ADASS response to the Commission on Improving Dignity in Care

The Association of Directors of Adult Social Services (ADASS) represents Directors of Adult Social Services in Local Authorities in England. As well as having statutory responsibilities for the commissioning and provision of social care, including the safeguarding of vulnerable adults, ADASS members often also share a number of responsibilities for housing, leisure, library, culture, arts, community services, and increasingly, Children's Social Care within their Local Authority.

ADASS welcomes the opportunity to provide evidence to the Commission on Improving Dignity in Care and to work with the Commission in taking forward any recommendations to ensure that that the dignity of individuals both remains and is promoted as a paramount priority in the context of adult social care.

Key Questions:

1. **What in your opinion are the main factors that contribute to the failure of some hospitals and residential care homes to meet the immediate health, nutrition, hydration and hygiene needs of older people? Do you have evidence to support these opinions?**

The main factors which can contribute to failure include:
- Insufficient Staff with appropriate qualifications, experience or expertise e.g. chefs/cooks
- Lack of staff training to meet specialist or diverse dietary needs
- Insufficient staffing levels in care homes/hospitals or lack of volunteer schemes to embed hospital 'Red Tray & Red Jug' system for assistance with eating/drinking at mealtimes
- Lack of varied menu/dietary choices – soft diet food looking unappetising
- Failure to recognise signs of malnutrition/dehydration or act on observations
- Food/fluid charts/records not completed or status regularly monitored
- Lack of ability for people to freshen up or wash hands before mealtimes
- 'Protected mealtimes' not is use so staff busy doing other required tasks
- Not providing people with their false teeth to eat, allowing sufficient time for food to be swallowed before supporting with the next mouthful which can cause choking or standing over person whilst supporting them
- Non roll-out of patient passport system, 'Butterfly' or 'Forget me not' schemes across all services to ensure people's needs addressed and improve communication between agencies
- Poor customer care, communication skills
- Failures of leadership and management to recognise and prioritise the individual and collective rights and needs of older people and the de-humanisation/de-personalisation/devaluation of older people in some institutions (there may be a better way of putting this). Failure to meet basic/essential standards of care

In terms of evidence to support these observations, there a range of sources to include:
- CQC inspection reports
- Dignity & safeguarding complaints reports
- Dignity audits of services
- LINk feedback - 'Enter & View' lay assessor visits
- Dignity events
- Issues raised via Dignity Champions
- Dignity Overview & Scrutiny Committees and focus groups
- National Dignity Board,
- Dignity Networks
- Safeguarding referrals, reviews and Board reports

2. **What in your opinion are the main factors that contribute to the failure of some hospitals and/or residential care homes to provide appropriate emotional and psychological support to older people? Do you have evidence to support these opinions?**

The main factors which contribute towards failure regarding appropriate emotional and psychological support include:
- Environment – in response to meeting clinical needs people often feel a lack of choice or control about their everyday lives
- Dignity and safeguarding portrayed and perceived as additional tasks rather than intrinsic to the ethos and activity of the establishment
- A lack of focus on the impact of institutions and organisational behaviour on the individuals involved.
- "Closed" institutions that are isolated from the local community
- Inability to eat meals at dining table/area – mealtimes as a social activity
- People feeling either not at all or not very involved in decisions about their care, this raises questions about person-centred care
- People in receipt of care/treatment or family members/carers being reluctant to make a complaint or raise concerns due to fear of repercussions
- Inconsistent culture and formality of procedures in response to complaints/concerns raised
- Lack of information, time for discussion and ineffective communication between clinical staff, care workers and people in receipt of care/treatment
- Inconsistent accessibility of complaints information – agencies systems differ
- Lack of holistic assessments or care plan tools in moving between agencies
- Poor communication between agencies on discharge or discharge planning
- Independent advocacy services being insufficiently used
- Lack of training or understanding in assessing capacity or making best interest decisions
- Poor staff attitudes/behaviour - importance dignity & respect
- A task focus that doesn't recognise the inter-relationship between people's physical and emotional/psychological health and a lack of recognition, in some instances, of the impact of loss (through bereavement, of social role and status, of mobility and intellectual ability, of home and family etc) and depression in older people
- A lack of coherence and consequence in relation to organisational and professional regulation
- Incomplete application of the MCA, DDA and HRA

In terms of evidence to support these observations, there a range of sources to include:
- CQC inspection reports
- Dignity & safeguarding complaints reports
- Dignity audits of services
- LINk feedback - 'Enter & View' lay assessor visits
- Dignity events
- Dignity Champions' feedback
- Dignity Overview & Scrutiny Committees and focus groups
- National Dignity Board
- Dignity Networks
- Safeguarding Boards

3. **What in your opinion are the main factors that inhibit appropriate communication with individuals and their families? Do you have evidence to support these opinions?**

The main factors which contribute towards inhibiting appropriate communication include:
- Poor communication between agencies on admission, discharge or discharge planning
- Poor customer care, compassion & communication skills
- End of life/palliative care – making decisions, informing of status/condition etc
- Delays in diagnosis, investigations and reporting of results
- Failure to access to specialist services e.g. advocacy, IMCA, interpretation etc
- Lack of understanding in caring/treating people with dementia and/or sensory loss
- Poor staff attitudes/behaviour - lack of appreciation/awareness of importance dignity & respect deserves
- Respecting or listening to people's choices
- People's lack of awareness about how services should treat them – 10 Dignity Challenges or support their Human Rights
- A management focus on task or process without enough focus on people's experiences of the tasks/process

In terms of evidence to support these observations, there a range of sources to include:
- CQC inspection reports
- Dignity & safeguarding complaints reports
- Dignity questionnaire & audits of services
- LINk feedback - 'Enter & View' lay assessor visits
- Dignity events
- Dignity Champions' feedback
- Dignity Overview & Scrutiny Committees and focus groups
- Equality & Human Rights Commission
- National Dignity Board
- Dignity Networks

4. **What in your opinion are the root causes of why some hospitals and residential care homes fail to deliver basic aspects of care and meet the needs of older people? Do you have evidence to support these opinions?**

The main factors which contribute towards failure to deliver the basic aspects of care and to meet the needs of older people include:
- Poor staff attitudes/behaviour - importance of dignity & respect
- Lack of or inconsistent leadership/ turnover of managers
- Ineffective staff management or supervision
- Lack of holistic person-centred assessments or care plans
- Poor or non-existent nursing observations, records or risk assessments
  - To assess/monitor changes or deterioration in people's conditions
  - For pressure ulcers/sores causing inadequate wound care
  - Pain assessments not completed
  - Falls assessments
  - For mental health/ psychological wellbeing
- Poor communication
- Lack/ limited availability of equipment to meet needs and promote independence
- Ineffective discharge planning
- Lack of training in assessing capacity or making best interest decisions
- Insufficient staffing levels or volunteer schemes for assistance with eating/drinking at mealtimes
- Buzzers being out of reach or insufficient staff to meet needs in responding
- Lack of privacy e.g. use of bed pans/commodes in hospitals instead of assistance to toilet
- Non-use of 'privacy' signs or pegs on bed curtains
- People being left in soiled clothing or bedding
- Insufficient number of training/qualified staff or use of ward matrons
- High staff turnover/ use of agency staff so there is no consistent care relationship established
- Lack of individual and collective focus on the experience of older people with little focus on involvement or patient/customer/ family feedback
- Lack of focus in practice (rather than in plans) on legislation/ guidance (e.g. the HRA – Right to life and freedom from torture, inhuman or degrading treatment etc – the DDA and the MCA)

In terms of evidence to support these observations, there a range of sources to include:
- CQC inspection reports
- Dignity & safeguarding complaints reports
- Dignity focus groups
- Dignity questionnaires & audits of services
- LINk feedback - 'Enter & View' lay assessor visits
- Dignity events
- Dignity Champions' feedback & Network
- Dignity Overview & Scrutiny Committees
- National Dignity Board
- Dignity Networks
- Safeguarding referrals, reports and serious case reviews

5. **How can we best monitor older people's experience of care? Including the views of people who have difficulty in expressing themselves or those nearing the end of their life?**

Examples of how best to monitor older people's experience of care include:
- Ask people what they want and how at the commencement of care
- Include some consideration of older people's earlier lives rather than just listing needs/ tasks in assessments and care plans
- Dignity questionnaires & patient experience surveys from people who accessing services
- Floor/practice observations by either senior staff or independent audits to evidence what actually happens in practice
- Improve feedback systems make them available in everyday venues e.g. supermarkets, GP surgeries, etc
- Make complaints procedures less formal and simplify processes across whole system
- Widely promote use of 'Patient Opinion' website on line through NHS Choices or, in future, through Heatlhwatch and/or the care version of Trip Advisor
- Publicise use of independent advocacy services

6. **What stops individual staff and organisations from dealing with the failure to provide appropriate dignity and care for older people? Or from responding proactively to concerns and complaints?**

Examples of reasons that stop individual staff and organisations dealing with failure include:
- Poor culture and institutional behaviours
- Poor Attitudes/behaviour
- Poor communication
- Poor training
- Lack of Executive or Strategic Director leadership to promote change – 'executive dignity champions'
- Poor Organisational systems & procedures
- Task-driven practice as opposed to person-centred
- High management and/or staff turnover
- Budgets pressures /resources challenges – staffing levels, capacity etc
- Lack of clarity between safeguarding and dignity issues – not knowing what actions they can or should take – pathway required
- Lack of staff empowerment to take ownership and proactively respond

7. **What tools and guidance already exist for improving the quality of care provided for older people? How extensively do you think these are used and what might limit their traction across the system? How helpful do you feel they are in changing practices and improving the ways that older people are cared for?**

See (8) - There is a lot of guidance and tools available. Good organisations make it accessible, straightforward and "plain sense for staff

8. **Please detail good practice examples from across the health and social care settings that you would you like us to consider when making recommendations. What specific factors do you think contribute to their success?**

- Dignity Champions' Networks encompass strategic level multi-agency whole system organisations working with vulnerable adults
- Implementing a multi-agency Action Plan and Dignity Charter to progress:
  o Awareness Raising & Culture Change
  o Quality & Improving Practice
  o Monitoring
  o Contracting & Commissioning of Services
- Suite of Dignity Audit Frameworks & questionnaire produced, to be implemented via whole-system roll-out following pilot:
  o Residential Care
  o Domiciliary Care
  o Hospitals
  o Generic services
- Dignity embedded within all provider monitoring, contract specifications, tender documentation and new strategies e.g. Dementia Strategy, Older People's Commissioning Strategy and Prevention & Early Intervention Strategy
- Strategic Director leadership and Elected Members foster/promote change – 'executive dignity champions' or safeguarding champions
- Implementation of Productive Ward programme
- Quality Pledges within hospitals
- Dignity matrons appointed
- Dignity being embedded within training
- Strong local for a of older people/ LInKs, PALs etc
- Designated safeguarding doctors and nurses for adults (as well as children) in some hospitals
- Proactive review of individuals that links to contracts management processes and to safeguarding activity that address quality
- Safeguarding Boards with a proactive approach to dignity, quality, patient safety, feedback from people using services
- Good whistle-blowing systems

- Best Practice Examples: Based upon **Halton** which is the only Local Authority to employ a dedicated Dignity Co-ordinator; and as such there is a lot of interest nationally and regionally which has been recognised as an area of good practice
- **Halton** utilise a partnership approach through appointment of a dedicated Dignity Co-ordinator with a leadership role towards embedding, improving and driving forward the change agenda across practice, systems and partners across all Health and Social Care agencies has proved successful - evidenced through the recent CQC Adult Social Care Inspection – awarded 'Excellent'. The Dignity Co-ordinator post in Halton was established in July 2009 and has provided us with an opportunity to positively impact on the key challenges that have been outlined within the Dignity agenda. It has also supported key areas of partnership working to enable a whole systems approach to dignity improving the quality of services being delivered
- **Halton's** Best Practice Pack with 25 case studies covering whole system produced

9. **What else would you recommend we consider as part of this work, either for this commission or potentially as a next phase of work?**

- Implementation of a Dignity and Human Rights-based approach including training to deliver dignity whole-system in context of Human Rights legislation
- Strengthen dignity links with prevention and early intervention agenda/priorities in practice to prevent dignity issues, poor practice/quality occurring
- Increase local awareness raising and publicity to progress work commenced in raising public awareness of dignity and complaints procedures
- Develop dignity and intergenerational work to engage children/young people with adults, raise awareness of dignity, dementia etc
- Ensure that whole-system monitoring information/system across multi-agency partners introduced to improve outcomes from learning, quality, and identify difference and trends
- Qualitative information gathered on ongoing basis via focus groups with service users/residents, carers and patients
- Make the safeguarding, dignity, patient safety, whistle-blowing, complaints and quality agendas coherent with each other
- Publish feedback from individuals
- Consideration of prosecutions in relation to 'wilful neglect'

10. **Are there any other comments that you would like to make?**

- To support whole system improvements suggest that the protection of adults – dignity/safeguarding be underpinned by formal legislation mirroring children's services.
- Consideration of a duty to safeguard and promote the wellbeing of adults.
- Debate about a crime of neglect to include wilful neglect of people with (as well as without) capacity?

Suggest the Commission focuses upon:
- **Understanding the problem and the need**
- **Establish what really works**
- **Driving change and improvement**

Peter Hay, President Association of Directors of Adult Social Services
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