

Dignity in Practice: An exploration of the care of older adults in acute NHS Trusts

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Preventing Abuse and Neglect in
Institutional Care of Older Adults

A RESEARCH INITIATIVE TO ENHANCE DIGNITY
IN CARE HOMES AND HOSPITALS



Executive Summary

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Background

Evidence from a number of recent national reports show marked variations in the level and provision of dignified care for older people in acute hospital Trusts. Lack of dignity results in many complaints and substantial media interest. There is also evidence that positive health and social outcomes result from ensuring patients receive dignified care. Whilst there is a growing international and UK literature exploring dignity in the care of older people, few studies have adopted a comprehensive approach that involves:

- Ascertaining the views of older people following discharge.
- Their family members or carers.
- Senior Trust managers and ward staff.
- Observation of care delivery.

Aim of the Study

This study sought to develop a body of evidence derived from exploring the experiences of service user, those of their carers together with interviews and observation of the behaviours and practices of providers, from which explicit recommendations and guidance on the provision of dignified care can be developed. This aim was pursued through the following study objectives:

Objectives:

- 1) Identify older people's and their carer's views and priorities in relation to dignified care.
- 2) Examine healthcare practitioners' behaviours and practices in relation to dignified care.
- 3) Identify the occupational, organisational and cultural factors that impact on dignified care.
- 4) Develop evidence-based recommendations and guidance for dignified care.

Methods

These objectives were explored through an ethnography of four acute hospital Trusts in England and Wales. The Trusts were purposively selected according to their organisational characteristics, quality of care, resource use and involvement in dignity related initiatives. In-depth interviews were undertaken with recently discharged older people (65+) (n=40) and their relatives/carers (N=25) about their experiences and priorities in relation to dignified care. This was complemented by evidence from 617 hours of non-participant observation of practices and activities in 16 wards across the four acute NHS Trusts. The observation periods covered 24/7 in each of the 16 wards to identify patterns of practitioner behaviour. In-depth interviews were also undertaken with a range of frontline staff (N=79) and with

purposive samples of middle and senior managers (N=32) to explore the occupational, organisational and cultural factors which foster or detract from dignified care. The data from the observations and interviews at each site were pooled and analysed using an inductive thematic approach. Users (older people/carers) were involved with and informed of each stage of the research process.

As a means of validation, four stakeholder workshops for NHS managers and staff, voluntary organisations and policy makers (≈150) were held throughout the UK to determine how the emerging themes resonated with their experiences.

Findings

The main findings are related to four overarching themes: 'Whose Interests Matter?'; 'Right Place – Wrong Patient'; 'Seeing the Person' and 'Influences on Dignified Care'.

'Whose Interests Matter?' explores the conflict of interest between the priorities of the Trust, those of the staff and of the patients.

The findings are discussed under the following headings:

- What matters is what is measured.
- The problem of risk and unintended consequences.
- Working the system and unintended consequences.
- Trust, blame and the culture of defensiveness.
- Protocols of care.
- Caring roles and the division of labour.
- Seeing the task.
- Staffing levels and the continuity of care.

The study shows that all individuals working in the NHS are motivated to represent patients' interests but these motivations are frequently compromised by systemic and organisational factors. Setting acute Trust priorities on the basis of measurable performance indicators; a culture of blame; the management of 'secondary risks'; high bed occupancy rates together with increased specialisation and rationalisation. These all impact on the care of older people resulting in them being continually moved within the system. Furthermore, local ward cultures have developed in the context of untenable staffing levels that operate within a strictly demarcated and hierarchical division of labour. This results in a failure to provide continuity of care and care which protects and promotes the individual's dignity.

'Right Place – Wrong Patient' refers to the almost unanimous view expressed by all staff that the acute hospital is not the 'right place' for older people.

In this theme, the key message echoed by staff at all levels in each organisation, that the acute hospital is not the 'right place' for older people is explored. The prevalence of this view results in the physical environment, staff skills and education and the organisational processes acting as barriers to delivering dignified care to older people.

Because acute wards are poorly designed to meet the needs of their main users, those over 65 years, the acute ward is not 'fit for purpose' as a place to treat older people with dignity, as the physical environment is confusing and inaccessible. The staff, whilst doing their best, are often ill-equipped in terms of their knowledge and skills to care for older people whose acute illness is often compounded by physical and mental co-morbidities. The atmosphere on the wards can be characterised as one of frenetic activity with little opportunity for engagement with individuals. That many interviewees recognised these issues but concluded that it was the older person who is in the '*wrong place*', together with the assumption that there must be a better place for '*them*' to be, suggests an underlying and widespread ageism.

'Seeing the Person' focuses on the impact of encounters that take place within the acute setting and the influence of these on the experience of dignity for patients, their relatives and staff. The findings discussed under this theme include:

- Participants' views of their care.
- Respectful communication.
 - Patronising older people.
 - Referred to as a task or number.
 - Being ignored.
- Power in place.
- Fundamental care.
 - Privacy.
 - Nutrition.
 - Using the toilet.
 - Washing and dressing.
 - Being informed.
- The views of relatives.
- Staff dignity.

Care provision is variable and something of a lottery with no clear patterns as to why emerging. In no ward was care either totally 'dignified' or totally 'undignified' and variability occurred from ward to ward, in the same ward when different staff were on-duty, or at different times of the day. Care is largely task based and reactive to patient's requests for assistance, which can result in low self-esteem by reducing patients to a state of dependence. Key elements of dignified care include: respectful communication; respecting privacy; promoting autonomy and a sense of control; addressing basic human needs such as nutrition, elimination and personal hygiene needs in a respectful and sensitive manner; promoting inclusivity and a sense of participation by providing adequate information to aid decision-making; promoting a sense of identity; focusing on the individual and recognising human rights.

Undignified care is that which renders individuals invisible, depersonalises and objectifies people, is abusive or humiliating, narrowly focused and disempowers the individual.

The degree to which staff are treated with dignity and respect by their colleagues, managers, patients and carers is also variable and the role of the ward manager in promoting a respectful working environment is critical. The inability to deliver appropriate standards of care because of systemic or organisational factors impacts on staff members' sense of dignity and results in demoralisation.

The final theme of 'Influences on Dignified Care' identifies from the above findings the key influences on dignified care for older people. In this theme, the barriers and enablers to the provision of dignified care that have informed the recommendations for change are highlighted and address the organisational and policy drivers, environmental and cultural aspects, as well as individual approaches to care provision.

Environmental barriers include:-

- the disempowering nature of acute wards which add to the disorientation experienced by many older people on admission to hospital.
- the concern engendered in many older people by being in close proximity to patients of the opposite gender.
- the boredom and dejection resulting from the loss of communal spaces and activities.
- the environmental hazards that the acute ward presents especially for older people whose acute illness is compounded by dementia, confusion and/or delirium.
- the lack of information about the personnel and ward routines.

Barriers to dignified care due to deficiencies in the knowledge and experience of ward staff include:

- a lack of attention paid to the care needs of older people in educational programmes.
- a lack of knowledge of the needs of people with dementia.
- the impact of increasing specialisation.
- the lack of training in relation to the provision of dignified care.

In terms of organisational processes, the main barriers are:

- the perpetual movement of older people both within and between hospital wards.
- the view that these patients should not be there anyway.

Enablers of dignified care include:-

- attention to the physical environment that takes account of the needs of older people including appropriate signage, careful use of colour, information and date boards, safe walking spaces and communal areas to improve social interaction and engagement.
- adequate space between beds to enable privacy especially when using hoists.
- gender specific washing and toilet facilities.
- staff appraisal systems which take account of the patient experience and offer opportunities for reflection on practice.

- appropriate staffing levels to meet the demands of patient care.
- sensitive delivery of fundamental care that takes account of individual patient needs, especially the need for privacy.
- the use of signs to prevent entry to the patient spaces when intimate care is being undertaken.
- courteous and respectful communication practices.
- respectful attitudes of staff to both patients and colleagues.
- social activities and engagement especially on wards that are exclusively for older patients.
- ward managers who have a visible presence on the ward and who foster collaborative team work.
- staff who are confident and competent in their expertise and feel supported by their managers.
- the use of volunteers to assist staff.
- organisational policies and operating procedures that place patient experience at the centre.
- Trust managers who demonstrate genuine involvement in both patient and staff experiences.

Recommendations

1) Recommendations for the NHS as a System

- 1.1 Older people are the most frequent users of acute hospital services therefore ageist attitudes which result in comments such as '*They shouldn't be here*' are inappropriate. This key message must be clearly understood throughout the organisation.
- 1.2 The NHS should understand the need to design and operate its acute services to explicitly meet the needs of frail, older people. Such services will also meet the needs of other users.
- 1.3 The connection between policy and practice must be made explicit by translating what developments in policy should mean in practice for both frontline staff and those responsible for implementation, to ensure that clear unequivocal messages are received.
- 1.4 Dignity and respect are core values that underlie the NHS Constitution, it is essential that all Trust and health boards are reminded by NHS chief executive(s) that they are responsible for all aspects of the quality of care and for ensuring that the values enshrined in the constitution become a practical reality for everyone in the organisation.

2) Recommendations for Royal Colleges and Regulators of Professional Groups

- 2.1 The education of all healthcare professionals needs to be reassessed to ensure it is in line with the needs of the majority of patients in acute hospital Trusts – older people. This reappraisal must include a better understanding and appreciation of co-morbidities, the nature and management of dementia and delirium and the complexity of older people's needs. Changes to professional curricula to better reflect these needs and meet them in a dignified manner would be appropriate (see National Service Framework for Older People, DH 2001a).

3) Recommendations for Commissioners

- 3.1 Commissioners must adopt an outcomes-based approach that includes outcomes relating to dignity and respect.
- 3.2 Commissioners must ensure that all older people with complex needs complicating acute illness are seen by a geriatrician in order to advise colleagues on management.
- 3.3 Commissioners must ensure that liaison services with old age psychiatry (or other specialist services for dementia/delirium) are provided in all acute settings.

4) Recommendations for Trust Boards

- 4.1 Patient movement must be reduced by either: a lower bed occupancy rate which would allow more flexibility when trying to place patients according to specialism or gender or, by altering how the hospital is organised so that there is less emphasis on the spatial separation of specialisms. This could be promoted by:
- i) Shared care approaches and joint responsibility for patients whose conditions span specialisms.
 - ii) Consultants and their teams undertaking 'patient rounds' rather than 'ward rounds'.
- 4.2 Trust boards must give attention to environmental design and where possible enable patients to participate in redesign/refurbishment projects. Specifically:
- i) Older people are the main users of acute hospitals. Therefore the NHS should understand the need to design and operate its acute services to explicitly meet the needs of frail older people. Such services will also meet the needs of other users.
 - ii) All hospital refurbishments and new builds must incorporate dementia-friendly design as standard for all areas. This should include safe walking spaces and the helpful use of colour, lighting and signage to help orientate those with dementia or delirium.
 - iii) The value of communal spaces on acute wards in terms of social engagement and activities must be recognised as a means of preventing deterioration and promoting recovery.

- iv) Minimum space requirements around bed areas should allow dignified care while using large hoists and other equipment. Secure, accessible storage space for patients' belongings should be available at all bed spaces.
 - v) Clear definitions and information concerning single sex wards must be provided prior to admission to prepare older people for situations where there may be members of the opposite sex in adjacent bays or sharing bathing or toileting facilities.
- 4.3 Trust boards must ensure effective management by developing communication strategies that guarantee the free flow of information from 'board to ward' and 'ward to board'. These strategies should be enhanced by visible and accessible middle managers and board members. The board members must accept responsibility for the day to day quality of patient care and therefore need to ensure that they are well informed about all aspects of the patient experience. Trust board meetings should focus on the experience of patients, both good and bad, and communicate the messages across all staff groups.
- 4.4 Trust boards must ensure effective implementation of policies through an awareness and understanding of the impact of policies and priorities on patient care and practices at the ward level. Resources to ensure privacy and dignity, such as the provision of adequate amounts of clean linen and nightwear must be seen as essential.
- 4.5 In relation to risk management, Trust boards must balance the impact of risk management strategies against patients' experience. Professional staff must be reassured that they will be supported and enabled to decide when risks are worth taking to promote patient dignity.
- 4.6 Targets and clinical governance directives can create an over-emphasis on checklist based audit and measurement, which may fail to see the person and be detrimental to patient care and experience. Broader approaches to determine the quality of patient care and the experience of patients should be adopted, including regular observation of care by middle and Trust board managers and qualitative interviews with service users and their family members.
- 4.7 Trust boards must ensure a comprehensive and compulsory programme of both induction and continuing training for all staff groups in relation to the provision of dignified care and the needs of older people, especially those with dementia (See National Dementia Strategy, DH, 2009b).
- 4.8 Time must be available for staff to reflect on practice and to question inappropriate practices that have become accepted norms, such as forms of address; respecting people's space and belongings; and task driven activity at the expense of engagement with patients.
- 4.9 Trust boards must adopt human resource policies that embed dignified care in the organisational structure, especially those in relation to recruitment and staff

appraisal, so that essential aspects of patient experience such as dignity and respect are included.

- 4.10 Trust boards must invest in leadership programmes for key staff, especially ward sisters/managers.

5) Recommendations for Middle Managers and Clinical Leaders

- 5.1 Middle managers must accept responsibility for promoting dignity and hold teams accountable for delivering high quality, dignified care at all times. They must challenge undignified practices and reward dignified care.
- 5.2 Middle managers must develop ward leaders giving them more autonomy and support to manage their staff.

6) Recommendations for Ward Managers

- 6.1 Ward managers must support staff in the delivery of dignified care and be willing to speak for them to ensure resources are in place to enable the delivery of care of an appropriate standard.
- 6.2 Ward managers must be willing to challenge inappropriate or poor practices and take necessary actions to ensure they do not recur.
- 6.3 Ward managers must foster team approaches to care and facilitate communication between team members, thereby ensuring that all staff are treated with dignity and respect.

7) Recommendations for Staff

- 7.1 All staff must be willing to engage with organisational policies and strategies designed to deliver individualised care and recognise and respect every individual's need to be treated with dignity.
- 7.2 All staff must take account of older people's sensibilities especially in relation to the gender of staff delivering intimate and/or personal care.
- 7.3 All staff must be willing to reflect on the impact of their own actions on patients' experience of dignity.
- 7.4 All staff must be aware that ageism is a societal presence and therefore present in acute Trusts. This awareness should result in an acknowledgement that the 'bread and butter' work of acute hospitals is caring for older people and they should commit to always demonstrating respect and acting to safeguard the older person's dignity.

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