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## Wicked problems or wicked people? Reconceptualising institutional abuse

Diane Burns<sup>1</sup>, Paula Hyde<sup>2</sup> and Anne Killeth<sup>1</sup>

<sup>1</sup>*Faculty of Medicine and Health Sciences, University of East Anglia, Norwich*

<sup>2</sup>*Manchester Business School, University of Manchester, Manchester*

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**Abstract** Institutional abuse is a global issue, sometimes ascribed to the behaviour of a few wicked people. It persists despite regulatory measures, interventions from enforcement and protection agencies, organisational policies and procedures. Therefore, the accurate recognition and early detection of abuse and taking corresponding steps to deal with perpetrators are critical elements in protecting vulnerable people who live in institutions. However, research is less clear about why and how abuse (re)occurs. Using the tame and wicked problem analysis of Rittel and Webber (1973) as a lens, we examine the ways institutional abuse is formulated in care settings. Drawing on case study data from eight care homes for older people, we show how solutions seeking to reduce institutional abuse and improve care quality can cause additional problems. The article reconceptualises institutional abuse through the lens of wicked problem analysis to illustrate the multifaceted and recurring, wicked problem characteristics of residential care provision.

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**Key words:** institutional abuse, older people, residential care, wicked problems

### Introduction

Institutional abuse in the form of neglect, mistreatment and loss of dignity, has been described, somewhat dramatically, as: 'the violent cancer in the world of caring' (Bennett *et al.* 1997: 2, see also Hawes *et al.* 2001, Hawes, 2003). As populations grow older it has become an increasingly important issue for governments in over 25 countries (Canadian Network for the Prevention of Elder Abuse 2009). In the UK alone there are around 6000 registered care homes providing care for over 400,000 older people and demand continues to grow (Laing and Buisson 2009). At the same time, abuse has been a significant problem in UK care homes. During 2009-2010, 400 regulated adult care services in England were rated as poor, with 34 care homes and eight staffing agencies being forcibly shut down and 39 care homes closing voluntarily (Care Quality Commission [CQC] 2010a). Abuses were related to the unsafe management of medicine, the lack of medical or nursing care, sanitation and insufficient staff training. A fundamental challenge is how to develop practices that enable the provision of residential care that can safely meet the individual needs of residents. The growing problem of institutional abuse has come to the fore in recent years as, most recently, CQC (2011) found that one in five hospitals inspected in England and providing care to older people were neglectful to the point of being illegal.

Abuse has been linked to poor management and lack of training, as well as being blamed sometimes on the abhorrent behaviour of a few wicked people (Martin 1984, Walshe and Higgins 2002). In this article we draw on Rittel and Webber's (1973) work on tame (well-defined and solvable) and wicked (ill-defined and difficult to solve) problem analysis as a lens to examine the issue of institutional abuse. We also examine solutions put in place to improve the quality of care or organisational performance, or both. To provide this theoretical analysis, we draw on empirical data from a study undertaken as part of a research project to examine the institutional dynamics of respectful care and mistreatment in residential care homes for older people. We show how solutions, often informed by tame formulations of the issue, either generate alternative problems or fail to solve the problem in the long term. We offer a reconceptualisation of institutional abuse to illuminate its multifaceted and recurring wicked characteristics.

This article makes a contribution to work in two previously separate academic fields. The first addresses problem-solving and definition and the second addresses care service failures. By bringing these strands of work together we show the existence of institutional and organisational aspects of abuse and consider the impacts on organisational performance, focusing specifically on institutional abuse. To accomplish this, the article first reviews the emerging literature on wicked and tame problems. It then draws on a more extensive literature that dates back to Goffman (1961), which examines the issue of service failure in institutions such as hospitals and care homes. After the research design, five examples from empirical research are presented to illuminate the wicked characteristics of institutional abuse in residential care provision. Finally, the article concludes by outlining pertinent implications of reconceptualising institutional abuse as a wicked problem.

### *Problem-solving and definition*

The concept of wicked problems refers to resistant, complex and recurring issues that are incompletely described and seem to have competing and changing requirements (Rittel and Webber 1973). Rittel and Webber use the term wicked 'in a meaning akin to that of "malignant" (in contrast to "benign"), or "vicious" (like a circle) or "tricky" ' (1973: 160) rather than denoting ethically unacceptable (evil) problems. They characterise wicked problems as those (i) with no definitive formulation; (ii) with an open-ended search for a solution; (iii) with solutions that are not true-or-false, but good or bad; (iv) with no rules to determine the correct explanation of a problem; and (v) where every wicked problem is a symptom of another problem. Thus, wicked problems involve chains of events that are interlinked and interdependent in spite of their seeming to be unrelated (Conklin 2006). Solutions to one problem tend to generate new problems. A simple example occurs where processes are speeded up in one part of a system and backlogs start to build up in another area.

In contrast, tame problems are relatively well defined and stable, have definite stopping points (that is, one knows when the problem is solved), have solutions that can be objectively evaluated as being right or wrong, belong to a class of similar problems that can be solved in a similar manner and have solutions that can be tried and abandoned (Rittel and Webber 1973). Where a problem resides on the continuum of wickedness to tameness is defined not only by how hard the problem is to solve but also by the extent to which the problem can be solved using conventional methods (Conklin 2006).

In relation to the first characteristic of wicked problems – having no definitive formulation – there is no definitive definition of institutional abuse (Dixon *et al.* 2010). In a review of 13 public inquiry reports about institutional abuse (Killett *et al.* 2012) organisational features commonly associated with institutional abuse were identified. These

reports are written as if the problems were amenable to definitive description as the result of particular issues with definitive solutions. Examples include the following: inquiries have explained abuse as a problem of weak and ineffective management (and thus solvable by stronger management); inappropriate and inconsistent application of guidelines and policies (solvable by a review of policies), insufficient recording keeping and monitoring (solvable by risk assessments and quality assurance mechanisms), poorly prepared staff (solvable by training); staff shortages and low morale (solvable by increased resourcing and professional development opportunities). However, the problem of institutional abuse has not responded to tame solutions and it is notable in its persistence. It is also wicked in that it is commonly considered to be a symptom of other familiar sets of problems (Walshe and Higgins 2002). In addition, each problem is linked to a particular recommendation and consequently a definitive formulation of the problem and solution is shown to be elusive.

Building on the work of Rittel and Webber (1973), Grint (2005) identifies three types of problem construction: tame, wicked and crisis. He highlights how decision-makers' construction of the problem legitimates the types of responses that tend to be put forward. For instance, responses to tame problems focus on linear solutions such as changing processes and policies, whereas responses to wicked problems focus on asking more questions to deepen the understanding of related issues. Problems construed as crises lead to command responses by decision-makers. Thus the way a problem is formulated is argued to legitimise the deployment of certain types of authority (Brown 2004). We argue that institutional abuse in care homes is formulated in two different ways; in the care homes themselves it is seen as a tame problem requiring linear solutions (see, for example, Bennett *et al.* 1997) and at a national level it is seen as a crisis problem requiring command and control responses (see, for example, Benbow 2008, Hannigan and Coffey 2011).

Wicked problem concepts have been applied recently in the health arena, for example, in mental health care (Hannigan and Coffey 2011), in quality and safety outcome measures (Harris *et al.* 2009) and in health inequalities (Blackman *et al.* 2006). However, there is a tendency to seek tame solutions for wicked problems (see, for example, Harris *et al.* 2009). Wexler cautions against the tendency to use a wicked problem formulation to generate solutions to tame the problem, as wicked problems are inherently unsolvable using one-off interventions (Wexler 2009). We suggest that, when faced with a wicked problem such as institutional abuse in a residential care home for older people, decision-makers may be tempted to treat the problem as if it is tame because each facet of the wicked problem appears reducible to a particular issue or solution.

### *Institutional abuse*

Institutional abuse in care organisations involves repeated acts and omissions due to either the regime in the institutions or abuses perpetrated by individuals directed at another individual in that setting (Bennett *et al.* 1997). More recently UK health policy describes institutional abuse as: 'a lack of positive response to complex needs, rigid routines, inadequate staffing and an insufficient knowledge base within services' (Department of Health and Home Office 2000: 12). There has been limited research into institutional abuse since Goffman's (1961) study of total institutions. Goffman showed how institutions control their members' needs en masse using bureaucratic means. He proposed that members of a total institution suffer degradation via social and physical abuse and they are divested of their roles in life and their property. They are subjected to objectifying regimes and procedures. This historic work has been used to identify negative aspects of hospitals and care homes and to identify measures for countering adverse effects. For instance, good practice is associated with the avoidance of batch living; increasing privacy, breaking down

institutional regimes and providing care for people in smaller groups (Cantley 2001). Other works examining mistreatment from multiple perspectives, interviewing people from across different groups within the elder care community, show the effects of established organisational routine in episodes of neglectful care of residents (Buzgová and Ivanová 2009, Lee-Treweek 1997, Teeri *et al.* 2006, Wiener and Kayser-Jones 1990). These practices were attributed to insufficient staff control over their work and diminishing motivation (Buzgová and Ivanová 2009). Rather than supporting the notion that abuse is perpetrated by a few wicked individuals *per se*, these findings suggested that residents and care staff may also be subjected to and limited by institutional practices restricting the potential to care (Letiche 2008).

While policy and regulation may deliver an improved detection of institutional abuse, formulations of the problem and the solution tend to be of either the tame or the crisis category. We argue that institutional abuse in the contexts of residential care for older people has characteristics associated with wicked problems. Therefore, we apply the lens of wicked problem analysis in this area. Drawing on research which examined care provision in eight residential care homes for older people, we outline five examples of institutional abuse that had wicked characteristics.

## Research design

### *Research context*

The findings are drawn from case study research at eight care homes that provided residential and nursing care for older people in England.<sup>1</sup> The purposive sample ensured that we included care homes varying in size (from 10-bed to 60-bed facilities) and sector provider type (corporate chain, independent, public and third sector). Inspection reports from the national regulator show three of the homes had a history of poor care quality and five of good care quality. Drawing on Eisenhardt and Graebnor's (2007) comparative case study method, we examined the organisation of care in these homes focusing on events, practices and processes leading to good care and to mistreatment.

### *Data collection*

The primary data for this research were collected between November 2009 and May 2011 (following ethical approval 09/H0306/63 from the National Research Ethics Service, Cambridgeshire 3 Research Ethics Committee in October 2009). The study involved comparative case studies focusing on (i) identifying organisational factors associated with institutional abuse and (ii) ethnographic accounts of residents' experiences of care and of the work experiences of care staff. A total of 294 hours of observations of day-to-day interactions, behaviour and activities (excluding personal care of residents) were carried out. This included observations of communal areas such as lounges, reading rooms, activity rooms, dining rooms, gardens, staff rooms, kitchens, laundry room and staff offices during morning and evening shifts, night shifts and at weekends. There were 124 interviews with 86 members of staff and 38 residents. The interviews were semi-structured and lasted for 30–60 minutes, and 99 were digitally recorded, professionally transcribed in full and anonymised. Our formal data were complemented by frequent informal conversations with members of staff, residents and visitors to the home and a wealth of internal documents such as the care home's statement of purpose, complaints records, policies and procedures and other publications.

*Data analysis*

The data were analysed using a process of systematic recursive cycling (Eisenhardt and Graebnor 2007, Eisenhardt 1989) to identify, establish and test out understandings of the relationship between organisational factors and processes and staff and resident experiences. In the following section we briefly present five illustrations before expanding on data from one care home, 'Honeysuckle Place' (consisting of 57 hours of observation; five interviews with residents and eleven with staff) to illuminate how problem and solution formulated at the macro policy level can create new problems when implemented in the local context of the care home setting. This particular case example is not exceptional; rather it is used to examine in-depth familiar patterns of problem definition and attempted solutions. In this particular case the problem identification centred on feeding and the solution generated problems for toileting.

**Wicked problems and tame solutions**

We found numerous examples of institutional abuse where residents' needs were not met through neglect, mistreatment or loss of dignity and when safeguarding procedures were followed.<sup>2</sup> We sought to understand how and why recurring problems were taking place. These problems centred on basic aspects of care such as feeding, toileting and hygiene. Additional problems occurred when basic care needs arose outside the set routines for care-giving. A further recurring problem was the inability of staff to adapt to changing care needs over time. Table 1 outlines five examples from different residential care homes. Each example describes how linear problem-solving gave rise to new problems in other areas. Table 1 also outlines five examples of tame formulations and solutions to problems with care provision and their subsequent, unintended consequences.

The five examples outlined in Table 1 are concerned with basic elements of personal care such as feeding, toileting, washing, moving and handling, resident safety and resident's additional needs outside established care routines. They highlight something of the wicked characteristics of institutional abuse. In the first case shown in the Table, attempts to improve mealtimes limited the extent to which toileting needs could be met. In the second situation, responses to family advocacy for some residents gave rise to a deterioration in care for those who did not have any advocacy. In the third case, initiatives introduced to increase choice about when they went to bed eventually reduced residents' choices about bedtimes. In the fourth, the introduction of safe, specialist care facilities for some residents was implicated in the unsafe use of equipment for others; and the fifth example shows that initiatives to increase the overall safety of residents led to increased risks of harm for some of them. The following detailed account of events at the care home 'Honeysuckle Place', illustrates in depth the relationships between seemingly unrelated problems.

Honeysuckle Place is a two-storey purpose built home run by the local authority and provides residential care for 20 older people. In response to national care standards, the arrangements for feeding residents were changed to improve the range of choices available and to emulate a restaurant service. Although this seemed to work well, mealtimes had lengthened as a result and there were delays in getting residents to the toilet after meals. This meant that some residents had soiled themselves during their wait to be taken to the toilet. Consequently, residents were keen to get in the queue for the toilets after their meals to avoid any further accidents. This example is presented in detail below.

Table 1 *Examples of linear problem-solving*

<i>Case study sites</i>	<i>Presenting issue</i>	<i>Tame solution formulation</i>	<i>Unintended consequences/problems</i>	<i>Potential for abuse, neglect or loss of dignity</i>
<p>'Honeysuckle Place': Purpose built 2-storey building run by local authority, with 20 residents</p> <p>'The Laurels': Purpose built 2-storey, corporate chain, with 60 residents</p>	<p>Rigid mealtime routines</p> <p>Families making complaints about care of a resident were considered to be too demanding.</p>	<p>Introduction of restaurant-style meals service to better meet nutrition needs</p> <p>Moving resident into a room closer to the manager's office at the front of the home.</p>	<p>Resident queuing. Lack of toileting facilities nearby. Movement from floor to floor via one small lift.</p> <p>Organisational rules about the use of the restaurant</p> <p>Increased work demands on staff working in areas close to manager's office. Poor quality care in other parts of the home not directly addressed. Residents without advocacy are less likely to be moved close to the manager's office where good care is provided.</p>	<p>Residents were not taken to the toilet when they needed to go, leading to soiling.</p> <p>In areas at a distance from the manager's office, residents with complex needs and without advocacy were more likely to experience poor care. For example, residents told us they were not washed after incontinence pads were changed and that they were shouted at by some staff for ringing the bell when they needed help. Conversely two residents also told us they had trained themselves to change their own pads or to be continent.</p>
<p>'Ash Court': Purpose built 2-storey, third sector provider, with 40 residents</p>	<p>Rigid bedtime routines</p>	<p>Introduction of residents' choice about when to go to bed</p>	<p>35 residents needed help to go to bed and work demands on staff were high at this time. Rules had developed that residents ringing their bell too often were not to go to bed until after 9 pm. One resident was repeatedly refused help to go to bed when she wanted to go. She was told she had to wait until later as then she would be tired enough to fall asleep more quickly.</p>	<p>The resident became distressed and asked to speak with the senior member of care staff on duty. He admonished her and told her they had evidence that she does ring the bell too often, as they keep a record in the office of how many times it goes off.</p>

Table 1 (Continued)

Case study sites	Presenting issue	Tame solution formulation	Unintended consequences/problems	Potential for abuse, neglect or loss of dignity
'Oak House' Purpose built, 2-storey, run by local authority, with 40 residents.	Increasing physical needs of residents	Introduction of unit with specialist equipment for the provision of safe, high physical care	Larger room sizes and the provision of specialist equipment for high physical care are available in the unit. The rest of the building has not been adapted. Staff are required to use mobile lifting equipment in areas outside the unit. Residents' rooms outside the unit are half the size of those inside and are too small to use the mobile equipment safely. The use of equipment in this way has led to an increase in staff absences due to injuries to backs and knees.	The increase in staff absences had reduced the number of staff available to work. This led to higher work demands being placed on staff on duty and delays in meeting residents' needs, more injuries and increasing rates of sick absences. A vicious circle had formed that management were finding difficult to change.
'Willow Drive'. Converted, 2-storey house, corporate chain, with 21 residents.	Keeping residents who have dementia safe and secure	Practice of locking the second of two lounges was introduced. Residents are grouped in main lounge near to staff office.	Residents do not have access to the second lounge, which is kept closed. Staff told us it was closed because the reduced numbers of staff make it difficult to cover both lounges. Staffing levels had fallen because the occupancy level had fallen. The door connecting the main lounge to the conservatory is blocked. There is an enclosed garden but residents are not taken outside. The second lounge is opened up when potential residents and their families come to view the home.	The organisation of residents in one place eases the demands on staff to monitor residents. Residents are denied access to communal places and facilities. The concentration of residents into a single semi-enclosed space contributed to agitation, anxiety, verbal and physical conflict between residents. For example, one resident needed additional one-to-one care to protect other residents; another resident had pulled another resident; and hot drinks had been thrown to the floor.

*Formulating the problem and implementing solutions*

One characteristic of institutions is batch living where people are grouped and treated in homogeneous ways (Goffman 1961). Person-centred philosophies and models of care,<sup>3</sup> enshrined in health policy and regulation may, depending on the extent to which they are enacted in practice, offer a means to counter institutionalisation. It has been noted recently that a common feature of poor care has been lack of the adequate nutrition and consequent weight loss. In response, government standards of care were introduced, which state that any resident can expect care, treatment and support to meet their needs, leading to outcomes such as choice of meals and adequate nutrition (CQC 2010b).

To this end, three years earlier Honeysuckle Place had taken part in a local authority-supported project to create a restaurant-style meals service designed to improve residents' dining experiences and better meet individual nutrition needs. Structural and cosmetic changes had been made to the dining room so it resembled a commercial restaurant in layout and furnishings. All the meals were freshly prepared on the premises and the menu was expanded to include an option of cooked food at breakfast, a soup course and two main meal options at lunch. Serving times were extended from one to two hours to give residents a choice about when they ate. The menu options were made available to residents on the day, replacing a system where residents selected their options 24 hours in advance. The care staff waited on the tables at mealtimes, placing a tabard over their uniform before commencing this part of their work. Staff told residents of the options on the menu and asked residents to choose. Staff took resident's orders to the service counter and a chef plated up the orders. The member of staff returned with the resident's food and would usually help residents with feeding where needed. Overall, the residents reported that the menus were a success:

We always have a soup at lunchtime and then a main, today it was fish and chips. Then they did a kind of a crumble mix that was very nice with custard for the sweet. If you wanted a biscuit after or anything else you can have it and the puddings vary from day to day. And there are always two choices, you know, if you have a roast you perhaps have something like macaroni cheese, yes, you could choose. It's quite exciting, really, waiting to see what's on for lunch. (Emily, resident)

The dining room is quite good, it's quite modern and the staff are always on time and the meals are nice. You can fancy any of the meals on offer and I'm a fussy one over food, you know. I think we're very lucky. (Isobel, resident)

The move to the restaurant-style service was also said to have had a positive impact on care beyond the immediate context:

Quite a few members of staff left when we went to restaurant service. But it was good for them to leave, if that makes sense, because the older entrenched staff, they didn't like being waitresses, basically. I think that actually helped change the culture quite a bit in the care staff group and gradually we got better people working here. (Evie, home manager)

The locally designed solution appeared to create a more person-centred meals service. Moreover, problems such as an increase in staff turnover were said to have had a positive outcome. However, while the meals were a success, the changes in arrangements lead to related problems that are detailed in the following section.



*Wicked problem analysis: broadening views of the whole problem*

In this section we show how the restaurant service, a genuine, and seemingly successful, attempt to increase residents' choices and mealtime experiences, created new problems associated with institutional abuse. As previously noted, another characteristic of wicked problems is that they tend to be symptoms of other problems. The time-consuming process of helping residents to the dining room for their meals and back to the floor where they live had become heavily routinised. The dining room was located on the ground floor and residents lived on the first floor. All 20 residents needed assistance to walk or had to be wheeled to the floor below by care staff via the use of a small lift. These activities demanded concentrated amounts of staff time. Firstly, the lift had the capacity to accommodate only one member of staff and one resident, if using a wheelchair, or two residents, if using walking aides. Secondly, the nearest toilets to the dining room were located on the floor above. Thirdly, organisational rules about when residents could enter and leave the dining room were firmly established. Staff were not allowed to take residents into the dining room any earlier than 20 minutes before meals were served and catering staff were not allowed to clear away tables and clean the dining room until all the residents had left. Consequently, staff assisted residents to use the toilets before they were taken to the dining room for meals and again after being taken back to the floor above:

We don't start toileting until we've got them all up to the top floor because the kitchen staff have got to get on with clearing and they can't do that until all the residents have left. (Mollie, care worker)

The location of the dining room on the ground floor, the reliance on one small lift, the lack of toilet facilities in the dining area and organisational rules combined to delay access to toilets around mealtimes. Consequently, residents tried to leave early to be near the front of the queue for the toilet. One resident who had lived in the home for several years commented about the need for residents to be ready to fit in with the routine:

You've got to do whatever is happening next. You've got to be ready. Now today at half past four, that's when we get started up at the top of the lounge for tea. Across in the wheelchairs they go to the toilets first, and then the people who are first go down below to the dining room. Automatic this is, and then the staff know exactly where one person and their chair will go in the dining room. And then you sit there and you wait. (Reg, resident)

More importantly perhaps, residents were acutely aware that the routine around mealtimes prevented them from being able to use a toilet when they needed to:

Well, the worst thing is using the toilet after breakfast. You have to wait. I go on the commode when they get me up in the morning at about 6.00 A.M., but then I want to go again after breakfast. If they can, they take me pretty quick but then there are several other people to take too. (Connie, resident)

One of the worst things is toileting. Now we have our breakfast in the morning and our medication and then we're sat in a line and as they take you up in the lift you are set in another line in the main circle. You stay there in your chair, no toilet. You can't go until

it's your turn after they've brought everybody up to the top floor. Then they decide who was first up and perhaps you're left until last because you're in a wheelchair and can't go yourself. Sometimes you're desperate if you've just had the medication, you know, I find that very, very difficult. (Emily, resident)

The extracts powerfully illustrate how arrangements for mealtimes were successful in improving the meals service. However, they combined to generate new problems. Changes to the mealtime arrangements impeded timely access to the toilet for residents, contributing to instances of neglect around toileting. We were told by two residents that delays in being taken to the toilet after mealtimes had led to soiling. While senior staff were proud of the home's restaurant-style meals service, more junior individual care staff also commented on the difficulties they experienced with taking the residents to the toilet when they needed to go:

After lunch is a particular example of high demand. Everybody wants the toilet but there are only three staff and there are 20 residents, so somebody's got to wait. Somebody's got to be last. But everybody's like, 'Oh, I need to go now' and that's a really stressful time. (Ruby, care worker)

Residents suggested that the problem was well known to senior staff;

Yes, the toileting is very difficult but what can the staff do? I don't know. If we say anything to the manager she'll say, 'Well, I'll tell them they should take you when you get to that point where you're frightened you're going to do it in your clothes. For goodness sake, take them don't leave them feeling like that'. But it's never worked. That's a very, very sore point with a lot of us if we've got to sit there waiting. (Emily, resident)

This example was a wicked problem in the sense that it also indicated the interconnecting factors contributing to the problem: structural constraints to the architecture and facilities and strict organisational rules combined to generate new problems by encumbering the ability of staff to meet toileting needs and resulting in routinised treatment that denied residents the care they needed when they needed it. Yet the problem of meeting residents' toileting needs was not linked to the arrangements for providing better feeding. In addition, this example illustrates another wicked characteristic of the problem as the issue was viewed differently by each set of stakeholders. The manager tried to resolve the problem by telling the care staff to take the resident to the toilet, whereas the care staff identified high demands for toileting as the crux of the issue. In contrast, the residents suggested that they had little say in how their care was organised, despite having rich insights into the routine and its potential for producing detrimental effects. Thus, the people most closely involved in receiving or delivering care appeared to have the least power to influence the formulation of the problem or to change practice.

However, senior staff told us about problems arising from the routine of care work for staff: 'I don't think my staff have enough time to enjoy their job, a lot of it is routine' (Evie, care home manager). In an attempt to address the problem of residents leaving lunch early and forming a queue to go upstairs the manager had introduced a change to the usual routine around mealtimes:

Time to sit and chat, could be for two minutes, just to sit and have a cup of tea or five minutes for staff to sit and have a cup of tea with the residents. We're trying that at the mealtimes, to slow mealtimes down. (Evie, care home manager)

Yet, junior care staff were adamant that activities to extend the lunchtime period caused more problems for them and for the residents:

To keep the residents at the dining table longer the manager's introduced having cups of tea and us staff can sit and have a cup with the residents. She's hoping to last the dinner out a bit longer but they all want to go to the toilet. Then it's all rush to get them upstairs and do the toileting before you leave off duty. That cup of tea after the meal makes a heck of a lot of difference. (Mollie, senior care worker)

This attempted linear solution to improve work routines for staff and for residents was treated as if it was separable from the toileting issue. As these extracts demonstrate, a consequence of treating an issue as if it is a tame problem is that the issue is assumed to be discrete and consequently linear solutions tend to be proposed. Hence, the way to interrupt a rigid routine is to extend the lunch time, and the way to increase interaction is to allow staff to sit down with residents and have a cup of tea. Yet care staff clearly recognised that the extension of the lunch period compounded the problem of meeting residents' toileting needs. Paradoxically, this increased the need for staff to take a more en masse task-based approach to providing care in the time available.

### **Reconceptualising institutional abuse**

In this detailed example we have indicated wicked characteristics of institutional abuse. These characteristics include the lack of a definitive formulation of a problem that remains elusive. In the care home settings, the examples we elaborate were not recognised as constituting institutional abuse by managers and other staff members. Moreover, when problems were detected, the explanations and responses did not link with the other interconnecting components of care provision, so the solutions focused on the immediate issue at hand. Consequently, rather than being able to determine whether the correct explanation of the problem had been reached, we argue that in practice, no rules for checking solutions were present. This is how tame solutions aimed at improving care provision can generate problems in other areas.

We conceive the totality of care provision as an interlinked system. Therefore, it has wicked characteristics. As well as outlining how improvements in feeding can adversely affect toileting, the other examples outlined in Table 1 indicate how improved attention for residents with advocacy adversely affected care for those without advocates as they were moved out of sight of the manager. Changes to bedtimes aimed at increasing residents' choices led to increased demands on staff for care outside their care-giving routines. Staff began to manage bedtimes in order to control additional demands. In effect, set bedtimes were reimposed. Attempts to provide specialist care for those with increasing needs were affected by unsuitable facilities in some parts of the home, meaning that staff hurt themselves when they tried to use equipment in unsuitable spaces. The final example describes how grouping residents together in an attempt to keep them secure meant that tensions mounted between residents as a result. So we have seen how genuine attempts to solve seemingly tame problems failed.

Care homes are often adapting to national, government, command responses. These national guidelines affected the personal care and private lives of residents, the work experiences of staff, the responsibilities of a registered manager and public scrutiny by regulators. Managers of care homes were acutely aware of the need to meet standards and to

pass inspections so they were actively involved in initiatives to improve care, gain good inspection ratings and win achievement awards. Successful care performance in care homes, in a Goffmanian sense, is linked to being able to supply convincing representations of care. The monitoring of residents' nutrition and hydration, the provision of menu choices and well-presented and appetising meals, for instance, were all practices given positive value in regulations and the inspection process (CQC 2010b). In this way the restaurant-style service at Honeysuckle Place provided a visible representation of good quality care.

The meals service and other practices around mealtimes were genuine attempts to increase residents' nutrition and to enhance work experiences for staff. As a stand-alone issue, the meals service was judged to be a success. However, the solution was premised on tame formulations of the problem. The problem of standardised routines for residents at mealtimes was separated from that of toileting regimes so the consequences for toileting were not easily recognised as being related. We have demonstrated how the mealtime solution enhanced a person-centred approach to nutrition with a positive impact for residents, at the same time as it encumbered personal care, with detrimental outcomes for residents. In addition, we have shown four other ways in which the potential for institutional abuse in the form of neglect (leaving residents unwashed, preventing residents from using inside and outside places and spaces, using equipment in unsafe ways) and psychological abuse (admonishing and shouting at residents, stacking up evidence used to challenge residents' perceptions) can arise from the unintended consequences of attempts to solve other problems.

Whilst we recognise that some problems in care quality will be easily solved with no consequent development of problems, we argue that institutional abuse has wicked characteristics. It is relatively difficult to define, there are no rules to determine the correct explanation of the problem and it cannot be easily separated into discrete parts nor easily controlled using conventional methods (Conklin 2006, Grint 2005). In Honeysuckle Place there was no consensus among staff, managers and residents over what was the best method to solve the problem of toileting, and instead conflicting views of the issue were identified. Wiener and Kayser-Jones (1990) showed key differences in the perspectives of doctors, residents and relatives about the problems of care provision in care homes. Despite these different perspectives, each group was argued to be contributing to a downward spiral of care as their powerlessness to change care provision resulted in apathy and the acceptance of poor care standards. Although apathy can be a feature associated with poor care provision, the findings of our study suggest, in the words of Rittel and Webber, that more 'malignant,' 'vicious' and 'tricky' phenomena are at issue (1973: 160). We propose reconceptualising institutional abuse as a wicked problem; that institutional abuse can arise from the unintended consequences of attempts to improve care provision.

Formulating institutional abuse as a wicked problem could draw greater attention to the particular ways in which organisational factors and recurrent problems interconnect in a care setting. It has been argued that conventional, solution-focused approaches are unlikely to solve wicked problems (Grint 2005). The wicked and tame problem framework can supplement the analysis and understanding of decision-makers' responses to problems. For instance, Grint (2005) proposed that the formulation of the problem shaped particular types of responses: tame formulations legitimate management of the problem through changes to process and policy. Long-standing and widespread abuse is likely to be formulated as a crisis problem, to use Grint's term, which requires a command response, such as closing down a home. An alternative conceptualisation using wicked formulations requires alternative approaches and methodologies for tackling wicked problems are emerging (see Conklin 2006). The wicked formulation indicates a collaborative approach, where stakeholders and decision-makers are involved in problem identification and solutions emerge from a process

of 'dialogue mapping' (Conklin 2006). By developing these methods for working with wicked problems, the problem must first be appreciated from a range of conflicting perspectives (Grint 2005, Weber and Khademan 2008, Wexler 2009). Indeed, it was the use of interviews to examine the multiple perspectives represented by senior staff, care staff and residents in this study that helped us to identify the complexity of the problems in these cases. Responses to wicked problems involve decision-makers in asking a range of stakeholders what Grint calls 'the right kinds of question' about the problem and using dialogue and participation to instigate change (Conklin 2006). This implies a type of continuous improvement approach where ongoing work to improve care involves looking for related problems as they emerge and to consider the totality of care provision even when tackling seemingly one-off issues.

## Conclusions

Institutional abuse in residential care homes remains a persistent and recurring problem. It is an emotive issue and there has been a tendency to blame wicked people for failures in care. We have used the concept of wicked problems to examine institutional abuses in context. We have shown how institutional abuse has wicked characteristics; the problems are difficult to formulate and searching for solutions tends to be open-ended, and good or bad, rather than true or false. There are no easily accessible rules about how to determine a correct explanation of the problem and each problem is a symptom of another problem.

By this account, institutional abuses in the form of recurring neglect, mistreatment and loss of dignity can arise out of attempts to solve other problems associated with care provision. Rather than being intentionally wicked, the staff work hard to improve care in one area and fail to provide adequate care elsewhere. This reconceptualisation of the evolution of institutional abuse through the lens of wicked problems suggests that solutions will not be easily found. Instead, alternative methodologies are indicated that keep in mind the various perspectives of those involved and the systemic nature of care-giving as opposed to taking an atomistic perspective. Such methods would be aimed at involving multiple stakeholders in continuous questioning and ongoing problem formulation. Rather than arriving at a solution, care provision may require constant re-examination and adaptation.

*Address for correspondence: Diane Burns, Faculty of Medicine and Health Sciences, University of East Anglia, Queen's Building, Norwich NR4 7TJ  
e-mail: diane.burns@uea.ac.uk*

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- 2 Ethical approval required researchers to follow the relevant local authority safeguarding guidelines, which were invoked as required during the study.
- 3 Under Person Centred Care, Standard 2 of the National Service Framework for Older People, people should be treated as individuals and receive appropriate and timely care that meets their needs (Do Once and Share, Single Assessment Process Action Team 2006).

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