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The scope of safety in English older adult care homes: a qualitative analysis of Safeguarding Adult Reviews

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Abstract

Purpose

In this article, we explore the content of Safeguarding Adult Reviews (SARs) from older adult care homes in order to understand how safety is understood and might be measured in practice.

Design/methodology/approach

SARs relevant to older adult care homes from 2015 onwards were identified via the Social Care Institute of Excellence (SCIE) SARs library. Using thematic analysis, initial inductive coding was mapped to a health-derived safety framework, the Safety Measurement and Monitoring Framework (SMMF).

Findings

The content of the SARs reflected the dimensions of the SMMF but gaining a deeper understanding of safety in older adult care homes requires additional understanding of how this unique context interacts with these dimensions to create and prevent risks and harms. Our review identified the importance of external factors in care home safety.

Originality/value

This study provides an insight into the scope of safety issues within care homes using the SARs content, and in doing so improves understanding of how it might be measured. The measurement of safety in care homes needs to acknowledge that there are factors external to care homes that a home may have little knowledge of and no ability to control.

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Introduction

Safety is increasingly seen as important in older adult care homes in England. These homes provide accommodation, alongside care and support to adults over the age of sixty-five. In some homes nursing support is also provided.

Safety is usually seen to refer to the absence of preventable harm and features in government frameworks for long-term care, including care homes (NHS Digital, 2019) and is also reflected in England's social care inspection regime (Care Quality Commission, 2016). Focus on assessment of safety in care homes is increasing (Rand *et al*., 2021), and attempts to improve safety in care homes have often drawn on initiatives and approaches from healthcare (Allen, 2009). These approaches mainly conceptualise safety narrowly as errors and harm arising from individual practice rather than a multidimensional systemic phenomenon. Implementation of initiatives that fail to address the specific context of care homes are unlikely to succeed (Marshall *et al*., 2018). For example, a key safety concept in care homes is safeguarding (Moore, 2016), which requires organisations, their partners and their users to work together to prevent risks to safety. More widely, less is known about how safety is conceptualised in this sector and whether healthcare derived measures are truly reflective of its scope (Gartshore et al., 2017).

New multidimensional system-based assessment models for safety are emerging in healthcare which consider the influence of wider aspects of the system on safety and may more closely reflect the safety issues found in care homes. We adopt one such framework, the Safety Measurement and Monitoring Framework (SMMF) (Vincent *et al.*, 2014) and apply it to the content of Safeguarding Adult Reviews (SARs) to identify the range of safety issues identified in these reports. SARs were introduced in England by the 2014 Care Act and are multi-agency reviews that occur when an adult with care needs dies of neglect or abuse and there is concern about how well social care agencies and their partners worked together. Going beyond the Act, some SARs are conducted where there is a case of neglect or abuse that does not result in death. In the three other UK nations slightly different systems exist for safeguarding and learning from incidents, these are summarised in Thacker *et al.* (2019).

The aim of SARs is not to apportion blame for harm but rather to identify learning to improve services and help prevent future neglect and abuse. However, as commentators have pointed out (Cooper and Bruin, 2017; Preston-Shoot, 2017, 2018), the lack of a compulsory central repository for SARs has limited their potential for learning outside of Safeguarding Adult Boards (SABs). While SARs focus on significant failures in safety that are rare in care homes, Manthorpe and Martineau (2017a) suggest that SARs are "*potentially rich sources of information about this largely overlooked sector and its workings" (p2094*). SARs often contain very detailed descriptions of safety in this specific context as well as the build up to the specific incident. Given the richness of the source of information about care homes, it is not surprising that there have been several reviews of SARs, including those focusing on older adult care homes (Manthorpe and Martineau, 2016, 2017a, 2017b).

Exploring the content of SARs can illuminate the scope of safety issues that arise and influence how safety might be conceptualised in this sector. This research is an essential step in informing how safety is understood and might be measured in practice. Mapping safety issues to the SMMF framework helps illustrate which dimensions of safety are represented in accounts of failures in care homes and where there might be additional areas of safety unique to care homes that are not identified by such models. Healthcare-derived models such as SMMF are beginning to be used for safety improvement in the sector. Although we do not expect such models to offer a full reflection of safety in care homes, we believe they can be helpful in identifying the potential scope of future care home safety monitoring and measurement. This work is part of a larger study looking at the measurement of safety in care homes that includes a review of international literature (Rand *et al.*,

2021) and qualitative interviews with stakeholders and care providers with the aim of informing how safety might be measured in older adult care homes.

Research Methodology

All SARs post the 2014 Care Act listed on the publicly available Social Care Institute of Excellence (SCIE) SARs library (https://www.scie.org.uk/safeguarding/adults/reviews/library) were downloaded on 29 July 2019. Although it is not compulsory to deposit SARs into the library, it was recognised as a central repository and represented a good coverage of reports. At the time of accessing the library, no reports dated beyond September 2018 were available. As of 27th January 2022, there were no additional reports beyond September 2018, although recent notices suggest that the library will be updated in due course. Where listed SARs were not available via the library, the relevant SABs were contacted, but none replied. All available SARs were reviewed for relevance to older adult care homes and, where this criterion was met, were included in the study.

Analysis was conducted by three researchers (NS, SR & SM) in NVivo 12. The analysis of the SARs utilised a thematic analysis and followed the phases outlined in Braun and Clarke (2006). First, the researchers familiarised themselves with the texts. Second, an initial coding framework was developed inductively. Each SAR was coded independently by two researchers. Coding was led by SM, who coded all the SARs. NS & SR acted as second coders, coding nine SARs each. Differences were compared and discussed by the researchers until consensus was reached. Third, the researchers reviewed the coding for themes. During this stage the SMMF was proposed as an organising framework for the analysis.

The framework takes a broad perspective on safety and can be applied at team, organisation, and system level and consists of five dimensions relevant to safety monitoring and measurement (harm, reliability, sensitivity to operations, anticipation and preparedness, integration and learning) (see Table 1).

Insert Table One

(Adapted from The Health Foundation, 2014; Vincent et al., 2014)

Two researchers (NS & SR) independently began to map the codes to the SMMF. During the next two stages, the mapping was revised iteratively. In the sixth stage, NS selected the most appropriate extracts for each theme. Disagreements regarding mapping of content were shared and resolved with the team.

Findings

Results of the SCIE library search

A total of 118 SARs were listed in the SCIE library. Five were unavailable and were not included in this review and two SARs listed in the library were duplicates. The remaining 111 SARs were reviewed for relevance to older adult care homes. 18 SARs were included in this review (see Table 2).

Insert Table 2

There was no standard format for the SARs, which varied from a few pages to over 100. In the findings below, SARs are identified by their SCIE library number. While all the SARs in this review are publicly available, any names and locations have been removed.

Analysis of SARs content

This section is organised into six sub sections. The first five reflect the dimensions of the SMMF. The final section outlines external care home safety factors.

Harm

Four key physical harms were found in the SARs reviewed: falls, malnutrition and weight loss, pressure ulcers, and physical harm caused by other residents.

Mentioned in five SARs (04, 49, 66, 80, 82), falls were often acknowledged as unavoidable for some residents due to the nature of their needs (04, 49). However, harm was often compounded by staff reaction to the incident. Examples included, staff failing to recognise and seek appropriate help (80), a fall not triggering a review of the resident's care plan (49, 82), and information about a fall not being passed onto the staff working on other shifts (82). Similarly, malnutrition and weight loss, found in several reports (04, 66, 82, 101), were not seen as necessarily avoidable. Nonetheless, areas for improvement regarding a home's recording of food provided (66), care staff's knowledge of special and fortified diets (66) and the lack of referral to those with specialist knowledge, such as a dietician were mentioned (04). Another SAR noted that staff did not "*provide enough fluids and did not provide mouth care*" (82), which were seen as examples of "*very poor*" care practice.

While mentioned incidentally in other SARs, four reports (28, 51, 61, 94) described serious pressure ulcers. Pressure ulcers were seen as reflecting quality of care. One report, for example, made recommendations that the local authority ensure that staff in care homes were able to '*identify*' and '*treat*' pressure ulcers (51), while another report concluded that pressure damage was 'avoidable' and therefore a marker of poor care and neglect (61).

The SARs also contained instances of harm caused by residents. Sometimes it was the focus of the report, such as a male resident requiring hospital treatment following an assault by another resident (93). At other times, general observations about the lack of supervision of residents or management of arguments were seen as symptomatic of wider problems with the management and culture of the care home (66).

The SARs also presented examples of care that failed to respect the person being cared for and could, potentially, psychologically 'harm' the resident. These included failure to provide female staff for personal care when requested by a resident (50), and examples of residents' environment and personal cleanliness not being supported in a respectful manner (82, 101). In one SAR, concerns were raised about the cleanliness of a resident's room, presenting a situation where psychological harm overlapped with potential physical harm:

> *There were faeces in the sink, the lavatory had not been flushed and [resident's] clothes were strewn on the floor. (50)*

Lack of dignity in care practice was shown to be an important factor in psychological harm. This included how care staff interacted with and spoke to residents (06, 82) and family members (82). At its most serious, care that lacked dignity and respect was seen as cause to involve local police (28). Its relevance to harm was clarified by its characterisation as "*degrading*".

Reliability

The reliability component of the framework focuses on the probability that systems and processes work as specified. Relevant issues identified in the SARs include the adequacy of night checks (37), the degree of supervision of residents (66, 101), implementation of infection control and environmental cleanliness standards (06, 28, 66, 82). Reliability of systems and processes related to medication management included issues with the repeat prescription process in homes (50, 66), leaving medication trolleys unlocked and unattended (82), errors and omissions in medicine administration records (15, 82), and failure to administer medications (15, 101).

Problems with systems and processes related to a lack of adequate risk assessment were reflected in four SARs (82, 80, 49, 66). These reports suggested that in the build up to the incident an inadequate or no risk assessment was conducted when it would have been usual to do so. Risk assessments could also be viewed as part of anticipation and preparedness.

Sensitivity to operations

This domain focusses on the current management of safety and asks if residents are safe right now. It prompts a consideration of whether the organisation has the information and capacity to ensure and monitor safety in real time.

In some SARs there was reference to staff reflecting on whether practice was currently safe. Three SARs described how care home staff raised the alarm on an unsafe situation, either to an external agency (06, 28) or internally (82). Several SARs found that staff did not appreciate the importance of promptly sharing safety information to identify and address day-to-day risks, such as failing to pass on information at staff shift changeovers (37, 82, 92). Sensitivity to operations was also captured indirectly in examples of how care homes identified and reacted to day-to-day risks within the home. The SARs presented several instances of family members raising concerns with care staff (06, 15, 28, 49, 50, 61, 82, 103) that received no response, while other SARs documented staff not reacting appropriately or in a timely manner to safety issues or health concerns (04, 15, 49, 50, 51, 61, 80, 82, 103).

The perspective of residents is also part of this domain; however, residents' experience was usually absent in SARs due to their nature as a retrospective account of an incident. Nonetheless, several reports (06, 37, 61, 66, 82, 101) drew on the findings of CQC inspections, which included resident experience. Other SARs made efforts to imagine the resident's perspective, such as a SAR that stated that the care home environment the residents' lived in must have been "*frightening*" and "*confusing*" (66).

Anticipation and preparedness

Asking whether care will be safe in the future, this domain focusses on being prepared for threats to safety. Key to this is the level of experience, training, and skills of staff, as well as the care home's leadership and culture.

Training was raised in several SARs, either as a general point (06, 66) or with regard to a lack of training related to the incident (37, 66, 82, 92, 101). Gaps in skills highlighted included communication with visitors to the home (06), providing hygienic care (82), nutrition and hydration (66), diabetes management (103), pressure sore management (37), wound care (66), administration of medicines (80), risk assessments (101) and responding to head injury (04). The contribution of agency care staff's lack of experience and unfamiliarity with the home was also highlighted (06).

Care home leadership shapes workplace and organisational culture, including aspects that relate to anticipation and preparedness. This manifested itself in several different ways, including where home managers did not provide staff with direction, oversight, or training, which led to a chaotic working environment (66, 105). In one SAR, it was clear that the culture and leadership within the home actively discouraged staff from raising concerns and making complaints (28), a key mechanism for identifying risks in the system. In one case, poor leadership was, in part, the result of a *"series of new managers adding chaos and no knowledge of residents"* (66). Some SARs (06, 15, 66, 82) also drew attention to the impact on safety caused by gaps in leadership due to sickness leave or resignation of care home managers.

Integration and learning

The integration and learning dimension of the framework represents the ability to reflect on, learn from and respond to information about quality of care and safety issues. In the SARs, this was usually articulated when organisations had failed to learn from past incidents. The SARs made clear the importance of such learning to safety:

> *Good governance and a culture of learning and improvement includes learning from incidents. (04).*

The SARs reports themselves could be seen as a learning resource. The number of recommendations in each report ranged from two to 23. In ten SARs the number of recommendations were in double figures. These recommendations were aimed at a wide range of organisations, including the care home, social care commissioners, community health teams, social work teams and CQC. The focus of the recommendations across the SARs was wide ranging and included process-focussed solutions such as improving communications between agencies (03, 06, 15, 66, 80, 82, 93, 101), training (06, 28, 37, 51, 66, 80, 82, 92, 94, 101, 103), and better care planning and reviews (15, 28, 37, 50, 51, 66, 80, 92, 94).

Factors external to care homes

Several SARs (28, 37, 49, 61, 66, 103, 105) noted that the safety and wellbeing of care home residents was the result (and responsibility) of not just the care homes, but also the health and social care organisations and agencies they worked in partnership with. Care homes rely on community-based healthcare services for their residents, working closely with other professionals e.g., pharmacy, GP, nursing. One SAR (28) highlighted the need for "effective partnership working". While another stated the following:

> *It is important to recognise that Care Homes are part of a wider system of health and care services for an individual, with a range of organisations working in partnership in delivery … This system requires development in true partnership with Care Homes if proactive,*

> *personalised care is be provided to manage effectively the needs of people living in them. (66)*

The contribution of external agencies to resident safety was articulated in different ways in the SARs, including problems with cross-agency communication (49, 66, 103), especially during transfers of care, and staffing issues within organisations and teams external to the home (37, 105).

Several SARs (28, 61, 66) attempted to place the incident that they were investigating in a wider system context. Most common was funding and its impact on safety. It was noted that both the homes and their partnership agencies in health and social care were increasingly working within tighter budgets due to decreases in funding. These reports often made a clear link between constrained budgets and the challenge of keeping residents safe.

Discussion

The study aimed to provide an insight into the scope of safety issues within care homes using SARs content and in doing so increase understanding of how it is conceptualised and might be measured. Although SARs generally focus on extreme failures, they often also contain a rich vein of information on safety issues that might have contributed to the incident or were latent in the environment. The SMMF was used to organise findings and highlight which dimensions of safety are represented in these reports and whether there are additional care home specific dimensions that need to be considered. This research is important in supporting the development of safety measurement in care homes such that it better reflects this particular context.

The SMMF provides a systems-based approach to assessing safety moving beyond solely measuring harm to incorporate assessment of the reliability of systems and processes, the ability to recognise and respond to day-to-day threats to safety, preparedness for future risks through the development of a well-led and trained workforce and the ability to learn and improve performance by monitoring data.

We found safety issues in SARs that mapped to each dimension of the framework which suggests taking a wider approach to safety measurement in care homes may provide both a more comprehensive mechanism for assessment but also provide more insight into where interventions might have most impact. However, there are some special considerations related to the context of care homes that need to be considered before such an approach might be adopted.

Collecting information on physical harms are a traditional approach to assessing safety in both healthcare and care homes. As in healthcare, poor mechanisms for appreciating risk and monitoring mobilising, skin integrity or nutrition were found to underlie some avoidable physical harm. Harms were often made worse by the failure to recognise the seriousness of the situation and institute appropriate review and follow up actions. Using physical harms as an indicator of safety can have challenges. Older adult care homes support some of the frailest members of society to live as functional a life as possible and debate will always surround the degree to which certain physical harms, such as falls, can be prevented, if residents are also to be enabled to live their lives to their full potential. However, in a care home context, SARs also suggested a shift in balance in the risk of physical and psychological harm between the healthcare and care home setting with psychological harm increasing in relative importance. Unlike most healthcare settings, for those that reside in care homes, the space is their home (Fleming *et al.*, 2017). In this very different context, the profile of harm is potentially altered, with psychological harm increasing in relative importance. For example,

in this setting, being treated without respect or dignity, or being subject to inter-resident conflict is likely to become a heavy psychological burden over time.

SARs highlighted safety issues related to the reliability of implementation of key safety processes including night checks, supervision of mobilisation and risk assessments. Measurements related to the reliability dimension have the potential to highlight opportunities for standardisation to improve safety across key care processes that require a high degree of fidelity such as medication administration and monitoring, environmental cleanliness, and infection control procedures. However, reliability indicators would need to be balanced against other more person-centred measures given that care homes should provide a suitably homely environment and care that improves quality of life. This tension between standardisation and individualisation is found all across social care where safety processes, including safeguarding, must be balanced with service users' individual choice and control (Scott *et al.*, 2017). Another limitation on a dominant focus on measurement of reliability is that it is likely to lead to a proliferation of standardised protocols and risk assessments as the main mechanism for improving safety. These safety interventions often don't work as well as predicted because they fail to take into account the ever-changing demand and capacity circumstances care staff face which requires an adaptive approach if residents are to be kept safe. Ignoring the need for adaptive behaviour could lead to workarounds which in turn increase risk.

In the SARs reviewed, the ability of staff to recognise a deteriorating situation threatening safety in real time, either by themselves or by taking on board family concerns, was often lacking. The sensitivity to operations concept fits well with the idea that a safe care home is one where residents, family members and staff can raise concerns and know that they will be taken seriously and inform care adjustments. Residents and their families, as well as staff, are key contributors to identifying day to day risks and the care home's receptiveness to their voices should form a part of assessment of safety in this domain. Where the resident's perspective of their safety may be difficult to establish due to cognitive and/or communication impairment, it is important to consider and triangulate feedback from different sources and constituent stakeholders.

The anticipation and preparedness domain captures the ability of an organisation to respond to risks. The quality of leadership is a key potential measure in this domain given the importance of leadership in developing an open and transparent workplace culture, where everyone can raise concerns which is essential for identifying and mitigating future safety risks. Studies have found that the safety culture is lower in nursing homes than in hospitals, with lower levels of learning from errors, less open communication, and a punitive culture among staff (Bonner *et al.*, 2008). It has been found that work environment influences resident safety outcomes more than the traits of individual care staff (Pickering *et al.*, 2017). The SARs reports contained multiple examples of safety issues related to poor staff skills and knowledge. Along with effective management oversight, an adequately trained workforce is key to safety improvement. However, assessment in this domain should consider the dearth of training opportunities in the care home sector. While there is a national patient safety syllabus being developed for NHS staff in the UK NHS, opportunities for care home staff to engage in this training are slim in the current context of the pandemic, staffing shortages and constrained financial resources.

The integration and learning dimension of the framework was not a key feature of the SARs reports in terms of identifying systems for tracking improvement over time. However, it is an essential component of a safety system (Thacker *et al.*, 2019) but is only likely to embed within cultures that support reporting of safety issues, protected time to reflect on safety data and team-wide engagement in planning for improvement. As such its assessment should be linked to the anticipation and preparedness domain. Until staff can engage in monitoring their own performance more effectively which requires not only availability of information that can stimulate action but also the skills amongst staff to interpret such data then many of the safety

issues identified by SARs are bound to reoccur. Despite being a a rich store of intelligence on safety, SARs are woefully underutilised because of limited systems to enable learning and change in the sector.

Our review also identified the importance of external factors in care home safety. This reflects the recent care home experience during COVID 19, where factors outside of care homes were shown to play an important role in the safety of care home residents (Rajan *et al.*, 2020). These factors do not necessarily sit outside of the SMMF as it can be applied to not only an individual home, but to a system. Most of the external factors were located in other social care organisations or organisations that fall under the banner of health care. However, this does have implications for how safety is measured and monitored. Monitoring needs to acknowledge that there are factors not just beyond the care home itself, but factors which, being organisationally far removed from the home, mean that a home may have little knowledge of and no ability to control. Capturing this in measurement though is fraught with challenges, but at this more conceptual stage of thinking about a framework for measuring and assessing safety in older adult care homes it is important to include all relevant factors.

Conclusion

To provide a starting point to understanding safety in care homes and how it might be measured, the content of the SARs was mapped to the SMMF. The content of the SARs reflected the dimensions of the SMMF and suggests that multidimensional system-based assessment models of safety are relevant to older adult care homes. However, if these models are to underpin approaches to measuring safety in care homes, recognition of how this unique context interacts with the dimensions of the model is vital. For example, SARs content highlighted the importance of what happens in other organisations when thinking about safety in care homes. Because of the importance of context, applying these models to social care more generally would also require an examination of the context around specific types of care.

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Table 1 Safety Measurement and Monitoring Framework (SMMF)

Dimension	Question & definition	Examples
Harm	Has patient care been safe in the past? The measurement of multiple types of harm, over time, to help assess whether care has been safe in the past.	Physical harm - pressure ulcers, malnutrition and weight loss, and physical harm caused by other residents Psychological harm - lacking dignity and respect for the residents
Reliability	Are our clinical systems and processes reliable? Gauging the probability that a task, process, intervention, or pathway will be carried out/followed as specified.	Protocols for safety critical care activities Problems with systems and process
Sensitivity to operations	Is care safe today? This domain concentrates on the day to day, hour by hour and even minute by minute management of safety.	Monitored through the residents' voice, or changes to residents' health or staff health or other factors that can be used to indicate that the safety of care might be under threat e.g., low staffing
Anticipation and preparedness	Will care be safe in the future? This domain focuses on the identification of possible sources of future harm and working to become more resilient to them.	Training before an event occurs
Integration and learning	Are we responding and improving? The development of systems to promote a cycle of learning and sharing from safety incidents, multiple sources of safety intelligence and insights developed through the other domains.	Learning from incidents and responding to previous failures. For example, training following an event

Table 2: Characteristics of SARs reviewed

SCIE Library number	Date of publication	Location	Subject (s) of review and age	Type of care home	Relevant incident / circumstances leading to SAR
4	May 2016	Rotherham	Female (90)	Residential	Recurrent falls and death due to head injury.
6	November 2015	Kirklees	33 residents	Residential	Emergency closure order by CQC.
15	May 2016	Rotherham	Female (92)	Nursing & Residential	Omission in respect to medication leading to death.
28	Dec 2016	Nottingham	28 residents	Unspecified	Death of resident following gross neglect.
37	September 2017	Richmond	Female (80)	Residential	Death by suffocation.
49	March 2017	Darlington	Female (86)	Residential	Death following a succession of falls.
50	Oct 2016	Stockport	Female (82)	Residential	Death following physical deterioration during short term placement.
51	July 2017	Kirklees	Female (unknown)	Unspecified	Death from grade 4 pressure ulcer.
61	May 2015	Isle of Wight	Female (mid 80s)	Residential	Death from skin condition and pressure ulcer.
66	June 2016	Dorset	7 residents	Nursing	Serious harm and neglect.
80	September 2017	Kent	Female (89)	Unspecified	Death following delayed admission to hospital after falling.
82	December 2017	Lancashire	Female (84)	Nursing & Residential	Recurrent falls and death.
92	December 2015	Worcestershire	Male (82)	Residential	Resident died unsupported outside the home.
93	April 2017	Worcestershire	Male (78)	Residential	Death following assault by another resident and falls.
94	Feb 2018	Worcestershire	Male (68)	Unspecified	Death following chest infection, septicaemia, and injuries to lower leg.
101	July 2017	Lewisham	Male (69)	Nursing	Death from burns.
103	August 2018	Northumberland	Male (90)	Nursing	Death from complications of diabetes.
105	September 2018	Stockport	Female (77)	Residential	Death from sepsis, empyema, purulent pericarditis and bronchopneumonia.