Dignity in Residential Care

Resource Guide

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How to use this resource guide and training programme

This resource guide gives information on providing dignified services to residents. It explains the Department of Health's Dignity Challenge, defines dignity, provides the criteria for best practice in dignity, explains how to implement best practice criteria and gives a brief outline of commissioning requirements.

There are three ways in which the resource guide can be used:

1. The resource guide can be used as a management resource, giving information about the provision of dignified services to managers.

2. The resource guide can be used as a self-directed learning tool, providing background information on treating people with dignity and respect. The resource guide will benefit newly qualified or promoted management or office staff and interested care assistants. This can be particularly effective for a care home that finds it difficult to arrange group-training sessions. In addition, some staff prefer to learn in their own time and at their own pace. Self directed learning would take approximately 1 hour.

3. The resource guide can be used by managers to give a 1:1 training session to individual staff members about dignity, either as a single training session or during appraisal or supervision. The training session would last up to 1½ hours.

The accompanying training programme covers much of the content of the resource guide with the difference that the training programme contains course notes, acetates, exercises and handouts to accompany the training.

The training programme is modular in design allowing for complete flexibility in the way it is used. It can be used in the following ways:

1. The training can be provided module by module, allowing for short, sharp sessions that will leave the participant anticipating the next module.
2. The training pack can be used as a two-hour training session.
3. The training pack can be used as a half day training session.
4. The training pack can be used as a full day training.

A matrix at the start of the training will explain how this can be achieved.

The training programme will be participative in nature, using exercises and other material to challenge behaviours and attitudes and promote best practice.

The contents of the resource guide and training programme is contained on a CD Rom and a memory stick.

Throughout the resource guide you will see this sign ⚑. This is used to signpost you to additional resources that will be of use to you when developing dignified services or training staff. A copy of each of them is also contained on the CD Rom and memory stick.

Introduction

Dignity starts at the very top of a care home with the manager or owner taking responsibility for ensuring their staff provide a dignified service. Care assistants are involved directly with residents and represent the care home. The care they provide and the way they provide it, are the standard by which residents will measure whether they have been treated with dignity and respect.

However, they are not the only staff within a care home who need to be clear about what a dignified service means and ensure they also deliver this level of care. Office staff, supervisors, trainers, managers and finance personnel may have contact with residents or their roles may impact on residents so all have their part to play in ensuring a dignified service can be provided.

In March 2005, the Department of Health published a Green Paper, *Independence, Well-being and Choice*[i], a consultation paper outlining its vision for adult social care for the future. The expected outcomes contained within the Green Paper focus very clearly on treating people with dignity and respect, assisting people to make a positive contribution to society, enabling them to exercise choice and control over their lives, guaranteeing freedom from discrimination and harassment and ensuring personal dignity is maintained.

The subsequent White Paper, *Our health, our care, our say*[ii], published in 2006, addressed these issues by setting out the vision for a new social care system designed to give people more choice and control, tackling inequalities and improving access to services, thereby guaranteeing freedom from discrimination, and providing more support to people with long-term needs.

In November 2006, Ivan Lewis MP, then Parliamentary Under Secretary of State for Care Services, gave a speech to launch a 'Dignity Campaign' with a view to "put dignity and respect at the heart of the care services we offer to older people". This campaign followed many discussions with older people receiving care services who wanted to be treated as individuals, who wanted to be listened to, who wanted to be treated with respect and who wanted the ability to exercise choice.

The aim of the campaign was to raise awareness of dignity in care, thereby inspiring people to act by spreading examples of best practice and rewarding those who made a difference.

Ivan Lewis MP launched a 'Dignity Challenge', to ensure people who use services know what to expect from a service that respects dignity. He also expected evaluations by providers, commissioners and residents to ensure that the services provided, do actually treat people with dignity and respect.

In November 2006, to support the Department of Health's Dignity Challenge, the Social Care Institute for Excellence (SCIE) published the *Dignity in Care Practice Guide (9)*[iii]*.* The Guide explains how to improve standards of dignity aimed at anyone involved in delivering care, including those who use the services and their carers, staff in all care settings, managers and service commissioners.

Other documents produced also have dignity enshrined within their contents. In 2001, the Department of Health published the *National Service Framework for Older People*[iv]. In Standard Two, Person-centred care, the rationale is to listen to people, treat them with respect and dignity, recognise individual differences and enable older people to make informed choices and to involve older people in decisions about their care. Whilst some progress has been made on asking residents about the care they have received, little mention has been made of staff training.

The Commission for Social Care Inspection (CSCI) have produced a *Performance Assessment Framework (*2008) [v] that has incorporated the outcomes from *Independence, Well-being and Choice* (2005) and now measures how well local councils meet these standards.

The *Care homes for older people: national minimum standards and the Care Homes Regulations: third edition (revised)*[vi] published in February 2003 contain a number of standards relating to dignity. Standards that specifically mention dignity include Privacy and Dignity (10) and Dying and Death (11).

See the *Care homes for older people: national minimum standards and the Care Homes Regulations: third edition (revised)* pp 11.

CSCI's *Annual Quality Assurance Assessment for Care Homes for Older People*[vii] asks care homes how they meet the care home standards and what areas are still to be improved upon. This provides an assessment of how the dignity challenge is being met.

Some care homes are doing a very good job and see dignity in care as an integral part of their service. Similarly, some care homes aspire to provide a dignified service but are unable to do so because of commissioning practices, ie. a lack of funding means there may not be enough care assistants to help people with washing and dressing in a timely manner, which can compromise dignity. Managers of care homes must be proactive in negotiating contracts that enable them to provide a dignified service.

This Dignity Resource Guide has been developed for the residential care sector, to enable managers and staff in care homes to provide services in a dignified and respectful manner and to assist care homes meet the Department of Health's Dignity Challenge. The Guide compliments SCIE's *Dignity in Care Practice Guide (9*) but has narrowed its focus so that it is directed specifically at care homes.

Definitions of dignity

SCIE's *Dignity in Care* Practice Guide concedes that 'dignity' is a difficult term to define. This is mainly because dignity is personal and can cover a wide range of topics. Dignity can mean one or all of the following and will mean different things to different people:

- Independence
- Choice
- Respect
- Privacy
- Freedom from discrimination
- Being listened to
- Being kept safe
- Being responsive
- Confidentiality
- Meeting the needs of the individual
- Recognising differences
- Contributing to society

There are a number of dictionary definitions for the term 'dignity' including:

'Being worthy of esteem or respect'
'True worth'
'Insist on respectful treatment'
'Poise and self-respect'
'An innate right to respect and ethical treatment'

There are many organisations who have researched the definitions of dignity to identify the key aspects that must be included in any care service and to ensure people are treated with dignity as an inclusive part of the service rather than as an add-on. Much of this research focuses on older people.

In Accident and Emergency Nursing (2005)[viii] an article by Griffin-Reslin outlined the four key aspects of dignity as:

- Respect
- Autonomy
- Empowerment
- Communication

Whilst these aspects have been cited as themes that encompass dignity, many other aspects need consideration too.

Another research project held focus groups for older people in six European countries (including UK) to discuss what dignity meant to them[ix]. The groups found it easier to recognise when they had not been treated with dignity, but they identified four key aspects of dignity:

- Dignity of merit – the position in society
- Dignity of moral status – the person's autonomy or integrity

- Dignity of identity – this is related to self-respect
- The value of human beings or self worth

Whilst these definitions certainly have value, they look a little vague when thinking about how they can be translated into dignified care services.

Between June and September 2006, the Department of Health elicited the views of members of the public, and health and social care staff in an online survey. This was reported on in October 2006[x]. The results of the survey identified what dignity in care meant to staff and the public. The list below encompasses these:

- Putting the individual receiving care at the centre of things, asking about their specific wants and needs and how they wanted services to be provided
- Being patient
- Not patronising the person receiving care
- Helping people to feel they can rest and relax in a safe environment
- Making sure people are not left in pain
- Ensuring people do not feel isolated or alone
- Respecting basic human rights, such as giving people privacy and encouraging independence
- Taking account of people's cultural and religious needs
- Services that are made up of smaller more specialised teams who have the time to get to know people individually.

This list appears easier to work with than some research recommendations. Many of these suggestions could be added into any service by way of staff training to ensure the needs of residents are recognised.

The definition that SCIE has taken from the dictionary and used as their working definition is:

"A state, quality or manner worthy of esteem or respect; and (by extension) self-respect. Dignity in care, therefore, means the kind of care, in any setting, which supports and promotes, and does not undermine, a person's self-respect regardless of any difference".

Unfortunately, the wordiness of this definition still does not assist care staff or service providers to interpret what a dignified service should look like and how to implement or evaluate those services. However, SCIE does concede that whilst dignity might be difficult to define, most people know when they have not been treated with dignity or respect.

The SCIE Dignity in Care Guide has a ten-point Dignity Challenge that is a statement of what a service that respects people's dignity should include:

1. Have a zero tolerance of all forms of abuse
2. Support people with the same respect you would want for yourself or a member of your family
3. Treat each person as an individual by offering a personalised service
4. Enable people to maintain the maximum possible level of independence, choice and control
5. Listen and support people and enable them to express their needs and wants
6. Respect people's right to privacy
7. Ensure people feel able to complain without fear of retribution
8. Engage with family members and carers as care partners
9. Assist people to maintain confidence and a positive self image
10. Act to alleviate people's loneliness and isolation

Each of these points comes with a means to test whether a service is meeting the dignity challenge within their service.

 See the SCIE Dignity in Care Practice Guide 9 pp 11 – 43 for the tests to measure dignity within your care home.

In *The Challenge of Dignity in Care* (2007)[xi] produced by Help the Aged, Ros Levenson explains that whilst everyone is agreed that dignity is important, there is no simple definition of what it consists of and therefore no ability to assess whether it is being achieved. The report aims to address this shortfall.

The report outlines a number of 'domains' which form a framework for providing dignified care and fits well with the ten-point Dignity Challenge.

This Resource Guide includes information about these domains and adds in another four. The domains identified by Help the Aged are:

- Communication
- Privacy
- Autonomy
- Social inclusion
- Personal hygiene
- Personal care
- Eating and nutrition
- Pain control
- End of life care

The other four domains that are added as part of this framework of providing dignified care are:

- Respect
- Diversity and equality
- Abuse
- Whistle blowing

The ten-point Dignity Challenge outlined in SCIE's Dignity in Care Guide, remains the key aim in providing dignified care services, and is endorsed by the Department of Health.

It contains specific information on some of the domains identified by Help the Aged including communication, social inclusion, autonomy, privacy, hygiene and personal appearance, mealtimes and nutritional care. It also provides information on the four additional domains, respect, diversity and equality, abuse and whistle blowing.

These domains form the 'best practice' elements of this Resource Guide. Adopting some of the criteria identified within the best practice 'domains' will assist social care providers to meet the challenge of dignity in care.

Legislation

Whilst there is little need to understand fully the different pieces of legislation that encompass dignified care and individual rights, there should be some acknowledgement and a brief explanation of these.

Human Rights Act 1998
The Act is based on the European Convention on Human Rights of 1950, which was drafted after the end of World War II to protect human rights and freedoms.

The Act came into effect in October 2000 and outlines 16 rights and freedoms for individuals. It contains rights such as the right to life and the prohibition of torture. Some of these rights and freedoms carry more weight than others and some might be restricted in times of national security or in the interests of public safety.

The Act makes it unlawful for any public body to act in a way that contravenes the rights and freedoms of people and must be taken into account on a day-to-day basis.

The Rights that have an impact on providing dignified services include:

Article 8 - Right to respect for private and family life
This means that everyone is entitled to have their home and family life respected. This includes correspondence and personal information and everyone has the right for this to remain confidential.

This Article is relevant when providing social care because the provision of care should remain confidential and the person providing the care should have respect for the care home, the way the person lives their life and written correspondence they see should remain confidential

Article 9 – Freedom of thought, conscience and religion
This means that anyone is entitled to hold a belief or follow a religion and this should not be restricted.

This Article is relevant to social care because someone who belongs to a particular religion is entitled to have this respected. This may have an impact on times that care is carried out particularly during a religious event. It may affect the purchase and provision of food and personal hygiene and care.

Article 10 – Freedom of expression
This means that a person is entitled to their own opinions, and should be able to express these opinions and ideas without interference. They are also entitled to give and receive accurate information.

This Article is relevant to social care. A person should receive all of the information known or required, with which to make an informed choice about their care and treatment. In addition, people should be listened to and their opinions acknowledged, accepted and acted on.

Article 14 – Prohibition of discrimination
This means that a person should be treated without prejudice on the grounds of their sex, race, colour, language, religion, political opinion, origin, birth, sexual orientation, disability, marital status and age.

This Article is relevant to social care. Everyone should receive the same level of care and should not be disadvantaged on any of the above grounds.

Sex Discrimination Act 1975
This Act prohibits discrimination on the grounds of gender or marital status.

Race Relations Act 1976
This Act prohibits discrimination on the grounds of race, nationality, colour, or ethnic origin.

Race Relations (Amendment) Act 2000
This Act places the onus on public bodies to eliminate discrimination and promote equality.

Disability Discrimination Act 1995 and 2005
This Act prohibits discrimination on the grounds of disability.

Employment Equality (Sexual Orientation) Regulations 2003
This Act prohibits discrimination on the grounds of sexual orientation.

Employment Equality (Religion or Belief) Regulations 2003
This Act prohibits discrimination on the grounds of religion or belief.

The Employment Equality (Age) Regulations 2006
This Act prohibits discrimination on the grounds of age.

Mental Capacity Act 2005
This Act provides a framework to ensure that people who are unable to make decisions about their lives, are protected.

It assumes, in the first instance, that everyone has the capacity to make their own decisions, even if these decisions are unwise. Where this becomes difficult, people are give support to make their own decisions.

Where decisions are made on behalf of a person who lacks the capacity to make their own decisions, these decisions will have the best interests of the person in mind and the decision made should be the least restrictive option available.

Mental Health Act 2007
This Act protects those who do not have the capacity to consent to their care and treatment, from the deprivation of their liberty, which should be avoided wherever possible.

Withdrawal of someone's liberty can only be authorised if an assessment has deemed this necessary to protect the person from harm. The Mental Capacity

Act 2005's principles of supporting the person to make a decision apply and previous wishes and feelings of the person are considered.

Sexual Offences Act 2003

This Act prohibits any sexual activity between a care assistant and someone with a mental disorder, even if the person is able to and does consent.

Safeguarding Vulnerable Groups Act 2006

This Act introduces a new scheme to help avoid harm or risk to children or vulnerable adults by preventing unsuitable people the ability to work with them.

Data Protection Act 1998

This Act provides a set of principles with which people holding information about an individual must comply. These principles include only keeping records for a specific purpose; that records kept are relevant; that they are accurate and only kept for as long as is necessary.

Freedom of Information Act 2000

This Act provides members of the public with the right to request information held by public bodies. This includes records held by hospitals and local authorities.

Poor practice

There are many examples of good practice in organisations around the country providing high quality dignified services. The *Dignity in Care Practice Guide (9)*[xii] provides a number of these good practice examples. However, some people receiving social care services have not always been treated with dignity and respect.

So what has lead some residents to believe they have not been treated with dignity?

As already mentioned, in 2006 the Department of Health elicited the views of members of the public, and health and social care staff in an online survey[xiii]. Both staff and patients identified times when dignity was not demonstrated. In their dignity in care literature review, Gallagher et al[xiv] categorised these into four groups:

1. Environment

This was in relation to the physical environment, the décor, the cleanliness, the rooms where people sleep, the toilet and bathing facilities and access to these facilities, and whether accommodation is segregated.

The survey included comments such as:

- Lack of privacy in toilets and bathrooms
- Doors that don't shut/lock
- Poor access to toilet and bathroom facilities
- Lack of a quiet room
- Mixed sex accommodation
- Shabby accommodation

2. Staff attitudes and behaviour

This was about the way staff treat residents. A lack of privacy, being patronising, using inappropriate endearments, being intolerant, being impatient and poor communication are all examples of inappropriate attitudes and behaviours.

The survey included comments such as:

- Not understanding what dignity and respect means
- A general lack of respect
- A culture of not respecting dignity
- Not being able to empathise about what it's like to be treated without dignity and respect
- Disabilities being mocked
- Residents being talked about as if they are not there
- Overhearing staff talking about other residents
- Rushing people
- The use of inappropriate or patronising terms such as 'love', 'darling' etc.
- Not perceiving the resident as an individual
- Residents being treated in an infantile manner
- Residents being patronised by staff

3. Culture of care

The care home has put its values, beliefs and goals before residents needs in the way it has organised its staff and provision of services. Budgetary constraints, targets, not adapting to change and lack of understanding and training in the principles of dignity can cause this.

The survey included comments such as:

- Poor commissioning practices eg, a lack of funding
- A lack of confidentiality such as handing over to other staff at the end of the bed where everyone can hear
- Uncaring staff
- Assessments which are budget related not needs related
- Staff not being treated with dignity by their employer and in return staff are not treating residents with dignity
- Being cared for in a way that suits the care home not the person
- Poor leadership
- Low staff numbers
- Busy staff
- Lack of staff time
- Complaints being ignored
- Being cared for by a constant stream of different staff
- Staff with poor English being unable to communicate with residents

4. Specific care activities

This was in regard to care assistants carrying out care procedures, such as personal hygiene, toileting, providing meals and drinks and controlling pain, without due regard for the dignity of the resident.

The survey included comments such as:

- Personal care taking place in front of others
- Leaving residents exposed in front of others
- Giving a resident their food whilst they were sitting on a commode
- Not being fed and a lack of proper support at mealtimes
- Being left in soiled clothing
- Walking into a room without knocking when the person is still in a state of undress
- Refusing to answer calls for the toilet

It is clear in the above examples that residents were not receiving dignified services either through the fault of the care home, its staff or the individual care assistant.

In many instances, staff could have provided a better service if they had attended a dignity training course or were aware of how to treat people with dignity and respect.

It is important that staff empathise with the person receiving the care, imagining themselves as a resident and thinking about how they would feel receiving care in the same situation.

Discrimination

Discrimination is the prejudicial behaviour towards or against a certain group of people or individuals. There are a number of acts of parliament that prohibit prejudicial behaviour on the grounds of race, origin, colour, language, sexual preference or gender realignment, religion or belief, political opinion, birth, disability, marital status and age although discrimination still takes place.

When thinking about dignified care services, those who are treated with little dignity or respect are often, but not exclusively, those who are already disadvantaged in some way, for example, those with physical, learning or mental health disabilities and those who are young or old or from minority ethnic groups. Already disadvantaged, they may feel too vulnerable or are physically and mentally unable to stand up for their own rights.

The use of advocates can be helpful in acting as a voice for vulnerable people. Unfortunately, there are too few advocates nationwide for all residents to receive their help. Care assistants and other staff are in a position to provide this support, but need comprehensive training to be able to give this assistance effectively to residents.

Care homes who fail to prevent their staff from providing discriminatory care could find themselves the subject of legal action, particularly if the behaviour was witnessed and reported (see whistle blowing policy on page 31).

Care homes who train their staff to provide services in a dignified, respectful and anti-discriminatory manner and carry out regular service audits to prove this, will be much less likely to receive threats of legal action.

Dignity – best practice

As previously mentioned, there are many examples of good practice in organisations around the country providing high quality dignified services. However, these are sometimes hampered by poor commissioning practices, such as poor funding. Negotiation with commissioners to provide better funding will assist care homes to adopt many of these practices.

The Challenge of Dignity in Care (2007)[x] highlighted the lack of a simple definition of what a dignified service looks like, even though people know when they have not received it. The report outlined a number of 'domains' or specific areas that could form an important part of a framework to a dignified care service.

We will now identify the criteria that make up of each of these 'domains' so that when put into practice they form a template for a dignified service. Many of the good practice examples mentioned in the *Dignity in Care Practice Guide (9)*[xv] will include a number of the criteria below. Those care homes who already provide good quality dignified services may use these criteria to improve their services further.

Although the *Essence of Care*[xvi] document produced in 2001 is a hospital-based document, it provides best practice information for some of the domains relevant to social care.

Communication

Residents and their chosen advocates engage in a two-way dialogue with care assistants and other staff about their physical, psychological and emotional needs and preferences. The assembled facts and information form an agreed care plan that gives the resident a choice about the care they receive.

In reality, this means:

- The care home has a communication policy that all staff understand and adhere to at all times
- Asking residents how they would like to be addressed
- Ensuring residents are not patronised or belittled
- Staff use respectful language and gestures and are courteous when communicating with residents
- Ensuring residents can understand the accent or language of care assistants
- An interpreter is provided if needed
- Appropriate methods and tools for effective communication are used
- There is the use of a room for private communication if required
- Care assistants are trained in how to carry out an assessment correctly and effectively
- A resident is always asked about their needs and preferences
- Care assistants do not make assumptions about services user's needs and preferences
- Discussion, assessment, risk assessment and agreement of the care plan takes place at a mutually agreeable time and place

- Sufficient time is allowed for residents to communicate their needs and preferences
- Residents are able to communicate their needs and preferences at all times and these are considered and acted upon appropriately
- Care plans are jargon free
- Resident's views are listened to, valued and respected.

Respect

Residents should receive respect for their rights as individuals, their values, beliefs, personal relationships and their property. Staff treat these with courtesy and thoughtfulness at all times.

In reality, this means:

- Residents are treated as individuals
- Residents are treated as a whole person and not as an illness
- Residents are treated without discrimination
- Residents are treated as an equal
- Sufficient time is given for care to be provided at the resident's pace
- Care assistants treat residents with courtesy
- Care assistants ensure that the service is person centred and not task oriented
- Staff allow time to listen to residents
- Care assistants allow time to talk to residents
- Residents are asked how they would like to be addressed
- Residents are involved in planning the care they receive
- Care assistants respect the resident's personal space
- Care assistants do not make assumptions about residents
- Care assistants allow time for residents to communicate their choices and preferences
- Residents are not disturbed or interrupted and care assistants knock before entering their room
- Privacy is maintained at all times by the care assistant being aware of when privacy could be compromised and negating against this
- Single sex facilities, including toilet and bathing facilities, are provided.

Privacy

Residents should be able to maintain their privacy at all times, this includes privacy of their personal care, confidentiality of any information owned by or kept about the resident and privacy of their personal space.

In reality, this means:

- The care home has a confidentiality policy that all staff understand and adhere to at all times
- Residents are not embarrassed when receiving personal care
- Residents are not exposed in front of others
- If the resident's own clothes cannot be used, appropriate clothing should be sought
- Care assistants do not invade the resident's personal space
- Single sex accommodation is provided

- Toilet and bathing facilities respect privacy
- Privacy is maintained in respect of sexual relationships
- Care assistants knock and, where possible, wait for an answer before entering a resident's room
- If an interpreter is required, they are chosen with the consent and participation of the resident
- Resident's personal possessions and documents remain private
- Resident's private conversations, phone calls and mail all remain private
- Where documents need to be shared, this is with the consent of the resident
- An area or room is provided for resident's wishing to have private conversations.

Autonomy

This means residents are able to take control over their own lives, making independent choices about their care, treatment and day-to-day living activities without reproach by care assistants.

In reality, this means:

- Staff communicate with residents in the most appropriate way
- Care assistants do not make assumptions about whether or not the resident can make decisions by themselves, even where mental capacity is an issue
- Care assistants allow residents time to communicate their requests for the day's activities and care assistants adhere to these
- Staff inform residents about local advocacy services to assist them to make decisions about their daily activities
- Care assistants do not make assumptions about the likes and dislikes of residents
- Care assistants treat residents as equals
- Staff provide information in an understandable way, free from jargon to allow residents to make their own choices
- Residents are allowed to take risks without compromising their care assistants safety
- Care assistants ensure residents are given the opportunity to participate in their chosen activities as fully as possible
- Services are accessible to people with disabilities, for example providing service information in alternative formats for people with visual impairment.

Social inclusion

Residents should be not be discriminated against because of their age, ethnic origin, sexual orientation or health status. They should be included in a range of social activities to enable them to feel integrated into the community and in society in general. This means where possible, having contact with family and friends, being able to go shopping, to go out socially, to be in control of their own financial arrangements and to do all this safely.

In reality, this means:

- Staff treat residents with dignity and respect
- Residents are able to chose their day-to-day activities and arrangements with care assistants without fear of rebuke

- Care assistants take time to talk to residents whilst carrying out their care
- Care assistants respect the past skills and experiences of the resident
- Staff enable residents to go out socially by addressing the barriers to this such as transport and safety issues.

Diversity and equality

There is a large amount of legislation designed to prevent unfair, unequal practice and discrimination. When people are in receipt of care services, there may be a tendency because of their age, gender, ethnic origin, religion or other reason, to treat a person differently. This would be discriminatory.

In reality, this means:

- The care home has an Equality and Diversity policy that staff understand and adhere to at all times
- Staff treat residents how they would expect to be treated themselves
- Staff treat residents with respect
- Staff listen to resident's requests and take the appropriate action
- The individual wants, needs and preferences of residents should be taken into consideration and if these cannot be achieved discussion should take place as to what can be achieved instead and whether this is acceptable to the resident
- Care assistants should not be insensitive to the resident's individual needs and preferences
- Care assistants give care suitable for the resident's individual needs.

Pain control

Keeping people pain free is a key aspect of providing dignified services, particularly toward the end of life. However, many older people do not receive adequate pain control and often have excruciating pain, which prevents them from being independent. Care assistants ensure residents receive sufficient pain control at all times.

In reality, this means:

- Care assistants should be proactive in discussing pain control with the resident
- Care assistants are empathetic about the pain that residents experience
- With the consent of the resident, care assistants report uncontrolled pain to the doctor or prescriber
- Care assistants encourage residents to discuss uncontrolled pain with the doctor or prescriber
- Care assistants find activities for the resident that alleviates rather than exacerbates pain.

Eating and nutrition

To some residents, mealtimes can be the highlight of the day. It is therefore important to make mealtimes significant and to ensure that the food received is highly nutritious. It is also essential that food is of the quality, quantity and variety expected by the resident, delivered at the times set by them.

In reality, this means:

- Care assistants understand the importance of nutrition and hydration and know the signs and symptoms of malnutrition and dehydration
- Care assistants have been trained in the subject of nutrition and food hygiene
- If there are problems with nutrition, care assistants discuss with residents the help they might need to improve this
- If the resident is assessed to be malnourished or dehydrated, after discussion with the resident, care assistants refer the resident to the appropriate professional eg. doctor or dietician
- Residents are enabled to maintain their independence with eating and clearing up for as long as possible
- Care assistants discuss food and drink likes and dislikes with residents and these are fed back to the kitchen staff
- Care assistants discuss any religious or special dietary needs the resident might have and these are fed back to the kitchen staff
- Care assistants don't make assumptions about residents food requirements in relation to their cultural or religious beliefs
- Care assistants respect the requests and wishes of the resident in relation to their diet
- Care assistants pay attention to any religious or cultural needs the resident has with regard to food eg, hand washing prior to eating
- Care assistants assist residents to identify aids that may help the resident maintain their independence with eating
- In consultation with the resident, care assistants provide assistance with eating
- Residents are not rushed when receiving assistance with food
- Residents are not interrupted when eating their food
- Care assistants and kitchen staff ensure any food served looks appetising for the resident
- Care assistants ensure a drink is given with all food
- Care assistants assist residents to clear away food and food debris afterwards according to their wishes.

Personal hygiene

A person's appearance is central to their feeling of self-worth. Care assistants ensure the standard residents set for themselves with their personal hygiene continues, particularly when they are unable to take care of this for themselves.

In reality, this means:

- Residents decide the level of assistance they need from care assistants with their personal hygiene
- Care assistants don't make assumptions about the level of cleanliness the resident chooses to adopt
- Care assistants assist with all aspects of personal appearance that the resident is unable to maintain for themselves, ensuring they maintain the resident's privacy and independence at all times. This includes assistance with:
    - Washing and dressing

    - Shaving
    - Oral hygiene
    - Hair care
    - Nail care
- Residents choose the times they receive help with personal hygiene
- Residents choose the clothes they wish to wear each day
- Care assistants assist residents with their toileting or continence needs as requested.

Personal care

Personal care includes those aspects of a resident's daily life, other than personal hygiene, about which they may be concerned. This will include the care they receive due to any illnesses, such as pain relief, wound care and general health promotion, such as food and nutrition but also other issues such as cleanliness of their room, laundry and general décor. Part of a care assistant's role will be to ensure they assist residents to meet these additional needs.

In reality, this means:

- Care assistants discuss with residents their arrangements and preferences for laundry and ironing
- Care assistants discuss the resident's requirements regarding the cleanliness of the room and the décor to make the living accommodation more hospitable and safe
- Care assistants discuss with residents how they might keep their room free from odours that cause the resident distress
- Care assistants treat the resident's preferences with respect.

Abuse

Abuse is a wide-ranging subject, of which there are many different types such as physical, psychological, financial, sexual, discrimination and neglect. Care assistants must be alert to the presence of abuse.

In reality, this means:

- Care assistants receive training about the different types of abuse and how these are revealed
- Care assistants follow the care home's abuse and whistle blowing policies and procedures for the reporting of incidents
- Staff are protected under the whistle blowing policy from recrimination by members of staff who are reported for abusing residents
- Suspicions of abuse should be reported by managers to the local Adult Protection Co-ordinator.

Whistle blowing

Care assistants and other staff should feel supported by the care home when raising concerns about any poor practice or abuse they witness or hear about on behalf of residents.

In reality, this means:

- The care home has a whistle blowing policy that staff know about and understand and which covers the statutory disclosures protected under the Public Interest Disclosure Act 1998 including:
    - A criminal offence
    - A breach of a legal obligation
    - A miscarriage of justice
    - A danger to the health and safety of an individual
    - Damage to the environment
    - Deliberate covering up of any information from the above list
- The policy is accompanied by a procedure for staff to follow when whistle blowing
- Training should be given to staff about whistle blowing
- Staff are empowered to blow the whistle when they observe poor practice or abuse
- The care home adopts a 'no blame' culture for those who whistle blow
- Care homes see whistle blowing as a means of quality assurance for their care home
- Actions taken by the care home show staff who whistle blow are supported
- Whistle blowers are protected by the care home
- Whistle blowers have the interests of vulnerable residents at heart
- Whistle blowers should ensure their information is factual and observations have been recorded accurately.

End of life care

Many residents are concerned with the potential loss of dignity when it comes to the end of their life. It is the task of the care assistant to maintain the level of dignity of the resident when the time comes, by ensuring they achieve all the actions required in all the domains above.

In reality, this means:

- Residents at the end of their life receive care with regard to privacy
- Residents at the end of their life are treated with dignity and respect by care assistants
- Care assistants provide residents with high quality care and treatment at the end of their life
- Care assistants ensure that the resident's surroundings are as comfortable as possible at the end of their life
- Residents receive pain relief to fully control their pain at the end of their life
- Care assistants respect the resident's personal preferences during this time.

Caring for people from specific user groups

In the past, people from certain user groups have suffered from poor services through discriminatory practices. The groups most at risk from this are:

- Older people
- Physically disabled people
- People with specific health needs eg, cancer
- People with mental health problems eg, dementia
- People with learning difficulties
- Young, physically disabled people
- People from minority ethnic groups

Services can respond to the needs of these groups of people in innovative ways. For example, people who have visual impairment can have service information provided in different formats or people from ethnic minority groups can have a care assistant from the same ethnic group providing the care for them.

Services that treat older people equally and with dignity and respect will be best placed to receive the preferred status by Commissioners in the future.

By using the thirteen best practice domains mentioned earlier in this Guide, by continually monitoring the service provided and by adhering to the ten points within the Department of Health's Dignity Challenge, a service will continually improve, providing the dignified services that users will come to expect as the norm.

People from the groups above should expect to receive the same level of service that anyone one else is entitled to receive. The success of the Dignity Campaign will be measured by the results of future reports, most specifically regarding these groups of people.

Commissioning

Commissioners are increasingly asking more questions about the services provided in relation to dignity and respect and have been changing their contracts to reflect this.

The *Commissioning framework for health and well-being*[xvii] published by the Department of Health in 2007, puts the resident at the centre of the commissioning process, and says that Commissioners should move towards services that "are personal, sensitive to individual need, and that maintain independence and dignity".

To enable this to happen, residents should receive all the information they need about the quality of the care home who, in turn, should provide responsive, personalised services.

Commissioners can use contracts to ensure residents' individual needs are identified and met and can award preferred status for care home that meet these objectives.

 See the Commissioning framework for health and well-being for further information on commissioning requirements for the future.

Commissioners can also use the *Care homes for older people: national minimum standards*[vi] within their contracts to measure how the service provider maintains dignity within their service.

Some Commissioners have written additional standards of performance for dignity into their contracts. This ensures that providers regularly audit their services to ensure residents are treated with dignity and respect.

Care homes must become responsive to residents' needs and preferences, re-designing their service to meet these requirements.

Implementing change

Why is change needed

Care homes that are not providing dignified services will need to make changes to their service. Changes may be required because of the following:

- The service hasn't achieved good results from the Dignity Challenge Monitoring Tool[xviii]
- Training exercises demonstrate a lack of dignity shown to residents and other staff
- The Government and Department of Health are focussed on ensuring residents receive dignified services
- Commissioners now ask the care home about dignity when monitoring the contract
- Residents and user groups are now more vocal about the type of service they expect
- A rise in complaints from residents about the lack of dignity and respect shown by care assistants
- A raised profile in the media means that everyone is looking at the type of services provided
- Bad publicity about the care received by a vulnerable resident

What changes are required?

The change required will depend upon the reason the change is needed. This might be one of the following:

- Changes to the type of service provided and the way it is provided
- Organisational change
- Improvements in staff attitudes and actions
- Structural changes
- Changes to commissioning practices

For example, if there have been complaints from residents about a lack of respect from care assistants, there will need to be changes to staff attitudes and actions. This can be achieved through staff training. There might also be a problem with the values of the care home, which will need to be addressed before staff training takes place.

Similarly, some care homes aspire to provide a dignified service but are unable to do so because of commissioning practices, eg, a lack of funding meaning that care assistants have to rush the process of helping people with their care which can compromise dignity. Managers of care homes must be proactive in negotiating contracts that enable them to provide a dignified service.

How to implement the changes required

Change can be made by discussing with staff the reason the change is needed. Change is often an unsettling experience for staff. It is therefore important to give a great deal of thought as to how the process of change can be managed sensitively within the care home.

The process will be made better by ensuring that there is consultation with, and involvement from, staff at all levels. Firstly, managers, staff and care assistants need to understand what all the issues are and why there is a need to change.

This may be by providing the results of the dignity monitoring audit or the contract monitoring report, sharing letters of complaint or providing staff with information about a change in government focus.

It is not for employees to manage change, only to do their best to implement it. This does not mean that employees cannot become involved in the change process. A six-step approach to involving staff in change can be adopted:

1) Get a commitment from staff to change by involving them in identifying the problem
2) Develop a shared approach of how the change can be organised
3) Obtain a consensus to this shared approach
4) Develop an action plan that contains targets of the change required and the dates for achieving these changes
5) As part of the action plan, develop a staff training plan and implement training for all staff
6) Monitor the action plan and the changes made on a regular basis. Involve staff in monitoring the change and reward positive action.

The cost of implementing change

The cost of implementing change may be high. However, it may not be as high as the cost of not implementing change, which can be vast. This can include a loss of reputation or a loss of contracts, which ultimately can lead to the care home failing.

In reality, the costs of implementing change are:

- Staff training costs, including the cost of training, staff replacement costs and staff expenses
- Implementation of new systems of work, which might include better complaints monitoring, updated customer care systems, implementation of logging systems
- Monitoring costs, such as carrying out additional audits, supervisions, spot checks, complaints monitoring and surveying
- By far the largest area of cost will be any structural changes, which need to take place, such as changing toilet facilities, re-organisation of rooms etc.

Conclusion

This Resource Guide outlines the expectations of the Department of Health in relation to the provision of dignified and respectful services. It gives information about the Department of Health's Dignity Challenge, which comes with a monitoring tool to enable services to assess themselves.

The Resource Guide is based on the research that has been carried out, to identify best practice when providing services. By focussing on some of the best practice domains, care homes can make the necessary changes to ensure that services are responsive to resident's needs.

Another area that must be considered is staff attitude. Care homes must ensure that staff attitudes towards providing dignified and respectful services are challenged. This can be done by using documents such as this or by providing staff training where attitudes can be challenged.

Commissioners are increasingly asking more questions about the services provided in relation to dignity, and are changing their contracts to reflect this. To ensure these contracts are being met, service providers must become responsive to residents' needs and preferences and design their services to meet this demand.

Continuous monitoring is required to ensure dignity service standards are being maintained. This can be in the form of undertaking the monitoring audit that accompanies the Department of Health's Dignity Challenge, but can also include surveying residents and care staff, staff training, staff mentoring and supervision and spot checks. Robust complaints monitoring systems also enable care homes to monitor their standards.

See SCIE (2006) Dignity in Care: Adult Services Practice Guide (9). Pg. 11 - 43. SCIE[xvi]

Appendix 1 - Sample policy – Confidentiality

1. Purpose

The purpose of this policy is to have an open, consistent and fair policy that affects all areas of confidentiality within the care home and during the course of day-to-day activities whilst carrying out care in the care home. Through this policy, the care home will protect itself against legal liability and set privacy expectations.

2. Scope

This policy applies to all employees and management who are full time or part time, temporary or permanent and those on fixed term contracts. Former employees will also have access to this policy after their employment has been terminated.

This policy applies to all communication and information, whether verbal or written including that which is not in the public domain.

3. Policy

The care home respects the privacy of all residents and recognises that individuals are different in the way they live their lives. Employees who attend to residents in the care home or accompany them on day trips during their usual course of employment are bound by the care home's confidentiality policy. Any employee who has access to privileged information has entered into a tightly drawn obligation to keep such information confidential during and after employment with the care home. This also means not using confidential information for illegitimate purposes.

The care home views the issue of confidentiality as important in the context of information where there can be sensitivities or perceptions of sensitivities which relates to the resident or the care home.

Employees will not divulge to third parties matters confidential to the care home or residents (whether or not covered by this policy) without written explicit authorisation from both the care home and the resident.

Where the care home discovers an actual or potential breach of this policy, the care home will act quickly with residents' permission to seek appropriate redress to prevent further damage to the resident or care home's reputation. Individuals who divulge confidential information to third parties about residents will be held personally liable for any legal action taken against them by the resident.

Except where specifically agreed, all material, data, information etc. collected during the course of employment will remain in the possession of the care home or the resident.

Appendix 2 - Sample policy – Whistle blowing

1. Purpose

In the course of normal employment, employees may raise problems or complaints about work practices that are dealt with informally at source. This policy is to inform employees about the procedure to follow where an employee believes and provides information to the care home about its practices and raising concerns about danger or illegalities that affect others or the general public in relation to the Public Interest Disclosure Act 1998 (whistle blowing).

2. Scope

This policy applies to all employees and management who are full time or part time, temporary or permanent and those on fixed term contracts. Former employees will also have access to this policy after their employment has been terminated if they wish to use this.

3. Principles

If an employee wishes to make a Public Interest Disclosure, they should first aim to bring the matter to the attention of their line manager or the designated person responsible for handling whistle blowing. This would enable concerns to be heard and investigated as quickly as possible.

This procedure is to ensure that evidence of any malpractice brought to the attention of, or presented to, the care home is fully investigated and, if necessary, put right and the appropriate action taken. Staff are encouraged to use this procedure as opposed to reporting concerns anonymously.

4. Responsibilities

The HR manager will support whistle blowers. Managers undertake training to become competent to deal with whistle blowing. Managers must take the concern raised seriously and make an objective assessment of it. They are responsible for keeping the employee updated on progress made and action taken to resolve the concern.

5. Policy

Where an employee has concerns about malpractice, they should raise it formally with their line manager. Their concerns should be related to a specific incident that has happened, is happening or is likely to happen that is dangerous or illegal and affects individuals and members of the public.

Where the allegations concern the employee's line manager, they should report the incident to a senior manager.

Staff who have reasonable belief can disclose matters such as:

- A criminal offence
- Breach of a legal obligation
- A miscarriage of justice
- Danger to the health or safety of any individual
- Damage to the environment
- Deliberate covering up of information from any of the above five matters

All concerns will be treated as confidential and employees who report suspected misconduct or malpractice will not be penalised for it.

Staff who disclose information will be protected from suffering a detriment for making such a disclosure, even in instances when the disclosure is found to be unproven. Staff who believe they have suffered a detriment such as denial of promotion, facilities or training opportunities are entitled to raise a grievance using the care home's grievance policy.

Staff will be protected if they always act in good faith and reasonably believe that the information and any allegation it contains are substantially true.

However, where staff make malicious accusations with the intent and purpose of discrediting or defaming the character of a colleague or the care home they may be subject to disciplinary action under the care home's disciplinary procedure. They must not make a disclosure for personal gain or have an ulterior motive as the predominant purpose of making it. Staff that act illegally to obtain information for the purposes of submitting a Public Interest Disclosure will be held personally liable for an breaches in the law.

Employees will be advised of the progress being made and the action that was taken.

Appendix 3 - Sample policy – Communication

1. Purpose

The purpose of this policy is to have an open, consistent and fair policy that affects all areas of communication between staff and residents in the course of their day-to-day activities when carrying out care in the care home. Through this policy, the care home will protect itself against legal liability and set communication expectations.

2. Scope

This policy applies to all employees and management who are on fixed term contracts and come into contact with residents and their carers.

This policy applies to all forms of communication with residents.

3. Policy

This care home recognises that in social care, it is important to create and keep good impressions with the people you look after, in order to put them at ease and communicate effectively with them. As such, the care home expects staff to create a good first impression by ensuring that their appearance, body language, demeanour and mannerisms are professional.

Employees are expected to be at ease, open and confident in order to communicate effectively with the resident. Staff should be courteous and attentive and portray a positive attitude of 'can do' for residents.

Staff should pay attention and show that they are actively listening to the client by:

- Nodding occasionally
- Smiling and using facial expression
- Making sure their posture is open and inviting
- Encouraging the client to continue with small verbal comments like 'yes', and 'uh huh'
- Reflecting what has been said by paraphrasing e.g. 'It sounds like you are saying...', 'What I am hearing is…'
- Ask questions to clarify certain points e.g. 'What do you mean when you say…' or 'Is this what you mean?'
- Summarise the resident's points periodically
- Select a tone that matches the resident's hearing ability
- Do not assume people may have a hearing impairment because of their age

As some residents may have some form of learning or communication difficulty, staff should avoid interrupting the conversation in order to minimise any frustrations that the resident may have. Appropriately respond by showing the resident respect and understanding of their needs. Care assistants should avoid putting residents down. Assert opinions respectfully and be candid, open and honest in your response.

Staff should avoid using words or phrases which some residents may find patronising like, 'love', 'darling', 'dear', 'mate'.

Appendix 4 - Sample policy – Equality and diversity

1. Purpose

This policy sets out the standards to be achieved by staff in relation to providing people with equality of opportunity and valuing people as individuals who have diverse experiences, backgrounds and beliefs.

2. Scope

This policy applies to all employees and management who are on fixed term contracts and come into contact with residents.

3. Policy

The Care Home is an equal opportunities employer, committed to ensuring that the talents and resources of all employees are utilised to the full. The Care Home aims to attract and retain staff and broaden their skill base in a stimulating and healthy environment that is free from prejudice. As such, the Care Home is committed to adopting, implementing and monitoring a policy of equal opportunities for all employees to exclude discrimination from the work-place and to ensure that access to employment and fair treatment are genuinely practiced.

Implementation and management of this policy is the responsibility of each individual employee and they are obliged to respect and act in accordance with the policy. It is the objective of the policy that there shall be no discrimination towards employees for any reason of age, race or ethnic origin, creed, colour, religion, political affiliation, disability or impairments, marital status, parenthood, sexual gender, sexual orientation or offending background. In this respect, employees with disabilities will only be prohibited from positions where the duties of the job involve activities that would make it impossible or inherently hazardous to perform.

Staff will be promoted on their individual ability to do the job and performance. All staff will have equal and fair access to learning and development as identified through their performance appraisal.

4. Training

All staff, including managers, throughout the care home will be provided with compulsory training to ensure that they understand the importance of equality, diversity and fairness.

5. Recruitment

For employee recruitment and selection, to eliminate possibilities of discrimination or prejudice before interview, employment application forms do not include questions concerning age, race or ethnic origin, creed, colour, religion, sex, political affiliation, parenthood or sexual orientation. Thereafter, employee selection criteria will proceed purely according to the merits and abilities of the applicant to perform the tasks and duties listed in the relevant job description. Employee recruitment and selection procedures are regularly reviewed to ensure that the elements of this Policy are maintained.

In order to ensure a fair working environment for all employees, discrimination or harassment (physical or verbal conduct that violates a person's dignity or creates an intimidating, hostile, degrading, humiliating or offensive environment) will not be tolerated within the care home. The Care Home provides facilities for any employee who believes that he or she has been treated unfairly within the scope of this policy to address the matter through a documented and established grievance procedure. Each complaint will be thoroughly investigated and where it is identified that an individual has treated a colleague unfairly they will be subject to the Care Home's disciplinary procedure.

Additional resources

In addition to the references.

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[xiii] www.dh.gov.uk/en/SocialCare/Socialcarereform/Dignityincare/index.htm

[xiv] Gallagher. A, Li. S, Wainwright. P, Rees Jones. I, Lee. D. (2008) Dignity in the care of older people – a review of the theoretical and empirical literature. BMC Nursing

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