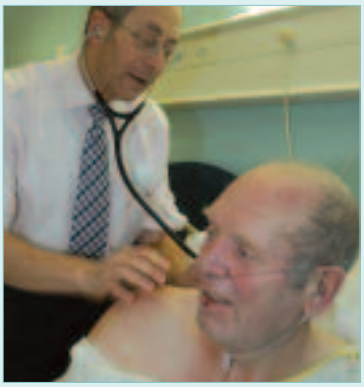
Inspecting Informing Improving

Healthcare Commission

Caring for dignity

A national report on dignity in care for older people while in hospital



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The cover includes a photograph from Kings College Hospital

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The Healthcare Commission

The Healthcare Commission exists to promote improvements in the quality of healthcare and public health in England and Wales.

In England, the Healthcare Commission is responsible for assessing and reporting on the performance of NHS and independent healthcare organisations, to ensure that they are providing a high standard of care. The Healthcare Commission also encourages providers to continually improve their services and the way they work.

In Wales, the Healthcare Commission's role is more limited and relates mainly to working on national reviews that cover both England and Wales, as well as our annual report on the state of healthcare. In this role we work closely with the Healthcare Inspectorate Wales, which is responsible for the NHS and independent healthcare in Wales.

The Healthcare Commission aims to:

- safeguard patients and promote continuous improvement in healthcare services for patients, carers and the public
- promote the rights of everyone to have access to healthcare services and the opportunity to improve their health
- be independent, fair and open in our decision-making, and consultative about our processes

Executive summary

Britain has an ageing society. The number of older people in the population is increasing rapidly. Many older people are living a healthy and active life, but despite this, a substantial proportion of older people need care in a hospital. This need increases with age and their stay in hospital may become more frequent or longer.

Older people account for the highest use of acute hospital services and the NHS spends 45% of its expenditure on them. Maintaining a patient's dignity and treating them with respect is of paramount importance to older people[1, 2], but anecdotal evidence indicates that older people are often not treated in this way while receiving care in hospitals. It is also evident that older people are more likely to give positive feedback on their care due to inherent gratitude or anxieties about their care being affected[3].

Initiatives from the Department of Health including the *National Service Framework for Older People*[4], the follow-up *Next steps* document[5] and the Dignity in Care Campaign incorporating the Dignity Challenge[6], all aim to promote the necessary changes in culture that are needed to ensure that older people and their carers are treated with respect, dignity and fairness. The Department's *Essence of Care: Patient-focused benchmarks for clinical governance*[7] also offers a framework for healthcare professionals to use in measuring their practice relating to privacy and dignity.

Recently the Race Relations Amendment Act[8] and the Human Rights Act[9] have been the focal point of discussions on legal issues around dignity, such as the duty of all organisations to promote and protect fair treatment for all citizens, irrespective of their background or situation. Similar concerns have been highlighted in the Healthcare Commission's ongoing work on race equality, as well as our response to the Joint Health Select Committee on Human Rights for older people in a care setting.

In March 2006, the Healthcare Commission published *Living well in later life*[1], which reported on a joint review of older people's services carried out by the Healthcare Commission, the Commission for Social Care Inspection and the Audit Commission. This report highlighted dignity and respect for older people as a major area of concern in improving services.

Despite this, findings from the NHS Inpatient Survey indicate that a high proportion of older inpatients are being treated with dignity and respect while in hospital, and many NHS trusts have declared compliance with standards relating to dignity in the Healthcare Commission's annual health check.

As a result of this, the Healthcare Commission decided to focus on 'dignity' as a key theme in the annual health check for 2006/2007 and to undertake a targeted inspection programme to assess the extent to which NHS trusts are meeting the standards relating to dignity in care for hospital inpatients. The aims of this work were to promote improvement in care – firstly through an in-depth look at those trusts that appeared to be performing less well, and secondly to identify and share examples of good practice.

This report highlights the key findings of the programme of assessment and inspection and sets out recommendations for action to improve the care and overall experience of older people in hospitals.

The review

The Healthcare Commission assesses NHS organisations to determine the extent to which they are meeting national standards for service provision. The annual health check requires trusts to declare each year whether they are compliant with the core standards published by the Department of Health in July 2004[10].

A number of standards are used to assess whether NHS trusts are treating people with dignity and respect and to ensure that nutritional needs and the need for privacy are being met (see Box 3 on page 17). The Healthcare Commission checks trusts' declarations against a wide range of information including comments from representatives of patients and other partners in the community. Where this information gives cause for concern, we can follow this up with particular trusts.

The information we considered in our assessments highlighted a number of trusts that were at risk of non-compliance with the standards relevant to dignity and respect for older people in their declarations for the 2006/2007 annual health check. We found 35 trusts to be at highest risk and, of these, 12 were already being pursued on dignity as part of other routine follow-up activity. As a result, 23 trusts were identified as requiring more detailed scrutiny. Although our approach was based on a limited sample of trusts, we were encouraged to find that these provided us with a framework with which to undertake a detailed assessment on dignity. The remaining trusts will be targeted in a routine manner as part of our follow-up of core standards.

We advised these trusts up to 14 days in advance that they would receive a visit, but the specific wards to be visited were unannounced until the day of the visit. The inspections included interviews with staff at various levels and observation of two wards – one for the elderly and one with a mixture of elderly and non-elderly people in each site visited. At least one ward was visited during mealtimes. Key aspects observed were:

- the ward environment, including privacy issues
- mealtime activity
- the behaviour of staff

During the visits, we focused on establishing whether certain systems were in place, including:

- policies to ensure that dignity is maintained (for example, dignity in care, race equality, training, whistle-blowing)
- practices that translate these policies into working guidelines (for example, protected mealtimes, provision of adequate staffing, provision of adaptable cutlery)
- the readiness of staff to deliver care that respects patients' dignity (for example, skills, awareness and training in issues relating to dignity for older people)
- assurance for the trust that policies on dignity in care are working (for example, monitoring, observation of care, reflection on practice, reports to the board, feedback from patients)

Following the visits, we assessed the trusts on a five-point scale and we issued notification letters to those trusts that were found to be at risk of non-compliance with one or more standards. These trusts were expected to reflect this in their declarations for the 2006/2007 annual health check.

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 respected their dignity 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
- supportive ward environment

Key findings

Overall, we were encouraged by evidence that acute trusts are making efforts to respond to concerns about delivering care that respects dignity. An increasing focus on the quality of non-clinical care for patients is essential and our findings indicate that dignity, nutrition, and privacy are moving up the agenda and achieving higher levels of priority. The practices we saw in many trusts demonstrate that, despite shortages of staff, it is possible to achieve the levels of service that patients and their families rightly expect. We found that the profile of dignity had been raised as a result of the Dignity in Care campaign and the Dignity Challenge, led by the Department of Health, and the focus on dignity in our regulatory work using core standards, which has led many trusts to start to examine their policies and practices around dignity irrespective of whether they were being visited or not.

However, although we found no major breaches of national standards, there is still a considerable need for improvement in many areas and we have made the necessary recommendations. There is no room for complacency and NHS acute trusts need to take actions to embed an approach to care that focuses on patients and ensure that their policies and procedures on dignity become an integral part of their care process across all clinical directorates.

Meeting core standards

Based on the screening of trusts against our surveillance data, 23 trusts were followed up for further scrutiny and assessment on core standards C13a, C15b and C20b (see Box 3 on page 17). Of these, eight trusts were found to be at risk of non-compliance with one or more of the relevant core standards. Two trusts were found to be at some risk of non-compliance on the core standard that relates to staff treating patients with dignity (core standard C13a), which was due mainly to insufficient assurance that there were clear policies or communication channels on dignity and privacy.

Of the 23 trusts, more trusts (seven) were at risk of non-compliance on the core standard relating to privacy (core standard C20b) than the other core standards looked at. This was due mainly to trusts not being able to provide single sex accommodation, including single sex wash and toilet facilities, at all times. Many trusts were finding it difficult to ensure single sex accommodation for older patients.

These trusts need to ensure that they undertake major urgent steps to rectify the situation in order to avoid a significant lapse in meeting standards on dignity in the future.

Looking at the core standard relating to nutrition (core standard C15b), trusts were already making improvements in providing meals and assistance with eating and drinking for older patients while they were in hospital (such as using volunteers, red trays, and raising awareness for staff on nutrition for older people). Although our observations on the day of our visit did not identify any lapses in this area, nearly half of the trusts visited (11) needed to improve services regarding nutrition arrangements. These related to:

- patchy implementation of policies and practices regarding nutrition, such as protected mealtimes
- lack of formal arrangements to identify and provide assistance with eating and drinking for those who needed it
- lack of adequate formal systems of monitoring

All these areas, if not improved, could potentially lead to a lack of provision of appropriate nutrition for older people. These trusts will be visited again in six months to review the progress they have made.

In 15 trusts out of the 23 visited, we identified several areas for improvement on one or more standards. These areas related mainly to improving the implementation of policies and practices, as well as the need for more robust arrangements for monitoring to seek assurance that policies were making an impact on the quality of care for older people. Some trusts needed to improve their arrangements for developing their workforce in terms of providing training and raising the awareness that is needed to provide dignified care for older people.

Following our assessments, four of the nine trusts that were given notification letters have declared non-compliance. Of the four that declared compliance, two are being followed up with an inspection that includes a standard on dignity.

Involving older people

Older people do not always feel adequately involved in their care. They attribute lack of involvement to ageist attitudes, the behaviour of staff and a lack of information, which often leads to a care package that is totally unsuitable for their needs. Treating older people as individuals and involving them in their care are important aspects of maintaining dignity. This includes asking them how they would like to be addressed, what their needs and preferences are and involving them in the planning and delivery of their care. Older people from vulnerable groups – such as patients from minority ethnic groups, people with a disability, those at the end of their lives and those with dementia and confusion – experience a greater lack of involvement.

We found that:

- although all inspected trusts had some mechanisms in place for involving older people, this was not always happening in practice. There were gaps in communication with patients and carers, and relatives were not always being involved in the process
- systems for involving older people from minority ethnic groups were not robust and there was a greater reliance on family members to provide translation. This may put an enormous burden on the family and may prove difficult for those who do not have any living relatives to provide this service. Some older people from minority ethnic

groups were not able to receive food that met their needs because of a lack of sufficient information on what services they could expect

- most inspected trusts were finding it difficult to engage with patients with dementia, as the staff did not have adequate knowledge of their condition. Lack of involvement from carers and family members exacerbated the situation for this group of patients
- there were a few good examples of using volunteers and advocates for improving patient involvement but these were not a universal phenomenon

Delivering personal care that maintains dignity

Providing a service that meets the personal needs of older people in a manner that respects their dignity includes identifying individual needs relating to nutrition, dementia and toileting, and special needs at the end of patients' lives. The wishes of older people are often disregarded in the delivery of care, despite having expressed their wishes at the time of admission. This leads to an unresponsive care package. Care planning is therefore the first step to ensuring that care is centred around the individual.

Nutrition is an important aspect of personal care and older people consider that having a choice of nutritious food – and being able to eat it – is a dignity issue. Some older patients need help with eating and drinking: by having periods reserved specifically for mealtimes and 24-hour access to meals, trusts can help to support the meal-related needs of older people.

We found that:

- while all trusts undertook care planning, monitoring of care plans was not happening everywhere, which could lead to gaps in services and a compromise in dignity
- delays in accessing specialist help because of shortages of staff often led to delays in assessing patients, which could lead to inappropriate care being given. Staff found it challenging to care for patients with dementia and confusion because of a lack of clear care pathways and inadequate training and awareness of the condition
- the implementation of specific pathways for end-of-life care was varied across trusts and less developed for non-cancer conditions. Staff found it challenging to ensure one-to-one support or to have private space for older patients in this group due to a lack of adequate staff and facilities
- there were inadequate arrangements to allow patients to have an uninterrupted mealtime environment. Initiatives such as the protected mealtimes policy were not being implemented uniformly and lacked commitment at board level in some trusts. Where it had been implemented, not all groups of staff were adhering to the policy
- staff felt unable to provide adequate assistance to patients who needed help with food and drink if there was a shortage of staff or if there was a higher number of patients with dementia. Some trusts used volunteers to assist with mealtimes but this was not happening in all trusts
- culturally-sensitive meals were not always available out-of-hours; 24-hour meal systems consisted of snack boxes, which may not always be suitable for people with specific dietary needs

- while many trusts had clearly-defined governance systems, many lacked robust systems of monitoring, which could lead to gaps in care and potential lapses in dignity

Workforce
Older people consider healthcare staff to be instrumental in maintaining their dignity while receiving care in hospital. To enable this, staff need to be aware of, and trained in, dignity issues, and supported in undertaking their duties.

We found that:

- translating policies into practice was vital for providing day-to-day care that respected patients' dignity and many staff expressed the need for training in the practical aspects of this. However, staff did not always attend training programmes on diversity and practical aspects of dignity, as attendance was not always mandatory. This needs to be monitored more robustly
- staff found maintaining dignity for patients with dementia or those at the end of their lives challenging due to lack of awareness of the condition
- staff were not always supported in practices such as protected mealtimes and having adequate numbers of staff. While arrangements were more robust in wards for the elderly, the same arrangements did not always exist in wards for non-elderly patients. This may have an impact on the dignity of patients
- while there were opportunities for staff to reflect on their practice in terms of ward rounds and peer reviews, some of these systems were not formalised and needed to be rolled out across the trust

Strong leadership at all levels
Dignity is everyone's business. Board level commitment is essential for ensuring that dignity is a high profile issue in trusts. Strong leadership at all levels can make a difference and there should be clear communication to staff about the trust's commitment towards dignity.

We found that:

- not all trusts had clear policies relating to dignity issues for older people (including nutrition and privacy). Many trusts claimed that these were embedded in other policies. In the latter case, the trusts need to be able to clearly demonstrate that their policies are addressing the issues relating to dignity for older people
- implementation of several policies and practices was fragmented and was left to individual wards, which caused variations
- not all trust boards received and considered reports on dignity issues regularly

However, we saw some good examples of trusts working with communities to ensure that the services are responsive to the needs of their diverse populations. Many trusts had 'dignity champions' who were leading on dignity issues. Dignity champions can make a difference to the way services are provided and they must be supported and developed.

Supportive ward environment
Creating and providing an environment that is clean and supports privacy and confidentiality is one of the key issues for older people in being treated as an individual. The Department of Health's patient-focused benchmarks in *Essence of Care* advises healthcare providers to ensure that quiet and private space is

available to patients when required and to identify and address the barriers that restrict this provision. Privacy includes having private space, not being exposed in an embarrassing manner while receiving care, and ensuring that staff behave appropriately regarding matters of a private nature. Provision of single sex accommodation is also a key requirement of the privacy required by older patients in hospital.

We found that:

- many trusts were struggling to provide single sex accommodation due to pressure on beds and the mix of patients
- in some cases, there were inadequate arrangements relating to providing privacy using curtains and locks on toilets and wash facilities
- some patients, such as those with stroke or MRSA, were being placed in mixed settings as staff found it easier to care for them. This practice should be discouraged as it puts the needs of the service before those of the patients
- older people consider that having private space for spiritual needs or for discussing confidential matters is important for maintaining privacy. Not all trusts were providing quiet areas for patients
- the structure of wards in older hospitals sometimes caused difficulties in providing privacy

However, we did observe some good examples of innovative practice by staff who provided privacy and dignity for patients, although these initiatives were restricted to particular wards. Our observations of the wards on the day of the visits indicated that the majority were clean and most staff understood and practised behaviours that supported the privacy of patients.

Recommendations

Although we found that the trusts we visited had begun to make improvements, there were still areas that needed to be improved. We therefore make the following recommendations that are explained in more detail in the main body of this report.

What can trusts do?
Dignity (including nutrition and privacy) is a human rights issue and should be the underlying principle when delivering services. Trusts must ensure that older people are not subjected to inhumane and degrading treatment while in their care. This includes being left in soiled clothes, being provided with inadequate nutrition and given no help with eating, or being placed in embarrassing situations. Trusts must consider the provision of care in a manner that meets the requirements of the patient as fundamental. They can make improvements to enhance dignity for older people in a variety of ways, from major changes in policy to small initiatives that have equal impact on patients. The following recommendations are for trusts to consider.

At board level:

1 There must be a commitment to dignity and privacy at board level, which should include nutrition. There should be a named lead for dignity at all levels which should be communicated to all staff and patients. It should be everyone's responsibility to ensure that dignity for patients is maintained at all times.

2 Trusts should have clear policies relating to dignity issues. If these are embedded in other policies, trusts need to be able to demonstrate that staff are addressing dignity issues for older people appropriately. The board should drive the implementation of policies relating to dignity.

3 There should be clear arrangements to ensure that these policies are translated into practical guidelines with support for staff to implement them, and strict adherence from all groups of staff must be ensured.

4 Meeting the needs of vulnerable patients must be a high priority for the trust's board and more sustainable systems should be put in place to meet their needs.

5 Trusts should recognise the spiritual and cultural needs of the local population and have systematic and sustainable links with community groups.

6 Robust mechanisms should be in place at all levels to monitor whether the policies and practices are working and making a difference to older people from all groups.

7 Trusts' leaders should endeavour to create a better environment to empower older people and staff to be able to express their views if services are below acceptable levels. They should also improve the handling of complaints.

At ward level:

1 Staff should develop more meaningful involvement with older people and their carers/relatives by making processes transparent, informative and responsive, and making use of volunteers or advocates.

2 The process of identifying personal needs (including non-clinical needs) should be open and must avoid making assumptions. The 'single assessment process' should be used more to ensure that the personal needs of older people are considered in care planning. Carers and relatives must be involved in the decisions regarding care, but they should not be expected to share the burden of care delivery.

3 Nutrition should be treated as an integral part of care. Assistance with food and drink should be provided in a manner that is dignified and centred on the individual so that all patients who need help are receiving it.

4 Staff must be supported in improving their ability to care for patients with dementia, confusion and those with end-of-life care needs, to avoid errors in risk assessment. Attendance on training courses on equality and diversity and practical aspects of dignity must be mandatory and must be a recurrent event. Adequate staffing needs to be provided to match the mix of patients.

5 Any compromise in dignity should be considered a serious issue and must be treated as a disciplinary matter. Older people's and dignity champions need to be more visible and should be used to ensure that dignity issues are being considered while delivering care.

What can strategic health authorities do?

1 Strategic health authorities should work with trusts to ensure that agreed action plans are implemented and that the necessary improvements are made relating to privacy and dignity for older people.

2 They should work with primary care trusts to ensure that commissioning of services reflects the principles of dignity in care.

3 Dignity in care should be a key component of the performance management of NHS trusts by strategic health authorities.

4 Strategic health authorities could develop and promote training initiatives as part of their role in developing the workforce.

5 Strategic health authorities should work with trusts to ensure that hospitals take action against placing patients in mixed sex accommodation. In doing so, they should consider the chief nursing officer's report on privacy and dignity.

What can voluntary organisations do?

Voluntary organisations can help older people, their carers and relatives to make informed decisions by encouraging them to actively seek information on what to expect while in hospital.

1 Community groups could make links with the NHS to develop and promote structured and sustainable partnerships to provide advocacy and voluntary services.

What can policy makers do?

1 Since we highlighted our concerns about dignity and respect for older people in our joint report from 2006[1], the Government has delivered many initiatives that have raised the profile of dignity in care. It is vital to continue this momentum and develop national policies and tools to support their delivery on a local basis, including the national nutrition action plan.

2 Dignity champions have a vital role to play and they should be supported adequately until they become embedded in the local structures.

What will the Healthcare Commission do?

Dignity in care is a matter of high priority for the Healthcare Commission. Through our work, including this audit, we have seen improvement in the attention given to treating patients with respect for their dignity. We have found that generally, there are systems in place to support this work. We have also found that when the spotlight is turned on this area, appropriate actions follow.

However, we know from other information available to us (for example, from complaints) that there continue to be lapses in the care given to individuals. When we see a pattern of such lapses, we will follow up with individual trusts to ensure that failures to treat patients with respect for their dignity are addressed.

1 We will continue to assess the performance of NHS organisations through the annual health check process, against the core standards relevant to dignity in care. We will improve and enhance the use of surveillance-based risk assessment, follow up where we have concerns and issue notification letters.

2 We will continue to encourage strategic health authorities to work with trusts at a local level, in particular to facilitate improvements in those NHS trusts that have declared non-compliance on standards relating to dignity.

3 We will actively seek local intelligence on lapses in dignity, which we will follow up as and when required.

4 We will consider the development of indicators relating to dignity issues that build on the work on 'dignity metrics' led by the Department of Health.

5 We will explore how our assessment of acute trusts might be adapted for other healthcare settings (for example mental health trusts and community hospitals) including patients' journeys between different care settings.

6 We will continue to work with our key stakeholders to develop and promote initiatives to enhance dignity for older people while receiving care, and highlight particular areas of concern.

7 We will continue to develop and promote good quality accessible information on the performance of NHS trusts on dignity issues as part of our annual health check website in order to empower older people to make considered choices.

8 We will ensure that dignity and human rights are underlying principles informing the work undertaken by the Commission.

Introduction

In March 2006, the Healthcare Commission published a report on services for older people; *Living well in later life*[1] was a joint report with the Audit Commission and the Commission for Social Care Inspection, which was based on the analysis of national data, joint inspections of services for older people and a listening exercise with older people and their carers. The report highlighted that while most people valued the services they received and felt that their dignity was respected, there were examples in acute hospitals where this was not happening, including:

- single sex bays that accommodated both men and women
- patients being moved frequently to release beds
- meals being taken away uneaten with no help offered to eat them

The report also highlighted that where care did fall short, a lack of training for staff was a particular issue in dealing with people with dementia in acute care settings. A subsequent analysis of data on complaints received by the Healthcare Commission and evidence from investigations reinforced the need to undertake a study in this specific area. The Healthcare Commission has since been developing an approach to help assess the extent to which NHS trusts are meeting the core standards relating to dignity in care for inpatients in acute hospitals.

This national report provides a commentary on our findings on dignity in care (including nutrition) for older people while in hospital. It also provides some examples of good practice along with recommendations for improving dignity in care for older people in acute hospitals.

Background

This section explains the policy context and presents evidence to make a case for treating dignity and nutrition as a high priority for the care of older people.

Older people account for the highest usage of acute services and the NHS spends 45% of its budget on them. While in hospital, maintaining dignity, respect and privacy is of paramount importance to older people. However, anecdotal evidence suggests that older people are often faced with situations where their dignity is compromised. The evidence from wide-ranging sources provides consistent messages that this remains an issue for concern.

The Department of Health's Green Paper *Independence, well-being and choice*[11] and its subsequent White Paper, *Our health, our care, our say*[12], along with the *National Service Framework for Older People*[4], the subsequent *Next Steps*[5] document and the *Dignity Challenge*[6] all aim to promote a change in culture to ensure that older people are treated with respect and fairness and that their dignity is maintained. In addition, the Department of Health's *Essence of Care: Patient-focused benchmarks for clinical governance*[7] offers a framework for trusts to measure their current practice relating to privacy and dignity.

The issue of nutrition and providing help with eating and drinking has been promoted as an integral part of personal care and a human rights issue by various reports such as Age Concern's *Hungry to be heard*[13], the Commission for Patient and Public Involvement's *Food Watch*[14] and the forthcoming national action plan (a joint initiative between stakeholders and the Department of Health) on nutrition for vulnerable adults in a health and social care setting.

Lack of dignity for patients with incontinence and people with dementia and confusion is also a major concern and has been highlighted by organisations representing older people in campaigns such as the British Geriatrics Society's *Dignity behind closed doors*[15] and Age Concern's *Dignity on the Ward*[16].

The Race Relations Amendment Act (2000)[8], the Human Rights Act (1998)[9], and principles from the United Nations and the recent Health Select Committee on Human Rights have all raised the need to consider equal and fair treatment as a matter of dignity and human rights.

A report from Age Concern, *Rights for Real*[17], identified a very close link between dignity and human rights and makes a case that older people should be made aware of their rights while receiving care and treatment in hospital.

The Healthcare Commission's assessment of organisations includes the principles underlying the Race Relations Amendment Act and the Human Rights Act. Trusts are expected to demonstrate that they are providing older people with fair treatment, maintaining their dignity and protecting them from discrimination and harm while receiving care.

Box 1: Common examples of compromises in dignity taken from complaints received by the Healthcare Commission

1	Being addressed in an inappropriate manner
2	Being spoken about as if they were not there
3	Not being given proper information
4	Not seeking their consent and/or not considering their wishes
5	Being left in soiled clothes
6	Being exposed in an embarrassing manner
7	Not being given appropriate food or help with eating and drinking
8	Being placed in a mixed sex accommodation
9	Being left in pain
10	Being in a noisy environment at night causing lack of sleep
11	Having to use premises that are unclean and smelly (toilets and wards)
12	Lack of protection of personal property including personal aids (hearing or visual)
13	Being subjected to abuse and violent behaviour

Our approach

This section explains the components of dignity used for this work, how we engaged with stakeholders, and the method of screening and surveillance used to provide a risk-based assessment of NHS trusts.

The definition of dignity

Dignity is a complex concept to define and is open to interpretation based on individual perceptions. Currently, no standard working definition for dignity is available, although there have been some attempts to give a meaning to the term. The Oxford Dictionary describes dignity as "the state or quality of being worthy of respect". The *Dignity on the Ward* campaign[16] stated: "The use of appropriate forms of address, listening, and giving people choice, including them, respecting their need for privacy and politeness, and making them feel valued emerged as significant ways to maintain older peoples' sense of self-worth and dignity". A research paper from Age Concern[18] states: "Older people are entitled to dignity and respect at all stages of their lives. That means protecting the vulnerable from abuse and setting high standards for services".

Being treated as an individual and having personal needs met are important aspects of dignity for older people. Britain has a diverse population and the needs of its population are therefore influenced by cultural background, which includes religious and spiritual beliefs. These needs influence the expectations of patients with regard to their personal care, ranging from information processing, nutrition and privacy. Older people often find that their treatment in respect of dignity is less than satisfactory. Although they find it hard to define the concept of dignity, it has been noted that older people, their carers and relatives find it easier to describe situations where their dignity was compromised. Box 1 shows some examples of compromises in dignity taken from data on complaints received by the Healthcare Commission, which are covered in more detail in this report.

While dignity in care is important wherever healthcare is provided, and throughout the patient's pathway of care, this report focuses on the issues affecting older inpatients in the setting of acute hospitals in particular.

Engagement with stakeholders

Dignity for older people is an issue that concerns a wide variety of stakeholders – each of whom brings a different perspective to the topic. In order to obtain a complete picture, we conducted workshops with older people, including those from seldom-heard groups, to identify the issues that were most important to them (see Box 2). A similar exercise was carried out with multidisciplinary staff teams to capture the perspectives of staff on issues relating to dignity. Professional bodies have also been involved in shaping this review and a list of the organisations consulted is given in Appendix 2.

Box 2: Questions asked of older people and staff in workshops

1 What does dignity and respect while in hospital mean to you?

2 When there is a lack of dignity and respect (including lack of appropriate food and help with feeding and drinking) what are the causes for such a situation?

3 What should be done to remedy this?

4 Who can change things? (for example, Government, trusts, staff, Healthcare Commission, patients, older citizens)

Screening and follow-up for risk assessment
The Healthcare Commission's annual health check uses a standards-based approach to assessing NHS organisations to determine the extent to which they are meeting the standards required to provide services that maintain patients' dignity.

Each year NHS trusts declare their compliance with the relevant core standards (see Box 3) and the boards of trusts are responsible for making a self assessment and public declaration on the extent to which their organisation has met the core standards.

These declarations are supplemented with comments from representatives of patients and other partners in the community.

We check these self-declarations against a wide range of information from other sources and undertake follow-up visits where we have concerns.

For the purpose of our review, we looked at those trusts that declared themselves compliant against core standards C13a and C15b in the 2005/2006 annual health check. We screened these trusts on the surveillance data available to us, which included:

- the Healthcare Commission's national survey of NHS inpatients from 2006
- Patient Environment Action Team (PEAT) scores
- Estates Returns Information Collection (ERIC) scores
- second stage complaints about NHS services received by the Healthcare Commission
- information from local engagement

The data from all of the above sources highlighted the trusts that were at risk of non-compliance with core standards in the 2006/2007 declarations. We found 35 trusts to be at highest risk and, of these, 12 were already being pursued on dignity as part of other routine follow-up activities. As a result, 23 trusts were identified to receive more detailed scrutiny, and the follow-up included interviews with staff at various levels and observation of two wards – one consisting of a mixture of elderly and non-elderly and one specifically for elderly patients in each site visited. At least one ward was visited during mealtimes.

Box 3: Core standards relevant to assuring that patients are being treated with dignity and respect	
Core standard C13a	Healthcare organisations have systems in place to ensure that staff treat patients, their relatives and carers with dignity and respect
Core standard C15b	Where food is provided, healthcare organisations have systems in place to ensure that patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day
Core standard C16	Healthcare organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after care
Core standard C20b	Healthcare services are provided in environments which promote effective care and optimise health outcomes by being supportive of patient privacy and confidentiality

Key aspects observed were:

- the ward environment, including privacy issues
- mealtime activity
- the behaviour of staff

The evidence collected during our visits to selected acute trusts enabled us to ascertain the extent to which issues of dignity were being addressed by trusts while delivering care for older people.

Examples of the lines of enquiry and questions asked during visits included:

- what policies are in place to ensure that dignity is maintained? (for example, dignity in care, race equality, training, whistle-blowing)
- what practices are in place to translate these policies into practical guidelines? (for example, protected mealtimes, adequate staffing, provision of adaptable cutlery)
- are staff ready to deliver care that respects patients' dignity? (for example, do staff have the skills, are staff aware of the issues and have they had training in issues relating to dignity for older people)
- how does the trust know that their policies on dignity in care are working? (for example, monitoring, observation of care, reflection on practice, reports to the board, feedback from patients)

Box 4: Five-point scale for risk assessment of trusts		
1	Findings show positive examples of steps being taken to ensure that older people are being treated with dignity and respect.	No further action required.
2	Insufficient evidence reviewed by the Healthcare Commission to determine a conclusion for this element.	No further action required.
3	Some areas for improvement identified.	Follow up through routine engagement meeting within an agreed period.
4	Some risks to the trust's compliance identified.	Issue notification letter.
5	Significant lapse identified.	Issue notification letter.

Our visits also collected evidence from the ward environment and, at the assessment stage, we also considered the requirements of core standard C20b (the standard on privacy). We assessed the trusts on the five-point scale shown in Box 4.

Trusts that were found to be at risk of non-compliance with one or more standards (C13a, C15b and C20b) received a notification letter and were expected to reflect this in their annual health check declarations. Each trust that we visited received an individual report on our findings.

This report

This report provides a commentary on our findings on dignity in care for older people in the acute hospitals that were selected for closer scrutiny based on the screening of trusts against our surveillance data in this area. It shares some examples of good practice as well as recommendations for policy makers and service providers.

The evidence for the report is based on the following sources:

- findings from our visits to 23 selected trusts (see Appendix 1)
- workshops and engagement with older people and NHS staff
- data from the Healthcare Commission's survey of NHS inpatients (2006)
- data from the Healthcare Commission's survey of NHS staff (2006)
- data from the Healthcare Commission's independent reviews of complaints

Five key themes emerged from the assessment of compliance with core standards and the issues identified by other evidence. It was apparent that these themes were the building blocks for ensuring that older people were given care that respected their dignity and focused on them as individuals during their stay 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 was equipped to deliver good quality care
- strong leadership at all levels
- supportive ward environment

Each theme is looked at separately and key issues are identified with the help of supporting evidence from other sources. Detailed findings from our inspections are then presented to build a complete picture on dignity in care for older people while they are receiving care as an inpatient.

This report also highlights gaps in service delivery and provides recommendations for improvements.

Key findings from the assessment of compliance with core standards are presented in the following section, which reports on how the 23 trusts performed against our five-point risk assessment scale.

This report has been written for a wide audience including older people, their carers, those with an interest in older people and dignity issues, managers at all levels, policy makers and staff who provide care for older people.

Key findings

Meeting core standards

Based on the screening of trusts against our surveillance data, 23 trusts were selected for further scrutiny. Of these, eight trusts were found to be at risk of non-compliance with one or more core standards (C13a, C15b or C20b) in the 2006/2007 annual health check.

Two trusts were found to be at some risk of non-compliance on core standard C13a. This was mainly due to insufficient assurance that there were clear policies or communication channels on dignity and privacy.

We found that more trusts (seven) were at risk of non-compliance on the core standard relating to privacy (standard C20b) than other core standards. This was mainly due to trusts not being able to provide single sex accommodation, including single sex wash and toilet facilities, at all times. These trusts need to ensure that they undertake major, urgent steps to rectify the situation in order to avoid an occurrence of a significant lapse in meeting standards on dignity.

In the area relating to nutrition (core standard C15b), we found that trusts were already making improvements in providing meals and giving older patients assistance with eating and drinking. Although our observations on the day of our visit did not present any lapses in this area, we found that almost half of the trusts visited (11 trusts) needed to improve services in this area.

Some of our findings included:

- patchy implementation of policies and practices regarding nutrition, such as protected mealtimes
- lack of formal arrangements to identify and provide assistance with eating and drinking for those who needed it
- lack of adequate formal systems of monitoring

All these areas, if not improved, could potentially lead to a lack of nutrition for older people. These trusts will be visited in six months' time to review their progress.

In 15 trusts, we identified several areas that required improvement on one or more standards. These were mainly around improving implementation of policies and practices as well as the need for more robust arrangements for monitoring to seek assurance that policies were making an impact on the quality of care for older people.

However, although we did not find any major breaches of national standards, there is an urgent need for significant improvements to be made to ensure that care in NHS acute trusts is more focused on the patient and that it respects the dignity and privacy of older people while they are in hospital.

Involving older people in their care

Key issues	
1	Being treated as individuals and involved in their care are important aspects of dignity for older people.
2	Older people did not always feel adequately involved in their care. Only 55% of older people surveyed said that they felt involved in their care as much as they wanted, while 94% were never asked for their views while they were in hospital.
3	Systems for involving older people from minority ethnic groups were not robust and there was a reliance on family to help with translation.
4	Most trusts inspected were finding it difficult to engage with patients with dementia, as the staff did not have adequate knowledge of their condition.
5	All trusts inspected had mechanisms in place for involving older people in their care but they were not always put into practice.
6	There were a few good examples of using volunteers and advocates for improving patient involvement, but these were not a universal phenomenon.

Involving older people in their care includes using appropriate forms of address, using appropriate communication methods and seeking their views and consent. According to older people, the starting point for maintaining their dignity while in hospital is being seen as individuals and having a say in their care and treatment. Some said that dignity is "being treated as a human being or an individual" or "not being invisible" or "being treated as if I had some intelligence". *The NHS Plan*[19] advocated and promised an approach that puts patients at the centre of the delivery of care. Involving patients in their care has been a key requirement of other policy initiatives such as the *Essence of Care*[7] and the *National Service Framework for Older People*[4].

Involving older people and their carers makes individuals feel valued and also ensures that the care focuses more on the person, therefore encouraging a better take-up of the service provided. However, care is often planned in such a way that older people do not relate to it and feel detached from the process. It is important that involvement takes place in a meaningful way and not just as 'lip service'. It must be recognised that each individual is different in the way they engage with the process, which is affected by their background, culture, religion, clinical condition and physical and mental wellbeing. This is more so for older people, who are often overwhelmed by the formal setting of acute hospitals.

The behaviour of staff, lack of appropriate information and inadequate planning can lead to a breakdown in the process, thus resulting in a care programme that is totally unsuitable for the needs of the patient.

According to the 2006 survey of NHS inpatients[20], only around 55% of patients felt "definitely" involved as much as they wanted to be in the decisions about their care and treatment, a third of the respondents felt involved "to some extent" and 9% did not feel they were involved at all.

Older people attribute lack of involvement to ageist practices. Discrimination due to age, faith or disability or other equality issues can have a profound effect on older people, particularly in a hospital environment. Standard 2 of the *National Service Framework for Older People* requires NHS trusts to root out discrimination, yet older people perceive ageist treatment by NHS staff.

"Age is the main factor". (older person from Black and minority ethnic group)

"Ageism is most certainly a factor in the poor behaviour of some hospital staff as evidenced by terms that they use for older patients, for example 'bed-blockers' or 'frequent flyers'. The elderly are not a priority in the health service despite the rhetoric." (older person)

Involvement in care includes asking patients how they would like to be addressed, what their needs and preferences are, providing them with choices and giving the opportunity to seek information about their care. Experiences of older people often indicate that they do not always know what they can expect while they are in hospital and do not always feel able to seek this information. Creating an environment that supports and encourages patients to express their needs is the responsibility of the care provider.

"Just to be asked how you would like to be addressed is important." (older person)

While involving all patients in their care is very important, this is even more crucial for older people from vulnerable groups such as black and minority ethnic groups, people with end-of-life care needs, those with dementia and confusion, and those with disabilities. Such groups may benefit from carers and relatives being involved in the care planning process, as patients in these groups may not be able to express their needs in an articulate way.

"Language is the major obstacle." (older person from black and minority ethnic group)

"To remove misunderstanding between the patient and the doctor, there is a need to provide an interpreter." (older person from black and minority ethnic group)

Anecdotal evidence indicates that this is not always happening. This also remains a priority for staff, as described to us by a healthcare assistant:

"It is all about developing trust with your patient, if you listen to them and get to know who they really are and what their needs are, you will begin to get their trust. When you know what they want you can ensure that this is communicated through handover, the nursing documents, referrals to the other departments and the doctors' rounds." (staff)

In some situations, older people may not wish to involve their family or relatives, particularly where intimate details about care and treatment are concerned. This may be a significant issue for some ethnic groups and must be respected. Alternative arrangements for involving these patients should be sought. In all cases, the consent of the patient should always be sought and their wishes respected before any details are shared.

What we found

Findings from our inspections indicate that many trusts were promoting equality and diversity policies and had training programmes in place for staff on diversity issues. Despite this, older people still believe that they experience ageist behaviour while receiving care in hospital. This indicates that there are gaps in the implementation of policies and staff lack the practical knowledge to ensure that there are no unintended consequences such as ageist behaviour. This issue is covered in more detail under the section on workforce issues on page 36.

We found that all 23 trusts visited followed the practice of involving patients and their relatives wherever possible. Interpreters were available for those patients who had a language need and all staff were aware of how to access these facilities. However, although there were language and interpretation facilities available for patients with language needs, there appeared to be a greater reliance on family,

Case study 1: Involving older people at King's College Hospital, London

The 'Improving Hospital Care for Older People Project' at King's College Hospital involved older people in developing teaching and learning materials for staff, using e-learning. Focus groups with older people and staff were used to explore views and identify issues. These sessions discussed some of the barriers to the effective involvement of staff and older people, and identified some benefits and opportunities presented by this approach. Selected older people's representatives were then involved directly in developing the learning materials.

The basic principle of this approach was to involve older people as teachers. Their voice can be very powerful and can make a real impact on improving the staff's understanding of the patient's experience. The trust expects that staff will find this method of teaching more meaningful than conventional methods, and be more likely to translate their learning into practice. To strengthen the impact and enhance the sense of reality and practicality in the hospital, demonstrations were filmed with hospital staff on site. Feedback from staff who have used this package indicates that this method has helped to improve the behaviour of staff and their awareness regarding care for the elderly. Work has continued with ongoing direct involvement of older people as patient representatives in producing a Dignity Toolkit, which is aimed at staff and offers additional learning resource.

Key factors for success:

- recognising the role of older people in improving hospital care
- willingness of older volunteers to get involved
- commitment from the trust's board

which could prove difficult if the patient has no relatives to provide this assistance.

We found some good examples where advocates from organisations such as Age Concern were being used to enable older patients who need additional support to be more involved in their care. Use of other volunteers was an option to support vulnerable patients, but some trusts reported difficulty in retaining the volunteers after having spent time and effort in training them and getting clearance by the Criminal Records Bureau. Some trusts had very clear strategies for engaging volunteers and training them in aspects of personal care.

Communication

Giving and seeking information plays a vital role in ensuring that older people feel that they are being treated with respect and maintain their dignity. *Essence of Care* benchmarking[7] requires staff to communicate with patients in a way that meets their communication needs. However, older people have reported that often communication either does not involve them or it happens in a way that is not appropriate to their needs. When asked whether doctors or nurses talked in front of them as if they were not there, just under a third of respondents to the 2006 NHS inpatient survey[20] reported that this was the case (27% for doctors and 28% for nurses). The survey also indicated that this happened more frequently with those aged over 85 compared to other patients.

The same survey of inpatients found that while 82% indicated that they were given the right amount of information, just under 18% did not feel they had enough information. When asked if the relatives and carers were able to raise concerns with a doctor if required, 12% responded negatively.

Some older patients from a minority ethnic group informed us that they did not know that they could ask for Halal food. Lack of this information often results in the patient's family having to bring in meals from home. Staff often misinterpret this by thinking that it is the patient's choice to bring in their own food.

Involving older patients in their care must include seeking their views and acting on them. While it is acknowledged that older people are more likely to give positive feedback due to inherent gratitude, or to anxieties about their care being affected[3], it is nevertheless important to seek their views on the quality of care received while in hospital.

The results of the survey of NHS inpatients[20] indicate that 94% of respondents reported that they had not been asked for views on the quality of their care during their stay in the hospital. This highlights the fact that while there are policies in place, these are not always being followed in practice.

What we found

Findings from our inspections indicated that there are some good practices around seeking the views of patients during ward rounds by various hospital staff such as Patient Advice and Liaison Service (PALS), matrons and, in some cases, by senior members of staff. However, this did not appear to be a universal phenomenon.

During our visits, we heard of some good examples of individual care being changed in response to feedback from patients. It is important that these positive changes are communicated to the patient to enhance their confidence in being able to express their views without fear. In all cases it must be remembered that 'one size does not fit all' – the engagement

needs to be tailored to individual needs without making assumptions or stereotyping the patients. Examples of such assumptions include the idea that all Asians are Muslims or vegetarians, or that all people with diabetes have the same needs or that all older people cannot look after themselves and need help. These needs may change over time and this has to be recognised.

All 23 trusts involved patients in the care process in a variety of ways. We observed that staff took time to explain and made sure that the information was understood. However, there were some concerns about people from groups with special considerations such as those with cognitive needs. Systems to provide support to these groups were ad hoc and appeared less sustainable. We also noted that carers and family were not always consulted when identifying

Delivering personal care that ensures dignity

1 Care planning is the first step to ensuring a focus on the individual. While all trusts undertake this activity, monitoring of care plans was not happening everywhere.

2 Delays in accessing specialist help due to shortages of staff often led to delays in the assessment of patients.

3 Staff find it challenging to care for patients with dementia and confusion because of lack of clear care pathways and inadequate training and awareness of the condition.

4 The implementation of care pathways for end-of-life care is varied across trusts and less developed for non-cancer conditions.

5 Protected mealtimes policies were not being implemented uniformly and lacked board level commitment in some trusts.

6 Where they had been implemented, protected mealtimes were not being adhered to by all groups of staff.

7 Culturally-sensitive meals were not always available out-of-hours.

8 24-hour meal systems consisted of snack boxes, which may not be suitable for people with specific dietary needs.

9 Staff feel constrained to provide adequate assistance to patients who need help with food and drink if there is a shortage of staff or if there are more patients with dementia on the ward.

10 Some trusts are using volunteers to assist with mealtimes but this is not happening in all trusts.

behavioural needs of older patients with dementia or confusion, therefore not making distinctions between the patient's normal behaviour and that as a result of their medical condition.

Personal care for older people includes care planning, nutrition, end-of-life care, dementia and toileting needs. Delivering care that focuses on the individual is a basic responsibility of any care provider. Anecdotal evidence indicates that often older people feel that their wishes are not adhered to and their dignity is not maintained. A prime cause for this is inadequate care planning, inappropriate or inaccurate recording of the information, or lapses in transferring information between different staff. Handovers to other staff and transfers to different wards have been identified as situations where this could happen. Key details related to care can get lost or misinterpreted, causing discomfort, anxiety or even risk to the patients. The delivery of care must always respect the individual's wishes and needs and protect their privacy, modesty and confidentiality.

A review of complaints undertaken by the Healthcare Commission[21] found that 7% of complaints were about basic nursing, which included inadequate care planning and documentation.

Care planning

Efficient planning of care is a crucial step in ensuring that care is responsive to the needs of the patient. Care plans should contain information on issues such as how patients like to be addressed, their physical and nutritional needs, any clinical conditions, their cultural, religious and spiritual preferences and how they would like their care to be delivered.

Care planning also gives staff an opportunity to familiarise themselves with the patient and manage their expectations. The design of the care plan document itself can be a good way of ensuring that all the required information is noted, without overlooking some of the patient's needs. Particular attention should be paid to the needs of vulnerable groups including those with dementia, confusion and end-of-life care needs.

The process of planning care requires an assessment of the patient to establish their functional ability, nutritional status and other clinical and non-clinical care needs. A multidisciplinary approach is vital to these assessments. A single assessment process that avoids multiple assessments by different healthcare professionals puts less burden on patients and also ensures a more 'joined up' care package.

Living well in later life[1] reported that the implementation of the single assessment process was slow in progressing and NHS trusts were expected to ensure that this was a priority. While remaining hopeful, older people still report difficulties during transfers between wards.

"A comprehensive assessment process will ensure that a unified, multidisciplinary team approach can be taken to meeting the needs of the individual patient." (older person)

"The transfer of personal data when patients are transferred between wards is needed to lessen the number of repetitive questions to patients." (older person)

What we found
Our inspectors were informed that all patients were assessed by multidisciplinary teams at the time of admission to a particular ward, including a re-assessment when transferred between wards or hospitals. The assessment included daily activities of living and nutritional status and information on cultural and religious needs. Carers and relatives were involved where possible.

We were told that care plans were reviewed on a daily basis and that changes were made where appropriate. Written, face-to-face and telephone handovers were undertaken to ensure continuity of care. If a patient was being transferred, the details of the care followed them and a member of staff would personally undertake the handover in the new ward. Audits of care plans were performed to ensure that the details were recorded correctly, although we found that this was not happening in all trusts. Other methods such as ward rounds, observation, feedback from Patient Advice and Liaison Service (PALS) and complaints received from patients were also used to monitor if care planning takes dignity issues into account.

Dignity in dying
Ensuring dignity at the end of a person's life is a key priority in the Department of Health's publication *Building on the Best*: *Choice, Responsiveness and Equity* (2003)[22]. This included a commitment to provide £12m in funding for the End of Life Care Programme (2004-2007), the aim of which is: "to offer all adult patients nearing the end of life, regardless of their diagnosis, the choice and access to high quality end-of-life care." This commitment is continued within the Department of Health's developing End of Life Care Strategy, which will be published later this year.

Providing care that respects people's dignity, as set out in *Standards for better health*, requires care plans to give special consideration to people at the end of their lives. This requires a clear pathway of care and protocols for before and after death, to ensure that dignity is maintained at all times.

What we found
Our inspections found that all 23 trusts visited were using the Liverpool Care Pathway* for providing end-of-life care for people who were dying, although the implementation of the care package was at various stages across the trusts. Patients with end-of-life care needs had a separate care plan and staff had the support of palliative care nurses and pain relief specialists. In some cases, end-of-life link nurses provided a more focused service. There were various types of training packages available for staff, including bereavement, palliative care, and protocols for last offices. However, attendance did not appear to be mandatory and staff did not always attend them.

It was also reported that due to pressure on beds, staff sometimes felt unable to respect the wishes of the relatives, particularly in providing a side room or keeping the deceased in their bed for a little while longer before moving them to, for example, a chapel or mortuary.

We also found some examples of liaison with primary care trusts to enable patients to be discharged into the community to allow patients to die at home if they so wished. Some trusts with a high minority ethnic population were working with local community groups to meet the cultural and religious needs of patients by involving the religious leaders.

We found that arrangements for care for those at the end of their lives are relatively less

* A continuous quality improvement framework for care of the dying, irrespective of diagnosis or place of death.

developed and established for conditions other than cancer. More work is required to increase the use of end-of-life care tools to avoid variations between wards or trusts and between clinical conditions.

Dementia and confusion

The Alzheimer's Society estimates that there are over 500,000 people affected by dementia in England. Patients with advanced dementia may need assistance with washing, bathing, eating and dressing. It is very important to maintain their individuality and dignity in all aspects of care. Mild or acute confusion is also quite common for older people because of their medication. This must be recognised and appropriate care provided.

Careful planning and review of care is even more vital for vulnerable groups of patients such as those with dementia and confusion. This has been a prime concern for older people who report that care is not always adequate and dignity is not maintained in such situations. They attribute this to lack of trained staff, inadequate awareness of the condition and insufficient involvement of carers. Caring for patients with dementia or confusion often requires more personal attention to meet their needs for privacy and dignity and protect them from the risk of self-harm. Using cot sides, restraint, inappropriate clothing, and inadequate or no monitoring of their food intake have all been listed as compromises in dignity by staff and older people.

What we found

During our visits, staff told us that caring for patients with dementia and confusion is challenging and they do not always feel well supported. Although there was support available from dementia nurses and consultant psychiatrists, there was often a delay in getting specialist help due to a shortage of specialists. Lack of awareness and training in identifying potential risk situations may result in staff not seeking help from specialists at the right time. However, in a small number of trusts, extra staff were provided to meet the needs of different patients. Cascade training by nurses from the Department of Medicine for the Elderly was also available in some trusts to raise the awareness of staff about dementia and confusion.

We saw some good examples of using appropriate clothing, using low profiling beds to prevent the risk of falls (instead of using cot sides) and using volunteers to provide one-to-one assistance in order to ensure that dignity was maintained for patients with dementia.

However, we also found that, in many trusts, there was no clear pathway for the care of patients with dementia and confusion. Having a clear strategy of care would also meet the needs of staff in terms of training and support.

Nutrition

Nutrition is an important aspect of the continued wellbeing of older people and mealtimes are an important activity for older people, including those from ethnic minority groups (see Box 5). A good diet can help to improve the chances of recovery and avoid malnutrition and risk of infections. Good intervention to tackle poor nutrition can also reduce the long term costs of care.

"Being able to eat the food that is supplied and manage the drinks offered is what dignity and respect is all about." (older person)

Box 5: The nutritional needs of older people

Clinical needs: Often patients who suffer from conditions such as diabetes or food intolerance need specific food that meets their requirements to manage their condition while in hospital.

Older people may need help with eating their meals. For example, a patient suffering from arthritis may need help with cutting up the food or may need specially-adapted cutlery.

Patients with stroke, dementia or a learning disability may have specific needs in terms of eating and drinking due to swallowing difficulties or cognitive impairment. Ensuring appropriate consistency of food is important for such patients.

Patients with dentition needs (for example dentures) may find it difficult to eat hard food and therefore need softer meals.

Emotional needs: Anecdotal evidence from the care of the elderly ward indicates that older patients have sometimes refused to eat food or drink because they have been asked to use the toilet in public, therefore compromising their dignity.

Similarly, patients with continence problems have been left in soiled clothes, much to their discomfort, and have been asked to use the bedpan in the presence of others. These issues have resulted in patients refusing to eat or drink to avoid such situations where their dignity may be compromised.

Patients with certain clinical conditions, for example depression resulting from a major physical illness, have also been known to lose their appetite, which may affect their food intake.

Cultural and religious needs: Many patients have cultural and religious preferences relating to food. These must be considered to ensure that the provision of meals takes the individual into account. Examples include vegetarian meals, Halal meat, use of certain foods such as pork and beef. Observing specific practices by certain religions, such as Ramadan, is also important.

Living well in later life[1] identified that many older people on hospital wards are missing their meals. Reasons for this include a lack of assistance with eating and drinking, meals not being suitable or because of clinical activity taking place during mealtimes. It also found that people with dementia were not receiving adequate or sensitive help with eating, as a result of which, meals were being taken away uneaten.

Of the complaints about NHS services received by the Healthcare Commission[21], 25% concerned poor nutrition in hospitals, and just over 59% of older respondents to the 2006 national survey of NHS inpatients rated hospital food as "good" or "very good".

Anecdotal evidence from older people confirms this evidence and adds the behaviour of staff as another factor explaining why older people do not have a satisfactory experience at mealtimes.

"When I was an inpatient in May last year, the person serving food was rude and unfriendly as well as frequently providing the wrong dish. For instance, the patient opposite me requested Halal food. When she eventually got it, the food had been over-microwaved until it came out like a piece of leather!" (older person)

The NHS Plan[19] promotes the need for good hospital catering by setting out an agenda for providing hospital food that requires patients to be able to access food 24 hours a day. In addition, *Essence of Care* benchmarks[7], clinical guidelines on nutrition support in adults from the National Institute for Health and Clinical Excellence[23] and *Standards for Better Health* all provide guidance on providing food that meets individual dietary requirements. They also emphasise the need to provide necessary help with eating and drinking.

The nutritional needs of older people are largely determined by a variety of factors including cultural and religious beliefs and clinical conditions as shown in Box 5. Nutritional assessment at the time of admission provides the necessary information about the meal-related needs of a patient. This also includes risk assessment, weighing, establishing diet needs and religious and cultural preferences. Specialist input from dieticians and speech and language therapists is also essential to identify any malnutrition and swallowing difficulties.

Providing an adequate choice of food and having appropriate food available, including the right consistency of food for patients with swallowing difficulties, is essential for meeting individual needs. Older people have reported that they experience difficulties in getting the right food.

"You have to eat what they give... food is not cultural, so you go hungry. My children used to bring in food for me." (older person)

Lack of assistance from staff in helping to make choices about food and the nature of menus – particularly the small print size used – was described as an issue for older people. Presentation and serving of food is also considered important for older people for maintaining their dignity. Large portions or food that becomes cold while waiting for assistance does not encourage patients to eat[14].

Guidelines for better hospital food recommend that a protected mealtime policy should be in place to ensure that patients who need assistance with eating and drinking receive it without interruption.

The guidelines also encourage patients to eat their meals in a peaceful environment. Implementing an effective protected mealtime policy requires identifying and altering the non-clinical activity, commitment from all staff, an adequate number of staff and information for patients and relatives.

Appropriate preparation helps to make mealtimes easier. This includes positioning the patient properly, washing hands or providing wipes. In some cultures hand washing is considered essential prior to eating meals.

Appropriate assessment regarding nutrition and food-related needs is not only important for delivering personalised care, but in some cases improper assessment may lead to possible risk to the patients, as shown in Table 1. Although some of the themes identified are low in number, the potential outcomes could be serious for individual patients.

Table 1: Incidents relating to a compromise in patients' safety regarding their nutritional and fluid management reported in one month to the National Patient Safety Agency			
Incident theme	**Number**	**Percentage**	**Examples**
Dehydration	4	4%	Patient required fluid resuscitation throughout the day and was then left for seven hours overnight without fluids. Patient had to be fluid-resuscitated again. Delays in medical staff canulating patients requiring intravenous fluid. Choking
11	5%	Patients	witnessed choking while eating a meal.
Incorrect diet	10	11%	Patient received normal diet when requiring a textured-modified diet. Patient given food containing mushrooms when they had an allergy to them. Patient with a wheat allergy given Weetabix.
Incorrect artificial feed	9	10%	Wrong dose of enteral feed given. Wrong artificial feed given to patients fed exclusively by intravenous food.
Catering	3	3%	Catering department unable to provide neutropenic meals.
Nil by mouth – patient fed	3	3%	Patient ate a biscuit prior to surgery, resulting in their surgery being cancelled.
Nil by mouth – prolonged period of time	27	29%	Patient fasted prior to surgery but waited excessive time for their assessment.
Lack of assessment	6	7%	No dietetic service available out-of-hours. Nutritional screening not completed.
Transfer of care	7	8%	Poor communication between different care settings, both verbal and written.
Pressure sores	5	5%	Nutrition status identified as a contributing factor in development of pressure sores.

Source: National Patient Safety Agency, January to February 2007

Older people believe that help with food is a basic element of maintaining dignity while in hospital, and feel that not enough time was allocated to patients who were too frail to manage themselves. In the Healthcare Commission's 2006 survey of NHS inpatients, 16.5% of older people responded that they never received help from staff with eating their meals.

Having a dedicated time for meals is helpful in ensuring that nursing staff are able to provide personal attention with eating meals. Provision of appropriate adapted cutlery or beakers is vital to ensure that older people with conditions such as arthritis are able to eat their meals.

What we found

Nutritional screening and assessment:
We noted that there were systems in place in all 23 trusts visited to undertake routine nutritional screening and assessment using various tools. Staff reported that sometimes the lack of specialist staff resulted in delays in assessment, which delayed meals for the patient, particularly on the day of admission. In some trusts, nurses have been trained to undertake swallowing assessments to avoid patients remaining on a nil-by-mouth regime for long periods. It was noted that a nutritional assessment would also identify any assistance required with food and drink.

In all 23 trusts visited, there were procedures in place to ensure that all patients were weighed at admission and then every week using a variety of means including weighing scales, hoists and upper arm circumference to calculate body mass index. However, we saw one isolated example where staff were encouraged to guess patients' weight if it was difficult to weigh them. Such practices are potentially harmful and must be discouraged at all costs. In this particular trust, the arrangements for weighing patients were ad hoc and not systematic.

Choice and access to food:
Our inspections found that not all trusts visited were providing menus in different languages although they reported that interpretation and translation facilities were available. It was noted that even in areas with a high ethnic population, menus were not always available in other languages. In some cases there was a reliance on family or other staff from these cultural groups to provide help with translation. These options may not always be sustainable if the patient has no relatives or if there is a shortage of staff. In areas with a smaller proportion of minority ethnic patients, reliance on family members appeared to be far greater.

We found that even though dedicated staff helped patients in choosing their food from the menu, some older people did not consider this to be helpful due to communication difficulties or insufficient knowledge on the part of the staff about the contents of the dish being offered. Some trusts were piloting a pictorial menu card to overcome the language barrier.

The 24-hour catering initiative is designed to allow patients to receive hot food at all times, including out-of-hours periods. However, our visits identified that many trusts found it difficult to provide hot meals or culturally-sensitive meals outside normal hours. In some trusts, meals had to be ordered in advance for patients with cultural requirements which did not accommodate any changes in needs. However food provided during normal hours catered to a variety of needs.

All 23 trusts reported availability of 24-hour snack boxes, but acknowledged that these were

not always suitable for patients with specific dietary needs. There was very limited choice for patients such as soup, toast or yoghurt. In some trusts, staff maintained a stock of frozen meals, which could be warmed up when required out-of-hours.

Contracted catering arrangements in some trusts meant that nursing staff did not have access to a kitchen on the wards because of safety reasons. This posed a problem if the consistency of food needed adjusting because the patient needed to eat soft food.

We found a variety of practices for serving food – some used pre-plated meals and some had food trolleys. We saw portion sizes being adjusted according to the needs of the patient where food was being served from trolleys. In general, we observed food being served in a calm and unrushed manner, which respected the dignity of patients.

Findings from our inspections indicated that not all the wards we visited followed the practice of making sure that patients washed their hands or used hand wipes before meals. This is an important issue for cleanliness and for avoiding infections.

In all except one ward visited, patients were prepared for the meal activity by positioning them appropriately according to their needs. We saw that food was placed appropriately and within reach and the bedside area was cleared of clutter to enable patients to eat their meals. Staff were seen to be encouraging patients to eat their meals.

Assistance with food and drink:
We found that patients who need help were clearly identified by a variety of means to ensure that they received the necessary help. Some trusts were using distinct methods such as red trays or stickers on menu cards to identify those who needed help. In a small number of trusts there were no such arrangements and staff relied on handovers to get this information. This practice could lead to gaps in communication and cause inconvenience to patients. There should be more robust and sustainable systems to ensure that people who need assistance receive it more efficiently.

We saw staff providing assistance with food including providing adapted cutlery, which was carried out in a manner that respected the dignity of patients. However, there was one isolated example where a shortage of staff presented difficulties in providing adequate assistance.

It was reported to us that some catering services that were contracted out only allowed assistants to serve food but not to help patients with eating and drinking. This puts enormous pressure on the staff, particularly when there are fewer staff, which finally impacts on patients.

Some trusts were using volunteers and relatives as an additional resource to provide assistance during mealtimes. However, trusts had difficulty in retaining volunteers after training them. This could be overcome by having a clear strategy of recruiting and retaining volunteers that was observed in some. Similarly too much reliance on family or carers would be difficult for those who have no living relatives.

Some trusts had implemented the protected mealtime policy successfully and others were in various stages of implementation. In the latter group, implementation was generally left to wards, which caused variations. Staff also told us that not all groups of staff adhered to this policy, which our inspectors also observed.

This trust has used nutritional screening to identify individual needs for 10 years, but found it difficult to implement on the wards to ensure that older patients received meals according to their identified needs. There were pockets of good practice but they were not rolled out across all ward areas. Anecdotally, the trust noted an increase in complaints regarding meals, as patients were being interrupted during mealtimes because of doctors' rounds. Nurses and support staff also had conflicting priorities at mealtimes because of drug rounds.

Essence of Care benchmarking placed the responsibility for nutritional care at ward level, and four years ago the trust invested in an *Essence of Care* lead, who has championed nutritional care and protected mealtimes, using a video to highlight the problems and benefits. Clinical directors were asked to sign up to the new approach and the practice was also introduced into the staff induction training. Staff who were not attending to meals were discouraged from being in the ward during protected mealtimes. Relatives were only allowed to be with a patient if they were there to assist in feeding. This has all resulted in improved mealtimes for the patients.

Senior staff carry out quarterly audits across the trust on wards where they do not routinely work. The audit comprises a six-point check including:

1 the position of the patient
2 hand washing for patients
3 oral care for patients
4 correctly prepared area for meals
5 any help needed
6 ascertaining whether all patients have eaten

The trust has developed a key performance indicator for nurses to develop this approach, which is now embedded in the directorates who manage the outcome of the audits. The director of nursing and chief executive still monitor the audits and will challenge wards on poor performance. Poorly performing wards must address problems immediately. Since its implementation, fewer complaints have been noted.

Key factors for success:

- board level commitment
- multidisciplinary team working
- creating an internal audit programme with published results

All trusts displayed posters to highlight the practice, but the nursing staff did not always feel empowered to ensure that everyone followed the protected mealtime policy. However, we saw some examples of staff stopping doctors from interrupting patients' mealtimes.

Monitoring patients' nutrition:
Our findings indicated that all trusts monitored the food intake of individuals by maintaining a food diary and fluid charts, and recorded the food eaten for patients who were 'at risk'. There were clear systems to ensure that patients' food intake was recorded, such as nurses serving dessert or removing the red trays, which ensured that all those who needed help with eating had received it. At ward level, PEAT scores were used as an indicator of how nutritional arrangements were working, but PEAT scores do not allow any data to be collected on those who need assistance. We also found that not all trusts were recording when meals were returned uneaten.

Other mechanisms such as nutrition-related audits, feedback from patients, ward rounds and feedback from complaints were used to monitor whether nutrition-related needs were being met. Some trusts had a nutrition committee and clear action plans on nutrition and protected mealtimes. We found that not all trusts were monitoring efficiently, which led to gaps in ensuring that the nutrition needs for all patients were met.

Toileting and incontinence
A high proportion of older people develop bowel and bladder problems in later years and toileting is a sensitive issue for them. Older people have reported highly unsatisfactory experiences while in hospital in this regard. Some examples include accidents due to lack of timely assistance with toileting, being asked to use the commode in the bed area, being asked to wear nappies and being left in soiled clothes with no immediate attention from the nursing staff. All these examples indicate undignified and inhumane treatment, which is unacceptable.

"They want you to use the commode but a lot of people don't use it or don't like the commode." (older person)

The *Dignity behind closed doors* campaign[15] advocates that wherever possible, patients should be allowed to use the toilet in private, irrespective of their age and physical disability and this must be treated as a human rights issue.

What we found
Our observations on the wards identified that patients were being given assistance in using the toilet facility and their dignity and privacy was maintained during our visit.

Workforce

Key issues	
1	Older people consider staff to be instrumental in maintaining their dignity.
2	Staff need to be aware and trained in dignity issues. We identified gaps in certain areas.
3	There are many training programmes relating to diversity and dignity-related issues, but staff were not always attending these.
4	Staff found maintaining dignity for patients with dementia or those receiving end-of-life care challenging due to lack of awareness of the condition.
5	While there are opportunities for staff to reflect on their practice in terms of ward rounds and peer review, some of these systems are not formalised and need to be rolled out across the trust.
6	Staff are not always supported in practices such as protected mealtimes and adequate staffing. This has an impact on the dignity of patients.
7	Attendance on training courses such as diversity and practical aspects of dignity must be mandatory and should be monitored.

Dignity is everyone's business. Older people consider staff highly instrumental in whether patients' dignity is maintained. Frontline staff can play a major role in providing care in a way that protects the dignity of older patients.

"I don't want to tolerate their (workers') unfriendly attitude. It doesn't matter to use more or less services. Dignity is the most important thing to me." (older person)

"Certain hospitals (staff) know how you would like to be treated and I had an excellent in-patient experience." (older person)

"They made me feel good, I found them pleasant and they make you feel comfortable." (older person)

Our evidence indicates that there is a difference in the perception of dignity in care between those who provide and those who use services. While both agree that it is an important aspect of treatment and care, the priority given in terms of service delivery is not the same. The main reasons for this are considered to be lack of training and awareness, time constraints, competing priorities and lack of resources[2, 24]. High levels of agency staff and a complex case-mix, compounded with emphasis on performance targets, often leads to a culture of focusing on tasks rather than individual patients in the ward[25].

"It is all about individualised care, it is about finding out about the person, but this requires skill and competency – sometimes this doesn't happen if the ward is short staffed and there are agency nurses who don't know the system, or if it is very busy with critically ill patients – then the communication can break down and the vital information about the patient is not carried on, and then people can feel not respected... and at other times we can fail to communicate with the right people, for example if a patient has had a stroke and needs to see the speech therapist for a swallowing assessment we can be trying and trying to get hold of them and it might take days because we only have one speech therapist who comes twice a week... that's not providing respectful care." (staff)

Staff identified systems and resources as the cause for compromise in dignity.

"No one intends to provide care that is undignified but because of lack of resources and the resulting task-oriented approach followed, there are unintended consequences of being in situations where compromise in dignity may occur." (staff)

However those who use services do not echo this.

"I think this point needs to be emphasised because so often there is the cry that 'we need more resources'. Well, in many instances, experiences which cause distress have nothing to do with money. It doesn't take more time or resources to be pleasant than it does to be unpleasant. Most of the time, staff are kind and considerate but, occasionally, there is what can only be described as 'mental cruelty' and thoughtlessness." (older person)

To deliver care that respects patients' dignity, it is important that staff have the necessary knowledge, skills and support to provide care that meets individual needs. This includes awareness of policies and practices relating to privacy and dignity issues.

There are no specific competencies regarding older people's care. While staff are introduced to the nursing of older people as part of their basic training, this area is still considered less attractive to pursue as a career. This may be due to deep-rooted ageist beliefs and stereotypes, which lead to an unhelpful attitude when staff are required to nurse older people. While the majority of nursing care is undertaken with tact and sensitivity, there are examples of staff behaviour that show a lack of awareness and understanding of the needs of older people.

"When in hospital they (staff) come to change clothes, they just come in (men/women) and do not show respect to us... just show up." (older person)

"Nurses don't bother feeding patients... the food just gets cold... then taken away, no one bothers asking." (older person)

The morale of staff and satisfaction with their job are key indicators of behaviour and attitudes at work. The Department of Health-led campaign on dignity at work highlights that if staff feel that their own dignity is respected,

they are more likely to provide care that respects the dignity of patients. The national survey of NHS staff[25] identified that 68% of staff surveyed in the acute sector were generally satisfied with their jobs. This figure is based on the level of satisfaction that staff have with various aspects of their job, including the recognition they receive for good work and the extent to which their work is valued by the trust.

The survey also reported that 70% of staff regularly worked more than their contracted hours and 57% were not paid for the extra hours worked. Many trusts now operate flexible working systems and a large proportion (70%) had taken advantage of this. Being valued by colleagues and patients is considered important for job satisfaction and the majority of staff reported positive experiences relating to this. However some staff did report that they were bullied or harassed by patients (26%) or staff (18%) in the last 12 months.

Lack of trained staff, lack of time for nurses to talk to patients, a bad press and the resulting low morale were some of the other reasons given for the behaviour of staff.

Raising awareness about issues relating to older people, care in general, and dignity in particular is crucial to altering some behaviours and attitudes. Lack of knowledge can often lead to inadvertent compromise in dignity.

What we found

Training and support:

We identified a range of training packages available for staff that included: induction, equality and diversity issues, care of vulnerable adults, and communication. With the exception of induction training, other training courses were not always mandatory. There were some examples of ongoing reinforcement on specific dignity-related topics, however most training arrangements were one-off at the time of recruitment. Although all 23 trusts visited indicated that attendance on some training courses is monitored, staff reported that they were not always able to attend due to shortages of staff.

Staff who worked in wards for older people had better access to training programmes relating to issues of maintaining the dignity of older people. We also noted that most policies relating to older people initiated from wards for older people, and therefore staff in these wards were better informed and equipped to provide care for the elderly. Where staff were being recruited specifically to nurse older people, their knowledge of dignity issues was assessed in particular.

Staff told us that they needed more training in caring for patients with dementia and also training in practical issues around dignity and diversity. They also needed support in terms of adequate staffing to provide care centred on the individual for those who needed one-to-one attention.

We found some good examples where the chaplain or the local religious leaders were involved in raising the awareness of cultural and spiritual needs and general diversity issues. Some trusts had specific courses in place, which focused on good behaviour, communication and role-playing. However, we found many cases where training programmes were not being utilised fully or were attended by junior staff that are not always able to influence the delivery of care.

We found examples where some wards maintained a folder of cultural information

Case study 3: Investing in the workforce – Queen Victoria Hospital, West Sussex

There is a strong belief in this trust that investing in the workforce at all levels can have a demonstrable impact on how staff deliver services to the patients. There are robust recruitment and retention mechanisms, and staff are given plenty of opportunities to attend various training courses with attendance always monitored.

Senior staff also present sessions on translating policies into practice as well as findings from initiatives such as surveys of patients and staff and visits from patient and public involvement forums. Similarly, the dietician runs a session for staff on nutritional issues for older people. These visual presentations focus on what these issues mean for the delivery of care on a day-to-day basis.

The trust has received awards such as Investors in People and Improving Working Lives Practice Plus. The board believes that having a happy workforce is linked strongly to recognising their work, and this principle guides the board in how they manage the workforce. Staff can receive a variety of awards for work including:

- awards for teamwork
- awards for innovation
- support worker of the year award
- awards for making a significant difference to patients' experience

The trust holds an annual awards event for staff, held off-site, to celebrate individual achievements. All staff, including cleaners and horticulturalists, are eligible for the awards. The trust believes firmly in recognising the smallest of achievements, as they may be an important part of someone's work. The executive team even cooks a barbecue at a Christmas event that recognises the efforts of staff.

As the trust is small, each member of the executive team has a large portfolio, which allows them to carry out 'integrated performance monitoring'. This involves, for example, the director of nursing looking at nursing, safeguarding, infection control and confidentiality, which are all linked.

A very small number of agency staff are employed and there are strict guidelines on acceptable standards. When there are higher numbers of patients with dementia on the ward, the staff who care for older patients with mental health needs are supported by employing additional mental health nurses from an agency.

There is a strong culture of 'putting the patient first'. All staff value and practice this and they are encouraged to report errors and near-misses without fear. Members of senior management get involved in ward level activity, thus giving staff support and providing a role model. Staff at the Queen Victoria Hospital feel empowered to provide good quality care that supports dignity for older patients.

Key factors for success:

- visible, fair and transparent leadership
- clear communication from the top-down and from the bottom-up
- prompt addressing of performance

which was updated on a regular basis. In others, study days were organised around specialist topics such as care for patients with dementia, disability awareness and religious practices and their impact on nutritional needs.

Peer support and role models were considered valuable in the personal development of staff. We found that there is often a shortage of experienced staff on the wards as they move away from care delivery and assume managerial roles. This creates a shortage of role models. There were some good examples where experienced senior staff worked on the wards regularly to share their expertise.

Another key example of support to staff is the protected mealtime policy and provision of adapted cutlery. As mentioned in the previous section, almost all trusts had a protected mealtime policy in place, but implementation and adherence with the policy was quite varied, with some medical staff not adhering to it. Implementation and adherence to protected mealtimes must be made compulsory and necessary training should be provided to highlight its significance for older people.

There are huge gaps in the knowledge of nursing staff regarding issues such as care for patients with dementia, cultural issues and practical aspects of dignity. This may affect their ability to recognise individual needs and the associated risks and could inadvertently cause compromise in dignity. According to the 2006 NHS staff survey, more than 60% of staff reported that they had not received any training in diversity issues, including cultural and religious practices.

Learning from practice:
Reviewing and learning from practice is essential to maintain high standards of care. Our inspections found that all trusts demonstrated a variety of ways in which staff could review their practice and learn from it, using, for example, ward rounds, peer review and challenge, and ward meetings. It was reported that while senior staff addressed minor lapses when they occurred, major or frequent lapses were dealt with as part of the performance appraisal process, which also identified the training needs.

However, the staff survey has highlighted that only 57% of staff had received an appraisal or performance development review in the previous 12 months. Only 29% said that their appraisal helped them to improve how they worked, set clear objectives and left them feeling that their work was valued.

This indicates that training and appraisal policies are in place but, in reality, these are not making the necessary impact. A structured approach for dealing with lapses in dignity is needed to avoid the recurrence of such a situation.

Strong leadership

Key issues	
1	Board level commitment is essential for making dignity a high priority.
2	Strong leadership at all levels can make a difference.
3	Clear communication to staff about the trust's commitment to dignity is needed.
4	Not all trusts had clear policies relating to dignity issues for older people (including nutrition and privacy). At many trusts these were embedded within other policies. In this case, trusts must be able to demonstrate clearly that they are committed to older people and dignity issues.
5	Implementation of several policies relating to dignity was fragmented and left to the discretion of individual wards, which caused variations.
6	Reports on dignity were not received and considered on a regular basis by the boards of many trusts.
7	Trusts should provide and promote a culture for staff and patients to enable them to report compromise in dignity without fear.
8	Better links with community organisations are needed to ensure that the services are responsive to the needs of their diverse population.

This section covers the essential ingredients of good leadership, such as clear policies, providing a lead for dignity issues, working in partnership, communication and commitment to learn.

"The management's leadership in a hospital should be paramount to ensure dignity and respect do not get lost." (older person)

Dignity in care is a philosophy that needs to be embedded in every aspect of the care organisation. This requires commitment at the highest level, clear and good leadership at all levels, robust policies that ensure and support dignity and an open two-way communication process between the care planners and care providers.

Learning from experience is vital to keep policies and practices dynamic and reactive to the changing needs of the organisation. To enable this, it is important to have mechanisms to ensure that policies are communicated to all levels, clear translation of policies into practices and feedback on whether the policies are effective. Unless there is commitment at every level, the efforts to implement these will be disjointed and the impact fragmented.

Although dignity is everyone's responsibility, having a clear lead for dignity issues is important as this ensures that dignity gets the priority that it deserves. It is also useful to have a dignity lead at board level, which will send a stronger message to the staff that this is an important issue for the trust.

What we found

Our inspection visits presented us with a variety of scenarios; in some there were clear policies on older people's care and dignity issues, while others had generic policies with older people and dignity issues embedded in them. We noted that all organisations perceived dignity as the right of every patient – not just older people – and this was reflected in their policies. A few organisations did not have separate policies for older people as they felt this was discriminatory. Whatever approach is taken, it is essential that the need to provide dignity in care was the underlying principle for all policies and this needs to be translated in all practices of care delivery.

Our inspectors noted that the director of nursing or the non-executive director were usually the leads at board level and were championing the cause of dignity and older people. At operational level, matrons or the chaplain were considered to be the dignity leads. Ward level leadership for dignity often came from the ward sister, who would ensure that the daily ward activity had dignity as the underpinning principle. Even though there were designated leads, it was clear that dignity was the responsibility of all staff.

There were also dedicated groups such as privacy and dignity groups, *Essence of Care* groups and nutrition committees, which looked at this issue on a regular basis. We also noted that at one trust, the chaplain was leading on dignity issues as it was felt that this role would ensure that diverse needs would be met more effectively.

In all trusts inspected, dignity was seen as part of the *National Service Framework for Older People*[4] or general *Essence of Care* benchmarking[7]. With the recent initiatives such as the Dignity Challenge and dignity champions, there is now more focus in furthering this agenda. Some trusts are also using the checklist from the Department of Health-led dignity campaign to self-assess their status on dignity issues. We also saw posters highlighting the Dignity Challenge displayed in some trusts.

Our inspections showed that policies were communicated in a variety of ways including: the chief executive's bulletin, the staff intranet, diversity folders, newsletters, staff away days, ward rounds, staff meetings, leaflets and other internal communication routes. Some trusts circulated a dignity in care newsletter, which highlighted the good practice to be shared by all wards. Internal audits in some trusts indicated that a high percentage of staff had not read these policies. In such a case, action plans were drawn up to rectify the situation. One trust had no clear policies or communication channels regarding privacy and dignity for older people.

All NHS trusts are expected to take account of the principles of *Essence of Care* benchmarking while taking steps to ensure that the care of patients respects their dignity. We found that the implementation of the *Essence of Care* benchmarking process was varied.

In some places this had a very high profile with board level leads for *Essence of Care*, while in others this was a matter for individual wards,

Case study 4: Fridays with a difference – Guys and St Thomas' NHS Trust, London

"It's easy to defend not doing office work but you can't defend poor patient care."

Every Friday, all senior nursing staff, including the chief nurse, are required to spend the day on the wards. This allows them to be in touch with activity in wards and be near to patients. The initiative started when senior nurses were setting priorities and deciding how to make a real focus on the patients' experiences and build on good practice within the trust. In addition, the trust wanted to ensure that the outstanding resource they have within the senior nursing workforce was used to the maximum effect for the benefit of staff and patients. Being a large trust, with two major hospital sites, there was also a need to bring staff together to share and reflect on practice.

This initiative provides the opportunity to:

- reinforce strong emphasis on visible clinical leadership
- work smarter in the current financial climate – using skills in the right place at the right time
- identify and resolve issues as they arise
- performance-manage policies and monitor their implementation
- break down hierarchical barriers and build relationships
- bridge the gap between the shop floor and the board
- provide role models and peer support for staff
- share information, reflect and have face-to-face discussion
- improve contact with patients and quality of care

The nurses meet at 2pm to discuss the real time data on a selected group of clinical indicators and to share learning. The initiative has helped to improve care, as the senior staff focus on what it is like to be a patient and on the support needed by nurses. A senior visible presence enables patients and staff to raise concerns easily.

There have been many positive outcomes, such as a reduction in slips, trips and falls within elderly care and greater ability to introduce change swiftly, for example successfully changing over all nursing documentation for the trust.

The key success factors are:

- having a joint chief nurse/director of operations
- persistence by the chief nurse
- raising awareness so that nurses can see the benefit for them and their patients

which resulted in variation. Some staff reported to us that *Essence of Care* was seen as a nursing issue and therefore involvement of non-nursing staff was very limited.

Our visits found that all trusts undertook some form of monitoring – both at board level and at operational level. This enables them to identify areas of potential compromise in dignity. Some examples of monitoring were the *Essence of Care* benchmarking audit, monitoring information from PALS, nursing audits, feedback from patients, and data on complaints. However, *Essence of Care* appeared to be the main method for emphasising dignity on the agenda.

It was apparent from the evidence collected from our inspections that monitoring at board level centred mostly around broader aspects of *Essence of Care* or core standards and often there was too much reliance on complaints as an indicator that dignity matters were being addressed. It was not always clear whether dignity issues pertaining to older people were getting the necessary prominence in the reports sent to the board.

At board level, external monitoring such as PEAT inspections, the patient and public involvement forum's 'ward watch', and results of the national inpatient survey were used to provide an insight into the quality of care delivered in the hospitals, and trusts were found to be using these findings to improve services.

Listening to complaints

Being able to complain and receive an acceptable response is also a matter of protecting the dignity of older people.

"Being treated with dignity and respect means that you feel that complaints will be listened to and acted upon." (older person)

Many older people told us that they didn't make complaints because they were not aware of the complaints handling process and they did not know who the named contact was. They also expressed a need for advocates specifically to help elderly and vulnerable patients to complain if they were treated unsatisfactorily.

It is essential to have appropriate robust mechanisms to gain feedback on performance in order to ascertain that the policies and practices are making an impact, and that older people are receiving a high level of care. The complaints process and other monitoring channels will enable the organisation to learn from practice.

Of the complaints received by the Healthcare Commission between July 2004 and July 2006, 26% concern the acute sector and many relate to inadequate measures by organisations to deal with complaints locally.

It is important that trusts resolve complaints as an issue of dignity. Lack of comprehensive systems to encourage complaints and their effective resolution will not only give older people a less satisfactory service but will also not allow mistakes to be rectified. Strong leadership and suitably trained staff to deal with complaints, supported by a robust complaints handling process, are vital for maintaining the dignity of patients.

While the complaints process is a formal one, usually undertaken after the care episode is over, identifying and resolving issues as they arise in the care setting is much more helpful for both patients and staff in improving services at an individual level.

Reporting of incidents and whistle-blowing are effective methods for reporting poor performance when staff do not want to be identified. This allows serious errors to be

Case study 5: Learning from practice: Christie Hospital NHS Trust, Manchester

Monitoring in Christie Hospital NHS Trust is guided by two main principles:

- knowing what is going on
- doing something about it

Underpinning these are two supporting elements – a commitment to fundamental care and seeing the patient's experience as integral to the performance management culture of the trust. This latter point ensures that nurses and general managers have a shared interest in ensuring the maintenance and improvement of measured care outcomes.

Knowing what is going on:
A central governance team manages complaints, comments, information from PALS, clinical incidents, data on infection and results of surveys. They feed this information back to clinical divisions and individual departments and report monthly to the board of directors through an integrated performance report, which also includes financial and operational targets. The chairman of the trust picked up an apparent increase in complaints within one of the divisions and asked for additional assurances to be formally reported at the next board meeting. Divisions take a balanced scorecard approach (currently being rolled out to wards), which is the subject of monthly performance review with divisions. Trends and trustwide issues are picked up through a governance structure.

Doing something about it:
Various initiatives have now been implemented as a result of the monitoring.

Some examples are:

- volunteers to support mealtimes
- improved choice of meals for patients
- improved curtains leading to better privacy and infection control
- cheaper cost of disposable curtains compared to laundering fabric curtains
- better gowns for patients
- provision of a specialist mental health nurse to support staff and relatives of patients

Key factors for success:

- high level commitment
- ownership by staff at all levels
- centralised governance systems

identified and ensures that the safety of patients is not at risk.

Promoting a culture that is blame-free and allows both patients and staff to feel able to report poor performance is a key part of strong leadership. This needs to happen at all levels.

What we found
In our visits we found that ward rounds, peer reviews, asking patients for feedback, and role modelling were some of the methods used by trusts for identifying poor performance. We saw that that while procedures on reporting of incidents and whistle-blowing existed in all 23 trusts visited, we noted that lapses in dignity were not always considered as important unless they were of a serious nature, such as someone going hungry for days or lying naked behind curtains for a very long period of time.

Visible leadership helps to promote a culture of learning. Our inspections found that in some trusts the director of nursing, matrons, the chaplain and older people's champions were leading on the dignity work and they had clear arrangements for identifying and reporting matters of dignity. A hands-on approach, where senior staff regularly spent time in the ward, was considered beneficial in ensuring that issues relating to dignity were addressed more effectively and we saw this happening in some trusts. We also noted that these arrangements were quite varied across the 23 trusts visited.

Acting on feedback
To make care responsive to the needs of people, it is vital that organisations learn lessons from the monitoring exercise and make changes accordingly. These may be high level changes resulting in modified policies or could be at ward level, where individual practices could be altered to suit the requirements of patients.

What we found
We found that in general, trusts have made changes as a result of monitoring. Examples include 'do not disturb' signs, larger and better-fitting gowns, protected mealtimes, a 'red tray' initiative to identify patients with special considerations, and better curtains. However, we have found that these changes are usually at the individual ward level and not across the trust. We learned that policies and practices relating to older people and dignity issues usually originated from wards within the Department of Medicine for the Elderly, and were then rolled out across the trust.

The process of implementing policies is slow and not always effective in other wards where older patients are mixed with different age groups. This is also an issue in trusts where the implementation is generally left to the ward-level leadership. Such a practice can create a variation in services for older people if they are transferred between wards or between hospital sites. Many initiatives were at a pilot stage and the way forward was not very clear.

Working in partnership with voluntary sector and community organisations
Delivering services that meet the needs of individuals is a key ingredient for maintaining the dignity of older people. This may seem challenging when dealing with patients from diverse groups due to their varied needs. Service providers must invest in building the knowledge of staff to support the provision of care for diverse groups, so that care can be centred on the needs of individuals. Catering to their needs requires an approach that goes beyond clinical care, taking into consideration non-clinical needs as well as personal preferences.

Case study 6: Working with volunteers – Staffordshire General Hospital, Stafford

Through the routine monitoring of complaints, the Mid Staffordshire General Hospitals NHS Trust identified wandering patients as an issue at Staffordshire General Hospital that needed to be addressed. In addition, the Hungry to be heard campaign highlighted the need for providing assistance to patients with eating and drinking. This required extra staff to help on the ward, which they were able to provide by recognising the role of volunteers to help with cutting up food, encouraging patients to eat and befriending patients with dementia.

In December 2006, the chief executive of the trust approached Age Concern South Staffordshire (ACSS), to identify ways of supporting older people while they were in hospital. A pilot project was run in one of the community hospitals and after six months, the project has been a great success and is now being rolled out across the trust.

The volunteers covered seven days between them, offering support to ward staff in serving food and drink and also encouraging older people to eat and drink. The volunteers provide emotional support, read, talk and listen to older people and also encourage group involvement with crosswords, activities and light exercise while sitting in chairs. The volunteers are trained by the hospital as well as Age Concern and have clearance from the Criminal Records Bureau. A steering group comprising staff from ACSS, a representative of the volunteers and hospital staff has been set up to monitor the progress monthly.

The volunteers have made an impact on improving care for older patients in a more effective way and also allow the nursing staff to concentrate on activities that only they can do.

Anecdotal feedback from patients, staff and volunteers has indicated that this initiative has been a success for everyone involved. A satisfaction survey is being undertaken to formalise this feedback.

The key factors for its success are:

- strong leadership
- support from ward staff
- good relations between the trust and the local Age Concern group

Links with community organisations that support these groups could prove invaluable in ensuring that the services are responsive to the needs of the groups. We pointed out in *Living well in later life*[1] that organisations providing services for older people needed to strengthen these links and work in partnership.

What we found

Many trusts had access to community support through their chaplain, who knew how to contact different organisations. In other cases we saw stronger links where some minority ethnic organisations were involved in developing policy and practice, including training, but this was mainly in areas with a very high population of a certain ethnic group. In other areas these structures appeared less developed and this support was accessed on an ad hoc basis.

Some trusts told us that they did not have many patients from minority ethnic groups and did not feel the need to develop systems to address these issues. Trusts should utilise these resources in a more structured way to meet the needs of a wider population, particularly in the light of the choice agenda where patients could seek treatment anywhere.

We did not find similar arrangements for improving services for other diverse groups, such as people with disabilities or those with lesser-known conditions, who do not find themselves well supported while in hospital.

There needs to be better partnership working between community and secondary care to allow more integrated services. Developing and sharing a profile of patients' non-clinical needs and preferences could be carried out in a non-hospital setting, which would support older people to make choices in a more supportive way. These arrangements already exist for some patients with dementia who have a social care package. This should also be explored for other groups of patients by linking in with social care systems.

Older people's and dignity champions

We reported in *Living well in later life*[1] that while the role of older people's champions was to root out age discrimination and promote the interests of older people within their organisations, they were not always effective in doing so. This was due to lack of clarity about their roles and inadequate training and support. Champions who were also healthcare professionals found this an additional burden on their working week.

Due to the recent emphasis on this role, many trusts now have dedicated dignity champions. Their responsibility is to ensure that older people receive care that respects dignity by raising the profile of dignity and challenging those practices that compromise it. This is a new initiative and some organisations seem to be taking advantage of this to improve the quality of services for older people. There is support for dignity champions in terms of knowledge networks and practice guides, but unless they receive the necessary support from within the organisation, they would find it difficult to make an impact. It is also important that these champions are highly visible to patients, as well as staff, to make best use of this resource. It remains to be seen if they are able to make the necessary impact.

A supportive ward environment

Key issues	
1	Many trusts are struggling to provide single sex accommodation due to pressure on beds and a complex mix of patients.
2	Some patients, such as those who have suffered a stroke or those with MRSA, were being placed in mixed settings as staff found it easier to care for them – a practice to be discouraged.
3	In some cases, there were inadequate arrangements for providing privacy by means of curtains and locks on toilet and wash facilities.
4	Old fashioned ward structures sometimes make it difficult to promote privacy.
5	Not all trusts provided quiet areas for patients.
6	Some good examples were observed of staff being innovative in providing privacy and dignity, but these initiatives are restricted to individual wards only.
7	Our observations indicated that most staff understood and practised behaviours that support the privacy of patients.

This section addresses issues relating to the ward environment that are vital for promoting privacy and confidentiality, such as ward structures, use of curtains, screens, private space and cleanliness.

Creating and providing an environment that is clean and that supports privacy and confidentiality is one of the key issues for older people being treated as individuals. The guidance in *Essence of Care* states that healthcare settings must ensure that quiet and private space is available to patients when required and that trusts must identify and address the barriers that restrict this provision.

Older people also consider access to space that meets their individual spiritual needs to be important for their dignity. Older people from different faiths may have requirements such as a prayer room or prayer mat or access to a leader of their faith. Trusts are expected to provide these services to patients.

"(Dignity means)... a place for prayers in the hospital for patients and visitors." (older person)

Privacy

The issue of privacy includes having private space and being covered appropriately and not exposed in an embarrassing way while being cared for. It also includes staff being sensitive to the need for keeping matters of a personal nature private, for example, not shouting across the ward that someone needed a bedpan or not asking in public "have you opened your bowels today?" both of which are unacceptable behaviour.

"The privacy of the patient should be respected during procedures at all times." (older person)

NHS organisations are expected to provide privacy with screens or curtains. However, the experiences of both older people and staff indicate that this does not always happen.

Providing appropriate clothing and ensuring that modesty is maintained at all times is vital to avoid a compromise in dignity. Wearing split hospital gowns has been a matter of concern for both patients and staff. This has already been recognised and moves towards improving the design of gowns or using larger size gowns that overlap have provided solutions, although in some areas this issue persists.

Having a day room or private space to discuss confidential matters or to have quiet time was considered important for older people.

The 2006 NHS inpatient survey[20] shows that only 76% of respondents were always given enough privacy when discussing their condition and treatment, a further 18% were given this facility "sometimes" and 5.5% did not get enough privacy in this situation.

What we found

We observed that some organisations had rooms dedicated for multi-faith use and were able to provide prayer mats if required, while others expected patients to use the chapel or the day room. All 23 trusts had access to the chaplain who was able to provide links with community groups. All staff were aware of how to access these facilities and were able to help patients if required.

Our observation of the wards on the day of the visit indicated that all patients were appropriately dressed and had their privacy and modesty protected. We also saw examples of staff ensuring that patients were appropriately covered while being transported and all interaction from staff demonstrated a consideration for dignity of the patients.

Our inspections identified that while some trusts were using day rooms or office areas as private space and were able to wheel beds in when required, in one case the day room was being used as a storage area. One trust was testing the use of headphones for consultations with patients.

We were told that staff found the provision of privacy for confused patients, or those with dementia, to be challenging, particularly when there was a shortage of staff. Providing privacy in the old-style nightingale wards and Victorian buildings was sometimes difficult due to shortage of space.

All 23 trusts visited were using curtains, but in some cases these were not appropriate and left gaps as they were too short or were not secured on rails adequately. We were presented with some good examples where these issues were being tackled by using long overlapping curtains and special measures such as red pegs or no entry signs to ensure that privacy was provided at all times. There were clear practices regarding the use of screens and general privacy issues, for example staff needing to knock when entering a covered bed area.

We also saw some wards nearer to external areas that were not providing adequate screening from the outside, as the windows were made of clear glass. This compromises the dignity of the patients and is not acceptable. Using frosted glass or curtains to cover the glass could address this.

Case study 7: Gowning around at the Royal Brompton Hospital, London

The traditional hospital gown has long been identified as a significant issue in terms of a patient's privacy and dignity. When the time came to award a new linen and laundry contract, managers and clinical staff at the Royal Brompton & Harefield NHS Trust took the opportunity to reconsider their approach.

Senior nurses at the trust had become aware of the availability of an improved gown design during a study day as part of the Royal College of Nursing's clinical leadership programme. They were impressed by the contribution that the gown could make to improve their patients' dignity, and they found out more about the suppliers and took details to the trust's managers. After discussion at various levels and with a variety of different groups of staff, there was so much support for the new design that the director of estates and facilities agreed that the provision of new gowns should be written into the new linen contract.

In February 2007, the trust entered into a new contract with their linen contractors, and a condition of the contract was to supply better-designed gowns for patients. Patients now enjoy a wider and longer garment than the traditional version. It fastens at the front rather than the back, has no gaps or openings and allows staff to access a patient's arm or neck to administer medication or take observations without removing it. Patients have welcomed the new gown enthusiastically and nursing staff are delighted to see their ideas in action. Strong working relationships between nursing staff and a variety of colleagues, both clinical and managerial, played a crucial role in ensuring this successful outcome.

The three key factors, which ensured success were:

- strong relationships with external colleagues
- cooperation and support for new ideas from internal colleagues
- writing the provision of the gown into the new linen contract, therefore embedding in practice at the trust

Single sex accommodation

Being in single sex accommodation and having access to single sex bathing, washing and toilet facilities is one of the most important considerations for older patients in maintaining their privacy and dignity. Some minority ethnic groups find mixed sex provision even more unacceptable due to their cultural background[26].

According to the 2006 survey of NHS inpatients[20], just under 23% of older respondents reported that they had shared a room or bay with patients from the opposite sex. A recent report on privacy and dignity and mixed sex accommodation[27] identified that with elective admissions, people would find it less acceptable to share the facilities with patients of the opposite sex.

The guidance from this report suggests that while it is ideal that patients should not be placed in mixed sex bays or rooms under any circumstances, it has been accepted that this is a possibility when patients are being assessed. Even in such circumstances, appropriate arrangements must be made to ensure privacy by means of curtains or screens.

Core standard C20b requires trusts to take steps to ensure that care is provided in environments that promote and support the privacy and confidentiality of patients, including provision of single sex facilities and accommodation.

When measured against the national target on eliminating mixed sex accommodation, it was found that NHS trusts had achieved 99% compliance on single sex accommodation and 97% on single sex wash and toilet areas.

What we found

Our inspections indicated that while placing patients in mixed sex bays was generally considered unacceptable in the trusts, it was possible that this would happen due to high demands on beds and a mix of patients. In some cases, this was done with the consent of patients. If patients did not consent they were not placed in a mixed environment.

It was also reported during our inspections that sometimes critically ill patients were placed near the nurse's station to enable better attention to care, and in such situations they could be placed in a mixed environment. Similar arrangements were in place for patients with stroke and MRSA. This practice must be evaluated in the light of whether this meets the privacy and dignity needs of the patients. It is important to reiterate that decisions relating to privacy and dignity matters in particular should be for the convenience of the patient and not for that of the system.

Staff informed us that patients could be placed in mixed sex accommodation after seeking consent from the patient. Consent must be sought in all cases, while recognising that critically ill patients may not always be in a position to understand and consent in a considered way. In many trusts, such questions were asked at the time of admission to ensure that the consent is fair and considered.

We found that provision of single sex wash and toilet facilities was more difficult for the trusts, particularly if there were more female patients or patients with dementia in the ward.

Case study 8: Initiatives to reduce incidence of mixed bays – Ashford and St Peters' NHS Trust, Surrey

This trust often found it difficult to maintain single sex bays because of the need to meet targets in the A&E department, which have implications for the number of available beds. With the opening of the new medical and surgical assessment facilities, an opportunity arose to have a more planned approach to placing patients in the ward areas.

A weekly snapshot of the number of mixed bays was carried out on Sundays, which collected data on the number of mixed bays, but this did not provide information on activity during the rest of the week or the number of patients involved.

The system of data collection has now changed and information is collated twice a day. This is then e-mailed to matrons, capacity managers and other identified senior nurses and managers in the trust, including the director of nursing and operations, the associate director of nursing, the deputy director of operations and the head of admissions.

This exception reporting is reviewed and discussed twice a day at the capacity (CAT) meeting and, if there are mixed bays, this practice can be challenged and plans to ensure single sex bays discussed, which enable better planning of the movement of patients on a daily basis.

This work is supported by the senior staff who use their daily ward rounds to ensure that any problems relating to mixed sex bays are resolved immediately. The head of admissions has also devised a flow chart to help staff in decision-making.

Regular monitoring meetings, a scorecard system, sharing ways of tackling poor practice and learning from good practice are some methods that have led to helping ensure that mixed sex bays are avoided except for clinical need in exceptional circumstances.

Key factors for success:

- recognising the challenges with the pressure on beds
- staff supported to challenge placement of patients to their areas
- all staff, including managers and medical staff, working together

We observed that, in some trusts, toilets and wash facilities were unisex and male/female signs were used to alter their use according to the need. All 23 trusts visited had some single rooms with en-suite facilities.

Having proper locks on toilets is important to ensure privacy. We observed in some places that there were no locks or the engaged signs were not working. In others, additional curtains and key fobs (to override in emergency) were used to provide the necessary privacy.

Core standard C20b also requires that all newly-built areas in NHS trusts must consider the provision of privacy as a key factor in designing facilities. We saw many good examples where the need for providing single sex facilities and single rooms with en-suite facilities was taken into consideration in a new development. However, the views of operational staff were considered in very few cases in designing facilities, thus missing out on input on the practical aspects of delivery of care.

Hygiene and personal appearance

A clean and welcoming physical environment is essential to the delivery of good quality care. Older people consider clean facilities as an important part of receiving dignified care. The Department of Health's *Privacy and dignity* report by the Chief Nursing Officer[27] states: "A clean environment is a proxy for good care".

According to the 2006 survey of NHS inpatients, approximately 56% of older respondents found their hospital room or ward "very clean", while around 37% thought it was "fairly clean". When asked the same question about the toilets and bathrooms just under 52% thought these were "very clean" and 38% thought they were "fairly clean". Lack of clarity of responsibilities regarding cleaning was an issue for both staff and patients.

"MRSA was previously not a problem. However, there is often no clear idea of cleaning responsibilities." (older person)

A clean ward environment was also considered instrumental in reducing infection and the related complications. Visible hand washing practices for staff were also mentioned as a way of providing clean environments. The 2006 NHS inpatient survey indicated that just over 70% of older patients said that doctors and nurses "always" washed their hands between touching patients. About 20% said this only happened "sometimes", while between 5% and 8% said doctors and nurses "never" cleaned or washed their hands between touching patients.

A good personal appearance and appropriate clothing were considered to be important by older people for maintaining their individuality and therefore their dignity.

What we found

During our visits to wards, we saw that the majority of wards were clean on the day of our visit with the exception of one or two where there was an unpleasant smell and the toilets were not clean. Findings from our observations of the wards showed that patients were appropriately dressed and staff took care to protect their modesty with particular attention paid to patients with dementia or confusion.

Conclusions

Our recent survey of inpatients shows that older people value healthcare services and feel that, generally, their dignity is respected. However, where care does fall short, lack of training and the resulting behaviour of staff are an issue.

Lack of dignity and respect has a profound effect on people from the older generation. They feel a lack of self-worth that could affect their emotional health and therefore hinder the recovery process. They also feel that they do not receive a service that treats them as a person.

Some of the main aspirations of older people are to be recognised and treated as people with experience of life, with intelligence and the ability to contribute to decisions about their care, and as having a right to express their disapproval when services are below the accepted level.

Maintaining dignity is very important to older people and this includes not being treated differently because of their age and not being referred to in a derogatory manner. A lack of involvement in their own care, lack of information and not receiving services that meet their personal needs often renders them powerless.

Being ill and being in a hospital environment makes people vulnerable, which is made worse when there are barriers because of differences in age, background, culture, religion or physical and mental conditions.

Fragmented service and variations in the delivery of care are detrimental to older people's emotional and physical wellbeing. Despite the policies and frameworks supporting a service centred on the individual, older people often express a lack of faith in the system. While they believe that the behaviour and attitudes of staff are key to maintaining their dignity, they are very sympathetic to their care providers. They do recognise the lack of training, time and inadequate support for staff, coupled with bureaucratic structures, as reasons for possible lapses in dignity.

Older people do not want to be seen as a complaining generation and do offer some suggestions as to how the situation can be improved. Some of the suggestions put forward by older people include more involvement of older people at board level, better processes to gather feedback, improving the behaviour of staff by visible and stronger leadership at all levels and better use of volunteers, carers and relatives. Some remain hopeful that the Human Rights Act will pave the way for ensuring that dignity issues are addressed and adhered to by all care providers.

Healthcare staff recognise dignity as an important part of care and acknowledge that there are situations when dignity may be compromised. They accept that meeting individual needs is paramount to delivering dignified care.

Our inspection visits found that policies and practices to support the delivery of care with dignity do exist. However, these policies are not always being translated into practice effectively. There is often a lack of adequate understanding of the practical aspects of dignity and privacy issues. Some trusts had disjointed arrangements instead of a whole systems approach, which could lead to gaps in care and potential lapses in dignity for older people.

We saw many examples where there are concerted efforts to address and improve dignity in care. Small changes can make a lot

of difference to older people and these do not always need resources. However, while the good practice initiatives need to continue in the ward and be rolled out across trusts, they also need to be sustainable in the long run.

Undoubtedly providing dignity in care for older people is important for both care providers and older people, and most NHS trusts are taking steps to address this. There is a need for more skilled staff, better training and awareness for dealing with patients with certain conditions, improved facilities and better working arrangements with contractors. Observing behaviour and challenging bad practice, providing role models, good leadership and better planning of resources are all instrumental in providing dignified care.

There is more work to do to ensure that older people actually receive the benefits of policies and are able to view their hospital experience as one that meets their personal needs, including dignity, rather than one that makes them more unwell both emotionally and physically.

Dignity is everybody's business. It is a joint responsibility of older people, care providers, policy makers and regulators to ensure that the care received by older people in hospital is centred around the individual and maintains their dignity at all times.

Robust mechanisms are vital to ensure that dignity underpins any activity while providing care, and to prevent dignity becoming a task at the bottom of the list that is never completed. Dignity is an integral part of the delivery of care and the fundamental principle should always be **'care with dignity'**.

Recommendations

What can trusts do?

Dignity (including nutrition and privacy) is a human rights issue and should be the underlying principle for delivery of services. Trusts must ensure that older people are not subjected to inhumane and degrading treatment while in their care. This includes being left in soiled clothes, being provided with inadequate nutrition and given no help with eating, or being placed in embarrassing situations. Trusts must consider the provision of care in a manner that meets the requirements of the patient as fundamental. Trusts can make improvements in a variety of ways, which would lead to better dignity in care for older people. These are often small initiatives that can make a huge difference to older patients and staff caring for them.

At board level:

1 There must be a commitment to dignity and privacy at board level, which should include nutrition. There should be a clear lead for dignity at all levels and this should be communicated to all staff and patients. It should be everyone's responsibility to ensure that dignity for patients is maintained at all times.

2 There should be clear policies relating to dignity issues. If these are embedded in other policies, trusts need to be able to demonstrate that staff address dignity issues for older people appropriately. Implementation of policies relating to dignity should be driven by the board, which would minimise variation between wards.

3 There should be clear arrangements to ensure that policies are translated into practical guidelines and staff must be supported to implement these guidelines, for example better arrangements should be made to implement the protected mealtime policy and strict adherence from all groups of staff must be ensured.

4 Meeting the needs of vulnerable groups must be a high priority for boards and more sustainable systems should be put in place to meet the needs of vulnerable patients.

5 Trusts should recognise the spiritual and cultural needs of their population. There should be systematic and sustainable links with community groups to enhance the quality of service to diverse groups of older patients.

6 Robust mechanisms should be in place at all levels to monitor whether the policies and practices are working and making a difference to older people from all groups. These mechanisms should include principles of *Essence of Care* benchmarking.

7 The leaders of trusts should endeavour to create a better environment to empower older people and staff in being able to express their views if services are below acceptable levels. This should include improving procedures relating to the handling of complaints.

At ward level:

1 Staff should develop ways to encourage older people and their carers/relatives to be more involved with their care and treatment, by making processes transparent, informative and responsive. Dignity should be included in the information for patients and the issues explained. Alternative ways of engaging with older people from vulnerable groups should be explored and developed, possibly using advocates and volunteers.

2 The process of identifying personal needs (including non-clinical needs) should be open and must avoid making assumptions. The single assessment process could be better utilised in ensuring that the personal needs of older people are considered in care planning. Carers and relatives must be involved in the decisions regarding care but they should not be expected to share the burden of delivering care.

3 Nutrition should be treated as an integral part of care. Assistance with food and drink should be provided in a manner that is dignified and focused on the individual. Appropriate measures should be put in place to ensure that all patients who need help are receiving it. More effort should be made in ensuring that meal-related needs are met for all groups of patients at all times.

4 Staff must be supported in improving their ability to identify and deal with issues pertinent to certain conditions, such as dementia, end-of-life care and confusion, to avoid errors in risk assessment. Attendance on training courses on equality and diversity and practical aspects of dignity must be mandatory and must be a recurrent event. Adequate staffing needs to be provided depending on the mix of patients to support delivery of care.

5 Any compromise in dignity should be considered a serious issue and must be treated as a disciplinary matter. Older people's champions and dignity champions need to be more visible and should be used to ensure that dignity issues are being considered while delivering care.

What can strategic health authorities do?

1 Strategic health authorities should work with trusts to ensure that agreed action plans are implemented and that the necessary improvements are made relating to privacy and dignity for older people.

2 They should work with primary care trusts to ensure that commissioning of services reflects the principles of dignity in care.

3 Dignity in care should be a key component of the performance management of NHS trusts by strategic health authorities.

4 Strategic health authorities could develop and promote training initiatives as part of their role in developing the workforce.

5 Strategic health authorities should work with trusts to ensure that hospitals take action against placing patients in mixed sex accommodation. In doing so, they should consider the chief nursing officer's report on privacy and dignity.

What can voluntary organisations do?

Voluntary organisations can help older people, their carers and relatives to make informed decisions by encouraging them to actively seek information on what to expect while in hospital.

1 Community groups could make links with the NHS to develop and promote structured and sustainable partnerships to provide advocacy and voluntary services.

What can policy makers do?

1 Since we highlighted our concerns about dignity and respect for older people in our joint report, there have been many initiatives

from the Government that have raised the profile of this important area. It is vital that this momentum is continued and national policies and tools are developed to support the local delivery. The forthcoming national nutrition action plan (a joint plan between stakeholders and the Department of Health) is a welcome initiative, which would ensure some consistency in the way that services related to nutrition are provided across the NHS.

2 Dignity champions have a vital role to play and they should be supported adequately until they become embedded in the local structures.

What will the Healthcare Commission do?

Dignity in care is a matter of high priority for the Healthcare Commission. Through our work, including this audit, we have seen improvement in the attention given to treating patients with respect for their dignity. We have found that generally, there are systems in place to support this work. We have also found that when the spotlight is turned on this area, appropriate actions follow.

However, we know from other information available to us (for example, from complaints) that there continue to be lapses in the care given to individuals. When we see a pattern of such lapses, we will follow up with individual trusts to ensure that failures to treat patients with respect for their dignity are addressed.

1 We will continue to assess the performance of NHS organisations through the annual health check process against the core standards relevant to dignity in care. We will improve and enhance the use of surveillance-based risk assessment, as a model to identify poor performing trusts. These trusts will be followed up for further scrutiny and notification if we identify concerns.

2 We will continue to encourage strategic health authorities to work with trusts at a local level, in particular to facilitate improvements in those NHS trusts that have declared non-compliance on standards relating to dignity.

3 We will actively seek local intelligence on lapses in dignity, which we will follow up as and when required.

4 We will consider the development of indicators relating to dignity issues that build on the work on 'dignity metrics' led by the Department of Health.

5 We will explore how the approach taken for assessing acute trusts might be adapted for other settings (for example mental health trusts or community hospitals) including the patient's journey between care settings.

6 We will continue to work with our key stakeholders to develop and promote initiatives that enhance dignity for older people while receiving care and will highlight particular areas of concern.

7 We will continue to develop and promote good quality accessible information on the performance of NHS trusts on dignity issues as part of our annual health check website, as stated in our accessible information strategy, to empower older people to make considered choices.

8 We will ensure that dignity and human rights for all groups of people (particularly those who belong to vulnerable groups) are the underlying principles informing the work undertaken by the Commission.

Appendices

Appendix 1: Organisations followed up during the visits

1 Barts and The London NHS Trust

2 Cambridge University Hospitals NHS Foundation Trust

3 Central Manchester and Manchester Children's University Hospitals NHS Trust

4 Dorset County Hospital NHS Foundation Trust

5 East and North Hertfordshire NHS Trust

6 Homerton University Hospital NHS Foundation Trust

7 Hull and East Yorkshire Hospitals NHS Trust

8 James Paget University Hospitals NHS Foundation Trust

9 Luton and Dunstable Hospital NHS Foundation Trust

10 North Middlesex University Hospital NHS Trust

11 Oxford Radcliffe Hospitals NHS Trust

12 Queen Elizabeth Hospital NHS Trust

13 Royal Berkshire NHS Foundation Trust

14 Sherwood Forest Hospitals NHS Foundation Trust

15 The Hillingdon Hospital NHS Trust

16 The Princess Alexandra Hospital NHS Trust

17 United Lincolnshire Hospitals NHS Trust

18 University Hospital Birmingham NHS Foundation Trust

19 University Hospital of South Manchester NHS Foundation Trust

20 Walsall Hospitals NHS Trust

21 West Hertfordshire Hospitals NHS Trust

22 Whipps Cross University Hospital NHS Trust

23 Wirral University Teaching Hospital NHS Foundation Trust

Appendix 2: Stakeholders who have shaped this work on dignity in care

1 Age Concern

2 Better Government for Older People

3 Black and minority ethnic elders

4 British Geriatrics Society

5 Department of Health

6 East Midlands Older People's Advisory Group

7 Help the Aged

8 National Audit Office

9 National Patient Safety Agency

10 Royal College of Nursing

11 Seldom Heard Network – University of Lancashire

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ENGLISH

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GUJARATI

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