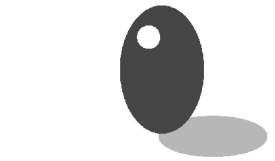

HASCAS

DIGNITY THROUGH ACTION
(Older People)

RESOURCE 2

DIGNITY THROUGH ACTION STUDY GUIDE

Health and Social Care Advisory Service (HASCAS),
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GLOSSARY OF USEFUL DIGNITY TERMS	
Abuse	Abuse is the harming, mistreatment or neglected of people. In the context of dignity it can also mean being spoken to insultingly or unkind behaviour, unjustness or corrupt practice.
Ageism	Age discrimination refers to the actions taken to deny or limit opportunities to people on the basis of age. These are usually actions taken as a result of one's ageist beliefs and attitudes. Age discrimination occurs on both a personal and institutional level. Ageism can be challenged by legal and policy changes, but ageist attitudes and practice remain a serious issue, demanding much further effort. The effects of ageism are compounded for many older people by other forms of inequality, disadvantage and discrimination. These include poverty, social class, gender, ethnicity, physical and learning disabilities and sexual preferences.
Autonomy	Autonomy is about the freedom to act and freedom to decide, based on opportunities to participate and comprehensive information.
Care	The term *care* covers all help and support provided by paid and unpaid workers in any setting *(hospital, residential, nursing, day centres and in people's own homes),* including care that is paid for either partially or wholly by the recipient.
Challenge	The term *challenge* can have several meanings. It can mean a difficult task (a challenge) or be something that requires a response (to be challenged).
Choice	The term *choice* means to be able to have the power to decide between possibilities.
Dignity	The definition of dignity is based on the moral requirement to respect all human beings, irrespective of any conditions they may suffer from. Dignity is a word that describes a **quality** of peoples' beliefs, values, behavior and actions towards others. Dignity can mean the quality of the: • Appreciation and respect we give to others, which lead us to treat people as we do *(e.g. the person was treated with dignity.)* • Appearance, bearing and behavior of people. *(e.g. people can appear to be dignified.)* This has a critical meaning which is discussed later. • Rank in society or the honours that may have been awarded. *(e.g. all the local dignitaries attended the party.)* This meaning is perhaps less important in care, but it still has some value in considering the meaning of dignity for older people.
Discrimination	Treating people differently on basis of a difference between some human characteristic such as race or colour.
Equality	The definition of equality is based on moral requirement to respect all human beings as being free and equal (the same) where all people should be treated with no discrimination (a human right).
Freedom	Freedom is the independence to act, say or believe. There are several freedoms listed as human rights, but there are social and legal restrictions where people have to act within the law.
Healthcare	Healthcare is the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions.
Humiliation	The emotional pain caused by injury to someone's self-respect or dignity.
Independence	Not depending on someone else's opinion, conduct or permission to act.
Merit	Merit is the quality of deserving something. In the context of dignity, merit is about people deserving benefit because the moral requirement that they are human beings.
Person-centered Care	Person-centered care of the older person puts the needs and aspirations of the individual older person at the centre of planning. Embedding the principles of person-centered care is still in progress, and evidence is mixed about how successfully this is being done. Barriers to achieving this kind of care in some settings include bureaucracy, tight budgets and restrictive commissioning which, reduce staff time for flexible, personal care.
Prejudice	Opinions held about other people whatever evidence exists to the contrary.
Privacy	Privacy means being left alone and undisturbed. It can refer to people and object, where objects and information are not seen by others. Privacy is often used in terms of personal space; modesty, personal care, confidentiality of treatment and personal information.
Resilience	Resilience describes the inner strength which, research has found, enables older people to bear difficult situations. A sense of self-worth and meaning was maintained by many, by reference to their families and previous life experiences and achievements, and a focus on everyday pleasures. Resilience could be reinforced or undermined by care workers.
Respect	Respect is the esteem shown to you as a human being and as an individual, by others, and demonstrated by courtesy, good communication and taking time.
Retribution	Punishing as a form of vengeance.

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Rights	The **rights** of people are those ways of being treated correctly and without reservation which is based on moral requirement to respect all human beings.
Social Care	**Social Care** Social care is about the provision of a range of services and support including help with everyday tasks such as cooking and shopping as well as personal care, which includes washing and help with eating. It supports the person with dignity and enables them to live their life in the way they want; whether that is to live in their own home or to receive support in a care home. General types are: **Residential Care** When an older person requires a lot of support, it may be necessary to have this care provided in a care home which provides care that meets their specific needs. **Care for Independence** Older people want to receive care which enables them to stay in their own home for as long as possible: • **Home Care**. When paid care is provided to someone living in their own home. This could be personal care and help with everyday tasks in the home, or support at a day centre. Many older people want to live independently in their home for as long as possible. • **Informal Care**. When family and friends provide care and support to a loved one. This can include help with everyday tasks and also personal care. The skills used may be highly specialized, but it is called *informal* because relatives or friends do not get paid.
Sources	Age Concern (2008), Department of Health (2008), Social Care Institute for Excellence (2008), Care Quality Commission (2009), The Concise Oxford Dictionary.

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RESOURCE 2:
DIGNITY THROUGH ACTION STUDY GUIDE

INTRODUCTION

DIGNITY THROUGH ACTION PROJECT

The Dignity through Action Project (2008-10) was sponsored by the Department of Health and carried out by the Health and Social Care Advisory Service (HASCAS) and the University of Winchester.

The purpose of the Dignity through Action Project was to:

- Improve the delivery of dignified care to older people by a wide range of carers by providing an educational and training approach.
- Challenge the values, beliefs and attitudes that can contribute to lack of dignity for older people.
- Deliver a positive action orientated programme that to help health and social care workers, their supervisors and managers make sustainable changes in the work place to support care with dignity.

DIGNITY THROUGH ACTION RESOURCES

There are five Dignity through Action resources:

- **Dignity through Action Facilitators' Handbook (Resource 1)**. A handbook to provide sufficient guidance on the use of the Dignity through Action resources and the Dignity Workshop to enable and encourage their wide spread use.
- **Dignity Study Guide (Resource 2)**. A core text that supports the implementation of dignity workshops, supervising action planning and supporting follow up work. This is a self-study guide suitable for a wide range of people involved in the care process and who wish to learn more about the subject of dignity. It is a particularly useful resource for Dignity Champions.
- **Dignity through Action Workshop Pack (Resource 3)**. The Workshop Pack contains all the materials people need to attend a Dignity through Action Workshop. It contains notes about the meanings of dignity, case studies and worksheets**.**
- **Organizations' Guide to Dignity through Action (Resource 4)**. A Guide to provide organizations *(senior managers)* with a briefing document about Dignity through Action and the issue of dignity from an organizational perspective
- **Older Persons' Guide to Dignity (Resource 5)**. A short guide for older people to provide a description of what older people should expect from care with dignity, how to identify undignified treatment and what to do about it. This has been designed to be part of the Dignity through Action Programme. Its use is described in the Facilitators' Guide.

PURPOSE OF THE DIGNITY THROUGH ACTION STUDY GUIDE

The purpose of this Study Guide is to explain the subject of dignity from the perspective of care for the older person, help you reflect on your current practice and to stimulate you to address the challenges to the delivery of care with dignity.

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LEARNING OUTCOMES

At the end of this Study Guide you should:

- Understand the terminology of dignity in care.
- Understand of the meaning of dignity in the care of the older person in a structured way.
- Recognise the current challenges to dignity with care in their own practice.
- Identify local problems in the dignified care of the older person.
- Consider new local approaches in your care of older people that encourages dignity.
- Develop local action plans and evaluate any changes in your working practice.

It is hoped that you will be stimulated by this Study Guide and become engaged with the ideas which are presented. Some of the ideas you will already know, but some information will be new to you. You may also find that some of the things you already know about will be presented to you in a new light.

Do take up the opportunity to look up the Internet links and carry out some further reading.

As you read the Study Guide take the opportunity for **personal reflection**. This is an important process where you *have a conversation with yourself*. You should turn ideas about dignity over in your mind, think about questions to ask, look for disagreements and generally try to get to the heart of the matter. You should also look very carefully at your own values, attitudes and general practice in care.

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UNDERSTANDING THE MEANING OF DIGNITY

WHAT IS DIGNITY?

There is a considerable amount of literature about the subject of dignity in the care of the older person and you will have seen increasing coverage of the subject in your professional reading, in the media and on the Internet. Once you start reading and thinking about the subject of dignity you will see that the term is used in several overlapping ways covering two perspectives.

- **Dignity is a quality of the way we treat others**. Dignity is one **quality** of our behavior and actions towards others *(e.g. the person was treated with **dignity**)*. You will find that when discussing care of older people, dignity seems to be most often considered from this perspective.

- **Dignity is a quality of a person's *inner-self***. Everyone has psychological needs and these are related to feelings of self-respect, self-esteem and self-worth. The term dignity can be used in more complex ways for example:

    - **Expectations of being treated with dignity**. People want to be treated with dignity and most people have a very individual finely tuned sense of whether or not they are being treated with the dignity they believe they deserve. Some older people may have considerable expectations with feelings of self-worth associated with previous achievements or status.

    - **Appearing and acting dignified.** Dignity can be used to describe how person can appear or behave (*e.g. looking or acting **dignified**'*). Firstly, the outward appearance or behaviour of a person may be a direct indication of how they feel about themselves *(self-esteem).* Secondly, maintaining a dignified appearance may be a major contribution to whether a person is treated with dignity by others. It takes training and experience to see past how a person looks or acts and to treat them with dignity even when they themselves do not look or act in a dignified way.

The Dignity and Older Europeans (DOE) Project Study (2004) (*Note 1)* produced a succinct and perceptive classification of four **types of dignity**:

- **Dignity of the Human Being** *(Note 2).* This type of dignity is based on the principle of ***humanity*** and the ***universal worth*** of human beings and their ***inalienable rights***- which can never be taken away. This is a ***moral approach***, which considers that we all have a moral obligation to treat other human beings with dignity because of the belief that all human beings have ***nobility*** and ***worth*** and people need to be treated with dignity as part of fulfilling their human lives. Various international conventions and legal instruments define this in terms of human rights and how all human beings ought to be treated. This brings with it other ideas such as ***equality***, where, for example, it is expected that all people merit treatment as human beings on an equal basis, whoever they are, whatever their age, whatever their background, how they are behaving or whatever they may be suffering from.

- **Dignity of Personal Identity**. This form of dignity is related to personal feelings of self-respect and personal identity, which also provides the basis for relationships with other people. Most people have a self-image and wish to be treated by others in the manner they believe they deserve. Most

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Notes:

1. European Commission (Undated) Educating for Dignity, The Dignity and Older Europeans Project (QLG6-CT-2001-00888). A report on the findings is available at:
http://www.cardiff.ac.uk/medic/subsites/dignity/resources/Human_Dignity_An_Operational_Model.pdf.

2. The Dignity and Older Europeans Study used the German word 'menschenwürde' to describe the wide concept of 'humanness' and the inalienable value of human beings.

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people have a very finely tuned sense of being treated in a dignified or an undignified manner. It is relatively easy to damage a person's perception of their self-esteem and self-worth with a few harsh words or with physical mistreatment. On the other hand, many people are quite robust and manage to keep their personal self-esteem, whatever bad happens to them.

- **Dignity of Merit.** This form of dignity is related to an older person's status. Many older people are proud to have held positions in society, been awarded honours and had significant achievements in their lifetime. Uniforms, awards, badges and titles all bring to the owner a level of respect and dignity in society. People have a reasonable expectation of continued recognition for their achievements as they become older and can be very disappointed when this does not happen.

- **Dignity of Moral Status**. This is a variation of dignity of merit, where some people have a *personal status* because of the way they are perceived and respected by others. This type of dignity is difficult to appreciate because the meaning and value of a person's moral status will vary from situation to situation and time to time. Unlike permanent awards or honours based on merit, an individual's *moral status* is not something everyone recognises. For example, an unelected *community leader* may well have a moral stature and be treated with considerable dignity by members of that community. Yet to others, this unelected individual may be seen as having no legitimate right to represent anyone and just be ignored. In this sense *dignity of moral status* will be very much in the *eye of the beholder*. This is a complex aspect of delivering care with dignity. Older people will also have an expectation of continued recognition of their previous moral status no matter how volatile that was.

WHAT IS RESPECT?

Respect is a term which is intimately related to dignity. Respect is a **verb** (*action or doing word*) and is probably the most important action word used to describe how dignity works in practice. The Concise Oxford Dictionary describes the action meanings of the word *respect* as:

paying attention to
honouring
avoid damaging - insulting - injuring
not interfering with or interrupting
treating with consideration
not offending

Therefore, dignity is brought to life by respecting peoples'

Rights and Freedoms
Capabilities and Limits
Personal Space
Privacy and Modesty
Culture
Habits and Values
Freedoms
Individual beliefs of self-worth
Personal merits
Reputation
Personal Beliefs

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SHORT EXERCISE ON UNDERSTANDING THE MEANINGS OF DIGNITY

Read the following real newspaper article taken from the ***Daily Telegraph (2008)***. There are many stories like this presented in the media.

Hospital 'degraded' hero then sent him home to die

101-YEAR-OLD WAR VETERAN PUT IN A TAXI WITH A BAG FULL OF SOILED CLOTHING

By John Bingham

A war hero aged 101 was sent home to die by a hospital while wearing only a nappy and a set of ill fitting pyjamas.

The family of Brigadier XXXXX, who won the Distinguished Service Order, for his leadership in one of the fiercest battles of the Italian Campaign in the Second World War, said he was discharged when unable to feed himself and clutching a bag of soiled clothing.

They said he was in a confused state and incontinent after a stay which left him "degraded and humiliated". During his five-day spell in a mixed-sex observation ward at in XXXXXXXXX District Hospital, his hearing aid was crushed, his false teeth went missing and soiled pyjamas were piled up unwashed in a locker by his bedside.

Knowing he was dying after losing his ability to swallow food, he asked to go home. But no ambulance was available so he was sent in a taxi on an hour-long journey to a care home where he died a few days later.

When his family complained about the hygiene issues involving the pyjamas, the hospital wrote back to say that it was unfortunate that he had been unable to avail himself' of its laundry service. It has since apologised to Brigadier John's family for the "unacceptable" nature of his discharge in late 2006.

His case came to light as Nial Dickson, chief executive of the King's Fund, warned of a deterioration of compassion among staff in NHS hospitals.

The Brigadier's daughter-in law, Amanda, said his case highlighted a "disgraceful" lack of care. "All that he had at the end of his 101 years was his dignity and they took that away from him," she said.

In May 1944, Brigadier XXXXX, then a Lieutenant Colonel, led men of the 2nd Battalion, the Somerset Light Infantry, in the assault across the Garigliano River. He was wounded twice during the operation and later received the Distinguished Service Order for bravery.

"They packed him off in the back of a taxi, with somebody else's pyjamas on and a nappy so tight that he could hardly breathe and two cotton blankets on his shoulders," said his daughter-in-law. "They had lost his false teeth ... and somebody had stood on his deaf aid, which was crushed."

She added: "I just can't believe that any hospital would keep excrement-covered clothing in a locker for five days. I got the impression this lack of attention must be endemic because it was so lightly treated."

In a statement, the hospital said: "Some aspects of Brigadier XXXXX's discharge from hospital in 2006 were unacceptable and the trust apologise for any distress that this has caused.

Daily Telegraph
Wednesday 31st December, 2008

Thinks about how this older person was treated. How do you think this older person's dignity has been affected?

Can you recognise and give examples of where the four types of dignity appear and are affected?

- Dignity of the Human Being.
- Dignity of Personal Identity.
- Dignity of Merit.
- Dignity of Moral Stature.

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FRAMEWORK FOR APPLYING CONCEPTS OF DIGNITY

To help you think about and understand the subject of dignity and its challenges for care of the older person, this Study Guide provides a framework which approaches the subject of dignity in the care of the older people from two inter-linked perspectives:

- Treating older people as human beings *(Dignity of the Human Being).*
- Meeting older peoples' human needs.

The framework provides you with an overall structure to think about dignity and to:

- Understand the current problems, wide challenges, initiatives and campaigns about dignity.
- Consider the dignity challenges that face you in your day to day work.
- Deliver your care work with a deeper awareness of the subject of dignity.
- Identify local dignity related problems in your care work environment.
- Making action plans for dealing with dignity problems.

TREATING OLDER PEOPLE AS HUMAN BEINGS

INTERNATIONAL CONVENTIONS

'All human beings are born free and equal in dignity and rights'

(Universal Declaration of Human Rights, 1948, Article 1.)

Dignity of the human being is based on belief in the ***universal worth of human beings*** and their ***inalienable right***. In this sense the term dignity is about the **moral quality** of the treatment given to people because they are human beings. Defining the rights of a human being identifies a **correct way** of acting or not acting towards all people in society. This correct way of acting towards all people is shown in the vision of the formal International Conventions. In the United Kingdom there are Laws, based on the international conventions, covering the treatment of people and the protection of their Human Rights. All these conventions and human rights laws cover core ideas of:

- Life and freedom from abuse.
- Justice.
- Privacy.
- Freedoms *(thought, conscience, religion, expression, association).*
- Prohibition of discrimination.

The subject of human rights has a long history. In modern times these rights and freedoms have included more about civil and political rights, such as the right to life and liberty.

All health and social care workers ought to be aware of the two main **International Conventions** on Human Rights which are:

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- **The United Nations Declaration of Human Rights (UDHR) (1948).** The UDHR (1948) was a declaration on human rights adopted by the United Nations General Assembly in 1948. The UDHR (1948) was created following the experiences of World War 2 and has been the basis for many other international agreements on human rights which provide the basis of international law. There are important sentiments in the Declaration which sets the tone of human rights as where all human beings, ***endowed with reason and conscience*** *. . .* ***are born free and equal in dignity and rights*** *. . .* ***and should act towards one another in a spirit of brotherhood*** (UDHR, 1948). The ethical principle about human rights is that everyone has the right to have equal opportunities to realize their potential in life, and to be protected against the random misfortunes of life whatever their origins.

- **European Convention on Human Rights (ECHR) (1950).** The ECHR was adopted by the Council of Europe *(one of the oldest European integration organizations)* in 1950 to protect human rights. The parts of the European Convention align closely with the Universal Declaration (1948). All Council of Europe member states are party to the Convention and any new members are expected to ratify the convention at the earliest opportunity. The ECHR is enforced by the European Court of Human Rights (ECtHR).

UNITED KINGDOM LAW HUMAN RIGHTS ACT (1998)

The UK Human Rights Act (1998) is based on the ECHR (1950), so it also aligns closely with the Universal Declaration (1948). It provides the United Kingdom, as a member of the European Union, with a legal basis for Human Rights. The Act covers the following rights and freedoms:

- The right to life.
- Freedom from torture and degrading treatment.
- Freedom from slavery and forced labour.
- The right to liberty and the right to a fair trial.
- The right not to be punished for something that was not a crime when it was committed.
- The right to respect for private and family life.
- Freedom of thought, conscience and religion, and freedom to express beliefs.
- Freedom of expression.
- Freedom of assembly and association.
- The right to marry and to start a family.
- The right to not to be discriminated against.
- The right to the protection of property.
- The right to an education.
- The right to participate in free elections.
- The right not to be subjected to the death penalty.

It is important to understand that while the Human Rights Act protects rights and freedoms, the Act also aims to ensure that not just the individual, but everyone's rights and freedoms are properly respected. This means that one person's individual rights will sometimes have to be balanced against another's, often in a court of law. The wider interests of the whole community will also need to be taken into account and may take precedence over an individual's rights and freedoms. Some Rights may be limited under explicit circumstances as described in the Act for example where a person is lawfully imprisoned. In other cases rights may be qualified with restrictions associated with respecting the rights of others *(such as you cannot say anything you like about another person)* or where there may be issues of national security or public

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safety, crime prevention or the protection of health or morals. In general terms the Human Rights Act is about respecting the rights of everyone. If an older person's human rights and freedoms are breached, then they should have an effective solution in law, even if the breach was by someone in authority.

Further details about the Human Rights Act are at:

- **Appendix 1**. A summary of the Human Rights Act (1998) and provides some detail about limitations and qualifications.

- See **Making Sense of Human Rights**, and other human rights material of the Department of Constitutional Affairs [Online] at Department of Constitutional Affairs [Online] at http://www.justice.gov.uk/guidance/docs/hr-handbook-introduction.pdf.

- There is a detailed description of the Human Rights Act (1198) at the Office for Public Sector Information (OPSI) (Online} at: http://www.opsi.gov.uk/acts/acts1998/ukpga_19980042_en_3.

The applicability of Human Rights Legislation in the care of the older person is complex. The following illustrates some possible breeches of the Human Rights Act in the UK and is based a submission to the UK Parliament, Joint Committee on Human Rights by the Geriatrics Society in 2007 *(Note 3).*

- **Right to Life**. Everyone's right to life shall be protected by law: Examples of failure to meet this right in the care of older people could illustrated by:

    - Older people being placed in care homes without adequate opportunities for assessment and rehabilitation to maximise their function.

    - Older people with certain conditions being left untreated *(because the medical condition is considered to be just old age related)* until crises arise, as it is perceived that they are in a place of safety or where reversible mental health conditions *(such as depression)* are not diagnosed and are not treated.

    - Older people being given the inappropriate medication, someone else's medication, medication in the wrong doses or no medication at all. The Geriatric Society (2007) stated that nearly half of care homes were failing to meet national minimum standards for how they gave people their medication, as prescribed by their doctors, to treat their medical conditions.

    - Care homes failing to meet national minimum standards and local authorities failing to provide adequate resources to support care.

- **Prohibition of Torture**. No one shall be subjected to torture or to inhuman or degrading treatment or punishment. This covers not only physical or psychological abuse but includes and rough treatment, physical restraint, inappropriate medication *(sedatives, tranquillisers)*, bullying, as well as patronising, and infantilising attitudes towards older people. Despite legislation to protect vulnerable adults, and detailed guidance for local action, there is still evidence that much remains to be done *(House of Lords and House of Commons, 2007).*

- **Right to respect for private and family life**. There are many issues about privacy for the older person in terms of personal space; modesty in personal care; and confidentiality of treatment and personal information *(SCIE, 2008).* Everyone has the right to respect for his private and family life,

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Note:

3. British Geriatrics Society (2007), Position Paper: The Human Rights of Older Persons in Healthcare Call for Evidence, [Online]. Available at: http://www.bgs.org.uk .

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his home and his correspondence although it is a **qualified right**. Otherwise a person has a considerable right to privacy. Some issues are:

- **Privacy of the Person**. Older people should not be made to feel embarrassed or humiliated through exposure of the body or placed in situations that lack modesty.
- **Privacy of Personal Space**. An older person's personal and private space is the immediate area in which a person lives and receives care e.g. bed space, consulting room, lounge in a care home and person's own home. Care workers' should not underestimate the impact on the privacy of an older person when entering a person's their home as guests or where an older person is admitted into a mixed ward or where they move out of their own home into care.
- **Privacy of Belongings**. Providers of care to older people have a responsibility to maintain a safe environment for the protection of older people's belongings including their information.

- **Freedom of Expression**. Everyone has the qualified right to freedom of expression. This right shall include freedom to hold opinions, and to receive and impart information without interference by public authority. Not involving older people in the planning of their care is damaging their right to freedom of expression.

OTHER UK LEGISLATION

A SUMMARY OF REALATED UK LEGISLATION *(After SCIE, 2008)*	
Sex Discrimination Act 1975	The Sexual Discrimination Act: • Applies equally to discrimination against men and women. • Prohibits discrimination on the basis of sex or marital status. • Prohibits discrimination against a person on the basis f gender reassignment.
Race Relations Act 1976	The Act prohibits discrimination on the basis of race, colour, nationality (including citizenship) national or ethnic origin.
Data Protection Act 1998	The Act introduced controls on information held by public bodies. Act supports the importance of sharing information with people using services. The data protection principles are: • Information must be fairly and lawfully processed and within the provision of Article 8 of the European Convention on Human Rights. Information must be processed for limited purposes and only used that purpose. • Information must be adequate, relevant, and not excessive. Only necessary information should be held and information must be accurate with systems in place for assessing that information is accurate. • Information must only be kept for the necessary period and then destroyed. • Information must be processed in accordance with the data subject's rights. Non-authorised people should not be able to get access to the information. Information should not be transferred to other countries without adequate protection.
The Race Relations (Amendment) Act 2000	The Act places a duty on public bodies in carrying out their functions to have due regard to the need to eliminate unlawful discrimination, and promote equality of opportunity and good relations between persons of different racial groups.
Freedom of Information Act 2000	The Act provides statutory rights for members of the public requesting information. Under the Act any member of the public is able to apply for access to information *(unless that information is covered by exemptions)* held by a wide range of public bodies, including local authorities and hospitals. Public bodies must adopt schemes for the publication of information which must be approved by the Information Commissioner.

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A SUMMARY OF REALATED UK LEGISLATION *(After SCIE, 2008)*	
Sexual Offences Act 2003	The Act modernised the law on sexual offences. In the past there had been difficulties in bringing prosecutions against individuals who committed sexual offences against people with mental disorders. Under the Act, any sexual activity between a care worker and a person with a mental disorder is prohibited while that relationship of care continues. A relationship of care exists where one person has a mental disorder and another person provides or may provide face-to-face care, where that care arises from the mental disorder. It applies to people working both on a paid and an unpaid basis and includes doctors, nurses, care workers in homes, workers providing services in clinics or hospital, volunteers and so on.
Employment Equality *(Sexual Orientation)* Regulations 2003	The Act prohibits discrimination on grounds of sexual orientation. The definition covers lesbians and gay men, heterosexuals and bisexuals and can include discrimination based on perception of a person's sexual orientation or association with individuals of a particular sexual orientation.
Employment Equality *(Religion or Belief)* Regulations 2003	The Act prohibits discrimination on the grounds of religion or belief. No definition of religion or belief although the explanatory note to the regulations states that courts and tribunals may consider a number of factors when deciding what is a religion or belief *(e.g. collective worship, clear belief system, profound belief affecting way of life or view of the world).*
Discrimination Acts 1995 and 2005	The Acts prohibit discrimination against a disabled person – i.e. someone who has a disability as defined in Section 1 and Schedule 1 of the DDA. From December 2006 all public bodies have had a duty to promote disability equality.
Mental Capacity Act 2005	The Act provides a statutory framework to protect and empower adults who may lack capacity (ability) to make all or some decisions about their lives. It governs the way decisions can be made for an individual who lacks capacity to make specific decisions at specific times. There is also a Code of Practice to the Act, which provides guidance and information on how the Act will work on a day-to-day basis for anyone who works with or cares for people who lack capacity to make decisions, including family, friends and unpaid carers.
Safeguarding Vulnerable Groups Act 2006	The Act set out a scheme to help avoid harm, or risk of harm, to children and vulnerable adults by preventing people who are deemed unsuitable to work with children and vulnerable adults from gaining access to them through their work. • It provides employers with a vetting service for potential employees. • It bars unsuitable individuals from working, or seeking to work, with children and vulnerable adults at the earliest opportunity.
The Employment Equality (Age) Regulations 2006	The Act prohibits discrimination on grounds of age (*young or old).*
Mental Health Act 2007	The Act amended the Mental Capacity Act 2005 to respond to the lack of a procedure to challenge the deprivation of liberty of a person resident in a hospital or care home who lacks capacity to consent to that deprivation. It defines clearly who can propose deprivation of liberty and for what purpose. It also describes procedures for the review of detention and appeals.
Health and Social Care Act 2008	The Act with the Care Quality Commission (Registration) Regulations (2009) describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect.

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MEETING PEOPLES' HUMAN NEEDS

'If you want to be respected by others the great thing is to respect yourself.
Only by that, only by self-respect will you compel others to respect you.'
(Fyodor Dostoevsky, (1821-1881)

All people have overlapping personal psychological needs which include.

- The need to feel respected by others.
- The need to be treated as an individual with independence, choice and control.
- The need to have self-respect, self-esteem, self worth and resilience.
- The need to develop and maintain inter-personal relationships.

It is beyond the scope of this Study Guide on Dignity to explore the complex psychology of human needs. However, some general ideas about human needs *(e.g. self-respect)* and their relationship to dignity are covered below. The general idea is that if personal needs are unfulfilled, then this can lead to unhappiness, frustration and a poor quality of life. Dignity from a human needs perspective is difficult to describe because it is about feelings and the perception of being valued by others.

Self-esteem

One definition of dignity in care is anything, in any setting, that supports and promotes, and does not undermine, **a person's self-esteem** *(SCIE, 2008).* Self-esteem is about a personal appreciation of own worth. It comes about by a complex and continual judgment about the way conflicting and complex *(often emotional)* issues are dealt with in ones daily life. Events are played back, relationships with other people dissected and emotions triggered *(sometimes over and over)* on a *minute to minute, hour to hour, day to day* basis. Some of a person's beliefs and feelings that underpin a level of self-esteem will be anchored deeply and be very stable. Other personal beliefs and feelings may be more volatile or unstable. How much control a person has over this internal and private mental reflection process and the stability of their self-esteem will vary from person to person and from period to period. The shaping of an older person's inner landscape ***(self-esteem, self-respect, self-confidence, self-worth, resilience etc)*** is likely to be based on a very dynamic and multi faceted set of interacting mental processes influenced greatly by the external world, and the recognition of worth and respect by others such as:

Friends and Family
Other older people
Neighbours
Authority figures *(e.g. doctors, policemen etc.)*
Care workers
Advocates

Dynamics of Respect

Older people always seem to know when they are not being treated with dignity and respect by others even though they might not be able to put it into words.

The problem is people who look nice, are well dressed, clean, calm and composed, and who are in charge of themselves *(i.e. look respectable)* and who, probably have a high level of self-respect, communicate the message that they should be respected for what they are: balanced and valuable human beings. Older people projecting such an image are perhaps more likely to generate positive feelings of respect and motivate others to treat them with the dignity *they deserve*. There is also an interesting message for care

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workers here as well. Careworkers *(and in fact anyone)* who appears to 'look the part' *(say wearing a uniform)* are more likely to generate positive attitudes from people towards themselves.

On the other hand, older people who are untidy, dirty, disturbed, unable to communicate or behave disreputably are less likely to motivate others to treat them with dignity. The care worker needs to pay particular attention to this because dignity in care is about a **respect for personal needs** and not about how people look, behave or expect to be treated. Treating older people with less dignity and not looking after their personal needs, even unconsciously, because they do not look or act as if they deserve to be treated with dignity, is the start of the 'slippery slope' into a cycle of to mistreatment, humiliation and abuse (Pinker, 2008).

Meeting the human needs of the older person, particularly for hygiene, appearance, grooming, mobility and competence is a major part of maintaining their personal self-esteem and how they are viewed by others in the community. There are some complications which you ought to consider:

- Treating older people with respect and dignity may not, in itself, increase a person's self-respect. You can do your best to care for older people *(and be paid to do so),* but some individuals will continue to lack personal self-esteem and resilience for many different reasons. However, their situation might be much worse if they are not respected and not treated with dignity.

- You will find some older people may have exaggerated personal requirements and be quite demanding about personal respect. You might find it difficult to meet their expectations whatever you do or say.

- One characteristic of being human is that some older people, even those treated in an undignified or degrading way or suffering from medical unpleasant conditions, will retain all or part of their self-esteem and resilience even in the most difficult circumstances.

- Many older people are willing to accept a considerable loss of dignity to receive benefits from what may be being done to them e.g. uncomfortable or embarrassing medical procedures. However, older peoples' tolerance of this will vary from situation to situation.

- All people, even those with impairments, will have feelings of self-esteem. Compared to the effort required to maintain the psychological needs of an older person, it can take surprisingly little effort to damage a person's self-esteem and self-confidence. It only takes a few ill chosen words or some thoughtless actions to devastate the self-esteem, self-respect, confidence and resilience of an older person.

- Real and authentic respect for another person can perhaps only be earned, never assumed or bought. You have to give respect to be respected. As with any interpersonal relationship, both the care worker and the older person receiving services probably need to invest considerable effort in developing and maintaining a productive, trustful and respectful rapport.

- Older people are more than just passive objects to be treated within the bounds of a range of care standards. However, there will be many practical and realistic constraints which include:

    - Local resource limitations and time constraints.

    - Older peoples' impairments and challenges.

    - The outcomes of risk assessments which may require you to treat older people in certain prescribed ways e.g. use of hoists in toilet and hygiene activities.

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OLDER PEOPLE'S CHALLENGES

OLD AGE AND WHO ARE OLDER PEOPLE?

The current world average life expectancy is about 66 years old *(Note 4)*, but it varies dramatically between countries. The average Britain believes youth ends at 35 years and old age starts at 58 years (Daily Telegraph, 17 March 2010). However, there is really no clear definition as to when a person, during the natural aging process becomes, 'old' – it is all relative. However, there are chronological, biological,- physical and psychological measures. Some people never feel old and look fit until quite advanced years. Other people seem to age prematurely looking or feeling old. Illness, injury and the environment can be contributing factors to aging and a relatively early death.

In the United Kingdom, in 2005, according to estimates based on the 2001 Census of Population *(Source: Age Concern, 2008)*, there were more than **11 million** people of state pension age in a population of about **60 million** with over. This was made up of:

9 million in England
1 million in Scotland
0.6 million in Wales
0.3 million in Northern Ireland

The number of people over pensionable age *(taking into account of the increase in the women's state pension age)* is projected to increase to.

12 million by 2011
13 million by 2026
15 million by 2031

Some Other Facts about the Aging Population
(Age Concern, 2008)

The fastest growing age group in the population are 80 years and older due to improvements in life expectancy.

Up to about 70 years old the number of male and females are about the same. From about 70 years on, females outnumber males with the ratio reaching 3:1 by the age of 90.

There is a spike in the aging population caused by post second World War 'baby boomers' born in the late 1940s and now reaching pensionable age.

Only 5% of the aging population is in care homes.

In England, from 1 April 2005 to 31 March 2006, 309,000 clients over the age of 65 received home care services, 99,000 received day care and 101,000 received meals.

It is probably useful to consider old age as starting at that point in a person's life when they retire from work and become pensionable. This may be considered to be a rather artificial statement as many people over the age of 60-65 years are far from 'old' in physical, health or mental terms in the sense that they are infirm or need any special care.

The quality of healthcare and life style has improved since the Second World War. Death rates in 'middle aged' groups by traditional killers such as heart disease are also falling. People should now expect to live into their 80s and perhaps much longer, leading relatively active and independent lives.

Defining older people is not so clear cut. Older people are not really a separate group and there is really no age which once reached, you

Some perspectives about old age
(*Older Person in Society (2001)*)

'I don't want to sit downstairs with all those old fogies.'
(86 year old man - Nursing Home)

'I will never be an old man. To me old age is always 15 years older than I am'.
(Bernard Baruch, 1870-1965)

'It's strange to think about my age I mean I am 47 and my sister is 49. My father thinks of us both as young things in the prime of life. He often says: "One day you will find out what it's like living on a pension. When you are older". This makes me laugh because I am always saying to my teenage son, who is at university: "One day you will find out what it's like to hold down a job and be responsible. When you older." To my son I am old and so is my sister, his aunt. To my father we are both young. To me, my sister is significantly older than I am. To my sister, I am significantly younger than she is, I am the younger sister.'
(Anonymous Interviewee)

Note:

4. CIA World Fact Book, 2010 [Online].

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must be considered to be 'old'. Most of us appear older to someone younger and the idea of 'older' is simply relative.

The increasing number of older people should be seen as a successful result of improvements to living conditions and progress in health and social care. Often these improvements were planned and carried out as government initiatives. Meanwhile the resulting increasing numbers of such older people can be viewed in negative ways, often reinforced by stories in the media where:

- Older people are seen as not contributing to the economy.
- There are concerns about the increasing size of the aging population and its likely future costs where older people are seen to expect to be cared for by the employed.

Made to feel like a scrounger
(Older Person in Society (2001))

'I have worked all my life. I've paid my National Insurance and income tax like everyone else. Yet I am retired I am made to feel like a scrounger.

I heard two politicians arguing on television about whether old people should be supported by the state if they can afford to drive their own car. What do they want from us? Go into the workhouse before we can claim our pension?

I have always driven a car. It gives me a sense of freedom and independence. Am I asking too much to be able to drive myself to the shops or to see my daughter once a week?'
(Anonymous interviewee)

Such attitudes ignore a number of facts *(Older Person in Society, 2001):*

- There are pressures on people to work until they are older to afford pensions, maintain their standard of living *(and healthy life styles)*, maintain their own self respect and care for themselves.
- Some older people enjoy work *(paid and unpaid)* and stay on past the normal retirement age. Therefore they remain contributory members of society.
- Older people may be caring for grandchildren allowing their own children to work and earn.
- Many older people have contributed throughout their lives to statutory and voluntary pensions schemes and have a right to see a return on this.
- Some older people may be carers in their own right and be caring for even older relatives.
- Many older people fought for their country or took part in productive war work. They expect this contribution to be respected.

AGEISM

The value of old age can also be viewed differently:

- In some other cultures old age is valued because of the wisdom and experience it brings. Elders are valued because of their knowledge and insight.
- Western societies tend to value the characteristics of youth and beauty, where older people are seen as being more conservative, with outdated views and values, and as a result, having less value. This is illustrated by the meaningless terms given to older people such as:

Boomers	Grumpys	Old farts	Oldies
Double Chins	Leakies	Old fogies	Saggies
Dried up	Little old lady	Old folks	Seniors
Elderly	Old biddys	Old fools	Slapheads
Grannies	Old codgers	Old geezers	Squinties

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These terms may cause amusement, but a little thought will show that they have little real meaning and they provide no understanding as to the worth of an older person as a human being or how they should be treated. They only slightly indicate what additional needs an older person may have, but these needs are shown in negative terms.

- Older people are **stereotyped**. Even the term older person *(a fairly modern neutral term, which has replaced the term 'elderly' in common use)*, indicates a group of people which we will all have in our minds as having certain characteristics *(at least a chronological age)* which sets them apart from younger people others in the way we think about them and treat them.

- As with any form of **prejudice**, once people are stereotyped and then labelled in negative terms, they will be seen to belong to that group and display these characteristics of that group, whatever other evidence and our own observation tells us. Negatively labelled people come to be viewed *(consciously or unconsciously)* with less value and then it is just a short step to negative **discrimination,** where people are actually treated differently because it is felt they are less deserving because of beliefs about their worth.

Thinking about anybody in a prejudiced way, labelling them and expecting them to behave in certain ways and then treating them in way that reinforces this prejudice is a particular bad habit of human beings. Unfortunately, we live in a prejudiced world and we really do need to reflect very carefully on how our personal preferences, prejudices and views influence the way we treat other people, and in the context of this Study Guide: older people.

It is too easy to:

- Convince older people that that should conform to the stereotype of being old.

- Neglect older peoples' needs by not recognising when individuals really do need specific help.

- Make assumptions about medical conditions and believe that conditions are chronic, less able to be remedied *(or relieved)* and where such conditions should be endured by older people because *it is all part of the ageing processes*.

- Treat older people as infants and to develop their increased dependence by encouraging them to believe they are fragile or helpless.

- Talk to older people in a patronizing way and in a tone *(and slowness)* that would not be accepted by younger people.

- Make older people feel incompetent by rushing them or making them carry out tasks that are now beyond their abilities.

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OLDER PEOPLES' VULNERABILITIES

If I knew I was gonna live this long, I'd have taken better of myself.

(Eubie Blake, 1883-1983)

The idea is that older people, because they are human beings, should still be treated with dignity whatever their age, whatever their background, whatever their behaviour or whatever they may be suffering from.

However the real world is not as kind as that. As people get older they become increasingly at risk from:

- Medical vulnerabilities.
- Mental health vulnerabilities.
- Discrimination – Ageism.
- Neglect.
- Abuse

While age does not automatically result in failing health, fragility or disability, peoples' aging bodies will start to let them down over time. The ageing process brings with it the potential for:

- Slower reactions with decreased co-ordination, strength and mobility.
- An increased risk of medical problems and where there may be several concurrent medical problems.
- Medical problems which can tend to last longer and may remain with older people until they die or even cause their death.
- Having to live with a loss of personal dignity due to the effects of disease caused by long chronic conditions or conditions with uncomfortable symptoms *(pain/vomiting,* loss of control of functions, incapacitation and disability.
- Delay, avoidance or denial of medical treatment because a person is seen as old and treatment is perceived as uneconomic.

OLDER PEOPLES' VULNERABILITIES

Injury:

In England in 2005, of people aged 65 and over, it is estimated that 23% of men and 29% of women had fallen in the last 12 months.

In 2005, in a three-month period, 25% of those aged 75 and over had attended the casualty or out-patient department of a hospital, compared with 14% of people of all ages.

In 2005, of 671 pedestrian fatalities on the road, 267 (40%) were people aged 60 and over.

Illness:

About 60% of the aging population have a long standing illness.

About 65,000 older people in the UK suffer from dementia.

In 2005, of those admitted to hospital in the previous 12 months, the average stay was 8 nights. However, those aged 75 and over spent, on average 13 nights in hospital.

50% of older people in general hospitals have mental health needs.

Death:

In England and Wales in 2005, the number of deaths of people aged 65 and over, which involved a fall as the underlying cause, according to their death certificates, was:

Age Group	Men	Women
65-74	243	141
75-84	439	506
85 and Over	360	702

In the winter of 2005-2006 there were 23,200 more deaths in England and Wales amongst people over the age of 65 compared to levels in the non-winter period.

Older people will also be at risk from neurological and mental health problems. Older people may have a decreased span of attention, a reduced ability to remember and may be confused easily. While age does not automatically result in mental health problems, there are a number of such problems associated with older people such as depression, strokes and dementia.

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Some examples of health problems which are common in older people are shown below.

Neurological	Depression Stroke Alzheimer's Syndrome (Dementia) Parkinson's Disease
Cardiovascular	Ischaemic Heart Disease Heart Failure Peripheral Vascular Disease - amputation
Respiratory	Chronic Obstructive Airways Disease Emphysema
Musculoskeletal	Osteoporosis/Fractures Osteoarthritis
Other	Bladder and Bowel Weaknesses
Impairments	Sight Hearing Speech
Terminal Illnesses	Cancer. Organ Failure

DEPRESSION *(Extract from Help the Aged (2009) Campaigns and Issues)*

Depression is the most common mental health problem in older people. It appears that of the third of older people with depression who discuss it with their GP, only half are diagnosed and receive treatment. Depression is an illness that blights the lives of many older people. It is not *"what you can expect at your age".* It is not an inevitable part of ageing. It is an illness that can be treated: if older people seek help, are diagnosed, and receive appropriate treatment. The scandal is that for many older people this doesn't happen. Many do not seek help. For those who do, ageist attitudes among health professionals can prevent diagnosis. And for the lucky ones who are diagnosed, access to the full range of treatments may be denied because of their age. This means that only about 15 per cent of all older people with clinical depression receive treatment. 850,000 out of 1 million people do not. Ignoring the problem is not an option: if not identified and treated, depression ruins people's quality of life, increases the risk of other illnesses, and can even lead to suicide.

More information about Depression can be found at: http://www.ageconcern.org.uk/AgeConcern/campaigns.asp

STROKE

(Extract from the Stroke Association, (2009))

A stroke is caused by a blood clot or bleeding in the brain, which causes brain cells to die. Every year, an estimated 150,000 people in the UK have a stroke**.** Most people affected are over 65, but anyone can have a stroke, including children and even babies.

A stroke is the third most common cause of death in the UK. It is also the leading cause of severe disability. More than 250,000 people live with disabilities caused by stroke.

The signs of a stroke are: facial weakness, arm or leg weakness, speech problems and a loss to half of vision. People can recover afterwards and **get back to a normal life** as much as possible. However a stroke can lead to continued problems with:

- Speech & vision.
- Swallowing.
- Toilet use.
- Psychological changes.

More information about Strokes can be found at: http://www.stroke.org.uk/information/index.html

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DEMENTIA

(Extract from Alzheimer's Society (2009))

Dementia is the medical term used for various different brain disorders where people have a loss of brain function that is usually progressive and eventually severe. It affects over 570,000 in England. There are over 100 forms of dementia such as:

- Alzheimer's disease *(most common).*
- Vascular dementia.
- Stroke related dementia.

People with vascular dementia may particularly experience:

- Problems concentrating and communicating and depression
- Symptoms of stroke, such as physical weakness or paralysis.
- Memory problems *(although this may not be the first symptom).* A 'stepped' progression, with symptoms remaining at a constant level and then suddenly deteriorating.
- Epileptic seizures.
- Periods of acute confusion.

Other symptoms may include: hallucinations *(seeing things that do not exist),* delusions *(believing things that are not true)*, walking about and getting lost, physical or verbal aggression, restlessness and incontinence.

'Unfortunately, two thirds of care-home residents have dementia, while most of those looking after them have no dementia training' (The Guardian Newspaper, 30 Nov 2007).

'Only a third of people with dementia get a formal diagnosis, denying them vital support'. (Neil Hunt, Chief Executive of Alzheimer's Society, 2009)

'According to the Alzheimer's Society, there are currently 700,000 people with dementia in the UK. One third of people with dementia live in care homes. Two thirds of care home residents have some form of dementia. Approximately one quarter of hospital beds are being used by people with dementia at any one time' (House of Lords and House of Commons Parliamentary Joint Committee on Human Rights 18th Report, 2007).

More information about Dementia can be found at: http://www.alzheimers.org.uk/site/

National Dementia Strategy for England (NDSE)

In February 2009, the UK Department of Health launched the National Dementia Strategy for England. It covers a 5 year plan to:

- Raise awareness and understanding about Dementia.
- Provide earlier diagnosis and support
- Help with living well with dementia.

More information about the NDSE can be found at:

http://www.dh.gov.uk/en/socialcare/deliveringadultsocialcare/olderpeople/nationaldementiastrategy/index.htm/

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AGEISM AND CARE

In general, older people live in a world that discriminates against them. They will be faced with the personal prejudice of other people and they are at increased risk from illness and injury. This is the very time in their lives when they are probably denied employment to ensure a regular earned income and they will also find as they get older there is less access to healthcare *(prevention measures, screening and treatments)* where they are less likely to be diagnosed in the early stages of medical conditions. There may also be surgical techniques with high survival rates that might cure some conditions in older people yet older patients are less likely than younger patients to receive all the necessary treatments. Doctors may fear their older patients are not physically strong enough to tolerate treatments and are more likely to have complications during surgery that may end in mortality. There will also be less access to care resources, which might actually surprise you. Consider the following examples of evidence quoted in the 18th Report (2007) of the Joint Committee on Human Rights.

DOES AGE DISCRIMINATION REALLY EXIST IN THE CARE OF THE OLDER PERSON IN THE UK?

Witnesses to the UK Joint Committee on Human Rights stated that direct age discrimination has become less common since the introduction of the National Service Framework for Older People. However, witnesses said that direct discrimination has not ceased altogether. Evidence was produced which showed:

- Almost half of a sample of 85 GPs, cardiologists and specialists in old age are influenced by age in deciding whether or not to carry out tests.
- Patients over 65 are less likely to be referred to a cardiologist, given an angiogram *(artery scan)* or given a heart stress test.
- Cardiologists are also less likely to recommend operations to open up blocked coronary arteries for older patients, and they are less likely to be prescribed statins to reduce cholesterol. They are, however, more likely to be offered a follow-up appointment and more likely to have existing drugs reviewed.
- Age Concern's report on age discrimination (2007) quoted examples such as:
    - Treatment for minor strokes is covertly rationed for people over 80 years of age.
    - Doctors are less likely to refer angina sufferers to see a specialist or to have tests if they are over 65.
    - National priorities for health and social care restrict targets for reducing heart disease, strokes and cancer to people under 75. Invitations to breast screening stop for women over 70.
- As reported in *Living Well in Later Life (Department of Health*) the organisational division between mental health services for adults of working age and older people has resulted in the development of an unfair system, as the range of services available differs for each of these groups. Older people who have made the transition between these services when they reached 65 have said that there were noticeable differences in the quality and range of services available.
- NHS Confederation reported that Local authorities have lower budgets for their older people's teams than for teams dealing with younger people. There is a lower financial cut-off point for care packages for older people compared with equivalently disabled younger people.

Extracts of the House of Lords and House of Commons Joint Committee on Human Rights, 18th Report (2007).
The report is online at: http://www.publications.parliament.uk

All people suffering from mental illness are subject to stigma. However, according to Age Concern older people older people can suffer from the *double whammy* of mental illness and discrimination (ageism). This is where mental illness in the older person can be masked by other problems, where it can be diagnosed poorly or where older people do not seek help.

Older people may also be willing to accept a considerable loss of their personal dignity during medical procedures/surgery *(particularly on intimate areas)* to gain the benefits of recovery. However, special attention needs to be paid to the dignity needs of older people by:

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- Ensuring they understand what will happen during medical treatment and the alternatives.
- Understanding what their life will be like after a medical treatment.
- Gaining consent for medical treatment *(essential component of dignity).*
- Ensuring privacy, lack of stigma and the avoidance of humiliation.
- Understanding their personal views about being resuscitated.
- Understanding their personal requirements for dying with dignity.

THE DIGNITY BALANCE

There are a number of leaflets published by various health and social bodies that use the term '**Dignity Balance'**. This is about the balance between treating people as human beings with quality versus treating them as economic objects. In an ideal world the balance would be heavily laden on the side of treating older people as human beings where:

- There is no discrimination in health and social care services.
- Services would be delivered by from professionals specifically trained in the care/treatment of older people.
- Care services would always be person-centered.
- Older people, with health problems would be helped to manage their own conditions, to retain/regain independence and to remain living in the community.
- Older people with complex needs would receive integrated and long term care services.

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THE DIGNITY CHALLENGE

INTRODUCTION TO THE DIGNITY CHALLENGE

Launched in November 2006, the Dignity in Care Campaign aims to stimulate a national debate around dignity in care and create a care system where there is zero tolerance of abuse and disrespect of older people. It is led by Government in partnership with many organizations that provide and commission care and protect the interests of those using care services and their carers. The Dignity Challenge laid out the national expectations of what a care service that respects dignity should value and focuses on ten different challenges to dignity. On the basis of this the Government challenged the following groups to see how care services measure up where:

- Care service providers should ensure their services respect dignity.
- Commissioners of care services should ensure they only commission services that respect dignity.
- The public should test how their local services measure up and to tackle, rather than tolerate, services that do not respect dignity.

The 10 Dignity Challenges provides a valuable checklist of factors against which to review the level of dignity in the care of the older person.

10 Dignity Challenges *(After SCIE, 2009)*	
Respect	Support people with same respect you would want for yourself or a member of your family.
Abuse	Have a zero tolerance of all forms of abuse.
Privacy	Respect people's right to privacy.
Autonomy	Maintain the maximum possible level of independence, choice and control.
Person-centered Care *(Individualisation)*	Treat each person as an individual by offering a personalised service.
Self-esteem	Assist people to maintain confidence and a positive self-esteem.
Loneliness & Isolation	Act to alleviate people's loneliness and isolation.
Communication	Listen and support people to express their needs and wants.
Complaints	Ensure people feel able to complain without fear of retribution.
Engage with Care Partners	Engage with family members and carers as care partners.
In their published form, the 10 Dignity Challenges were labelled with numbers (e.g. Challenge 1 = Abuse, Challenge 2 = Respect etc). In the Dignity through Action Resources, the Dignity Challenges are listed and used <u>without numbers</u>, because they are presented in a different order.	

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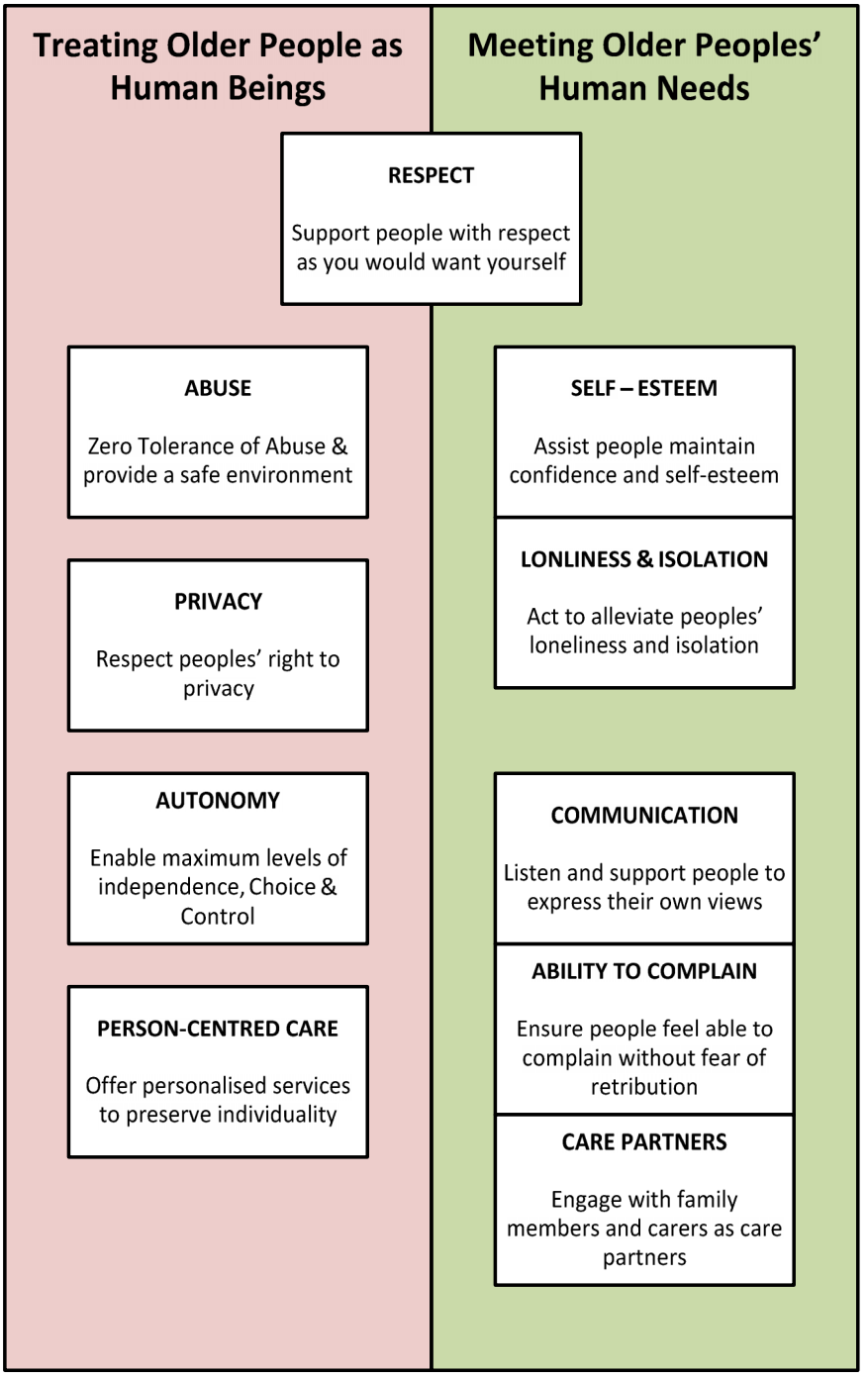
To help you understand these challenges in more detail the Study Guide considers them in a structured framework from the two points of view:

- **Treating Older People as Human Beings.** Older people should be **respected** as human beings and be **treated** accordingly.
- **Meeting Older Peoples' Human Needs.** Older people need to feel **respected** as part of meeting their personal human needs and be **treated** accordingly.

The idea of respect operates across both points of view.



A Framework for Dignity Challenges

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OVERALL DIGNITY CHALLENGE: RESPECT

The key principles behind respect are that carers should:

- Support older people with the same respect they would want for yourself or a member of their family.
- Care for older people in a courteous and considerate manner, ensuring time is taken to get to know them.
- Help older people participate as partners in decision-making about the care and support they receive.
- Encourage and support older people to take responsibility for managing their care themselves in conjunction with, when needed, care staff and other information and support services.

Respect is a term which is intimately related to dignity and is applicable throughout the subject of dignity. Respect is a **verb** (*action or doing word*) and is probably the most important action word used to describe how dignity works in practice. The Concise Oxford Dictionary describes the action meanings of the word respect as:

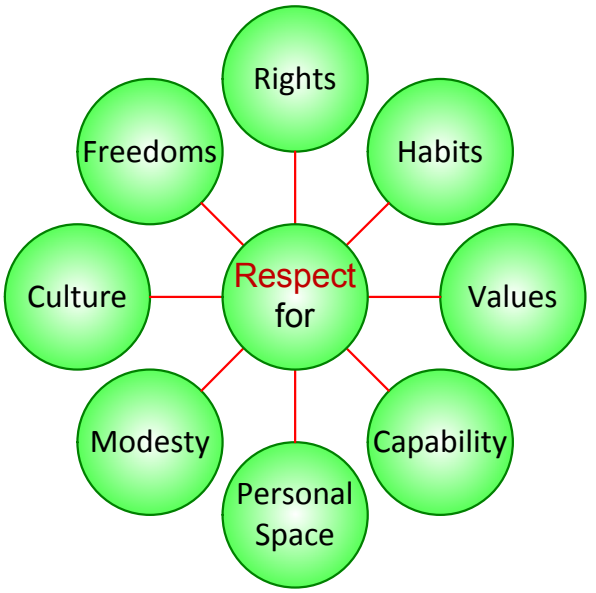
'paying attention to'	'not interfering with or interrupting'
'honouring'	'treating with consideration'
'avoid damaging - insulting - injuring'	'not offending'

Respect and Your Personal Care Practice
(After RCN, 2008; SCIE, 2008)

Respect for dignity should be seen as important by all careworkers at all levels in the organisation, from the leadership downwards.

As a basis for your care of older people <u>with dignity</u> you should strive to respect their:

- Rights and Freedoms.
- Capabilities and Limits.
- Privacy, Personal Space &Modesty
- Freedoms.
- Culture, Habits and Values.
- Individual beliefs of self-worth.
- Personal merits, Reputation & Personal Beliefs.



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DIGNITY CHALLENGES AND TREATING PEOPLE AS HUMAN BEINGS

DIGNITY CHALLENGE: ABUSE

The core idea is that care and support should be provided in a safe environment and free from abuse.

Abuse can take many forms including physical, psychological, emotional, financial and sexual, and extend to neglect or ageism. Older people are vulnerable to abuse where they can be harmed, mistreated or neglected.

Unfortunately it has been found that two thirds of abuse is committed at home by someone in a position of trust.

Those aged between 80 and 89 years seem to be the most vulnerable to abuse.

There are several types of abuse:
(Help the Aged, 2007):

Psychological and Physical Abuse
Financial Abuse and Theft
Sexual Abuse
Neglect
Abuse through Ignorance

THE SCALE OF ABUSE
(Based on analysis of calls to the Action on Elder Abuse Helpline. Help the Aged, 2008)

Action on Elder Abuse reports from an analysis of helpline calls the problems can be classified as:

Psychological	**34%**
Physical	**19%**
Financial	**20%**
Neglect	**12%**
Sexual	**3%**

Calls were related to more than one type of abuse (**44%**) showing that older people may be subjected to several forms of abuse at the same time.

The call pattern also showed other characteristics:

- **46%** of abuse complaints were about abusers who were related to their victims.
- **34%** of abuse complaints were about paid care workers.
- **62%** of abuse complaints were about paid workers continuing with institutional abuse practices.

- **Psychological and Physical Abuse**.
    - **Bullying**. Bullying is about persecuting or oppressing another person through fear or force. Bullying can have a mix of physical and psychological aspects. Older people can be easily into acting a way their better judgement tells them not to. *(For example there have been many stories where older people have been taken to the bank to draw out large sums of money because they have felt threatened.)* It is very difficult to expose bullying because people may have been threatened with *further consequences*, if it is exposed.
    - **Physical Abuse**. Physical injury in older people may or may not be visible even when they have been assaulted directly. Constraining older people in chairs, rooms, beds, rough handling or exhausting them, lack of exercise, tranquilizing them, poor pain control during medical procedures and mismanaging their medication are all forms of physical abuse.
    - **Neglect**. Neglect is a very wide ranging term and is more about not providing *(consciously or unconsciously)* or allowing access to the necessities for daily living *(food, clothing, personal care, freedom, choice etc).* Neglect can include being left in soiled clothing, not being given the right medication, not being given enough food of the right quality or the time to eat a full meal, not being provided with sufficient fluids and not being provided with the right accommodation. Neglect can be associated with the failure to provide access to services such as chiropody. Neglect may also occur through poor risk and safeguarding assessments.
    - **Verbal Abuse**. Verbal abuse is about using negative language to older people *(for example, being called stupid or smelly*). It can also involve speaking to people as if they were a small child, or slowly and patronisingly on a regular basis.

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  - **Humiliation**. Humiliation is a feeling of hurt and embarrassment. In general, older people can be humiliated when they are put in situations where:
    - Their privacy is affected *e.g. during Intimate procedures and examinations where their bodies are exposed.*
    - They are semi-conscious, but treated as if they were unconscious.
    - Their problems of disabilities are made worse, especially during moving and handling.
    - They can no longer do what they used to be able to do easily.
    - They have lost control of their body functions.
    - They need to be supervised to go to the toilet.

- **Financial Abuse and Theft.** Theft can occur where people in position of trust use money or possessions in ways the owner is not happy with. Older people are particularly at risk from theft of money, jewellery and items of sentimental value. It is sad that stolen items can often have low monetary value, but have significant sentimental value to an older person.

- **Sexual Abuse**. Physical sexual abuse is about being touched inappropriately and can be a criminal sexual assault. Non-physical sexual abuse can include remarks and jokes, and can be related to bullying.

- **Abuse through Ignorance.** Abuse through ignorance is probably the most frequent form, and probably the most difficult to identify and isolate because both the givers and recipients of care may not perceive that abuse is taking place. Such abuse may be quite unintentional. Abuse through ignorance may occur where carers are, for example, rushing to complete work or where carers become frustrated and impatient *(Help the Aged, 2007).*

Exposing Abuse

According to Age Concern (2007) abuse is difficult to expose because:

- The abuser can be someone who is a member of the family and who should be trustworthy. The older person may also be a dependent of the abuser *(who maybe the financial supporter).*
- The abused person's belief is that they must have done something to deserve this treatment or they may fear further harm if the abuse is exposed.
- The older person does not know who to speak to about the abuse or is too embarrassed to and may believe that exposing the abuse to another person or an organisation is a sign of personal weakness.
- The older person believes that the abuse is considered to be too trivial to matter or that it will not stop, even if it is reported.

Identifying Abuse in Older People *(Help the Aged, 2008)*

There are no hard and fast indicators of abuse. Abuse can be immediately obvious, but it can also take considerable experience and observation over an extended period to identity signs of abuse. Even then these signs may be mistaken as signs of abuse when in fact they indicators of other medical or psychological problems. However, some simple indicators of abuse maybe:

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- **Injury Indicators**. Injuries that are unusual, unexplained or which occur regularly *(black eyes, bruises, cuts).*

- **Behavioural Indicators**. Changes in behaviour where older people:

    - Become unexpectedly withdrawn, weepy, angry or depressed.

    - Seem to off their food and losing weight.

    - Undergo a change in appearance – wearing the same clothes, not washing hair or using make-up.

    - Change lifestyle, routine or circumstances – no longer going out, not welcoming visitors or saying they cannot afford things they could previously.

    - Change in behaviour when somebody specific comes into a room.

    - Have an over-emphasis on everything being normal and that nothing is wrong.

    - Seek attention from numerous people – this may be that the person feels safer when other people are around or appearing frightened when a certain person comes into the room.

    - Unusual difficulty with finances – unpaid bills or debts building up.

Reporting Abuse and Your Personal Care Practice

You have a duty of care not only to deliver care without abuse, but if you become aware of it taking place then you should take action to stop it within the **Abuse Reporting Policy, Reporting Processes and Action Guidelines of your employer**. This subject should have been covered during your Induction Training.

In general common sense terms, if abuse is suspected then:

- You should try to discuss the matter with the older person in a way that preserves their dignity and does not humiliate or upset them. If you have a working relationship with the older person then you might be able to discuss the matter with them and if they are willing, you might be able to discuss with them how to avoid situations where abuse might occur.

- You should remain open and honest with the older person. Some older people may seek reassurance that you will not tell anyone else about the abuse. Relatives, friends and care professionals should always be honest with older people and never make false promises. You should allow the person the opportunity to talk and make your willingness to listen clear. It is vital for both the person and the carer to stay calm when talking about being abused.

- Carers should ask the older person what they want to happen next and how they want the matter pursued. People who experience abuse can take a long time to have the courage to speak out and to seek help. Carers should always try to explain about who might be able to help further. However, you will be subject to reporting requirements laid down by your employer.

- Common sense and great care needs to be applied about whether or not to confront an abuser directly. Evidence may need to be gathered, and it would be good practice to seek the advice and support of your manager at the earliest opportunity before you do anything else.

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CHALLENGE: RESPECTING THE RIGHT TO PRIVACY

The core ideas of respecting the right to privacy are: *(RCN, 2008; SCIE, 2008).*

- Older people have a right of respect for *a private, family life, home and correspondence* and *peaceful enjoyment of personal possessions* (UK Humans Rights Act (1998)).
- Older people receiving services should be respected and protected in areas of sensitivity which relate to modesty, gender, culture or religion and basic manners.
- Older people should have access to have access to private and personal spaces when needed.
- Older people should have their belongings *(including information)* respected and protected.

Privacy of the Person. Older people should not be made to feel embarrassed or humiliated through exposure of the body or placed in situations that lack modesty. There are many areas of care that can lead to embarrassment or humiliation, many of which are covered later in this Study Guide. Risk areas include:

- Living in mixed sex accommodation.
- Support with hygiene and dressing.
- Moving and handling practices.
- Exposing procedures associated with intimate procedures and examinations.
- Toilet use and level of independence/supervision.
- Access to religious areas and multi-denominational areas.
- Use of *signals* and *flags* for special needs *(e.g. coloured trays etc).*
- Poor storage of aids (*e.g. commodes and stacks of hygiene pads being visible).*

Privacy of Personal Space. An older person's personal and private space is the immediate area in which a person live and receives care e.g. bed space, consulting room, lounge in a care home and person's own home. Older people, because of their potential vulnerabilities, are at increased risk of having their privacy of personal spaces compromised.

- Older people have to accept a loss of privacy when leaving the comfort of their own homes to gain the benefits of care in shared surroundings. Having made such a move older people should have continued access to private or quiet spaces when needed. Older people should have the choice to decide when they want to be quiet and when they want to interact with others.
- Older people may have carers appointed who will enter their home. They may have to accept what may seem like an invasion of privacy in order to gain the benefits of care and comfort this brings.
- Care workers' should not underestimate the emotional impact on an older person when they enter a person's home as *guests*.

Privacy of Belongings. Providers of care to older people have a responsibility to maintain a safe environment for the protection of older people's belongings. Personal possessions have a wide range of meaning and covers property, money, and personal and financial information, computerised records, and personal and medical information.

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Right to Privacy and Your Personal Care Practice *(After RCN, 2008; SCIE, 2008)*

In your care of older people you should strive to:

- Always consider an older person's personal privacy in any activity or procedure.
- Respect and protect privacy and modesty.
    - Never assume you have a right of intrusion because you are a care giver.
    - Always knock before entering *(and allow a pause for a response!).*
    - Never pull back bedclothes or remove clothing without asking.
    - Always ask before entering somebody's personal space or touching their possessions.
    - Use and accept *Do Not Disturb* signs *(including closed modesty/privacy curtains).*
    - Use the organization's *private signals* about people with discretion, without drawing attention to people requiring special attention e.g. use of *red trays* to indicate people that need help with eating their food.
- Respect personal and private space. Remember a care workers is a guest in an older persons' private space or home.
- Assist older people when they want *quiet time* and not force them to interact with others if they do not want to.
- Support discretion.
    - Maintain the confidentiality of a peoples' private information.
    - Respect what people tell you and treat it in confidence.
    - Report instances where personal information is being mismanaged.
    - Never discuss older peoples' medical or private matters with other unless this is required for care purposes.

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CHALLENGE: RESPECTING AUTONOMY *(INDEPENDENCE, CHOICE AND CONTROL)*

Meaning of Autonomy

The core idea about autonomy is that human being has full control over their body and its functions. Autonomy is a characteristic part of the right to life, freedom of thought and expression, freedom of association and prohibition of discrimination. Autonomy is about a person's ability to control, cope with and make personal decisions about how they live on a day to day basis, according to personal preferences.

Autonomy and Choice

The first general idea about autonomy is that an older people should be responsible for themselves. The presumption is that individuals are the best guardians of their own interests; therefore we should involve them in the decisions that affect them. Older people receiving care services should be involved as *care partners* in decisions about their personal care and be given the maximum possible choice and control over the services they receive. Therefore:

- Older people should be made aware and understand of all the services available to them with techniques that take in account impairments and minority languages. This choice of services must be seen in the context that there is always a risk of age discrimination.
- Older people should be able to meet any member of staff concerned with their care, and should be supported in asking questions about their care.
- Where possible, consent of the older person should be obtained before introducing any change to the level or form of their care.
- Independence and self-care should be promoted wherever possible including the opportunity to self-medicate.
- An older person's preferences should be respected in examples such as:
    - Preference for family care rather than professional care.
    - Preference for independent living rather than professional care.

In practice, such ideals may be difficult to meet. Older people vary in their ability to pay for or to attract state support and older people may have to accept compromises. In the United Kingdom there are two other factors:

- The availability of care services and the quality of its resourcing can vary geographically.
- There is a significant division of responsibility between health services and the care services. The level of support and autonomy provided by different care agencies may vary in consistency.

Autonomy, Independence and Control

The second general idea of autonomy is the need to balance independence and dependence. For every older person there is the need to understand their strengths and weaknesses. Everyone lives with risk, but the 'right to life' with dignity as a human being is about accepting risk, and living, as far as possible, competently and independently. The issue for carers is to understand that point in risk assessment where it is judged that intervention is necessary and where, as a result, the wishes of an older person should be disregarded in order to safeguard them. There is probably no simple answer to the question of how far and when should carers and family members intervene and overturn the wishes of an older person.

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You should also reflect on the following general ideas:

- Risk assessments are subjective, may not promote choice and, for many reasons, be risk adverse manner *(err on the side of caution).* On the other hand older people should be encouraged to be independent rather than be constrained and safe. How much personal freedom of choice is removed from an older person should be related directly to the assessed risk *(which should remain under review).* If there is any doubt about the outcomes from risk assessments then further professional advice should always be sought.

- Older people should never be misinformed about the risks they face and they should be consulted and participate *(if possible)* during risk assessments. Autonomy is about having the opportunity to refuse intervention by professionals and family.

- A central premise of autonomy is the concept of ***informed consent***. The term originates in medical practice where *informed consent* assumes that a person is competent to make judgments about their treatment on a voluntary basis and the medical system is honest about what is to happen and what the choices are. At some point a person must make an *informed decision* and *sign up* to treatment.

Autonomy and Your Personal Care Practice *(After RCN, 2008; SCIE, 2008)*

Older people, if assessed properly and advised fully, can contribute greatly to the maintenance of their own independence. You can help older people understand that risk reduction is about:

Keeping warm.

Eating and drinking properly.

Regular eyesight checks.

Being aware of the effects of medicines.

Understanding their physical limitations e.g. raising arms can make some people feel light headed and unsteady.

Not wearing unsuitable clothing *(e.g. long dresses or flared/baggy/ill fitting trousers etc).*

Caring for feet and using chiropody services. Not using unsuitable footwear. Wearing the correct outdoor shoes. Not walking in bare feet on slippery or wet surfaces. Not walking on difficult surfaces and negotiating hazards. Keeping stairs free from clutter.

Using appropriate mobility aids.

Using a non-slip mat in the bath.

Never standing on chairs or beds. Using a low step ladder.

Carrying out a designed exercise programme to improve strength and balance.

Having regular balance assessments.

Some examples of risk reduction by carers to maintain the independence of older people in care is through regular assessment and careful management of:

Food and feeding habits.

Basic foot care.

Toilet use for bladder and bowel weaknesses following appropriate assessment and use of aids.

Impact of impaired communication.

Medical and mental conditions ensuring they are treated.

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CHALLENGE: PERSON-CENTERED CARE

Person-centered care is the term used to describe putting the needs and aspirations of older people treated as individuals and that they receive appropriate and timely packages of care which meet their needs as individuals, regardless of health and social services boundaries.

Person-centered Care is the Second Older Peoples' National Service Standard. The standard aims to preserve an older person's identity and individuality by recognising the importance of identity and individuality of human beings who are worthy of such treatment. DH NSF Standard 2 aims to ensure a single comprehensive needs assessment is carried out as soon as possible after a older person enters the care system, integrated commissioning arrangements and integrated provision of services, including community equipment and continence services (DOH, 2008). There are some other ideas associated with Person-centered Care:

- **Involvement as Care Partners**. Older people should be involved in their assessment, so personal goals and preferences are reflected in care planning.
- **Personalised Services**. Services should not be standardised, but be personalised and tailored to each meet the needs of each individual. Examples of this include:

  Ensuring the appropriateness of the food on offer.

  Providing appropriate help with eating.

  Waiting list management.

  Use of *enhanced pathways* to gain access to treatments and resources.

  Regular health checks.

- **Use of Personal Information Books or Cards**. Personal Information Books can hold details of individual needs and preferences of older people so this information is available to all. The contents of these books should be reviewed regularly with an older person.
- **Person-centered Care and Nutrition.** Maintaining the nutrition of individual older people is an example of the need for person-centered care. Food is an essential commodity for people. Without adequate nutrition older people deteriorate quickly. The Age Concern (2006), Hungry to be Heard Campaign provided practical guidance on nutrition. It is described in some detail here as it illustrates the sort of activities required to implement any person-centered care.
  - Carers must become *food aware* and listen to older people, their relatives and carers and act on what they say.
  - Introduce patient representatives to a *food discussion group*. Management should sample the food provided on a regular basis.
  - There should be sufficient choice, volume and combinations of food.

Age Concern (2006) reported that :

60% of older people are at risk of malnutrition *(or situation getting worse)*.

40% of older people are malnourished on admission to hospital.

Patients over 80 yrs admitted to hospital have 5 time prevalence of malnutrition than those less than 50 yrs.

Malnourished people stay in hospital longer and are 3 times more likely to develop complications and infections.

50% of older people in general hospitals have mental health needs.

Cost of malnutrition on health care costs is £7.4bn pa (more than obesity). Half of this cost is spent on people over 60 yrs.

Of those who said they needed help to eat their food, 18% said they got no help and 21% said help was only given sometimes.

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- Older people must be assessed for the signs or danger of malnourishment on admission to the care system and at regular intervals *(regular screening and logging weight, MBI etc).* Identify older people with a high risk of malnutrition.

- Provide appropriate and relaxed areas for eating coupled to the use of *protected mealtimes*. There should be time to enjoy food *(and reduce waste).*

- Use volunteers *(including family and friends)* to help and encourage older people with eating even during protected mealtimes.

Your Personal-centered Care Practice *(After Age Concern, 2006; RCN, 2008; SCIE, 2008)*

In your general care of older people with dignity you should keep in mind the principles of person-centered care and strive to:

- Take time to get to know the person receiving services. Agree with them how formally or informally they would prefer to be addressed.
- Provide individualized care and support where possible.
- Adapt care to the care needs, rhythms and habits of the individual older person.
- Anticipate individual needs of older people and respect an individual's capabilities and limits.
- Allow time for older people to carry out and complete tasks and be aware to older peoples' individual personal safety risks. Treat peoples' toilet needs on an individualised basis.
- Deliver medication with accuracy and dignity. Supporting self-medication would be an example of individualisation and autonomy.
- Avoid the use of rotas and only treat people in groups where appropriate.
- Be aware of and assist older people on an individual basis when they have problems with swallowing and digestion.
- Conform properly to the organized signals that identify older people as needing individualised care *e.g. coloured trays, positioning of knives and forks*. Ensure that older people eat any special diets which have been designed for them.
- Actively discourage unsupportive practices such as:
    - Delivery of fortified drinks and water, but leaving them inaccessible or out of reach.
    - Allowing hot food and drink to go cold.
    - Pureeing food for staff convenience.
    - Telling older people off for not eating food.
    - Catering staff being rude to older people or commenting on their eating habits.
    - Use of obvious baby bibs or unsuitable/incorrect cutlery.
    - Forcing people to eat with their fingers.
    - Leaving meals next to people who are *nil by mouth*.
    - Forcing family members to take up the role of feeding monitor or assistant. This includes where family or friends consider it necessary to bring food in to the older person.
    - Not delivering the food requested or forcing an older person to make do with food they have not requested.

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DIGNITY CHALLENGES AND: MEETING OLDER PEOPLES HUMAN NEEDS

DIGNITY CHALLENGE: MAINTAINING SELF ESTEEM

Care should aim to develop, and never harm, the self-esteem of the older person receiving services while at the same time promoting health and well-being. Care practice to build and maintain self-esteem should include:

- Any form of assistance that develops confidence and maintains a positive self-esteem and for older people to believe in themselves. This includes the development of self-confidence by the promotion of health and well-being.
- Encouragement to develop contacts and relationships with other people.
- Maintenance of a dignified appearance *(including hygiene/grooming regimes).*
- Opportunities to participate in shared activities *(within their competence and personal wishes).*
- Conservation of social standing even when mental or physical deterioration takes place.

Some Practices that Encourage Self-esteem. *(After RCN, 2008; SCIE, 2008)*

To develop good communication practices you should strive to assist older people to:

- Wear own clothes wherever possible.
- Maintain their personal appearance, grooming and hygiene.
- Take part in meaningful therapeutic activity programmes, where older people can see improvements.
- Use various therapies to build confidence and participation for example:
    - Quizzes and competitions.
    - Craft work.
    - Exercise activities including chair based activities.
    - Drama, music and dance with constructive occupation rather than medication.

Older people should never be placed in situations where they:

- Can fail as a member of a group.
- Cannot manage a situation or where they do not have time to complete tasks.

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DIGNITY CHALLENGE: ALLEVIATION OF LONELINESS AND ISOLATION

The general idea is that loneliness and isolation of older people is closely related to maintenance of self-esteem. Loneliness and isolation of older people receiving services can perhaps be alleviated by:

- Encouraging older people to maintain contact with family and friends as well as the general community. Special consideration should be given to this when older people are in living in remote locations.
- Offering older people opportunities to feel valued as contributing members of the community. This also involves providing information and support to help individuals engage in activities which help them participate in and contribute to community life. This has a very close relationship to maintain the self-esteem of older people.
- Offering older people enjoyable, stimulating and challenging activities that are compatible with their individual interests, needs and abilities. This should include access to varied leisure and social activities that are enjoyable and person-centered. However, there can be an issue where such activities may not represent the interests of older people or be perceived as old fashioned or discriminatory.

Some Practices that alleviate loneliness and isolation. *(After RCN, 2008; SCIE, 2008)*

Care workers should promote inclusion and participation, where relevant, through encouraging for example:

- Paid or unpaid work activity (community work, charity work).
- Activity or social club membership.
- Educational activities.
- Family activities.

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THE COMMUNICATION CHALLENGES

Communication Skills

Good communication skills involve the development of:

- **Effective Listening**. It takes much effort to stop expressing your own views and allow others to speak. Really listening to others is an essential acquired skill for care workers.
- **Effective Speaking *(& writing)***. The quality of what a person says is directly related to how much thought and organization has been given to what is being said or written.
- **Supportive Non-verbal Skills**. There are many forms of non-verbal communication cues and include:
    - **Style and Tone of Voice**. The style and tone of a person's voice is very powerful cue about the value of what is being said and the level of respect being given to an older person.
    - **Body Language**. Use of hand gestures and touching can be an important indicator of meaning and value in communication.

Maintaining Communication with Older People

There are many older people who cannot take part in a dialogue and make their needs and wants known easily because they have communication difficulties or cognitive impairment. This may be coupled to dementia, debilitating effects of stroke, distress or sensory loss *(hearing, eyesight, speech etc).* Other older people may only have English as a second language. For older people with communication difficulties it is essential to obtain adequate support and advocacy where required. It is beyond the scope of this Study Guide to identify all the ways people with impaired communication can be helped. However, from a dignity perspective care workers should establish the arrangements for:

- Providing additional support and advocacy to assist older people express their wants and needs clearly.
- De-escalation techniques approved by your organization for dealing with abusive and distressed older people.
- The provision of communication support in the form of interpreters/translators.
- Finding out information about the preferences, concerns and requirements of older people.
- Tailoring information to meet religious or cultural requirements.

From the perspective of older people receiving care services they need to know:

- Who is in charge, who they can talk to and who they can raise concerns with.
- How they can change information recorded about themselves, their preferences and requirements.
- How to call for assistance.
- Where the toilets are.
- Details about single sex separation and other privacy arrangements.
- The nature and limitations of the care process they have entered.

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- The risk assessment regime and how the results of assessments will be communicated.

There are a wide range of effective communication support tools in use and you should be aware of what is in use in your organizations. Examples include:

Formal *patient* interviews.

Suggestions Boxes.

Complaints Books.

Use of *hospital books* – pre-prepared statements about older people that provides for the passage of information from a care environment in to hospital.

Use of Goals folder.

Use of *life books*.

Use of diaries.

Use of Posters *(for staff and older people).*

Patient surveys and user groups.

Patientline feedback.

User Group feedback.

Good communication and co-ordination between different care organizations is vital when older people are moving between care environments (e.g. home – care home- hospital – nursing home – home).

- Carers and older people should be informed about possible discharge as early as possible.
- Care packages should be discussed with older people and the care providers as early as possible.
- Information about discharge arrangements should be shared with the older person people as soon as possible.
- Systems should be in place to ensure timely availability of the drugs, which are to be taken home.

The Communications Related Dignity Challenges.

The Dignity Challenge lists three component communications related challenges:

- **Listen and support people to express their needs and wants**.
- **Ensure people feel able to complain without fear of retribution**.
- **Engage with family members and carers as care partners**.

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DIGNITY CHALLENGE: LISTENING TO AND SUPPORTING OLDER PEOPLE TO EXPRESS THEIR NEEDS AND WANTS

The first dignity challenge related to the quality of communication is to ensure that older people are listened to and supported. Good communication is a fundamental characteristic in the *correct way* of treating older people with dignity as human beings and it also provides the basis for older people to express their human needs and wants. There are three principles:

- Older people should have access to the information and advice they need.
- The care organization should encourage openness and participation in decision making about care.
- The organization can support those older people with communication difficulties or cognitive impairment and adequate level of support and advocacy.

Communication: Good Personal Care Practice *(After: RCN, 2008; SCIE, 2008)*

To develop good communication practices you should strive to:

- Be responsive, welcoming and available.
- Develop and foster professional interpersonal relationships with older people.
- Try to listen to people with an open mind.

To communicate well you:

- Need to ensure there are proper and personal introductions.
- Should show respect and courtesy in your manner, tone of voice and in what you say at all times.
- Need to know how a person wants to be addressed and always address them in that way *(a respect issue).*
- Should understand how different people respond to familiarity and you need to recognise when you have *overstepped the mark*.
- Should be aware of communication challenges for people who are in wheelchairs, in bed or who may be semi-conscious. It is too easy to *talk over them* and forget to involve them in conversation. Sometimes it is necessary to bend or kneel down to talk to a person in a wheelchair or a bed so as to be at the same height.
- Must be aware of the presence of others when talking to an older person about something that requires discretion e.g. incontinence. You must discuss embarrassing or humiliating issues with older people in private.
- Must be aware of the impact of the tone of voice and its volume. Many older people have good hearing and are very able to detect subtle meanings from the tone of your voice and hear things from some distance away.
- Should recognise touch is an important form of communication. Appropriate touching e.g. handholding can communicate empathy, reassurance, comfort and sensitivity.

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DIGNITY CHALLENGE: ABILITY TO COMPLAIN WITHOUT FEAR OF RETRIBUTION

The second dignity challenge related to the quality of communication is to ensure that people feel able to complain without fear of retribution. The general principles are:

- The organization has a responsibility to provide information in a way that enables older people make a complaint and have a procedure in place to respond in a positive and timely manner.
- The organization should support its staff help older people raise *concerns and complaints* with the appropriate person in the organization.
- There should be the opportunity for older people to access an *advocacy services* if required.
- Older people, family, friends and advocates should not fear any form of retribution in the form of reduction in the quality or level of care if a concern has been raised or a complaint made.
- The organization should have a clear *feedback process* for informing older people about their complaints.
- The organization should have a *lesson learning process* gathering suggestions, complaints and mistakes made by staff. Individual care workers should be ready to contribute to the feedback process ensuring all staff members learn lessons from mistakes.

Communication: Good Complaints Handling *(After: RCN, 2008; SCIE, 2008)*

An effective caring organization should have:

- A routine management process in place that identifies mistakes and puts them right. A blame culture is not good management practice. Routine processes can include:

  Feedback processes such as *Patientline* or suggestion cards.

  Regular client satisfaction surveys.

  Seeking the opinion of advocates and family members.

- Sound Record Keeping:

  Accurate records, action trail and feedback given *(and ability to audit this).*

  Collecting evidence.

  Progress communication.

- Complaints Handling Processes. Good care management practice demands a robust system of complaints handling which should have.

  Procedures which are user friendly and accessible.

  An efficient and responsive complaints handling process.

  An effective organizational escalation procedure for serious complaints.

  An Independent Appeals Process.

  Management processes for introducing recommended changes swiftly.

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DIGNITY CHALLENGE: ENGAGING WITH CARE PARTNERS

The third dignity challenge related to the quality of communication is to ensure that carers and their organizations communicate with an older person's family members, friends and advocates as care partners.

Family and friends are also a rich source of information about an older person and their needs and wants. Sometimes it is easier to communicate to an older person through a family member, friend or advocate because they already have a long term interpersonal relationship based on respect and trust.

Sometimes an older person's visitor may see things that have been missed by carers which should be avoided or corrected. Carers ought to be responsive and see family, friends and advocates as care partners who should have the have the same agenda – the best care of the older person. On the other hand carers should be able to explain any limitations and constraints in the care of an older person, so as to deal early on with any false expectations and sources of miscommunication.

Some Indicators of Good Practice

- The views of the user's family are taken into account.
- The active contribution of family and carers to the care of the user is encouraged and supported.
- Care partners are involved appropriately in care planning.
- Food and drinks are available for family and friends at reasonable times while visiting older people.
- Clear arrangements exist, and are publicised, to enable family and carers to travel to and from the location of the older person. This includes the availability of parking for visitors.
- Clear arrangements exist to enable family and carers to stay overnight if necessary.
- There is provision to accommodate multiple visitors at times of death.

Relationship with Care Partners: Good Personal Care Practice *(After: RCN, 2008; SCIE, 2008)*

- Relatives and carers should experience a welcoming ambience.
- Relatives and carers should be kept fully informed and receive timely information.
- Relatives and carers should be listened to and encouraged to contribute to the benefit of person receiving services.
- Use of admission checklists should be used to ensure no information is missed. Care partners are valuable sources of information.
- Relatives and carers should know *who is in charge* and how to raise issues.
- Are you alert to the possibility that relatives' and carers' views may not always the same as those of the person receiving care services?

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DIGNITY THROUGH ACTION

'Failing to plan is planning to fail'

(Alan Lakein – Time Management Expert and Author)

RECOGNISING DIGNITY RELATED PROBLEMS AND INCIDENTS IN CARE PRACTICE

Problems with dignity can be identified in a number of ways:

- **Reflective Practice**. During your training you will probably have been taught to reflect on your care practices and assess your own performance. You may have been taught about formal models of reflection and their use in different circumstances. Examples of formal recording of personal reflection include:
    - Portfolio Development, where you are asked to record evidence of practice.
    - Critical Incident Analysis.
    - Journals recording thoughts about your work.
    - Records of professional reading.
    - Details of meetings and discussions.

  Formal reflection is a very useful way of identifying dignity problems and considering your personal, team's or organization's attitudes, behaviour and care practices.

- **Using the Literature**. There is an increasing amount of published material on the subject of dignity. For example:
    - The Social Care Institute for Excellence (SCIE) Practice Guide 09: Dignity in Care (2006) provided an in-depth review of dignity in care and its problems, and it is recommended for further reading.
    - The Care Quality Commission Guidelines (2009) provided detailed outcomes for care to achieve. This material will make you very aware of the issue of dignity in your care practices. As a result you may recognise many deficiencies in local care practices.

- **Using Dignity through Action Audit Tools**. The Dignity through Action Audit Tools provides a range of tools to assist staff at different grades, responsibility and levels of experience consider their own attitudes, behaviour and care practices from the perspective of dignity. The **Careworkers Personal Dignity Audit Tool** and the **Supervisors'/Managers' Dignity Audit Tool** have been designed for use at a Dignity through Action Workshop although they can be used at any time.

- **Using Local Care Organization's Records**. The local organization is likely to have concerns about dignity in practice will probably hold some records about this. There may also be information recorded in the Complaints System. In general terms you should seek managerial approval before addressing organizational level dignity concerns.

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ACTION PLANNING

Action planning is a skill that you should cultivate because it a *smart activity*. It helps you focus carefully on what is important and it allows you to check if you have achieved what you set out to do. Action planning is about being clear about what you want to do or what you want others to do in some detail.

Informal *(Quick)* Action Planning

Many problems related to the care of the older person with dignity may be minor and, when identified, can be put right immediately with perhaps just a small change of personal practice, a kind word, better staff awareness of an individual's needs, some sound advice or a change to the way a particular individual older person is being treated. At this level, action planning may just be based on changes to your own practice within the local laid down procedures. At this level you may only be planning for changes that affect your own work, the work of your immediate colleagues or your team. You are unlikely to need to spend much time carrying action planning at this level and a formal written plan will probably not be required. However, it is still important to go through the thought processes of action planning and perhaps write some notes because:

- You will have a record of what you were trying to achieve *(and a timetable)* and some record of whether or not you achieved what you set out to do.
- You will be able to present any request for change to supervisors and managers in a professional manner.
- You may be asking supervisors and managers to take further action at a team or organizational level.

Formal Action Planning

It is difficult to say when the need for a more formal action planning process starts. It is suggested that action planning becomes a more formal process when a plan needs:

- Authorization to proceed.
- More than one person to carry it out.
- Uses resources and/or costs money.
- Introduces changes to agreed working practices.
- A co-ordinated timetable.

Formal action planning can take places at two levels:

- **Team Level Action Planning**. Many dignity problems, perhaps identified by a single member of staff, are probably beyond the capability of a single individual to put right and require effort by a number of staff to right. Team and cross team planning will probably involve money, time, resources, many staff, many clients and good co-ordination. Team action planning probably involves seeking managerial approval for the introduction of any changes. Various options may have to have been examined and the *best way forward* may be constrained by money or the availability of other resources. Action planning at this level is likely to be carried out using organizational procedures and may require written arrangements *(timetable, resource plan, co-ordination plan etc)* written out in the *house style*. Changes introduced at a team level will probably need a formal evaluation.

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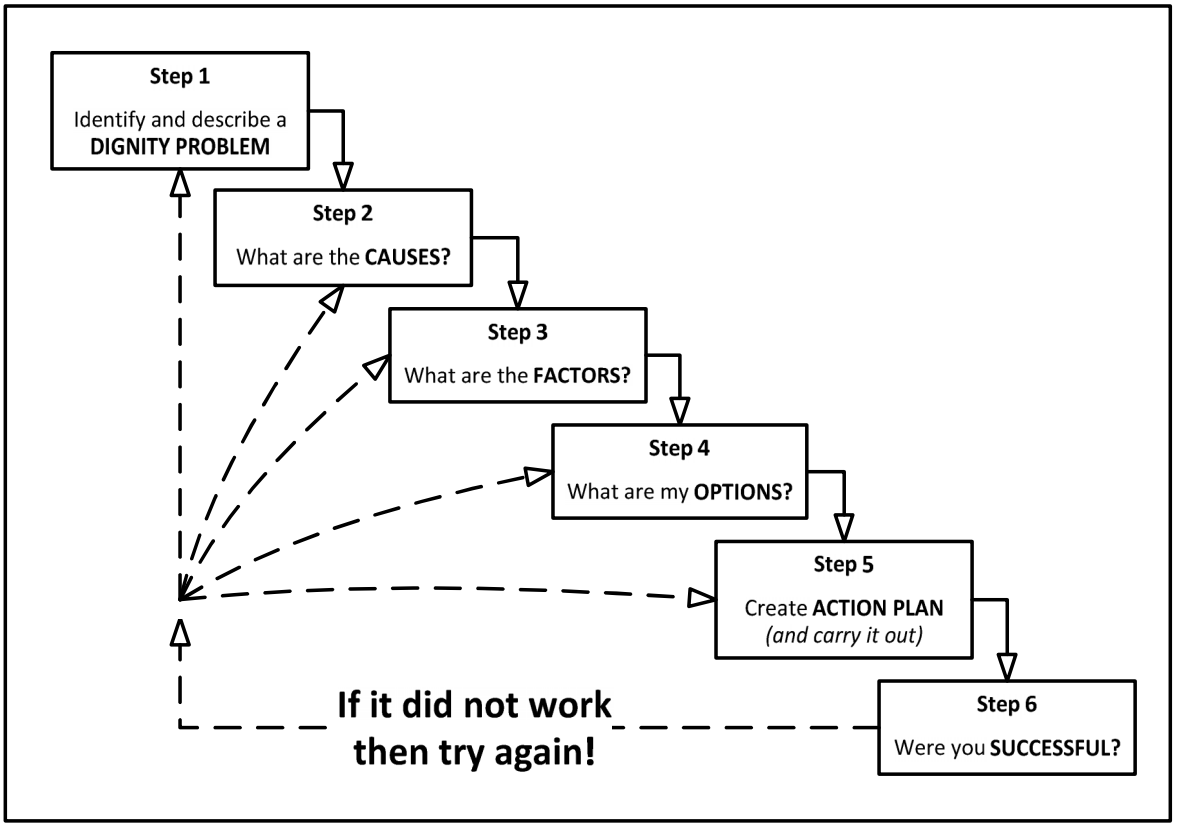
- **Organization Level Action Planning**. Action planning at an organizational level will require careful preparation, planning and co-ordination. Organizational changes will probably require formal proposals which examine options *(advantages and disadvantages)* and costs. Senior staff will need to consider the detailed plan, its implications, its co-ordination and evaluation before approval is given. In some cases changes may be subject to detailed, expensive and time-consuming formal project planning and evaluation procedures. At an organizational level it must be demonstrated that changes have been effective. Every organization will probably have its own preferred methods of planning and evaluation.

GENERAL METHOD FOR ACTION PLANNING

To deal with any general problem you need to make an action plan. The common sense steps of action planning are the same no matter what the scale of the problem or the amount of effort required to put it right. The six action planning steps are illustrated below.



The Steps of Action Planning

Following the six action planning steps is sound practice because it helps you deal with problems of any complexity in the care environment and it provides you with a way of coming up with sound proposals which can be approved and delivered in a controlled way.

A detailed description of these steps is at **Appendix 2**.

Checklists for the planning steps is at **Appendix 3**.

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The Characteristics of Change

There are several characteristics of change:

- **Level of Change**. Action plans can be for individuals, teams, departments and organizations. In general terms, the bigger the problem the more change, resources and level of authorization will be needed to deal with it. Action plans that introduce change for individuals can be short and simple, at the team level there will be emphasis on co-ordination and at the organizational level there will be an emphasis on resource use and costs.

- **Method of Change**. An action plan can introduce change in small steps *(low risk)* and may be the result of a process of continuous improvement. Major change that happens all at once, *(high risk - particularly at the organizational level,*) is often known as a ***Big Bang approach*** and is prone to failure. Alternatively, and with less risk, change can be introduced by carrying out trials, perhaps involving carefully planned development steps, so that lessons can be learned before the next part of the change is introduced. This approach is most likely to succeed.

- **Type of Change**. There can be an action plan to carry out remedial changes putting matters right, bringing care practice up to the correct standard or perhaps training people to meet the right standard. Alternatively an action plan may be introducing a new development to care practice, improving standards or perhaps meeting new legal or professional requirements.

Human Factors in Action Plans

Introducing change into care practice requires commitment to that change. It may also require the support of other staff, supervisors and managers to ensure the benefits of any change are sustained. Developing commitment in staff may not be easy, but some practical common sense steps include:

- The explanation of changes carefully to all staff and clients involved

- Generating enthusiasm, motivation and engagement amongst the participants.

- Obtaining the sponsorship and commitment of senior staff to support you in your action plans to deliver change.

Advice on Gaining Formal Approval to Proceed with Changes

If you need supervisory or managerial permission to make changes to care practice then you will need to gain formal approval. You need to be aware that the idea of a ***best option*** is likely to vary from different peoples' viewpoints.

- Senior managers are likely to want to minimise costs.

- Supervisors are likely to favour a way of doing things more effectively and perhaps more simply.

- Care workers are likely to prefer options that make their work easier.

- Older people receiving care services might prefer options that deliver changes quickly and make their life better.

There is no easy way of predicting how proposed options for changing care practices will be acceptable to all those involved. The practical advice is that you should always discuss the dignity problem and possible changes to practice with your colleagues, other teams, supervisors, managers, older people and their relatives. You will seldom come across a solution to a problem that will please everyone and you should always be prepared to compromise in order to stimulate change in the organization. In particular, you need

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to identify and gain the approval of the ***gatekeepers*** – those staff whose approval for change is critical to the way forward.

You may find that your organization has a set procedure for making change proposals and perhaps even a set format for documents. You should use the existing management processes to propose changes. However, where you need to gain management approval to introduce change the general advice is to:

- Only present realistic options that will meet your goal in a practical, sensible, timely and probably cost effective way.

- Wait for a management decision about which option to use before planning any change in fine detail.

You should see that it is sound practice for managers to consider carefully all the factors involved, taking time to examine the options and be questioning in their approach.

Managers may also interpret factors differently and what may seem an obvious solution to you may be rejected by more senior staff.

You should be prepared to defend why you believe one of the options is the best approach.

Finally you should always have a *way out*. You need to build into any plan assessment points where you can check if your plan is working or whether or not you need to stop and re-think the plan. This is a characteristic of good project management.

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SOURCES FOR FURTHER READING

Source and Description	Links
Age Concern Internet site for older people providing useful advice, services and contacts. Describes campaigns about: Depression, Quality Care, Financial Assistance, Advice to Older People, Malnutrition and Chiropody. A general position statement with interesting evidence about nutrition for older people. Firm practical guidance with useful examples which covers 7 step plan to end the scandal of malnutrition in hospitals. The ideas are useful for all care settings.	Age Concern (2008), *Campaigns and Issues,* [Online]. Available at: http://www.ageconcern.org.uk/AgeConcern/campaigns.asp. Age Concern (2006), *Hungry to be Heard*, [Online]. Available at: http://www.ageconcern.org.uk/AgeConcern/Documents/Hungry_to_be_Heard_August_2006.pdf.
British Geriatrics Society A campaign to raise awareness that people, whatever their age and physical ability. The aim of the campaign was to raise awareness that people, whatever their age and physical ability, should be able to choose to use the toilet in private in all care settings **British Geriatrics Society** Submission by the BGS to the UK Parliament, Joint Committee on Human Rights. Very concise summary of all the problems from a Human Rights perspective.	British Geriatrics Society (2006), *Behind Closed Doors: Using the toilet in private*, [Online]. Available at: http://www.bgs.org.uk/campaigns. British Geriatrics Society (2007), *Position Paper: The Human Rights of Older Persons in Healthcare Call for Evidence*, [Online]. Available at: http://www.bgs.org.uk
Care Quality Commission The Care Quality Commission: Guidance about compliance (2009) Essential Standards of Quality and Safety has been designed to help organizations comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009, and the Care Quality Commission (Registration) Regulations 2009. This detailed guidance covers the standards of quality and safety that people who use health and adult social care services have a right to expect and is based on the what people who use services tell have expressed as being what matters most to them.	The Care Quality Commission: Guidance about compliance (2009) [Online]. Available at: http://www.cqc.org.uk/_db/_documents/Essential_standards_of_quality_and_safety_FINAL_081209.pdf
Care Service Improvement Partnership (CISP)	Care Service Improvement Partnership (CISP), (2008), *The Dignity Care Campaign*, [Online]. Available at: http://networks.csip.org.uk/dignityincare/DignityCareCampaign/.
Department of Health	Department of Health (2006), *A New Ambition for Old Age*, [Online]. Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4133941 .

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Source and Description	Links
Department of Health	Department of Health (2007), *About the National Service Framework (NSF) for Older People*, (Updated: 8 November 2007). Available at : http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Olderpeople/DH_4073597. Department of Health (2007), *Essence of Care: benchmarks for the care environment,* [Online]. (Updated 1 Nov 2007), Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080058.
Department of Constitutional Affairs Making Sense of Human Rights. A general reader on human rights. Human Rights Act (1998). A useful resource for in depth reading on this subject.	Department of Constitutional Affairs (2006), *Making Sense of Human Rights*. [Online]. Available at: http://www.justice.gov.uk/guidance/docs/hr-handbook-introduction.pdf. Department of Constitutional Affairs (2006), *A Guide to the Human Rights Act,* 3rd Edn. [Online]. Available at: http://www.justice.gov.uk/docs/act-studyguide.pdf.
Dignity and the Older Europeans Project An EU sponsored multi-disciplinary workbook that covers general points from a wide perspective to make people think about dignity. Wide focus and so does not just cover nursing perspective. Some very useful questions and exercises.	European Commission (Undated) *Educating for Dignity*, The Dignity and Older Europeans Project (QLG6-CT-2001-00888). [Online]. Available at: http://www.cardiff.ac.uk/medic/subsites/dignity
Forum of Young Global Leaders This site provides a wide ranging and international perspective of dignity.	Forum of Young Global Leaders (2008), Global Dignity Initiative, [Online]. Available at: http://www.younggloballeaders.org/development_and_poverty/Global_Dignity_Initiative/Global_Dignity_Initiatve.html. *Dignity 101 - A Course in Dignity*, [Online]. http://www.globaldignity.org/view/COURSEINDIGNITY/.
Healthcare Commission A national report on dignity in care for older people while in hospital. Focus is on care considered from wide perspectives *(trusts, boards, ward levels and voluntary organizations).*	Healthcare Commission (2007) *Caring for Dignity*, London: Commission for Healthcare Audit and Inspection.
Help the Aged Internet site for older people providing useful advice, services and contacts. Describes campaigns about Age Discrimination, Elder Abuse, Health and Social Care, Neighbourhoods, and Pensions and Benefits.	Help the Aged (2008), *Campaigns and Issues,* [Online]. Available at: http://www.helptheaged.org.uk/en-gb/Campaigns/.

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Source and Description	Links
Help the Aged General information for older people on the subject of abuse. A Vision for Social Care Practical leaflet guidance on mobility for the older person.	 Help the Aged (2007), *Elder Abuse: What it is and How to Stop It*, [Online]. Available at: http://www.helptheaged.org.uk/NR/rdonlyres/2B789046-6FEF-488C-A5DD-17A90F3FE11D/0/elder_abuse_adv.pdf. Help the Aged (2008), *A Vision for Social Care – Principles for Change*, [Online]. Available at: http://www.helptheaged.org.uk/NR/rdonlyres/AEAFF67D-6B5A-4D03-8667-53D6D2FBCD8C/0/HtA_executive_summary.pdf. Help the Aged (2007), *Staying Steady: Improving your strength and balance,* [Online]. Available at: http://www.helptheaged.org.uk/NR/rdonlyres/F6D4F2BB-5DAD-42B4-8141-9354FE24AF6F/0/staying_steady_adv.pdf.
Patients Association The publication contains 16 real life care case studies.	 Patients Association, (2009), *Patients ... not numbers, People ... not statistics.* See http://www.patients-association.com.
Royal College of Nursing This is a report of the results of the RCN Dignity Survey. It covers the physical environment, individual care, care by the employing organization, ability to deliver care and a comprehensive discussion. RCN training material about dignity.	 Royal College of Nursing (2008) *Defending Dignity*, London: RCN. Royal College of Nursing (2009a) *Delivering Dignified Care: a practice support pack for workshop facilitators.* Royal College of Nursing (2009b) *Small changes can make a big difference: how you can influence to deliver dignified care.*
Social Care Institute for Excellence (SCIE) Detailed guidebook with wide coverage of the subject of dignity in care. Contains useful examples and thinking exercises.	 Social Care Institute for Excellence (2008) *SCIE Practice Guide 09: Dignity in Care*, [Online]. Available at: http://www.scie.org.uk/publications/practiceguides/practiceguide09/overview/means.asp.

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APPENDIX 1: FURTHER NOTES ON HUMAN RIGHTS ACT (1998)

Human Rights Act 1998

(Source: Department of Constitutional Affairs, 2006)

You can see a full description of the Human Rights Act (1998) at the Office of Public Information Website (OPSI) at:
http://www.opsi.gov.uk/acts/acts1998/ukpga 19990042 en 3

Article	Title	Brief Summary
Article 2	RIGHT TO LIFE	Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law. Note the death penalty is abolished in another part of the Act. There are some circumstances resulting from the use of force when this article is not infringed to do with serious situations resulting from defending others from unlawful violence, during lawful arrests and quelling riots or insurrections.
Article 3	PROHIBITION OF TORTURE AND DEGRADING TREATMENT	No one shall be subjected to torture or to inhuman or degrading treatment or punishment.
Article 4	PROHIBITION OF SLAVERY AND FORCED LABOUR	No one shall be held in slavery or servitude. No one shall be required to perform forced or compulsory labour.
Article 5	RIGHT TO LIBERTY AND SECURITY	Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in certain situations and in accordance with a procedure prescribed by law e.g. detention following lawful conviction or detention of people spreading infectious diseases or being of unsound mind.
Article 6	RIGHT TO A FAIR TRIAL	In the determination of a person's civil rights and obligations or of any criminal charge against them, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law. Judgement shall be pronounced publicly, but the press and public may be excluded from all or part of the trial in the interest of morals, public order or national security in a democratic society. Everyone charged with a criminal offence shall be presumed innocent until proved guilty according to law.
Article 7	NO PUNISHMENT WITHOUT LAW	No one shall be held guilty of any criminal offence on account of any act or omission which did not constitute a criminal offence under national or international law at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the criminal offence was committed.
Article 8	RIGHT TO RESPECT FOR PRIVATE AND FAMILY LIFE	Everyone has the right to respect for their private and family life, their home and their correspondence. There shall be no interference by a public authority with the exercise of this right, except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic wellbeing of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.
Article 9	FREEDOM OF THOUGHT, CONSCIENCE AND RELIGION	Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change their religion or belief and freedom, either alone or in community with others and in public or private, to manifest their religion or belief, in worship, teaching, practice and observance. Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.
Article 10	FREEDOM OF EXPRESSION	Everyone has the right to freedom of expression. This right shall include freedom to hold opinions and to receive and impart information and ideas without interference by public authority and regardless of frontiers. It is also subject to the same kinds of limitations described above.

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Human Rights Act 1998

(Source: Department of Constitutional Affairs, 2006)

You can see a full description of the Human Rights Act (1998) at the Office of Public Information Website (OPSI) at:
http://www.opsi.gov.uk/acts/acts1998/ukpga 19990042 en 3

Article	Title	Brief Summary
Article 11	FREEDOM OF ASSEMBLY AND ASSOCIATION	Everyone has the right to freedom of peaceful assembly and to freedom of association with others, including the right to form and to join trade unions for the protection of his interests. No restrictions shall be placed on the exercise of these rights other than such as are prescribed by law and are necessary in a democratic society in the interests of national security or public safety, for the prevention of disorder or crime, for the protection of health or morals or for the protection of the rights and freedoms of others.
Article 12	RIGHT TO MARRY	Men and women of marriageable age have the right to marry and to found a family, according to the national laws governing the exercise of this right.
Article 14	PROHIBITION OF DISCRIMINATION	The enjoyment of the rights and freedoms set forth in the Human Rights Act is be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.
Article 16	RESTRICTIONS ON POLITICAL ACTIVITY OF ALIENS	Nothing in Articles 10, 11 and 14 shall be regarded as preventing restrictions on the political activity of aliens.
Article 17	PROHIBITION OF ABUSE OF RIGHTS	Nothing in the Human Rights Act may be interpreted as implying for any state, group or person any right to engage in any activity or perform any act aimed at the destruction or limitation of any of the rights and freedoms described by the Human Rights Act.
Article 18	LIMITATION ON USE OF RESTRICTIONS ON RIGHTS	The restrictions permitted under the Human Rights Act must not be applied for any purpose other than those for which they have been prescribed.
Protocol 1 Article 1	PROTECTION OF PROPERTY	Every natural or legal person is entitled to the peaceful enjoyment of their possessions. No one shall be deprived of their possessions except in the public interest and subject to the conditions provided for by law and by the general principles of international law. However the state has the right to enforce laws necessary to control the use of property in accordance with the general interest or, for example, to secure the payment of taxes or other contributions or penalties.
Protocol 1 Article 2	RIGHT TO EDUCATION	No person shall be denied the right to education. In the exercise of any functions which it assumes in relation to education and to teaching, the state shall respect the right of parents to ensure such education and teaching in conformity with their own religious and philosophical convictions. *(The UK has accepted this Article is subject to a reservation that it does so only so far as it is compatible with the provision of efficient instruction and training and the avoidance of unreasonable expenditure.)*
Protocol 1 Article 1	RIGHT TO FREE ELECTIONS	The Government must hold free elections at reasonable intervals by secret ballot, under conditions which will ensure the free expression of the opinion of the people in the choice of the legislature.
Protocol 6 Article 1	ABOLITION OF THE DEATH PENALTY	The death penalty is abolished. No one shall be condemned to such penalty or executed.

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APPENDIX 2: A GENERAL METHOD FOR ACTION PLANNING

General Advice.

In general terms the bigger or complicated a problem the mores resources, effort and time will be need to solve it. This in turn will be directly related the amount of effort required for planning required. Therefore, you need to apply this method with some common sense, matching your approach and the amount of effort you put in to the needs of each particular situation. Whether you are planning to deal with the most trivial or complicated problem these 6 steps are relevant to any form of action planning.

Step 1: Identify and describe dignity problems.

It is important that you describe a problem in as much detail as possible, so you can understand the extent of the problem.

Step 2: What are the causes?

When you identify dignity problems, their causes will hopefully be obvious. However, the symptoms of a problem may not point immediately to its causes. Causes may be masked in a cloud of conflicting symptoms, especially in the relatively complex subject area of dignity. You should be aware that dignity is quite a fluid concept. It can change rapidly in time, be very much related to place and to the people involved. What may be undignified for one set of people may be acceptable to others even in the same circumstances. In this sense older people are likely to have different *(perhaps unfashionable)* perceptions of dignity compared to the perceptions of their younger carers. Furthermore, people are willing to trade in dignity for other benefits. Modern medicine is a gauntlet of indignities, which older people accept to gain the benefits of recovery from sickness and injury.

You always need to consider carefully what the causes of a dignity problem are. Make sure you understand the causes before trying to start putting things right. If you have identified a dignity problem it is good practice to discuss the matter with others, because at the very least you will be able to put the matter into words.

Step 3: What are the factors?

This is the step that many people either avoid or just skim over because they just *know what to do . . . because it is so obvious.* However, failure to consider the **factors affecting a problem** and **what has to be taken into account to find a solution** are the main reasons why people fail to plan properly. There is much to think about in the care environment, but if you do not work through Step 3 carefully then there is a good chance that when you try to carry out changes things will start to go wrong because you have not taken everything into account. You may even be caught out by being unable to answer simple questions when making make change proposals to managers. They will simply ask you questions you cannot answer because you have not thought about the problem and its solution fully.

Your organization should have policies, processes and detailed procedures which provide a **pre-planned basis** for standardised care and maintenance of quality in the care service. You may find all the planning work has already been carried out and all you need is to implement practices properly. On the other hand you might well find that something is missing in the organization's documents.

Most problems with organizational policies, processes and detailed procedures can normally be put right through the organization's review and change process. Most organizations will have review schemes which should carry out the regular audit of policies, processes, procedures to ensure they are working as well as meeting the current legislation or benchmarking standards. In general terms it is not good professional practice to make unofficial personal changes to organizational policies, processes or detailed care procedures *(whatever the reason)* without supervisory or managerial approval. Making such changes could lead to other problems and even disciplinary action. All careworkers should also know how to record and make suggestions for changing local organizational policies, processes and detailed procedures.

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You may find that the problem with dignity may be occurring because careworkers are not really following what is required of them because of:

- Lack of training and/or inexperience of staff.
- Lack of available resources *(people, time, equipment and accommodation).*
- Lack of supervision.
- The adoption of local practices to suit personal convenience.
- Staff attitude problems that contribute to problems with dignified care.

You should consider various factors affecting the problem and its potential in a systematic way and try to appreciate how **they contribute to the problem** or **will help you solve the problem**. Example factors are: time, accommodation, training, money, equipment and staffing. Thinking about factors and coming up with conclusions is a standard management practice, although many organizations use their own terms for factors. The RCN (2009) uses the term *themes* to describe the three major clusters of factors under the headings of **place**, **process** and **people**. The checklist below provides you with a list of factors to consider and general questions to answer for Step 3.

Step 4: What are my options?

You may already have come to some conclusions about how you are going to solve the dignity problem and the best way forward may be obvious to you. However, if your solution involves the use of resources *(people, time and money)* then you are probably going to have to consider a number of options of how best to solve the problem. Selecting the best way forward is normally carried out by comparing the **advantages** and **disadvantages** of each option. It is always good practice to:

- Discuss the dignity problem and the possible options for with your colleagues, other teams, supervisors, managers, older people and their relatives.
- Explore published sources of information to see if the dignity problem has been addressed successfully elsewhere. You might find that another organization has already implemented something which would solve your problem. Useful sources of information include the Internet *(Note 5)* and the general literature including professional journals. This might save yourself much time and effort if you search the literature.

Step 5: Create an action plan and carry it out.

- **Setting your goal.** One of the most important aspects of planning is to define your goal carefully. A goal is a **simple statement**, probably only a sentence long and says clearly what you want to achieve with an action plan. Goals should be written in such as way that everyone who reads your plan understands what the target is, so it can be seen clearly what is to be done. Later it can be used to assess whether or not you have achieved it when you have completed the work.
- **Setting the Objectives.** Objectives are action statements about what has to be achieved in detail to reach the *goal*. There can be many objectives to achieve to meet a single goal. The

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Note:

5: For example there are over 80 examples of 'best practice' initiatives in dignity see the SCIE Guide 15:' Dignity in Care' and in particular the Section on 'Ideas from Practice'. This can be found at: http://www.scie.org.uk/publications/guides/guide15/ideas/index.asp.

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terms: **S**PECIFIC, **M**EASURABLE, **A**CHIEVABLE, **R**EALISTIC and **T**IMED are the basis for the acronym '**SMART**' and describe the common characteristics of objectives. Writing SMART objectives is a common characteristic of good management.

Main Desirable Characteristics of Objectives	
Specific	**Specific** means: • Writing each objective as a clear statement as to what is to be achieved. Everyone needs to understand what is to happen. • Each objective must be related to the main goal. • The language used must suit the organization. • Not using impressive sounding, vague management jargon.
Measurable	Objectives must be written in measurable terms. Measures include time, money and resources. **Measurable** is the most important consideration. You and others will know whether or not you have met your objective when the measurement conditions have been met.
Achievable	Objectives must be **achievable** and this characteristic is linked to characteristic of **measurable**. There is little point in starting a job unless you know can finish it or know that it is finished. One way of dealing with an objective that seems too complex is either to state it in terms that are clear or break it down into smaller steps and write objectives for each step.
Realistic	Objectives must be realistic about money, equipment, resources and time.
Timed	Objectives must indicate a *best guess* timescale. A balance must be struck between optimism vs. pessimism for timings and dates. Sometimes there is a fixed end *(must do by)* date to introduce change. Timing objectives is very important for co-ordinating the overall work to meet the goal.

Objectives, particularly for care provision with dignity, perhaps ought to have other characteristics as well. Management literature describes a range of **additional desirable characteristics** for objectives which are useful for writing objectives particularly for changing care work practices.

The characteristics of *specific, measurable, achievable, realistic* and *timed* can also be extended to include '**Inspiring'**, '**Enthusiastic'** and '**Sustainable'** providing the acronym '**SMARTIES**'.

Additional Characteristics of Objectives	
Inspiring	Does the objective want to make people want to change their behaviour?
Enthusiastic	Does the objective excite people and increase their enthusiasm?
Sustainable	Can the objective be maintained in the long term?

These extensions to the qualities of objectives may be particularly useful to consider when working out objectives for changing care practices associated with the subjects of dignity and respect.

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- **Producing a Written Plan.** It is good practice to produce a written plan. A written plan is important because it:
    - Allows you and others to check the detail to see nothing has been left out.
    - Is a good form of communication because it allows others to see their contribution and how work is co-ordinated between staff members *(who are responsible for what).*
    - Provides managers with a clear understanding as to:

        What they have given permission for.

        Who is involved.

        Who is to do what and by when.
    - It also allows the plan to be *signed off*, which means that you have an authorised record as to what changes have been approved by your managers.
    - Provides you with a record of what was to be achieved when you come to assessing your actual success.
- **Carry out the Action Plan**. Once you have permission to proceed *(if that is required)* you should aim to start the work described in your plan according to the timetable. You should review progress on a regular, but sensible basis. Good project management involves balancing ***time***, ***resources available*** and the ***effort required***, so as to complete the work to the standard required.

Step 6: Where you successful?

It is good practice to evaluate whether or not you have achieved the goal you set in your action plan. You need to assess:

- If you completed all the objectives set in your action plan to the standards required.
- If the changes you have introduced have been successful.

You may even be required to report formally to your managers on progress and the level of success. Evaluation should take place after a period of time to ensure any changes you have introduced can be assessed properly. One important aspect of evaluation is that it is an opportunity to identify if further work is necessary or whether or not a different approach is required. You should also assess:

- What else could you have carried out.
- What you could do better next time.

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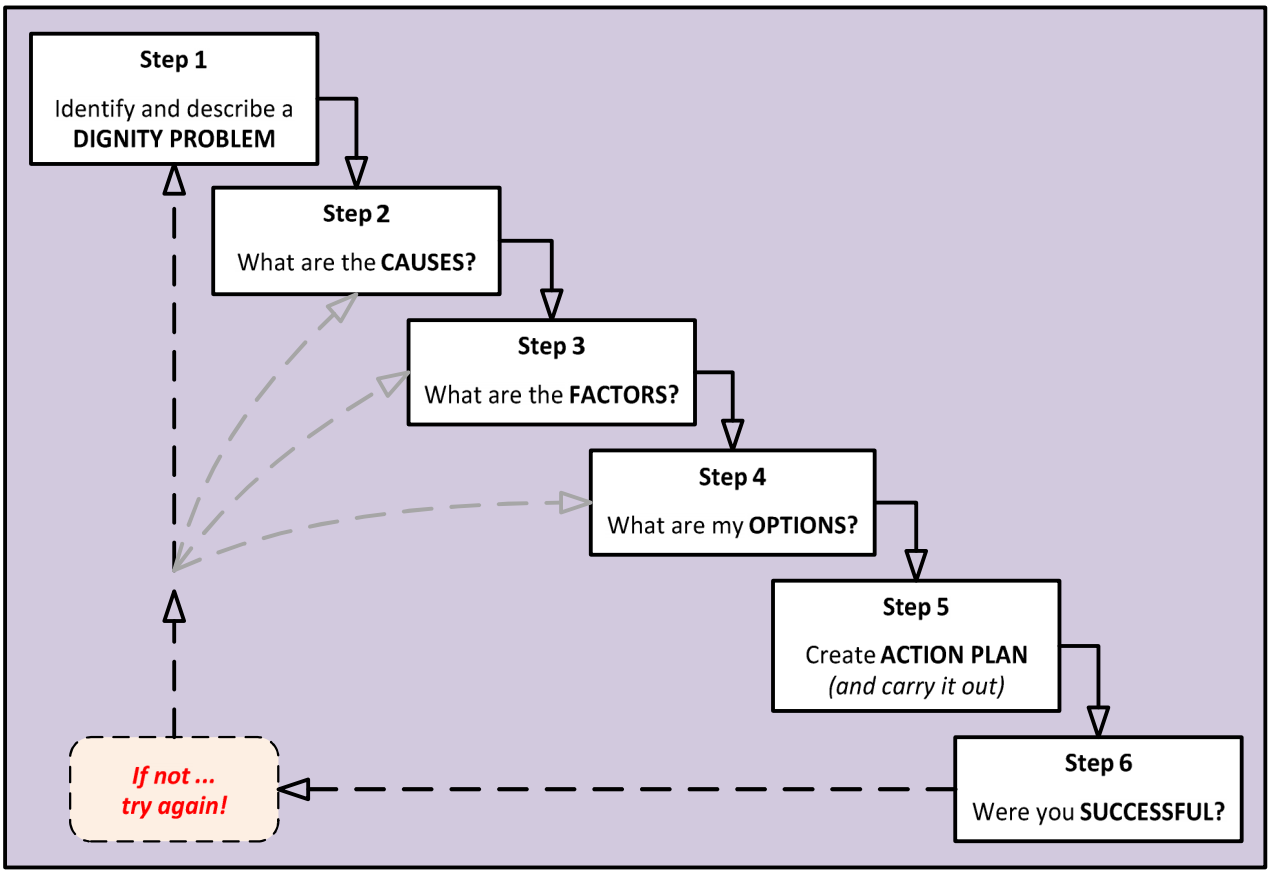
APPENDIX 3: CHECKLISTS FOR THE PLANNING STEPS

The following planning checklists are also contained in the Dignity through Action Resource 3: Workshop Pack.



STEPS 1 & 2: CHECKLIST - DESCRIBING DIGNITY PROBLEMS AND IDENTIFYING CAUSES

STEP 1: Action Planning Step 1: Identify and Describe

What happened*? (Relate to the Dignity Challenges)*

Gather the details:

- **When**, **where** and **how** often did it happen?
- **Who** was involved?
- What were the consequences for the older person, staff & relatives?
- Had the problem been identified before?
- What was done about the problem last time?

STEP 2: Action Planning Step 2: Causes

What are the causes of the dignity problem?

Is there anything else you need to record?

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STEP 3: CHECKLIST - CONSIDERING THE FACTORS – Some questions to consider *(After RCN, 2009)*

PLACE *(Physical environment, its resources and funding).*

What environmental issues are causing or affecting the dignity issue. You need to consider e.g.:

- Physical environment (privacy, hygiene, housekeeping etc).
- Resources *(equipment, storage and tidiness).*
- Safety, security and access.

How would you need to change the care environment, so as to solve the dignity issue?

What resources are needed to deliver this change?

PROCESS *(How care activities are conducted).*

Are there existing organizational policies, processes and procedures covering the problem?

- Are local policies, processes, detailed procedures and other actions good enough?
- Are local policies, processes and procedures up to national standards?
- Do Audits take place that include 'dignity'?

Do organizational targets and resource levels affect the level of dignity in care?

Are there constraints on what you can and cannot do?

Are there proper reporting procedures for staff to state concerns in place?

Is staff training or induction involved? Is there proper staff induction and training?

Can older people and their relatives register complaints?

Is there a proper process for dealing with complaints?

PEOPLE *(Behaviours, attitudes, culture & staffing*

If there is a dignity problem – how am I involved?

What are the staff doing that is good, questionable or poor practice?

Do I and the other staff members have the knowledge/skills necessary for delivering care with dignity?

Who does the problem affect *(which older people, which relatives, which careworkers, which supervisors and managers)*? Who will be affected by any changes to practice?

What is the relationship between carers/older people/advocates & relatives?

What are the attitudes and level of self-esteem amongst the older people?

Managerial Support

- Who do you need to influence for change to care practice to occur?
- Who needs to give specific permission for any changes to take place?
- Who and what is going to help you with your plan to solve the problem?
- Who and what is going to hinder or stop you with your plan to solve the problem?

In the organization who needs to know about the dignity problem? Are other teams involved?

Is the problem or issue about staff behaviours, attitudes and culture or is it about procedures and processes?

Is the dignity issue to do with individual older people and staff or is it more widespread?

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STEP 4 CHECKLIST - IF THERE IS MORE THAN ONE OPTION FOR SOLVING THE PROBLEM

Identify the possible options to solve the problem.

Work out the resources required for each option.

Which option has the best advantages *(also consider the disadvantages)*?

Which option has the best chance of success *(do not be unrealistic).*

Management Approval:

- Is this required?
- Who needs to give approval?
- Do they need to choose the best option or can you do it?
- What information do they want and in what format?

STEP 5: CHECKLIST - CREATING THE ACTION PLAN

Have you a clear goal? *(Can you say in a single sentence what you propose to do?)*

- *If you have a single objective then this is the same as your 'goal'.*
- *Otherwise you may have several objectives that make up what you are trying to achieve to meet your overall goal.*

Are your objectives SMART? *(Specific, Measurable, Achievable, Realistic and Timed),*

(Do not forget you may need to inspire other people, generate enthusiasm in others and make changes sustainable and this may need to be reflected in your objectives.)

Have you identified the logical steps for your plan? For each step you need to be clear about:

What is to happen.

Who is involved and **what tasks** each person must carry out.

When and **Where** tasks are to happen.

The **order** of the tasks to be carried out. Do you need a **Timetable**?

Does the Plan need formal management approval?

What do you need to do to obtain approval?

How are you going to communicate with others involved in the action plan?

STEP 6: CHECKLIST - EVALUATION

Have you included arrangements for review and evaluation?

How are you going you communicate the results?

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ACTION PLANNING – AIDE MEMOIRE

Step 1: Identify and describe the dignity problem.

Step 2: What are the causes of the dignity problem(s)?

Step 3: Consider the factors.

- *Place: Physical environment and its resources, funding.*
- *Processes: How care activities are conducted.*
- *People: Behaviours, attitudes, culture.*

Step 4: What are the options?

- *What are the advantages/disadvantages of each option?*
- *Select the best option – be prepared to justify*.
- *What approval do you need to proceed?*

Step 5: Write the Action Plan.

- **GOAL** *(keep this short and simple).*
- **OBJECTIVES**: Objectives should be specific, measurable, achievable, realistic, timed, inspiring, enthusiastic & sustainable.
- **WHAT** is to be done and **ORDER** of tasks.
- **RESOURCES**: What is needed?
- **WHO** is involved and reporting arrangements?
- **COMMUNICATION**: Who needs to know what and when?
- **TIMETABLE**: Detail the order of tasks, allocate responsibilities and list timings *(dates, times, periods etc).*

Step 6: Evaluation Arrangements.

- How are you going to evaluate the success of your Action Plan?
- How are you going to communicate the results?

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