Dignity on the wards: improving hospital care for older people

Despite improvement in the care and experience of older people being prominent features of NHS health policy over recent years, a number of high level reports show the effectiveness of such policy initiatives has been limited and the provision of dignified care for older people remains difficult to translate into practice.

In England and Wales, respective reports by the Ombudsman (Parliamentary and Health Services Ombudsman, 2011) and the Older People's Commissioner for Wales (2011) both revealed attitudes that failed to recognize older people as individuals and respond to their needs with compassion and sensitivity. Following this, the Care Quality Commission (2011) report on dignity and nutrition inspections demonstrated widespread failures in many acute trusts.

The media response to these findings has been one of highlighting the failures of nurses to care and even the Prime Minister has waded in to pronounce on what nurses should and should not do (West, 2012). The authors' own research (Tadd et al, 2011), as well as that of others (Gladman, 2012) show that scapegoating nurses, or any other professional group, is unlikely to bring about the necessary changes as the failures are systemic and strategic approaches are needed to produce and sustain the required transformations in care.

Dignity in Practice study

The Dignity in Practice study adopted an ethnographic approach to explore why provision of dignified care is problematic. The study, undertaken in four acute trusts in England and Wales, involved in-depth interviews with 40 older people and 25 carers following discharge, 32 senior trust managers and 79 ward staff from a range of professional groups. These interviews were augmented by 617 hours of non-participant observation in four wards in each trust (16 overall). The wards covered a range of specialisms including general medicine, surgery, acute stroke care, rehabilitation, care of older people, orthopaedics, vascular surgery, respiratory medicine and acute care of people with dementia. Below is a summary of the key findings.

Organizational processes

The vast majority of NHS staff are motivated to represent and support patients' interests but are frequently compromised by systemic and organizational factors, including setting acute trust priorities on the basis of measurable performance indicators, cultures of blame, management of 'secondary risks', high bed occupancy rates as well as increased specialization and rationalization which all impact on older people's care. The intense concentration on timely discharge and 'moving' patients through the system results in patients being continually moved around the wards to ensure they are in appropriate specialist (or gendered) beds in ways that are neither therapeutic or conducive to rest or recovery. Older people are particularly prone to multiple moves as their needs and multiple pathology means they are less likely to fit into neat medical specialisms.

One aspect of institutional life that is especially problematic is board-level aversion to risk, which affects staff–patient interactions and prevents staff from considering an appropriate balance between risk-taking and promoting individual autonomy. In many of the observations undertaken on the wards, the authors found that the fear of patients falling or otherwise coming to harm took precedence over patients' dignity and their need for control. Often when patients asked for help to go to the toilet, they were encouraged to use the incontinence pads they were wearing rather than risk a fall.

Local ward cultures and practices had developed in the context of untenable staffing levels operating within a strictly demarcated and hierarchical division of labour. This often resulted in a failure to provide continuity of care or care which protects and promotes the individual's dignity. Care delivery was largely task based and reactive to patients' requests for assistance, which can result in low self-esteem by reducing patients to a state of dependence.

Ward leadership

Crucial to good care was the visible nursing authority on the ward. Patients and families rarely knew 'who was in charge' on the wards and who they could talk to about their condition or progress. Ward managers complained that they had little input into recruitment, selection or removal of staff in their own clinical areas and yet they were responsible for staff supervision, support and team building for which little time was available. Little support was given by senior managers who were rarely present in the clinical areas talking to patients, visitors and staff or observing what happened in wards. Current staffing levels also meant that there was little opportunity for reflection on practice and many staff were reluctant to challenge inappropriate practices.

Right place, wrong person

The median age of hospital patients in England is 68 years and people over 65 years of age account for 60% of admissions and 70% of bed days (Oliver, 2008). A similar situation exists in Wales where, in one of the study sites, a 1-day census of a 200-bedded medical unit showed that the average age of patients was 82 years and 10% were over 90 years old (Tadd et al, 2011). However, staff at all levels in the acute trusts did not accept that their core business was caring for older people and in interview after interview, staff insisted: 'they [older people] do not belong here' or 'it's not the right place for them'.

The prevalence of this view resulted in the physical environment, staff skills, education, and the organizational processes acting as barriers to delivering dignified care to older people.

The environment of care

Because acute wards were poorly designed, inaccessible and confusing, they failed to meet the needs of their main users, older people. The physical design of the acute wards left much to be desired: there was nowhere for patients to go away from the bed, no day-room or dining area, physical hazards were apparent everywhere, wards and bays looked alike and there was a lack of signage or even clocks displaying the correct time to orientate patients. While patients had little to occupy them, the staff rushed about and the atmosphere on the wards could be characterized as one of frenetic activity with little opportunity to engage with individuals.

Staff skills and knowledge

The staff, while doing their best, were often ill-equipped in terms of their knowledge and skills to care for older people whose acute illness was often compounded by physical and mental comorbidities. Most staff stated that they had not had training in meeting the needs of older people or in delivering dignified care. The majority of staff had not had the necessary training to care for older people with dementia, a finding also borne out by Gladman (2012).

Conclusions

Many of the barriers to providing dignified care are systemic and require long-term systemic solutions, but there is an urgent need to change the culture surrounding older people's care. Few if any staff set out to deliver undignified care but the systems in which they work resulted in dignity and quality of care being compromised.

At all levels of the NHS there must be a recognition that older people are the main business of acute hospitals. As highlighted recently (Taylor, 2012) the worrying claim that 25% of patients would be better cared for in the community without any supporting evidence reflects the widespread views of interviewees that 'older people ought not to be here'. The fact that staff recognized all of these issues but concluded that it was the older person who was in the 'wrong place', together with the assumption that there must be a better place for 'them' to be, suggests an underlying and widespread ageism. BJHM

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KEY POINTS

- There is a failure and ongoing reluctance to accept that older people's care is the core business of the acute NHS.
- Shared care approaches and increased involvement of geriatricians and psychogeriatricians is essential in care provision for older people, together with a comprehensive geriatric assessment for older adults.
- There should be compulsory induction and training for all staff in the provision of dignified care and meeting the needs of older people, especially those with dementia, and staff should have time to reflect on their practice.
- Poor care and behaviour happen in a context where the unacceptable becomes the norm. It is the responsibility of senior trust managers to ensure that robust monitoring systems are in place to root out poor practices.

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