Older People's Commissioner for Wales
Comisiynydd Pobl Hŷn Cymru

Protection of older people in Wales

Raising concerns in the workplace

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An independent voice and champion for older people across Wales

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Foreword

In Wales, there is much excellent work being done that shows we value our older people. This includes a national Older People's Strategy, a Welsh Senate of Older People, and many public and third sector agencies who provide outstanding support and services for older people. In 2010, the Welsh Government conducted a full review of adult protection policies and processes, including the guidance document 'In Safe Hands'. The Care and Social Services Inspectorate for Wales (CSSIW) and Healthcare Inspectorate Wales (HIW) conducted reviews of the role of social care agencies and the NHS in safeguarding and protecting vulnerable adults and pinpointed areas for improvement.

In 2011, in the paper 'Sustainable Social Services for Wales: a Framework for Action', the Welsh Government made a welcome commitment to enact new legislation to underpin and improve current safeguarding and protection arrangements, and this is being drafted as part of the forthcoming Social Services and Well-being (Wales) Bill.

As Older People's Commissioner, I have a particular role in ensuring that older people are safeguarded and protected, which is why we commissioned the work that underpins this report. We were deeply concerned about the culture of silence that surrounds the matter of raising concerns about poor care and mistreatment; we wanted to break that silence and that is the chief aim of this report. The report gives voice to those who work with older people on a daily basis, many of whom are unrecognised for the valuable work they do. I believe that the report's findings and the recommendations I have made build upon, and will help develop further, the good work that is already being done by organisations such as the Royal College of Nursing and the Care Council for Wales[1] and others to enable workers to raise concerns with confidence.

We must remember that our systems are only as strong as the relationships that bind them, which is why an open, supportive workplace culture that has the well-being and safety of older people at its heart is so important. If we can transform closed and inward-looking workplace cultures into open and learning cultures, we will be taking further steps towards addressing the issues raised not just in this report but also in our previous reports, 'Dignified Care' (hospital care) and 'Voice, Choice and Control' (independent advocacy).[2]

This report explores the dilemmas and barriers people may encounter when faced with poor care or practice in the health or social care sectors. It highlights the need in Wales to change the culture that surrounds the policies designed to assist workers in raising concerns at an early stage. The recommendations in the report set out a practical way forward for achieving change. It is my expectation, as the Older People's Commissioner, that key health and social care agencies will respond to them. I am confident that we can work together in Wales to dispel the culture of silence, build a confident workforce and make Wales a safe place to grow older, not just for some but for everyone.

Sarah Rochira

Older People's Commissioner for Wales

1 Such as the RCN's whistle-blowing hotline and the Care Council's Code of Practice for Social Care Workers.

2 Both reports are available on www.olderpeoplewales.com or by request from 08442 640670.

Background

The Older People's Commissioner has a particular role in relation to the promotion of effective safeguarding of older people and ensuring that policies and procedures for raising concerns in health and social care settings are effective.[3] Most health and social care organisations have such policies, yet there is still much fear and apprehension throughout the U.K. about raising concerns or 'whistle-blowing', and an unacceptable culture of silence around the subject of raising concerns. This report is being published under s.9 of the Commissioner for Older People (Wales) Act 2006 to break the silence and highlights issues that must be addressed by and across health and social care.

Three pieces of evidence underpin the report. The first is an extensive piece of research carried out for the Commissioner by Cardiff University, giving voice to front line staff on the subject of workplace culture in health and social care settings and how it can support or prevent the raising of concerns. The second is a short report by Public Concern at Work[4] which looks at the data it has gathered over the past ten years from health and social care workers in Wales who contacted their helpline. The third is evidence gathered from individuals who contacted the Commission in response to a call for evidence from those who have had experience of raising concerns.[5]

In bidding for the research project, Cardiff University demonstrated an approach to this very sensitive subject which, we believe, allowed front line staff who took part in focus groups or interviews to be open and honest, giving them a voice. This has provided us with a valuable insight into the workplace culture in which policies and procedures operate, and helps us understand some of the barriers that must be overcome to enable workers to confidently raise concerns about standards of care.

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3 Section 5, Commissioner for Older People (Wales) Act 2006
4 http://www.olderpeoplewales.com/en/news/news/12-08-08/Raising_concerns_in_the_workplace.aspx
5 See Appendix for more details

Executive Summary

1

Workplace culture is a primary factor in determining how effectively concerns are raised and responded to. It is more powerful than policies, procedures, codes of conduct or guidance.

Those responsible for health and social care services, particularly those in positions of leadership, must take seriously the findings and recommendations of this report and make an open and evidenced commitment to work to address the concerns raised by it in order to change workplace culture in the care of older people in Wales.

2

The word 'whistle-blowing' has become a 'scary' word that induces feelings and uncertainties that cause worry and may seriously inhibit a person's freedom to raise concerns.

A move to the use of a different term may well give scope for fresh thinking and help lay the spectre of 'whistle-blowing' to rest. The Commissioner recommends that the word 'whistle-blowing' is no longer used in Wales and is replaced with the term 'raising concerns'.

3

Closed, inward-looking cultures can lead to collective blindness to matters of concern and, therefore, it is important to develop a culture of openness and learning in the workplace.

In Wales we need to share examples of successful practice and develop good practice in the care of older people.

4

A supportive workplace culture is vital to raising concerns. Workplace 'norms' emerge, evolve and are accepted over time; where these norms are not supportive of those who raise concerns, they must be changed.

A strategic partnership in Wales needs to be developed for the purpose of identifying and taking forward action that will achieve real change in workplace culture in Wales.

5

The research project found an absence of reference to professional codes of ethics, regulations or best practice guidelines to help guide decisions about raising concerns. Workers were, instead, guided by personal ethics. Student nurses felt that in training not enough attention was given to the ethics of caring for older people.

Work needs to be carried out to ensure that the value of raising concerns and robust professional ethics are embedded in the training of those who will work with older people in any health or social care setting, whether initial training or ongoing staff and professional development.

6

Those who work with older people can find their work to be demanding and undervalued. It can also be lonely, particularly for managers working in isolated settings.

Work must be undertaken to determine how those working in particularly demanding work settings can be supported to deal with their work and maintain resilience. A particular focus should be on the role of managers and the unique challenges they face.

Introduction

Although the raising of concerns is recognised as making an important contribution to patient safety[6] and saving lives[7], doing so has had a somewhat laboured history in the health and social care sector. The vast majority of those who work with older people would say that it is vital to raise concerns at an early stage and would agree that poor practice should be reported.

However, the experience of those who speak out about poor practice can be difficult and raising concerns can sometimes have a devastating effect on their career and even their personal life. The mention of the names Margaret Haywood ('Panorama' documentary on neglect of elderly patients in Brighton), Graham Pink (understaffing on care of the elderly ward in Stockport) and Kim Holt (understaffing and poor record keeping at Great Ormond Street hospital - Baby P case) evokes a rush of feelings and sparks debate not only amongst those in the health and social care professions, but also amongst the wider public.

Those who raise concerns may have to choose between resigning or being dismissed from their employment.[8] There is also the prospect of those who remain in their jobs being blacklisted or ostracised by work colleagues, leading to personal suffering, marital breakdown or long-lasting health, financial or personal problems.[9] Those who choose to remain silent in the face of apparent wrongdoing may also experience great moral distress.[10]

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6 Bolson S, Pal R, Wilmhurst P, Pena M (2011) Whistle-blowing and patient safety: the patient's or the profession's interests at stake? Journal of the Royal Society of Medicine 104: 278-282

7 Public Concern at Work (2008) Public Concern at Work/Nursing Standard Whistleblowing Survey 2008. www.pcaw.org.uk/files/WBsurvey_summary.pdf

8 Gallagher A (2010) Whistle-blowing: what influences nurses' decisions on whether to report poor practice. Nursing Times 2 February 106 (4):22-25

9 Jackson D, Peters K, Andrew S, Edenborough M, Halcomb E, Luck L, Salamonson Y & Wilkes L (2010) Understanding Whistleblowing: qualitative insights from nurse whistleblowers. Journal of Advanced Nursing 66(10): 2194-2201

10 Corley MC, Elswick M, Gorman M & Clor T (2001) Development and evaluation of a moral distress scale. Journal of Advanced Nursing 33: 250-256

Case study

Karen worked as a care assistant in a nursing home in Wales. She was particularly concerned about the behaviour of one particular carer. Karen said this included leaving residents in their wet bed sheets, dragging a resident out of bed when they would not stop crying and taking buzzers away from residents so they would not disturb the carer.

Karen and another colleague reported the behaviour of the carer, who was initially dismissed but later reinstated. The home was then reported to the Care and Social Services Inspectorate for Wales (CSSIW) via an anonymous tip-off. Karen was worried because she thought the home had concluded this was her. Karen was dismissed shortly afterwards. When she came to collect her wages she was told that the home would not provide a good reference because Karen was a gossip. Karen did not wish to continue working there but remained concerned about the reinstated carer and was worried she would not find another job.

Source: 'Whistle-blowing in Wales – a report by Public Concern at Work for the Older People's Commissioner for Wales', February 2012, p.6

This report explores the dilemmas and barriers people may encounter when faced with poor care or practice in the health or social care sectors. It highlights the need in Wales to change the culture that surrounds the policies designed to assist workers in raising concerns at an early stage. It calls for a new culture of openness and learning that supports both those who raise concerns and those who investigate them. It calls for a change in working practices and it proposes a way forward for ensuring that Wales is a safe place to grow older, not just for some but for everyone.

'Raising concerns'

The term commonly used to describe the raising of concerns is 'whistle-blowing'. Some participants in the Cardiff University research project described whistle-blowing as a positive or neutral term:

> **"…it's like whistling for help, for someone from the outside to come in and help you…"**
>
> **"To me it really doesn't matter, the important thing, whatever you call it, is if people have concerns, to say – which I hope that we do here."**

However the majority saw the word as something 'negative', 'major' or 'serious':

> **"It's a bit like being in the playground, isn't it? If you are going to whistle-blow then you're going to tell on your friends and everyone wants to be popular at the end of the day, they don't want to be seen as the one that's…you know."**
>
> **"Telling tales."**
>
> **"I see it as meaning something very severe…you know, to go to the media or the police."**
>
> **"I mean, it sounds a bit scary…"**

Several of the participants felt that a better term was needed:

> **"I think perhaps raising concerns for individuals or something along those lines would be better…"**
>
> **"(Whistle-blowing is) like you are grassing on people, whereas you're not really, you're raising a concern aren't you?"**

Terms such as 'raising concerns', 'raising professional concerns' or 'talking about worries' were considered preferable to whistle-blowing and were described as being more supportive and less accusatory terms to use.

Participants in the research project also spoke about the way in which the media portrays whistle-blowing:

> **"I think you hear the stories on the news, you know somebody has been whistle-blowing and then they've been hounded out of their job and I think that then gives everybody the sort of worries about it."**
>
> **"The thing is, there's a lot of negativity on television and**

things at the moment, in the last couple of months or so all you've got is bad publicity about carers in the homes, in the communities, everywhere really isn't it…so that has an effect on the carers as well because they're wondering if they're all getting tarred with the same brush…"

"The sad reality that I find is that all the negative cases are out in the media, and not the positive, so it gives nursing as a profession a bad name sometimes."

When asked about emotions associated with the word 'whistle-blowing', participants used phrases such as 'quite scary' and 'quite frightened'. Some spoke about feeling 'as if you're being blamed' and others referred to 'the aftermath that happens' or 'being labelled'.

The general feeling was that the word 'whistle-blowing' has become seriously tainted and induces feelings and uncertainties that cause worry and may seriously inhibit a person's freedom to raise concerns. It would be naïve to think that the elimination of the word from the vocabulary of health and social care would lead to immediate change; however, a move to the use of a different term may well give scope for fresh thinking around the subject and help lay the spectre of 'whistle-blowing' to rest.

Workplace culture

The impact of workplace culture on the operation of policies was central to the research project. Workplace culture is the atmosphere or environment within which workers fulfil their roles. It determines the way they interact with each other and is a result of the beliefs, morals and ethics upon which an organisation is built. The culture of the workplace will have a bearing upon the worker's sense of value and confidence, their sense of achievement and ability to influence change, and even their personal happiness. It will determine what they value most and where their loyalties lie.

Participants in the research project, particularly managers, felt that a supportive workplace culture was vital to raising concerns.

"(staff) need to have confidence in the manager…because if they feel if, as in the past, there's been a culture of … you know, 'Why are you coming whingeing at me?', 'Why are you telling me this?', you know, 'Get on with your job', you know, then they're not going to go to the manager."

Culture, behaviour and workplace 'norms' develop over time. 'Norms' are institutionalised systems that regulate the relationships of individuals with each other and are particularly powerful because they influence behaviour without necessarily being articulated.[11] They are 'picked up' along the way.

Participants in the research project spoke about how norms emerge, evolve and are accepted over time:

"It's crept in and it's amazing what I hear from my office and I said I don't like it because if the inspector walks in or a visitor and they just hear the staff shouting it, you know, I said yes they would think it's abuse."

"When you think there's quite a high turnover of staff in quite a lot of social care organisations, and staff who've been there the longest develop ways of doing things like cutting corners and so when somebody new comes, say if they're shadowing that person that's the way they learn how to do it."

"It's that sort of habituation of abnormal behaviours which then leads you to actually believe that, oh, it's okay when in fact it's not. So there are some things which I believe people just accept which they shouldn't be doing, then it's up to us to police it as much as we can…it even happens with the senses because if you go to the floors, if people are working on those floors day in, day out they don't smell if there's a scent of urine. Yet I'll go there and I'll say 'I can smell urine can you please come and do something about this, it's obvious there's something in the carpet here or whatever' and I mean that's a sensory thing, a sensory habituation, but there is a psychological habituation to it…"

Previous research has looked at workplace culture[12] and found that a 'closed, inward looking and insular' culture can lead to 'unprofessional, counter-therapeutic and degrading - even cruel - practices to taking place'.

Of course, the converse is also true and an open and learning culture can lead to positive change in an organisation. This is discussed further below in the section on 'Openness and Learning'.

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11 Vaughan D(1996) The Challenger Launch Decision: Risky Technology, Cultureand Deviance at NASA. Chicago: University of Chicago Press

12 The Commission for Health Improvement Inquiry Report into the North Lakeland Trust (2000), Report to the Secretary of State for Health, London

The wider culture

Some of the participants felt that workplace culture, and relationships within the workplace, could also be influenced by culture and connections *outside* the workplace. This was particularly true in smaller or rural communities and was described as both a strength and a weakness.

> **"We're not a large (care) home, nearly all our staff are local people so basically we all know each other outside of work, not just inside of work, and it does help that I know a lot of them. Really if anybody does have a problem they usually just come out and say it and clear the air and then it's sorted, you know. So I mean if there is really anything serious then it is serious."**
>
> **"…they could have reported something and whether or not it has happened, but you have people that are obviously friends or support the other colleague that has been blamed or whatever for it, and they would obviously stick up for that person and it is a whole big social conflict… even probably friends and relatives outside of the workplace to that individual as well, so, yes, it makes it difficult if they are popular."**

Workers may experience divided loyalties when confronted with the unethical behaviour of a colleague, especially if they are a friend or a relative. Moral conflict can occur when care workers feel forced to choose between relationships, professional standards of practice, responsibilities to clients and their contractual obligations to their employers.[13] It is because of these divided loyalties that the raising of concerns is so often described as 'difficult'.

Previous studies[14] have found that professionals, faced with the unethical behaviour of a colleague, may collude not to see what is going on, may ignore their intuitive feelings, dismiss rumours as gossip, minimise or trivialise the behaviour of the colleague, or adopt a method of rationalisation in an attempt to avoid having to speak out.

This report shows that the culture within which policies operate strongly influences decisions about raising concerns. It will either support or undermine written policies; it will help determine what workers will do when faced with concerns about standards of care and it will influence what managers will do with concerns that are brought to them.

13 Peternelj-Taylor C (2003) Whistle-blowing and boundary violations. Nursing Ethics 10: 526-38

14 ibid.

Raising concerns

'What would you do if…?'

Participants in the focus groups and interviews were asked what they would do if they observed mistreatment of an older person. The overwhelming response was that it depended on the severity of the wrongdoing. If an older person was subjected to severe physical harm the response from participants was that they would, without hesitation, contact senior members of staff internally within the organisation and external agencies such as the police and health and social care regulators.[15]

> **"It depends on how bad or severe the treatment is. When I saw that programme where residents were being pinned to the ground by carers or hit then it just makes me sick, I would just go to everyone, the manager, police, MP and make sure they did something."**

When discussing responses to seemingly less severe incidents of mistreatment, participants mentioned intervening directly with colleagues. In particular phrases such as 'having a word' or 'taking them to one side' were used:

> **"I would take them to one side and say I'm really unhappy about the way you spoke to Mr so and so…"**
>
> **"…initially I would get the person, take them into a room and I'll talk to them and I'd say what I'd heard or seen or whatever, I would make it quite clear and then I'd say if it happens again, or if someone comes to me again, if someone was to come to me and said I saw someone doing, then yes I would, I would go to the matron…"**

Participants did not always confront colleagues verbally about their

15 The report prepared for the Commissioner by Public Concern at Work found that most workers they had had contact with from Wales raised concerns internally at first, but the data gathered also seemed to indicate that people in Wales might raise concerns outside of the organisation, for example with a regulator or a local authority, more frequently than across the UK as a whole. Public Concern at Work (2012) Whistleblowing in Wales – a report by Public Concern at Work for the Older People's Commissioner for Wales

concerns. Two of the focus groups were held with student nurses, some of whom used less direct strategies and their status as 'learners' to question staff about incorrect practices as opposed to 'pointing the finger' or 'being aggressive':

> **"You don't have to go around pointing the finger at people but you can say, oh, is that all right to do that, or … you can kind of question things, I think, without being, you know, too … aggressive and that, or not aggressive, what's the word? Too direct or too challenging, I guess, you can kind of like, is that okay? Because sometimes people will go, oh well, yes, no, you probably shouldn't do quite that, you know."**

Others described how humour would be used as a 'tongue in cheek' way of raising concerns:

> **"Sometimes I need to say something but, instead of going for it, I'd try and draw attention by laughing and saying something like 'Oh, she's in a rush cos she's going out tonight' or something, you know, if they were feeding a patient too quickly or taking a plate away without giving them a proper chance to finish. Sometimes you get a look and you know it has hit home."**

It is also clear that those who took part in the research project were setting their own 'thresholds' for determining how they should deal with concerns – the matter of thresholds is discussed further below in the section on 'Barriers to dealing effectively with concerns raised'.

Reporting upwards

Without exception, participants who were unregistered care workers (healthcare support workers or care assistants) said that when they observed what they considered to be a poor standard of care they would report their concerns to the registered nurse (if one was present in the care home) or 'nurse in charge' of the shift. In so doing, carers believed this would result in further action being taken about their concerns. Such reporting would occur regardless of whether the registered nurse may have worked with the carer for many years or may be a temporary member of staff working for the first time in that area. The rationale for this was that registered nurses have a Code of Conduct and are therefore bound by their Code to act on concerns. The research project revealed that care workers themselves believed they had little or nothing by way of a formal Code of Conduct to guide them when confronted with poor care standards. This is discussed further in the section on 'Codes of Conduct' below. Once the incident had been reported, carers said they would not pursue their concerns further and seldom asked for feedback.

This tendency to 'report upwards' and then not pursue the matter further is an important finding. First, it places the burden of responsibility onto the registered nurse to act on concerns. Secondly, it demonstrates an assumption on the part of carers that action will always be taken. Carers seemed satisfied with reporting concerns upward and leaving their concerns at that, perhaps feeling absolved of further involvement once they had made the report.

Barriers to dealing effectively with concerns raised

Participants identified what they saw as barriers to raising concerns. Very little was said about administrative barriers, although some comment was made on the Protection of Vulnerable Adults (POVA) process – see p. 21. The barriers identified tended to focus on the personal impact of raising concerns: not wanting to 'swim against the tide', not wanting to suffer as someone else had suffered, worries about confidentiality and feelings of isolation. A barrier for some was a belief that it would not change anything or 'get rid' of the wrongdoer.

Defying norms

One significant barrier to raising concerns identified by participants was that of defying the norms of the workplace.

> **"…you tend to find that there's a lot of older staff in these residential homes that have worked there for years; they will have a set of rules about how to do things which no-one challenges or criticises…"**
>
> **"They just said to me you're the new one, this is what we do you know, like it or lump it sort of thing."**

When participants were asked how they thought poor standards become established, their answers referred to 'lack of supervision' and not picking up on poor practice at an early stage, as well as ways of working becoming 'ritualised' and unquestioned.

Focus groups with student nurses revealed that even they, as those who may be relatively new to older people's care, picked up the unwritten rules and practices very quickly whilst on placement and assessed the impact they might have on them.

> **"We're quite low down the pecking order, really. We're relying on them, not just to sign our competencies, but to teach us. It's hard, I think."**
>
> **"I think some people would wait maybe until after the placement had finished (to raise concerns), because sometimes you need, it sounds terrible, but you need things signed off and if people are going to be malicious about complaints you make against them …"**
>
> **"And even though you're only there for six weeks, if you see something on like your first day or your first week, five weeks is a long time to be working with someone when you've just put a complaint in and they're not that happy with it…it's a long time to be ignored…"**

The observed negative effect on others

For others, observing the suffering of others who had raised concerns was sufficient to make them think twice about doing so themselves.

> **"It's an unsettling experience…I've worked with people who have been very much intimidated and harassed…she (a colleague) came to me and she said, "They're saying to me 'she's got two children, she's on a single income, she's going to lose her job and it's your fault, how can you do that, she's been here ten years', and she kept saying to me, 'I did do right'. Absolutely she did the right thing."**
>
> **"I know the carer involved at the time, the one who blew the whistle, and, I mean, she went home crying you know and then talking it over with her mother and her sister."**

Case study

"I raised concerns and the POVA process was initiated. The care home was closed and the residents moved to other care homes; the previous manager was found guilty of neglect and abuse. Although it was a positive result in that the older people were then safe, during the closure process I was faced with a lot of negativity and verbal abuse from the staff of the home and from the relatives of service users...Following the closure of the service, I was made redundant. The support I received was minimal to say the least, I was even made to feel, by my then employers, that it was partly my fault...Since the incident, I have been in a constant state of anxiety (despite reassurance from colleagues) and have been on medication to manage my blood pressure, believed by my GP to be brought on by stress."

In response to the Older People's Commissioner's call for evidence on raising concerns (anonymised)

The effect of raising concerns was also described as reaching beyond individuals and impacting on personal relationships within teams. In particular, the nature of intimidation between employees was discussed:

> **"I remember one time somebody was suspended and it was like right then, who's done it, who's done it (reported it), and that was like the hot topic…I don't think anyone actually knew at the time…but it's all pretty awful because it was a popular person and nobody knew anything else, quite awful. And then everybody was like, oh, I bet it's so and so and everybody was up for suspicion in a way that was really negative."**
>
> **"…they kind of put the frighteners on people and then people are frightened to whistle blow and to, you know, report any problems. Yeah, dominant personality, been there a while, usually older people, you know, and when you have to work with them on a 12 hour shift then it's quite difficult because usually, even though they're not meant to know that you've blown the whistle about them, they usually do have some sort of idea what's gone on."**

Confidentiality

It was clear from the research that confidentiality was an issue of importance, particularly the 'catch 22' situation where keeping information confidential in order to protect people can also result in the flourishing of rumours, hearsay and misinformation.

Several participants spoke about the importance of confidentiality in enabling staff to raise concerns.

> **"Everything's kept confidential here…we are told during induction that everything is private and confidential and it won't go any further…the matron's brilliant."**
>
> **"It has to be (confidential), especially, if you feel that there are going to be repercussions, if you say 'I saw this person doing whatever' and you're afraid that that person is then going to come and knock on your door, how are you going to feel?"**

Managers described the difficulty of maintaining confidentiality, especially in a small setting, such as a care home or a domiciliary care agency.

> **"The thing is, they all know who is in and out of my office. They will tell me not to say anything and I can't really go straight out and pull someone in as they will then know who did the reporting…I'll sit on it for a couple of days but keep a closer eye on someone or a situation. When I think the coast is clear I'll bring that person in and have a chat."**

> **"…they know who's been in with me for supervision, they just all know. That ties my hands, so I have to leave things and observe for a little while. Obviously it depends how severe the thing is, but I'll bring it up when there's less chance of things flaring up."**

Managers also described how they often felt unable or unwilling to provide feedback to staff who had raised concerns. For example, managers described being caught between competing demands such as the need to maintain confidentiality on behalf of the person raising concerns, the alleged wrongdoer and the service user, whilst also aware that staff members and possibly older people themselves were looking for reassurance that steps were being taken to resolve the concern. Managers also have a duty to maintain confidentiality about disciplinary action taken.

> **"I've learnt from my experience that staff who we are having issues with won't go out and discuss it with anybody else, so I suppose then people think that nothing has actually been done…Confidentiality makes it very difficult because you don't, you don't want to be pinning anything up on the board saying this person has been reprimanded...then I wouldn't perhaps divulge anything else because you know really we are governed by the employment laws as well."**

However, this lack of feedback was sometimes construed by staff as evidence of a lack of progress with investigating or dealing with the concerns they raised, or staff thought managers had chosen to ignore their concerns. This is an important issue as many participants stated that believing their concerns would be acted upon was a key factor in deciding whether to report their concerns, sentiments best captured in the following extracts:

> **"(I want a guarantee) that they will look into it and make sure something is done and that it gets sorted really. I wouldn't want them to brush it under the carpet, no. You'd want to know something's being done and I'm not sure if that is always the case…I know of someone, one of the girls, who mentioned something to the manager and that's been it, silence, not heard a thing. Just wondering then we are, why bother?"**
>
> **"I know it's difficult, but the managers here don't seem to take these things seriously sometimes. Some of the people that work here, they get away with things even though we know it's been mentioned during supervision by some of us…you know the way they talk to patients sometimes and don't take time feeding them just like they can't be bothered, basically, being decent to them."**

'Difficult to get rid of them'

Along with expectations about confidentiality and managers dealing with concerns, participants also mentioned other expectations or conditions which they expected to be met when disclosing information about the mistreatment of older people. One expectation that was discussed as being repeatedly unmet was that perpetrators of mistreatment should no longer work in health or social care. For example, participants discussed a combination of exasperation and annoyance that former colleagues who had concerns raised about their practice were 'allowed' to either return to work in the same establishment, or were known to be working at a nursing or residential home nearby. During the course of these discussions it became evident that participants (both managers and non-managers) blamed defensive practice on the part of insurers, solicitors and 'employment law' for making it "difficult to get rid of them".

> **"… thankfully one of the really bad lot that was here, they're no longer here but one of them is still working in another nursing home and I find that terrifying…absolutely terrifying because she was wicked, absolutely wicked and despite all the statements, the evidence, everything, she's still working with vulnerable people. Just wondering, there we are, why bother?"**
>
> **"I know employees need rights and they need protection but I think it's gone too far, especially if you know someone is being abusive towards someone who's fully compos mentis, what the hell are they doing to those that can't speak up? I think you can't afford to take the chance."**

A further variation on this theme emerged during interviews with managers who discussed dilemmas such as the expense of suspending staff on full pay and of placing returning staff on a re-training programme.

> **"There'd been an issue with a member of staff actually slapping one of the residents…I had to deal with it then**

> **straightway because of course it became a POVA issue anyway…the carer who had reported it was concerned that if this person came back to her, because of course employment law is so, you know, you don't sack anybody, you bring them back in you give them this re-training…but sometimes, I mean, to me the fact that somebody had hit somebody that's the end of it as far as I'm concerned…I don't think any amount of re-training or even putting in supervision will help, I mean for a small organisation that's also very difficult and costly as well."**

Feeling isolated

A factor common to all the managers interviewed (in the NHS and the independent and local authority care sectors) was the extent to which they felt lonely in their work. Even within large, multi-layered organisations such as the NHS or a local authority, care managers communicated a very strong sense of isolation, especially when talking about maintaining standards of care and staff discipline. Participants who were managers would clearly demonstrate signs of emotion or would simply laugh when discussing what they saw as their perceived isolation.

> **"I believe mine is a very, very lonely job and it's a very lonely job in most companies, a very lonely job…(support) is missing, something missing there."**
>
> **"As a registered home manager it's a very lonely place to be, terribly lonely, terrible. My line manager, CCW[16] and others will give me plenty of information about what to do but no support. If anything goes wrong they are very happy for me to take the blame. I know I signed up to this as a registered manager, but my hands are tied with resources and hiring and firing, and at the same time they want me to take total responsibility for everything (laughs)."**

Formal reporting and bureaucracy

Many participants felt that formal reporting and bureaucracy were potential barriers to raising concerns.

> **"We were told initially that we could have that discussion so I could go and speak to that member of staff and that would be it. Then it moved, and my senior manager said you have to make a file note of it which, to me, makes it formal… But reporting everything in staff files or patients' notes is a sledgehammer that stops people from discussing things."**

16 CCW – Care Council for Wales

> **"I think there's been experiences in the past where we had inspectors coming in and they'd come in and they'd really sat down with the staff and then the staff have opened up but then we've had a negative report and then it puts, yeah, and that certainly puts people off from talking."**

Protection of Vulnerable Adults (POVA) policies and procedures were specifically singled out for criticism by participants. There was consensus that POVA had become a byword for 'over-reaction'. Participants stated 'we almost can't do anything' without fear of being reported, saying it leads to a situation where hundreds of referrals are being made to POVA, with only a tiny fraction of the total referrals resulting in any further action.

> **"…we have training here with POVA, it's done yearly with our staff and you know they come out of there and it's, oh if I shout at somebody it's a POVA issue, I'm reported and I mean it's too much really and it frightens staff…when you sit there with some of these POVA things and you think, oh this is nuts."**

Although POVA policies and procedures were not the focus of the research it did indicate that care staff in particular have lost faith, to some degree, in the POVA system, with some of the strongest opinions being expressed during interviews for this part of the research process. Responses included views that the practical working of POVA results in staff being overly fearful of being reported, that the process results in a lot of time being wasted "farting about doing nothing" (quoted from an interviewee) and, most notably, a belief that the POVA system demeans safeguarding and the issue of when to raise concerns about mistreatment. This last point appears to be linked to a lack of adequate 'thresholds' to determine what constitutes abuse.

> **"What I feel is lacking in POVA is that there's no clear thresholds really, you get everything from somebody being refused to have their slippers put on, and somebody who may have a small pressure sore or they were washed and the heat, the emersion heater had broken, to a full blown physical abuse, they're all going in the same pot and I think they should do like they've done in safeguarding children, they should start to identify thresholds…because I found that the referrals that get into POVA sometimes are ludicrous."**

It is of concern that the very system set up to protect older people at risk of harm does not seem to command the respect of those who must interact with it.

Codes of Conduct

All participants in the research project were from organisations that provide them with a whistle-blowing policy and process to follow should they wish to report concerns. It was notable, however, that there was an absence of reference to professional codes of ethics, regulations or best practice guidelines to help guide decisions about raising concerns.

Nurses did not refer to the Nursing and Midwifery Council's Code of Conduct[17] and care home managers or those with a social work qualification did not refer to the Care Council for Wales' Codes of Practice for social care workers or for employers.[18] Neither did anyone refer to the NHS Code of Conduct for Healthcare Support Workers in Wales.[19] As mentioned earlier, care workers did refer to nurses' Code of Conduct as a reason for 'reporting upwards'. Indeed, participants confirmed several previous studies that suggest that nurses fail to use Codes of Practice to consider the moral dimensions of their practice, and tend to rely instead on personal values and experiences.[20]

Participants appeared to base their practice on personal ethics, particularly the idea of treating older people as one would one's self or one's own parents or grandparents:

> **"…you are looking after those people and I think that is so important to remember; it could happen to you. Because if it was my mum or dad here, well, in any care home, hospital or whatever, I would trust those people - so I'm in the same situation here with other people's parents."**
>
> **"I treat people the way I'd want to be treated or if, you know, my grandparents needed care then I'd treat them as I'd treat my grandparents then, and as long as you're treating them with respect, giving them their dignity and you know just the basic things like that, chatting to them."**

17 Nursing & Midwifery Council (2008) The Code: Standards of conduct, performance and ethics for nurses and midwives. http://www.nmc-uk.org/Publications/Standards/The-code/Introduction/

18 Care Council for Wales (undated) Code of Practice for Social Care Workers and Code of Practice for Employers. http://www.ccwales.org.uk/code-of-practice-for-workers/

19 NHS Wales (undated) Code of Conduct for Healthcare Support Workers in Wales http://www.wales.nhs.uk/sitesplus/documents/829/Final%20-%20NHS%20HSW%20Booklet%20ENG.pdf

20 For example, Tadd W, Clarke A & Lloyd L (2006) The Value of Nurses' codes: European nurses' views *Nursing Ethics* 13 (4) 376-393

For all practical purposes, it appears that codes of ethics or other regulatory guidelines were forgotten about when participants discussed their responses to mistreatment or poor standards of care. Although adopting codes of ethics and 'best practice' guidelines are undoubtedly a positive development, they alone seem to offer an insufficient frame of reference to guide ethical or moral behaviour and shape the culture of the workplace. The aspiration of 'do unto others as you would have them do unto you' is a worthy one, but a further finding of the research presents that aspiration with a challenge: the belief that caring for older people puts particular and difficult demands on workers.

Working with older adults

Several participants referred to the difficulties inherent to working with older people and contrasted it to working with children.

> **"I think people think how difficult it is to look after older people and they may make allowances for that, but at the end of the day it should be like children, it should be zero tolerance as far as I am concerned, because abuse is abuse whatever shape or form… I think because they're adults they can be more challenging because of confusion, dementia, incontinence issues, you know some want to go to the toilet 20 times in an hour, how frustrating is that, you know, so I can understand why some places find it could be more difficult with elderly."**
>
> **"I think staff get complacent, a lot if they have been working with these sorts of patients for a long time and they think they've seen it all. They then don't see things when they happen so don't raise concerns or maybe they choose not to see things, I don't know."**

Some participants felt that with dementia patients it can be difficult to separate fact from fiction, so it was not clear whether statements made by dementia sufferers would be taken at face value or believed. Others felt that societal attitudes towards older people are reflected in the value attached to work with older people.

> **"Older people are less attractive, you've only got to walk into any care of the elderly ward in the hospital to see what sort of activities and equipment they've got. Then you walk into a paediatric ward and you see the amount of equipment and resources and everything that's fed in that direction. But it's actually shameful that we don't actually enable people to pass on from this world with dignity and appropriate care and part of that…is lack of funding and lack of energy."**

> **"I came here when I was sixteen, basically, and, if you know what I mean, all my friends they couldn't believe I was coming here and doing this work…most of my friends have gone to work with kids…"**

Student nurses also picked up on the fact that they had to complete an ethics workbook on paediatric placements, but not on placements involving older people. They felt this was a significant omission that needs to be addressed.

Openness and learning

The 'All Wales Interim Policies and Procedures for the Protection of Vulnerable Adults from Abuse', the current authoritative guidance on procedure in safeguarding and protecting adults in Wales, are clear that strategic managers of health and social care, and their human resources departments, should, amongst other things:

- create workplace cultures that are open and fair, and which encourage self-questioning and reflection, openness, learning, and feedback from service users, carers, the public and staff;
- promote whistle-blowing/reporting of concerns;
- learn from, share and publicise safety lessons from incidents, 'near misses' and practice.[21]

There are factors that can inhibit such learning, including the projection of blame onto others, lack of corporate responsibility and a mistrust of constructive criticism. Ineffective communication has also been identified as a 'barrier to learning'.[22]

Setting an example

Several participants in the research project shared how they thought an open culture could be developed. One domiciliary care manager interviewed spoke about how she was starting to change the culture on raising concerns in her organisation:

> **"I was in a training session the other week and I had nine of the girls in here and I said, 'Look, you are my eyes and ears at the end of the day; if you don't tell me about it how will I get to know? How will I be able to support the service users?'...it's got to be open, you've got to be honest…they've got to be able to trust you as well."**

Another domiciliary care manager spoke about openly admitting her own mistakes to demonstrate that openness and honesty are also required of her. Others said that their approach was based on their own personality or experience.

> **"Quite frankly, I'm one of these people better out than in, you know, and I'd rather that we opened things up and looked and healed and dealt with things."**
>
> **"I'm trying to be a positive role model in this, you know, I say the door's open, come and see me but when I was a junior staff nurse I was never encouraged to do that..."**

Participants felt that an effective management style that comes 'from the top down' needs to be in place to encourage staff to share and learn through their experiences, but that it needs to come from the 'very top', not just middle management, and middle managers need as much support as anyone.

The literature reviewed as part of the research project overwhelmingly portrays reports from staff to superiors about the mistreatment of older people as representing 'bad news' for organisational senior management. Reputational risk in admitting to failure appears to be a highly significant barrier to open workplace and organisational culture.[23]

Induction and team meetings

The managers interviewed also used induction processes as a way of introducing new staff to an open way of working.

> **"...on the first day... I make it quite clear even if it's me they see or hear doing anything they don't hesitate... if they're being asked to do something they know is wrong then they don't have to do it..."**
>
> **"...the induction is quite powerful in the culture then, isn't it?"**
>
> **"When they are doing their induction all the supervisors try to go...so it's a face behind the name as well... they have our phone numbers from the start and it's just an open**

21 All Wales Interim Policies and Procedures for the Protection of Vulnerable Adults from Abuse. http://www.ssiacymru.org.uk/media/pdf/m/o/cont305092.pdf

22 Smith D & Toft B (2005) Towards an organisation with a memory – exploring the organisational generation of adverse events in health care. Health Services Management Research 18:124-140

23 Jones A, Brown P & Kelly D (2012) Whistle-blowing in health and social care: a narrative review of the literature

> **communication thing which I think if you instil that at the beginning then you should hopefully have open communication. We instil that we are a team but we have different responsibilities - but we are a team, we are not the gods up there."**

Team meetings were described by participants as an opportunity for staff to 'open up' and concerns to be raised, as well as a forum for educating staff about the importance of raising concerns.

> **"Everybody, managers and all, need to be re-educated about having open communication and not going all defensive when someone complains. Complaints are there for learning, for opening people's eyes and for highlighting risks. I really, really think this should be from the top to the bottom with no hierarchy thing. So we use this in our team meetings, we involve everyone and anyone can bring up an issue and we all look at complaints we've had and how we can make things better and improve our service."**
>
> **"On Ward X we have monthly staff meetings which are really good where the sister will discuss something that has been going on like an IR[24] being filled in and we get a chance to talk things through as a group. Often there are similar things that come out, occasionally we go off on a tangent but it's good to hear what others are thinking and that they think like me sometimes (laughs)."**

Participants said that team meetings allowed various viewpoints to be voiced about emerging situations which staff had concerns about. They were also described as a means of mediating or making sense of 'black and white' policies and codes and the inherent messiness of practice.

No participants referred explicitly to learning from other organisations – all learning or sharing was described as an internal activity. Little was said about training from an external source, other than POVA training. One significant danger of a culture that has little input from sources external to itself is that collective blindness to important issues can develop.

24 IR – Incident Report form

Reading the signs

Experience and research studies strongly suggest that organisations can become adept at ignoring explicit or implicit warnings that a situation exists which may result in harm, or even death. For example, the events occurring at Bristol Royal Infirmary between 1984 and 1995[25] have been described as a disaster based on an organisational lack of foresight.[26] The Bristol Inquiry Report documents the persistent disregard of warnings and adverse information and the marginalisation of the one doctor primarily responsible for raising concerns.[27]

Similarly, the first public inquiry into the Mid Staffordshire NHS Foundation Trust[28] found that the culture of the organisation showed "acceptance of poor standards of conduct", "denial" and "isolation".[29] The evidence gathered for that Inquiry pointed towards a culture that seemingly allowed poor practice to be condoned[30], did not reflect on patient feedback to any great extent[31] and "appeared not to have been as open to outside influences and changes in practice adopted elsewhere as would be expected".[32]

One of the common themes arising from such inquiries and 'serious case reviews' is that organisations and individuals fail to learn lessons from either their own or others' mistakes and misdemeanours, and do not read the signs of looming disaster. Participants in the Cardiff University research project said very little that would indicate they recognise the possible dangers of a closed workplace culture or the benefits of learning from those outside the organisation.

25 At least 29 babies died undergoing heart surgery even though concerns were raised internally by staff about death rates in 1991
26 Alaszweski A (2002) The impact of the Bristol Royal Infirmary disaster and inquiry on public services in the UK. Journal of Interprofessional Care 16 (4): 371-378
27 See http://news.bbc.co.uk/1/hi/health/532006.stm
28 http://www.midstaffsinquiry.com/
29 Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009, Volume I, p.152
30 ibid. p.175
31 ibid. p. 180
32 ibid. p. 170

Conclusion and recommendations for a way forward in Wales

The research findings outlined in this report suggest that in Wales we do not yet have a workforce that is confident in making judgements about when to raise concerns. The decision as to whether or not to raise concerns is strongly influenced by the workplace culture, by an individual's own judgement about 'thresholds' and by the individual's personal morals and ethics.

Workplace culture must change in order to support workers and also to ensure that the 'norms' of the culture correspond with expectations and standards set out in policies and codes of practice. If this does not happen, some of the most vulnerable older people in our society, who rely on others for their care and health needs, will remain at risk of harm.

The Welsh Government is in the process of drafting a new Social Services and Well-being Bill which is designed, amongst other things, to 'build a stronger workforce, more confident in its own professional judgement'.[33] Running through our health and social care services we need a culture of openness and learning that strengthens the resilience of the workforce, particularly as it develops to serve a growing population of older people, and that strives for excellence.

We do not have easy solutions to the problems highlighted by participants in the research project, but the Older People's Commissioner makes the following recommendations so that a plan for change can be put in place and implemented over the next three years. This plan will require strong commitment and partnership working from key health and social care agencies in Wales, with involvement from those at the 'very top' as well as those who work with older people on a daily basis.

33 Welsh Government (2011) Sustainable Social Services: A Framework for Action

Recommendations

1. **Those responsible for health and social care services, particularly those in positions of leadership, must take seriously the findings of this report and make an open and evidenced commitment to work to address the concerns raised by the report and to change workplace culture in the care of older people in Wales.**

2. **A strategic partnership should be developed for the purpose of identifying and taking forward action that will achieve change in workplace culture in Wales.**

3. **The word 'whistle-blowing' should no longer used in Wales and should be replaced with the term 'raising concerns'.**

4. **Work must be undertaken to determine how those working in particularly demanding settings can be supported to deal with their work and maintain resilience. A particular focus should be on the role of managers and the unique challenges they face.**

5. **Work should be carried out to ensure that the value of raising concerns and robust professional ethics are embedded in the training of those who will work with older people in any health or social care setting, whether initial training or ongoing professional development.**

6. **A means of sharing examples of successful practice and developing good practice in the care of older people should be established jointly between health and social care.**

7. **A 'speak up' campaign should be run throughout Wales in 2014.**

Acknowledgements and thanks

First, we would like to thank participants in the research project for being willing to speak with the researchers from Cardiff University. Their honesty and openness has brought a sense of reality to this report, whilst demonstrating their commitment to learning and openness. It is our hope that we will find a way forward to support them in the important work they do with older people in Wales.

Secondly, we are grateful to the brave few who have had experience of raising concerns and responded to our call for evidence in February 2012.

We pay credit to Professor Daniel Kelly, Dr Aled Jones and Patricia Brown of the School of Nursing and Midwifery Studies, Cardiff University, for carrying out work for us around a highly sensitive topic. Without their awareness of the feelings that this subject can evoke, it is doubtful that we would have secured such candid evidence. We are also grateful to Dr Ann Gallagher from the University of Surrey for her input on ethics, and the members of the project's steering group: Martin Semple (RCN), Hilary Kinchen (Care Council for Wales) and Dr Christine Smith (Cardiff University).

Appendix - Methodology

Research by Cardiff University

- The research carried out by the School of Nursing and Midwifery Studies, Cardiff University, involved interviews and focus groups with fifty front line care staff including registered nurses, student nurses, care assistants, senior care assistants, ancillary workers, managers and other professionals in health and social care settings (nursing and residential homes, Health Boards in North and South Wales, domiciliary care agencies), the Nursing and Midwifery Council and the police about their experience of, and attitudes to, raising concerns in the workplace.

  In line with recent changes to NHS research ethics regulations regarding data collected from NHS or social care staff, internal ethical permission was sought from Cardiff University School of Nursing and Midwifery Studies Research Ethics Committee. Approval was also required from NHS and social care governance bodies related to each setting.

  Approval was also required from NHS and social care governance bodies related to each setting.

- The research also included a literature review, which covered literature from the UK and across the world. Health and social care databases were searched but the review also covered databases in the humanities, law and business because activity around raising concerns also takes place in these spheres. Public inquiry documents were accessed, relating to health and social care and also to events in the private sector.

A copy of the full research report and literature review undertaken by Cardiff University can be obtained by contacting ask@olderpeoplewales.com or by telephoning 08442 640670.

Public Concern at Work report

- The Public Concern at Work report was a straightforward data mining project on a thematic basis using historic evidence (over a period of 10 years). Consent for using case studies was sought and secured. The full report can be found at www.olderpeoplewales.com.

Call for evidence

- In February 2012, the Commissioner put out a call for evidence via her website, newsletter and the networks of other organisations, such as the RCN and Care Council for Wales, seeking to hear from those who have raised concerns in the past. Those who responded were given the option to do so anonymously, but no-one chose this option. Consent for using the case studies was sought and secured.

Older People's Commissioner for Wales
Comisiynydd Pobl Hŷn Cymru

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