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'I often worry about the older person being in that system': exploring the key influences on the provision of dignified care for older people in acute hospitals

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ABSTRACT

Older age is one stage of the lifecourse where dignity maybe threatened due to the vulnerability created by increased incapacity, frailty and cognitive decline in combination with a lack of social and economic resources. Evidence suggests that it is in contact with health and welfare services where dignity is most threatened. This study explored the experiences of older people in acute National Health Service (NHS) Trusts in relation to dignified care and the organisational, occupational and cultural factors that affect it. These objectives were examined through an ethnography of four acute hospital Trusts in England and Wales, which involved interviews with older people (65+) recently discharged from hospital, their relatives/carers, and Trust managers, practitioners and other staff, complemented by evidence from non-participant observation. The picture which emerged was of a lack of consistency in the provision of dignified care which appears to be explained by the dominance of priorities of the system and organisation tied together with the interests of ward staff and clinicians. The emphasis on clinical specialism meant that staff often lacked the knowledge and skills to care for older patients whose acute illness is often compounded by physical and mental co-morbidities. The physical environment of acute wards was often poorly designed, confusing and inaccessible, and might be seen as 'not fit for purpose' to treat their main users, those over 65 years, with dignity. Informants generally recognised this but concluded that it was the older person who was in the 'wrong place', and assumed that there must be a better place for 'them'. Thus, the present system in acute hospitals points to an inbuilt discrimination against the provision of high-quality care for older people. There needs to be a change in the culture of acute medicine so that it is inclusive of older people who have chronic co-morbidities and confusion *as well as* acute clinical needs.

KEY WORDS – ageing, acute hospital care, dignified care.

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Background

Dignity under threat? The context of older age

There is much debate about the value of the concept of dignity (Macklin 2003) and how it is characterised and defined (Nordenfelt 2009; Wainwright and Gallagher 2008). There may be stages of the lifecourse or other social contexts where dignity and its core elements are enhanced or threatened. Dignity is most threatened when people do not have the resources (social, economic, psychological and physical) to control their lives and resist dependency and exclusion. It has been argued that this is typical in older age where there is increased prevalence of ill health, disability and poverty (Philipson 1998).

This typification of 'old age as hardship' and dependency suggests that older people would be likely to have their dignity threatened both collectively as citizens and individually in everyday interactions. However, it has been argued (Gilleard and Higgs 2000, 2010; Higgs and Rees Jones 2009) that to associate older age with declining health and increased dependency is misrepresenting the experiences of older people. There are alternative or competing narratives of older age such as 'older age as activity' associated with the third age characterised by health and agency (Polivka 2011). It is in the fourth age, where many older people suffer incapacity, frailty and cognitive decline, that challenges to dignity may occur. The key characteristic of this fourth age, at least according to Higgs and Rees Jones (2009), is the loss of agency over the body and, more crucially in terms of implications for identity, the impact of cognitive decline.

Recent evidence derived from focus group discussions (Calnan, Badcott and Woolhead 2006; Tadd and Calnan 2009) shows that older people's discourses on dignity were dominated by two interrelated themes: dignity as *identity*; and dignity as *independence or autonomy*. In relation to the former, the informants emphasised the need to personally maintain self-esteem and self-respect, particularly in interpersonal care. The context of care provision was where dignity as independence or autonomy was particularly evident. This is unsurprising as it is claimed that when the body fails, caring for oneself becomes problematic (Twigg 1999). Managing intimate activities such as bathing becomes awkward and embarrassing with an essentially private and personal activity now occupying the space between the public and the private (Twigg 2000). It appears that this concern about maintaining independence and not 'being a burden' are prevalent in older people's discourse, irrespective of whether they are living in the community (Baldock and Haddow 2002) or in a health-care setting. This evidence (Calnan, Badcott and Woolhead 2006) also showed an expectation amongst older people that

gradually or acutely declining health and diminishing autonomy will inevitably result in the infringement of their dignity.

Dignity under threat: the context of health care

The importance of dignity in older age and the need for dignified care for older people seems to have been recognised in recent English health service policy discourse, *e.g.* the Dignity in Care Campaign aimed 'to put dignity at the heart of care' (Department of Health 2006). The overall aim of these policies (Department of Health 2000, 2001*a*, 2001*b*, 2004, 2010) appears to have been to ensure that dignity is firmly embedded within health and social care policies in the core operating principles of the National Health Service (NHS), the National Service Framework for older people, and the inspection and regulatory framework (Commission for Healthcare Audit and Inspection 2007). Yet, its effectiveness may have been limited as recent evidence, such as in the report on complaints to the English Health Service Ombudsman (2011), showed that the NHS was 'failing to treat older people with care, dignity and respect'. NHS inpatient care has continually been a source of public dissatisfaction (Calnan, Almond and Smith 2003) and it appears in settings such as acute hospitals, where older people and their carers may have less control than when living at home, their identity and autonomy is more likely to be threatened (Baillie 2009; Matiti and Trorey 2008). For older people this may be difficult to reverse once discharged from hospital (Pleschberger 2007).

Evidence from practitioners' accounts have identified the salience of professional, organisational and institutional influences on dignity (Calnan *et al.* 2005; Jacelon 2002, 2003; Jacelon and Henneman 2004). However, there is limited, recent, observational evidence of everyday practices about the care of older people in acute hospitals (Baillie 2007; Matiti and Trorey 2004) and the extent to which these practices might be shaped by the interaction or negotiations between clinical interests and local organisational and managerial priorities. These in turn are embedded within national policy structures which have recently used performance targets, audit and monitoring, and risk management to improve the efficiency, quality and safety of patient care (Brown *et al.* 2011). The increasing priority is claimed now to be based on assessing institutional risk and concern with the reputation of the organisation rather than meeting individual patient needs (Kemshall 2002; Rothstein 2006). This approach has not only been shown to have led to tension between clinicians and managers but also has been shown not to be conducive to providing personalised care (Brown *et al.* 2011). The specific focus in this paper is on identifying aspects of the ward environment and activity, processes and organisation that maintain and

challenge dignity in relation to the care of older people and the dominant interests that shape this pattern of care.

Methods

Study design

An ethnographic approach (Dixon-Woods 2003) was adopted as the aim was to explore the prevalence, meaning and practice of dignified care as well as the structures and rules that influenced its provision. Ethnography is usually associated with a combination of qualitative methods (Bryman 2008) and this study adopted two such methods of data collection: face-to-face interviews and non-participant observation. The face-to-face interviews took place with two sample groups: recently discharged older people (65+) along with their relatives/carers who were interviewed in relation to their experiences of dignified care; and health-care practitioners and other members of staff, including managers from different hierarchical levels, who were interviewed to identify patterns of ward practices and the occupational, organisational and cultural factors fostering or detracting from dignified care. The non-participant observation complemented these data by providing evidence of ward activity across 16 wards in four NHS Trusts.

Sampling

The four study sites were purposively selected to reflect a range of organisational and system characteristics which may impact on care (Calnan *et al.* 2005; Tadd *et al.* 2011). These included health-care commission ratings on quality care and resource use, organisational characteristics such as the provision of services to diverse urban/rural populations, and Trust involvement with dignity initiatives.

With regard to older people, the inclusion criteria for the selection of the sample was that the informant was aged 65 years or over, had been discharged from hospital within the previous four weeks and were willing to give informed consent. This resulted in a final set of 40 interviews across the four study sites with the sample including a distribution of informants within their sixties, seventies and eighties and an even split by gender (20 men and 20 women; site 1=8, site=21, site 3=5, site 4=6). In addition, 25 interviews were carried out with their relatives/carers addressing similar issues (site 1=6, site 2=8, site 3=4, site 4=7).

In terms of hospital employees, the sample was split between Trust managers and ward staff. In recruiting Trust managers, the inclusion criteria was that the informant worked in a senior/middle management role, had

responsibility for patient experience and was willing to give informed consent. Across the four sites, this resulted in 32 interviews (site 1 = 8, site 2 = 10, site 3 = 5, site 4 = 9).

Interviews took place with staff working on four wards in four clinical areas in each Trust. These areas were chosen in consultation with senior Trust staff. Two acute wards where older people are cared for along with other adult users and two wards exclusively for older people were chosen (site 1: Stroke, Trauma/Orthopaedic, Care of the Elderly, Dementia; site 2: Quick Discharge/General Medical, Stroke, Care of the Elderly, Rapid Rehabilitation; site 3: Care of the Elderly Ward, Orthopaedic, Female Surgical Ward, Elderly Care/Orthopaedic Rehab; site 4: Care of the Elderly, Vascular/Rheumatology, Respiratory, Trauma/Orthopaedic).

The ward staff were recruited on the basis that their work involved direct contact with inpatients within the chosen clinical areas and a willingness to give informed consent. Interviews were carried out within each of the 16 wards across the four Trusts. In total, 79 interviews were undertaken with staff from a range of occupational groups including: ward managers, nurses, health-care assistants, domestic staff, receptionists, doctors, physiotherapists and occupational therapists (site 1 = 27, site 2 = 22, site 3 = 16, site 4 = 14).

Data collection

Older people's views of dignified care were examined through semi-structured interviews exploring beliefs and feelings about the following themes: ageing; dignity; their inpatient experience – including when, where, the good and bad things that they experienced; professionals – including communication and care given; care planning and professionals – including involvement and information; the environment; patients and visitors; and improving care for older people. Similar themes were explored in the semi-structured recorded interviews with relatives/carers as well as their beliefs and feelings towards their caring role and responsibilities.

Senior managers were interviewed using a semi-structured schedule exploring broader influences on the ability of the service/organisation to provide dignified care including organisational and cultural factors (Ormrod 2003) which might foster or detract from dignified care. More specifically, informants were asked about their role and responsibilities and their beliefs about the following topics: dignity and the staff; ageing and dignity; older people's care; dignified care; and the organisations' policies, responsibilities, priorities, resources and complaints procedures.

Ward staff interviews explored beliefs about what enhances and detracts from their ability to provide dignified care and exploration of particular

aspects from the observations. More specifically, informants were asked about their role and responsibilities and about the following topics/themes: ageing and dignity; dignified care and what promotes/inhibits it, *e.g.* environment, ward organisation, policies; education, training and guidance; improving care for older people.

Written information about the study aims, the funder and sponsor together with what participation would entail, were given to all potential informants. Written consent was obtained at the interview to ensure full understanding. Informants were informed of their right to withdraw at any time, without giving reasons and without affecting their right to treatment or care. All participants were given assurances that their confidentiality and anonymity would be protected. In particular, they were assured that their comments would not be disclosed to the Trust involved and permission to use anonymised quotes in reports or publications was also sought.

In addition to the interviews, non-participant observation (Bryman 2008) was carried out to overcome possible discrepancies between what people say they do and what they actually do, avoiding the apparent 'bias' inherent in individual accounts of actions (Hammersley and Atkinson 1995; Mays and Pope 1995). The observations totalled 617 hours across the four wards in each of the acute Trusts with approximately 30–40 hours of observation carried out on each ward covering the 24/7 period. The number of hours of observation for each hospital site were: site 1 = 142.5, site 2 = 142, site 3 = 156.5, site 4 = 176.

The observation identified aspects of ward activity, processes and organisation that maintain and challenge dignity. Data included assessment of organisational and environmental aspects of each ward, geographical layout and physical elements. No intimate personal care was observed, for example researchers did not enter closed rooms or curtains as this in itself could infringe a person's dignity. All staff were notified in writing of the observations and informed of when researchers would be available to answer their questions. Particular aspects of the observation were discussed with in-patients as a means of triangulation to check on the researchers' interpretation of events. There was an initial discussion with the ward manager before observation on each ward commenced to decide on the practicalities of the observation sessions and a verbal feedback session at the end of the period of observation to discuss the overall impressions gained by the researcher and any specific issues which they may wish to address.

The observations were unstructured (Bryman 2008) but there was a general topic guide which was informed by the literature (Baillie 2007; Jacelon 2002, 2003; Jacelon and Henneman 2004; Matiti and Trorey 2008;

Tadd 2006; Woolhead *et al.* 2004). Thus, observers reported practices including those which were associated with enhancing, maintaining or detracting from the older person's identity (*e.g.* being recognised and respected) and/or from their independence or autonomy.

The observations were recorded in handwritten field notes throughout the sessions and were finalised and typed up after the session had ended. Balance had to be struck between recording events as immediately, fully and accurately as possible and appearing threatening to staff by writing in front of them. Sometimes the researcher would write in the presence of staff and on other occasions would take short breaks away from the ward to complete notes. The field notes were finalised and typed up as soon as possible after the session had ended. However, as with the interviews, while the focus was on observing practices which enhanced as well as detracted from dignified care, it was easier to identify the negative rather than positive aspects of dignified care, as was shown in previous research (Calnan, Badcott and Woolhead 2006). Positive aspects may be assumed and taken for granted and thus be less likely to be reported.

The fieldwork was carried out between November 2008 and April 2010. The study was granted NHS ethical approval and Trust R&D governance clearance in 2008.

Data analysis

An inductive, thematic analysis was carried out on the data, using the method of constant comparison which allowed for inclusion of *a priori* understandings as well as emergent concepts (Bryman and Burgess 1993). Thus, key themes were developed according to both existing relevant issues and those arising from the data. Both field notes and interview transcripts were pooled from each of the four sites and analysed thematically within Nvivo 8. The fieldwork was evenly divided between two university teams with each team collecting all the data in two hospital sites. However, to ensure consistency across the study the two teams observed at each others' sites and a sample of interview transcripts were double coded. Regular team meetings were held to discuss the emerging themes and all the data were coded by theme. The data were collected iteratively so that the analysis and the coding informed the data collection and vice versa. Findings from the first two sites helped to shape the focus of data collection in the second two sites. User views were taken into consideration in the refinement of the coding strategy and the analytical approach and two older people and one carer were employed as members of the research team to try to ensure the study as a whole took due account of older people's concerns and that the research was relevant to their needs (Entwistle *et al.* 1998; Oliver 1999).

Findings

'*It's just not the right place for them*'

This was a comment from a member of the ward staff echoed in many interviews with staff and managers in the Trusts. The '*them*' refers to the people who form the majority of patients in acute hospitals who are more likely to be old, confused either chronically or acutely, and suffering from more than one condition (Oliver 2008). The '*place*' that they come into is seen to be inappropriate primarily because the environment is not conducive for the care of older people and because many of the nursing staff appear to lack the core skills to meet their needs.

The environment of care

The evidence suggested that there were a number of reasons why the place might be seen to be wrong. First, the environment is often not well suited to the older patient. Hospitals appear to be confusing places with little signage to guide patients through what appears to be identical corridors and similar looking wards:

One ward looked very much the same as another. If they'd moved me when I was asleep, I simply would not have known I'd been moved. It was like that. (Patient interview)

There were also few cues about time or dates which seemed to add to the confusion. Clocks, where they existed, were often wrong:

He asks what time it is and I look over at the clock and say well that one's stopped at 3.15 but I think it's actually around 12 or quarter past. (Observation)

Secondly, acute wards can be embarrassing places for older people. For example, where there were mixed wards with single-sex bays but with communal toilet and washing facilities:

Then you've got, you know, the wanderer, the lady, you know, and she was wandering in and out of the men's bays . . . The same thing, you know, when you've got gentlemen in there, you know, they're confused as well and they'll wander and you've got nothing . . . they've got nothing on the bottom, you know. (Ward staff interview)

Well certainly mixed-sex wards I find that very undignified, for not just the women, for men as well. One would go in – you'd go in there [the toilet] and as you're coming out a gentleman's going in. I mean I was okay because I had you [her husband] with me or Julia [her daughter]. But if you were on your own and worrying about whether the toilet door's shut or the bathroom door, that's very undignified. (Patient interview)

Thirdly, treatment on the acute ward tends to be focused on the space around the bed and other patient areas such as day rooms are

usually given over to storage or space for staff meetings and training activities:

The staff comment on the lack of a day room on the ward. They say people have nowhere to go, they are often on the ward for a long time and they get depressed and go downhill. Later I notice John and William from Bay 3 who have come out of their bay and are sitting talking by the nurses station as there is no where else for them to go. (Observation)

I think they'd benefit from having a day room for the patients because like those that are recovering from hip operations and that and learning to walk again . . . it's just something for them all to do and somewhere to go. (Patient interview)

Fourthly, it was observed that there was a considerable amount of technical equipment on the acute wards which had to be negotiated. Staff expressed concerns about the dangers of patients falling over or interfering with this equipment and spent much time trying to get people to sit by their beds:

Phillip is standing up and is trying to walk. Both the staff nurse and the senior staff nurse rush to him and take him gently back to his chair – saying 'There's a cup of tea coming round in a minute' (I later discover Phillip is a 'wanderer' and has had a number of falls) . . . Phillip has got up again; he says he is going next door. The health care assistant says 'I need you to sit down, will you sit down for me? Stay there for a bit, stay there for me . . .' (Observation)

Finally, from the perspective of patients, confined to the bed or the chair, the ward seems a busy place with a frenetic atmosphere that restricts interactions between staff and patients:

They seemed awfully rushed and so they didn't really have time, I don't think, to look at you, and to take the time to see if you was OK. (Patient interview)

Well sometimes you wouldn't get, always get any or too much response from them, but perhaps that's because I wasn't like an urgent case or something I don't know but . . . I didn't have much cause to ask them for anything. But I suppose they may have been busy sometimes but they've got to attend to the most ill haven't they? (Patient interview)

This was conducive to some patients maintaining their dignity where dignity was defined in terms of the degree of dependency:

I kept my dignity. I didn't have to keep asking to be helped. (Patient interview)

However, even when staff did have some free time they did not find it easy to switch from their tasks to patient engagement:

I think if you have an extra two members of staff on at a weekend people would see that as an opportunity to get off the ward early, to do a bit of cleaning, to do the weights. They would still . . . Because you can't switch from the tasks to the individualised care. Teams can't do that. Leaders can try and swing it and try and bring it but you can't switch on and off with that. Some people can. And I think quite a lot of the trained . . . the very good ones would be able to . . . right I've got an extra half

hour here, we've got an extra nurse, you know, I wonder whether you'd have to have a bath today or who'd like to go out in the wheelchair as it's a sunny day or . . . People won't think like that because it's a one-off and maybe it's because it's too depressing because they might then realise that they can't achieve that on a daily basis so it's like a defence against that, you know? (Ward staff interview)

Skills and training

. . . in a busy acute hospital because with the best will in the world it . . . they do need to be somewhere where the staff have some awareness of the needs of people. (Ward staff interview)

The accounts from managers and some ward staff suggested that there was a skills gap in relation to caring for older people, particularly for those who are confused or have dementia.

Obviously when you train to be a nurse you go through so many different placements every year and they normally do throw in a health care of the elderly placement. So that's all the real training you get. (Ward staff interview)

This applied both to nursing and medical staff where the main thrust of education was on future work in a specialist area or even a sub-specialism. Additionally, caring for older people was seldom regarded as an *exciting* career option and there was a general devaluing of core skills.

We have forgotten the generalised humanity that we have to deal with . . . we want to partition everybody into their ism or their ology . . . What I'm trying to convey is . . . that there are some aspects of patient need that we're almost in denial about because somebody else specialises in it – but whoever it is, it ain't me. (Trust manager interview)

I've got a huge number of specialist nurses but they're usually about something vanishingly special . . . I have, to my knowledge, no specialist nurses in this Trust who specialise in the care and support of staff caring for the demented patient. (Trust manager interview)

However, there were staff whose professional backgrounds involved working with older people who recognised the value of their skills:

A nurse, a good nurse, has a good set of core skills. What we actually do sometimes we do the reverse you know? We actually de-skill them because we make them specialised and we actually take something away from them. (Trust manager interview)

And a lot of the hospital staff that come over here, you know, didn't have those acute skills and stuff. We've all learnt that now and . . . but we've still got those skills on how to deal with somebody who's elderly, frail, in pain, not eating. (Ward staff interview)

And there were also managers who recognised their value:

It's about being a positive role model in working with . . . older people, and the skills that are required and, you know, and recognising and celebrating those skills as well. (Trust manager interview)

The emphasis on specialism and the need to have acute patients in the right specialist ward together with the requirement to achieve high bed occupancy levels, appeared to create a 'conveyor belt' with the constant movement of patients both into and out of wards and between beds and bays within wards:

The lady was very confused . . . she should have been in a different ward really . . . I think she was an outlier so I think that was the issue, she wasn't under her speciality and so with regards to that you don't get as much regularity or follow-up from your team and perhaps the nurses don't feel maybe as qualified to look after those patients that they're not . . . (Ward staff interview)

I often worry about the older person being in that system because often they – they've got more needs, are more vulnerable . . . and I do worry in a – in a system where we're encouraged to sort of move people on, . . . are we moving them on at the right place? Are we moving them on for the right reasons? (Ward staff interview)

Thus, it is often the older person with multiple chronic conditions, who does not fit into any specialist setting, who gets moved the most:

She suggests moving someone from Bay 2 into Bay 3 so that there is a spare bed for admission. Another staff nurse suggests Mary could go back to Bay 1 (Mary has recently been moved from Bay 1 to Bay 2). (Observation)

. . . but the pressure is to find a bed for people. That's the problem with having speciality wards you see, if they need to be on that ward you've got to create room. (Ward staff interview)

What happens if they get on the wrong ward where that ward doesn't know them and if they've got a stoma? It's about prioritising to put the right people on the ward, on the – the general medical and elderly wards, and sometimes because of bed pressures we have to move patients who are elderly into a surgical or an orthopaedic or – or whatever. And I think that disorientates them even more. But we have to do it to bring in the more acute people, but they still need to be in hospital . . . I have a thing about, you know, are we moving the right type of patients? (Ward staff interview)

Some of the hospital Trusts included in the study had specific policies for enhancing dignity but there was little evidence to suggest that there was any difference in the consistency in the provision of dignified care across the four hospitals. One reason for this appears to be the difficulties involved in the implementation of these policies at the ward level which is illustrated by the discrepancy between reports from managers about policy and observation of actual practice with regard to moving patients around:

But there is a group of patients particularly elderly, confused patients that we would look . . . and say, 'No, these aren't the right people to transfer these aren't appropriate' and certainly we wouldn't, you know. (Trust manager interview)

It is the [transfer ward] who are expecting the patient the nurse gives a verbal handover on the phone. The staff are not happy about this as they know she

does not want to go (it is Midnight) and 'she is confused already'. However they ring the Medical Assessment Unit who apparently have a special 'transfer team' tonight whose sole task is to move patients around, and ask for help moving N . . . saying that that will mean they have a bed on this ward for one of the Medical Assessment Unit patients (you scratch my back etc). I talk to the Staff Nurse about moving patients around like this – especially at night. She says there was a patient admitted from another ward last night at 3.20 in the morning – she was asleep and woke up in the morning not knowing where she was. She comments that all this activity makes the night staff's night go more quickly. The other Senior Nurse comes back from the patient 'I've just had a telling off – she don't want to move – I said it's not my decision, I've got nothing I don't agree with it'. (Observation)

The organisational context

The analysis in the previous section hinted at how care for older people in acute hospitals might have taken its current shape which included maintaining high levels of bed occupancy, resource efficiency and service rationalisation which involves specialist areas being focused on one site. Here this question is further examined by considering the interests, priorities and policies of the key groups involved in the management and provision of acute hospital care. These priorities appeared to be dominated by the needs of the hospital to survive financially by meeting national NHS targets:

Nothing gets equal weighting to targets and finance regardless of what people say to you about the NHS. At the end of the day that is what drives people because it's about sustainability. What is an organisation supposed to do but concentrate on survival . . . will it ever be survival to us around the quality of care that people get? (Trust manager interview)

In the acute Trusts emphasis was placed on patient safety, which tended to be dominated by the need to minimise risks of infection, falls and untoward incidents, with the former two reflected in performance targets. This drive had unintended consequences for patients' experience of care. Many patients reported feeling isolated when separated in side rooms with limited contact with others and this was often exaggerated by restricted visiting hours.

You wouldn't want to be in a little room on my own because you felt lonely, on your own. You're not feeling well. If there's something going on around that you can watch it takes your mind off it. But that's the only time I've cried in hospital being in a little room on my own. No I didn't like it. (Patient interview)

Policy implementation often had unintended consequences. For instance, de-cluttering intended to control infections led to the loss of patients'

possessions and personal space. One ward sister felt that patient needs often come last due to the focus on infection control:

She showed the researcher round the bays and pointed out that there were no lockers anymore as they had been told to remove them as part of the 'de-cluttering' drive. She said she tried to keep hold of them for as long as possible. It means now that patients have to keep everything on their table which becomes very cluttered or in the cupboard high on the wall which they cannot reach. There is a real problem with things getting lost particularly hearing aids which are expensive. (Observation)

Concern over falls led to patients being confined to their beds or chairs and using commodes or bed pans instead of being helped to the toilet. Such risk-aversion policies were also useful to staff in terms of providing a reason for making their tasks less burdensome but compromised patients' dignity as shown by the following observation:

> Annie calls out again and Amy goes to her.
> 'Can I go to the toilet please?'
> 'You've got a pad on.'
> 'Can I have help to the toilet please?'
> 'If you . . . (she sighs with frustration) you've got low pressure, when you stand up your blood pressure drops and you'll be falling.' (Observation)

The emphasis in the NHS on recording, auditing and accountability appears to have led to an emphasis on self-protection and defensiveness:

Two members of staff I hadn't seen before come up to the nurses' station and asked Jim (Nurse) about the man who'd had a fall. He tells them that the man said he's fallen but he was back in bed and given how much he struggles in and out of bed I don't 'know how he would've got himself back into bed'. They nodded and headed down to the bay. Jackie (a health-care assistant) tells me, 'This man says he had a fall out of the bed on to the floor right there he never could've got off the floor if that'd happened.'

Jim: 'He did say this morning that he almost fell.'
Jackie: 'That's why no-one will see to him on their own now.'
Jim: 'It's turned into a big game of them and us.' (Observation)

This was also reflected in the increasing reliance on standardised checklists and procedures when observing and treating patients where the need to record information becomes a replacement for the provision of care itself. Recording of information also replaced the need for engagement and thus the use of a more holistic assessment of the patients' needs and the general emphasis on proceduralism led to constraints on staff discretion. In this

example, following the procedure of setting up a food chart was seen to solve the problem rather dealing directly with the patient.

William says he doesn't want any – The health care assistant tries to persuade him to have some soup and the Domestic shouts out that he didn't eat anything the night before nor for breakfast. The health care assistant says 'I think he needs to be referred to the dietician and we need to set up a food chart.' (Observation)

Following Trust priorities can lead to trade-offs such as between the need to reduce waiting times which leads to maximum throughput and minimum length of stay at an obvious cost to patients, particularly those people who need more time and care, in terms of their dignity.

So in a sense it's [targets] a good thing . . . but everything has a price and the price is relentless pressure on the wards to shift people through as quickly as possible . . . it's too easy to lose sight of the fact that patients are human beings too and they need to be treated carefully and with respect . . . it is a genuine tension between the conveyer belt maximum throughput minimum length of stay, get them out, get them through the system, next one please . . . we do it [meet targets] at a price and that needs to be understood. (Ward staff interview)

The ward culture

The consequences of NHS policy and Trust priorities for staff practice and dignified patient care have been outlined but what of the concerns and interests of the staff? The culture on the wards tended to be task oriented which led to work practices being adopted which allowed staff to get things done in the quickest and easiest way, not necessarily in the best interests of patients. The task-oriented culture also leads to separation of tasks and lack of responsibility for overall care which in turn leads to the neglect of patients and their dignity:

R: Oh I'm going to see him as well or else he won't have anything to eat, because he couldn't eat, he was flat on his back.
I: And nobody in the ward thought it was their responsibility?
R: No. (Relative interview)

This system of care could also cause some conflict in the staff pulling in different directions according the particular aspect of patient care they were responsible for rather than working together for the overall care of the patient. The following example on a stroke ward exemplifies the problem in which staff focus only on the aspect of care they are directly responsible for rather than seeing their work as part of a team and one part of an overall process.

Tim is waiting for his dinner while the other patients are being washed, changed etc ready for their food in between helping George with his food as he keeps losing where

things are on his table. The dietician comes over to Tim's bed and looks around. Jenny (a health care assistant) asks her what she needs and she replies 'I'm just wondering why he's not eating that's all' – as she leaves the bay she rolls her eyes at me. It's interesting that each member of staff is very focussed on their particular tasks whether it be nutrition (dietician) or personal care (HCAs) and this can mean that the staff pull against each other. (Observation)

The evidence suggests where the interests of the key actors come into conflict, dignified care may be compromised. The NHS performance targets in combination with the organisational demands of the acute hospital, the environment of the ward and the skills of the staff worked together to detract from rather than facilitate the provision of dignified care. This included practices associated with respectful communication (*i.e.* forms of address, recognition), ensuring privacy, addressing nutritional and personal hygiene needs, encouraging a sense of independence, control and adequate information to aid decision-making. Within this context variation in practices were observed within wards (as the following first example illustrates) and between wards (as the second example illustrates) which appeared to depend primarily on the values and energies of individual ward staff:

There was a young woman in there who obviously was severely brain damaged and . . . oh the poor thing. She was only a young woman but you had certain members of staff that were wonderful with her, gave her so much attention and really cared what they were doing and gave her dignity because they pulled the curtains around while they changed her. She was incontinent, the whole thing, poor little thing but others didn't, they never even pulled the curtains around. And like one of the elderly ladies who was next to her in the bed she did actually shout a couple of times and say 'she's a person'. (Patient interview)

R: I do think that no-one spoke to me really other than I mean they'd come along and do this and, you know . . . Whenever anybody did speak to me it was really saying 'this is not right'. So I didn't actually have a conversation with anyone really the whole time.

I: What about when you were on the other ward?

R: Oh different. Completely different. They actually came to see whether I'd settled in alright. Can I put stuff away . . . help you put stuff in your locker? In fact I don't know what a green uniform . . . She was a lovely lady, she had a green uniform. She actually even came up and said do you need us to ring anyone and tell them you've changed wards? Well I thought that was lovely. Nobody's spoke to me for four days and this lovely lady came up and said do you want us to let anyone know? And I thought that was superb. And that was what was totally and utterly lacking in the other ward . . . All of a sudden I was someone . . . And I mean I must have looked a complete freak because as I said they'd had to take all these stitches out and re-do them . . . It was: 'Oh my dear you've been in the wars' and found me a bed and made a fuss and everything. I mean I

couldn't obviously have a cup of tea or anything like that but you felt . . . you know, it was like are you alright now?' You know, 'if you want to go to the toilet just press your buzzer' and so on. Completely and utterly different. (Patient interview)

Despite this variability in the provision of dignified care older people's overall perception of their care was generally favourable. This may have reflected the high-quality care that they received but for many may also have reflected their low expectations of what the care should be like. For example, this informant on being asked if everyone was treated with dignity replied:

Oh yes, I wasn't made any exception, everybody had the same care, the old fellow with Alzheimer's he wanted to use the toilet, so he rung his bell and they came and they said, 'Oh, we'll bring you a commode'. And they brought the commode and he said, 'Oh . . .' he said, '. . . I can't use that, I want to go to the toilet'. They said, 'Well you know, this is a toilet, it's just that you know that, we're not allowed to transport you on a commode to the toilet and we don't have any means of getting you there'. And he said, 'Well I'm not using it' and the nurse said, 'That's fine, you go in the bed . . .' she said, '. . .and we'll come back later and we'll change it'. And about ten minutes later they came back and they washed him, cleaned his bed, fresh bedding on there and put him back into bed. So I thought that was really good. (Patient interview)

However, not complaining or reacting to poor treatment was one strategy of maintaining dignity. For example, this man implies that dignity or being dignified involves behaving appropriately, even though later in the interview he goes on to describe the 'massive' problems he experienced with privacy:

R: Well, dignity in my opinion is, has been, for me is to keep quiet and keep out of things and so, you know, that's it really and that way you – you don't get involved and – and they respect you because you're quieter or . . .
I: Did you feel that you had enough privacy if you wanted it?
R: Well, I had as much as anybody else, I suppose, I couldn't expect more but that that was a massive thing. (Patient interview)

Discussion

The picture which emerged from this study was of a lack of a consistent pattern of personalised and dignified care for older people across the wards in the different hospitals. The aspects of dignified care addressed in this study focused on practices associated with enhancing or detracting from self-respect, recognition as a person and supportive independence (Calnan, Badcott and Woolhead 2006). This inconsistent pattern was explained by the dominance of the priorities of the system and organisation tied together with the care environment and the working practices of clinicians and ward staff which in combination provided a significant impediment to the

provision of such care. This was despite the national policy initiatives coupled with the local initiatives in some of the hospitals aimed at enhancing dignified care for older people. There was some evidence of the practice of dignified care although this existed due to individual staff efforts in spite of organisations and policy, as opposed to being facilitated by them.

The policy narrative about the NHS over the last ten years or more is characterised by the introduction of principles from the new public management aimed at improving accountability, efficiency and quality of care (Calnan and Rowe 2008). Such policies have involved the use of performance targets, audit and monitoring, and risk management. The impact of these policies on professional practices have (Brown *et al.* 2011) suggested that the distraction of the professional's needs to satisfy stipulations and accountability frameworks diverts their attention away from the patient's interests. The greater extent to which this is the case, the more the audit society (Power 1997) 'robs actors of the meaning of their own actions' and therefore comes to be resented by the professional (Brown 2008). This is especially the case where 'what gets measured has to be done', but where the measurable, bio-medical indicators of quality are blind to a more holistic notion of patient care (Brown 2008).

The evidence from this study portrayed a similar picture with the dominance of the priorities of the organisation in combination with the influence of the pressures to meet targets and manage risks leading to the neglect of patients, mainly older people with complex needs. This is not to say professionals and practitioners do not have a degree of agency or discretion as the evidence about the variations in the dignified care suggests. However, there were examples of ward staff acting like *street-level bureaucrats* (Taylor and Kelly 2006); those practitioners in the public sector on the 'front line' directly dealing with patients who use bureaucratic procedures to pursue their tasks in the easiest way possible. The nursing model of care which seemed to be prevalent on the wards tended to be based on 'getting through the work' and task orientation rather than person-centred care. As Daykin and Clarke (2000) have shown, much of the work was routinised, focusing on the physical aspects of care even amongst the qualified nurses (a form of deskilling) and there was little staff initiation of communication with patients. This was evident in the difficulties that nursing staff found in being more flexible in their working practices even where there was time and space to spend more time with patients. Daykin and Clarke (2000) argue that the explanation for the discrepancy between the professional rhetoric of holistic and person-centred care and the reality appears to lie with the inability of nurses to resist the demands of management strategies and adverse working conditions coupled with the devaluing of their caring role (Theodosius 2008).

The evidence from this study, however, suggested other explanations. While the ward space seemed to be dominated by the interests of nursing staff, the prevailing emphasis on specialism seemed to be dominated by the interests and career values of the medical profession (Flicker, Denaro and Mudge 2008). This emphasis on specialism appears to have been taken on as a more attractive career option by nursing clinicians (Glen 1998; Shewan and Read 1999; Tadd and Calnan 2009) although it also may be seen as a safer strategy in that nurses may be seeking refuge from wider demands and pressures by tying their work more directly to medical interests. Such an approach fits more comfortably with the philosophy of the acute hospital where the value is placed on speedy and effective treatment of patients with one, specific condition. The priority given to specialism (Oliver 2008), at least in hospital care, may have led to the erosion of the influence of generalists such as geriatricians; the new specialisms in the care of older people seem to be frailty and dementia commonly associated with the fourth age. Thus, the problem for nursing may not be that their training is of a low standard but that it does not appear to provide the skills needed to care for older people (Delamothe 2011).

Further, the evidence of this study points to a fundamental strategic problem – acute hospitals do not seem to be working for their major client group (Rockwood and Hubbard 2004). The NHS performance targets and the organisational structure of the hospital, the culture and environment of the ward, and the skills of the staff might be suitable for speedy and effective treatment of patients with one, specific condition who can recover quickly but they appear inappropriate for the care of the majority group – older people with more than one health problem, some of whom may be confused, have dementia and require a longer recovery time. Certainly, the present system in acute hospitals points to an inbuilt discrimination against the provision of high-quality care for older people, suggesting a form of institutional ageism. Thus, there needs to be a change in the culture of acute medicine so that it is inclusive of older people who have chronic co-morbidities and confusion *as well as* acute clinical needs. This will only happen once there is a recognition and acceptance by policy makers, managers, professionals and ward staff that the majority of patients are not in the wrong place, but that the place and the system itself must change to accommodate the majority of patients (Tadd *et al.* 2011). Finally, the evidence in this paper points to the dominance of clinical and managerial interests in shaping the pattern of care in the context of the NHS in England and Wales, but further research needs to be carried out in the context of different systems of acute care for older people to identify the relative strength of the influence of systemic compared with professional interests.

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