Is institutionalisation being recreated in modern care and support settings?

No going back
Foreword

Housing and social care providers must do more than move away from outdated bricks-and-mortar institutions if they want to upgrade their services for vulnerable users.

Institutional malpractice in service provision is not just a product of dreadful institutional buildings; it is about a long-standing culture.

We are all horribly aware – from the Winterbourne View case – of what can happen behind closed doors. But services in the community can be infected by the transfer of an outdated and inappropriate culture.

This is the important and uncomfortable truth from Family Mosaic’s timely report. Unless organisations are vigilant, the older institutional culture can re-emerge anywhere: this report shows the fight is a constant battle.

The local authorities that commission care and support services must guard against cost cutting exercises that can undermine the recruitment of quality staff. We need councils to be in the forefront of supporting improved, personalised services and avoiding a return to an era we thought we had left behind.

It was brave of Family Mosaic to face up to this issue and I congratulate the organisation for its honesty and transparency. As the report shows, all of us need to recognise the risk of a “re-institutionalisation” of services for our most vulnerable citizens – and confront the problem – and take steps to tackle it. This report shows the way.

Lord Richard Best OBE
Family Mosaic is a housing association with over 24,000 homes in London, Essex and the Southeast. For the past 40 years, we have also been providing care and support services.

Currently, we supply care and support services to over 8,000 people, ranging from low level visiting support and accommodation-based supported self-contained and shared housing to registered care homes. We deliver direct care and support services in 125 schemes.

Services are provided for people with a range of needs, including:
- adults with learning disabilities;
- adults with mental health issues;
- older people;
- young people;
- homeless people;
- teenage parents;
- vulnerable families;
- people with an acquired brain injury.

Family Mosaic was also involved in a number of re-provision programmes, which involved moving people from long-stay hospitals and hostels into the community. This programme included housing over 300 people who had previously lived as inpatients in Friern Barnet in London, South Ockendon Hospital, Turner Village and Bridge Hospital in Essex. Many had lived in institutions for significant lengths of time, some since childhood.

Over 200 staff were also transferred from the hospitals, including qualified nurses and care assistants. Many had worked in these hospitals for years – some for their whole careers – and would have undergone their nurse training there as well.
This report looks at the risk facing present-day care and support services of slipping back into the institutionalised practice so common in the past, and suggests ways of guarding against it.

In spite of the laudable aims of current social care policy to provide personalised services to vulnerable people that can enable them to live fulfilled and secure lives, experience nationally over the last 20 years has shown that this has not always been achieved.

Institutional practice was commonly seen in the large long-stay hospitals for older people, and for people with a learning disability or mental health issues. Typically, it included harsh regimented regimes, cold clinical environments, lack of choice, dignity or respect. In many hospitals there was large scale abuse. Public opinion about the harshness of this care, along with the commitment of some pioneering doctors, resulted in the planned closure of these institutions.

These closures and the move towards care into the community were supposed to eradicate institutionalisation. Unfortunately, the scandals have continued. Winterbourne View, the Cornwall Partnership and a Panorama programme showing elder abuse in 2012 shows that institutional practice does not always go away when the buildings close.

As a significant provider of care and support services in London, Essex and the Southeast, Family Mosaic has seen how quickly even the most modern supported housing schemes can move to institutionalised practice if providers are not vigilant. The organisation is committed to raising awareness so that theirs and others providing services do not slip backwards into the old, discredited styles of practice.

The current public spending pressures make the risk of institutional care even more relevant. As local authorities, particularly within adult social care and supporting people teams, are driven to make ever greater budget savings, commissioners must be vigilant about the risk of driving prices too low. Where there is insufficient funding, good staff will not be recruited or trained. And where there are insufficient staff to provide a personalised service, then institutional practice is more likely to occur.

Simultaneously, commissioners need to encourage transparency. Where providers have identified areas of concern, and put in place actions to address these concerns, commissioners must be supportive. If they are not, then they may drive poor practice underground, as providers are too afraid to report for fear of repercussions.

This review highlights the warning signs providers should look for. It suggests ways of combating any return to the past. These will only be effective if all commissioners and providers of care and support accept that the institutionalised culture is possible in their service.

We would argue that if providers don’t believe this has ever happened in their services, it just may be that they haven’t looked hard enough.
The past

Institutional care: a hangover from the past

The huge, often ornate, buildings that still grace the landscape in many parts of the country bear witness to the long and sad history of institutionalisation in the UK.

Such institutions characterised long-term care and support for many people with mental health issues and learning disabilities in Britain until relatively recently.

Some are crumbling. Others have been turned into modern housing developments. Those that remain provide us with a glimpse into what life was like for many of our most vulnerable members of society.

Shared bedrooms and shared bathrooms. Locked wards and locked cupboards. Secure areas to contain people and a clinical environment with little warmth. That, though, was just the buildings.

The culture of institutionalisation that characterised long-stay hospitals included a range of practices and attitudes:

- strict systems of rules and codes of conduct;
- oppressive, authoritarian regimes based on hierarchical systems of management and a lack of training, particularly of lower level staff;
- strict routines that gave no opportunity for choice, for example, in what time to get up or go to bed, or even when to go to the toilet;
- excessive reliance on medication and physical restraints, often for minor perceived misdemeanours;
- a denial of individuality through the stripping of personal identity;
- a lack of empathy and respect for patients leading to them being seen, and treated, as objects rather than as individuals;
- patients left alone with no interaction for hours at a time;
- a lack of respect for patients, leading to many types of abuse and denial of human rights;
the values and norms are all-pervasive, and staff become as institutionalised as the patients, with dissent implicitly prohibited, leading to a narrowing of individual critical judgement and reasoning.

It is worth remembering that institutional practice was not always borne out of the poor practice of staff. Many of the staff who worked in the hospitals were kind and caring, but were worn down by gross staff shortages and the often mundane routines that were put in place. They simply did not have the time to interact with patients. And, because it was a hospital, they often became obsessed with the cleanliness and tidiness of the ward and patients. This obsession would often take precedence over anything else.

**The history of change**

The reason long-stay hospitals eventually closed was because of a number of factors, including:
- pioneering doctors recognising the possibility of using a mix of short-term treatment and long-term outpatient care;
- advances in medication;
- growing public awareness and opinion of the poor practices within long-stay hospitals;
- recognition that the majority of long-stay patients were not in need of acute health services.

A number of scandals in the late 1960s and early 1970s revealed the appalling conditions and cruel treatment in long-stay hospitals. This had a major impact on public opinion. Then, in the 1970s, a series of white papers took a radical look at mental illness, learning disability and older people’s services. They proposed changes that would result in the closure of these hospitals and a fundamental change in attitudes to care.

**The growth of community care**

Community care, or care in the community, became official policy in the 1970s. It was based on the belief that institutional care was an outdated and inappropriate form of care.

While community care as both a concept and a goal has gained widespread support, understanding and implementing it in its fullest sense has been more difficult. It has been beset by shortages of resources and variable standards, and has tended to be overshadowed by the priority given to other policy areas, notably acute services in the NHS.

Moreover, there is alarming evidence to show that the practices and attitudes generally associated with institutionalisation that were embedded in the old long-stay institutions, have not disappeared with the advent of community care. Scandals have occurred over the years to show that the old practices still persist.

The scandal involving the abuse of people with learning disabilities at Winterbourne View revealed in 2011 by undercover filming by the BBC TV Panorama programme is one example. There have, however, been others, including, in 2006, homes for people with learning disabilities run by Cornwall Partnership NHS Trust and, in 2012, a scandal about Ash Court, a care home run by Forest Care for older people with Alzheimer’s.
Investigations into recent scandals have highlighted a number of common features in the bad practice and abuse that has been discovered.

These features include:
- poor nutrition resulting from a lack of support at mealtimes,
- rough handling in delivering personal care,
- over-reliance on restraint (both physical and through the over-prescription of tranquilising drugs – the ‘chemical cosh’),
- rigid routines relating to morning and evening bedtimes, going to the toilet and mealtimes,
- lack of attention paid to individuals’ personal circumstances,
- residents being ignored for long periods of time,
- failure to update care plans,
- lack of attention paid to the biographical details of residents leading to failures to meet specific needs (e.g. religious observance, language needs).

Casual staff recruitment practices, a lack of training and a failure to provide continuing and effective supervision of staff once in post have also been identified.

The reality is institutionalisation and the processes associated with it don’t only occur in residential settings. A report from the Equalities and Human Rights Commission published in 2011 showed that it can be found in all settings including in people’s own homes. The EHRC looked at the problem as a human rights issue. The report described cases of older people in their own homes...
not being fed, or being left without access to food and water, or left in soiled clothes and sheets. In other instances older people were ignored by care workers who talked over them, were strip-washed, confined to their home or bedroom, put to bed in the early afternoon or were unable to participate in their community.

Winterbourne View was a specialist private hospital providing assessment and treatment for adults with learning disabilities, complex needs and challenging behaviour. The situation that had been allowed to develop there represented an extreme example of the way institutionalisation affects staff and impacts on the people they are employed to look after.

While the undercover reporting by BBC’s Panorama programme broadcast in May 2011 presented an appalling snapshot of events at the hospital, the subsequent inquiry revealed that this situation had evolved over the three years since the facility was opened. Patients were controlled using forms of restraint that are illegal and often provoked by the cruel behaviour of staff. The staff lacked training and worked in an environment where leadership was lacking and management oversight poor. Several of the staff involved were subsequently sent to prison.

The Care Quality Commission, which by its own admission had been slow to react to reports of the standards and performance at Winterbourne View, subsequently established a special inspection of all such registered services throughout England. This focused on two outcomes: care and welfare of people using services; and safeguarding people who use services from abuse.

The main concerns identified by these inspections related to care planning. An absence of person-centred planning was a significant feature, as was the use of restraint, which was a product of poor care planning, or poor skills among staff, or both.

These examples of abusive care are all too familiar: they are characteristic of the institutionalised regimes from the past. One link between all these cases is that the residents are vulnerable and unable or unwilling to raise the alarm.

**Personalisation, dignity and respect**

Since 2009, the overarching framework for government initiatives to improve care and support has been the personalisation agenda. This connects the key themes of control and choice for all recipients of care and support...
with the call for everyone to be treated with dignity and respect. This is how all modern services should be delivering care. It is how we believe they are being delivered, but experience tells us that this is not always the case.

**Lessons from the past for the present**

In the past, institutionalisation was generally associated with the location, size and scale of the buildings where care was provided. Recent events, however, have shown that these physical characteristics are not the only preconditions for poor and abusive services to develop. Other features are just as significant, particularly for services today.

**Frame of mind:** the key to the growth and entrenchment of institutionalised practice tends to be connected to the frame of mind of the people responsible for providing the service. If those individuals are predisposed to allow institutionalised behaviour to develop then, history shows, it will happen.

**Home and homeliness:** one of the biggest lessons for the champions of community care was the realisation that people in long-stay settings needed to live in places they could regard as their homes. And those homes should indeed be homely, in terms of scale and the manner of care and support that is provided, as well as the range and variety of choices open to them in their daily lives. If buildings are devoid of a homely look and feel, it is easier for staff to forget they are working in someone’s own home.

**Social value:** a more general lesson learned from the past was the realisation that if society places no value on people who are disabled or dependent through age and illness, then it is likely this will be reflected in the way they are treated and cared for. The care that is provided for them is an expression of society’s assessment of their value. Recognition by society of the value of vulnerable people, and its obligation towards them, needs to underpin decisions about prioritising and targeting public spending. One of the key lessons of the past is that if insufficient resources are allocated to enable staff to provide good quality support then institutional routines and practice are much more likely to re-emerge.

**What does this mean for Family Mosaic and other providers?**

There are two key questions for us that we have to continually address: first, how does a large and diverse organisation take on board the lessons learned from the past about how and why the old institutions got it wrong? And secondly, how and why can this type of practice arise in modern settings and what we can do to prevent and recognise early warning signs?

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**Endnotes**

2. South Gloucestershire Safeguarding Adults Board (2012) Winterbourne View Hospital: Serious Case Review by Margaret Flynn
Family Mosaic has been one of the pioneers in introducing personalisation to their services.

Our staff have always worked in a person-centred way, an approach recognised in the good reports we’ve received for our services from the Care Quality Commission as well as their A grade ratings under the Supporting People quality assessment framework. A number of safeguarding alerts in 2012, however, prompted us to look at the issue of institutionalisation in more detail.

When we investigated the services we provide to over 8,000 people, we found that, overall, we provide good quality, homely accommodation for people with mental health issues and learning disabilities. We also have all the necessary strategies and policies that are recognised as being necessary to prevent the growth of institutionalised practice, such as:

- robust safeguarding policies;
- good recruitment practices;
- training and development programmes;
- supervision and appraisal systems.

Even with all of this in place, however, in a small number of services, staff were working in an institutional way. In two shared housing schemes, there were strict routines in place denying people any choice or control. This included set times for getting up, eating and going to bed.

In one scheme a customer’s so-called challenging behaviour was managed by telling them where they had to stand in a room. In another scheme, a customer who kept taking her clothes off had them put on back-to-front to...
stop her undressing. Finally in a third scheme, access to toilets and kitchens were being controlled by staff.

In another scheme the staff team would talk over the customers, gossip was rife and staff had an obsession with housework. So while the home was immaculate, the customers were ignored.

Some of the cases were clearly abuse and staff were immediately suspended and dismissed. While some of the poor practice was associated with staff who had worked in long-stay hospitals, and who therefore may have become institutionalised themselves, others involved had no experience of institutional care.

Recognition of the fact that institutional practice can spring up anywhere, led us to question how this can happen and what can be done to reduce the risks of it happening in future. On reflection, we identified a number of warning signs that might have alerted us to what was going on:

- service users being described by staff as having “challenging behaviour”;
- service users with no communication skills and no way for them to make their views known;
- schemes that although located in the community were still isolated from other people;
- some very dominant staff members who limited the opportunity for other staff to make their views known;
- high staff turnover or, on the other hand, no staff turnover;
- obstacles put in place to prevent unannounced visits (such as “it upsets the customers”);
- locks on doors (“for the customer’s safety”).

In some situations, staff struggled to get involved with customers on a one-to-one basis in activities in the home. They would leave them to watch television, listen to the radio or, as one record stated, “watch staff work”. As a result, customers in these schemes did little more than eat and watch television all day.

Unchanging routines around mealtimes and drink times meant that customers would rarely be taken out of the home to get involved in outside activities in the community. As a result, even the smallest of homes or schemes ran the risk of becoming a mini institution.

Some might argue that a lack of resources resulted in inadequate staffing levels, so that staff were too busy with housework to pay attention to customers or arrange outside activities. Others might suggest that staff had not taken on board the lessons from induction and any subsequent training they had received. Whether or not these were factors, the reality is that it was a long time before a member of staff reported problems up the management line.
One of most challenging questions emerging from our investigation was why did staff not report any of this earlier? Staff and managers had all received training on safeguarding, they had been inducted into the commonly held values of the organisation and they knew that whistle blowing is encouraged. Yet they still did not report poor practice as soon as they saw it.

The role of the scheme manager was also questioned: did they instigate the behaviour, or were they complicit in it? Or did it only happen when they were absent from the scheme? And why did staff not feel able to report their concerns to them?
Why are staff afraid of telling the truth?

Why didn’t staff report poor practice? There may be several reasons behind their reticence.

A culture of fear, blame and punishment: being afraid to speak up. The people who work in a service or scheme are a key source of information on how it is doing, its strengths, its weaknesses and how it could be improved. They have detailed knowledge of the problems staff confront and deal with. Yet they may often find themselves unwilling or unable to report their concerns and alert their managers.

Apathy and lack of concern: it doesn’t occur to them to speak up. In some cases staff may lack the will to make their worries known. It may be they don’t consider their role to keep managers informed of things they ought to know. This can perhaps be expressed as “why should I do their job for them – they don’t do mine”. It indicates a reluctance to take individual responsibility – or as part of a team – for the overall performance of the service and to be committed to providing the best possible quality of life for service users.

Ignorance: they don’t know anything is wrong. Some staff may have become blind to their own and others’ performance, and the impact it has on the people they are employed to support. They may just not know any better or don’t realise there are, or could be, better ways of doing things. In some cases, they may lack confidence in their own judgement of situations involving more experienced colleagues or managers, and consequently refrain from taking action.

Individual cruelty: too much to hide. Although low level abuse is more prevalent than physical or sexual assaults, the situation may arise where the sustained and systematic abuse of an individual’s rights becomes so serious as to cause serious harm. Staff may then – individually or as a team – deliberately withhold information and cover up the real situation by any means available to them. This may include elaborate deceptions such as restricting access by outsiders, even if they are colleagues from their own organisation, to premises or people. Often this will be for spurious reasons, such as professional concerns for an individual’s welfare or claims of infections and illnesses.

The existence and promotion of whistle blowing policies may not be sufficient to counter strong feelings of loyalty towards workmates or a fear of retribution from those same people. At the same time, staff might believe that nothing will change if managers are informed, or that their account of events will not be believed, or that they may be implicated and blamed for the abusive behaviour.
or the team. These may take precedence over their loyalty to, or concern for, those who use services. Managers have a responsibility to ensure an ethos prevails that allows for staff to speak up.

**Why do organisations get it wrong?**
Staff are employed by organisations and the organisation bears ultimate responsibility for what goes on within its services. But they don’t always get it right for a number of reasons:

**Over-reliance on policies and procedures:** most organisations want to do the right thing, to provide a service that meets the needs of its customers in a way that respects their dignity and assures their wellbeing. Developing a model of care applicable to the whole organisation along with policies, protocols and procedures to assure its achievement is a first step. In some cases, though, it simply stops there. The gap between theory and practice is never bridged.

**Distance from the front-line:** decision-makers may tend to be clustered at the top of the organisation, robbing local services of their ability to make meaningful decisions about the running of their service themselves. The top or centre may be reluctant to devolve responsibility down the line, either because it simply wants control or because it doesn’t have confidence in lower level managers.

A disjuncture between the top and the frontline may leave the organisation open to poor practice developing. This is true of any size organisation whether they manage 1 or 100 services: the issue isn’t about the size of the organisation, but about its safeguarding and management culture.

As part of the review we asked other providers of their experience, all those we spoke to had experienced cases of institutional practice in their schemes.
The organisation as a whole, and its top level management in particular, should be committed to continuous monitoring.

They should know what they are looking for using the classic audit loop, feedback and reaction. Policies, protocols and procedures are only useful if they are effective in ensuring overall aims and objectives are achieved. Otherwise they become mantras which may be stated over and over again, but without any understanding or any chance of their being put into practice. Where monitoring throws up evidence of problems, then those problems must be addressed at once and the audit process be put into action to check they have been resolved.

The bigger and more diverse the organisation becomes, the greater the danger that those at the top become disassociated from the front-line. There may be a need to assess how far responsibilities and decision-making powers can be devolved down the system, while ensuring overall aims and objectives are met.

Change that is delayed because it is dependent on approval or resources from higher up can be a recipe for disillusion and loss of confidence in the system. This is especially the case when such change has been enthusiastically accepted by customers and staff alike. Similarly, where the need for physical improvements are identified and promised, but never materialise, there can be a loss of confidence in the centre, as well as a sense of apathy.

Senior management may be understandably reluctant to
devolve decision-making and resource allocation if they don’t have confidence in the ability of lower management to manage effectively in line with organisational aims and objectives. Hence the need for all round improvement throughout the system.

There are certain performance indicators that are widely recognised as possible evidence that poor practice is taking place within the organisation. These include locked cupboards, a lack of engagement and over-tidiness with no evidence of activity. As part of the monitoring process, evidence of this should be regularly examined and followed up. Similarly, sudden spikes in staff turnover, or consistently and unacceptably high levels of staff leaving, may also indicate problems at the front line, and should always be followed up.

In addition, regular analysis and follow up of complaints from customers, their families or friends is essential. These may provide evidence of failure, both individual and systemic. There should also be an organisation-wide understanding that whistle-blowers will be listened to and not persecuted. This needs to be fostered, both during induction and subsequently.

An organisation needs not only to be listening and learning, but also has to be willing to adapt and change.

**Universal truths**

There are some universal truths at the heart of providing good care which will combat any creeping tendency towards institutionalisation. Looking at it systematically, there is a cascade of factors that count. Responsibility for the standard of care and support provided in any service starts at the top, with the owners and directors of the organisation providing the service, whether it’s independent or statutory, as well as those who commission places for the vulnerable people who use it. They must have mechanisms for developing the vision and setting standards and assessing and ensuring that these are met.

Next, the quality of leadership and management is a key component in developing and sustaining a good care service. This links to the quality of staff recruited to provide the service. Their experience, qualifications and commitment to the job of care-giving, and their strength to speak out when practice does not meet the values. Good managers will spot the potential in those aspiring to care.

All staff need to understand the history of care: they need to be able to recognise institutional practice when they see it.

Finally, there is the issue of organisational culture. This is the glue that holds together an organisation, and is critical to thwart the return of institutional practices.
In the light of revelations about the instances of poor practice, it could have been all too easy for Family Mosaic to carry on regardless.

The scale of the problems reported was not extensive (a handful out of 8,000 customers) and nearly all of our services provide excellent care and support. We could have written off these incidents as the actions of a few rogue staff.

Instead of being complacent, however, we recognised the need to reiterate messages to all of our staff so that they understood the dangers of the encroachment of institutionalised care. We wanted them to be able to look openly and honestly at how they and others worked, so they would have the courage to report practice that was not in line with the values of the organisation. So we introduced a programme called Changing Direction, which was rolled out across our care and supported housing services.

This included back to the floor days for all senior managers including the Chief Executive and Executive Directors, as well as setting up a ‘concerned@’ mailbox, so staff were able to report concerns anonymously.

A series of training days were held for all staff teams starting with a dedicated managers day, that included a look back to institutional care, the current picture and how to prevent re-institutionalising care. We recognise that this sort of initiative cannot be a one-off, and will be repeated regularly, as well as via inductions.

Developing a model and good practice to combat institutionalisation

The recent national scandals and our own and others local issues show that every service needs to guard against the development of institutionalised practice.

If providers think it has never happened in any of their services,
the question needs to be asked as to whether they have ever looked.

To prevent the development of institutionalisation, the operation of each service should be based on a clearly articulated model of care and / or support. This should incorporate the fundamental principles of personalisation, dignity and respect, and demonstrate very clearly the values staff should embody.

Every member of the organisation should be aware of and subscribe to delivering a service that:
- fully meets customers’ physical, social and emotional needs;
- is provided by caring and competent staff who have an empathy and understanding for all their customers;
- respects customers’ dignity and privacy, and gives them choice in all aspects of their daily life and overall life goals;
- develops and changes according to customers’ needs and wishes over time;
- respects customers’ human rights and is always alert to the dangers of abuse;
- does not rely on rigid routines around the activities of daily life (for example, in a residential setting, going to the toilet, bathing and washing, getting up and going to bed, monotonous and repetitive menus at mealtimes, and monotonous social activities);
- enables customers to maintain their relationships with family and friends.

The service should cultivate an outlook that governs a truly caring approach that involves:
- identifying and championing leadership, recruiting the right person as manager or to another leadership role, with the necessary competencies and qualifications, while ensuring the person receives appropriate professional development training once in post;
- valuing the qualities of empathy and compassion in everyone working or volunteering for the service;
- prioritising the training of staff, ensuring in addition to comprehensive induction that everyone receives additional training over time;
- a knowledge of what is required: having a model of what constitutes good...
care in a particular setting with the manager and staff working to a model of care which is clearly articulated;
  ✔ regular rotation of managers so that new eyes and ears are constantly in place;
  ✔ a revisiting of values with the staff team on a regular basis, ensuring that the message has not been forgotten or watered down.

While providers are required to have policies relating to the prevention of abuse and to demonstrate the steps they are taking to safeguard the people they are looking after or supporting, it is what staff do on a day-to-day basis at the individual level that is most important. How each member of staff goes about their work, the attitudes they display towards individual customers, their families, and their colleagues and managers are what count. In other words, small things make a big difference in determining what people think about the services they receive.

Individuals should feel valued and confident that the care and support they receive has been truly tailored to meet their particular needs. This, after all, is the core of what personalisation should mean.

**Change from top down and bottom up**

Given the range and diversity of provision, it is helpful to distinguish between those strategies which apply across the board on the one hand and those that are more relevant to some services than others.

**Across the board:**
  ✔ an organisation-wide spelling-out of the philosophy of care and support on which all services are based (for example, respect, dignity, choice, individuality) that is constantly brought to the attention of the whole organisation;
  ✔ a profile of what providers look for in staff, that governs their recruitment policy and in-service training programme (for example, possession of empathy and understanding, skills and qualifications required) that is regularly reviewed and updated;
  ✔ an agreed understanding of what constitutes poor practice involving a challenging and reflective scrutiny of the organisation’s services regularly. This should involve learning from mistakes by analysing causes when things go wrong, and looking at the reasons behind safeguarding alerts and complaints;
  ✔ constant vigilance in guarding against the danger of institutionalised practice against the key criteria: isolation, curtailment of liberty, loss of personal identity, lack of engagement, staff’s lack of empathy;
  ✔ welcoming the involvement of families and friends and the local community to ensure external scrutiny is based on the positive principle of openness and not just on bureaucratic obedience to official inspection.

**Service specific, front-line issues:**

A series of briefings on the theme ‘Think small, think personal – make a difference’ have been devised as an aid for staff and are appended to this report (see pages 28-31). They provide detailed examples of how managers and staff can guard against the drift towards poor practice and the encroachment of institutionalised attitudes, whatever the setting. They look at how the key principles of choice, dignity and respect can be operationalised in different settings by members of staff who interact directly with their customers. They provide a template which can be built on by groups of staff themselves, using them as guides for their own reflective practice.

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Endnotes

4: see, for example, www.scie.org.uk/socialcaretv/video-player.asp?v=whatisexcellence and www.nssocialcare.co.uk/programmes/emerging-leaders-programme
The old institutions of the past were recognised as places that often brought rise to poor practice, severe conditions, regimented and abusive behaviour, and were lacking any choice or control for the vulnerable adults living there.

This report has shown that it is not always easy to get rid of the institutionalised practice and attitudes of the past. Even with the advent of community care and personalisation, institutional care still arises in modern care and support settings. Thankfully these cases are in the minority.

The majority of current provision does provide a home with quality care and support, choice and control over how people live their lives. None of us can be complacent. A change in buildings does not automatically mean a change in care.

The report raises the question of funding resources for long-term care and what value society puts on our most vulnerable citizens. Institutionalisation is not all about the level of funding, but scarce resources can lead to inadequate staffing levels, along with poor quality staff. Commissioners have to be wary of this.

The report sets out some other reasons for institutional care, showing how poor practice can re-emerge — and how it can be combated — even in the best of care services. It argues that care providers need to be constantly vigilant against the risk of poor practice developing insidiously.

Our commitment to such vigilance is evident in the actions we have taken and the effort we have made. Other providers need to be just as vigilant if we are collectively to stop institutional care coming back to modern settings.

Conclusion
Everyday activity – keeping things private
Living with others – or being reliant on others for help around the house with various daily activities – brings safety, security and companionship. It also increases the scope for losing control of the detail of daily living, and key parts of a good life.

Life may become – or feel – altogether more public, with staff discussing matters related to a person’s wishes or care needs in front of others.

There may be times when you get drawn into discussing a customer with a colleague when passing in a hall or on the stairs. While this may be entirely natural – to pass on information when you remember or see the person who needs to know – it could compromise privacy and possibly break confidentiality too.

So, think carefully as to whether what you are saying can be saved for another time or another place, and whether your conversation could be overheard by others.

Sometimes breaches of privacy may not be about what we say, but what we do – for example whether doors are shut when intimate care is being given or discussed. Doors to toilets and bathrooms – located in areas where passers-by can unwittingly catch a glimpse of someone should always be kept closed and have signs stating whether they are engaged or vacant. Good record keeping means we are likely to have lots of information written down about the people we are looking after – this should not be left open or accessible in offices so that visitors, regardless of who they are, can see this information unless specific consent has been given by the person concerned.

Individual customers may choose to keep the door to their own living space open – so that they can watch the world go by – but others may choose to have it closed, yet find that this is not respected, either by people coming into the room, or when they leave.

One way of thinking about the importance of this topic is to consider when the last time was that someone, a stranger or a friend, perhaps of the opposite sex, saw you washing, dressing or preparing to get into the bath? Is your personal correspondence read aloud in front of others with whom you haven’t chosen to share the content? How do you feel when you overhear others talking about you?

Priorities for action
There are some simple rules, most likely already written down as Family Mosaic policy, that any member of staff can follow to ensure that privacy is upheld:

▶ never enter a customer’s room without knocking and waiting to be invited to enter – your knowledge of individuals will help you to decide whether you need to vary this due to, for example, poor hearing, or concern about risks to health;
▶ when leaving a customer’s personal space – whether this is a room, or a flat – always ask whether the occupant would prefer that you close the door, or leave it open;
▶ never assume you know the answer to that question on the basis of their previous answers – today, or any other day;
▶ someone happy to have the door wide open yesterday, or even earlier today, may want the door closed for peace from the sounds of others, for personal privacy, to avoid being distracted while watching or listening to a favourite programme, or simply as a change;
▶ always avoid discussing private matters in public spaces, whether with the resident, family members, other members of staff, visiting professionals or other customers;
▶ ensure that paper and computer records are kept confidentially, including using passwords to restrict access.

Finally

▶ How easy is it to overlook a user’s privacy in your service – and in what ways?
▶ How do you make sure that you and your fellow staff don’t fall into the bad habit of overlooking customers’ privacy?

Think small, think personal – make a difference
Everyday activity – dignity
Dignity is a key principle in looking after people, whether we are helping them to live independently in their own property, in a group home, or with much more support in a registered care home.

Our commitment to high standards means we should always think about the way that we provide support to customers so as to protect and promote their dignity.

Some of what we do – or avoid doing – will be similar to the issues raised in the context of privacy, as some of the most common ways that dignity can be compromised or undermined arises when we don’t pay enough attention to privacy either when giving personal care or when discussing matters associated with an individual’s needs.

The way we talk to people, especially in the company of others, or the language we use to describe a situation and our customer’s needs can also give the impression that we don’t value them or their dignity.

Priorities for action – by you
The overall theme of these briefings for staff is that you can do small things that make a big difference to the lives of the people you are looking after. So, identifying the things that you can affect is the starting point:

- ensure that you always approach personal care matters in a way that gives customers the same – or higher – level of privacy as you would expect for yourself;
- avoid discussing intimate or confidential matters in public or communal spaces, or getting drawn into conversations with colleagues, staff of other agencies or visitors in places where you can be overheard by others;
- consider carefully the language you use to address or talk about your customers, some may like to be called by their first name others their full name, don’t assume you know;
- respect the choices that people make even if they aren’t what you would choose;
- review as a staff group instances where you – or others – have failed to meet these basic standards so that you can avoid repeating them.

Obstacles to making this happen
Having the time to get to know your customer’s, how they like to be addressed, how they like to be approached when busy or when very familiar with the customer it’s easy to forget.

This more considered approach like other aspects of a personalised service is likely to take longer and so you and your manager will need to identify the best ways of ensuring that time is well used.

Visiting professionals or family members may not understand why you don’t want to talk about a customer for example on the stairs or in the lounge and so you will need to provide a crisp clear explanation of your commitment to providing support in a way that protects and promotes the dignity of all our customers over and above the convenience of any professional.

Finally
- How easy is it to undermine a customer’s dignity – and in what ways?
- How do you make sure that you and your fellow staff don’t fall into the bad habit of talking about people as if they are not there, or have nothing to contribute to a discussion?
- How easy is it for you or other members of staff to raise their concerns about the way we talk about the people we are looking after?

Think small, think personal – make a difference.
Everyday activity – raising difficult issues
It is often the things that most need to be discussed with managers and colleagues which are most difficult to raise because they may seem critical of “the way we do things here”. But experience tells us that difficult issues rarely go away of their own accord, and frequently become bigger issues because they aren’t dealt with.

You may be concerned not to appear disloyal to colleagues who are also friends, on whom you rely to enjoy coming to work. You may also be worried that raising issues will make life difficult for you, perhaps leading to being shunned by people you work with, or for the customer whose interests you were intending to protect.

But these worries that lead you to hold back from talking about bad practice, or individual shortcomings may be quite minor when compared to the situations for customers unhappy with the way in which they are looked after. They may be bothered by the tone of voice or content of conversations they have with staff they rely on, or by being ignored.

Knowing that something isn’t right and doing nothing about it should not be an option you consider – in that situation you are as much a part of the problem as those staff who have let their standards slip.

Sometimes customers may not feel confident to raise their concerns with any member of staff and so ensuring that they are aware of and assisted to make contact with other sources of support – either a befriending scheme that could match them up with a non-professional who will look out for them – or a professional advocacy service that will support them to get their voice heard.

Priorities for action – by you
The overall theme of these briefings for staff is that you can do small things that make a big difference to the lives of the people you are looking after. So, identifying the things that you can affect is the starting point:

- whatever your role you have a duty to raise any concerns about poor practice;
- use supervision sessions to raise concerns, to seek support to challenge others and to plan ways of doing this in a constructive fashion;
- suggest staff meetings address topics such as dignity, engagement and empowerment in a way that develops individual and collective understanding and improves skills;
- ensure that customers are aware of and assisted to make use of other sources of support and friendship.

Obstacles to making this happen
Staff groups or individuals within them, may be defensive in the face of any criticism, and may close ranks in the face of challenges to their established routines.

Customers may be too frightened to raise their concerns or consider it pointless as they have mentioned issues before without any action being taken.

We may be cautious about encouraging outsiders – individuals or organisations – to get involved with our customers because they may challenge things we were unaware of and could unsettle both customers and staff. Individuals who might like to befriend customers may be unaware of the opportunities or reticent because they can see the scope for conflict with staff or other customers.

None of these issues ought to be allowed to get in the way of addressing matters of bad practice.

Finally

- Do you have regular personal supervision sessions and group or staff meetings – and do the agendas for these meetings include opportunities to raise critical issues?
- Do you have links with groups, organisations or individuals who could become buddies for your customers?
- Are customers supported to link up with outside organisations that could provide them with additional support to get their voice heard?

Think small, think personal – make a difference.
Everyday activity – choosing
We all expect to be given choices about things we buy, and the services we use so it’s reasonable for tenants/residents/customers and their families to expect to be given choices about the way they live no matter whether the service we are providing is a registered home or supporting people to live as independent a life as is possible in non-registered housing.

Our commitment to high standards has at its heart a commitment to enabling our customers to make known and act on their choices about all kinds of things affecting their life including how their home is decorated and furnished.

Dependent on the kind of service – independent living, group homes or a residential care home – some kinds of choice present more difficulties than others. For example it’s easier to manage a staggered start to the day, with breakfast being offered over a much longer period of time than may be possible for the main meal of the day, at lunchtime or in the evening. Choosing what to eat, from a range of possible choices, is now firmly established as routine rather than out of the ordinary, but may present problems in cooking sufficient quantities of each of the meals available on any given day or in having items available in the stock cupboard if someone changing their mind on what they'd like to eat. Anyone with a family knows this issue all too well.

Groups of people living together have many different interests that may sometimes lead to conflicts between individuals or groups, for example heavy metal fans may believe that the only way to play music is at full volume, while others consider this to be an awful din. You’ll need to devise strategies for mediating between people that are open, honest and fair – tricky, but vital to ensure that people have a good life.

Priorities for action – by you
The overall theme of these briefings for staff is that you can do small things that make a big difference to the lives of the people you are supporting. So, identifying the things that you can affect is the starting point:

► ensure that customers are assisted to make choices about things that matter to them – there may be some core themes that affect everybody, but there will be other matters that are all about individual choices;
► start with those topics over which staff have greatest control and therefore most likelihood of your being able to demonstrate that you have listened to - and heard – the person’s opinion;
► review as a staff group the topics identified in this way to see where collective action needs to be taken or whether policies may need to be changed;
► timing of some activities may create the biggest headaches for both parties – user and supporter. But some of them can be adjusted more readily: think about making a list of the easy topics and the more difficult or challenging ones;
► try to explain why something is not possible, rather than simply saying "I can’t do that";
► record details of choices in care plans - but don’t make the mistake of thinking today’s preference is tomorrow’s too!

Obstacles to making this happen
Individuals’ choices may conflict with one another, causing you to have to think through ways of mediating between two or more people. Sorting out these conflicts may take time and eat into the time you had set aside to assist people to fulfil their wishes.

People are more likely to be understanding and prepared to compromise if you explain the difficulties the team is having meeting lots of needs at the same time.

Finally
► How easy is it to overlook asking users to make choices in your service – and in what ways?
► How do you make sure that you and your fellow staff don’t fall into the bad habit of overlooking opportunities for customers to make choices?

Think small, think personal – make a difference
Credits

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