Making the Most of it

International perspectives on safeguarding frameworks and the move to individualized funding

STAFFORDSHIRE UNIVERSITY

THE CONNECTED UNIVERSITY

An Opportunity

People with disabilities, families, friends, all of us here

Where do we start….

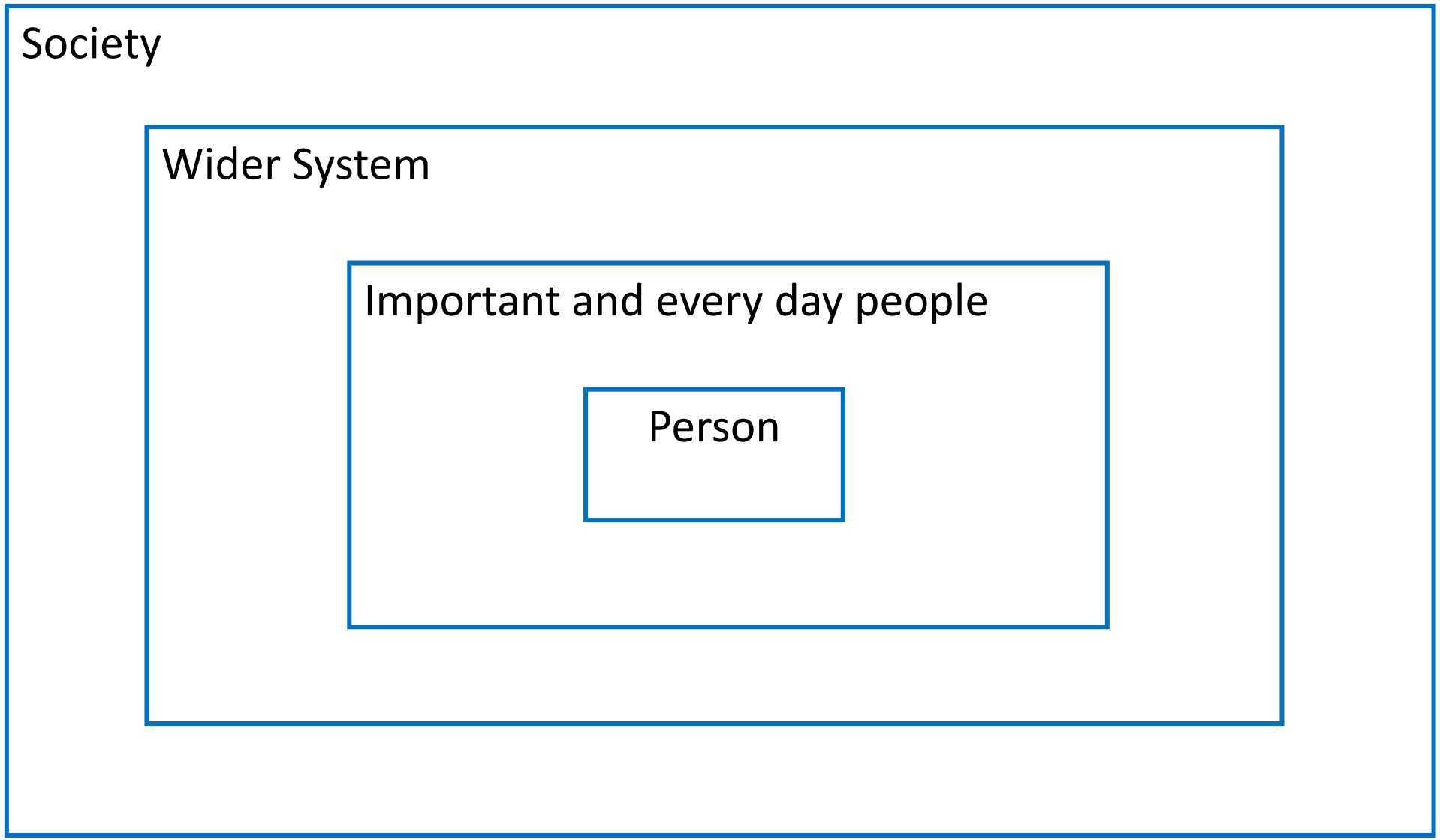
- All human beings and all citizens – face to face

- Hope and possibility

Outline

- Introductions
- Context
- Outcomes
- Response
- Start again - theory and evidence
- Start again – what might we do
- Remember why and stay hopeful

Greetings from Kingston upon Hull and Stoke on Trent


Society
Wider System
Important and every day people
Person

Context – Society: the plan

From deserving poor, patient and consumer to: Citizen

- Beautiful
- Powerful
- Part of things
- Ordinary
- Vulnerable but secure

Context: Wider System – the plan

- Change in relationship
- In community
- It won’t happen here
- New types of support
- Separation of work, home and play

Context – families and supporters – the plan

- Facilitators and enablers
- Allies and Advocates
- Active citizens
- Listeners and fellow travellers

Context - Person the plan

New kind of relationship

- Increased choice and control
- New experiences and opportunities
- Influencers and contributors
- Friends and lovers

Person – what happened

- Some improvement in choice and control for
- Genuine progress in work, love and life

… for some

- No change
- Small unkindness's leading to gross violations

…. for others

Families and supporters – What happened

- Everything we planned

… for some

- Fearful box tickers
- Abusers
- Leavers

… for others

Wider System – what happened

- New Types of Support
- New and important opportunities
- No single model
- No coherent funding system
- Vast unregulated workforce
- Scandal

Wider System – what happened

- Solution defined in terms of a service model
- Aggressive target driven “transformation”

Reactive Target Driven – no more hospitals

Society – What happened

- Attitudes – the same
- Actually still characterized by generosity and tolerance
- Who’s to blame
- It must never happen again

Starting over – Two foundations

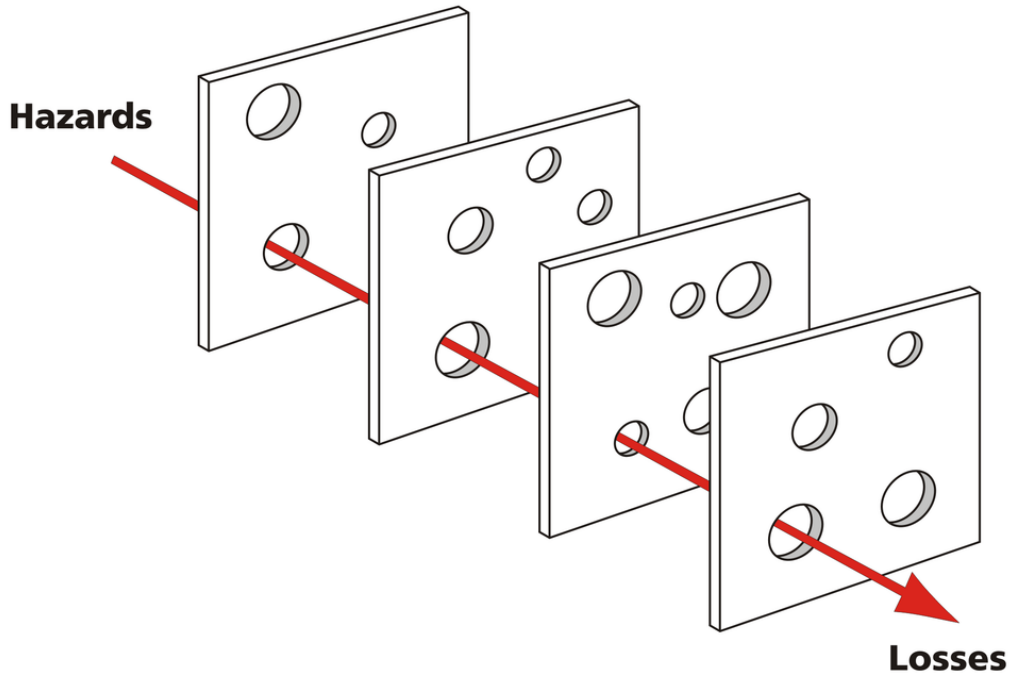
- Why
- What
- How

- Principles
- Ends justify means

- Virtues
- Face to Face

When things went wrong

Swiss cheese model



Doing the wrong thing – What's going on?

Three possibilities:

- individual ("bad apples")
- ethical issue itself ("bad cases")
- organizational environment ("bad barrels")

The individual

- Moral Development - reasoning
- Idealists not relativists – never harm or harm may be necessary to do good
- Impulse not planning
- Machievelli
- Locus of Control
- Job satisfaction

(not gender, age or education)

The individual

Virtues

- Anticipation and preparedness
- Awareness of self
- Conscientiousness
- Humility
- Vigilance

The Teams

- In some studies up to a third of standard team tasks and checking were not completed

- A team that is working poorly multiplies the possibility of error. Teams that work well are safer than any one individual.

The case

- Moral intensity – how big an issue it would be and the social consensus – general sense was very strong predictor
- Do we as a society still give the impression that we want people out the way?
- Does it do any real harm – they don’t know it’s wrong, not like us…

The Barrel - People Create safety

- We didn’t know…
- Culture, Climate and Leadership

We didn’t know: Listen to people and families

- People are not only experts in their own experience but also in the system of support they are experiencing

- The first to notice the small unkindness, mistake or humiliation (someone else’s jumper)

We didn’t know: Listen to people and families

- People probably won’t fill in a form or challenge directly
- 30% of people said they would challenge a doctor or nurse who didn’t wash their hands and only 5% actually did

None of us knew – Listen to the System

- Research interviews
- Analysis
- Indicators –people with learning disabilities and older people

None of us knew - Indicators

Management and leadership

- The Manager can’t or won’t make decisions or take responsibility for the service
- The Manager is often not available
- There is a high turnover of staff or staff shortages

Staff skills, knowledge and practice

- Members of staff appear to lack skills in communicating with individuals and interpreting their interactions
- Communication across the staff team is poor
- Abusive behaviours between residents are not acknowledged or addressed

None of us knew - Indicators

Concerns about wellbeing and behaviour

- Communications and interactions change – increasing or stopping
- Behaviour change – perhaps becoming withdrawn or anxious

Concerns about isolation

- There is little input from outsiders
- Not maintaining links between individuals and people outside of the service e.g. family, friends,
- Hostile or negative attitudes to visitors, questions and criticisms

None of us knew - Indicators

Concerns about the way services are planned and delivered

- Peoples' needs are not being met as agreed and identified in care plans
- The group appears to be incompatible
- The diversity of support needs of the group is very great

Concerns about the quality of basic care and the environment

- There is a lack of care of personal possessions
- Essential records are not kept effectively
- The environment is dirty/smelly
- There are few activities or things to do

Concerns about management and leadership	Concerns about staff skills, knowledge and practice	Concerns about residents' behaviours and wellbeing
Concerns about the service resisting the involvement of external people and isolating individuals	Concerns about the way services are planned and delivered	Concerns about the quality of basic care and the environment

The Barrel

The Climate

- Egotistical promoting self interest (weak)
- Benevolent - individuals see that what is best for employees, customers, and the community is important in the organization
- Principled - principled organizational climate, decisions are perceived to be based on formal guidelines, such as laws and explicit policies regarding appropriate behaviour

The Barrel

The culture

- Expectations as seen in employees' beliefs about the patterns of ethical and unethical conduct that the organization supports or discourages.

- Systems such as leadership, norms, and reward policies encourage the achievement of bottom-line goals only, with no attention to ethical concerns, the culture is more likely to support unethical conduct. (strongly affirmed)

- Code of Conduct - only if enforced

So what – People make Safety

- Listen to people
- Listen to teams
- Listen to the service
- Climate and Culture

In case we haven't got that…

The psychology of error and human performance,

- Many errors are beyond the Individual's conscious control and are precipitated by a wide range of factors, which are often also beyond the individual's control
- Systems that rely on error-free performance are doomed to failure
- Error prevention that relies exclusively on blame, discipline and training is also doomed to failure

Leape 1994 p1852

People make safety

- Listen to people on a daily basis
- Listen to people who love the person

People make safety – Good apples

Can we keep from picking bad apples?

- Probably but demographic strategies are not likely to be useful
- Instead select the most likely to behave ethically (on impulse)

People make safety

Looking after people and teams

- Virtue ethics
- Supervision – individual and team
- Clarity and communication

People make safety – face to face

- For example, unethical behaviour may be reduced if employees learn to associate potential unethical behaviour with severe, well-defined harm (magnitude of consequences) to a familiar or recognizable victim similar to the actor (proximity).

- Likewise, organizations may be able to prevent unethical behaviour by making behavioural norms (creating strong social consensus) more prominent and clearly defined.

People make safety

Culture is key but work on the climate

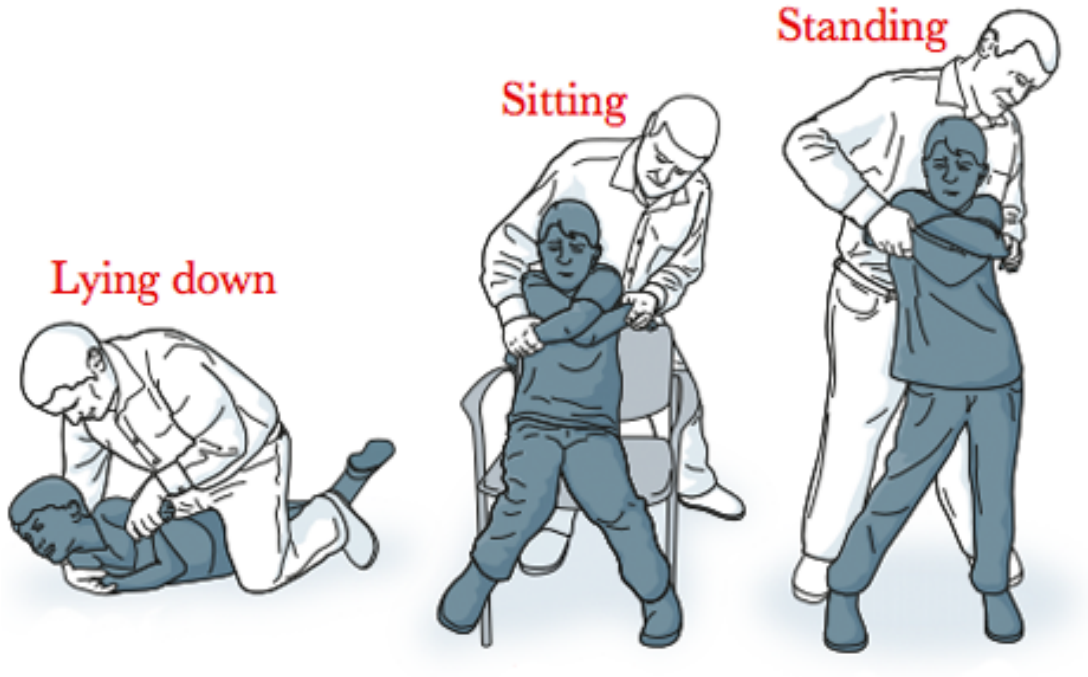
- Further, our results suggest that organizations interested in gauging how employees perceive their broad ethical environments should assess the three climate dimensions

- Fostering self interest is there but weaker than ***Benevolent*** and ***Principled***

Before you go…

We need to talk about…

Restrictive Interventions



Restrictive Interventions

The huge variation in the use of physical restraint across England is unacceptable. In a single year, one trust reported 38 incidents while another reported over 3,000 incidents.

Face down restraint? - last year alone it was used over 3,000 times. Yet some trusts have put an end to face down restraint altogether.

A report on physical restraint in hospital settings in England June 2013

mind.org.uk/crisiscare

We need to talk about

Survey of physical restraint, PRN medication and seclusion use in 931 children and adults with learning disabilities. Fully 36% of the sample has been restrained, 22% had been secluded and 27% had received PRN medication

Having a behaviour plan predicted restraint and seclusion

Sturmey, 2009

We still need to talk about

- No form of strait-waistcoat, no hand-straps, no leg-locks, nor any contrivance confining the trunk or limbs, or any muscles, is now in use. The coercion chairs, about forty in number, have been altogether removed from the wards.

John Connolly (1840, cited in Deutsch 1946)

We need to talk about…

We found examples of where staff have taken action that has resulted in a marked reduction in the use of physical restraint and seclusion. However, we remain concerned about the high use of restrictive interventions in some inpatient services. (CQC report, 2014-2017)

A little less conversation…

- No more policy papers! No more surveys!

- Researchers have thoroughly documented the problem of excessive use of restrictive behavioural practices and their negative effects. We must now move towards the safe elimination of restrictive behavioural practices for both individual clients and entire services: It can be done!

Sturmey, 2009

It can be done

- Information gathered
- Training
- Presence by managers
- Team to support and encourage newly trained techniques.
- A formal system to learn from each restraint and prevent the situation in the future.

It can be done

Results

- The use of physical restraint reduced by 99.4% and client-induced employee injuries by 37.7%

Saunders, 2009

So what – People make Safety

- Listen to people
- Listen to teams
- Listen to the service
- Climate and Culture

Now I will stop!

References

- Kish-Gephart, J.; Harrison, D. and Klebe Trevino, L. (2010) Bad Apples, Bad Cases, and Bad Barrels: Meta-Analytic Evidence About Sources of Unethical Decisions at Work. Journal of Applied Psychology 95(1):1-31 · January 2010
- Leape L. (1994) Error in medicine. Journal of the American Medical Association, 272(23):1851-7.
- Sanders, K. (2009), The Effects of an Action Plan, Staff Training, Management Support and Monitoring on Restraint Use and Costs of Work-Related Injuries. Journal of Applied Research in Intellectual Disabilities, 22: 216–220. doi:10.1111/j.1468-3148.2008.00491.x
- Sturmey, P. (2009), It is Time to Reduce and Safely Eliminate Restrictive Behavioural Practices. Journal of Applied Research in Intellectual Disabilities, 22: 105–110. doi:10.1111/j.1468-3148.2008.00476.x
- Vincent C. Patient Safety, 2nd edn. Oxford: Wiley Blackwell; 2010.

References

- Bright, N.; Hutchinson, N.; Marsland, D. and Oakes, P. (in press) Families' experiences of raising concerns in healthcare services: An interpretative phenomenological analysis. Journal of applied Research in intellectual disabilities.
- Marsland, D., Oakes, P., and White, C. (2007) Abuse in Care? The identification of early indicators of the abuse of people with learning disabilities in residential settings. *The Journal of Adult Protection* 9 (4) 6-20
- Marsland, D., Oakes, P. and White, C. (2015a) "Abuse in care? A research project to identify early indicators of concern in residential and nursing homes for older people", *The Journal of Adult Protection,* **17**; 2, pp.111 – 125
- Marsland, D., Oakes, P., & Bright, N. (2015b). It can still happen here: systemic risk factors that may contribute to the continued abuse of people with intellectual disabilities. *Tizard Learning Disability Review*, *20*(3), 134–146
- Oakes, P. (2012), "Crash: what went wrong at Winterbourne View?", Journal of Intellectual Disabilities, Vol. 16 No. 3, pp. 155-62.
- White, C., Holland, E., Marsland, D. and Oakes, P. (2003), "The identification of environments and cultures that promote the abuse of people with intellectual disabilities: a review of the literature", Journal of Applied Research in Intellectual Disabilities, Vol. 16 No. 1, pp. 1-11.

Stay in touch ☺!

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