the *Influencing style audit* tool contained in Section 3.1 will help you identify your influencing style, and give you pointers around the skills you might like to develop to increase your ability to influence effectively.

### 1.2 Understanding your organisation

Understanding the wider context of your organisation is central to your ability to influence for change and promote dignified care, both at a local and at a strategic level.

Senior nurses are expected to have a broad understanding of the complexity of health and social care, so that they can interpret and translate this into simple clear messages for their team. The emphasis placed on patient/client experiences means the nursing team must be clear about how they contribute to overall patient/client satisfaction.

As health professionals it is important to understand how internal and external contexts and processes affect the way in which dignified care is provided. In the first instance, it is important to understand the values and processes of your organisation. For example, what do you know about your organisation's:

- vision, mission and strategic objectives?
- decision-making structures and processes, and how to access them?
- governance, quality assurance and financial structures and processes?
- infection control policies and processes?
- equality, diversity and human rights policies, processes and actions?



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If you are uncertain about any of these areas, speak with senior colleagues to find out how you can get the necessary information.

Implementing equality of opportunity, valuing diversity, and adopting a human rights-based approach to health and social care is everyone's responsibility and is a key aspect when considering dignity issues. Public authorities and service providers have specific requirements under the law, and are expected to function with demonstrable respect for equality and human rights. Organisations in the independent sector are recommended to follow the lead taken by NHS organisations and other public authorities, as it is unlawful for any service provider to discriminate in providing goods, facilities or services on the grounds of race, gender, disability, sexual orientation and religion or belief.

Undertaking an initial Equality Impact Assessment (EQIA), in partnership with your organisation's lead for this activity, is a key part of the preparations for your dignity project (see Section 3.6 of this guide) and will enable you to:

- take into account the needs of those groups who may be affected by proposed changes
- identify the possible inequalities people will/do experience
- think about ways to achieve aims which will not lead to inequalities.

We recommend that organisations in the independent sector follow the statutory requirement for NHS organisations and other public authorities, as it is unlawful for any public service provider to discriminate in providing goods, facilities or services on the grounds of race, gender, disability, sexual orientation and religion or belief.

For the latest information about diversity, equality and human rights issues, visit the RCN website at [www.rcn.org.uk](http://www.rcn.org.uk).

### 1.3 Clarifying the issues relating to dignity

When you reflect on the three factors (place, people and process) that support or diminish dignity in your practice it is likely that you will identify a number of areas that could be changed for the better. It is important, therefore, that you select one aspect of practice where change is achievable. Sustainable change takes a while to implement, and it might take time for you and your team to see the results of your effort.

You might find it helpful to consider the following questions:

- who is it an issue for?
- who owns the issue?
- why is it an issue?
- why is it an issue now?
- how do you know it is an issue?
- what effect is it having on patients/clients, relatives, staff, the team, the department, the organisation?

The answers might relate to some of the things you need to influence to bring about change. For example, not having a private, uncluttered, well-decorated space to discuss sensitive issues with patients/clients and relatives is clearly an issue for patients and their families. But in order to influence change in areas over which you do not have direct control you might need to make it an issue for the wider multidisciplinary team, or the estates/facilities department, or the budget holder for the department/unit/home/team.

The issue you want to influence to improve dignified care might already have been identified through some of the formal monitoring or quality assurance processes that take place in your area. For example:



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1. Your organisation might already be involved in such initiatives as:
  - benchmarking
  - developing and auditing nursing and midwifery quality indicators.
2. You might want to look at the following:
  - your area's Care Commission/Inspectorate report (see Section 4: Additional resources)
  - your area's Patient Advisory Liaison Services, or equivalent information related to the provision of dignified care
  - patient/client complaints
  - staff surveys
  - incident reports or audits.

Having identified a dignity issue in your area, the next step is to consider the actions needed for change. The three stages in this process are: scoping and data gathering, implementation, and evaluation.

### **1.4 Scoping and data gathering**

#### **Identify barriers and challenges**

A lot of information may already be available, and it saves time and effort to use what already exists. However, you might want to gather more information about the issues affecting the provision of dignified care in your area.

Two methods the RCN has found useful are patient/client stories and observations of care. These have been developed and tested over many years through the RCN Clinical Leadership Programme and have been found to be very powerful for identifying issues and influencing for change.

A brief overview of patient/client stories and observations of care can be found in Section 3.2.

## Section 1: Influencing for dignity

### Define your outcome

This is a crucial part of any influencing and change process. You need to be clear about what it is you are hoping to achieve. Useful questions to ask yourself and your team are:

- what changes are you seeking to make?
- why is the change necessary?
- what would be different to what happens now?
- how will we know when we have achieved them?
- how are we going to measure or evaluate the changes?

### Identify key stakeholders

The identification of people (stakeholders) that can support you in taking your ideas forward is a key aspect of influencing for, and implementing, sustainable change. Your ability to link your idea to your stakeholders' priorities will increase the potential for success.

Once you have agreed the focus of your dignity change, the next step is to identify the people who can help you to make it happen. The stakeholder analysis template developed and used in the RCN Political Leadership Programme (see Section 3.3) will help you with this activity.

As part of this process, you may wish to consider:

- professional leads, matrons/senior nurses, nurse consultants, colleagues from other disciplines
- governance team – what is the risk to the organisation if change does not happen/what are the risks associated with implementing the change?
- board members and executives within the organisation
- human resource department staff
- equality and diversity leads



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- finance department
- estates/facilities
- training department
- professional forums and networks
- Patient Advisory Liaison Services (see Section 4) or other groups who link regularly with relatives and service users
- League of Friends, patient/client forums, staff forums.
- RCN representatives, including stewards, safety reps and learning reps.

Who else can you think of to add to the list? Who can support you to make your change happen?

Different stakeholders will be persuaded by different arguments presented in different ways. Below are some of the ways in which you might present evidence to support your case:

- patient/client stories
- clinical audit
- risk assessment
- statistical evidence
- linking to targets
- linking to strategic objectives
- presentation of research evidence
- the Human Rights Act.

Citizens of the UK have certain fundamental human rights, enshrined in the Human Rights Act 1998, which government and public authorities are legally obliged to respect. The five pillars of the Act (freedom, respect, equality, dignity and autonomy) may all be used to influence positive outcomes for dignity and to deliver dignified care.

### Can you learn from others?

Has what you are trying to achieve been undertaken somewhere else? Use professional forums and networks to access regional and national examples of best practice. If you have a contact name, get in touch and request a visit or information to help you take your ideas forward.

The RCN will be able to help you with this. The Information and Knowledge Management Team in the RCN Learning and Development Institute can help you search the literature; the Nursing Department can connect you with relevant clinical expertise and national networks; the Quality Improvement Network can link you in with others interested in quality improvement; and your regional office might know of others doing similar work locally.

You can add to this body of knowledge by sharing your experiences of promoting dignity in the working environment.

### 1.5 Implementation

Having completed the first stage of preparation and data gathering, the next task is to review all the information and draw up an action plan for what you actually want to do. Think of at least three solutions which will make your issue or concern better than it is now. Involving your team in this process will give you multiple perspectives, and help keep people involved and motivated towards the change.

To clarify your goals, you might find it helpful to draw up a project plan using SMART objectives:

- **Specific.** Decide on objectives that are clear and not too broad. For example, reducing the number of patient complaints is specific, but providing excellent care is vague and general.
- **Measurable.** It is possible to measure a reduction in the number of written complaints, but measuring care in broad terms is more challenging. You would need to ensure that you have the



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appropriate tools, techniques or instruments to measure what it is you set out to improve.

- **Achievable.** The delivery of excellent care is a worthy aspiration, but for objectives to be achievable you need to state something more manageable. For example, you might, in the first instance, decide that you and your team wish to improve patients' experience during intimate care activities (focusing on **people** and **process**), or perhaps improve the physical environment (focusing on **place**).
- **Realistic.** You need to ask “is the objective realistic?” Can you, for example, work towards this goal in addition to your other practice commitments?
- **Timely.** Bringing about dignity improvements can take time and you need to consider what you and your team can achieve within a specific timescale. You might find it helpful to identify smaller objectives with manageable deadlines.

Having developed your **SMART** objectives you can next draw up an action plan which clearly identifies the actions, who is responsible for these actions, and regular review dates. You'll find a template for an action plan provided in Section 3.4 of this guide.

Starting with small changes will give you quick wins which will motivate you and the team towards further change. You might also want to undertake the Circle of Concern, Circle of Influence activity to help you further clarify the focus of your work (see Section 3.5).

### 1.6 Evaluation

The importance of regular reviews, feedback and updates can not be overemphasised. These are essential for keeping people engaged in and motivated by the process. It might be useful to ensure you have some additional support from a mentor or supervisor during the implementation phase.

In order to evaluate against intended outcomes, you need to have

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defined your outcomes or what you want to achieve, before you start. Plan your evaluation strategy before you commence your action plan, so you can gather some baseline data to see whether any changes have occurred.

As part of the evaluation process you should gather feedback, note what works, invite others to learn from your process, and take time to consider next steps as you prepare to begin again.

Don't worry if things have not gone as you anticipated. There is always valuable learning which can be shared, and sometimes unexpected outcomes can be the most beneficial.

### 1.7 Summary of Section 1

Points to consider:

- Have you identified your own influencing style (using the *Influencing style audit* tool in Section 3.1) to identify where your own strengths and areas for development lie?
- Do you have copies of your organisation's mission and vision statement, equality impact assessment, together with all relevant policies and procedures?
- How does the dignity practice change you have identified link to the objectives and vision of your organisation?
- How will your dignity change add value to your organisation, department, ward or team?
- What are the main issues that impact on you and your team's ability to provide dignified care in your area, and how do these relate to **place**, **people** and **process**?
- What recent and relevant data do you have to support your claims?
- What outcomes are you hoping for?
- Which key stakeholders have you identified and engaged with?
- Which **SMART** objectives have you included in your project plan?



## Section 2: Examples of good practice

The following case studies illustrate the actions and influencing approaches taken by teams in a variety of settings as they worked to improve dignified care in their area of practice. In working through each example, you and your team might wish to pause and consider how these issues related to the three areas identified in the RCN dignity survey, namely:

- **place** (the physical environment)
- **people** (behaviours, attitudes and organisational culture)
- **process** (the way care activities are conducted).

### Case study 1:

Project to improve the inpatient experience of people with a learning disability

#### The setting:

Acute hospital trust

#### The challenge:

A high number of complaints from patient's carers highlighted that their relatives or clients were not receiving the same quality of care offered to other people accessing health care services. These complaints included:

- patients were ignored and their needs openly discussed with others while they were present
- patients were talked to in a patronising manner
- inappropriate language was used by some staff members; for example, asking 'what the person's mental age' was
- patients with complex needs were not receiving adequate care and attention
- staff appeared uncomfortable when delivering care.

## Section 2: Examples of good practice

### Scoping and data gathering:

Working in partnership with patient liaison staff, senior nursing staff undertook an initial analysis of the patient feedback.

To gain a deeper understanding of issues, staff undertook observations of care (see Section 3.2 of this guide); the objective of the series of short 30 minute observations was to see how staff engaged both with inpatients and patients visiting outpatient departments. These observations were not restricted to patients with a learning disability. The observations highlighted some excellent engagement with a diversity of patients, but also provided evidence of some skills shortages and a lack of confidence when dealing with patients with a learning disability.

Subsequent consultations – via a short questionnaire and a series of multi-disciplinary focus group sessions – were undertaken with staff to obtain their input. These revealed that many felt ill-equipped to offer care to patients with a learning disability, and a clear training need was identified for all trust staff.

### Stakeholders/drivers/levers

The senior nursing staff, working with the support of a nursing advisory group and the deputy director of nursing, escalated the need for education – including competence based training – for staff working with people with a learning disability.

As part of their approach and recommendation to the trust board, the project team linked the identified training need with the findings presented in the Sir Jonathan Michael's *Healthcare for all: report of the independent inquiry into access to healthcare for people with learning disabilities*, published in July 2008.

The trust board was very supportive of providing training and education to staff in line with recommendations outlined in the *Healthcare for all* report.

### Outcomes:

A programme of mandatory training for all staff, which focussed



on attitudes and behaviours which can compromise the dignity of patients, was developed.

To support this learning, links to useful websites and publications were made available to staff via the trust's internal website.

Easy-to-access links to the Learning Disability Community Team were established, to ensure staff could access support and guidance from skilled practitioners, 24-hours a day.

A pocket-sized publication was produced. Containing 10 'top tips' for meeting the needs of patients with a learning disability, this publication helped staff to overcome communication difficulties and maintain the dignity of patients with a learning disability.

Finally, a proposal to appoint a learning disability liaison nurse to co-ordinate the care of patients with a learning disability in primary and secondary care was drafted, and this is now being implemented.

This example sets out some real life clinical challenges, but the team utilised their leadership skills to best effect, particularly by seizing the opportunities set out in a high profile report (Michael 2008) and translating recommendations into action. Putting in place some straight forward changes has generated real benefits for people who have a learning disability.

### **Case study 2:**

Project to improve the timeliness of care delivery to patients

#### **The setting:**

Community district nursing team

#### **The challenge:**

Following a patient/carer feedback survey, it was noted that a patient and her main carer were dissatisfied with the time of day that the district nurse visited to assess and re-dress the patient's ulcerated and fungating breast tissue. The process was a time consuming and tiring procedure for the patient, and it often

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interfered with her lunch.

The patient had terminal breast cancer and her daughter, who was residing at the patient's house, was her main carer. The nurses tried to visit between 11.30 and 13.00 hours daily, sometimes as early as 11.00 but often after 12.30, which meant the patient did not know what time to expect the nurse.

The feedback was received with some concern by members of the community nursing team, as it had not been considered to be an issue by the nurses delivering care to this patient. In this particular case, the district nursing team had not taken into consideration the timings of their visits as part of the care planning process for this patient.

### Scoping and data gathering:

The district nursing team, together with the support of an audit facilitator from the clinical governance department, undertook a mini audit of data collected in the patient/carer feedback survey to identify possible themes regarding the timeliness of care delivery to patients. All positive feedback, identified as part of this process, was used to gain a picture of what worked well for patients and carers, so that this could be mirrored as appropriate.

Further investigation of the specific complaint regarding the patient and her carer was undertaken using patient/client stories (see Section 3.2 of this guide). These revealed the following issues:

- it was difficult to plan meal times, which had implications around medication and nutrition
- it was difficult to plan pain relief effectively, so that the procedure caused minimal discomfort to the patient
- the patient was left exhausted by the procedure, which had a negative effect on her appetite
- it impacted on the quality time the carer could spend with her mother.



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At a team meeting, several case management issues were shared with the team:

- the preferences of the patient, and the wishes of her carer, had not been adequately considered during the nursing assessment of her care needs
- the nursing case load was not time managed effectively to ensure that the patient and her carer had a clear expectation of when the care would be delivered
- the nurse's expected time of arrival to deliver care, on a given day, was not effectively communicated to the patient's carer.

Working with the *Circle of Concern, Circle of Influence* tool (see Section 3.5 of this guide) the team identified a number of areas for positive action. These included:

- induction of new staff should incorporate training around the requirement to respond to patient preferences as well as patient needs
- a communications process between nurses and patients/carers should be put in place to manage unexpected delays in arrival.

### Stakeholders/drivers/levers

The trust's quality assurance policy states that patient's and carers should have their preferences considered by the visiting nursing teams.

Several facilitated staff groups – including registered nurses and health care assistants from the community – were convened to discuss current case loads, time management, and a communications strategy to keep patients and their carers adequately informed.

A stakeholder analysis (see Section 3.3 of this guide) identified the key people who needed to be involved in facilitating change. These included:

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- the community nursing team
- managers
- administration staff
- the palliative care team.

An action plan to take work forward was developed (see Section 3.4 of this guide). The plan clearly assigned specific tasks and responsibilities to individuals and teams – together with timescales for specific actions.

### Outcomes:

The nursing assessment procedure and the nursing documentation is now much more person centred and includes clear and detailed direction to ensure compliance with the requirement to identify and deliver against the needs AND preferences of both the patient and their carer.

A communications process has been developed and introduced. This ensures that patients and carers can rely on the time specified for the community team's visit. In the event that staff are unexpectedly unable to comply with the scheduled time of arrival, contact is initiated to advise them of the change.

All members of staff have had the opportunity to attend a training session to update them on the new procedures and documentation, and a programme of action learning sets have been introduced to enable the community nursing team to raise awareness and understanding of dignity and end-of-life care. Mentorship and ongoing supervision is available to staff on an ongoing basis to support this learning in practice.

New staff inductions now include specific input related on the timeliness of care delivery and its impact on the dignity of patients and their carers.



### **Case study 3:**

Project to maintain patient dignity while undergoing intimate procedures

#### **The setting:**

Acute ward

#### **The challenge:**

The nursing team on an acute surgical ward was often interrupted while changing dressings and delivering intimate care, even though they were undertaking these procedures behind closed curtains. They were regularly interrupted by ward staff and members of the multidisciplinary team, causing embarrassment to the patient, and disruption to delivery of care.

Staff raised their concerns about the issue at the ward team meeting.

#### **Scoping and data gathering:**

Following short 30 minutes observations of care (see Section 3.2 of this guide) undertaken on the ward to gain further insight and evidence relating to practice and cultural ‘norms’, the team reviewed the findings and agreed that tackling these would be dependent on ensuring that other members of the multidisciplinary teams became engaged with the issue.

Using the *Circle of Concern, Circle of Influence* tool (see Section 3.5 of this guide), the team scoped and defined the issues discovered through the observations and identified a simple but powerful potential resolution: the introduction of a system where a red peg placed on the outside of the curtain meant ‘do not disturb’.

#### **Stakeholders/drivers/levers**

The team undertook a stakeholder analysis (see Section 3.3 of this guide) to identify everyone who could become ambassadors in the process of change and development. In addition, if their solution was to be successful, members of the multidisciplinary teams had

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to be educated on the issue and the proposed resolution.

Initially, the team approached the infection control team to ensure that the pegs could be cleaned adequately between patients to ensure there was no risk of cross infection.

Next, to test the effectiveness of the solution in practice, the team approached key stakeholders to gain agreement to implement a localised trial of the proposed process. These included:

- senior nurses
- heads of service (who would communicate to the multidisciplinary teams)
- clinical managers
- the infection control department.

### Outcomes:

Following the successful completion and assessment of the trial, and following consultation on the outcomes with key stakeholders, the new procedure – a red peg indicates a ‘locked door’ – was implemented on the ward.

The team documented their good practice (see the template contained in Section 3.7 of this guide) and, with the support of the senior nurses’ forum and the policy group, this example of good practice has now been replicated across the trust.

### Case study 4:

Project to improve the client engagement

#### The setting:

Mental health assertive outreach service

#### The challenge:

An assertive outreach service team was concerned that a number of its client group was disengaging with mainstream services for a variety of reasons, some of which included differences of opinion,



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stigma, and discrimination associated with severe and enduring health problems. Clients had also expressed dissatisfaction and disillusionment with service provision.

As a priority, the outreach team wanted to understand more clearly the reasons for disengagement in order to identify how the team could work alongside service users and engage them in the service delivery. As part of this process, the team wanted to ensure they were not making assumptions about what people want or need from services but instead actively consulted with service users to gain a better understanding of what they valued.

### Scoping and data gathering:

The team reflected on value based practice in mental health care, and how, as an assertive outreach service, it could ensure that the value base of the team matched that of its client group. This would be essential to underpin service delivery.

A stakeholder analysis (see Section 3.3) was undertaken to ensure inclusion of all key stakeholders – specifically, the service users themselves – in the development of a changed service. As a first step, to develop an operational policy statement, the team undertook a series of focus groups with staff, and undertook a number of discussions with individual service users to identify what they wanted and valued.

To support the direction and the structure of the work undertaken by the team, they drew on the following materials:

- K Woodbridge and B Fulford (2004) *Whose values? A workbook for values-based practice in mental health care*, London: The Sainsbury Centre for Mental Health
- Wallcraft J (2003) *Values in mental health – the role of experts by experience*, a discussion paper developed as part of a NIMHE project

## Section 2: Examples of good practice

- Allot P, Loganathan L and Fulford KWM (2002) Discovering hope for recovery from a British perspective: a review of a selection of recovery literature, implications for practice and systems change, *Canadian Journal of Community Mental Health*, 21, pp.13-33.

### Stakeholders/drivers/levers

The National Service Framework and Mental Health Implementation Guide, developed by the National Institute for Mental Health England, contain clear guidelines relating to quality care provision.

The trust's business plan and vision affirm that the service user is to be central to care.

Stakeholders committed to the development of a recovery and framework model that would enable creative and flexible services. As part of this process, the project development team would work in partnership with service users, and ensure that all staff involved in outreach services would be trained to respect the experience of service users and their carers when delivering care.

### Outcomes:

Delivering a value-based service has enabled the service team to engage better, and have a clearer and more comprehensive understanding of the needs of clients.

Service users helped to lead the way and signpost the change requirements. This collaborative approach is now central to the ongoing evolution of service delivery. The team has moved away from the medical model of delivery to a person-centred recovery style. This approach has helped people engage more easily with services, to work towards their personal recovery, and elevated their social functioning and feelings of being valued.

The pilot work completed to date is still in the process of being evaluated by the trust's audit team and service users. However, early results have been disseminated to other assertive outreach teams in the trust and outcomes are also being shared with a national assessment team.



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## Section 3: Tools to support influencing for dignity

The tools contained in this section will help you get to the heart of your issue impacting on dignity and support you on the journey to positive change. From undertaking the initial information gathering process, to scoping the challenge, identifying stakeholders, defining your objectives, and preparing your action plan, these tools are designed to enhance your ability to influence for dignity.

Guidelines on each tool, together with additional ideas about who to approach, what you need to consider, and how – as a team – you can work to influence for change, are also included.

The section contains the following tools:

- 3.1 Influencing style audit
- 3.2 Patient/client stories and observations of care
- 3.3 Stakeholder analysis
- 3.4 Action plan template
- 3.5 Circle of Concern, Circle of Influence
- 3.6 Equality impact assessment
- 3.7 Good practice template

### 3.1 Influencing style audit

Your ability to influence successfully may be affected or improved by your approach. Developed through the RCN Political Leadership Programme (see Section 4: Additional resources) this tool will help you to identify your preferred influencing style, which in turn will build your confidence and enable you to understand how you might work best with different stakeholders to influence for dignified care. It will also give you some pointers about skills you might like to develop to increase your ability to influence effectively.

Reflect on each of the items below and select a score which best

### Section 3: Tools to support influencing for dignity

represents how you generally behave when you are influencing others. Use the following convention to allocate points:

- 0 means “I never do this”
- 1 means “I rarely do this”
- 2 means “I sometimes do this”
- 3 means “I often do this”
- 4 means “I always do this”.

Items	Score
1. I fully express my personal values when I talk to others	
2. I work hard to ensure that aims and objectives are absolutely clear	
3. I try to find out exactly what sort of help other people need	
4. I excite other people’s imagination by communicating images of how the future should be	
5. I use rational argument to make my points	
6. I am prepared to make a fuss to get things done	
7. I get myself into formal positions of power and influence	
8. I take great care to educate others so that they can understand what I am thinking	
9. I encourage and support other people with good ideas	
10. I am emphatic when expressing what I believe in	
11. I make sure that people understand the objectives they should strive to achieve	
12. I help other people to solve their own problems	



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Items	Score
13. I am good at vividly communicating what the future could be like	
14. I carefully collect data to demonstrate the validity of my case	
15. I push other people to give me support	
16. I take steps to acquire formal authority to enable me to implement my plans	
17. I encourage people to learn new ways of thinking	
18. I support those people who want to make changes for themselves	
19. I have clarified what I believe is important to me	
20. I carefully monitor the performance of others who are working with me	
21. I help people find effective answers to problems that concern them	
22. I am able to communicate what needs to be done to create a better future	
23. I ensure that my views are based on demonstrable facts	
24. I “lean on” people who are not pulling their weight	
25. I acquire formal authority to give me more clout	
26. I ensure that people are given training	
27. I go out of my way to encourage people struggling to change things for themselves	
28. I have a clear code of principles which I communicate to others	

### Section 3: Tools to support influencing for dignity

Items	Score
29. I make sure that I check up on other people's performance	
30. I help people find answers to their own problems	
31. I strive to inspire other people by the way I present my ideas	
32. I take great care to present logically sound arguments	
33. I use psychological pressure to get what I want	
34. I try to acquire formal authority and responsibility for getting things done	
35. I use "education" as a way of opening people's minds	
36. I give moral support to people who want to make changes	

#### Influencing style audit: answer grid

Enter your scores below:

				Totals
1	10	19	28	I
2	11	20	29	II
3	12	21	30	III
4	13	22	31	IV
5	14	23	32	V
6	15	24	33	VI
7	16	25	34	VII
8	17	26	35	VIII
9	18	27	36	IX



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Add up your scores for each horizontal line. Transfer your totals onto the profile overleaf to illustrate your influencing style profile. These are the headings:

- |     |                             |      |                       |
|-----|-----------------------------|------|-----------------------|
| I   | Value driven style          | II   | Goal setting style    |
| III | Need fulfilment style       | IV   | Visioning style       |
| V   | Rational presentation style | VI   | Pushing/driving style |
| VII | Institutionalising style    | VIII | Educating style       |
| IX  | Supporting style            |      |                       |

### Influencing audit: profile

Plot your total score for each horizontal line against each of the styles (represent I – IX)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
I																
II																
III																
IV																
V																
VI																
VII																
VIII																
IX																

Your score gives you insight into the ways that you influence and are influenced, with the higher scores indicating your preferred style. Consideration of these styles will enable you to become more effective.

## Section 3: Tools to support influencing for dignity

### Influencing style audit: explanatory notes

Consider each of the nine distinct influencing styles that follow and identify those styles that you should develop further on the action planning sheet (below). It is helpful to discuss your profile with another person who can help you consider how to increase your skills.

#### **I. Value driven style**

You have deeply held beliefs about what is good and bad, important and unimportant. By expressing values you capture interest and goodwill. Your values touch a chord in others and your conviction is persuasive. You invoke respect and admiration. Your skills include value clarification, effective presentation and ability to delve below the surface. You attract others by appealing to their moral sense.

#### **II. Goal setting style**

You ensure that aims and objectives are clearly understood by all concerned and direct effort towards achievement. You monitor the performance of others, set success measures and provide co-ordinated plans. By setting milestones and avoiding being put off the scent, you manage situations. Your style is administrative in the best sense of the word. You use management techniques to channel effort. Your skills include objective setting, action planning and performance measurement, controlling and giving feedback. You drive others by obtaining their commitment to objectives, then keeping performance on track.

#### **III. Need fulfilment style**

You are concerned with being practically helpful. You identify others' needs and show how these can be fulfilled. You work at being a useful resource to others in problem solving. Your credibility and influence come through being genuinely helpful. Your skills include sensitivity, active listening, being client-centred, action planning and co-operative counselling. You attract others by



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winning confidence and being a valued colleague.

#### **IV. Visioning style**

You create ‘pictures’ of a desirable future that offers better ways of doing things or redressing wrongs and bringing meaning and direction into people’s thinking, giving an understanding of what could happen. Your strengths include the capacity to express vivid images, imagination, opportunism, farsightedness and practicality. You are an architect of the future. You attract others by providing a positive direction.

#### **V. Rational presentation style**

You are good at argument and debate. Your facts are valid. You collect data, evaluate information, build a logical case, and present sound arguments. You appeal to reason and intellect. Your position is always defensible and reasonable. Your skills include analysis, concept development, logical thought and formal presentation. You attract others by the force of argument and rationality.

#### **VI. Pushing/driving style**

You are influential because you use weight to cajole, demand, insist or push people to act differently. You have a forceful, controlling and dominant style, although this may be very subtle in expression. You are prepared to make a fuss to get change. Your skills include deep knowledge of people, assertion, and the constructive use of conflict. You drive others by personal willpower.

#### **VII. Institutionalising style**

You believe in obtaining formal authority to give a power-base. You want to obtain powerful positions and build a legitimate role. You seek to acquire the right to decide how to allocate resources to further a cause. You concentrate on getting the foundation properly laid. Your skills include organisational design, planning, performance control and administration. You drive others by legitimate power.

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### **VIII. Educating style**

You expose people to new ideas, experiences, concepts, possibilities or inner reflections. You act as a teacher, educator, catalyst, counsellor and guide, enriching people's experience through demonstration and the opening of minds. You cause people to discover that their current thinking/behaviour is, in some ways, inadequate. Your skills include diagnosis, designing learning, communicating principles and teaching. You attract people by causing them to re-evaluate the world around them.

### **IX. Supporting style**

You encourage and empower people to identify needs, evaluate options, formulate action programmes and take initiatives on their own account. You are supportive and positive, adding extra energy and giving confidence. You do not seek to guide, but to enable others to act. Your skills include listening, counselling, giving positive feedback and advising. You give permission to act, moral support and, sometimes, practical support. You drive others by giving them energy.

#### **Influencing style audit: action planning**

Now that you have established the influencing styles that you feel most at ease with, it would be useful to explore when you have used a particular style and how it helped, or indeed hindered, your ability to influence.



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The influencing styles I most use are:

**Existing styles**

**When used**

Exploring ways to develop some influencing styles which you have not previously favoured would also be a useful exercise.

**Wanted styles**

**How to develop**

### 3.2 Patient/client stories and observations of care

#### Patient/client stories

Whilst undertaking patient/client stories is not complicated, there is some preparation required for you, your team, and your service users, to really ensure that you get the most out of collecting stories. For this reason it is advised that you undertake some training and preparation in your organisation before you start. The training takes between half-a-day and two days, and provides an opportunity to get people involved and excited about the work, allow people to ask questions, fully understand the process and have the opportunity to practice interviewing, mind mapping, action planning and thinking about influencing. If you want more information about running patient/client story training, contact the RCN Consultancy Service [consultancy.service@rcn.org.uk](mailto:consultancy.service@rcn.org.uk) or call 020 7647 3951.

#### What are patient/client stories?

The term ‘patient stories’<sup>1</sup> is used for the technique developed and refined through the Ward Leadership Project (Cunningham & Kitson 2000a,b). Stories are audio-recorded interviews with patients/clients about their experience of receiving care in your service. This is a very powerful way of getting service users to help you identify areas for quality improvement, as well as finding out which aspects of their experience they value.

The strength of this method is that the interview is led by the individual service user, and not the member of staff. Unlike patient/client satisfaction questionnaires – where the questions are often decided by health/social care professionals and reflect the issues that they feel are important – the content is led by the individual user, so it provides an opportunity to find out about the service from their perspective.

<sup>1</sup> The term ‘patient stories’ is used as the specific methodology for the technique developed and refined through the Ward Leadership Project (Cunningham & Kitson 2000a,b). In this context, the term ‘patient’ refers to any person using the health or social care service. People using this resource will use whichever collective name is given to those who use their service.



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The information gained during stories can be very powerful. It is likely that it won't just be related to the immediate team and may have implications for other departments. You need to decide how the information collected is fed back to others. Undertaking a stakeholder analysis (using the tool contained in Section 3.3) may help you with this.

Before you begin to gather stories, you will need to inform the research governance lead (usually the Director of Nursing) or whoever else has a lead for quality in your organisation, advising that you are undertaking this activity as part of a practice development/quality improvement process that involves a written agreement.

### **Observations of care**

Observation is a simple tool that allows nursing teams to take some time to step back and watch what is going on from the position of an observer. It can be a shock and quite challenging for us to realise that there are differences between what we think we do and what we actually do.

When undertaking observations of care, two people – usually one who works in the team where the observation is taking place and one from another team – stand back and observe what is going on for 30 minutes. Following their period of observation they feed back to the team what they have observed, and the team then develops action plans to take forward any areas of practice they wish to either celebrate and spread or improve.

### **Observations and the organisation**

The information gained during the observations can be very powerful. It is likely that it won't just be related to the immediate team and may have implications for other departments. What forums exist where you can and should share this information?

## Section 3: Tools to support influencing for dignity

### How does observation work in practice?

#### **Team preparation**

Before you start, it's important that work colleagues are informed about what is going to happen. To be observed can initially feel uncomfortable, so it is important to prepare people well. Find time to discuss what will happen, how they feel about it, what might be the positive aspects, what might be more difficult. Allow time for questions.

#### **Self preparation**

Observers require an ability to stand back and open themselves up to be observers, to resist the temptation to join in, make quick judgements or only see what you want or expect to see.

It's not uncommon to feel anxious about what the other observer is writing down, particularly if it's your first observation. We all see the world differently. Observers should relax and not worry about what their fellow observer is seeing or writing down. All observations are unique and useful, and during feedback the importance of the information gathered becomes clear.

#### **What about patients/clients?**

It is important to let any people who use the service and may be present during the observation period know what is happening. It is important to emphasise that they are not being observed. The observation is of the care or service.

#### **Undertaking the observation**

Identify a specific area that is going to be observed. For example:

- hospital ward – perhaps focus your attention on four beds
- social services – the reception area where the public come in
- accident and emergency department – you may decide to sit in the admissions area
- a physiotherapy department – you may decide to observe a session in the gym



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- a team meeting
- GP surgery – waiting room
- in the community – perhaps attend a clinic.

Different locations can be used for each episode of observation. Or you may find it useful to decide to focus on the same area again, depending on the context; for example a new area or an area you are concerned about.

### Who does the observation?

Two people carry out each observation:

- the inside observer is a member of staff from the area under observation
- the outside observer is someone unfamiliar with the service area.

If a member of staff is particularly uncomfortable with the exercise it may help them to be an observer for one episode, to help them understand how ‘stepping back’ to take a view can be useful.

Once you have become more confident with the process and your feedback skills, you may like to invite others to be the ‘outside’ observer, for example, a service user or their relative, a non-executive/executive director from the board of your organisation.

### Observing

As an observer you should position yourself as unobtrusively as possible. Concentrate on opening up your senses to take in as much as you can about what is happening around you.

Sometimes, during the first episode of observation, staff seem to ‘disappear’. Initially they may be anxious about the presence of an observer. Expect it to take a little while for them to get used to being watched.

An observation should last for 30 minutes. During this time both observers write down a description of everything they see. In addition to the actual description of what was observed you should

## Section 3: Tools to support influencing for dignity

include the following information:

- the observers' names
- start and finish times for the session
- area under observation
- where the observers were seated
- precise details of the area (for example, numbers of patients or occupied beds, or in a GP's surgery the numbers of those waiting and/or consulting rooms observed).

This information provides a context for the discussion later. The description of what you observe may include sounds, smells, snippets of conversations or the language used between professionals and patients/clients/users.

Remember to **describe** what you observe and try to avoid making value judgements, for example: "The receptionist smiled and gained eye contact with people as they came in for their appointments", rather than "The receptionist was very friendly" OR; "The receptionist looked at the computer screen whilst people came to the desk to book in for their appointments", rather than "The receptionist was rude and unwelcoming."

Remember that although it's very easy to focus on the negative, it's equally important to report back good practice that has been observed. Staff may often take their own good practice for granted and will find it motivating to have specific incidences highlighted.

### Feeding back after the observation

#### **Observer feedback**

After the 30 minutes of observation, you should find somewhere private to discuss your notes and what you will feed back to the team. After this discussion - which will probably take about 20 minutes – you agree what and how you will feedback to staff, remembering that principles of feedback should allow for staff to read exactly what's been written if they wish to.



### **Feedback to staff**

Feedback needs to be given constructively and should take place in a quiet area where you won't be disturbed. Depending on the issues that are raised, feedback should take between 15 and 30 minutes.

The observers offer their feedback, in descriptive non-judgemental ways. Staff members will then be invited to expand on what they were doing – to 'make sense' of what was happening in the area at that time. Staff may feel defensive at this stage, trying to rationalise and justify why they behaved in a particular way. It is therefore important to be explicit that the purpose of this exercise is not criticism; but to think about, and understand, the reasons behind what has been observed and to help make sense of the observation.

This understanding is vital, because the observers won't always have the full picture. For instance, in one example, a nurse woke a patient up in order to assist him with a wash. When the observers described what they observed, the nurse explained that she had earlier asked the patient what time he wanted his wash and agreed that if he was asleep it was all right to wake him. This provides an important lesson – it is important to talk to and clarify with the staff, rather than making assumptions.

It is helpful to ask the team if they want to make any additions to the observations you have made. There will be times when the practice that is observed isn't very good. If this is the case, how the observers handle the feedback is key in helping staff to commit to improve these areas.

At the end of the session all the participants will need to agree on any necessary actions for improvement, and how to recognise, celebrate and spread areas of good practice. It is important to keep a record of action plans, so that these can be reviewed.

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### Summary of observations of care

#### **Preparation**

- Engage all key stakeholders in your organisation, ensuring they are aware of what impact observations of care may have on their work and their potential involvement in the action planning.
- Prepare the whole team for the observations taking place.
- Always have an internal and an external observer.
- Always ask permission from patients.

#### **Undertaking observations**

- Observations last for 30 minutes.
- If you see any unsafe care or practice you will need to intervene.
- You should record everything you observe, and your written record must be made available to staff if they wish to read it.

#### **Feedback**

- Feedback to staff as soon as possible after the observation (approximately 30 minutes later).
- Always introduce outsider observers, and ensure the context of why you are doing the observations is understood.
- Share your observations; do not make any value judgements in your feedback.
- Invite discussion and clarifications of your observations – avoid being defensive or attacking.

This technique is very powerful and the information gathered may not just be related to the immediate team, and may have implications for other departments. As with patient/client stories, you need to decide how the information is collected and fed back to other departments and colleagues. Undertaking a stakeholder analysis (see Section 3.3) may help you with this.



## References

Cunningham G and Kitson A (2000) An evaluation of the RCN Clinical Leadership Development Programme: part 1, *Nursing Standard*, 15 (2), pp.34-37.

Cunningham G and Kitson A (2000) An evaluation of the RCN Clinical Leadership Development Programme: part 2, *Nursing Standard*, 15 (13), pp.34-40.

Royal College of Nursing (1997) *RCN ward leadership project: a journey to patient-centred leadership*.

### 3.3 Stakeholder analysis

This tool has been adapted for use in this resource from work originally produced in *Action Sheet 3: Developing your strategy for influence*, part of the RCN's Political Leadership Programme.

Undertaking a stakeholder analysis is about identifying the people who have an interest, or 'stake' in the dignity issue you want to influence. Who do you need to get 'on board' to really make the change happen? Get a team together that's interested in taking your dignity issue forward, and think about all the potential stakeholders.

These may include, for example:

- your line manager
- service users
- professional leads, matrons, senior nurses, nurse consultants, colleagues from other disciplines
- board members and executives in the organisation
- finance department/budget holders
- equality and diversity team
- training department
- estates and facilities department.

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Be open and ready for surprises, because support (or resistance) can come from the most unexpected places. Think especially about those whom you may be tempted to leave out because you know, or suspect, that their views might challenge your own. You should also consider the people or organisations you could develop as stakeholders or powerful collaborators, helping them to see the connections between your issue and their interests in order to facilitate partnership working.

In your enthusiasm to forward your concerns, don't forget that others may have already been working around the same issue as you. Acknowledge and applaud their work – they may become important allies.

### **How can the stakeholders help (or hinder) your aims**

From the stakeholders you have mapped out, select six that you – and the group you are working with – think are the most important. In undertaking this process, you should consider:

- what kind of power do they have in the process of decision making and implementation?
- do they have access to the levers of power – where and how?
- can they block or sabotage a decision – why or where?
- what are the key concerns of the stakeholders and what will make your dignity issue of interest to them?
- what benefits can your dignity issue bring to this stakeholder and how can they 'own' this benefit?

If you do not have the information to answer these questions, how will you find out?

Now map these stakeholders onto the grid that follows. Mark on the grid where your stakeholder is now (with a \*) and where you need the stakeholder to be (with a ✓). For example, you might mark your line manager as someone who currently will 'let it happen',



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but you want to move her/him to the point where she/he will ‘help it happen’. How you go about changing this stakeholder’s position requires you to think about how you will specifically influence them. For instance, what benefits or risks does this dignity issue hold for your stakeholder? Identifying this, using the other tools contained in this section, will help you to influence your stakeholder.

### **Choosing your approach**

Your aim is now to move your stakeholders into the positions on the stakeholder grid where you have indicated you would like them to be. As you have revealed, there will be different messages for different stakeholders:

- what are the values and priorities of your identified key stakeholders and how can these be used constructively?
- how can potential opponents of your issue be converted into supporters?

Using the information, evidence and stories you have collected, you can start to build persuasive arguments that are sensitive to the priorities of each stakeholder group. Remember, you are aiming for support and joint action.

Think about:

- what kind of language or arguments would persuade the stakeholder to treat your dignity issue as a priority?
- what other evidence would you need to present in order for your arguments to carry weight?

Finally, consider the different methods you might choose to present your arguments and attempt to influence. For example; you might:

- request an agenda item at the senior nurse forum
- request an individual meeting with relevant stakeholder (for example, head of nursing or modern matron)

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- write a business case
- go to a board meeting with a service user
- hold a carers open afternoon
- instigate an equality impact assessment with your equality and diversity lead.



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### 3.4 Action plan

You and your team will find it easier to stay focused on your dignity change if you have a detailed action plan. Complete this template and display it in your practice area. This will enable everyone to see the outcomes the team is aiming for, and how they are contributing to dignified care.

Work area:		Date:	
Description of area for improving dignified care and intended outcome	Action to be taken	Review date	Person responsible



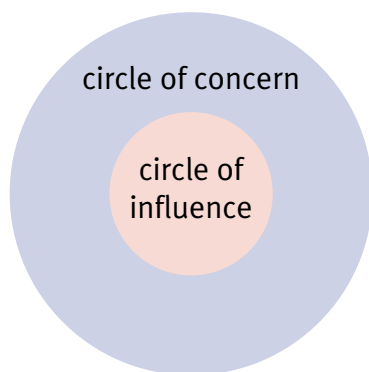
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### 3.5 Circle of concern and of influence

This tool is based on Stephen R Covey's<sup>2</sup> (1989) model and can help you direct and focus your energy on where it may be of most use.

Becoming aware of what we can control and influence, and what we cannot, is vital to the process of change. We each have a wide range of concerns – our health, our children, problems at work, the national debt, nuclear war. Covey calls this our Circle of Concern, which will contain a number of things over which we have no real control. However, within this circle we can also identify concerns over which we can do something about. Covey calls this our Circle of Influence (see Figure 1). For example, we can give up smoking, support our children, or recognise that colleagues may do things in different ways.

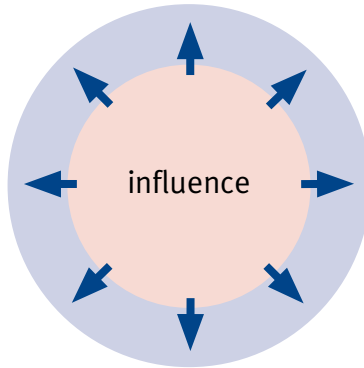
Figure 1



When trying to influence for change, becoming more productive and successful is more likely if you identify and focus on the things you can do something about – your circle of influence. By doing this, you become proactive, and your circle of influence will increase (see Figure 2). According to Covey, people who focus on their circle of influence will take a positive approach, resulting in developmental, non-blaming discussions and constructive actions that can feel energising and creative.

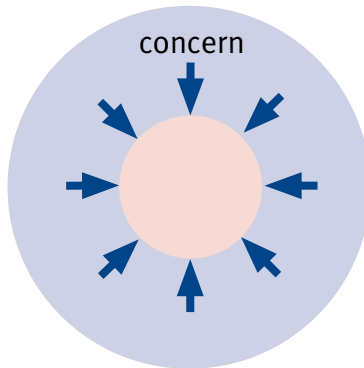
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Figure 2



Covey suggests that reactive people, on the other hand, focus their efforts on the circle of concern. This approach can result in blaming and accusing attitudes, reactive language and increased feelings of victimisation and powerlessness. This causes their circle of influence to shrink (see Figure 3).

Figure 3



### How to use the circles

This exercise can be done on your own, although it is often useful to do with others. You could use some 1:1 time with your manager, ask for space in a team meeting or think about it in an action learning set.



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### Step 1 – Identify the issue

Firstly think about what it is you want to change or influence. Working through other sections in this guide will help you do this. For example, imagine you are a team leader in a supported housing scheme and you want to change the system about the keys to residents' bedrooms. At the moment all keys to the residents' bedrooms are held centrally in the staff office and residents are expected to leave them there when they go out, or when they are in other communal parts of the house. Several residents have said they find this demeaning and want to keep their own keys with them all the time. The staff team is rather resistant to the idea of the change and you feel stuck.

### Step 2 – Identify the concerns

With your team list all the 'issues of concern' about this. They may say things like:

“Not all the residents want to take their keys out”

“People will always be losing their keys and it will cost too much to keep getting them replaced”

“Some of the more vulnerable residents may be at risk of others 'stealing' their keys from them”

“It's a way of knowing who is in or out of the building”

“They aren't doing this in the homes in the south”

“The Board of Trustees will never agree.”

Put everything raised in the outer circle of concern – don't filter or censor. At this point everyone may feel rather overwhelmed with everything, and feel it is far too difficult to take any action.

### Step 3 – What can you influence?

Once you have listed all of the concerns in the outer circle, ask yourself the following question about each concern raised: does this concern fall within our sphere of influence and if so, what actions can we take? Put your ideas in the inner circle.

## Section 3: Tools to support influencing for dignity

For example, some ideas might be:

You can not make people take out their keys if they don't want to; those that want to can still leave their keys in the office.

You could start a pilot and keep a record of how many times keys get lost to see if it really is a problem. You could find out how much replacement keys cost. What would the real expense be? Who holds the budget and is there any money for replacement keys? Residents may have to pay for a new key if they lose it more than twice. Remember, people lose keys all the time; it is part of life and not specific to people living in supported housing schemes.

You could speak with the residents to find out what they wanted – what they see as difficulties and advantages.

How does the team address intimidating behaviour amongst residents? A review of this might be useful.

Are there are other ways of knowing who is in the building?

Have you asked the Board of Trustees?

This second list will hopefully feel less overwhelming and give you some ideas about where you might focus your energy and the potential actions you could take. If there are concerns identified outside of your sphere of influence, agree to share them with someone who does have the responsibility and authority to influence these.

### 3.6 Equality impact assessment

An equality impact assessment (EQIA) is essentially a health check to ensure that a policy, practice, process, strategy or project has fully considered how it impacts on promoting equality of opportunity and eliminating discrimination for different groups.

*In undertaking an EQIA you should aim to work with your organisation's designated equality lead and seek out support*



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*from your RCN representative. Accredited RCN stewards, learning representatives, and health and safety representatives can access further training on equality impact assessments through the RCN's Auditing for Equality and Diversity Masterclass, details of which can be found on the RCN website at [www.rcn.org.uk](http://www.rcn.org.uk).*

The EQIA process involves gathering data, consultation and analysis of available evidence to make an informed judgement about how a particular policy, strategy or practice affects – or is likely to affect – different groups of people when it is implemented. Focussed heavily on outcomes, organisations need good systems and processes in place to ensure that EQIAs are routinely part of the initiation, development and review process.

Undertaking an EQIA establishes whether the matter being assessed yields a differential impact, and whether this impact is positive, negative or neutral on specific equality target groups. In the event of an unjustified negative being identified, an EQIA enables an organisation to explore what actions need to be taken to remove, reduce or mitigate this impact. The measures taken, and the improvements or changes introduced, ensure fairness, encourage diversity and ensure policies are not unlawfully discriminating. This makes an EQIA an important and very powerful influencing tool.

By undertaking an impact assessment, organisations are able to:

- take into account the needs, experiences and circumstances of those groups of people who will be affected by the proposed changes to the functions/policies
- identify the possible inequalities people will experience and then take action to improve those outcomes
- think about other ways to achieve the aims of the functions/policies which will not lead to inequality
- increase transparency in the way the organisation works and improve the public's confidence in the fairness of policy delivery

## Section 3: Tools to support influencing for dignity

- develop better policy-making procedures and services.

An EQIA should be carried out at the very beginning of a policy development, service review, consultation or project. Its purpose is to improve service delivery by thinking about possible impacts on the service, the workforce or the public, at an early stage and embedding good practices into the work.

You should always begin with an initial or screening impact assessment which is normally based upon data that you already have. A full impact assessment to build on this may be required. This will outline the risks and benefits in more detail, taking into account the views of experts and interested groups. It will also include the results of external consultation, a final recommendation, along with arrangements for monitoring and evaluating the policy and its impact.

The EQIA should be a practical working document which is revisited regularly and updated as more information becomes available. It may be that priorities change as a piece of work develops.

More information and guidance is available from the RCN website [www.rcn.org.uk](http://www.rcn.org.uk).

### 3.7 A good practice template

You may wish to share your experience of influencing change in relation to dignity in your area of work with other practitioners, in order to support them to influence dignified care in their area of practice. This template will help you capture the key points.

Provide a brief summary that describes the initial dignity issue:

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## Section 4: Additional resources

### Influencing Resource Practitioner Group – led by Christine McKenzie and Janine Dyson

Name	Job title	Workplace
Ann Gallagher	Senior Research Fellow	Faculty of Health and Social Care Sciences, Kingston University & St George's, University of London, England
Cleopatra Phiri	Senior Therapeutic Care Worker	Glen Care homes, England
Jayne Quigley	Assistant Director of Nursing – Leadership & Patient Experience	St George's NHS Healthcare Trust, England
Austin Whyte	Senior Nurse	St George's Hospital, Stafford, England

#### People

- RCN learning representative, stewards, safety reps. Contact your country/regional office to find who your local representatives are.
- RCN Political Leadership Programme – this can help you further develop your influencing skills 01204 552 440
- RCN Nursing Department 0207 647 3752
- RCN Forum Activists – staff in the Nursing Department will be able to tell you how to contact people in the relevant forums
- Quality Improvement Network 01865 787 129 or see the RCN website [www.rcn.org.uk](http://www.rcn.org.uk)

### Organisations

- Patient Liaison Services (Scotland), Patient Advisory Liaison Services (Wales), Health and Social Services Council (Northern Ireland), Patient Advisory Liaison Service (England), or similar in your place of work
- Your local Care Commission/Inspectorate:
  - Scottish Care Commission, Scotland  
[www.carecommission.com](http://www.carecommission.com)
  - The Regulation and Quality Improvement Authority, Northern Ireland  
[www.rqia.org.uk](http://www.rqia.org.uk)
  - Health Care Inspectorate, Wales  
[www.hiw.org.uk](http://www.hiw.org.uk)
  - Care Quality Commission, England  
[www.cqc.org.uk](http://www.cqc.org.uk)

### Equality and Human Rights

- Human Rights Act (1998)  
[www.justice.gov.uk/whatwedo/humanrights.htm](http://www.justice.gov.uk/whatwedo/humanrights.htm)
- *Human rights in healthcare – a framework for local action*, available for download from [www.dh.gov.uk](http://www.dh.gov.uk)
- *Equality and human rights in the NHS: a guide for NHS Boards*, available for download from [www.dh.gov.uk](http://www.dh.gov.uk)
- Government response to the Joint Committee on Human Rights: *A life like any other? Human rights of adults with learning disabilities*. Available for download from [www.dh.gov.uk](http://www.dh.gov.uk)
- Equality and Human Rights Commission (England, Wales and Scotland) [www.equalityhumanrights.com](http://www.equalityhumanrights.com)
- The Northern Ireland Human Rights Commission [www.bih.org.uk](http://www.bih.org.uk)
- Equality Commission for Northern Ireland [www.equalityni.org](http://www.equalityni.org)



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## e- Resources

A variety of resources are available from:

- RCN Dignity Campaign on the RCN website at [www.rcn.org.uk](http://www.rcn.org.uk)
- RCN Learning Zone on the RCN website at [www.rcn.org.uk](http://www.rcn.org.uk)
- Team effectiveness guides which can be located on the RCN website at [www.rcn.org.uk](http://www.rcn.org.uk)
- Nursing and Midwifery Council [www.nmc.org.uk](http://www.nmc.org.uk)
- Department of Health [www.dh.gov.uk](http://www.dh.gov.uk)
- The Welsh Assembly [www.wales.gov.uk](http://www.wales.gov.uk)
- The Scottish Government [www.scotland.gov.uk](http://www.scotland.gov.uk)

The majority of nursing journals can be accessed online from the RCN website ([www.rcn.org.uk](http://www.rcn.org.uk)) and are free to RCN members.

The British Institute of Human Rights has an excellent online library containing materials related to health and human rights, which can be accessed at [www.bihhr.org.uk](http://www.bihhr.org.uk).

### Intute Health and Life Sciences online resources

Intute is a special online resource freely available on the Web which will help you find good quality health information at whatever level you are working or studying. Visit Intute Health and Life Sciences at [www.intute.ac.uk/healthandlifesciences](http://www.intute.ac.uk/healthandlifesciences), or visit their Nursing, Midwifery and Allied Health gateway at [www.intute.ac.uk/healthandlifesciences/nursing](http://www.intute.ac.uk/healthandlifesciences/nursing).

You can find out how to use Intute more effectively by accessing the course Use your Intute effectively!, which is located in the Skills for Learning section of the RCN Learning zone at [www.rcn.org.uk](http://www.rcn.org.uk)

### Useful publications

- Burdett Trust for Nursing (2006) *Who cares, wins: leadership and the business of caring*, Burdett Trust for Nursing: London. Available for download at [www.burdettnursingtrust.org.uk](http://www.burdettnursingtrust.org.uk)

## Section 4: Additional resources

- Castledine G (2008) Guiding behaviour towards giving care with dignity, *British Journal of Nursing*, 24 April 17(8), p.557
- Department of Health (2008) *Confidence in caring: a framework for best practice*, available for download from [www.dh.gov.uk](http://www.dh.gov.uk)
- National Institute for Clinical Excellence (2007) *How to change practice: understand, identify and overcome barriers to change*, available for download from NICE at [www.nice.org.uk](http://www.nice.org.uk)
- NHS Education for Scotland (2008) *Education and development framework for senior charge nurses*. Available for download from [www.nes.scot.nhs.uk](http://www.nes.scot.nhs.uk)
- NHS Modernisation Agency (2003) *Essence of care: patient-focused benchmarks for clinical governance*. Contains a privacy and dignity benchmark (pp.118-127). Available for download from the Department of Health website at [www.dh.gov.uk](http://www.dh.gov.uk). Note: the EoC has also been adopted by Northern Ireland
- Royal College of Nursing (2007) *RCN ward leadership project: a journey to patient-centred leadership*, London: RCN
- Royal College of Nursing (2008) *Defending dignity – challenges and opportunities for nursing*. London: RCN
- Royal College of Nursing (2008) *Delivering dignified care: a practice support pack for workshop facilitators*, London: RCN
- The Scottish Government (2008) *Leading better care: report of the senior charge nurse review and clinical quality indicators project*, Edinburgh: TSG. Available for download from [www.scotland.gov.uk](http://www.scotland.gov.uk)
- Welsh Assembly Government (2008) *Free to lead, free to care. Report and recommendations for guiding behaviour towards giving care with dignity*. Available for download from [www.wales.gov.uk](http://www.wales.gov.uk)



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### **Other useful information**

**Department of Health: Government launches national dignity tour**  
Sir Michael Parkinson is to become National Dignity Ambassador for the Government's drive to ensure that all older people using care and health services are treated with dignity and respect at all times (20 May 2008). Available from [www.dh.gov.uk](http://www.dh.gov.uk)

**Welsh Assembly Government (WAG): Action taken to improve respect and dignity of older people**

The International Day of Older People celebrations (1 October 2007), which promoted awareness of the dignity and respect programme in Wales. Available from [www.new.wales.gov.uk](http://www.new.wales.gov.uk)

**Department of Health (2005) Elimination of mixed sex accommodation (PDF, 79K)**

Outlines the three objectives set for all NHS trusts providing inpatient accommodation, designed to deliver single-sex accommodation. Available for download from [www.dh.gov.uk](http://www.dh.gov.uk)

**Welsh Assembly Government (WAG): Dignity in Care National Co-ordinating Group**

This group, which has representatives from a range of organisations including NHS, local authorities, voluntary sector, older people's groups and Community Health Councils, will meet on a quarterly basis. The first meeting was held in July 2008. Information available for download from [www.wales.gov.uk](http://www.wales.gov.uk)

**NHS Quality Improvement Scotland (NHS QIS) (2005) Clinical governance and risk management**

Information available for download from [www.nhshealthquality.org](http://www.nhshealthquality.org)

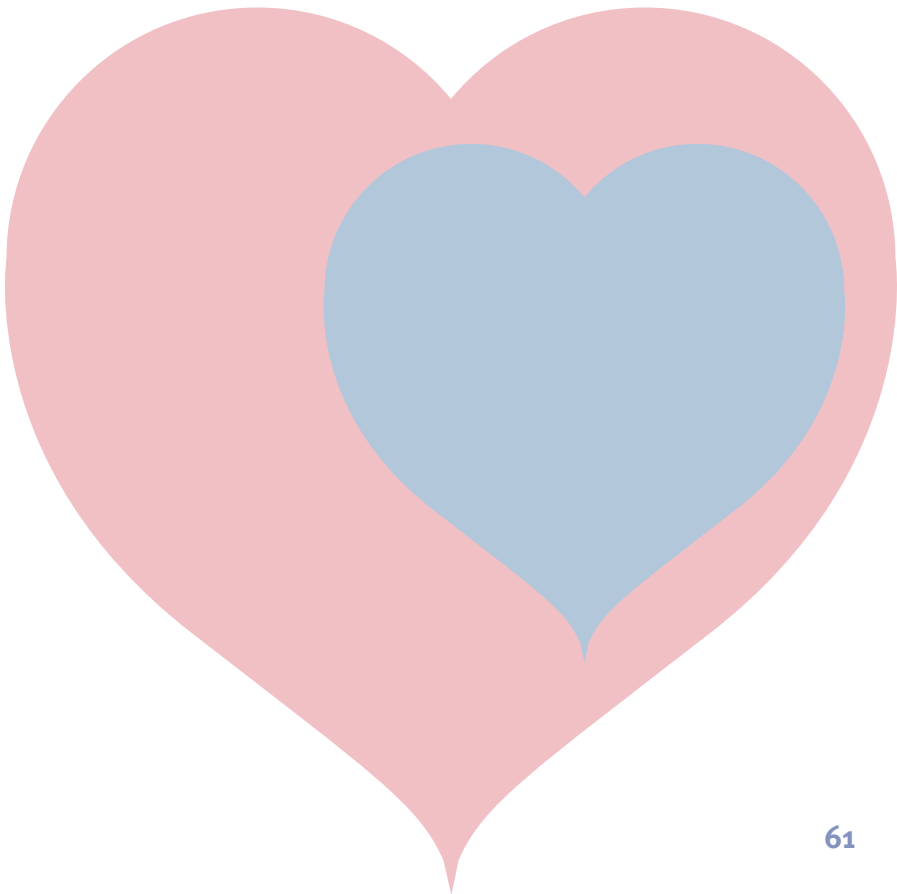
## Section 4: Additional resources

Royal College of Nursing (2006) *RCN principles: a framework for evaluating health and social care* (PDF, 2.3M)

“The RCN principles provide a standard against which we can evaluate service and policy developments, consultations and initiatives across health and social care settings and sectors within and outside the UK”. Dignity is included as an element within the quality domain. Available for download from [www.rcn.org.uk](http://www.rcn.org.uk)

Royal College of Nursing (2008) *Principles to inform decision making: what do I need to know?*

Available for download from: [www.rcn.org.uk](http://www.rcn.org.uk)





Royal College  
of Nursing

The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies.

March 2009

Published by the  
Royal College of Nursing  
20 Cavendish Square  
London W1G 0RN

RCN Direct 0845 772 6100

RCN Online [www.rcn.org.uk](http://www.rcn.org.uk)

Publication code 003 285