On Our Own Terms

The challenge of assessing dignity in care
We were deeply saddened by the death of Professor Janet Askham part way through this project. We commissioned the Picker Institute Europe to prepare the *Measuring Dignity in Care* report on the basis both of its deep experience of researching the views of service users and Janet’s leadership in the field of dignity. Her death was a huge loss and we dedicate both this publication and the full report to her.
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Why does dignity matter?

Everyone has a different understanding of what it means to have dignity. Although it is difficult to capture in academic terms, it is soon apparent when dignity is missing.

‘They treat you as though you were nothing.’
(care home resident)

‘When my husband was in hospital… the trolley came round with all the medication… and this particular [staff member] – I think she was a sister – she was on her mobile all the time she was dishing out things.’
(hospital visitor)

It is unfortunate but true that years of investment in health and (to a lesser degree) social care services, legislation in the area of human rights and numerous campaigns have not translated into significant improvements in the experience of those who use these services the most: older people. Progress is at best incremental: ‘It’s three steps forward and two steps backwards’, as one informant told us.

It is time to call an end to the idea that it is acceptable to leave frail older people isolated, ignored and in pain. Dignity must not become the victim of political slogans – a concept that everyone agrees is important but no one quite knows how to deliver. This applies just as much to care in the home as it does to care in hospitals and care homes.

Help the Aged aims to bring clarity to the debate about what dignity in care means for older people. In 2007 we proposed a framework of nine domains of care that are important for supporting the dignity of older individuals using health and social care services. We have now asked older users of those services to identify what we need to be assessing under each domain if we are to make real progress in providing patient-centred care and monitoring and delivering dignity. Our dignity programme aims to set out the key measures and milestones by which we will be able to assess future progress.

This research is especially timely given the emergence of the new Care Quality Commission. The dignity of older people is as relevant to social care as it is to health. Help the Aged is developing its framework of dignity measures to ensure it adequately covers all settings where care and support are provided. As the new regulatory body develops, we urge it to work with us and older people to embed within its own regulation processes the issues that older people have identified as important to preserving dignity.

Paul Cann
Director of Policy and External Relations Division,
Help the Aged
1 Introduction

This publication presents the key findings of a study commissioned by Help the Aged and carried out by the Picker Institute Europe to develop indicators for use in measuring the extent to which older users of health and social care services feel their dignity is maintained.

This work is rooted in the views of older people. Following conversations with a number of key informants, including practitioners working in health and social care, we held focus groups with older people to define what should be measured if we are to capture whether services in different health and social care settings support dignity.

We have in addition laid the groundwork for the next significant phase of work, to develop practical methodologies for assessing those areas identified as important by older people. Our research has identified a number of existing indicators and associated questions which may be used for surveys to capture user feedback. A list of these questions is available in the full report (see inside front cover). Such survey questions will have met tests for reliability, validity and responsiveness necessary for them to be robust.

However, to date these measures and associated questions have not been universally applied: many have been used only in academic settings rather than to assess and improve services. Furthermore, there are gaps where no existing survey questions correlate to the indicators proposed by older people. In such instances, our researchers suggest new questions (see full report, as indicated on the inside front cover). These questions are however not tested.
In 2007 Help the Aged published a report, *The Challenge of Dignity in Care: upholding the rights of the individual*, which identified that all too often, for older people, use of health and social care services involves an erosion of fundamental dignity. This is despite years of investment in health and social care services, campaigns to highlight the often poor experiences of older users and associated policy responses from government.

One of the principal issues has been an inability to translate the relatively abstract term of dignity, one associated with the essential experience of being human, into meaningful practice. It has therefore been difficult to robustly assess the extent to which dignity is being delivered. Arguably, the result has been a performance management framework that focuses on process delivery rather than individual experience, which has led to the neglect of those personal aspects of care which contribute to an individual maintaining dignity.

*The Challenge of Dignity in Care* proposed a framework of dignity domains, i.e. those that are essential to maintaining the dignity of older people using health and social care services. They are:

- autonomy
- communication
- eating and nutrition
- end-of-life care
- pain
- personal care
- personal hygiene
- privacy
- social inclusion.

These Help the Aged dignity domains were based on an extensive review of literature including significant research probing the views of older people themselves. We asked the Picker Institute, an organisation with deep experience in this area, to:

1. test the dignity domains with individuals working in the field and, most importantly, older people themselves: does dignity remain an issue and do the Help the Aged dignity domains capture the aspects of care that matter?

2. develop the framework of dignity domains further by working with older people to identify the most appropriate and realistic indicators for dignity in care, from their perspective. What should be measured if we are to assess progress in delivering dignity?

3. assess the extent to which appropriate measures exist and identify where there are gaps which need to be filled if we are to capture the totality of dignity in care.
3 Emerging findings from the research

A number of overarching messages emerged from the research which are summarised below.

1 Dignified care remains a challenge for older people

Research participants suggested a number of reasons why dignified care for older people remains problematic:

- over-emphasis on targets and budgets that militates against dignified care in some instances
- the sacrifice of compassionate nursing care in the development of a more technical skills base
- ageism in society and among healthcare staff.

‘I heard a presentation today by an incontinence nurse specialist who explained that, for cost reasons, they are limited to four pads a day per patient. Where’s the dignity in that?’
(telephone interviewee)

2 Current measures do not necessarily capture the deficit of dignity in care

Secondary analysis of older people’s responses to the 2007 National Inpatient Survey revealed that older people tended to give more positive responses to questions about whether they were treated with respect and dignity than younger people. They also responded more positively to questions about their general care, privacy, food, pain control and cleanliness.

However, this benign impression is contradicted by the findings of qualitative research, raising important questions about the validity of the range of methods used for measuring experience.

It is possible that older people have lower expectations of their care than younger people and are therefore less critical. Equally, older people could be more forgiving as they have a greater experience of receiving care and therefore a better understanding of the pressures facing staff. Or they could have a different understanding from staff of what it means to be treated with dignity.

On the other hand, it could be that the ‘global’ measures used in large-scale surveys are insufficiently sensitive to pick up the nuances of a complex concept such as dignity.

The researchers also highlighted that expectations about being treated with dignity altered depending on the care setting. The
suggestion is that in hospitals, where more urgent care is provided, patients are willing to compromise on aspects of dignity. In care, rather than hospital, settings it was more important to be treated with dignity because the care was more long-term.

A more detailed and targeted approach might well produce more reliable and useful results. In particular, more detailed survey questions should be developed to focus on dignity rather than ‘global’ assessments of patient experience. Such a survey should be supplemented by qualitative studies and observation wherever possible.

3 The Help the Aged dignity domains capture most of the aspects of care important to older people

Older people generally agreed that the Help the Aged dignity domains satisfactorily covered the main aspects of care. However, they proposed in addition that certain elements of the existing domains could be highlighted more explicitly, such as money and financial control.

4 Care setting is relevant in maintaining dignity: home care has received a lower profile in the dignity debate

Approaches to maintaining dignity and therefore the aspects of care that should be assessed differ according to setting (hospital/residential or nursing home/home care).

Over 300,000 older people in England currently receive care in the home. However, compared to the other settings, relatively few indicators and measures exist that are specifically for use in the home care setting, perhaps owing to a relative lack of research involving home care service users. Our focus groups with older people highlighted some key indicators of high-quality home care. However, more needs to be done in this vital area to ensure measurement frameworks take into account both developments in service provision and older people’s views on what is important.

5 It is difficult but vital to capture the experience of some of the most vulnerable older people, particularly those in care homes

Although the large national surveys of hospital and primary care patients achieve relatively high response rates from people over 65 (for example, the 2007 inpatient survey response rate among those aged 66 and over was 62.1 per cent compared to an overall response rate of 56.1 per cent),³ it is much more difficult to survey care home residents when a high proportion have varying degrees of cognitive impairment. It may therefore be important to develop alternative methods for exploring the experiences of those with cognitive impairment. This may include involving carers or other representatives in answering questionnaires and assessments.

The use of observational tools to assess dignity may also be useful in this situation, although such tools may require further development.

In these cases, a number of options might be considered:

- the use of relatives as representatives (although they will have a different perspective and have only a partial picture of what is happening in a care home)
- the use of care staff as representatives (but their views will inevitably include some bias)
- the development of checklists to be used in observation exercises by independent assessors
- the use of specialist communication tools for interviewing older people with dementia: for example, Talking Mats. This product aids decision-making for the cognitively impaired by providing a system of picture symbols and a textured mat to allow people to express their feelings about various options.

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4 What should be measured in order to assess the maintenance of dignity in care?

‘If somebody is really good about ensuring that curtains are always drawn, people are helped to go to the toilet etc., but in a way that is frosty and unfriendly, then it’s not care with dignity.’

(telephone interviewee)

In answer to this, the main research question posed, older people and key informants identified a series of indicators of good-quality care for all the Help the Aged dignity domains. The consultation exercise revealed a high level of consensus among participants. A number of cross-cutting themes important for maintaining dignity also emerged:

- choice
  - support to make choices (both information and practical support)
  - personalisation and tailoring of care
- control
  - respect for individual lifestyle and preferences
- involvement in decision-making
- staff attitudes
  - respectful attitude in relation to all aspects of care
  - courtesy and sensitivity in all forms of communication
- facilities
  - availability of and access to appropriate facilities/equipment
  - cleanliness of facilities.

The table overleaf summarises the indicators of good-quality care identified by this consultation exercise. For every dignity domain, there is a series of indicators. The indicators are also organised according to the cross-cutting themes which emerged from this consultation exercise. Gaps in the table signify where indicators identified by older people for each of the dignity domains could not be organised according to all four cross-cutting themes.

Although we recognise that the care setting has a significant bearing on the aspects of care that are likely to support dignity, our research concludes that it is necessary to use a set of indicators that include common ‘core’ elements, relevant to any care setting, together with indicators which are specific to the care setting.

The table therefore presents both indicators which should be common to any health or social care setting and those which are specific to particular settings.

Those indicators where a tested measurement tool already exists in some form are marked with an asterisk (*).

This enables us to see those areas which have been neglected by previous work. It does not, however, offer a value judgement on the appropriateness of existing measurement tools. It should also be noted that where measurement tools do exist for particular indicators, they may not be relevant for all settings. This is particularly true for home care.
Table  Indicators of dignity in care: what should be measured to assess whether health and social care services support the dignity of older users?

<table>
<thead>
<tr>
<th>Dignity domains</th>
<th>Choice</th>
<th>Control</th>
<th>Staff attitudes</th>
<th>Facilities</th>
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<tr>
<td>Autonomy</td>
<td>Information to support decision-making*</td>
<td>Respect for personal property*</td>
<td>Availability of advocacy services</td>
<td>Safety in own home</td>
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<td></td>
<td>Choice in daily routines</td>
<td>Involvement in decision-making about care and treatment*</td>
<td>Specialist equipment to maintain independence if needed</td>
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<td></td>
<td>Choice of how to arrange own room in care home</td>
<td>Freedom to complain without fear of repercussions</td>
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<td></td>
<td></td>
<td>Responsibility for long-term medication if desired</td>
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<td></td>
<td></td>
<td>Control over own life*</td>
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<tr>
<td>Communication</td>
<td>Being listened to*</td>
<td>Respect for religious and cultural beliefs</td>
<td>Courtesy of staff*</td>
<td>Access to interpretation and translation</td>
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<td></td>
<td>Openness and clarity*</td>
<td></td>
<td>Forms of address agreed with service user</td>
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<td>Information provided with sensitivity*</td>
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<tr>
<td>Eating and</td>
<td>Choice of what, when and where to eat*</td>
<td>Respect for religious and cultural beliefs</td>
<td>Appropriate and sensitive assistance to eat available when required*</td>
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<tr>
<td>nutrition</td>
<td></td>
<td></td>
<td>Presentation of food</td>
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<td></td>
<td>Availability of additional snacks</td>
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<tr>
<td>End-of-life care</td>
<td>Information/support to make decisions</td>
<td>Respect for advance directives/‘living wills’</td>
<td>Support for bereaved families and friends</td>
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<td></td>
<td>Opportunity to discuss personal wishes</td>
<td>Sensitivity to cultural/spiritual needs</td>
<td>Timely verification and certification of death</td>
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<td></td>
<td>Relief of pain and discomfort</td>
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<td></td>
<td>Choice of where to die and who to be with</td>
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<td>Care of body following death</td>
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<tr>
<td>Dignity domains</td>
<td>Choice</td>
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<tr>
<td>Pain</td>
<td>Choice of types of pain relief</td>
<td>Responsibility for own pain relief if desired</td>
<td>Appropriate and timely relief of pain/discomfort*</td>
<td>Availability of a range of treatments to manage pain</td>
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<td></td>
<td>Opportunity to reject pain relief medication</td>
<td></td>
<td>Avoidance of care practices that cause pain where possible e.g. hoists</td>
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<td></td>
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<td></td>
<td>Staff ask about/acknowledge pain</td>
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<tr>
<td>Personal hygiene</td>
<td>Choice of type/level of assistance</td>
<td>Use of own toiletries etc.</td>
<td>Appropriate, timely and sensitive assistance*</td>
<td>Sufficient, clean and suitable washing/toilet facilities*</td>
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<td></td>
<td>Choice of who provides assistance</td>
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<td>Practical assistance/</td>
<td>Assistance that reflects user’s needs and wishes*</td>
<td>Support to maintain personal standards</td>
<td>Respect for personal possessions</td>
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<td>personal care</td>
<td>Respect for personal preferences/lifestyle choices</td>
<td>Agreed timetable of visits from carer or relatives*</td>
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<td>Privacy</td>
<td>Permission sought before students or others are present during</td>
<td>Precautions taken to protect personal information</td>
<td>Privacy when using the toilet/bathroom, or being examined, treated for or</td>
<td>Single-sex facilities*</td>
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<td></td>
<td>treatment or examination*</td>
<td></td>
<td>discussing condition*</td>
<td>Availability of private space*</td>
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<td></td>
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<td></td>
<td>Permission sought before physical contact</td>
<td>Curtains, blinds, use of ‘do not disturb’ signs</td>
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<td></td>
<td>Protection of modesty*</td>
<td></td>
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<tr>
<td>Social inclusion</td>
<td>Equality of treatment*</td>
<td>Religious and cultural needs satisfied*</td>
<td>Valued as a person*</td>
<td>Contact maintained with friends, family*</td>
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<tr>
<td></td>
<td></td>
<td>Consulted about service-planning</td>
<td></td>
<td>Cultural, recreational and social needs satisfied*</td>
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<td></td>
<td></td>
<td>Opportunities to discuss impact of living situation on health</td>
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The research produced significant qualitative data concerning the practice that participants believed was important for maintaining dignity when using health and social care services. This detail is provided below under each of the Help the Aged dignity domains.

**Autonomy**

“People sleep less as they get older, yet if someone is wandering around the ward at 4am, should we be offering them a cup of tea rather than telling them to go back to bed? It should be right to take a risk.”

(telephone interviewee)

This is a major aspect of dignity in care. Although it may be problematic for very dependent older people and less easy to address in highly institutionalised settings such as hospitals, a wide range of issues was highlighted:

- support to be involved in care if people want to be
  - appropriate, sensitive and timely assistance available to help people to make decisions
  - availability of advocacy services
- ascertaining people’s desire to be involved in their own care
  - establishing what people would like to do for themselves and what they would like help with, and providing them with choice wherever possible
  - constant review of cognitive capacity
- involving people in their own care:
  - in care planning, if desired
  - in care and treatment
  - wishes and needs taken into account when planning treatment
  - complaints listened to, taken seriously and acted upon where necessary
- responsibility for own medication where possible
- support to maintain and maximise independence, including:
  - support and services available to help maintain independence (even at the end of life)
  - availability of appropriate equipment to maximise independence in all settings
  - availability of accommodation/environment that meets needs and matches expectations and preferences.

**Communication**

“If you’ve got good staff who listen to you. They should listen to you… and make you feel you’re somebody.” (care home resident)

This domain can be interpreted quite broadly, often revealing the attitudes of health and social care professionals towards service users. There was widespread agreement about the most important aspects:

- readily available, approachable, qualified staff to discuss any concerns
- appropriate, courteous and sensitive communication from staff at all times
  - being acknowledged and seen as ‘real’ people
  - feeling listened to and understood by care professionals
  - consent obtained for any action
  - appropriate forms of address from care professionals
  - appropriate and respectful verbal and non-verbal body language
- support to communicate with care professionals where required, including:
  - availability of interpreters
  - carers who speak service users’ language
– strategies to help people with communication difficulties
  – effective communication, including:
    – consistent messages about treatment, condition or everyday living arrangements
    – clear and understandable explanations of treatment and conditions.

**Eating and nutrition**

“That one man was opposite me… One nurse would come in, get hold of his head… and put it back, the other one would get potatoes, which were never cooked properly anyway, with a fork, pushing it in his mouth and then holding his mouth up there so he got to swallow it.”

(recent inpatient)

Dignified care entails more than simply ensuring patients are eating enough. The following concerns were also raised:

– choice of when and what to eat
  – availability of a wholesome, appealing and balanced selection of meals

– recognition of the cultural and religious significance of certain foods
  – sensitive, appropriate and timely assistance with eating:
    – being positioned correctly
    – having food cut up if necessary
    – provision of help to complete menu forms

– presentation of food (e.g. ‘proper’ cutlery; eating as a social experience at a nicely laid table)

– drinking and rehydration (particularly during end-of-life care).

**End-of-life care**

“I had a terrible argument with the director of [hospice] about whether a hospice was the right thing and I said it wasn’t for me and he ended up saying… “What you’re doing is taking away the rights of my nurses to look after dying people,” which I thought was atrocious.”

(recent inpatient)
Many of the other domains could be applied to end-of-life care, but a number of additional concerns were highlighted:

- maintenance of a sense of control
  - information to support decision-making
- effective management of symptoms
- expert help available from health professionals
- opportunity to express personal wishes in an advance care plan (this would ideally include where the individual wants to be and with whom when they are dying, how they want to be cared for, family involvement and lasting power of attorney)
- resolution of unfinished business
- being active to the last, if possible
- support for bereaved families and friends.

**Personal hygiene**

“If somebody gave you a shower, what were they doing, is that water too hot? Do they care? Do they bother? Or do they just leave it and let it run cold and don’t give a damn about you?”

(care home resident)

Appropriate attention to older people’s wishes regarding their personal hygiene was considered essential to their self-esteem. The following key issues were highlighted:

- respect for personal preferences and choices
  - choice of when and how often personal hygiene tasks are carried out
  - choice over what to wear
  - wishes should be discussed, written down and acted upon
  - opportunity to determine how much attention is needed
  - ability to specify the nature of that attention and, ideally, who provides it
- suitable facilities and staff available to help maintain personal hygiene
  - timely and readily available assistance with personal hygiene (for example, not having to wait too long for a bedpan)
  - speedy attention to soiled bed linen and clothes
  - clean living environment
- respectful delivery of care, including:
  - discretion, gentleness, modesty and a personal approach
  - care taken with personal items (for example, false teeth and hearing aids).

**Privacy**

“I remember being taken to the toilet in hospital and they left the door open. They couldn’t understand why I was concerned about it. The nurses were having a conversation while I was on the toilet as if I didn’t exist.”

(recent inpatient)

While privacy was regarded as a key aspect of being able to preserve one’s self-respect, the research highlighted the difficulties associated with maintaining privacy in certain care settings. The following issues were discussed:

- design of care environments
  - curtains and blinds that close (although these provide only visual and not auditory privacy)
  - separate rooms in hospitals for the exchange of confidential or sensitive information
- respectful staff attitudes in relation to all aspects of care
  - privacy when washing, dressing and using the toilet
  - knocking on doors before entering a resident’s room
  - permission asked by health or social care professionals when privacy might be infringed
– consent to monitoring devices (for example, in care homes and sheltered accommodation)
– privacy when discussing any issues related to health or well-being
– privacy during treatment or examination by health professionals
– respect for confidentiality
– privacy in relation to day-to-day living arrangements when desired
– availability of appropriate facilities to help maintain privacy
– availability of private rooms (although a balance may have to be struck in hospitals between the comfort of a single room and the welcome distractions of being on a ward)
– single-sex wards and washing and toilet facilities
– gowns that do not gape.

Pain

‘It’s different from person to person, but if you’re suffering pain and you’re not looked after and treated, that’s a loss of dignity because you are no longer in control, are you?’ (carer)

The research suggested that this domain should include all forms of physical discomfort, including sickness, nausea and breathlessness. The main issues raised were:

– involvement in discussions about pain management
  – support to enable people to make decisions about pain management and to manage their pain
– choice over pain relief options
  – support and information to enable choice about pain relief
  – control of pain medication when desired
– care which minimises pain experienced
– avoidance of practices that contribute to pain (for example, the use of hoists in care homes)
– timely and sensitive provision of pain relief
– appropriate level of pain medication given to manage pain when needed.

Personal care (practical assistance)

‘A carer comes and they won’t listen to you… They will do it how they like to do it… not the way I want the thing to be done.’
(home care service user)

‘If care staff are only allowed 15 minutes per visit, they may technically do what is required of them, but they won’t leave the person feeling they’ve been treated with dignity.’
(telephone interviewee)

This domain was often confused with ‘personal hygiene’. As it primarily relates to help at home, it has been suggested that it be renamed ‘practical assistance’. The following issues were raised:

– knowledge of an individual’s preferred lifestyle (including dress, timetable, pets, religious and cultural background etc.)
– respect for an individual’s preferred lifestyle, including:
  – flexibility to meet individual needs
  – timetables to suit the client
  – assistance that reflects individuals’ wishes
– respectful delivery of care and support
  – support to maintain personal standards
  – regular information about changes to help and assistance
  – consistency of carer
  – respect for property and possessions
– sufficient time for home care visits
– regular monitoring of the service provided to each client.
Social inclusion

‘They treat you like children. Their idea of a good time is to give you a tambourine. For some people that might be good, but not for me.’
(care home resident)

‘Drinking and draughts and whisky and all the things that these people did before they went into the home.’
(carer)

Although the concerns raised were not always expressed in terms of social inclusion, there were a number of common themes reflecting older people’s fear of loneliness and the importance of social relationships:

- choice over social relationships and activities
  - choice of activities
  - control over degree of involvement in activities
  - availability of support to attend activities outside home

- support to maintain social relationships
  - visitors to care home welcomed
  - support to maintain contact with family and friends and the local community, if wanted
  - availability of day care centres
  - opportunity to discuss how general problems, family and/or living situation might be affecting health

- residents consulted about the performance and running of the home and their ideas acted upon

- respect given to religious beliefs
  - opportunity to practise religious beliefs.
Help the Aged appreciates that government policy has increasingly recognised the issue of dignity in care for older people. This has most obviously been demonstrated through the Dignity in Care campaign, launched by the Care Services Minister Ivan Lewis in November 2006. However, there is a question concerning whether, to date, dignity has been a victim of slogans, with a lack of associated rigour. Why, if our services purport to hold dignity so dear, is there a constant stream of stories in which the fundamental dignity of older users of health and social care services has been undermined by poor-quality treatment? Help the Aged work in this area, in particular the findings from this research, points to a number of issues.

- Dignity is an end, rather than a means to an end. Practitioners cannot ‘do’ dignity through any one action. However, dignity can be supported by appropriate, high-quality care tailored to the needs of older individuals.

- Any assessment of the extent to which dignity is supported by health and social care providers must therefore look across multiple dimensions of care. Older people agree that the high-level framework of nine domains proposed by Help the Aged in 2007 is a good starting point. They also agreed that all of the domains can be used in both health and social care settings.

- However, it is important that the assessment system itself does not militate against practitioners supporting dignity by attending to individual needs of users, which is the charge laid against the current planning and budgeting system. Meeting process targets such as four-hour waits in hospitals can divert attention away from the needs of individual users.

- Injecting the voice of older users into performance assessments is the obvious way to achieve a better balance of practice.
focused on users’ needs. Although there are good examples of current practice, such as the current Commission for Social Care Inspection (CSCI) inspections of care services, for which the views of the service users assist in determining the star rating of the service, the fact that this does not happen routinely within our health and social care services points to a suspicion that patient views are not considered a valid or objective way of assessing service quality.

Our work through the Picker Institute demonstrates that this is not the case. In the first instance, older users can provide a valuable and essential insight into how performance management systems should be designed so that they reflect their needs and concerns. Secondly, it is valid to incorporate users’ views into the feedback loop of service assessment. Only then will services understand the extent to which they are genuinely supporting the dignity of their older users.
7 Conclusions and next steps

As the Government proceeds with reforms within health and social care it is essential that the dignity of older users, who use these services most, is at the heart of any developments. For too long dignity has been a sideshow, undermined by lack of consensus on what it means to support dignity and lacking any rigour in terms of performance assessment. This research demonstrates that dignity can be measured in a meaningful way, and that service users in both health and social care strongly support the idea that dignity forms the backbone of any high-quality service.

Help the Aged is committed to ensuring the Government delivers on its promise to ensure high-quality care for all, including those who are most vulnerable and whose dignity may be challenged by lapses in quality of care. This research should inform activity on a number of levels.

- It is relevant to those developing health and social care policy on a national level, including the Department of Health and the new Care Quality Commission

- It should also offer those providing services to older people a comprehensive insight into what they should be assessing if they are to understand the extent to which they are supporting the dignity of their users.

We appreciate that this is not a closed subject. The very subjective nature of the term ‘dignity’ will mean that our proposed measures will trigger debate concerning, not least, whether stakeholders agree they are correct. Help the Aged welcomes this. This topic can never remain static and should be frequently reviewed.

Moreover, some work remains to be completed in terms of translating these measures into tools which may be used in assessment at either national or local level. Help the Aged hopes to work with relevant stakeholders to move on to this next vital stage.
Fighting for disadvantaged older people in the UK and overseas,

WE WILL:

**COMBAT POVERTY** wherever older people’s lives are blighted by lack of money, and cut the number of preventable deaths from hunger, cold and disease

**REDUCE ISOLATION** so that older people no longer feel confined to their own home, forgotten or cut off from society

**CHALLENGE NEGLECT** to ensure that older people do not suffer inadequate health and social care, or the threat of abuse

**DEFEAT AGEISM** to ensure that older people are not ignored or denied the dignity and equality that are theirs by right

**PREVENT FUTURE DEPRIVATION** by improving prospects for employment, health and well-being so that dependence in later life is reduced