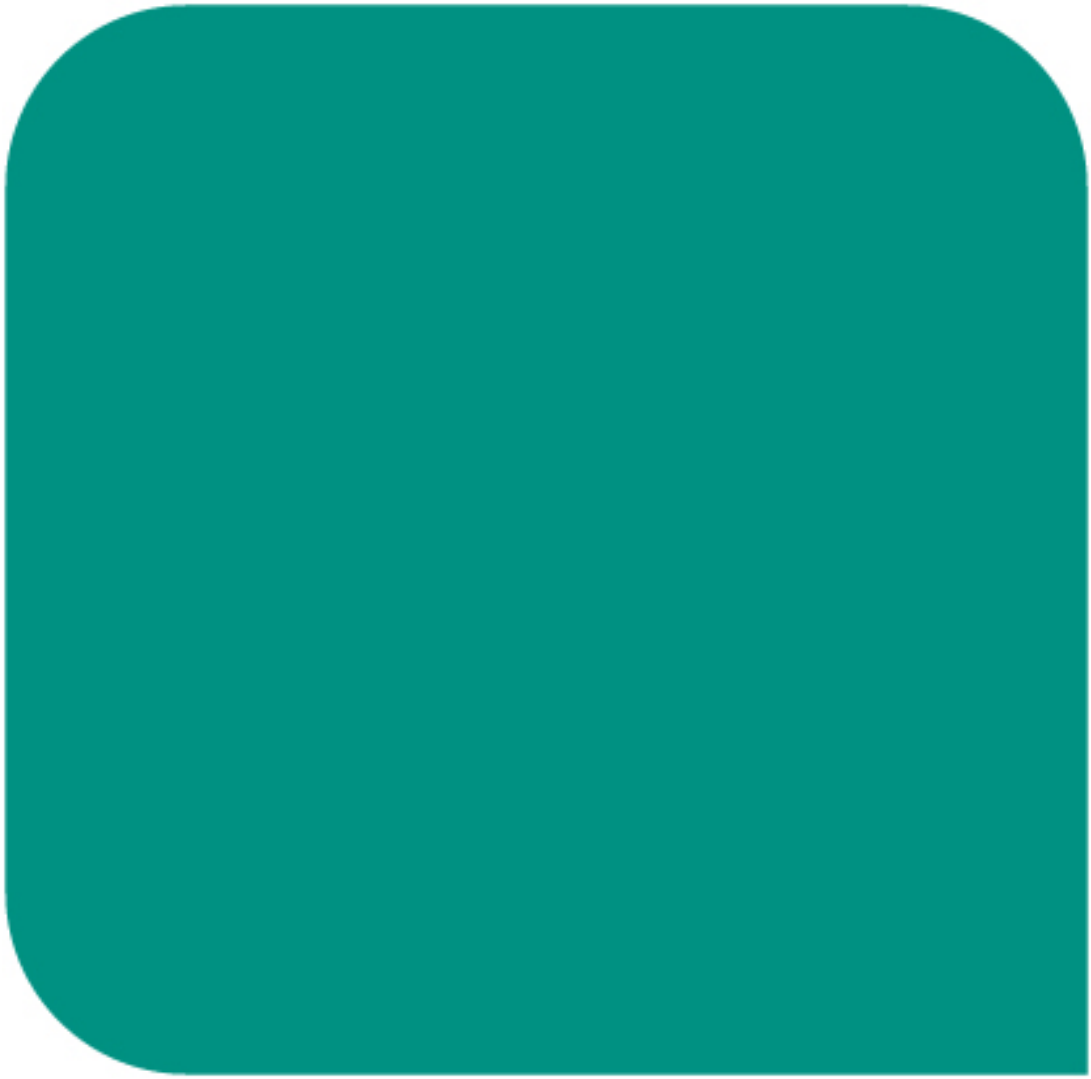
social care
institute for excellence

Commissioning care homes: common safeguarding challenges



The Social Care Institute for Excellence (SCIE) was established by Government in 2001 to improve social care services for adults and children in the United Kingdom.

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SCIE works to:

- disseminate knowledge-based good practice guidance
- involve people who use services, carers, practitioners, providers and policy makers in advancing and promoting good practice in social care
- enhance the skills and professionalism of social care workers through our tailored, targeted and user-friendly resources.

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This guide aims to identify the issues that commonly lead to safeguarding referrals from care homes. The underlying causes are also identified; neither are in order of prevalence. Prevention checklists are provided to help both commissioners and providers to work towards a reduction in occurrence of these issues. There are additional links to resources.

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The evidence underpinning this work was gathered from people using services, carers, commissioners, service providers, safeguarding leads and the Independent Safeguarding Authority (ISA). It shows clearly that most safeguarding activity relating to care homes occurs as a result of poor practice and poor quality of service rather than malicious intent. The impact of poor practice and neglect can be just as significant as intentional abuse and yet it is arguably far easier to prevent.

In all cases of suspected neglect or harm, local multi-agency policies and procedures should be followed. The safety of the individual concerned should be of paramount importance, and all action taken and decisions made should be clearly recorded. Local protocols should determine when a concern should be referred through safeguarding procedures and when it should be dealt with through supervision, training and other practice improvement mechanisms. We provide a number of examples of decision-making tools from across the country.

Common safeguarding issues

Maladministration of medication

There are isolated cases of medication being mismanaged intentionally, such as the misappropriation and misuse of drugs by staff. There are more widespread issues regarding the misuse of sedatives to control challenging behaviour. There is no doubt that such issues are extremely serious and should be referred through safeguarding procedures.

The issue of poor management of medication, however, is far more common. Recent research for the Department of Health shows that 7 out of 10 residents are exposed to at least one medication error per day. Mistakes are made by people across the process from the GP to the pharmacist and care home staff. In the care home, incidents occur where the resident is accidentally given the wrong medication, given too much or too little of their own medication or given it at the wrong time. Most errors do not result in significant harm but mistakes can lead to serious and, in some cases, fatal consequences.

Good medical care also includes the proper use of non-oral medication, equipment and appliances including catheter care, use of oxygen etc. Only trained staff should be providing such care.

Prevention checklist

- All residents should be supported to manage their own medicines unless they are assessed as lacking mental capacity to do so.
- Medication should be stored in the resident's room in a locked cupboard. An assessment should be made of the risk to each resident and to others as a result of them having unsupervised access to the cupboard.
- Robust systems for medication administration and record-keeping are clearly set out in the home's procedures. There is evidence that the manager checks adherence on a regular basis.
- All staff responsible for administration of medication receive regular training and can demonstrate that they are competent in this area of practice.
- Training includes administration procedures, knowledge of the medicines and expected effects of taking them, including side-effects and knowledge of the conditions or illnesses being treated.
- Staff are aware that they should report concerns about over-medication through safeguarding procedures.
- The home has an open and supportive culture. Staff discovering an error feel confident in reporting it and are not tempted to cover it up.
- Staffing levels are always adequate to enable staff to adhere properly to agreed practice and protocols on the administration of medication.

- The GP carries out regular reviews of all patients receiving medication and there is a focus on the reduction of medication where possible.
- The home works with the GP and pharmacist to examine mistakes with a view to improvement.
- Staff receive support from community health professionals in the management of health conditions.
- The home has a multi-agency and person-centred approach to the management of challenging behaviour.
- Where the decision to use, or not use, medication could be considered as serious medical treatment, staff should adhere to the Mental Capacity Act. If a person lacks capacity, and there are no relatives or friends to act in their best interests, staff should refer to an Independent Mental Capacity Advocate (IMCA).

Resources

- The Royal Pharmaceutical Society: The Handling of Medicines in Social Care

Pressure sores

Many people who are frail and have restricted mobility are at risk of developing sores on the points of their body which receive the most pressure. These are known as pressure sores and are sometimes called bed sores or ulcers. Pressure sores start with skin discoloration but, if left untreated, they can become very deep and infected; in the worst cases they can be life threatening. With management and care, pressure sores can be avoided in most cases.

Pressure sores are not always due to neglect and each individual case should be considered, taking into account the person's medical condition, prognosis, any skin conditions and their own views on their care and treatment. These things, rather than the grading of the pressure sore, should determine whether a safeguarding referral is appropriate. Other signs of neglect, such as poor personal hygiene and living environment, poor nutrition and hydration may help to influence this decision.

Prevention checklist

- All care staff receive training on how to prevent pressure sores and how to identify the early stages.
- All residents are assessed on the risk of developing pressure sores.
- Individuals at risk of developing bed sores are assessed for appropriate equipment and it is provided promptly.
- Key people in the home are trained in pressure sore care.

- Staff make timely referrals to, and receive prompt support from, community health professionals in pressure sore management.
- Body maps are completed to identify and monitor any current pressure sores.
- Managers regularly review pressure sore care and develop action plans, including identifying training, where needed.

Resources

- The Waterlow score for grading pressure sores
- Waterlow - Other free resources
- Royal College of Nursing clinical practice guideline for pressure ulcers
- Alzheimer's Society pressure sore information

Falls

Residents should be supported to stay as active and independently mobile as possible and the support they need should be recorded in their care plans. Some people who are frail or have mobility problems may be at greater risk of falling. The consequences of falls can be very costly for both the individual – in terms of their health, wellbeing and mobility – and for services. Following a fall, the individual may require more intensive services for longer and, in some cases, may never return to previous levels of mobility. A fall does not automatically indicate neglect and each individual case should be examined in order to determine whether there is a safeguarding concern. There are a number of things that can be done to reduce the risk of falls while keeping residents active and mobile.

Prevention checklist

- All residents are assessed on the risk of falls and care plans reflect the support needed by individuals to remain active and mobile.
- Individuals are supported to make decisions about how they may reduce their risk of falling.
- Where there are concerns about a resident's capacity to understand the risk of falling, the outcome of a capacity assessment is recorded in the person's care plan.
- Any restrictions or restraint used to reduce the risk of falls, for people lacking capacity to manage their own risk, is evidenced in records of the best interest decision-making process and in the care plan.
- All care staff are trained and competent in moving and handling procedures.
- Appropriate referrals are made to community health care professionals following risk identification.

- There is a clear process for staff to follow when someone has fallen, including how to help the person up, when to refer for medical attention and when to refer for safeguarding.
- Appropriate aids and equipment to reduce the risk of falls are provided promptly following risk identification.
- The home provides good nutritional care and residents are properly hydrated; poor nutrition and hydration can cause dizziness and weakness. (see SCIE A a glance 3: **Nutritional care and older people**)
- The home provides opportunities for residents to exercise and individuals are supported to stay as mobile as possible.
- The home has links with the local falls prevention service.

Resources

- NICE clinical guideline on falls
- SCIE research briefing on falls prevention
- Independent Living falls prevention advice
- "Stop Falling: Start Saving Lives and Money", Age UK

Rough treatment, being rushed, shouted at or ignored

The research underpinning the SCIE ***Dignity in care*** guide highlighted that people receiving care support often feel they are being roughly treated, rushed or ignored. People can experience such treatment as abuse. Unexplained bruising is a common reason for safeguarding referrals and rough handling may often be the cause. Care workers should be mindful that the people they are caring for may be in pain due to illness or disability and may bruise easily due to physically frailty. People with dementia, learning disabilities or mental health problems could be fearful of physical intervention due to lack of understanding of what is happening to them.

Shouting, raised voices or the tone used may also cause distress and harm to people and they may experience such interactions as intimidating. This can occur when people make assumptions about the person's inability to hear or understand, it can be due to cultural difference where a worker may naturally converse more loudly than the care recipient, or it could be a result of the care worker being busy and stressed due to inadequate staffing levels. Tone is important: people should be addressed in a respectful manner and not in a way that is sharp, abrupt or condescending.

It is very important that the home demonstrates a 'zero tolerance' approach to insensitive care and that residents are encouraged to comment on their experience of receiving care so that such matters can be addressed.

Prevention checklist

- The home actively promotes ***Dignity in care*** and has a zero tolerance approach to insensitive care.
- The home has adequate staffing levels so that staff are not forced to rush or ignore requests from residents.
- Staff are trained and competent in manual handling techniques and the use of mobility aids.
- Care provision is personalised and tailored to individual needs.
- Residents' individual communication needs are recorded on their care plan and staff are trained in how to communicate with people with particular difficulties.
- Care plans identify those most at risk of being subjected to abuse (this includes people who are quiet or isolated, unable to communicate well and those who are demanding or considered difficult to work with).
- Residents are never denied access to staff call buttons and alarm cords.
- The home regularly seeks feedback from residents and relatives on the quality of care provided.
- Problems arising from cultural differences between staff and residents are identified and addressed through training and supervision.
- Staff are encouraged to identify and challenge inappropriate care by their peers.
- The home has a whistleblowing policy, which includes the option of alerting externally through the local authority, and staff are aware of their individual responsibility to raise concerns.

Resources

- **SCIE Dignity in care guide**
- The **My Home Life** movement offers a range of resources to improve the quality of life of older care home residents.
- **Public Concern at Work** advice and support on whistleblowing

Poor nutritional care

Poor nutritional care in care homes and hospitals has been frequently highlighted in recent years. This led to a host of reports and guidance to support improvements in the health and social care sectors. As part of the Joint Action Plan: ***Improving nutritional care*** (DH, 2007), SCIE has produced **a comprehensive guide** on this issue.

Food is the 'highlight of the day' for many people in care homes and a measure of the overall quality of the service. Between 19 and 30 per cent of all people admitted to hospitals, care homes or mental health units are at risk of malnutrition (BAPEN 2007). The consequences of malnutrition and dehydration can be very costly both for the

individual, in terms of their health and wellbeing, and for services as people may become ill and require more intervention for longer.

Prevention checklist

- The home carries out nutritional screening for residents on admission and regularly thereafter.
- Care plans reflect the individual's nutritional needs, including those as a result of medical conditions or risk of malnutrition.
- Concerns highlighted in screening are acted upon and timely referrals are made to community health professionals.
- Daily food and fluid intake is recorded for those who are identified at risk.
- The home provides a choice of good quality food in adequate amounts.
- Privacy is offered to those who have difficulties eating or need help and may wish to avoid loss of dignity in communal eating areas.
- The food is well prepared in a safe environment and food hygiene standards are met.
- Individual needs and preferences, including any specific dietary, cultural and religious requirements, are recorded in individual care plans and catered for.
- Residents have access to food and drink 24 hours a day.
- Food is provided in an environment conducive to eating and with regard to individual choice (e.g. when and where people want to eat).
- The home ensures that there are sufficient staff and volunteers to support those in need of help and encouragement to eat their food.
- Residents who are able to prepare their own snacks and drinks are encouraged to do so.
- The home seeks regular feedback from residents on the quality of food provision.

Resources

- **SCIE guide 15 offers a comprehensive list of resources on eating and nutritional care**
- **SCIE has produced a Social Care TV film on good nutritional care**

Lack of social inclusion

People in residential care and their relatives often complain of lack of stimulation, activity, opportunities for social interaction, including sexual relationships, and community participation. The results of inactivity and social isolation can be experienced as harmful and abusive by individuals and can have a negative effect on mental health

and general wellbeing. Commissioners should ensure that service specifications include support to access social activities and opportunities for community participation.

Prevention checklist

- The home provides frequent opportunities for individuals to be supported in activities of their choice both within the home and in the community.
- Each resident has a care plan that outlines their preferred social activities, who they prefer to spend their time with and how they wish to be supported.
- Individuals' preferred activities are supported and not restricted by staff shift patterns.
- Residents are encouraged to form relationships, and supported to safely pursue sexual relationships if they wish.
- Transport is not a barrier to participation and individuals are supported to use transport that suits their needs.
- Friends and family members are welcomed and are able to spend as much as time as they wish with their friend/relative.
- Specific attention is given to those people who are at particular risk of social isolation because of mental incapacity, physical disability, or lack of family or friends. Action to be taken is recorded in their care plan.

Resources

- **SCIE Dignity in care guide: Social inclusion**

Institutionalised care

'Institutional abuse occurs when the routines, systems and regimes of an institution result in poor or inadequate standards of care and poor practice which affects the whole setting and denies, restricts or curtails the dignity, privacy, choice, independence or fulfilment of adults at risk' (SCIE 2010). For example, people being forced to eat or go to bed at a particular time can be experienced as abuse. The culture of the organisation may promote institutionalised care and may cause 'the practices of well-intentioned staff to deteriorate'. It may also allow intentional abuse to go unreported (Marsland et al. 2007).

Care homes should promote a personalised service through flexibility and avoid strict routines. Staffing rotas should be focused around residents' individual needs and preferences.

Prevention checklist

- The home demonstrates good management practice and strong leadership.
- All residents have their needs and preferences recorded on their care plan and staffing is arranged to accommodate this. Where best interests decisions need

to be made because of lack of capacity, the person is still involved in addition to family or friends who can represent them.

- Residents are involved in any decision that affects their care, including personal decisions (such as what to eat, what to wear and what time to go to bed), and wider decisions about the service (such as menu planning or recruiting new staff).
- Those who need support with decision-making due to cognitive impairment receive the help and advice they need and have access to advocacy.
- Staff are trained and competent in communicating with people with communication difficulties or cognitive impairment.
- Residents are supported to pursue activities and interests of their choice and this is not restricted by staff shift patterns (e.g. if a resident wishes to go out in the evening they can return at a time of their choice).
- Night staff are available to support residents and not restricted in doing so by task-centred work.
- Visits from family and friends are encouraged and not restricted to certain times. Their involvement in decisions and the running of the home is encouraged.

Resources

- **SCIE Dignity in care guide: Choice and control**
- **PANICOA: Prevention of Abuse and Neglect in the Institutional Care of Older Adults**
- **Berkshire protocol for institutional investigations**

Physical abuse between residents

Care homes often have to deal with altercations and abuse between residents, some of which entail physical attacks. This could be the result of tensions between people living in close proximity, and may also be caused or exacerbated by misunderstandings due to dementia, learning disability, or mental health problems. Some instances of challenging behaviour may be due to poor relationships with, and poor management of, residents. Training in managing challenging behaviour, appropriate restraint and de-escalating situations is important.

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Prior to someone choosing a home, their assessment should consider their compatibility with other residents and any risks to the individual or other residents due to challenging behaviour. In order to reduce or avoid abuse and harm, care homes should work to prevent such incidents occurring by identifying triggers and supporting individuals who perpetrate abuse as well as their victims.

Prevention checklist

- All residents are assessed in terms of their risk of being abused or of abusing others.
- Physical screening takes place to rule out infections which could alter behaviour.
- Staff are trained to identify the causes of challenging behaviour and understand that it may be used as a method of communication.
- Where risks are identified, plans are in place to support individuals and to prevent and reduce the risk of abuse.
- Care home staff are trained and competent in the management of challenging behaviour and supported by community health care professionals.
- Medication is reviewed regularly, whenever behaviour changes and at least every six months.
- Investigations are carried out to assess for medical or other reasons which may be causing behaviour that is difficult to manage.
- Where there are ongoing issues between individuals, the care home takes a multi-agency approach to long-term resolution.
- All incidents of abuse between residents are recorded and reported under local safeguarding procedures. Close family or friends should be informed unless there is a legitimate reason for not doing so.

Resources

- **SCIE At a Glance 37: Challenging behaviour: a guide for family carers on getting the right support for adults**
- **SCIE Dementia Gateway: Aggressive behaviour**
- **SCIE training materials: Managing risk, minimising restraint: Challenges, dilemmas and positive approaches for working with older people in care homes**
- **SCIE resources on Minimising the use of restraint in care homes**
- **The Challenging Behaviour Foundation**

Practice examples

- **Challenging behaviour in older people's residential care**

- **Developing person-centred care for people who have challenging behaviour**

Financial abuse

A study into the abuse of older people in the UK (O'Keeffe et al. 2007) found that financial abuse is the second most prevalent type of mistreatment after neglect. The ***No secrets*** definition of financial abuse is:

'financial or material abuse, including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits' (DH 2000).

Older people, particularly people with dementia, are among those at greatest risk of financial abuse. Indications are that 60–80 per cent of financial abuse against older people takes place in the home and 15–20 per cent in residential care (Help the Aged 2008). People in care homes may be better protected than those who are isolated or living alone, for example, they may be less likely to be targeted by rogue traders or telesales fraud, but there are different risks of financial abuse for this group. Some residents will have little or no control over their own money and are reliant on relatives or the home to safeguard their finances. Examples of financial abuse in care homes include:

- the home using resident's own money to pay for things for the home without the person's agreement
- a care worker accepting an inappropriate gift or reward
- a relative receiving benefits on the person's behalf but not passing on the personal allowance
- an appointed deputy not managing the person's finances in their best interest.

A report on financial abuse (PDF) (ACPO/SCIE 2011) highlighted that some care providers did not see it as their role to raise concerns about the decisions of a 'deputy' or an 'appointee'. Others reported that they had raised concerns with the local authority only to be told that – if a deputy or appointee was in place – nothing could be done.

If people are to be safeguarded against financial abuse then concerns about deputies and appointees must be reported so that best interests meetings can take place. If the local authority receives an alert it can apply to have the deputyship or appointeeship revoked and awarded to the local authority deputy.

Prevention checklist

- The home keeps clear records of people's individual finances.
- People's individual finances are audited monthly by the home manager or administrator – relatives are kept informed of transactions as appropriate.

- The home ensures that residents receive their full entitlement of benefits and income.
- Care home staff understand that they have a responsibility to report concerns about financial abuse through safeguarding procedures and, where appropriate, the Office of the Public Guardian (OPG) or the Department for Work and Pensions (DWP).
- Local authority income teams make a safeguarding referral if a person's care fees are not being paid.
- The local authority deputy maintains links with care homes in the area.

Resources

- **Help the Aged (2008) The Financial Abuse of Older People: A Review of the Literature**

Underlying causes

Recruitment

The Independent Safeguarding Authority (ISA) has identified poor practice in recruitment, induction and supervision as root causes of many safeguarding issues. This presents a major opportunity for the prevention of abuse. Commissioners should examine recruitment procedures of the home to ensure they are robust.

Prevention checklist

- The home manager and senior staff demonstrate good leadership skills.
- The home closely scrutinises applications for employment and actively investigates any gaps in employment history.
- The home always checks references rigorously and makes further enquiries where necessary.
- At interview the home establishes that the candidate has the appropriate attitudes and values to be considered for care work.
- The home employs care staff with a good understanding of English (or other language spoken by the majority of residents) to ensure good and clear communication.
- The home has a comprehensive induction programme and evidence that it is provided for all staff.
- The induction programme includes safeguarding practice and procedures and the individual's responsibility to raise concerns.
- New staff are mentored by existing staff and their practice is monitored.
- There is evidence of regular supervision which monitors safeguarding practice and encourages staff to raise concerns.
- All staff receive Mental Capacity Act training (see the **SCIE MCA resources**)

Resources

- **SCIE Guide 1: Managing practice: Supervision and team leadership**
- **SCIE People management: Effective support and supervision**

Staffing levels

Staffing levels that are inadequate to meet the assessed needs of individuals are often cited as a reason for poor quality care. There are a number of problems that lead to inadequate staffing that are interrelated in that each problem can exacerbate other related problems:

- the low status and pay of care work

- poor training and support for staff
- staff feeling stressed, rushed and overworked leading to low morale, burnout and potentially poor standards of care
- high levels of sickness increasing pressure on the remaining staff in the workplace
- high staff turnover resulting in wasted training resources and high recruitment costs.

Prevention checklist

- Commissioners and providers agree on adequate levels of staffing to meet individual needs.
- Commissioners provide sufficient funding for agreed staffing levels, including absence cover, and monitor to ensure agreed levels are consistently maintained.
- Care workers in the home are valued, respected and properly supported. They are well trained, supervised and adequately paid.
- The home has a register of regular bank staff and is not reliant on agency care workers.
- Staff show a good awareness of how to access external support (e.g. community health teams, voluntary organisations).

Resources

- **CQC Essential standards of quality and safety – Outcome 13: Staffing (p132)**

Adherence to policy and procedure

All care homes should have policies and procedures in place to cover all areas of care home practice, including those highlighted as frequently leading to safeguarding referrals. These policies and procedures should be submitted as part of the Care Quality Commission (CQC) registration process and subsequent inspections. However, it is often the case, particularly with regard to safeguarding referrals, that procedures are not followed.

To ensure good quality services and good safeguarding practice, commissioners must make regular checks to ensure that the procedures are followed.

Prevention checklist

- The home demonstrates good quality leadership and management.
- The home has robust policies and procedures in place.

- The home has clear guidance for staff to support decisions on making safeguarding referrals.
- There is clear guidance for staff on when to call out emergency services and what to do when they arrive.
- All staff, apart from those in induction and direct supervision, have signed to confirm they have read and understood the policies and procedures.
- The home has a whistleblowing policy, which includes the option of alerting externally through the local authority, and staff are aware of their individual responsibility to raise concerns.

Resources

- **SCIE Guide 1: Supervision and team leadership**
- **SCIE Guide 29: Changing social care: an inclusive approach**
- **SCIE Guide 34: Practice development: collaborative working in social care**
- **Public Concern at Work**

Training

Care home staff often receive only minimal training in line with statutory requirements. This is of course related to resources, but a lack of investment in staff is likely to be costly in the long run due to increased turnover and recruitment costs.

It is also the case that when staff are trained individually by being sent on a course they find it hard to change their practice on returning to work because of the culture, environment and peer pressure. It is often wiser and more economical to provide training to the staff as a team so that they can support each other to implement changes.

Prevention checklist

- The home has a robust training regime that extends beyond statutory requirements.
- The local authority offers safeguarding training to all providers and addresses issues of cost and staff cover within contractual arrangements.
- Staff receive training in safeguarding, mental capacity and Deprivation of Liberty Safeguards as part of their induction and attend regular refresher courses.
- The home carries out a regular training needs assessment within a culture of continuous improvement.
- People who use services are included in the provision of staff training.
- All night staff have the same access to training as daytime workers.

- There is a trained first-aider on duty at all times.
- Each member of staff has a plan for progression and development.
- Staff can demonstrate the benefits of their training and identify changes in practice resulting from it.
- The home demonstrates that it learns from mistakes that lead to safeguarding referrals and includes issues raised in the training programme.
- The home has a culture of continuous improvement taking account of the views of residents, relatives and frontline staff.

Resources

- **Skills for Care**
- **SCIE Research briefing 34: Communication training for care home workers: outcomes for older people, staff, families and friends**
- **SCIE Mental Capacity Act training resources**

Choice of service

From the perspective of people using services, it is clear that as long as there is a lack of choice and alternatives in service provision, poor services will continue to operate. There are many reasons why people may use services that are poor including lack of alternatives, affordability, location, choice and pressure from family members.

With real choice, individuals would choose not to use poorer services and such services would consequently have to improve or go out of business. This is a key point for commissioners as they must, where the market has failed, encourage variety and flexibility in provision to promote quality, choice and control for individuals. This in turn will reduce the risk of abuse, neglect and harm.

Prevention checklist

- Commissioners plan, through the Joint Strategic Needs Assessment, to meet future identified care needs in the area.
- People are not placed far away from their local area due to lack of provision.
- Local services offer a good range of choice and flexibility.
- Gaps in the local market are identified by commissioners and they work with people using services and providers to address local need.
- Existing providers are encouraged to diversify the services they offer.

Resources

- **The Department of Health: Practical approaches to market and provider development**' sets out a framework for development based on strong

engagement, market intelligence, provider development and flexible arrangements.

- **Think Local, Act Personal: Resources to support market development**

Record-keeping

Poor record-keeping is essentially poor communication and can put both staff and residents at risk. Records include:

- pre-admission assessments
- care plans
- risk assessments
- safeguarding referrals and investigations
- medication records and administration sheets
- end of life care planning, including clear instructions on whether individuals wish to be resuscitated
- referrals to other organisations and professionals
- staff handover documents
- staff supervision and training records
- complaints.

Prevention checklist

- Resident's care plans are person-centred and accurate.
- Care plans include risk assessment and risk enablement.
- There is evidence that staff adhere to care plans and they are regularly updated.
- All records are recorded clearly in a manner that can be easily understood by others.
- The home manager regularly monitors the standard of record-keeping.
- All records are accessible to those that need them while appropriate levels of confidentiality are maintained.
- Where the home manages any aspect of a resident's finances, either through resident choice or lack of capacity, the records are subject to robust and regular checks.
- All record-keeping practice is regularly reviewed, with input from frontline staff, as fit for purpose.

- There is evidence that the home uses complaints to improve quality and practice.
- There are records of regular staff supervision and team meetings and evidence that actions are followed up.

Resources

- **CQC Essential standards of quality and safety &ndash Outcome 21: Records (p170)**
- **Essence of Care 2010: Benchmarks for Record Keeping**

Dehumanisation

People using care services often report the experience of being treated in a way that is 'less than human' or 'dehumanising'. Research has examined the way in which workers can distance themselves from, and fail to show empathy towards, the people they support. 'The tendency to view a patient as less than human has been identified with a need to defend oneself against the anxiety that their condition provokes' (Menzies 1977). Wardhaugh and Wilding (1993) referred to the concept as 'neutralisation of moral concerns'. This can 'place residents beyond the bounds of normal, acceptable behaviour, allowing abusive behaviours to be justified and perceived as legitimate' (Marsland et al. 2007). This issue has been closely related to the concept of 'burnout'. Workers who feel that they put more into the job than they get out are more likely to detach themselves emotionally from their work (Thomas and Rose 2009; Rai 2010).

Institutionalisation can also lead to dehumanisation as the regimes and routines of the home are placed above the needs of individuals. (**Institutionalised care**). Dehumanisation can be experienced in a number of different ways including being:

- discriminated against or treated differently to others
- isolated, dismissed or ignored
- disrespected, mocked or belittled
- deprived of dignity and privacy
- deprived of choice and control
- stripped of one's identity
- deprived of basic needs (e.g. food)
- abused physically, sexually or in any other way.

Prevention checklist

- Staff are respectful towards residents, treating them as individuals, promoting choice and upholding their rights.
- Staff are respected and valued.
- Residents participate in staff training and exercises that encourage empathy are included.

- The home offers person-centred care and promotes dignity for all, including those who lack capacity or have problems with communicating their needs.
- Staff are encouraged to get to know residents, their preferences and their personal histories.
- Staff work in close partnership with residents' friends and family.
- Residents are encouraged to make a 'life story book'.
- Particular effort is made to ensure that people who lack capacity or have problems with communicating are treated as individuals and every effort is made to ascertain their wishes.

Resources

- **SCIE Dementia Gateway: Getting to know the person with dementia**

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