

# Whistleblowing as a means to raise concerns, or a means to an end!

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## **Abstract**

This is a discussion about a whistleblowing policy in practice. This will be linked to a specific issue from practice relating to the nursing care of residents in an older person setting. This reflection will consider the impact of culture within the setting and its impact on the ability of me to raise concerns.

While whistleblowing is an option where a staff member has serious concerns about quality of care, it is one that is only taken when all other avenues are exhausted. It will explore some of the challenges that staff and healthcare professionals which can include student nurses or allied health professionals can encounter when making a decision whether or not to whistleblow. It will explain how a whistleblowing policy can support professionals in practice. It argues how those on the receiving end of care may have limited choice on the quality of that care, but as healthcare professionals we do have choices and it is about the choices we make.

## **Keywords**

Safeguarding; Nurse; Documentation; Whistleblowing; Culture

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## Introduction

I worked as a staff nurse in an area providing long term care for older people. Most of the residents had lived there for a number of years. Equally many of the staff had been employed in this area for a number of years. This was my first post as a staff nurse and I was the first new member of staff in this area for a number of years. I have chosen to discuss our local policy on whistleblowing relating it to the Winterbourne View Serious Case Review (Flynn 2012). Phrases such as raising concerns or speaking up can also be used in relation to whistleblowing (Francis 2015). He has described whistleblowing as raising concerns where there are issues of safety and this could include issues about bullying or oppressive behaviour.

I have chosen the Whistleblowing policy to enable me to discuss how as a healthcare professional we can raise concerns about practice and care and I will use the Winterbourne Inquiry (Flynn 2012) to consider some of the challenges and opportunities associated with this. Healthcare staff can choose this option when they have exhausted all other avenues to have issues addressed. There was a failure by the organisation Castlebeck Care Limited to act on allegations of abuse which were made (DoH 2012). Some issues such as poor professional practice can give rise to safeguarding concerns, for example what happened in Stafford (Francis 2013b). There were patients whose drinks were out of reach, medication errors and patients treated with cruel indifference (Francis 2013a). Under the Nursing and Midwifery Council (NMC) *Code*, the nurse is required to have a "... 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk" (NMC 2015, p.22), one of the recommendations of Francis (2013b). Moreover, it is included in the NHS

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Constitution (DoH 2013, p.12) where staff "...can raise any concern with their employer, whether it is about safety, malpractice or other risk, in the public interest".

Examples of staff such as Margaret Haywood in 2005 who went to *Panorama* (a BBC programme used to expose issues in the public interest through their investigative journalism) to raise concerns about standards of care, having tried a number of other avenues, led to the NMC suspending her registration pending an inquiry, later to reverse this decision following a public outcry (Mandelstam 2013). This case amplified the need for a formal process to raise concerns where other avenues had failed, known as whistleblowing.

The whistleblowing policy supports staff to raise concerns, making the process explicit to the member of staff, where there are issues in the workplace that can or may impact on the quality of care and this supports the requirements of the *Code of Conduct* (NMC 2015), the regulator for nurses midwives and health visitors, when other avenues have been exhausted. However, the decision whether to raise concerns remains the responsibility of the healthcare professional and whether they feel the issue is a concern.

### **Impact of past experiences on future practice**

The issues in Winterbourne View private hospital were first exposed by *Panorama*. Winterbourne View was a private hospital responsible for residents with learning disabilities (Flynn 2012). It took a TV programme to expose the poor standards of practice staff had with the residents in their care. It was not until this programme was in

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the public domain that actions were taken to safeguard the residents in Winterbourne View. Despite the poor care experienced by the residents on a daily basis it was not a permanent member of staff but an agency nurse who attempted to raise these concerns initially at a local level. However, as the nurse was not listened to, he, like Margaret Haywood in 2005, turned to Panorama to have the concerns heard.

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No Secrets (DoH 2000) was introduced to raise the profile of safeguarding and protect vulnerable adults from abuse and neglect, omissions of care and/or institutional abuse. However, it did not stop what happened at Winterbourne View. Publications such as No Secrets (DoH 2000) can raise public awareness of such issues, the document in itself cannot prevent such behaviour towards people occurring.

The question remains whether vulnerability already exists or is created by the actions or omissions of others who are responsible for looking after them such as happened at Winterbourne. It has been suggested that some groups of people are considered vulnerable because they are dependent on other people for essential needs such as food, care, comfort or protection from harm (Baillie and Black 2015). Many of the residents in Winterbourne View and the setting where I worked may be considered more vulnerable due to their lack of capacity under the *Mental Capacity Act* (2005 cited in Baillie and Black 2015) in addition to the illnesses which they lived with. Where there are concerns staff make a decision about the action that should be taken. Some may choose to act on a concern where others would not. As healthcare professionals we make judgements every day and sometimes they can be difficult particularly if we fear

Pat Clarke: Whistleblowing as a means to raise concerns, or a means to an end! what the consequences of raising such concerns may be (Francis 2015). This was one of the issues that concerned me when I was considering whether to raise concerns over the quality of care delivered by some colleagues of mine. I wondered if my views/concerns were an exaggeration of reality or what the consequences of raising such concerns might be.

The Care Quality Commission (CQC) under the *Health and Social Care Act* of 2008 registers, reviews and can investigate health and social care providers (Mandelstam 2013). The CQC were made aware of some of the issues at Winterbourne View but did not act on the concerns at the time (Flynn 2012). Furthermore these concerns were not identified by the CQC through their routine inspections bringing the CQC as the regulator under scrutiny. As a consequence the CQC were given greater powers to make more unannounced inspections, get feedback from service users and families along with putting all reports in the public domain (Francis 2013b).

The *Care Act 2014* (DoH 2015) is the first act to focus on safeguarding specifically, prior to this there was no similar legal framework. It introduced a model which allows lessons to be learnt from safeguarding adult reviews, similar to how lessons can be learnt from serious case reviews such as Winterbourne View (Flynn 2012).

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**Policy – organisation, service users**

While healthcare professionals may observe poor practice, Francis (2015, p.22)

suggested there may be a "... disproportionate impact on others who are deterred from speaking up by the fear of adverse consequences or the belief nothing will be done".

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Students working in healthcare environments can see practice on a day to day basis and are in a key position to ask challenging questions about practice as part of their learning experience central to the nursing *Code of Conduct* (NMC 2015, p.13) where the nurse is expected to "...take all reasonable step to protect people who are vulnerable or at risk from harm neglect or abuse'. The whistleblowing policy provides the pathway for staff who wish to raise concerns in the workplace, formalising the process.

Some student nurses may feel reluctant to raise concerns as they are reliant on their mentor to complete their documentation for the placement. Students may fear the repercussions of raising concerns about a placement area. Students have failed placements after raising concerns during their experience (Francis 2015). Negative experiences (Milligan et al. 2016) when raising concerns may impact on their decision should they need to raise concerns again. Moreover the student may learn the negative consequences of raising concerns. The staff nurse is also vulnerable by their need for the job to fund their lifestyle in addition to its contribution to their career (Mandelstam 2013). This may affect their perceptions of the seriousness of the issues.

Those who choose to raise concerns have sometimes experienced victimisation because of the actions they have taken (Francis 2015) which can lead to the nurse

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becoming considered as an 'outsider' (Becker 1963) among the team. This can act as a deterrent to raising concerns. Certain groups of staff are thought to be more vulnerable than others should they make the choice to raise concerns. These include agency and bank staff, staff from black and minority ethnic backgrounds, student nurses as well as staff working in primary care organisations (Francis 2015). While organisations encourage whistleblowing, in reality many only pay lip service to it (Mandelstam 2013, Plomin 2013).

At the centre of this are the residents in our care and a decision needs to be made whether to raise a concern or not. While at the extremes it may be easy for the nurse to raise concerns, there may be times when it is challenging to understand whether the threshold has been reached, that the standard of care delivered is having a negative impact on a resident? Considering the case of Phyllis Foster who died following poor care from Whipps Cross Hospital (Mandelstam 2011), helps to highlight the potential outcomes of substandard care. Decisions about threshold are often made on our own experiences both personal and professional, therefore each one of us might have different thresholds (Clarke 2015).

### **Exploring Challenges**

In relation to the healthcare context, culture has been described as how we do what we do (Vincent 2010 cited in Francis 2013b). The culture within the placement constitutes the place of work for the staff nurse and other healthcare professionals as well as the home of the residents who live there. Milligan et al. (2016, p.5) refer to a "...positive safety culture" as one that can encourage healthcare professionals to raise concerns if

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needed. Many areas have more than one culture within an organisation such as different teams and departments (Francis 2015) often considered subcultures, suggesting there are many ways to do the same thing. There may be some that may not be considered as “positive safety cultures” as described by Milligan et al. (2016). The ability to raise concerns may depend on the culture prevailing within the workplace and whether it is deemed the right thing for staff to speak up. Those who choose to raise concerns may be considered as ‘outsiders’ within some settings such behaviour may be deemed unacceptable by those who work there (Becker 1963).

While training may help staff to understand the process of questioning practice, there must be a culture of openness supported by good management to enable this to happen (Francis 2015). Training can update the staff about the processes and policies within the workplace but in the absence of organisational support for best practice, the impact of the individual can be limited (Pike et al. 2010). Policies alone do not protect/safeguard people, it is the actions taken by people that protect the person or increase their vulnerability.

As Mandelstam (2013) suggested, where staff have mortgages, bills and career hopes, they may choose to keep quiet or fear victimisation or as Francis (2015) suggested, some may regard the act of raising concerns as risky. While policies and procedures can be in place for staff to follow, in the absence of support from the organisation, and a positive safety culture (Milligan et al. 2016) of listening to staff concerns about practice, it can be difficult to challenge poor practice.

## **Conclusion**

Staff who use whistleblowing do so as a last resort, where they feel they have exhausted all other avenues, an example of this was Margaret Haywood who had tried other avenues to get her concerns addressed before whistleblowing. Whistleblowing can create a dilemma for the health professional. Professional regulations require nurses to raise concerns but individual reasons may deter them, such as the consequences of the decision, not being listened to, victimisation in addition to a belief they will be ostracised (Mandelstam 2013).

This article has raised my awareness of some of the challenges of whistleblowing. It is multifactorial, increasing my awareness of the courage of staff such as Margaret Haywood who choose to raise concerns, putting the care of patients beyond themselves and their career. While the healthcare professional has a choice about whistleblowing, the resident has limited choice whether to receive sub-standard care, particularly if they lack mental capacity. While policies provide a pathway to follow should healthcare professionals wish to raise concerns, they do not eliminate the perceived risk that can be associated with raising concerns (Francis 2015, Milligan et al. 2016).

Nurses are expected to have courage as one of the 6 Cs (Star 2012), indeed the 6C's (courage, commitment, communication, courage, care and compassion) are considered desirable for all healthcare professionals (Baillie 2015). Those who choose the whistleblowing route are examples of staff who have courage and put the people in their care at the centre of what they do. Healthcare professionals need to be encouraged to move away from what could be considered "...a cowardly stance, given the vulnerability

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of some of their patients; that is, passing by in silence the suffering of those they are  
meant to be caring for” (Mandelstam 2011, p.366).

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