

ORIGINAL ARTICLE

Demonstration of the usefulness of a theoretical framework for humanising care with reference to a residential aged care service in Australia

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Aims and objectives. To demonstrate the usefulness of a theoretical framework for humanising care of dementia patients.

Background. The term humanisation of care has been increasingly used to describe an approach to health care that is informed by core dimensions of what it means to be human. Recent developments in dementia care highlight the importance of maintaining personhood in people with dementia.

Design. A conceptual framework is proposed by which the humanisation of care can be understood and applied. Eight dimensions that articulate core features of what needs to be attended to in order for a person to feel more deeply 'met' as a human being are discussed. Evidence from an evaluative study of a dementia outreach service is used to illustrate the usefulness of the humanising framework.

Methods. Case study examples demonstrate the value of this framework by describing how a dementia outreach service enables care staff in residential aged care facilities to change their focus in the provision of care to residents with dementia. Each of the eight dimensions of humanisation/dehumanisation is used to illustrate how the dementia outreach service team have led to the improvements in resident care.

Results. Positive outcomes can be achieved by providing humanised care to residents with dementia.

Conclusion. The paper highlights the potential for the humanising framework to be used in dementia care and shows how the framework can be helpfully translated into practice so that carers are supported to adopt an inclusive view of care delivery.

Relevance to clinical practice. A comprehensive framework, grounded in a strong philosophical foundation, can name a breadth of criteria for humanly sensitive care and can be translated into practice in such a way as to potentially transform the provision of care to residents in residential aged care facilities.

Key words: dementia, humanising framework, residential aged care

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Introduction

The term humanisation of care has been increasingly used to describe an approach to health and social care that is informed by core dimensions of what it means to be human.

The emergence of the term can be noted in both Western and Eastern contexts, with conferences dedicated to humanising care occurring in Thailand and China in 2007 and 2009, respectively, and an entire volume of a series of books concerning 'whole person health' devoted to the issue (Serlin

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2007). Through the use of illustrated examples, we describe how humanising the care of residential aged care facilities' (RACF) residents with dementia can significantly improve their quality of life.

Contributing to the trend towards human-centred approaches to health care, two of the co-authors of this paper have proposed a conceptual framework by which the humanisation of care can be understood and applied. Derived from the broad tradition of existential phenomenology and lifeworld philosophy (Todres *et al.* 2009), they have proposed eight dimensions that together articulate core features of what needs to be attended to in order for a person to feel more deeply 'met' as a human being. These eight dimensions, which form the conceptual framework for this paper, are based on a deeply relational ontology and epistemology that acknowledges both the socially embedded qualities of being human and an acknowledgement of vast sources of subjectivity and personal organisation beyond any simple deterministic framework (Todres *et al.* 2009).

Case studies that will demonstrate the value of this framework are presented, by describing how a dementia outreach service (DEMOS) is helping care staff in RACFs change their focus in the provision of care to residents with dementia, specifically those who have behavioural and psychological symptoms of dementia. RACF staff are encouraged to 'see the person behind the disease' and provide more person-centred care. Practical strategies are modelled by DEMOS in how this can be achieved.

The humanising framework provides eight bipolar constructs, each of which communicates both the humanising and dehumanising features of care and its context. Before we describe the nature of the DEMOS and its practical potential for humanising dementia care, we would like to locate this conceptual framework within earlier and emerging developments in dementia care.

Background

While the term 'humanisation' has not been used in dementia care, it should be noted that discussion relating to personhood is central to recent thinking. Contemporary thinking around dementia care has challenged the idea that people with dementia encounter a 'loss of self' (Cohen & Eisdorfer 1986) and that the trajectory of the disease is a 'living death' (Woods 2007). These developments highlight the importance of maintenance of personhood in people with dementia, arise from an essentialist understanding of the person as developed by enlightenment philosophers such as Locke and are supported by the medical 'representation' of dementia. This approach was challenged in the late 1980s by Kitwood

(1997) who in his development of 'person-centred care' defines 'personhood' as 'a standing or a status that is bestowed on one human being by another, in the context of relationship and social being' (Kitwood 1997:8). While person-centred care successfully 'placed the person [*with dementia*] first' and supported approaches that enhanced the well-being and dignity of people with dementia, person-centred care has not been without its critics (Adams 1996, Davis 2004). An important area of critique argues that seeing personhood as something bestowed on people with dementia undermines recognition that people with dementia have agency (Adams 2005) and continues to position a person with dementia as someone that is passively dependent upon others for affirmation (Bartlett & O'Connor 2010). It has been argued that a citizenship approach is key to acknowledging the agency and power of people with dementia, by recognising that they are active citizens in society (Bartlett & O'Connor 2010).

An alternative critique seeks to recognise the 'lived experience of people with dementia' and uses the notion of 'embodied selfhood' to describe how agency arises in people with Alzheimer's disease in part through their body, rather than merely their cognition. This argument contends that selfhood comprises primarily in one's intrinsic corporeality of being in the world which comprises a synthesis of primordial and social being (Kontos 2006, Kontos & Naglie 2009).

Lastly, the dominant recovery approach sees recovery not in terms of an absence of illness, but rather as growth, hope and a journey. While there is much common ground between this approach and person-centred care, the agency of people with dementia is better acknowledged in recovery approaches in that people with dementia are seen as able to seek opportunities that allow them to develop their life-journey, despite having dementia.

The conceptual framework in this paper was developed by Todres *et al.* (2009) and highlights the notion of humanisation. The approach is epistemologically consistent with Kontos's (2005) phenomenologically oriented epistemology but wishes to take this discourse more explicitly beyond the potential polarities that personhood and person-centred care can engender. In a previous paper concerning how 'lifeworld led care is more than patient led care', Dahlberg *et al.* (2008) highlighted how patient-led care, in reaction to the 'medical model', was in danger of being co-opted by both an economic-consumerist and political-citizenship discourse. It is within this context that the term 'humanisation' of care can offer helpful nuances of meaning that the term 'personhood' and 'person-centred' care may obscure.

In Table 1, we name the eight dimensions of humanisation together with their polar opposites (dehumanising

dimensions) in each case. The table is presented to help the reader imagine each dimension along a spectrum of possibility rather than implying either/ or extremes. Next follows a practical description of the DEMOS that forms the case studies within which we illustrate the framework.

Before introducing the nature of the Dementia Outreach Service (DEMOS), we would like to address one or two conceptual issues concerning the humanisation framework with its eight dimensions that have been addressed in greater detail in an earlier paper (Todres *et al.* 2009), but they are also relevant here in relation to the way we draw on illustrations and apply the conceptual framework in practice. The dimensions within the humanising framework are best seen as ‘matters of overlapping emphasis’ rather than discrete independent categories. This is as we would expect within a phenomenological orientation that sees human phenomena and experiences as holistic but with discrete variations and emphases. We do not have enough space within this current paper to conceptually illustrate the value of each discrete dimension as before (Todres *et al.* 2009), and we refer readers to this earlier paper for further clarification. The over-lapping emphases of the eight dimensions mean that a particular practice example could be used to illustrate more than one conceptual dimension, and this is what you will see in the illustrations offered in our results section. However, we would like to suggest that although readers may be able to see the examples given as addressing more than one dimension, readers are invited to adopt each illustration given in relation to the particular dimension referred to.

Methods

The Dementia Outreach Service has been designed by one of Australia’s first nurse practitioners specialising in dementia care. The aim of DEMOS is to assist staff in RACFs to manage residents who display difficult behaviours related to the behavioural and psychological symptoms of dementia (BPSD). The focus of the service is on building staff capacity to recognise the causes of these behaviours and deal with them appropriately, in a manner that takes into account the needs of the resident and which are also factors in the various environmental issues that could be causing the behaviour. RACF staff are encouraged to step into the shoes of the resident and see things from their perspective, to give them a better understanding of what may be causing behaviours and what appropriate solutions may be, which are sensitive to the resident’s needs. Recipients of the DEMOS service must have a diagnosis of cognitive deterioration or dementia to be eligible for the service. The DEMOS team is led by a nurse practitioner (NP), assisted by a clinical nurse (CN) and

Table 1 Conceptual framework of the dimensions of humanisation

Forms of humanisation	Forms of dehumanisation
Insiderness	Objectification
Agency	Passivity
Uniqueness	Homogenisation
Togetherness	Isolation
Sense making	Loss of meaning
Personal journey	Loss of personal journey
Sense of place	Dislocation
Embodiment	Reductionist body

endorsed enrolled nurse (EEN), an assistant-in-nursing (AIN), clinical facilitator, social worker and administrative assistant.

After receiving a referral (for example, from a RACF, GP or family member), the NP conducts an assessment of the client and determines what the possible triggers for the behaviour could be. Following the assessment, the NP provides advice to RACF staff on how to change the resident’s care plan to reduce the behaviours. In some cases, if the interventions are not leading to an improvement in the resident, the NP may refer the resident to the DEMOS team for further assistance.

The DEMOS team intervention involves the EEN and AIN spending time ‘on the floor’ with staff, observing the resident’s behaviour and the RACF staff responses to the behaviour. The DEMOS team take in the range of environmental factors that may affect the resident. The team then model appropriate behaviours to RACF staff. Additionally, the CN provides educational sessions focusing on specific issues in relation to providing care to residents with dementia.

The DEMOS service has been evaluated using a longitudinal repeated measures model. The evaluation included two major components: Part 1 consisted of surveys and interviews carried out with RACF management and staff regarding the efficiency and effectiveness of the service, focusing on staff knowledge about dementia, stress, self-confidence and satisfaction with the service, and their perceptions about residents’ quality of life; Part 2 included qualitative information gathered from the DEMOS team via interviews and reflective journals. Care staff at 21 facilities (seven intervention facilities plus 14 non-intervention facilities) participated in the evaluation. Surveys were completed by staff both prior to the service being introduced in addition to three months after the withdrawal of the service. Comparisons between the intervention and non-intervention facilities provided indications of the extent to which the service has led to improvements for both residents and staff. Additionally, qualitative

information gathered from the DEMOS team provided in-depth information on how the service worked in practice. Results are promising regarding the effectiveness of the service, particularly in relation to staff stress levels and self-confidence. Ethical approval for the evaluation study was granted from the ethics board at the relevant healthcare authority and the university that conducted the evaluation.

Results

The aim of this paper is to demonstrate the relevance of the aforementioned humanising theoretical framework by applying it to the examples from the DEMOS study. The DEMOS project provides a useful practical context to reflect on the human dimensions of care. The examples used to illustrate the humanising dimensions are drawn from reflective journals completed by the DEMOS team in addition to the extracts from qualitative interview data published in a separate article (Borbasi *et al.* 2010). Therefore, this paper does not report on the research itself, or the data analysis, but rather selectively uses some of this material to meaningfully clarify the humanising framework and its possible practical value.

Insiderness and objectification

Objectification has been defined as the dehumanisation of patients resulting from 'focusing excessively on how they fit into a diagnostic system, part of a statistical picture or any other strategy by which they are labelled and dealt with that does not fully take account of their insiderness' (Todres *et al.* 2009). Objectification is also seen by Kitwood (1997) as a type of interaction by staff that gives rise to diminished personhood in people with dementia. Incidents of objectification were evident in reports from the DEMOS Team who reported that some staff, in going about their daily work, were seemingly unable to see beyond the disease or a sum of tasks to the person behind the disease.

The DEMOS Team are aware of the importance of taking into account the feelings of residents, to encourage belief that their views are valued and accepted, and yet saw some examples of RACF staff insisting on residents doing activities that clearly went against their wishes. Consider the ritual of daily bathing, for example. In a number of cases, resident feelings were not taken into account, but only the need to accomplish this routinised task. One such example concerned a resident whose staff believed required frequent showering but it always made her upset. DEMOS were able to demonstrate that actually asking the resident whether and when she would like a shower, listening to her responses, considering her feelings and allowing her choice resulted in

the resident no longer being aggressive while being assisted to shower. The RACF carers were really surprised by this response. In losing the sight of this woman as a person in her own right, they had come to expect resistance whenever she was approached.

The nurse practitioner describes an incident that demonstrates how important it was to try to imagine the inner experience of the patient, as this further example indicates:

we figured out that the staff were attempting the activities of daily living (ADLs) before the medication had been given and the resident was also in a lot of pain before they did it. So these are some of the things we got going – medication before ADLs. When he was aggressive we suggested don't insist that he have that shower, sponge instead, because they were just putting him in the shower all the time. How they were actually handling him in the shower, they were restraining him... We just said 'have you tried it this way?' ...without offending them or making out we knew more. We were also very careful about how we stepped in and showed them another way. So we'd suggest not 'holding on to him' but be at a 'safe distance'. And we found then that he calmed down. We also gave him something to hold, a washer, and then he started to wash himself. When you took that force away he wasn't fighting. The staff were surprised. They were actually shocked. One of the carer staff said they had never thought of doing things that way.... She didn't see it from his perspective at all – that he was fighting because he felt trapped

Agency and passivity

The ability to make one's own decisions is a key to personal freedom and agency. Often, in the provision of care to residents with dementia, individual choice is taken away. This is often necessary, especially in people with severe cognitive deterioration. However, it cannot be assumed that residents do not have a right to exercise agency in some aspects of their lives. Indeed, when residents do try to display agency, but cannot articulate themselves in a way that is understood by care staff, this can sometimes be misinterpreted as being caused by other factors, such as BPSD. One such example where the resident was trying to express agency, but becoming more and more frustrated, was demonstrated in his reluctance to shower. The resident was particularly aggressive at shower time, lashing out at care staff. The DEMOS Team observed this behaviour and discovered that the temperature in the shower room was very cold:

There was no heater in the bathroom. There was a heater in his room, but the staff weren't turning it on so they were stripping him off in the freezing room – so that set everything off. And they would sit him

down turn the water on and it wasn't even on him but he was getting splatters of cold water hitting his back

When observed, staff did not appear to accept that this resident's attempts at agency made any sense and seemed to act in ways that rendered him feeble. Following advice from the DEMOS Team, the RACF care staff increased the heating in the shower room, which led to a marked reduction in the resident's aggressive behaviour. This example highlights the need to be aware that residents are individuals and that their behaviours are not necessarily caused by BPSD. Taking time to examine all of the factors at play in situations such as these will ensure that residents are not treated as passive recipients of care. This example illustrates how with this humanising dimension in mind thoughtful practice attends to the more general or transferable concern of how to restore a sense of agency in a situation that has been reduced unreflectively to task orientation, without realising its dehumanising effect.

Uniqueness and homogenisation

In the RACF setting, because of heavy workloads and staff shortages, it is often difficult to provide individualised care to residents. However, this does not remove the obligation to treat residents with dignity and to respect their differences. In one incident observed by the DEMOS Team, residents were seated in an arrangement that was cramped. With two rows of residents facing each other, each row of residents was seated very closely, so there was limited 'elbow room'. Some residents were observed consistently bickering with each other. It was discovered that these particular residents 'did not get along', but were regularly seated next to one another. It was suggested that the seats be re-arranged into smaller groupings. When made aware of the issue, the RACF manager was supportive of the change. The issue here relates to viewing the residents as a homogenous group of people and failing to understand that each resident has an individual personality and that personality clashes are inevitable. By becoming more aware of a person's individuality, it is easier to provide more humanised forms of care. This example illustrates how thoughtful practice within this humanising dimension attends to the more general or transferable concern of how to account for individual preferences within an environment in which it may be much more convenient to assume homogeneity of needs and wants.

Togetherness and isolation

While it is important to ensure that all residents in RACFs are treated as individuals, it is also important to realise that

companionship and friendship are fundamental to personal well-being. Often, however, relationships between residents in RACFs can be seen as inappropriate, especially when involving people with severe cognitive decline. However, sometimes residents can form healthy companionable relationships, which benefit both parties. An example of such a friendship was observed by the DEMOS Team in one RACF. In this case, a male and female resident shared a friendship disapproved by facility staff. Staff at the facility referred to the male resident as a 'dirty old man', and some staff were overheard scolding him when they observed him holding hands with the female resident. In the opinion of the DEMOS Team, the relationship was one of companionship, stating '[Female resident] depends on [male resident] just as much as he does on her. It is a friendship that is meeting both their needs. He has never been inappropriate with [the resident] and feels he is helping to care for her.'

In this case, the male resident was actively discouraged from sharing a relationship with the co-resident, despite, in the opinion of the DEMOS Team, the relationship having a positive effect on both residents. The problem of isolation is a serious one among the residents in RACFs who may have infrequent visits from family and friends. By assuming that residents are incapable of forming companionships, they are dehumanised, and opportunities for personal contentment are reduced. This example illustrates how unthoughtful practice can minimise and even devalue the deep need for a sense of companionship through a 'well meaning' rush to control and manage. The more general or transferable concern here is how to be sensitive to the healthy human need for human togetherness and to positively encourage appropriate interactions.

Sense making and loss of meaning

A serious issue faced by residents with cognitive decline is that of sense making. Often, residents are confused and unsure as to where they are and why they are there. In carrying out the activities of daily living, residents often put up resistance, as they do not know why they are being forced to do something they do not understand. In cases such as this, it is often helpful to try to approach the situation in a way that will make sense to the resident. For example, the DEMOS Team observed one resident who was reluctant to take a shower because of, as it turned out, not understanding the purpose of a loofah sponge. When RACF staff handed the resident a cloth and called it a 'flannel', she could comprehend what it signalled and was far more willing to cooperate. This simple strategy that is based on increasing the resident's

understanding of processes rather than simply carrying out tasks without explanation impacted positively on the resident and also made providing care easier for staff. This example illustrates how thoughtful practice within this humanising dimension attends to the more general or transferable concern of how to help people make sense of their situation and surroundings in the face of life circumstances where familiar details and taken-for-granted routines may be lost.

Personal journey and loss of personal journey

Another significant issue for residents which is strongly linked to cognitive decline is the loss of a personal journey that they themselves can experience and also the lack of focus on their history in the provision of their care. In one case, the DEMOS Team observed that one resident liked talking about his life, and they made efforts to learn more about him. One member of the Team gathered information about places the resident had worked and at the next visit took time to discuss these with him. Initially, the resident was hesitant, but then began to speak freely about his experiences. She stated:

I think we both just found it amazing, he was clearly an intelligent man with so much information that he was extremely happy to share

It was clearly very important for this resident to speak about his life history, and the DEMOS Team made efforts to ensure the RACF staff understood the need to ask him about it. To facilitate this, they prepared a one-page laminated sheet of conversation starters which was fixed to the resident's door and could be used on visits by various staff members.

The following comment about this resident by a member of the DEMOS Team highlights how important it is to get to know the person behind the disease. She said:

I look at him and see a man that has led a very colorful life, a man with a lot of knowledge and experiences.... he was reaching out to be heard and seen...

This example illustrates how thoughtful practice within this humanising dimension attends to the more general or transferable concern of personal history and 'story' helping people connect with their sense of self. This is an important living resource in contexts that often emphasise discontinuity with all of its attendant feelings of fragmentation and loss of self.

Sense of place and dislocation

Another issue of critical importance to RACF residents is the need to make sense of their surroundings. Often, dementia

can lead to disorientation and confusion among residents. Unfamiliar surroundings and unfamiliar routines can cause significant stress. The example below of making a resident comfortable in their surroundings exemplifies how simple strategies can lead to significant improvements in a resident's quality of life. In this example, a resident refused to eat her meals in the dining area. The DEMOS team recommended moving the resident to a quiet area on her own and 'setting her up' comfortably to eat. This had a significant impact on the resident's quality of life, as not only did she start to take in food again, but she also began to feed herself. This example illustrates how thoughtful practice within this humanising dimension attends to the more general or transferable concern of how to facilitate a sense of 'home-ness' in the face of more instrumental routines and functional built environments.

Embodiment and reductionist view of the body

Often, residents with dementia who display difficult or unmanageable behaviours are restrained either physically or chemically to manage those behaviours, particularly when there is a lack of understanding about the underlying causes. This type of treatment, which is sometimes necessary as a means of protecting the resident themselves as well as other residents and staff, can reduce the resident to a physical body, without understanding how human embodiment is best understood within a much greater relational context of how that body is meaningfully interacting with the world and situations, even if these meanings cannot be articulated by the person. So, for example, the very physical experience of comfort or lack of comfort needs to be understood within broader relational contexts of meanings and interactions in the world and with others. The body is never in isolation. In this case study, a resident was physically restrained in a high-backed chair in an effort to manage difficult behaviours. The resident was unable to feed himself, because of his position in the chair. The DEMOS Team observed the resident was experiencing some level of discomfort and suggested moving him to a lower, more comfortable chair and providing a table. Almost immediately, the resident's behaviours improved. The Team stated:

... his whole face changed... It went from a pained look when he was on the high-backed chair to just ...relief. He started having eye contact with us and gave us a bit of cheek every now and then... he was so much happier

This impacted positively on the resident's quality of life, in addition to reducing the workload of staff, as the resident was able to now feed himself.

Recognising that a range of issues need to be considered when providing care is important in this context. Simply being task oriented and focused on restraining the resident prevented RACF staff from identifying other issues that were causing his aggression – that is, physical discomfort and frustration about the lack of ability to feed himself. In this context, the DEMOS Team demonstrated that positive outcomes can be achieved by providing more humanised care. This example illustrates how thoughtful practice within this humanising dimension attends to the more general or transferable concern of how to facilitate a sense of embodied comfort as a result of attending to well-being as something beyond the view of the person as a body – object.

Discussion

The examples above illustrate that while there were exemplars of excellent care stemming from some RACFs, there were also occasions when care could only be described as dehumanising. Not through any wilful intent, but through lack of understanding. Feedback from the DEMOS team indicated that when staff were shown a way to understand care through a humanising perspective rather than through a model that limits residents to a medical and psychological diagnosis, staff were surprised and pleased at the success of their efforts and became eager to learn more ways to individualise care.

It is well documented that the biomedical paradigm creates a limited view of a person as an object, a thing to be studied and measured. For people with any form of cognitive decline, this approach can be especially marked. In the DEMOS project, it was shown that residents with dementia can sometimes be treated akin to a sum of tasks needing to be accomplished in as orderly and timely a manner as possible with insufficient regard to the person as an individual embedded in a social, cultural and historical context or indeed as one that has agency. Indeed, among some grass roots staff, any true understanding of the human condition as reflected in approaches to care was limited. Research has shown that the words and actions of people with dementia reveal personhood and meaning (Kimble 2003), and ‘despite the accumulating neuritic plaques and tangle in their brains’, these people have not lost their humanity (Kimble 2003, p. 27). It is important for RACF carers to take the time to get to know patients personally, rather than focusing solely on the disease. From a person-centred perspective, improving life for people with dementia ultimately depends on the human bond that develops between residents and staff (Wylie 2003).

According to Gadamer, within the human condition, there is a fundamental desire to understand and be understood (Landridge 2007) and to make sense of ourselves and others. Kimble states that ‘in Alzheimer’s disease, there is an inner spiritual core that remains intact in spite of the loss of instrumental and expressive faculties. The spiritual core of a person transcends all boundaries of ability and disability. People with Alzheimer’s disease might lose the capacity to talk and to use language, but the spiritual core remains’ (Kimble 2003:32). These traits are basic to personhood, and in any approach to long-term health care delivery, steps need to be taken to ensure such needs are met. For these reasons, it is our contention that in any caring relationship each dimension on the humanisation conceptual map needs to be acknowledged and valued.

Conclusion

This paper has highlighted the potential for the humanising framework to be used successfully in the provision of care to residents with dementia. If carers are taught to look at service delivery to people with dementia using a wider and more inclusive frame of reference, it is hoped their awareness of the person as one who is actively and intentionally seeking meaning in their lived world (Kimble 2003) can be raised. This would encourage carers to focus more on attending to individual human needs rather than the need for carers to get a job done. The humanisation framework described in this paper is founded on an established philosophical discourse about what it means to be human but is presented in an easily understood and applicable format. Carers may be unlikely to read philosophical treatises, but they are capable of learning a frame of reference to help inform their practice; the DEMOS project examples illustrate that in the main, staff are highly receptive to being shown other ways to care. We recommend the use of the humanisation framework in educating carers about how they can improve life for people with dementia.

The increased worldwide prevalence of dementia highlights the importance of thinking through new strategies for providing dementia care. The question remains whether the humanising care agenda is a demand too far beyond the current topical foci in aged care on ‘keeping people safe’ and ‘reducing harm’. We believe that as older people come to understand that more attention to human dimensions of care is not just ‘an added extra’ but an ethical necessity on any aged care agenda, they will be, if they are not already, ‘voting with their feet’.

Relevance to clinical practice

We hope that the humanising framework and its eight dimensions can be viewed as a whole and that the separate dimensions are understood as linking together in a seamless way. The experiencing person does not make these separations, but we hope we have shown that it is useful to emphasise these different emphases for the sake of reflection and as a directional guide for changing practice. We believe the humanising framework is highly accessible and has the potential to improve care provision in a range of healthcare settings. The increasing importance of the humanisation of care is illustrated in the recent international conferences that have taken place which indicate this is an area that is likely to contribute significantly to healthcare provision in the future.

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participants in the research project from which the case studies in this paper are drawn.

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