Strategies to enhance privacy and dignity in care of older people

Pritchard, 2000).

Policies to promote dignity

In 1997 *The Observer* newspaper ran an article by Martin Bright on the poor quality of care his grandmother received in hospital. This led to the launch in the same year of the Dignity on the Ward campaign (Help the Aged et al, 1999). This resulted in an independent inquiry by the Health Advisory Service (HAS) in 2000 into the care of older people in hospitals, and the subsequent publication of the report *Not Because They Are Old* (HAS 2000, 1998). The Dignity on the Ward campaign had four principal objectives:

● To ensure the government improved the care of older people in hospital;

● To see that hospitals were run to the standards that older people expected;

● To promote good practice in the care of older people by ward staff;

● To help older people and their relatives to improve their situation if they ran into problems in hospital.

The Essence of Care (DoH, 2001b) is a key document in ensuring that issues relating to an individual's right to privacy and dignity are addressed. It contains a toolkit for benchmarking in eight clinical areas. One of these is privacy and dignity, the aim of which is for patients to benefit from care that is focused on respect for the individual. This involves the right to expect privacy (freedom from intrusion) and dignity (being worthy of respect). Underpinning this are seven factors that health care staff need to address (Box 2).

It is vital that we see beyond the patient in the bed and instead see a person who has had a past, has a present and a future, and who has a 'patchwork of life experiences' that makes that person an individual

BOX 1. THE SIX KEY AREAS OF THE *NATIONAL SERVICE FRAMEWORK FOR OLDER PEOPLE*

● **Improving standards of care**

● **Extending access to services**

● **Ensuring fairer funding of long-term care**

● **Developing services that support independence**

● **Helping older people to stay healthy**

● **Developing more effective links between health and social services**

(Webster and Whitlock, 2003).

Enabling strategies
Leadership

The ward sister, as a clinical leader, has the ideal opportunity to act as a role model for promoting therapeutic, person-centred practice.

A key way of ensuring that individuals' right to privacy and dignity are respected is to create 'norms' in the way in which the team works. Team members may need to be able to explore their own values and beliefs before taking on new ways of working; this can be achieved by team away days, clinical supervision, practice development through informal discussion in the ward, team meetings or interactive learning/education.

After ensuring that such activities become the norm in practice, health care professionals need to ask themselves why they would not provide care in a way that values and respects the individual. In essence, the right of patients to expect privacy and to be treated with dignity needs to be the basis of professional practice and expert clinical leadership.

However, there are challenges. For example, the team may not value or feel able or empowered to achieve an approach to working that captures person-centredness. Frequently when this is the case, the 'person' will take on the role of 'the patient' and the 'power' will be with the professional groups.

Ford and McCormack (2000) suggest that adopting 'simplistic notions of individualised care' does not mean that the real needs of older people are being met. The authors suggest that for older people the ability to engage in activities that promote and maintain their personhood are seriously compromised, therefore nurses are key to helping older people retain their sense of being a person and ensuring they do not become a passive recipient of care.

Creating a suitable environment

The environments in which we care for and work with older people are not always conducive to the promotion of privacy. In hospitals, curtains dividing beds may act as a limited barrier and afford patients a little privacy. Frequently, however, patients' right to dignity may be denied by members of the multidisciplinary team who enter curtained areas without seeking permission first. We have introduced a simple curtain clip/peg and have found that this small, insignificant device has been key to making people think before entering a curtained area. The nurses now carry these pegs about with them, and ensure that they are used at all times. A policy to 'knock', even if only verbally, is also encouraged before

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BOX 2. FACTORS THAT STAFF NEED TO ADDRESS TO ENSURE PATIENTS' PRIVACY AND DIGNITY, AND THEIR CORRESPONDING BENCHMARKS OF BEST PRACTICE (DoH, 2001b)

FACTORS	BENCHMARKS
Attitudes and behaviours	Patients/clients feel that they matter all of the time
Personal world/personal identity	Patients/clients experience care in an environment that actively encompasses individual values, beliefs and personal relationships
Personal boundaries/space	Patients'/clients' personal space is actively promoted by all staff
Communicating with patients/clients	Communication between patients/clients takes place in a manner that respects their individuality
Privacy of patient – confidentiality of client information	Patients'/clients' information is shared to enable care, with their consent
Privacy, dignity and modesty	Patients'/clients' care actively promotes their privacy and dignity, and protects their modesty
Availability of an area for complete privacy	Patients/clients/carers can access an area that safely provides privacy

AUTHORS Jonathan Webster, MSc, BA, DPSN, RGN, is consultant nurse, older people, Royal West Sussex NHS Trust and Western Sussex Primary Care Trust; **Sarah Byrne, BSc, DPSN, RGN,** is ward sister, Royal West Sussex NHS Trust.

ABSTRACT Webster, J., Byrne, S. (2004) Strategies to enhance privacy and dignity in care of older people. *Nursing Times;* 100: 8, 38–40.
Respecting and enabling an individual's right to privacy and dignity is an essential part of professional practice. Older people and their supporters face many challenges as part of the ageing process. The key role of nurses is to ensure that, as part of their therapeutic care, people can expect freedom from intrusion and be regarded as worthy of respect. This paper outlines some strategies that enable privacy and dignity to be put into practice.

The needs of older people and their supporters are increasingly coming to the forefront of both policy and service development. For example, *The NHS Plan* (Department of Health, 2000) has laid down a series of changes and reforms that need to take place in the future and, more recently, the *National Service Framework for Older People* (DoH, 2001a) has initiated a reform programme that will be taken forward through six key areas (Box 1).

There are four themes that run through the reform programme of the national service framework (NSF):
● Respecting the individual;
● Intermediate care;
● Providing evidence-based specialist care;
● Promoting an active, healthy life.

The NSF makes it clear that in the past older people and their carers were not always treated with respect or with dignity. It goes on to suggest that delivering good care for older people in hospital requires that staff have the appropriate skills and experience. This care should be underpinned by fundamental principles that promote dignity.

The importance of dignity

Calnan et al (2003) cite a European Union-funded study carried out in 2002 that used focus groups to explore how important dignity was to older people, what it means to them and how they are treated. The results of the study showed that dignity was important to older people, although they found it easier to talk about its absence or when they had been treated in an undignified manner. The key examples of lack of dignity related to:
● Lack of thought given to helping people with their personal appearance;
● The attachment of labels to older people such as 'bed-blockers' or 'geriatrics'.

Other examples cited as violations of an individual's right to privacy and dignity included:
● Exposing a patient's naked body to strangers or to other patients when using a hoist;
● Not asking the person how he or she would like to be addressed;
● Mixed sex wards;
● Lack of thought being given to the gender of the carer;
● Mixing tablets into food.

An older person has value and worth equal to that of any other person. It is important to see older people in the context of their own life cycle and their ageing process. Seeing all people as having equal worth does not exclude the presence and value of difference. Taking ageing into account is much better than ignoring it, as this serves only to devalue the person (Dewing and

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people enter a curtained area.

We have also placed 'Do not disturb' signs on cubicle and bathroom doors, which makes people think and knock before seeking permission to enter. Again, this is a simple solution to preserving patients' privacy but it has made staff think about their behaviour and actions, and the impact that violation of an individual's right to privacy can have on the person.

Quiet areas within a clinical environment allow for personal space. This is at a premium but it is essential that individuals are able to talk in private without fear of being overheard and that they are not distracted by the activities of a busy clinical setting.

Maintaining choice

The simple addition of 'preferred name' written on name boards above the beds of our patients has encouraged and prompted staff to ask each person how he or she would like to be addressed so that they do not assume that all people like to be referred to in the same way. Asking people how they would like to be addressed helps challenge ageist beliefs and attitudes such as calling older people 'dear' or 'sweetie'.

Personal choice is essential to maintaining dignity, therefore we ask patients how and when they would like to dress, what is important to them about their care, what their normal routines are, and how we as nurses can help them maintain these normal activities. For some nurses this can be challenging, as they need to be able to acknowledge that their work is not just about 'getting all the washes done'; rather it is about working with a person and identifying what is important to him or her. Adhering to traditional routines can prevent this from happening (Walsh and Ford, 1990).

For patients who are unable to communicate verbally, we have introduced special communication books to enable staff, therapists and families to record progress and build up a picture of the patient's previous experiences and life. This provides a way of 'seeing' the person better. The information (if it has been agreed that it can be shared) can then be used by staff as a basis for the person's care and the therapeutic working relationship.

Challenging others

It is essential to be able to consistently and positively challenge practice, including that of other health care professionals, when a patient's right to privacy, dignity and modesty is being compromised. Recently, I saw a doctor in a ward ignore the pulled curtains round a patient and go through them without seeking permission first. The nurse with the patient asked the doctor in an assertive but non-aggressive manner to wait outside until it was convenient for him to enter. All health care professionals need to feel that they are able to challenge others constructively when a patient's right to privacy and dignity is being compromised. All health care professionals should be expected to refer to patients by their name and not as 'the man in bed seven' or 'the stroke in bed five'.

Evaluating practice

BOX 3. AN EXAMPLE OF PERSON-CENTREDNESS IN AN ACUTE MEDICAL WARD

The team had been caring for a patient who had been newly diagnosed as having widespread metastases. It was anticipated that she would be discharged home and cared for by her husband with support, which was what she and her family wished. However, she suddenly deteriorated while in hospital and the nurse looking after her telephoned her husband, advised him of the change in his wife's condition and asked him to come in.

The nursing team positioned the lady in bed and made her comfortable so that her husband could climb into bed next to her. Here he was able to hold and comfort her until she died peacefully. During this time a nurse stayed with them to provide comfort and support, which was their wish.

This is an important part of identifying what works well, based on a person's real-life experience, and how practice can be developed. It is also essential in ensuring that we do not become complacent about the way we work. We have used patient satisfaction surveys modelled on those in *The Essence of Care* (DoH, 2001b) in one of our wards to gain feedback on care. The surveys are analysed and used to empower, develop and shape practice and the way the team works.

It is vital that we are able to identify where our strengths and weaknesses lie so that positive changes can be brought to practice. This is being achieved in a culture in which team members feel able to reflect on their practice and are able to explore new ways of working to meet their patients' needs.

Striving for person-centredness

Nurses may be concerned that they are too busy to worry about privacy and dignity, yet we have implemented the changes to practice outlined above in a very busy acute medical ward.

There is no doubt that on occasions we are working in less than ideal situations. But for the nursing team respecting and valuing each individual while enabling privacy and dignity is core to the way the team works. Underpinning this is a culture that is striving to achieve person-centredness. The case study in Box 3 illustrates an instance of this in practice.

Conclusion

Respecting and valuing the needs of older people and their supporters should be the basis on which all members of the nursing team work, the culture of the organisation and the standard for practice. It is essential that nurses not only reflect on their own working relationships with older people and their supporters but also challenge others when an individual's right to privacy and dignity is not being maintained. ■