Dignity, values, attitudes, and person-centred care

Learning outcomes

By the end of this chapter, you will be able to:

- define 'positive ageing' and the contribution that older people make to society;
- discuss ageism, and the stereotypes and labels that are associated with ageing and old age;
- demonstrate an understanding of the importance of dignity and respect for many older patients;
- recognize the possible signs of abuse or neglect, so that concerns can be raised to ensure the safety and empowerment of vulnerable adults;
- identify best practice and opportunities to achieve person-centred care in both community and hospital settings; and
- reflect on your own practice and the standards of care provided within your practice setting, and establish actions that you can take to ensure that patients are treated with dignity and respect, and receive care that is person-centred.

Introduction

Everyone is an individual with their own unique values, attitudes, beliefs, and preferences. To achieve care that is person-centred, the nurse needs to recognize individuality and diversity, whilst consulting with and involving the individual at all stages of their patient journey. When caring for older people, it is important to have an understanding of ageism—that is, stereotypes and labels associated with older people—together with the impact that this can have on their experience and patient outcomes.

This chapter examines values and attitudes relating to the care of older people, and explores best practice regarding the promotion of person-centred care. The principles discussed within the chapter are applicable to both health and social care, and within community or other settings.

Ageism

Ageism is also referred to as 'age discrimination' and relates to discrimination or prejudice against a person, or persons, on the basis of their age. Ageism in health care can relate to receiving a lower standard of service or even to being denied access to a service—for example, being told that symptoms experienced are directly related to old age, not receiving a general practitioner (GP) referral to a consultant on the grounds of age, or not being involved in decision-making about transfer of care arrangements when being discharged from acute hospital care.

A New Ambition for Old Age (DH, 2006a) was informed by older people and argued that age discrimination is now uncommon in English health services; nonetheless, '*deep-rooted negative attitudes and behaviours*' still exist towards older people. The new ambition outlined in this document was that, by 2011, older people and their families will have confidence that older people will be treated with respect for their dignity and their human rights in all care settings.

See also Chapter 18 on ageism on a personal, cultural, and structural level in relation to end-of-life care

Stereotypes and labels

There are a number of stereotypes and labels associated with old age.

- A **stereotype** relates to a standard or convention shared by members of a social group. Stereotypes might include, for example, the perception of older people being incontinent, experiencing confusion, or making no contribution to society.
- A **label** relates to a descriptive phrase or term ascribed to an individual. Labels associated with old age can be similarly derogatory and include a plethora of terms such as 'geriatric' and 'coffin dodgers'.

Values, attitudes, and beliefs

Each person is unique, with their own personal values and beliefs shaped by a number of factors that include culture, religion, and personal experiences.

- **Values** relate to our personal principles, morals, and ideals—that is, what we consider to be important.
- **Attitudes** relate to a person's views, which may be evidenced in the way they behave.
- **Beliefs** relate to those things in which an individual has faith—'religious beliefs', for example—which may not necessarily be founded on fact.

Societal norms change over time, and the healthcare practitioner needs to take account of generational influences and culture to help them in providing care that is patient-centred. In addition to establishing and respecting the values, attitudes, and beliefs of older people, the healthcare practitioner also needs to be aware of their own personal values, attitudes, and beliefs, and needs to ensure that he or she provides non-judgemental, personalized care to their patients.

Spirituality and religion

Religion and spirituality are often perceived as being one and the same thing. Gender (2002) defines 'spirituality' as focusing on answering questions related to the meaning and purpose of life, and 'religion' as relating to the personal or institutional system of organized beliefs, practices, rituals, and/or forms of worship, and states that religion is a means to achieving spirituality. In providing person-centred care, it is important to address spirituality and religious beliefs. Hindu and Muslim women, for example, may prefer to be treated or cared for by a healthcare practitioner of the same gender.

See also Chapter 18 on spirituality in relation to end-of-life care.

Sexuality

'Sexuality' can be defined as:

an individual's self-concept, shaped by their personality, and expressed as sexual feelings, attitudes, beliefs and behaviour, expressed through a heterosexual, homosexual, bisexual or transsexual orientation.

(RCN, 2000)

Sexuality can be expressed through personal thoughts, feelings, behaviours, presentation, intimacy, and roles in life.

Many older people have a number of gender-specific roles, such as wife/husband, partner, civil partner, mother/father, and grandmother/grandfather, and their roles and responsibilities relating to these roles need to be acknowledged—for example, caring responsibilities. Other issues can include the loss of a long-term partner, and the grief and loss that is associated with this. Healthcare practitioners should not take a person's social networks for granted and should ensure that stereotypes of families or social relationships reflect diversity.

Achieving culturally competent care

'Cultural competence' relates to an individual's ability to treat every person with dignity, respect, and fairness, in a way that is sensitively responsive to differences and similarities, and thereby contributes to creating a genuinely inclusive culture. In order to achieve this, nurses need to examine their own values, beliefs, and cultural identity, and understand discrimination and racism in all of its forms. They also need to be able to recognize and continuously develop the skills, roles, and functions needed to perform cultural assessments, to plan, implement, and evaluate culturally sensitive care, and to challenge discrimination and prejudice.

Additional care needs

It is imperative that healthcare practitioners treat all patients as individuals regardless of age, religion, belief, gender, or sexual orientation. A holistic patient assessment is essential to identify patient needs, which may require specific interventions in order to ensure that dignity is maintained and person-centred care is achieved. It is important, for example, to establish whether the patient experiences any sensory impairment, such as hearing or sight loss. If this is the case, the patient's care or treatment plan should reflect care-delivery interventions that are necessary to support effective communication—for example, the use of a portable hearing loop or patient information leaflets that are printed in a specific font and in a larger font size.

See also chapter 3

Health and social care policy

In *High-quality Care for All: NHS Next-stage Review Final Report* (DH, 2008a), the Department of Health sets out the vision for the National Health Service (NHS) as '*an NHS that gives patients and the public more information and choice, works in partnership and has quality of care at its heart*'. The report highlights how achieving the vision will be dependent upon addressing variations in the quality of care and empowering patients. The report sets out the development of the NHS Constitution to empower both patients and staff (ibid.).

Respect and dignity comprise one of six NHS values, which were informed by staff, patients, and the public, and are outlined within the NHS Constitution (DH, 2009). It states:

[W]e value each person as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest about our point of view and what we can and cannot do.

(DH, 2009)

Other NHS values include commitment to quality of care, compassion, improving lives, working together for patients, and the idea that everyone counts.

Dignity

'Dignity' is a difficult concept to define and has a strong association with respect. 'Privacy' has been defined as '*freedom from intrusion*' and 'dignity' as '*being worthy of respect*' (DH, 2003). A Europe-wide study of dignity and older people identified that it is often easier to describe and provide examples of *indignity*—that is, the opposite of dignity (Doe Consortium, 2005).

Within this study, four types of dignity were identified, as follows.

- Merit—This relates to dignity or social status that is ascribed to people because of their role or position in society, or because of what they have achieved. For example, a nurse, or a doctor, or a therapist has status that is recognized by other people. When older people retire, they may be excluded from wider involvement in society and may experience associated loss of their dignity.
- Moral status—This is emphasized by the person's moral autonomy or integrity. If an older person is able to live according to their own moral principles, then that person will experience a sense of dignity.
- Personal identity—This was found to be the most relevant in the context of older people: '*It relates to self-respect, and reflects an individual's identity as a person. This can be violated by physical interference as well as by emotional or psychological insults such as humiliation*'.
- Menschenwurde—This type of dignity '*refers to the inalienable value of human beings*'. It was identified as being grounded in *'what it is to be human'*. Three themes were identified within this type:
  - **(a)** a control of physical functions;
  - **(b)** that human beings are storytelling animals, a core of which is the capacity to build and shape one's identity and understanding of oneself through the development of meaningful stories about our lives; and
  - **(c)** that, as social creatures, human beings require self-respect that comes from them being recognized by others as worthy of respect.

An evaluation on the impact of the *National Service Framework for Older People* (NSFOP) (DH, 2001a) on the experiences and expectations of older people found that there were perceptions of improvements in systems, but that there were also negative personal experiences of using services and ageist attitudes that altered quality of life and standards of care (Manthorpe et al., 2007).

The report into the NSFOP highlighted where dignity is not maintained, including:

- **Being cared for in mixed sex bays and wards that accommodate both men and women**
- **Feeling neglected or ignored whilst receiving care**
- **Being made to feel worthless or a nuisance**
- **Being treated more as an object than a person**
- **Generally being rushed and not being listened to**
- **A disrespectful attitude from staff or being addressed in ways they find disrespectful, e.g. when they have not been asked about their preferences about the preferred form of address to be used**
- **Being provided with bibs intended for babies rather than a napkin whilst being helped to eat**
- **Having to eat with their fingers rather than being helped to eat with a knife and fork**

(DH, 2006a)

More recently, the *Robert Francis Inquiry Report into the Mid-Staffordshire NHS Foundation Trust* (the Francis Report) exposed serious issues relating to patient experience and dignity (DH, 2010a). Included in the report's recommendations is a review of the systems and processes, values, and behaviours that make up a system for the early detection and prevention of serious

failures in the NHS. It emphasizes that everyone has a role to play in safeguarding quality of care to patients (DH, 2010a).

Improving dignity

The Royal College of Nursing (2008) gathered the perspectives of nurses, healthcare assistants, and nursing students regarding the maintenance and promotion of dignity in everyday practice. This revealed '*a high level of dignity and sensitivity to dignity issues amongst nursing staff, combined with a strong commitment to dignified care and concern in relation to dignity violations*'.

The findings of this research mirror those of other studies in the identification of three main factors that maintain or adversely affect dignity in care:

1. **The physical environment and the culture of the organisation (Place)**
2. **The nature and conduct of care activities (Processes)**
3. **The attitudes and behaviour of staff and others (People)**

(RCN, 2008)

The government's 'Dignity in Care' campaign was launched in 2006 with the aim of eliminating tolerance of indignity in health and social care services through raising awareness and inspiring people to take action. The Campaign incorporates the 'Dignity in Care Challenge', which comprises ten dimensions for the delivery of high-quality care services that respect people's dignity:

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

(DH, 2006b)

In addition to, and in support of, the Department of Health's Dignity campaign, a number of other national campaigns and best practice guides have been launched by public-sector, professional, and voluntary organizations to raise the profile of dignity and to promote privacy, dignity, and respect in health and social care environments. These include the RCN Dignity Campaign (2008), the Social Care Institute for Excellence (2006) *Adult Services Practice Guide: Dignity in Care*, and the Age UK campaign for demanding quality care for old people (Age UK, 2010).

The Healthcare Commission focused on dignity as a key theme in its annual health check for 2006–07 and carried out a targeted inspection programme to assess the extent to which NHS trusts were meeting the government's core standards relating to dignity in care for hospital in-patients. Based on the scrutiny against standards and the issues identified by other evidence, a number of key themes emerged as the essential elements for ensuring that older people were being provided care in a way that was dignified and that matched their personal needs while in hospital. The themes identified were:

- involving older people in their care;
- delivering personal care in a way that ensures dignity for the patient;
- having a workforce that is equipped to deliver good-quality care;
- strong leadership at all levels; and
- a supportive ward environment.

See chapter 9

The Healthcare Commission (2007: 9) states that '*Dignity (including nutrition and privacy) is a human rights issue and should be the underlying principle when delivering services*'.

The dignity model detailed in Figure 2.1 below provides a framework of best practice for healthcare practitioners to help them to ensure that patient dignity is maintained in their practice setting and that the care that is delivered is person-centred.

Another initiative that set out to improve the dignity and care of older people was the Champions for Older People Programme (Hindle, 2008). This evolved out of a need to address Standard 4 'General Hospital Care' in the NSFOP and was implemented across every acute hospital in the West Midlands (DH, 2001a). The programme included provision for 'older people champions' to attend an intensive two-day workshop and then to cascade the themes from the workshops to their colleagues. In addition, they were tasked with undertaking evaluation of their care environments, promoting dignity, and implementing positive change via action plans. Box 2.1 offers some examples of champions' action plans taken from their service evaluation.

See Chapter 7 for more on medication management.

Deference →	Respect the person and their wishes.
Individual →	Treat each person as a unique human being, with unique values, beliefs, and preferences.
Gain →	Gain information through a holistic assessment to support the delivery of person-centred care.
Name →	Refer to people using their preferred form of address.
Information →	Provide information and support, and respect informed decision-making.
Treatment →	Treat the whole person, both physically and psychologically.
Yourself →	Treat others as you would like your family members to be treated.

Figure 2.1 The dignity model.

Box 2.1 Examples of champions' action plans taken from their service evaluation

- **Communication**—Poor documentation and poor communication with patients regarding care plan.

  Action plan: Undertake a monthly audit looking at documentation, progress to documenting in one set of notes, and raise awareness of hearing problems.

- Pain management—There is currently no assessment of pain relief or management or use of tools.

  Action plan: To introduce education for staff on pain management, make more referrals to the pain nurse, and have monthly monitoring of the use of pain assessment tools.

- Values and attitudes—Nurses not always using preferred name to address patients.

  Action plan: To improve communication with patients, to act as a role model, and to be advocates. Senior nurses to educate junior staff at handover—for example, patient aged 90 with heart failure will feel exhausted.

- Medicines—Elderly patients are not always able to take on new information regarding their medication.

  Action plan: Dosette boxes have been used increasingly in the community to aid medication concordance by prompting patients to remember to take medication each day. In view of this increased usage, it was decided that Dosette boxes should be provided on the ward before discharge in order to assess a patient's ability to use them, provide an opportunity to develop the habit of using the Dosette system, and thereby promote the patient's independence.

- Mental health support—Poor emotional and psychological support from medical and nursing staff, because focus is very much on the physical illness. Lack of awareness of depression in older people.

  Action plan: Use the education/teaching board to cascade information and establish psychiatric link nurse on the ward. Include depression scoring for each patient, implement psychological/mental healthcare plan and re-evaluation, and involve patient and family in this.

- Incontinence/toileting—Continence not being maintained.

  Action plan:

  - Implement 'behind closed doors' audit.
  - Ensure continence assessment tool is available in all wards.
  - Education for staff regarding continence—identification, and how to assess and manage via specialist nurse.
  - Launch staff awareness to increase patient choice.
  - Improved signage.
  - After toileting, staff to ensure environment is clean.

(Hindle, 2008).

Adult protection and elder abuse

With dignity comes respect, compassion, and esteem—but the loss of dignity is one of many factors that can lead to the

development of abuse and abusive practice. Nurses have an important role in safeguarding vulnerable adults, as well as in the prevention and detection of abuse.

Widely accepted definitions of both 'vulnerable adults' and 'abuse' were included in *No Secrets: Guidance on Developing and Implementing Multi-agency Policies and Procedures to Protect Vulnerable Adults from Abuse* (DH, 2000).

A 'vulnerable adult' was said to be:

A person who is aged 18 or over who is or may be in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to take care of him or herself against significant harm or exploitation.

(DH, 2000)

'Abuse' was defined as '*a violation of an individual's human and civil rights by any other person or persons*'.

The UK charity Action on Elder Abuse (AEA) sees elder abuse as having at its heart the violation and/or exploitation of the expectation of trust in a relationship. It defines 'elder abuse' as:

A single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person.

(AEA, 2010)

Abuse can take many forms and occur anywhere, including:

- in someone's own home;
- in a carer's home;
- in a day centre or social care setting;
- in a care home; and
- in different types of NHS/health settings, such as within a hospital, a community or intermediate care setting, or a mental health unit.

Both older men and women are at risk of being abused. The abuser is usually well known to the person being abused—for example, a partner, child, or relative, a friend or neighbour, a care worker, a volunteer, or a healthcare professional.

In a study reviewing the prevalence of abuse, it was found that:

Overall, 2.6% of people aged 66 and over living in private households reported that they had experienced mistreatment involving a family member, close friend or care worker (i.e. those in a traditional expectation of trust relationship) during the past year.

(O'Keeffe et al., 2007: 4)

Fifty-one per cent involved a spouse or partner; 49 per cent involved another family member; 13 per cent involved a care worker; and 5 per cent, a friend.

Older people may also be abused by the person for whom they care (Homer and Gilleard, 1990). Some forms of abuse can have a significant negative impact on an older person's mental health and well-being.

The main forms of abuse are described as being physical, psychological or emotional, financial or material, sexual, or neglect, each of which is briefly explored below.

Physical abuse

Physical abuse may be a crime, but is not always prosecuted because of a lack of evidence or the unwillingness of a person to take action. Very often, when people are asked to describe elder abuse, they will talk about physical injuries. However, it can also include the prescription or administering of medication that is not licensed for the purpose used, which can have a traumatic effect.

The possible signs of physical abuse include:

- any injury, such as bruising, cuts, burns, fractures, or unexplained marks, which may be new or untreated, and with which the person's explanation may not equate;
- signs of being restrained; and
- the inappropriate use of medication either by overdosing or underdosing.

Psychological or emotional abuse

Psychological or emotional abuse can include threatening or denying access to older people and may also relate to the older person having to comply with threats or demands, or being isolated from others. Not surprisingly, older people subjected to such abuse may feel trapped, threatened, and humiliated.

The possible signs of psychological abuse can include:

- depression;
- denial of a situation;
- withdrawal or a unwillingness to communicate;
- loss of sleep or appetite;
- implausible stories;
- disorientation or confusion;
- sudden changes in behaviour or unusual behavior; and
- unexplained fear and anxiety.

If the signs indicated above are detected, then this does not mean that abuse is taking place—but it should raise the index of suspicion and lead to further assessment or enquiry by the professional.

Financial or material abuse

As with physical abuse, financial or material abuse may be a crime, but it is not always prosecuted. There are a number of

reasons for this, which may include a reluctance on the part of a competent individual to report to matter to or pursue it further with criminal justice agencies. Examples of financial or material abuse can include exploitation and the theft of cash by family members, fraud and deception, and possible misuse of lasting powers of attorney (LPAs).

See Chapter 4 for more on LPAs and the law.

The possible signs of financial or material abuse include:

- a loss of money and unexplained withdrawals of large sums of money;
- uncertain signatures on cheques or documents;
- additional names on bank accounts;
- the misappropriation of property and possessions;
- the sudden appearance of previously uninvolved relatives in the older person's financial affairs;
- unpaid bills, disconnections, or eviction notices; and
- a lack of basic amenities.

Sexual abuse

Sexual abuse of older people can be opportunistic or planned, or may also be found in situations of domestic violence, which continues into old age. Where sexual abuse is suspected, it is vital that forensic evidence is not lost, thus it may be appropriate to avoid washing the older person or their clothing. Contacting the police at the first opportunity is advised.

The possible signs of sexual abuse include:

- bruising, particularly around the breasts or genital area;
- unexplained vaginal or anal bleeding;
- venereal disease or infections; and
- difficulty in walking or standing.

Neglect

Neglect can include intentional neglect by an individual or the practices of an institution, or passive neglect—for example, where a carer is unable to manage the situation or is not getting adequate help.

The possible signs of neglect include:

- people left in poor hygiene and a lack of personal care—for example, dirt, faeces, or urine left on the person;
- rashes, pressure ulcers, and/or lice;
- over-sedation or withholding medication;
- untreated medical problems, including depression and confusion; and
- malnutrition or dehydration.

Legislation

Several pieces of law assist in the recognition and prevention of abuse of vulnerable adults in the UK. These are accompanied by a range of policies across the UK.

For more on these policies, see the Online Resource Centre that accompanies this book

In England, the following key policies apply.

No Secrets

No Secrets provided a framework with which local agencies could develop strategies to tackle abuse, with the local authority being the lead agency (DH, 2000). In 2008–09, there was a review of the policy guidance, which included a consultation at national level about what changes might be necessary to the policy guidance in order to enable society to empower vulnerable adults to keep safe from abuse or harm. This included consideration of whether new legislation was necessary.

The government response to the review, issued in January 2010, was to indicate that it would, within time:

- **Establish an Inter-Departmental Ministerial Group on Safeguarding Vulnerable Adults**
- **Plan legislation to strengthen the local governance of safeguarding by putting Safeguarding Adults Boards on a statutory footing**
- **Launch a programme of work with representative agencies and stakeholders to support effective policy and practice in safeguarding vulnerable adults.**

(DH, 2010b)

The Vetting and Barring Scheme

The Protection of Vulnerable Adults (POVA) List was replaced in 2009 by a Vetting and Barring Scheme under the Protection of Vulnerable Groups Act 2006, which aims to safeguard the most vulnerable members of society, including vulnerable older people. The Independent Safeguarding Authority (ISA) makes all decisions on who should be barred from working with vulnerable people. Employers need to check in advance whether employees or volunteers are barred from working with vulnerable groups, in addition to undertaking the Criminal Records Bureau (CRB) checks that are routinely made in health and social care employment practices. Individuals will also have to register with the ISA when taking up employment in these areas of work (in which there is regular contact with vulnerable individuals). See http://www.isa-gov.org.uk/ for more information.

The Mental Capacity Act 2005

The Mental Capacity Act 2005 applies in England and Wales. This Act enables those people who lack 'capacity' to be at the centre of the decision-making process, safeguarding them and the professionals who work with them. Under this Act, new offences of mistreatment and wilful neglect of people lacking decision making capacity (for example, people with severe dementia) were introduced. New statutory forms of advocacy were also introduced.

See Chapter 4 for more on the law relating to mental capacity.

The Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) were introduced into the Mental Capacity Act 2005 through the Mental Health Act 2007 to provide a legal framework in relation to deprivation of liberty. The DoLS resulted from the *Bournewood Case*, in which an individual with learning disabilities was taken to a mental hospital because of the way in which he was behaving; despite his carers wishing him to be returned home, he was kept in hospital. The case was brought before the courts.

See the Online Resource Centre that accompanies this book for more on the Bournewood Case.

Safeguards are provided for vulnerable people who lack capacity to make decisions relating to their care or treatment in hospital and care homes, or care homes with nursing. The aim of the safeguards is to protect the interests of the most vulnerable service users and to:

- **ensure people will be given the care they require, but in the least restrictive regimes**
- **prevent arbitrary decisions that may deprive vulnerable people of their liberty**
- **provide additional safeguards for vulnerable people**
- **provide individuals subject to the safeguards with rights to challenge unlawful detention**
- **avoid any unnecessary bureaucracy**

(DH, 2008a).

NURSING PRACTICE INSIGHT: RAISING CONCERNS OF SUSPECTED ABUSE

The nurse has a responsibility to raise concerns about suspected abuse or neglect, and to ensure the safety and protection of vulnerable adults.

He or she must:

- be aware and familiar with local adult-safeguarding policies and procedures;
- know who the lead person is within their organization for adult safeguarding;
- discuss any issues of potential abuse and/or neglect with a line manager in the first instance, and liaise with the lead for adult safeguarding;
- maintain clinical and professional competence, providing high standards of care;
- always take time to listen to the older person or the carer of the older person;
- maintain accurate written records; and
- practice zero tolerance of any abuse and be prepared to 'blow the whistle' around managers, colleagues, and wider teams.

Person-centred care

The terms 'patient-centred care', 'personalized care', and 'individualized care' consistently feature within government documents for health and social care services. Within the *Essence of Care*, the term 'person-centred' is used to signify '*activities that are based on what is important to a person from their own perspective*' (DH, 2001b).

'Person-centred care' has been defined as treating people as individuals and enabling them to make choices about their care (DH, 2001b). Figure 2.2 illustrates a number of concepts that support the achievement of care that is person-centred.

- **Communication** relates to a two-way process that involves exchanging information; it is important for the sender of the information to establish that the receiver understands the message and that it is communicated in a way that meets any individual communication needs that the receiver may have.
- An **advocate** is a person who intercedes on behalf of another person in a bid to ensure that their best interests are communicated and met.
- **Involvement** is the inclusion or engagement of the patient and, within the context of health care, can relate to communicating with patients regarding their planned care or treatment.
- **Participation** takes involvement a step further, and relates to taking a more active role and sharing. In the context of health care, this can relate to the healthcare practitioner actively engaging the person in the development of their care or therapy plan.
- **Trust** relates to having confidence in another person—that is, to having faith that they are reliable and honest.
- A **partnership** involves working together for a shared purpose and, within the healthcare practitioner–patient relationship, can relate to, for example, jointly developing a plan of care and agreeing how both parties will work

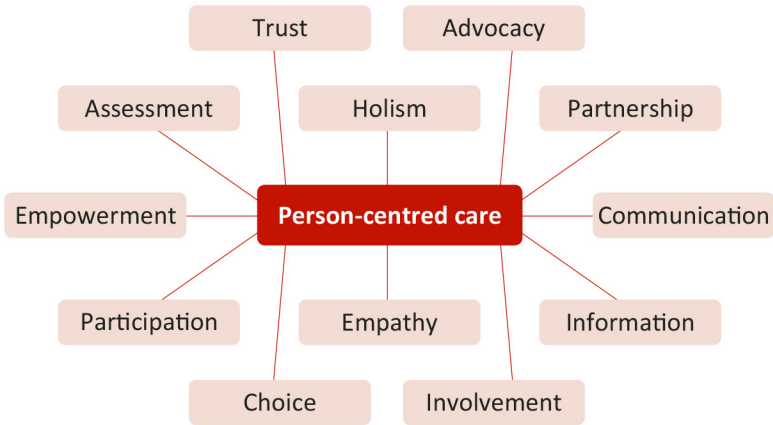

Figure 2.2 Concepts central to person-centred care

together collectively to achieve the outcomes to which they agree.

- To **empower** is to give or delegate power or authority to and, in the context of health care, entails letting the person take responsibility for their consequences.
- **Empathy** involves the healthcare practitioner considering the situation of the person and imaginatively entering into their feelings.
- **Choice** involves providing the person with alternatives from which to choose and goes one step further in respecting the decision that is made, as far as possible.
- **Holism** refers to the practice of considering the person as a whole, addressing their physical and psychological needs collectively, rather than seeing them as two separate entities.
- **Assessment** needs to be undertaken at a level commensurate with patient need and must address patient values, needs, and preferences, as a foundation for the achievement of care that is person-centred.

At the beginning of the patient journey, it is important for the nurse to undertake a holistic assessment to identify the person's needs and personal preferences. These can then be addressed in the care plan, ongoing evaluation of care, and patient outcomes.

See Chapter 8 for more on personalized care planning in primary care.

Case study

Mr Oliver is a 70-year-old man admitted to hospital with a chest infection. He worked as a farmer for over forty years and gets up at 5 a.m. every morning. The ward routine is that lights are not switched on until 7 a.m. in the morning. Mr Oliver wakes up at 5 a.m. the following morning, rings his call bell, and requests a cup of tea. The health care support worker (HCSW) who answers his call bell informs him that it is too early and tells him to go back to sleep.

In this example, the general routine of the clinical area was prioritized and the patient was expected to fit in. In institutions, it is necessary to have routine and also to address the needs of other patients; it is also important to recognize individuality and to address specific needs. Perhaps, in this situation, the patient could have been provided with the drink that he requested and could have been nursed in an area of the ward in which his preference to get up at 5 a.m. would have minimal or no impact on his fellow patients? A holistic assessment of the activities of daily living and personal preferences could have identified Mr Oliver's lifestyle and proactive steps could have been taken to address his need.

The Essence of Care (EoC)

The *Essence of Care* (EoC) benchmark was developed to support the fundamentals of care and to ensure quality of service provision within health care (DH, 2003). The benchmarking process contained within the EoC allows practitioners to take a structured approach to sharing and comparing practice, enabling them to identify best practice and to develop action plans to improve practice where appropriate. Privacy and dignity comprises one of ten EoC benchmarks. Dignity is defined within the benchmark as *'being worthy of respect'*, respect as *'freedom from intrusion'*, and modesty as *'not being embarrassed'*.

Table 2.1 details the benchmarks of best practice for each of the seven areas contained within this benchmark.

Caring

'Caring' is a concept that is central to nursing; encompassing care, compassion, and comfort. *Confidence in Caring* focuses on the relationship between nursing and caring, and

Table 2.1 Essence of Care benchmarks for privacy and dignity

Agreed patient-focused outcome Patients benefit from care that is focused upon respect for the individual	
Factor	**Benchmark of best practice**
1. Attitudes and behaviours	Patients feel that they matter all of the time
2. Personal world and personal identity	Patients experience care in an environment that actively encompasses individual values, beliefs, and personal relationships
3. Personal boundaries and space	Patients' personal space is actively promoted by all staff
4. Communicating with staff and patients	Communication between staff and patients takes place in a manner that respects their individuality
5. Privacy of patient—confidentiality of patient information	Patient information is shared to enable care, with their consent
6. Privacy, dignity, and modesty	Patients' care actively promotes their privacy and dignity, and protects their modesty
7. Availability of an area for complete privacy	Patients and or carers can access an area that safely provides privacy

Source: DH (2003).

provides best practice guidelines and a framework within which to improve patient confidence in nursing care (DH, 2008b). The framework includes five core issues that are important to patients:

- a calm, clean, safe environment;
- a positive, friendly culture;
- good teamwork and working relationships;
- well-managed care with efficient delivery; and
- personalized care for every patient.

It also includes 'means', 'ways', 'skills and will', and 'overall outcome and performance measures', together with simple rules for staff such as '*anticipate and act without being asked*' and '*do what you say you will do—keep promises*'. The framework also highlights the importance of involvement at all levels of the care system, from organizational to individual level.

Supporting dignity in care

There are a number of ways in which healthcare practitioners can promote and achieve dignified care.

Leadership

Staff can demonstrate leadership regardless of their seniority and role in the organization, and healthcare practitioners can act as champions for older people either informally or in a more formally nominated role. Being a 'champion' relates to supporting and defending a cause; in the context of this chapter it relates to ensuring the delivery of privacy, dignity, and person-centred care. The champion role entails acting as a role model, respecting older people as individuals, and ensuring that they receive high standards of care. It also includes challenging negative perceptions and poor practice.

The care environment

The environment in which care is delivered has a significant impact on achieving dignity, and there are factors at both the organizational level and the individual service/practitioner level that can be implemented to ensure the achievement of dignified care. The provision of single-sex accommodation was identified earlier in the chapter as a priority for older people—but single-sex accommodation is often more difficult to achieve in more specialist areas, such as intensive care. Within such areas, dignity needs to be a key priority and staff should implement best practice guidelines, such as those produced by the NHS Institute for Innovation and Improvement (2008).

Other environmental aspects that support dignified care include:

- a well-maintained and well-decorated clinical area;
- dignity curtains—that is, curtains with a printed dignity message or sign attached to them;
- a private room in which to discuss personal, sensitive, or confidential information; and
- segregated washroom and toilet facilities for male and female patients they are fitted with patient safety locks.

Care delivery

A key aspect of the dignity equation relates to the care delivery process in which individual healthcare teams and practitioners can directly influence the standard of dignified care that is achieved on a day-to-day basis.

Interventions can include:

- completing person-centred assessments;
- involving patients in all aspects of their care and treatment;
- respecting closed curtains/doors and seeking permission prior to entry;

- taking steps to ensure safe staffing levels;
- explaining procedures prior to undertaking them; and
- covering patients during personal care activities and ensuring appropriate dress.

Case study

Following an assessment by her community matron, Mrs Jones was admitted to her local community hospital with a chest infection. Mrs Jones became increasingly confused and was diagnosed as suffering from delirium. She had a high temperature and became restless, throwing off the bedclothes and uncovering herself. Lightweight female pyjamas were provided for Mrs Jones to ensure that her dignity was maintained.

In a situation such as this, it can be difficult to ensure that the patient's dignity is maintained at all times. The provision of female pyjamas is a simple and effective way in which to reduce the risk of a patient exposing themselves when they are in a confused state.

The healthcare team

Each and every member of the healthcare team has a responsibility to main privacy and dignity, and, in addition to their own practice, they must act as the patient's advocate and remind or challenge colleagues should they fail to practise the same standards.

Case study

Staff Nurse Lloyd was inserting a urinary catheter on Mrs Ellis, a 75-year-old lady who had developed retention of urine. Just as Nurse Lloyd was about to insert the catheter, a doctor popped her head around the curtains. 'Oh, sorry', said the doctor and proceeded to ask Nurse Lloyd a question, to which she responded.

In this situation, the doctor failed to respect the privacy of the patient and made no attempt to gain permission to enter the bed space. Equally, the nurse failed to challenge the doctor and act as the patient's advocate by letting the doctor know that this practice is unacceptable.

Monitoring and evaluating the achievement of dignity in care

It is important to measure patient outcomes in order to monitor the standard of care delivery achieved, to address any shortfalls that may be identified, and to look at how the outcomes achieved can be further improved. The healthcare practitioner can draw upon a number of strategies, both informal and more formalized, to establish the standards that are being achieved within their practice setting. Strategies can include: professional judgement; evaluating care plans with the patient; completing EoC benchmarks; accessing and reading patient complaints; undertaking patient experience surveys; accessing patient evaluations that are posted on the intranet, such as on the NHS Choices website; and accessing the results of national patient satisfaction surveys—for example, those published by the Care Quality Commission (CQC).

The CQC coordinates the completion of a number of national surveys to reveal patients' evaluations of their recent experiences of health care. Surveys coordinated include, amongst others, in-patient, outpatient, accident and emergency, and maternity. Some surveys, such as the adult in-patient survey, are completed on an annual basis and others less frequently. These surveys enable NHS care providers to benchmark their services against the standard that is achieved nationally.

The *Adult In-patient Survey 2008* included more than 72,000 respondents from 165 acute and specialist NHS trusts in England (CQC, 2009). Table 2.2 provides the results for some of the areas contained within the survey that relate to dignity. The survey results reveal that 79 per cent of patients reported that they were always treated with dignity and respect during their in-patient stay. Conversely, 3 per cent of patients reported that they were not treated with dignity and respect, with a further 18 per cent reporting that they were sometimes treated with dignity and respect. These results reveal that further work is needed to realize the government's target that patients will be treated with dignity and respect in all care settings, all of the time.

In addition to the national report, reports for individual acute and specialist trusts are also published on the Internet that allow the benchmarking of results against those achieved by the 20 per cent that are the best-performing trusts, 60 per cent that are average-performing trusts, and 20 per cent that are the worst-performing trusts.

NURSING PRACTICE INSIGHT: TREATING PEOPLE AS INDIVIDUALS

Always treat each and every person as an individual by:

- completing an assessment to establish their values and beliefs, and to identify their personal preferences;
- establishing and respecting their preferred form of address;
- involving them in all decisions about their care;
- providing them with choices, and respecting their preferences and decisions;
- using a biographical approach for patients who experience memory loss;
- promoting independence in everyday activities;
- promoting independent living within the community;

Table 2.2 Adult In-patient Survey Results 2008

Question	Yes, definitely	Yes, to some extent	No	Yes
When you were first admitted to a bed on a ward, did you mind sharing a sleeping area, for example a room or bay, with patients of the opposite sex?			68%	32%
Were you given enough privacy when being examined or treated?	88%	10%	2%	
Were you given enough privacy when discussing your condition or treatment?	70%	22%	8%	
Were you involved as much as you wanted to be in decisions about your care and treatment?	52%	37%	10%	
Overall, did you feel that you were treated with respect and dignity while you were in the hospital?	79%	18%	3%	

Source: CQC (2009).

- **acting as a role model and advocate, and challenging any instances in which the achievement of person-centred care is compromised; and**
- **having a listening ear, a kind word, and a smile.**

Conclusion

Older people need to be cared for holistically and to achieve this their psychological, social, and physical needs must be addressed. Completing a person-centred assessment enables the healthcare practitioner to identify the person's individual needs and preferences in order to inform their plan of care. The practitioner also needs to recognize and respect diversity, and to deliver care that is culturally sensitive to individual needs. The patient needs to be central to the care delivery process, and the healthcare practitioner must actively seek to engage and involve them in decision making at all stages of their patient journey. Lastly, dignity needs to be a core value and embedded in practice.

Questions and self-assessment

Now that you have read the chapter, answer the following questions.

- What is meant by 'ageism' and how does this impact on care delivery?
- Reflect on a recent clinical experience when working with an older adult. How did you and others involved in care-giving convey dignity and respect to that person?
- Review the EoC benchmarks for privacy and dignity, and consider the degree to which this identified best practice is prevalent within a recent practice setting.
- Talk to one or more of your patients to establish their evaluations and perceptions of the degree to which their privacy and dignity have been maintained.
- Who is the adult-safeguarding lead in your organization and how can you contact them?
- Access a patient survey on the CQC website http://www.cqc.org.uk/—ideally one that relates to your employing organization or, alternatively, to a local healthcare institution.

Self-assessment

- Having read the chapter, how will you change your practice?
- Consider the role of the 'champion', as discussed within the chapter. Reflect upon your own practice, and assess the extent to which you act as a role model in caring for and supporting older people.
- Identify up to three areas relating to dignity in care in which you need to develop your knowledge and understanding further.
- Identify how you are going to develop this knowledge and understanding, and set deadlines for achieving these.

Further suggested tasks to complete

- **Privacy and dignity within my practice setting**
  - Reflect on the standards of privacy and dignity that are achieved within your practice setting.
  - Consider how far the patient perceptions and national survey findings relate to your personal reflections regarding the standards achieved.
  - Consider what you and your colleagues could do to address any areas that require development or could be further improved upon.
  - Discuss your reflections and suggestions with your colleagues and manager, as appropriate.
  - Invite the safeguarding lead to a team or unit meeting to provide updates on new policies and procedures.
- **Being a champion for older people**

  A healthcare practitioner can be a formal or informal champion, and support and defend the provision of privacy, dignity, and person-centred care for older people.
  - Think about the opportunities that are available to you to provide best practice and to encourage your colleagues to do the same.
  - You may wish to join the Department of Health's Dignity in Care Champions Network, information about which is available online at http://www.dh.gov.uk/en/SocialCare/Socialcarereform/Dignityincare/DH_065407

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Statutes

Mental Capacity Act 2005

For further reading and information

Independent Safeguarding Authority: http://www.isa-gov.org.uk/.

NHS Choices: http://www.nhs.uk/Pages/homepage.aspx

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Royal College of Nursing 'Dignity' page: http://www.rcn.org.uk/dignity.

Online Resource Centre

You can learn more about dignity, values attitudes, and person-centered care for older people at the Online Resource Centre that accompanies this book: and care http://**www.oxfordtextbooks.co.uk/orc/hindle/**