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## Whistle-blowing and workplace culture in older peoples' care: qualitative insights from the healthcare and social care workforce

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**Abstract** Inquiries in the UK into mistreatment of older people by healthcare employees over the last 30 years have focused on introducing or supporting employee whistle-blowing. Although whistle-blowers have made an important contribution to patient safety it remains a controversial activity. The fate of whistle-blowers is bleak, often resulting in personal and professional sacrifices. Here we draw on the views of healthcare and social care employees working with older people to explore perceptions of whistle-blowing as well as alternative strategies that may be used to raise concerns about the mistreatment of patients by co-workers. Whistle-blowing was perceived as a negative term. Managers said they promoted open cultures underpinned by regular team meetings and an open-door ethos. Others described workplace norms that were somewhat at odds with these open culture ideals. Whistle-blowing was considered risky, and this led to staff creating informal channels through which to raise concerns. Those who witnessed wrongdoing were aware that support was available from external agencies but preferred local solutions and drew upon personal ethics rather than regulatory edicts to shape their responses. We argue that the importance of workplace relationships and informal channels for raising concerns should be better understood to help prevent the mistreatment of vulnerable groups.

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**Keywords:** whistle-blowing, older people, workforce, workplace culture

### Introduction

The World Health Organisation (WHO) states that although elder abuse is not a new phenomenon, the pace of population ageing will inevitably lead to a worldwide increase in its incidence and prevalence. Ageing may trigger an additional risk of abuse to the increased dependence of older people on others due to illness or social isolation. The fact that older people are abused and mistreated when receiving healthcare or social care has been known for some time, although it continues to be a largely taboo topic; and is at risk of being underestimated and ignored until a scandal occurs. Unless the healthcare and social care sectors are equipped to understand the factors that prevent or promote the mistreatment of older people in relation to workplace cultures, abuse will continue to be 'underdiagnosed and overlooked' (WHO 2008: vii). One response has been the widespread introduction of whistleblowing policies into the

workplace, with the aim of making organisations and their workers trustworthy and accountable. A broad definition of whistleblowing would encompass internal or external disclosure by employees (and former employees) of malpractice, illegal acts or omissions at work (Lewis 2006).

In simple terms healthcare and social care organisations have introduced whistle-blowing policies in an attempt to guide employees who wish to report concerns about malpractice at work. Furthermore, national regulators and professional bodies, such as the UK's Nursing and Midwifery Council (NMC), have also produced guidance for nurses, midwives and students who wish to raise or escalate concerns about the quality and safety of care. Such systems are premised in the belief that those delivering frontline care are also well placed to observe and report wrongdoing within an organisation. However, even though whistle-blowing is mandated and promoted by regulators, as well as in local and national health policies, the fate of whistle-blowers has been characteristically bleak, with individuals often facing the prospect of being dismissed, ostracised and resented by their work colleagues. Whistle-blowing has therefore emerged as a conflicted concept as well as a mechanism of management exemplified by shortcomings and controversy.

## Background

Whistle-blowers have been characterised in the literature as courageous employees who act to maintain standards against the might of faceless organisations (Jackson and Raftos 1997), sometimes at great personal cost (Ilfie 2002). An alternative view, and one that is sometimes promulgated by targeted organisations (Firtko and Jackson 2005), is that whistle-blowers are also malcontents, who will stop at nothing to pursue their own agenda, regardless of the destructive and negative consequences of their actions for colleagues and organisations. Whether the whistle-blower is viewed as tragic hero or a trouble-maker, it is the anomalous nature of whistle-blowing that makes it of special interest to those researching the care of vulnerable groups, such as the elderly.

Although some progress has been made in understanding the nature of whistle-blowing, questions remain which may, in part, be due to a tendency by policymakers and researchers to oversimplify the ways that concerns about care standards are managed in workplace settings. For example, Teo and Caspersz (2011) have found a tendency in the literature to focus on a dichotomous choice between whistle-blowing and silence: where faced with wrongdoing an individual employee makes the conscious choice either to remain silent or to act by 'blowing the whistle'. The whistle-blowing or silence dichotomy is problematic as it obscures a spectrum of alternative kinds of behaviour that employees may utilise, which may not result in whistle-blowing but might nonetheless be effective in identifying and preventing wrongdoing by others. Such behaviour may include using interpersonal strategies such as humour or sarcasm to signal discontent, or speaking to a manager in an informal off the record discussion.

The dichotomy's prevalence may be explained further by the emphasis placed on attitudes to whistle-blowing commonly explored using quantitative methods. Examples of the inclination to polarise responses into two contrasting kinds of behaviour are illustrated by research examining whistle-blowing in relation to nursing. For example, McDonald and Ahern's (1999: 5) survey report concluded: 'when misconduct or incompetence is identified in the patient care setting ... the nurse must decide whether to report the incident ('blow the whistle') or remain silent ('non-whistleblow')'. Similarly, Moore and McAuliffe's (2010) quantitative study of whistle-blowing responses by Irish nurses to incidents of poor care states: 'The dilemma occurs for nurses when misconduct occurs. In this situation nurses are faced with

two options, they can report the misconduct or remain silent' (p. 167). As a result of their survey the authors conclude in a later article that a 'culture of silence' (Moore and McAuliffe 2012: 333) exists in Irish hospitals. However, the survey results clearly state: '70% of those that observed poor care reported it' (Moore and McAuliffe 2010: 166). The conclusion that a culture of silence exists in the face of poor care seems to be at odds with a 70 per cent reporting rate. This appears to be a clear case of the authors being misled by the whistle-blowing–silence dichotomy, as what they seem to be reporting is more analogous to the deaf effect (the tendency for managers to ignore staff concerns, a concept we introduce later), rather than silence. We suggest that the whistle-blowing–silence dichotomy raises questions about the validity and subsequent conclusions of studies that have not fully considered the limitations of such a narrow understanding of reporting behaviour.

We now further set the scene by exploring features of whistle-blowing, including the importance of interpersonal factors between co-workers in the reporting of concerns of wrongdoing. We draw particularly on the classic sociological work of Barry Turner on man-made disasters, as well as Diane Vaughan's analysis of the normalisation of deviance in the National Aeronautics and Space Administration (NASA) and the events leading up to the Challenger Space Shuttle disaster in 1986 (Vaughan 1996). Recent conceptualisations of such phenomena as the deaf effect in other industries (Keil and Robey 2001) will also be discussed. Our empirical data will then be presented, which describe nurses' and care workers' views of whistle-blowing in relation to their roles with older people, before offering an interpretation of these accounts via the sociology of disasters framework already introduced.

#### *Whistle-blowing and nursing work*

Few in-depth qualitative studies have been undertaken into whistle-blowing in nursing practice. This is notable in comparison to literature from other areas, such as business studies and law. Consequently, the antecedents and consequences of whistle-blowing, as well as the beliefs and values of the whistle-blowers themselves, have not been well described either in the nursing or the broader healthcare literature (Black 2011). Instead, many of the studies in relation to nursing have focused primarily on hypothetical scenarios and intentions. For example, King (2001) ask what nurses would do if confronted with an unethical situation, while others focus on nurses' concerns about standards of care more generally (Attree 2007, Burrows 2001, Beckstead 2005). However, the findings of such studies have to be considered limited, as a meta-study of whistle-blowing in the field of business studies (Mesmer-Magnus and Viswesvaran 2005) has suggested there is a common, but significant, psychological distance between employees' whistle-blowing intentions and their taking action.

Most of the research into whistle-blowing has been conducted via large-scale surveys, which have revealed general trends. For example, Black (2011), who surveyed 564 registered nurses (RNs) in the USA found that 34 per cent indicated that had they been aware of a situation that could have caused harm to a patient but had not reported it. The most common reasons given for non-reporting included fear of workplace retaliation (44%) and a belief that nothing would come of any reports that were made (38%).

Of the qualitative work undertaken, Attree's grounded theory study stands out in terms of scale, consisting of 142 interviews undertaken with student and RNs in the UK. Echoing Black's results, Attree found that nurses feared repercussions, retribution, labelling and blame for raising concerns – especially where they felt further action would not be taken by their managers. Reporting was perceived as an action with high risks and low-benefits. Notable studies from other countries include a body of work from Australia (Jackson *et al.* 2010, 2011) that reinforces findings about the negative personal costs of raising concerns in the healthcare setting. Jackson *et al.*'s (2011) study provides a vivid account of the potential

complexities of whistle-blowing in organisations. For example, they describe how ensuring confidentiality for the whistle-blower might, on the one hand, encourage nurses to raise concerns while, on the other, confidentiality was also perceived as a means of silencing certain individuals and oppressing the workforce further.

#### *Introducing the deaf effect*

One of the problems with the whistle-blowing–silence dichotomy is that the absence of evidence of whistle-blowing reporting leads to erroneous conclusions that staff avoid raising their concerns at all. For example, the recent Francis Inquiry (Department of Health 2013) in England into patient neglect at a failing hospital demonstrated how the impression of silent inaction by the staff who were confronted by wrongdoing was, in reality, untrue. In 2009 the then Health Secretary said he was amazed that nurses and doctors ‘failed to blow the whistle on poor practice’ (Snow and Boulton 2009: 5). Both inquiries into Mid Staffordshire National Health Service Trust describe, however, how nurses repeatedly but unsuccessfully raised concerns with managers, a situation described by Inquiry counsel Tom Baker as ‘a cry from staff who appear to be being ignored’ (Transcript day 102, Mid Staffordshire NHS Foundation Trust Public Inquiry 2013: 48). Indeed, several inquiries into patient neglect and harm in the National Health Service (NHS), dating back to the Howe Report (1969), have concluded that attempts by nurses to report concerns about patient care to senior managers often prove fruitless.

There is a paucity of healthcare literature on reasons why senior decision-makers in organisations ignore those who are bold enough to voice their concerns. In management and information studies Keil and Robey (2001) coined the term deaf effect to describe the reluctance of policymakers and those in authority to hear bad news coming from their colleagues. Cuellar (2009) says the deaf effect occurs ‘When a decision maker doesn’t hear, ignores or overrules a report of bad news to continue a failing course of action’ (p. 23).

The concept of the deaf effect, and its focus on the reluctance of organisations to respond to concerns, has a clear resonance with notable accidents, disasters and incidents that have occurred throughout the world in both the private and the public sectors and across several industries. For example, inquiries in the USA into the events of 9/11 and in the UK into numerous avoidable incidents that resulted in harm and loss of life (for example, the sinking of the passenger ferry *The Herald of Free Enterprise* and the Ashworth Hospital scandal) all demonstrated that, far from being silent, staff in organisations frequently raised concerns only to be ignored by senior colleagues and managers, or for their concerns to be rejected following perfunctory internal reviews (House of Commons Library 2013).

Nurse managers not listening to or acting on concerns feature prominently in the literature as a barrier to effective whistle-blowing (Attree 2007, Public Concern at Work 2008). This is sobering in light of the recent Royal College of Nursing (2013) survey that found that 45 per cent of the 8000 respondents who had raised concerns said their employer took no action. In another survey 49 per cent of nurses ( $n = 752$ ) reported that serious concerns were not handled fairly or well by managers (Public Concern at Work 2008). Thus, the hierarchical culture that permeates healthcare and social care settings emerges as a highly relevant factor.

#### *Learning from events, disasters and inquiries in other sectors*

It is our belief that similarities between the hierarchical structures of organisational norms allow the application of concepts, models and theories from diverse industries and organisations to healthcare contexts. For example, insights from the work of sociologists such as Turner and Vaughan into so-called man-made disasters in a variety of industries may usefully be applied to health care. Turner (1976) suggests that, like the deaf effect, industrial disasters

are often preceded by failures of foresight, amounting to long incubation periods typified by signals of potential danger that were either ignored or misinterpreted by the organisation's leaders.

Following the *Space Shuttle Challenger* disaster Diane Vaughan (1996) found failures of foresight in the tendency for organisations to tolerate warning signals in an incremental fashion, allied to a process she called the normalisation of deviance. This process involves a gradual erosion of normal procedures and acceptable standards that would never be tolerated if they were proposed in one single, abrupt leap. Instead, deviations in practice are observed and slowly tolerated as acceptable. Lacking a high profile negative outcome, such as a catastrophic, highly publicised event, to draw attention to these changes, the deviant practices slowly become normalised.

An organisational culture had emerged in NASA, for example, that tolerated the gradual acceptance of more risk in the interest of perceived efficiency and on-time schedules (NASA's project management approach at the time was named 'Faster, Better, Cheaper'). Boundaries were pushed to new extremes without referring to the reasons where, or why, the original safety limits had been established. Alongside this gradual erosion of acceptable boundaries, verbal complaints and memos sent by engineers to signal potential dangerous events were apparently ignored or dismissed by management at all levels.

Up to this point we have shown the difficulties associated with whistle-blowing; whether this is due to staff fearing retribution by their colleagues or the managers' reluctance to act on reports. We have also shown how concepts such as the deaf effect, failures of foresight and the normalisation of deviance challenge the conventional understanding of how employees respond when confronted with wrongdoing. This body of sociological writing, allied to recent testimony from the Francis Inquiry (Department of Health 2013), raises the possibility that staff are not silent in the face of wrongdoing: instead, they may raise concerns internally that are often ignored.

Following the lead set by Teo and Caspersz (2011) we were particularly interested in how whistle-blowing in health care may be seen as only one of many forms of prosocial behaviour that may prevent or rectify a deterioration in care standards. As a result, this study aims to address a gap in the healthcare literature by exploring perceptions of whistle-blowing and the alternative strategies and interactions that employees may adopt to raise concerns about standards in older people's care.

## Methods

A qualitative study of participants who were employed in or associated with elderly care in Wales was carried out in 2012. Individual, semi-structured interviews or focus groups were conducted with a range of individuals across Wales (see Table 1). The interviews lasted between 35 and 65 min and the focus groups between 43 and 67 min. The interviews and focus groups were held away from areas of direct clinical care, thus increasing privacy. Four telephone interviews took place with one representative of the NMC, and three representatives of the Welsh police (who are involved if reports of mistreatment are made directly to them).

### *Research aims*

The study was commissioned to explore perceptions of whistle-blowing in staff who are employed in care settings for older people's care. A further aim was to explore alternative strategies to whistle-blowing and to collect views on barriers and enhancers to establishing alternative, less formal reporting mechanisms in the workplace.

Table 1 *Overview of data collection method by participants*

	<i>Regulators/ police</i>	<i>Registered nurses</i>	<i>Nurse managers</i>	<i>Care assistants</i>	<i>Student nurses</i>
Individual interviews	4	9	5	20	–
Focus group 1		3		3	–
Focus group 2		–		–	8
Focus group 3		–		–	8

The interviews followed a topic guide drawn on findings from the literature and the overall aims of the study. Interview prompts consisting of relevant newspaper extracts were also distributed to both individual and focus group participants to stimulate discussion.

The ensuing discussion reflected the participants' perceived obligations and attitudes to whistle-blowing. We also focused on perceived barriers and enablers that might suppress or support the raising of concerns more generally. As a result, the discussion moved from generic to specific issues in each workplace context, raising the topic of the relevance of maintaining care standards to each participant's role and progressing towards the object of focus (whistle-blowing) rather than tackling it directly from the start. This permitted both breadth and depth of perspective and was intended to encourage open responses (Krueger and Casey 2000).

#### *Settings and participants*

Data collection (see Table 2) was undertaken with 60 participants (including managers, RNs, care assistants and domestic staff) from two older people's wards in a large NHS teaching hospital, as well as nursing and residential homes (ranging from 35 to 90 beds) and domiciliary care organisations providing care in the home (including washing, providing meals and assisting with cleaning).

For legal reasons participants who were involved in an ongoing whistle-blowing case were excluded from the study.

#### *Research ethics and governance*

University and NHS research ethics and governance approvals were obtained prior to data collection. Written informed consent was obtained from the participants, and interviews and focus groups were conducted. Each interview was audio-taped with the participant's agreement and transcribed in full. The opportunity was provided for the interviews to be conducted in Welsh.

Table 2 *Research participants and settings*

	<i>Nursing/residential homes</i>	<i>Hospital</i>	<i>Domiciliary care</i>	<i>Other</i>	<i>Total by type of participant</i>
Registered nurses	7	8	2		17
Care assistants	10	7	6		23
Regulators/police				4	4
Year 2 nursing students		16			16
Total by setting	17	31	8	4	60

*Data analysis, rigour and limitations*

A thematic analysis of interview transcripts took place concurrent to data collection. The data analysis was partially foreshadowed by the aims of the research; however, analysis proceeded in an inductive fashion, starting with themes generated by the participant's responses. This process consisted of a pattern of reading and re-reading the data, a method of analysis that eventually enabled the progressive understanding of the participants' views expressed in the data to interact and be compared with our own perceptions as researchers and the existing literature (Atkinson and Coffey 1996). Peer review of data analysis, undertaken in the research team (AJ and DK) was undertaken at all stages, further adding to the rigour of the study.

**Findings**

In practice, the experiences of whistle-blowing and raising concerns manifest themselves in the accounts of nurses and carers in a number of overlapping ways. We structure the findings around those issues that emerged as being the most important to the participants, while also presenting the findings in a way that is consistent with the aims of the study. The findings therefore include a discussion of the perceptions of whistle-blowing before moving on to explore alternative strategies to whistle-blowing in creating an open culture in the workplace and diverse responses to wrongdoing. The final section discusses how attempts to promote an open culture and employee's responses to wrongdoing may be checked or impeded in the evolution of workplace norms.

*Perceptions of whistle-blowing*

Concurring with previous studies (Attree 2007), the following extracts exemplify how the term whistle-blowing was perceived negatively by interviewees. As one care home assistant said:

I think it's kind of a negative effect, isn't it, with the wording of it. I think, perhaps, raising concern for individuals or something along those lines would be better ... I think with a lot of the carers, they feel as if they're, sort of, um, for want of a better word, grassing on their colleagues or, um, say, a family member or something if there's an issue with a service user.

In a focus group with student nurses a similar sentiment emerged, even though some participants had had little exposure to healthcare workplaces:

It's like a grass or something. It's a bit like being in the playground, isn't it? If you are going to whistleblow then you're going to tell on your friends and everybody 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.

Some participants offered a more positive perception of the term whistle-blowing, although these were in the minority. For example, one nursing home manager stated:

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. It's academic what it's called isn't it really? ... And I think if people are told that it's okay to come and speak up then I don't think it should bother them what it's called, as long as they're told that it's okay there won't be repercussions, you know. They need to know that whatever you call it.

The term whistle-blowing was also perceived as reporting behaviour related to observing severe misconduct or mistreatment of patients. The following extract from the student nurse focus group is characteristic of the views expressed by many:

When I think of whistle-blowing I think of really serious things like that nurse Beverly Allitt, or when patients are badly abused. The sort of really serious things you see on the television or read in a newspaper.

That most participants disliked the term whistle-blowing echoes findings from other studies that report similar objections to the term (Gallagher 2010). Interestingly, even those who did not object revealed in their responses some understanding of the problems associated with the term, indicating that it 'sounds a bit scary', as the act of whistle-blowing is associated with personal repercussions. Given the general apprehension and dislike of the term whistle-blowing, the interviews naturally moved to exploring alternatives that participants might use in their workplaces. Creating a culture where staff felt able to communicate and support each other through team meetings was most frequently discussed as alternative mechanisms to ensure concerns were raised. These strategies are the focus of the next section.

#### *Creating an open culture in the workplace*

Managers strove to instil in staff the importance of concerns being discussed openly, as these quotations from different participants illustrate:

So I think, from my point of view, the very first few months were about showing and supporting them in the office that this is the way I do things ... I made a mistake which meant we had a missed call ... so I copied [name withheld] into the e-mail that reported myself. It was much better for her to see what I'd done and if people say, 'Oh, well, actually, she put her hand up, so maybe it won't be so bad if I make a mistake, I can tell the manager about my mistake and she won't you know, she's not going to be cross with me'.

When I look back to when it was the 80s my approach is different to the sisters back then. 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, you just got on with it and that was it.

The above extracts describe overt attempts by these managers to create a workplace culture that encouraged staff to communicate openly about issues associated with working in such a highly demanding and potentially stressful environment. As well as role-modelling desired behaviour, all the managers suggested regular team meetings as means of facilitating two-way communication with their staff members. Team meetings were also constructed as opportunities to reflect, leading to group learning and mechanisms to foster team improvement. Concerns could also be raised during such meetings and their deployment demonstrated (both to the staff and to us as visiting researchers) a culture of openness in action. As one manager from a domiciliary care service said:

Everybody, managers and all, needs 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.

In this Welsh context, rather than relying solely on self-organised or naturally occurring group discussions for staff to air their views, managerial intervention appeared to be the norm. The need for managers to create a space in team meetings for staff to vent their feelings and gain mutual support may well be a symptom of the demise of the morning tea break ritual, which historically provided time, space and a workplace environment for front-line nurses and other care workers (Lee 2001). As nurses increasingly report the difficulty of taking breaks during shifts, managerially arranged team meetings may therefore serve as a substitute support mechanism as well as a forum for raising concerns, and act as a useful alternative to formal whistle-blowing. As a result of team meetings the sharing of concerns might be becoming embedded less formally in the cultures of these workplaces. As Turner (1976 p. 388) points out, organisations develop elements of a continuous culture that relates to their primary tasks – and the environment in which they occur – and that 'part of the effectiveness of organisations stems from the development of such cultures'.

Another theme that recurred during this study was the value placed on staff induction programmes as a means of helping to create an open culture that might be more receptive to concerns being raised by staff. In one interview with a RN the following example emerged:

- Int: So do you talk about this [whistle-blowing] during the induction?  
 RN: Absolutely: on the first day and I make it quite clear even if it's me they see or hear doing anything they don't hesitate ... if they know that something is wrong, if they're being asked to do something they know is wrong then they don't have to do it. Instead to come and say, you know, um, I think certainly these days we try and encourage all members of staff to, to be a part of it you know to come up with ideas, to make decisions, you know, or say 'Can we try this?' or 'That's not a very good way of doing it'.  
 Int: Would you say it was to have a voice or something like that?  
 RN: They love to have a voice because if you don't feel part of something what's the point, if you think you're just coming in, wiping bottoms and going home.

Staff induction, according to Antonacopoulou and Güttel (2010), introduces employees to the organisation and its norms and offers the opportunity to impart these in a way that is acceptable to the social group that the individual is joining. In our study participants viewed staff induction as a crucial first step in the socialisation of employees, which has been defined as 'the learning process by which newcomers develop attitudes and behaviour that are necessary to function as a fully-fledged member of the organization' (Ardts *et al.* 2001: 16). Staff induction may also offer an area for further research to explore how cultural norms in healthcare and social care settings are passed on, both formally and informally.

In this section managerial strategies have been presented, such as role-modelling openness to their staff, promoting team meetings as environments for staff to air concerns and using staff induction to promote organisational values and encourage staff to discuss concerns. Although staff may 'love to have a voice' the next section shows how they do not necessarily wait for team meetings to make themselves heard. Instead some learn to raise concerns in different ways; often directly with the work colleagues whom they perceive to be in the wrong.

#### *Diverse responses to wrongdoing*

As already discussed, most of the existing whistle-blowing literature describes how employees, when faced with an incident of organisational wrongdoing, elect either to blow the whistle or

to remain silent. Even though prominent theorists such as Miceli and Near (1992) note that whistle-blowing is only one course of action open to individuals confronted with wrongdoing, there is little or no consideration in the research or healthcare policy literature about potential alternatives. Instead, the common opposite to whistle-blowing is uniformly presented as silence. As a result, a spectrum of behaviour is overlooked that may offer a viable means of preventing wrongdoing and unacceptable care standards.

With the notion of Teo and Caspersz's (2011: 238) 'whole spectrum of behaviours' in mind, we were eager to stimulate discussion on questions such as 'What do you, or would you do if you identified a potential wrong-doing?' The majority response to such questions was that it depended on the perceived severity of the event. Where service-users were subjected to severe physical harm the response from participants was, without hesitation, to contact senior members of staff in the organisation, or external agencies, where relevant:

Int: If you observed harm being done to a service user then what would your response be?

Care assistant:

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.

Alternatives to whistle-blowing, both internal or external, were discussed in situations that were perceived to be less serious. In such situations, participants discussed intervening directly with colleagues. In particular, phrases such as 'having a word' or 'taking them to one side' described the nature of interpersonal strategies used to raise concerns about a colleague's conduct. One RN in a care home provided an example of this approach:

Int: If something did happen, if that line was crossed does that always mean that you would report it to the matron or do you do other things?

RN: No, 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.

However, participants did not always directly confront colleagues about their concerns. For example, less direct strategies are described by nursing students in the next extract, who consciously employed their status as learners to question staff about perceived dubious practices:

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, say, 'is *that* okay?' Because sometimes people will go, 'Oh well, yes, no, you probably shouldn't do quite that', you know?

As opposed to pointing the finger or being aggressive, students discussed other roundabout ways of drawing attention to what they considered to be lax practices; this time by bringing the patient into the conversation:

You can do it in a roundabout way as well ... somebody said to me, like, about going out on a weekend, and I'm like, thinking about the patient lying there, and I say, 'Oh, I'm sure you don't want to hear what they've been up to all weekend', and you, kind of, like, bring it in like that, because I just think, 'Oh, you know, poor patient!' They don't want to know, and like, I don't really want to know either [laughter] ... You're there to work and to make the patient feel like they're being looked after, not that they're in the way.

Humour or innuendos were also strategies used by junior members of the workforce, in this case a care assistant, as a tongue in cheek way of raising concerns with co-workers:

Sometimes I just 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's hit home.

Little attention has been given to these informal ways of raising concerns or of monitoring practices between immediate members of the care workforce. By their very nature these interactions remain unrecorded and invisible to external oversight and are subsequently not reflected in official reports, surveys or organisational accounts of whistle-blowing, or of raising concerns in the workplace. Our finding that the overwhelming preference for verbally reporting, rather than documenting concerns is supported by the work of Moore and McAuliffe (2010).

The imperceptible way of raising concerns at the interpersonal level in an organisation may well be one reason why, when the spotlight is turned on an organisation, the immediate appearance is that of silence or inaction by staff. Nevertheless, such activities were reported in our data as having an immediate and powerful effect on questionable practices in ways that official workplace policies cannot. Questions remain, however, whether such informal behaviour should be further acknowledged and encouraged, or whether more emphasis should be placed on rendering such informal behaviour into formally recording concerns.

It is also important to note that participants do not refer to the use of professional codes of ethics or regulatory edicts to help guide their decisions to report concerns, or not. Indeed, these participants confirmed previous studies that suggest that nurses usually take little account of codes of practice when considering the moral dimensions of their practice and tend to rely instead on their personal values and experiences (Tadd *et al.* 2006). An example of this was where one RN aspired to base care standards on a personal ethic of treating older people as though they were family members:

Families trust us when they are here, erm, you know, we are looking after their mum, dad, sister, even, erm, in some situations, it can be their son or whatever, you know, that has happened and 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.

While the role of codes of ethics in developing a shared value base for healthcare and social care professionals is not contentious, the participants did not say they were a useful or immediate frame of reference to guide individual ethical or moral behaviour in the workplace. Instead, the participants reflected what Bauman (1993: 11) calls the 'moral impulse'; an

individual's capacity to act morally that arises out of a moral conscience and responsibility to an immediate other, not to an employer, a regulatory body or a code.

We have demonstrated in this section that care workers respond to perceived wrongdoing in numerous ways. As suggested by Teo and Caspersz (2011), the participants spoke of informal, interpersonal strategies to raise concerns with colleagues that have largely been hidden from external scrutiny as well as formal reporting and whistle-blowing. They also showed that personal values and ethics, rather than regulatory guidance or rules, were used as yardsticks to judge whether standards of care were deficient or not. In the final section we explore the complex relationship between such personal values, behaviour and collective workplace norms.

### *The evolution of workplace norms*

In this section we explore participants' perceptions of workplace behaviour and norms, how they evolve and their effect on an individual's likelihood to whistle-blow. Following Parsons (1990), workplace norms are constructed here as institutionalised systems that regulate interpersonal relations and behaviour. We were also aware of the power of norms in the workplace and the manner in which they can influence behaviour without being specifically expressed (Vaughan 1996). During interviews, the participants clearly explained how workplace behaviour and norms developed and became habitual over time. For example, the following extract from a manager of a nursing home describes how, when constantly exposed to the smell of urine, staff actually believed it's OK when in fact it's not:

The problem, I believe, is that sometimes, with staff who are dealing with dementia, that what happens is, as I recognised when I was once a psychiatric nurse, that the abnormal becomes the normal. 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 also a psychological habituation to it.

A similar sense of the abnormal becoming the normal can be seen in the following extract where a manager explains how she recently held a staff meeting following her own anxieties and complaints from a visitor about some staff shouting at, rather than talking to residents:

Respondent: It 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, you know', I said 'Yes, they would think it's abuse'.

Int: OK, it crept in. So staff – they don't say, 'Oh, from today we're going to start shouting at people'?

Respondent: No, no, it just crept in here. People get familiar [with it] and they think, 'Oh well, this is okay' ... Some of the staff, myself included, are going home and their families say 'You come back down to me now, don't shout at us all'... but I wasn't aware I was doing it. I was just in that mode because I had to raise my voice to talk to most of the residents.

In relation to the sociological literature discussed earlier we were particularly struck by the phrases 'the habituation of abnormal behaviour' and 'it just crept in'. These resonate with

Vaughan's (1996) description of the incremental expansion of normative boundaries; how small changes – new forms of behaviour that were slight deviations from the normal course of events – gradually become the norm, providing a basis for additional gradations of deviance. The impression here is that there is no evidence of a conscious intention to adopt lower standards of care or deviant behaviour. Instead, a situation materialises where an erosion of dignity is permitted incrementally, which would initially have been considered unacceptable. Participants also described how workplace norms are commonly reinforced by longer serving staff, who were often perceived as barriers to the raising of concerns:

- Int: Why is it that different standards, or a different tolerance, establishes itself in some places?
- RN: There's no picking up on poor practice at an early stage and then it can become embedded, perhaps, and, you know, new people come and they think this is the way to do things.
- Int: Can you explain a bit more what you mean by embedded?
- RN: Well, I mean, I think, historically, in a lot of domiciliary care or residential homes people have generally gone to work in care; mainly women, because it fits in with childcare usually and they start off sometimes in the kitchen, sometimes as domestics and then a vacancy becomes available as a care assistant so they go in and then a senior care assistant. And it's over many, many years they've seen the way things have been done and that's the way they do it. It becomes almost ritualised and is wrong ... 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.

Thus, while managers may try to encourage a culture where staff raise concerns about questionable standards of care, the everyday workplace norms can work as countervailing forces, leading to previously unacceptable behaviour becoming normalised over time. Such ritualised workplace norms allied primarily to longer serving staff were implicated in the appearance of a closed, inward looking and insular culture which had led to the mistreatment of older people at Garlands Hospital (Commission for Healthcare Improvement 2000). As in Garlands Hospital (where nurses initially raised concerns about standards of care) our data suggest that comparative outsiders to the immediate care team (such as student nurses, hospital managers and relatives) are a source of challenge to otherwise normalised behaviour, be it accepting the smell of urine or talking over or shouting at a patient.

## Discussion

As noted in the background section of this article, incidents of poor practice and mistreatment of patients in healthcare and social care settings may be characterised as a gradual build-up of events and missed opportunities to act on the concerns of staff, relatives or others. We draw parallels between cases of mistreatment in healthcare and social care and the literature on man-made disasters to suggest that an incubation period – prior to revelations of mistreatment – has similarities with the failures of foresight commonly identified in organisations prior to high profile disasters. Failures of foresight occur when, among other things, existing danger signs are ignored or given low priority, or are considered insignificant (or expensive distractions) in organisations (Turner 1976). The tendency to disregard staff concerns has itself been

largely ignored in the healthcare and social care literature, but has recently been described elsewhere as the deaf effect.

In an attempt to counter such failures, organisations have been encouraged to foster a safety imagination through the use of, among other things, workplace meetings to elicit as many varied viewpoints as possible about potential hazards in the workplace (Pidgeon and O'Leary 2000). Strategies by managers in this study to foster an open and supportive culture could also be seen as attempts to counteract the deaf effect. For example, team meetings and staff induction were presented as means of creating a more democratic culture, empowering those closest to the patient to speak out in a forum attended by their peers. Induction was also be seen as a means of insulating new staff from the powerful forces of socialisation where questionable tricks of the trade may be passed on by more experienced co-workers (van Maanen and Schein 1979). Team meetings were framed by participants here as offering a means of mediating, or sense-making, when faced with the inherent messiness of clinical practice. There are obvious caveats, however, such as the fact that we did not attend the staff meetings and have no way of verifying whether these events had any preventative effect by discussing poor care or wrongdoing. Such strategies merit further attention using in-depth observation.

On the surface, promoting a workplace culture that fosters open communication between staff and managers may encourage more foresight and the confronting of issues that may otherwise remain unvoiced by staff or ignored by managers. However, our data also show that the pre-existing workplace culture can be a countervailing force that suppresses openness and, over time normalises deviance, including suboptimal care. Vaughan (1996) captures the potential for such dualism in workplace cultures when she notes that the routine, taken-for-granted organisational culture in NASA prior to the *Challenger* disaster 'provided a way of seeing that was simultaneously a way of not seeing' (p. 394). In this case NASA created systems to enable individual engineers and managers to raise concerns over safety fears, but these existed within a wider, pre-existing and more powerful set of priorities negotiated within and between NASA, its contractors and political bodies such as Congress and the White House.

The combination of Vaughan's insights and the findings from our data suggest that efforts to encourage more openness about suboptimal care have to be understood within a complex, pre-existing and multifaceted workplace culture. Any attempt at nurturing a culture of openness has, therefore, to be take into account the wider social system that includes workplace history, power, norms and hierarchy.

There are several possible answers to important questions such as, 'What constitutes an issue worthy of whistle-blowing?' and 'How should employees respond to matters of concern?' Each may run in parallel in the same organisation, with the answer depending, ultimately, on the perceived seriousness of the events and the interpersonal dynamics that shape the culture therein. We found that individual responses to instances of possible mistreatment of older people were shaped by the individual (and often mundane) interactions taking place during daily routines. Solutions to problems such as, 'Shall I report this?' have to be seen, therefore, as the product of interpersonal relationships, not merely relying on guidance based on personal morals, regulation or workplace policies.

The participants in this study often used informal and circumlocutory means of communicating their concerns to colleagues whose standards of care were perceived to be suboptimal. These informal means of raising concerns were reported as subtle but effective means of challenging co-workers' behaviour, but they may be undetectable to external observers or regulators. However, they may also offer highly significant alternatives to whistle-blowing, which is often perceived of as an option of last resort that includes 'snitching' (Older People's Commissioner for Wales 2012).

This is not to suggest that healthcare and social care organisations and processes that support the most vulnerable can never be influenced in a positive way by external regulatory bodies or policies. Indeed, from a legal perspective, they remain a necessity. However, merely judging an individual's action by the decontextualised and bureaucratic enactment of a policy or code of professional conduct is to conceive of misconduct, and reporting misconduct, as an inherently rational act that is never constrained or modified by the workplace culture or broader organisational forces. We suggest that this is not the case and that there is a need to think differently about how, as a society, we conceptualise and manage whistle-blowing and the raising of concerns in healthcare and social care more generally. For example, more of a focus is needed in regulatory frameworks and policy on the layered context of action described by Teo and Caspersz (2011), rather than framing whistle-blowing as a simple all or nothing alternative to silence. In the end it seems that workplace relationships could offer a new way to monitor (in more acceptable and open ways) co-workers' behaviour – as has occurred in the aviation industry for a number of years (Gill and Shergill 2004).

## Conclusion

The litany of catastrophic cases and inquiries into the mistreatment of older patients over the last 30 years have provided tangible evidence that healthcare and social care organisations commonly fail to listen to staff concerns and seem unable to learn the lessons from either their own, or others' misdemeanours. The recent scandal at the Mid Staffordshire NHS Trust has once again raised the issue of understanding why workplaces, which are intended to offer care, can become so brutalised (Department of Health 2013).

This article has sought to provide an empathetic appreciation of the realities of those who work in older people's care and their experiences of raising concerns. We have shown how organisations are currently attempting to enable staff to speak out through the promotion of openness and communication in the workplace. In order to instil such openness in workplace cultures, however, managers were found to prefer solutions focused on questioning unacceptable standards of care and promoting open communication between employees. This move reflects recent calls by healthcare regulators in the UK to avoid self-censorship and to enhance communication and an open culture in healthcare environment (Nursing and Midwifery Council 2009).

However, the countervailing effect of social forces on the way that information, interpretation and ultimately actions are played out, especially in the face of wrongdoing, are very difficult to control. Nevertheless, the process of socialisation and habituation in the workplace offers insights into the reasons why suboptimal care of vulnerable older people may continue to go unchecked or unreported, or is noticed only by organisational outsiders such as students, new recruits or, more rarely, by regulatory agencies. Given this fact, there is a need to emphasise the potential of everyday interactions taking place between co-workers that may offer alternatives to the more extreme option of whistle-blowing. While whistle-blowing may always be needed, we suggest that the everyday mundane workplace culture that underpins older people's care needs to be better understood in order to enhance safety, the wellbeing of employees and the promotion of humane standards of care.

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