



Kent Academic Repository

Smith, Nick, Rand, Stacey, Palmer, Sinead, Jones, Karen and Hogan, Helen (2026) *The measurement of safety in older adult care homes: A qualitative study of the perspectives of strategic-level health and social care professionals*. Journal of Long-Term Care, 2026 . pp. 294-304. ISSN 2516-9122.

Downloaded from

<https://kar.kent.ac.uk/116424/> The University of Kent's Academic Repository KAR

The version of record is available from

<https://doi.org/10.31389/jltc.559>

This document version

Publisher pdf

DOI for this version

Licence for this version

CC BY-NC-ND (Attribution-NonCommercial-NoDerivatives)

Additional information

Versions of research works

Versions of Record

If this version is the version of record, it is the same as the published version available on the publisher's web site. Cite as the published version.

Author Accepted Manuscripts

If this document is identified as the Author Accepted Manuscript it is the version after peer review but before type setting, copy editing or publisher branding. Cite as Surname, Initial. (Year) 'Title of article'. To be published in **Title of Journal** , Volume and issue numbers [peer-reviewed accepted version]. Available at: DOI or URL (Accessed: date).

Enquiries

If you have questions about this document contact ResearchSupport@kent.ac.uk. Please include the URL of the record in KAR. If you believe that your, or a third party's rights have been compromised through this document please see our [Take Down policy](https://www.kent.ac.uk/guides/kar-the-kent-academic-repository#policies) (available from <https://www.kent.ac.uk/guides/kar-the-kent-academic-repository#policies>).



The Measurement of Safety in Older Adult Care Homes: A Qualitative Study of the Perspectives of Strategic-Level Health and Social Care Professionals

RESEARCH

NICK SMITH

STACEY RAND

SINEAD PALMER

KAREN JONES

HELEN HOGAN

**Author affiliations can be found in the back matter of this article*



ABSTRACT

Context: Ensuring the safety of older adults living in residential care homes is an international priority. Residents are often highly frail and vulnerable, making safety a critical concern. A growing range of organisations collect safety-related data from care homes, yet there is limited understanding of how effectively these data support learning and improvement.

Objective(s): To explore strategic stakeholders' views on the scope, collection, and use of safety data in older adult care homes, and to identify opportunities to better support learning and improvement.

Method(s): Semi-structured online interviews were conducted with 18 purposively sampled strategic-level professionals in England, representing regulatory bodies, NHS organisations, local authorities, care home providers, and representative organisations. Data were analysed thematically.

Findings: Data collection largely reflected organisational roles in regulation or quality monitoring and focused predominantly on adverse outcomes and incidents. Care homes were subject to overlapping data requests. Barriers to effective use of safety data included siloed data collection, limited sharing between organisations and care homes, a blame-oriented culture associated with harm-focused measures, and limited capacity to analyse and use data for improvement.

Limitations: This was a small, qualitative study focused on strategic stakeholders; perspectives of care home staff, residents, and families were not included.

Implications: Improving safety assessment in care homes requires rationalising and standardising data requests, balancing harm-focused indicators with measures of proactive safety practices, enhancing data sharing, strengthening analytic capacity, and ensuring care home staff have the skills required to use safety intelligence to stimulate safety improvement.

CORRESPONDING AUTHOR:

Nick Smith

The University of Kent, UK
n.j.smith@kent.ac.uk

KEYWORDS:

Care homes; Patient safety; Safety measurement; Data use; Older adults; Qualitative research

TO CITE THIS ARTICLE:

Smith, N., Rand, S., Palmer, S., Jones, K. and Hogan, H. 2026. The Measurement of Safety in Older Adult Care Homes: A Qualitative Study of the Perspectives of Strategic-Level Health and Social Care Professionals. *Journal of Long-Term Care*, (2026), pp. 294–304. DOI: <https://doi.org/10.31389/jltc.559>

INTRODUCTION

Ensuring the safety of older adults living in residential care homes is an international priority (Rand et al., 2021; WHO, 2021). Across many countries, care home residents are increasingly older, frailer, and living with multiple long-term conditions (OECD, 2025). This makes them particularly vulnerable to avoidable harm. Safety in these settings encompasses a broad range of issues, including falls, pressure ulcers, medication-related incidents, healthcare-associated infections, safeguarding concerns, and avoidable transfers to hospital (Rand et al., 2021; Smith et al., 2023; Giebel et al., 2020). As governments and care systems seek to improve the quality of long-term care, there is growing interest in how safety can be measured and how safety-related data can be used to support organisational learning and improvement. Safety is often defined as the absence of preventable harm. However, understanding what constitutes meaningful safety information, and how this information should be collected and used within long-term care settings is challenging. Although safety has become an increasing focus of policy and practice, featuring in frameworks for long-term care (NHS Digital, 2019),¹ it is still seen as a neglected area (Gartshore, Waring, and Timmons, 2017; Goodman et al., 2017; Marshall et al., 2017; Waterson, 2014). Indeed, attempts to improve care home safety often have their origins in healthcare settings, despite important differences between healthcare organisations and residential care homes (Allen, 2009).

These issues are particularly relevant in England, where older adult care homes support just under 300,000 people aged over 65 (ONS, 2023), providing accommodation alongside personal care and support, and in some homes, nursing care. Those who reside in older adult care homes tend to exhibit severe and profound needs, often living with long-term conditions, and functional and cognitive decline (Bebbington, Darton, and Netten, 2001; Gordon et al., 2014; McCarthy et al., 2020; Oliver, Foot, and Humphries, 2014), making safety a key concern. England also provides an informative case for understanding the use of safety data because responsibility for monitoring care home safety is distributed across multiple organisations, each with distinct statutory responsibilities. This creates both extensive opportunities for collecting safety information and challenges in coordinating that information for learning and improvement, issues that are relevant to many health and social care systems internationally. A review of international safety measures concluded that safety in older adult care homes is increasingly being assessed in ways that align with healthcare data collection concepts and practices, but with some recognition of how long-term care settings are distinctive, especially since they are *home* to the residents (Rand et al., 2021).

In England, the Care Quality Commission (CQC), the independent regulator of health and adult social care services, has monitored safety in older adult care homes since 2015, primarily via inspections and quality ratings, though also through statutory notifications and portals that allow anyone to raise and record a safety concern. However, reflecting the fragmented and complex nature of social care provision in England, monitoring safety in older adult care homes is also conducted by a range of other organisations. Local authorities, which commission publicly funded adult social care and have statutory safeguarding responsibilities under the Care Act (2014), monitor the quality and safety of care services within their localities. For nursing homes, Integrated Care Boards (ICBs), regional NHS organisations responsible for planning and commissioning healthcare services, also have responsibilities for overseeing quality and safety. In addition, because of the overlap between health and social care, NHS England collects, collates, and uses care home safety data. Care home providers themselves collect extensive information, both to meet external reporting requirements and increasingly through their own digital care record systems that support operational management and quality improvement (Burton et al., 2022; Smith et al., 2024).

The collection of such data has the potential to provide stakeholders in the older adult care home sector with insights into how to improve care (Hanratty et al., 2020). Broader work on safety has suggested that collecting data on risks, harmful incidents, and related indicators to inform learning is a key method for improving organisational safety (Drupsteen and Wybo, 2015). Nonetheless, research suggests that adopting monitoring and measurement approaches directly from healthcare, where the measurement of safety is more developed, without considering the specific context of social care more generally, and older adult care homes specifically, may limit how effective learning from safety data is (Rand et al., 2021; Richardson et al., 2019; Smith et al., 2023). Care homes are sources of large amounts of data (Hanratty et al., 2023; Shenkin et al., 2022), but little is known about what safety data they currently collect and how it is used (Burton et al., 2020; Hanratty et al., 2020). This represents an important gap in the literature. Research has largely focused on the types of data collected within care homes or on the perspectives of individual organisations, with less attention given to how strategic stakeholders across the wider health and social care system understand safety measurement and use safety information to support learning and improvement. Addressing this gap is important because these organisations shape both the information requested from care homes and the ways in which those data are interpreted and used.

In this study, we aimed to understand the views of key stakeholders in the English care home sector on the scope

of safety data collected and how they are currently used. By looking at the views of regulators, commissioners, NHS organisations, and care home providers, this study contributes new evidence on how organisational roles shape approaches to safety measurement and identifies barriers that limit the use of safety data in sector learning and improvement.

METHODS

The study is reported in accordance with the Standards for Reporting Qualitative Research (SRQR) (O'Brien et al., 2014). Please see Supplemental File 1 for the SRQR checklist. Semi-structured qualitative interviews were conducted with strategic-level professionals in England, who were expected to have an informed professional view on measuring safety for monitoring, improvement, and learning in older adult care homes. A purposive sample was recruited through the authors' professional contacts and the respondents' professional contacts (snowball sampling). This was supplemented with direct recruitment following reviews of local authority websites for details of relevant roles within the study scope, i.e., safeguarding managers, safeguarding adult board members, and local authority quality monitoring managers. For both approaches, no geographic or regional constraints were imposed beyond a focus on England only. Professionals were contacted by email with details about the study and an invitation to participate.

A total of 47 stakeholders were invited to take part in the study. Of these, 18 participated in an interview. Of the 29 who did not agree to participate, 8 represented local authorities, 8 care home providers, 7 the NHS, 3 the CQC, and 3 represented other organisations such as informal care groups. We did not collect the reason for non-participation, though in most cases it was due to non-response to the invitation.

The participants included professionals with strategic managerial and oversight roles at local, regional, or national levels (see Table 1) and from a range of organisations including care home providers, local authorities, the CQC, and the NHS. Those who participated in the interviews were, broadly, not involved in providing direct care. For example, those from care home provider

organisations were usually from a care home chain that had a number of homes, and their roles were regional management and above. The only exception was the inclusion of two GPs, who, while providing direct support to care home residents, also had a strategic role in their local Clinical Commissioning Groups. Further details, such as job titles, are not reported to protect anonymity.

The research team included researchers with expertise in adult social care, care home research, and health services research, and a healthcare researcher with a background in general practice. The interviewers (NS and SR) were experienced social care and care home researchers. Some participants were identified through professional networks; however, interviewers had no prior working relationship with the participants whom they interviewed. Throughout the analysis, coding decisions were discussed across the research team and transcripts were double-coded to support reflexive consideration of assumptions and interpretations. The research team was supported by public and patient involvement (PPI) advisors at key points within the project, although they did not work on the project directly. The Public Involvement and Strategy and Implementation Operation Group (PISIG-O) for the Policy Unit funding and conducting this study reviewed the focus of the study and its research questions before the start of the project, and reviewed both how the study was conducted and its findings at regular intervals during the study.

Between July and November 2020, one-to-one interviews were conducted remotely, using MS Teams, Zoom, and telephone. Each interview was conducted by one of the two researchers. The duration of interviews was from 28 to 51 minutes. In all cases, the researcher who contacted the potential participants, and, if applicable, subsequently conducted the interview, did not have prior professional contact or a working relationship with the interviewee. The interviews were conducted using a topic guide, which focused on experience of safety measurement, including collecting and using data and perspectives on measuring and using safety data. The interview schedule can be found in Supplemental File 2.

The interviews were audio recorded and transcribed verbatim, except for the omission of personal, organisational, and place names. Transcripts were analysed using Braun and Clarke's (2006, 2019) reflexive thematic analysis approach. Analysis was conducted by three researchers [NS, SP, and SR] using NVivo (QSR International, 2020). Following Braun and Clarke's six phases of analysis, in the first stage, researchers familiarised themselves with the transcripts. The second phase involved collaboratively creating an initial coding framework (see Figure 1).

This was based on codes that emerged inductively from close readings of four interview transcripts by NS, SP, and SR. Codes were reviewed and agreed by all the authors. In the third stage, the transcripts were coded

	n
CQC	3
CCGs/GP practices	2
Local authorities	4
NHS England, NHS Digital	3
Care home providers and provider representatives	6
Total	18

Table 1 Organisational/professional background of participants.

Collection and application of safety indicators

- Data currently collected
- How data is collected
- Benefits
- Challenges and barriers
- How data is used
 - How is data shared, linked and reported/presented
 - How is data used in improvement and learning
 - Key stakeholders or users

Figure 1 Coding framework.

according to this initial framework. Each transcript was double-coded. During the fourth and fifth phases of the analysis, differences in coding were reconciled through discussion, and the coding framework was reviewed for coherence and credibility and, where necessary, revised. Themes and preliminary findings were shared with the project team, and in presentations to wider audiences. Feedback from the project team and others was incorporated into the analysis. The sixth phase of the analysis consisted of selecting the most appropriate extracts and writing the findings section.

FINDINGS

SCOPE OF CARE HOME SAFETY DATA COLLECTED BY STAKEHOLDERS

Interviewees reported the collection of a broad range of safety data, generally describing the scope of these data in terms of their organisations' key roles. CQC representatives framed safety data from the perspective of being an independent regulator of the sector and responsible for monitoring minimum standards for quality and safety at the national and registered organisation level:

Safety's a big part of what [organisation] look at. It's one of the five key lines of enquiry and it's probably one of the most important, really... if you haven't got safety at the beginning that's got to be the foundation, really. (CQC representative 01)

Emphasis was placed on identifying adverse outcomes, including deaths, serious injuries, and safeguarding failures, alongside mechanisms for assessing risk reduction such as the use of care, or Medication Administration Records (MARs). Such intelligence came from a number of sources, including care home providers, staff, residents, community health, police, and ambulance services, ensuring signals of concern were not missed. NHS England also focused on collecting information on harm or risk factors for harm alongside data on NHS service use. Care home data on specific harms such as falls, pressure ulcers, or safeguarding alerts were combined with wider intelligence on NHS

service use in order to identify national priorities for improving the maintenance of residents' health and wellbeing and reducing potential pressure on acute NHS services. As one NHS stakeholder explained,

Over the last probably six months we've been looking at falls, nutrition, oral health, pressure ulcers. Those have been the four kind of big hitters that we've been looking at because they tend to be the biggest reasons why people get admitted to hospital and biggest reasons for safeguarding alert or any patient safety incidences. (NHS representative 01)

Both the CQC and NHS England highlighted the key role of care home staff in the maintenance of safety and staff skills, with staff confidence and formal training seen as important safety indicators. The GP interviewees provided a similar 'healthcare-orientated' view of safety and its measurement to NHS England, particularly the need to profile demand for ambulatory and acute hospital care and drivers within care homes that lead to such use, though this was supplemented by mentions of safeguarding data and contextual data such as number of care home beds as important measures of safety.

Local authority representatives' views on safety data reflected their organisation's role as the lead for promoting high-quality, safe, and cost-effective care for vulnerable older adults in their locality:

...in my authority ... [data] generally are ... around quality, safety, outcomes, measures. (Local authority representative 03)

They highlighted the importance of local tacit knowledge in identifying issues:

They [colleagues] know their local providers and if they're picking up a number of concerns—and they will separate those out into what we call safeguarding concerns and quality in care issues. (Local authority representative 01)

Care home providers and their representative bodies not only provided safety data to multiple external agencies but also often had their own sets of safety measures, resulting in broad and detailed interpretation around the scope of safety data in this setting:

...anything resident-related from pressure care, weight loss, infection, mental capacity assessments. ... We've got things like anti-psychotic drugs, ... how many? We look at deaths. The cause of death ... We look at medication errors, medication reviews, health reviews, care reviews, bed rail use ... We look at the amount of,

um, services that have been attended. ... attending A&E, emergency services, ... how often dentists are going in. Chiropodists. We look at ... compliments, complaints, comments, resident involvement. How many times the residents—that could be things like resident meetings, relative meetings, services. We look at things like whether people are going outside of the home, ... then analyse that against a resident wellbeing score. (Care home provider representative 04)

When care home providers were asked to describe safety measures, their primary focus was usually on those capturing adverse outcomes, such as incidents of harm, hospital admissions or deaths, and the risk factors for harm, including medical errors, weight loss and nutritional assessments, or the use of Deprivation of Liberty Safeguards (DoLS). Some stakeholders from this sector mentioned the collection of intelligence on proactive efforts to improve safety and reduce the risk of harm, such as medication reviews, resident and relative involvement activities, and access to preventative health services such as chiropody. Alongside quantitative data collection, interviewees from the CQC and local authorities stressed the importance of qualitative 'local intelligence' in providing a 'wider' understanding of care home culture (CQC representative 02). The CQC used observational and interview data to better understand, interpret, and even challenge other sources of safety information, such as written records:

They [the inspectors] will corroborate that [an incident] by talking to people, talking to staff, looking at daily records, etc, and sometimes we find that people have got absolutely perfect wonderful care plans and risk assessments but they're aspirational and so, in reality, they're not followed (CQC representative 01)

THE USE OF CARE HOME SAFETY DATA FOR LEARNING AND IMPROVEMENT

The interviews with stakeholders provided examples of safety data being used to inform and drive improvements in safety. A CQC stakeholder outlined how information collected from care homes was used to inform their reports and reviews at a national level, and how learning from this was available to all care homes:

We were asked to do an infection prevention and control thematic review back in August, and in September, we published some initial findings around good practice. So, whilst not every service that we regulate was involved in that thematic review and inspected through that thematic review, actually, every service had the ability to reflect on the learning that we have. ...So, that is widely

shared, and therefore services are able to use those things to improve. (CQC representative 03)

Other interviewees also talked about learning from the data they collected, including a care provider who shared their experience of using data showing variation in pressure ulcer incidence across homes to promote learning and improvement at a home and group level (Care home provider representative 04). A local authority representative spoke about learning for both their organisation and for care homes from quality audit framework data, which included safety data:

...once they've [local authority staff] completed the whole of the quality audit framework, that comes to me. And I'll go over that, some of the learning, with the team managers, around ...And, again, share good practice around, you know, what we could do differently. It doesn't just stop with me. It then goes to ... our Head of Service. And, again, we look at kind of how we can sort of develop things across all services. ... there might be some shared learning. (Local authority representative 02)

Stakeholders also recognised that there were a number of barriers to achieving such improvements. Principal amongst these was the fact that data on safety tended to remain siloed, remaining within a single organisation or locality. External organisations used their own discrete data collection tools to collect similar and overlapping data items from care homes. This was an issue that had been very apparent during the COVID-19 pandemic:

We've been round and round in circles about whether it should be this tool or that tool or the other tool. And we've ended up having—I mean, [company]'s doing one thing with one tool and care homes are doing a different thing with another tool. If ever there was a screaming need for having that data in one place it's—C-19 has just proved it. (Care home provider representative 01)

Once collected these data did not appear to be widely shared:

This might just be my fantasy about it, but local authorities seem to be a bit more protective that we are local authorities and therefore there isn't that—there isn't that mind-set or necessarily the mechanisms, apart from the Association of Directors of Adult Social Services, to be having that more broad sharing of information and learning on a national basis. So I think there's probably a bit of work for us to do. (Local authority representative 01)

Care home providers often felt that data flowed one way. Information they provided on request to local and national bodies was not then made available in a form that could be used for improvement activities.

I don't think it's [care home safety data] widely used in my experience, or it could be more widely used. I mean by frontline practitioners. Or given in a form that would—or in a way that would support them professionally in terms of their—in terms of their role. (Local authority representative 03)

Even care home providers themselves could appear distanced from the data collection process itself.

Given the emphasis many organisations placed on collecting information on harm and other negative outcomes, it was not surprising that a number of stakeholders felt that such data were inevitably used to apportion blame rather than promote learning:

the only real way that we [the local authority] measure the safety is around the adult safeguarding alert and the patient safety incidences that are coming in. And that tends to be a very punitive approach and I think because of that, and because of fallout of any kind of safeguarding alert that means a social worker's got to come in and it's very much seen as like a blame culture. (NHS England representative 01)

CQC representatives acknowledged that their key role in ensuring resident safety did involve looking for evidence that a home might be an outlier for safety and, in some rare cases, using such information as a basis to commence legal action.

Another commonly cited barrier to improvement was the fact that care home safety data, including safeguarding data, were collected but not used effectively. One local authority representative stated, 'we often hear a narrative that we're drowning in data, not always to best effect' (Local authority representative 03) and a care provider commented,

we're focusing far too much ... on data collection rather than data analysis and understanding what action we need to take to prevent unsafe care. So, we need to reframe it. (Care home provider representative 02)

An NHS England stakeholder (02) highlighted how some of the data asked for were not used to identify priorities for policy development. One of the GP interviewees confirmed this point:

we're now supposed to ask, when you were in hospital did they look after you properly? And

when you came out, is there anything that they said they would do that they've not done? ... so we have a process for everybody who comes out of hospital; I have a little questionnaire that I run through ... but nobody checks on it... Absolutely nothing. Absolutely nothing. (GP representative 01)

Another barrier to use was the perception of lower levels of data analytic skills within the care home sector, but also sometimes within external bodies. One care home provider commented,

... people internal to the home or even people looking at a home, and that can be from governance roles or otherwise from CCGs (Clinical Commissioning Groups), health boards or other, they don't get the data they're necessarily look at, they don't pull out the correlations, it's something that you have to spell out. (Care home provider representative 03)

Although many of those interviewed agreed that information on safeguarding was a key element of a care home's safety profile, there were mixed views on its effectiveness in informing improvement across the older adult care home sector. Some stakeholders felt that mechanisms for collecting this type of data were not as developed as in healthcare or children's services. For some organisations, such as the local authorities, Safeguarding Adult Reviews (SAR), which take a multiagency approach to reviews of serious harm or death, are important sources of information on safety that drive improvement:

SARs is the key tool if you like to be able to shine a light, lift—or if you want, lift a stone and look underneath when something has gone seriously wrong. A person's been exposed to abuse and harm, or there is the suspicion that they have. And we've got also evidence that agencies didn't work effectively together. And so, it's probably the key method we've currently got about using that to make system improvement. (Local authority representative 03)

However, other stakeholders felt that the value of SARs in driving improvement was limited because they were too often conducted in an unsystematic manner, failed to involve all the relevant agencies, or were inaccessible or restricted in terms of access.

DISCUSSION

This study focused on the perspectives of strategic stakeholders on care home safety data, their collection, and use. The principal contribution of this article is that it shifts attention from the measurement of safety within

individual care homes to the strategic systems responsible for collecting, interpreting, and using safety data across the sector. Previous research has largely focused on describing the data collected within care homes, developing minimum datasets and digital technologies, or understanding the perspectives of frontline care staff, with less attention paid to how the organisations responsible for regulation, commissioning, and oversight conceptualise and use safety data (Burton et al., 2020; Carroll et al. 2025; Hanratty et al., 2020; Burton et al., 2022; Shenkin et al., 2022; Smith et al., 2024). Our findings show how regulators, commissioners, NHS organisations, and providers understand safety differently according to their organisational responsibilities. These different perspectives help explain why care homes experience multiple overlapping data requests and why safety information often supports accountability rather than learning. By exploring the views of participants from a range of organisations rather than a single stakeholder group, this study identifies both convergence and divergence in how safety data are conceptualised. Stakeholders broadly agreed that safety data should support learning and quality improvement. However, the priorities of the organisations shaped which data were seen as important and how they were subsequently used. This helps explain persistent fragmentation in care home safety measurement despite widespread agreement about its importance.

Interviewees in the study described the considerable range of safety and safety-related data being collected from this sector, reflecting previous research findings related to care home data more generally (Hanratty et al., 2023; Shenkin et al., 2022). This broad scope of safety assessment is consistent with international literature, which demonstrates that care homes across North America, Europe, Australia, and parts of Asia are increasingly using a diverse range of indicators to monitor safety, spanning both resident outcomes and organisational processes (Rand et al., 2021). However, our findings suggest that collecting safety information alone does not ensure that it is effectively used for learning and improvement.

Despite the broad scope of safety assessment in the sector, there was still a tendency for stakeholders to predominantly identify safety measurement with its more negative outcomes, such as safety incidents and harm. This traditional view of safety, sometimes referred to as Safety I, has been criticised for its association with a blame culture and for having a stigmatising impact that can inhibit learning (Hollnagel, Wears, and Braithwaite, 2015). However, there was acknowledgement that such data should go beyond information on harm and include aspects of organisational culture, staff training and skills, and proactive risk reduction activities, suggesting that, at least at a strategic level, the monitoring and measuring of older adult care home safety is moving towards a more

systems-based approach to safety assessment (Vincent, Burnett, and Carthey, 2014). This potentially represents a positive step towards a more balanced perspective that assesses and learns from not just what goes wrong, but also what has gone well, and the successful adaptations made day-to-day to manage risk, sometimes referred to as Safety II (Hollnagel, Wears, and Braithwaite, 2015). Such measures might include information on staff training and capability, medication reviews, resident and family involvement in care planning, proactive risk management activities, and examples of successful adaptations made by staff to maintain resident safety.

A key concern about data collection in care home settings is the potential burden it places on an already pressured sector. This issue features in both government policy (NHS England, 2016) and in exercises to streamline data collection in care homes (Burton et al., 2022; Carroll et al., 2025; Johnston et al., 2020; Towers et al., 2023). This burden is not made any lighter by the use of a variety of data collection tools and slightly different and overlapping data requests from different stakeholders. These challenges have been more widely understood and acknowledged in recent years, even if they remain, for now, unresolved (Burton et al., 2022; Carroll et al., 2025; Johnston et al., 2020; Towers et al., 2023).

Interviewees widely acknowledged that safety data are not always effectively used for learning, either by their organisations or by the care homes themselves. Data tend to remain local or in 'silos', are not fed back to care homes in an accessible way, and sometimes are not used at all. A notable tension identified in this study is that care home providers have a dual position. They both produce safety data and are subject to scrutiny by external organisations. While providers were expected to collect and supply large volumes of safety-related information, many interviewees felt that they received little feedback or support in return. This dual role may help explain concerns regarding reporting burden and perceptions that data collection is more strongly associated with accountability than organisational learning. The siloed nature of data is supported by other work that concludes that data collected in the care home sector are poorly used, often because of a lack of mechanisms for sharing (Burton et al., 2020; Darby et al., 2017; Hanratty et al., 2020; Shenkin et al., 2022). This wider work also acknowledges two other reasons we found for a lack of use: a lack of skills and experience in data analysis, and a lack of standardisation of data collected.

The findings suggest that these patterns are not just the result of technical issues in data systems. Instead, they reflect a fragmented care system and the different organisational functions that safety data serve across the sector. For regulators, commissioners, and safeguarding bodies, safety data are primarily used to identify risk,

monitor performance, and provide assurance. For care home providers, however, these data may be expected to support service improvement and learning. This creates a tension where information collected for external accountability is not always perceived as useful for local learning. The focus on harm-related measures may reinforce this. Safety data may be associated with identifying failures rather than supporting learning. In this context, it is perhaps unsurprising that interviewees frequently described one-way flows of information from providers to external organisations, while examples of collaborative learning were comparatively limited.

The findings of this study have implications for the assessment of safety in care homes and its use in supporting learning and improvement. Finding ways to rationalise the amount of safety information requested by external stakeholders is likely to be key. This will require more joined-up reflection on what is collected and why, as well as identifying where there may be opportunities for both sharing these data and for reducing the number of slightly different but overlapping items requested. The need for data standardisation is clear from this work and echoes calls made by those researching care home quality more widely (Hanratty et al., 2020; Towers, 2022). This rationalisation should also include efforts to balance the collection of data focused on poor safety outcomes (Safety I) with information that reflects positive safety practices and successful risk management activities (Safety II), such as staff capability, proactive risk reduction measures, and resident involvement in care. Such measures may be more likely to support staff engagement, organisational learning, and continuous improvement.

The final implication for practice is about the capacity of the sector to work with data and use them in a manner that helps learning and improves practice. As part of a wider issue around research capacity in adult social care, other research has found that older adult care homes and related bodies lack the capacity and resources to carry out the analysis of data required to inform ongoing learning (Darby et al., 2017; Hanratty et al., 2020; Smith et al., 2024). Investing in building this capacity is vital if data are to be meaningful to and used by care home staff themselves to improve safety.

Digital technologies may help address some of the challenges identified in this study, particularly by reducing duplicate data collection, supporting data sharing across organisations, and providing care homes with more timely feedback on performance. However, technology alone is unlikely to improve safety unless accompanied by investment in analytic capacity and support for care home staff to interpret and use data for learning and improvement. Indeed, advances in the development of digital data collection tend to identify more potential safety indicators. It will be important to moderate this likely increasing demand for data with reflections on how safety data might best be used to inform quality improvement

at the front line and provide assurance at the strategic stakeholder level. Until as much focus is given to the use of safety data as to their collection, their potential to inform improvements in resident safety will not be maximised.

STRENGTHS AND LIMITATIONS

This study gathered views from a range of different stakeholders to ensure representation from across the multiple organisations that have a stake in collecting these types of data. We were able to analyse data from across interviewees to identify common themes. While some commonly held perspectives were identified, this was a small, focused study, and other experiences and perspectives may be missing from our findings. The views of other stakeholders, care home managers, care staff, residents, and their families, on both what safety means to them and the utility of the data they are asked to collect, may be quite different from the perspectives presented here. Gathering these views will be important to establish the full picture of the best place to intervene to ensure data drive learning. Follow-up work from the study presented here aims to address these omissions.

CONCLUSION

This study demonstrates that although extensive safety data are collected across the English care home sector, sector fragmentation means that these data are more often used for accountability than for shared learning and improvement. Stakeholders predominantly identify safety measurement with its more negative outcomes, such as safety incidents and harm, and safety conceptualised in this way tends to drive blame and stigmatisation rather than a culture of improvement. Safety data remain siloed in requesting organisations and tend not to be fed back in an accessible form for use by care homes. Further progress on developing assessment of safety in care homes to support learning and improvement will require balanced data collection that captures proactive steps to improve safety and reduce risk as well as harm, a rationalisation of the number of safety measures requested, increased sharing across organisations, and ensuring care home staff have the skills required to use safety intelligence to stimulate safety improvement.

NOTE

1. In 2023, NHS Digital and NHS England merged into a single organisation, making NHS England responsible for designing and operating national data infrastructure and digital systems. In 2025 its responsibilities began a process of being transferred to the Department of Health and Social Care.

ADDITIONAL FILES

The additional files for this article can be found as follows:

- **Supplemental File 1.** Standards for reporting qualitative research (SRQR) checklist. DOI: <https://doi.org/10.31389/jltc.559.s1>
- **Supplemental File 2.** Interview Topic Guide. DOI: <https://doi.org/10.31389/jltc.559.s2>

ETHICS AND CONSENT

Ethical approval for this study was granted by the Staff Review Committee, Division for the Study of Law, Society and Social Justice, The University of Kent, on 19/07/2020 (application ref. 692). Informed consent was obtained from all participants.

ACKNOWLEDGEMENTS

The authors wish to thank all the care professionals who participated in the study.

FUNDING INFORMATION

This research was funded by the National Institute for Health and Social Care Research (NIHR) Policy Research Programme, conducted through the Quality, Safety and Outcomes Policy Research Unit, PR-PRU-1217-20702. The views expressed are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care.

COMPETING INTERESTS

The authors have no competing interests to declare.

AUTHOR CONTRIBUTIONS

NS, SR, HH, and KJ conceptualised and planned the study; NS and SR undertook data collection; NS led on analysis, with support from SR and SP, produced the draft manuscript, and was supported by SR, SP, HH, and KJ in refining it. All authors approved the final version of the manuscript.

AUTHOR AFFILIATIONS

Nick Smith  orcid.org/0000-0001-9793-6988
The University of Kent, UK

Stacey Rand  orcid.org/0000-0001-9071-2842
The University of Kent, UK

Sinead Palmer  orcid.org/0000-0001-8106-3078
National Centre for Social Research, UK

Karen Jones  orcid.org/0000-0003-0851-8341
The University of Kent, UK

Helen Hogan  orcid.org/0000-0002-0920-2093
The London School of Hygiene & Tropical Medicine, UK

REFERENCES

- Allen, D.** (2009) 'From boundary concept to boundary object: The practice and politics of care pathway development', *Social Science and Medicine*, 69(3), pp. 354–361. Available at: <https://doi.org/10.1016/j.socscimed.2009.05.002>
- Bebbington, A., Darton, R. and Netten, A.** (2001) *Care Homes for Older People: Volume 2 admissions, needs and outcomes. The 1995/96 National Longitudinal Survey of Publicly-Funded Admissions*. Canterbury: Personal Social Services Research Unit, University of Kent.
- Braun, V. and Clarke, V.** (2006) 'Using thematic analysis in psychology', *Qualitative Research in Psychology*, 3(2), pp. 77–101. Available at: <https://doi.org/10.1191/1478088706qp0630a>
- Braun, V. and Clarke, V.** (2019) 'Reflecting on reflexive thematic analysis', *Qualitative Research in Sport, Exercise and Health*, 11(4), pp. 589–597. Available at: <https://doi.org/10.1080/2159676X.2019.1628806>
- Burton, J.K., Goodman, C., Guthrie, B., Gordon, A.L., Hanratty, B. and Quinn, T.J.** (2020) 'Closing the UK care home data gap – methodological challenges and solutions', *International Journal of Population Data Science*, 5(4). Available at: <https://doi.org/10.23889/ijpds.v5i4.1391>
- Burton, J., Wolters, A., Towers, A., Jones, L., Meyer, J. and Gordon, A.** (2022) 'Developing a minimum data set for older adult care homes in the UK: exploring the concept and defining early core principles', *Lancet Healthy Longevity*, 3(3), e186–e193. Available at: [https://doi.org/10.1016/S2666-7568\(22\)00010-1](https://doi.org/10.1016/S2666-7568(22)00010-1)
- Carroll, R., Smith, N., Palmer, S., Burton, J., Gordon, A., Towers, A.-M., Rand, S., Tracey, F., Killelt, A., Webster, L., Hanratty, B., Spilsbury, K., Akdur, G., De Corte, K., Meyer, J., Jones, L. and Goodman, C.** (2025) 'Piloting a Minimum Data Set (MDS) in English care homes: a qualitative focus group and interview study of professional perspectives on implementation and use', *BMC Geriatrics*, 604. Available at: <https://doi.org/10.1186/s12877-025-06260-6>
- Darby, J., Horne, J., Lewin, J., Crocker, C., Coates, E., McEwan, K., Schols, J., Halfens, R., Lohrmann, C., Eglseer, D., Gladman, J.R.F. and Gordon, A.L.** (2017) 'Benchmarking the prevalence of care problems in UK care homes using the LPZ-i: a feasibility study', *East Midlands Research into Ageing Network (EMRAN) Discussion Paper Series*, 13. Available at: <http://www.nottingham.ac.uk/emran/documents/issue-13-emran.pdf> (Accessed 2 January 2026).
- Drupsteen, L. and Wybo, J.-L.** (2015) 'Assessing propensity to learn from safety-related events', *Safety Science*, 71, pp. 28–38. Available at: <https://doi.org/10.1016/j.ssci.2014.02.024>

- Gartshore, E., Waring, J. and Timmons, S.** (2017) 'Patient safety culture in care homes for older people: A scoping review', *BMC Health Services Research*, 17(1). Available at: <https://doi.org/10.1186/s12913-017-2713-2>
- Giebel, C., Harvey, D., Akpan, A. and Chamberlain, P.** (2020) 'Reducing hospital admissions in older care home residents: a 4-year evaluation of the care home innovation Programme (CHIP)', *BMC Health Services Research*, 20(94). Available at: <https://doi.org/10.1186/s12913-020-4945-9>
- Goodman, C., Sharpe, R., Russell, C., Meyer, J., Gordon, A.L., Denning, T., Corazzini, K., Lynch, J. and Bunn, F.** (2017) *Care home readiness: a rapid review and consensus workshops on how organisational context affects care home engagement with health care innovation*. Report. The University of Hertfordshire. Available at: <https://doi.org/10.18745/pb.18200>
- Gordon, A.L., Franklin, M., Bradshaw, L., Logan, P., Elliott, R. and Gladman, J.R.F.** (2014) 'Health status of UK care home residents: a cohort study', *Age and Ageing*, 43(1), pp. 97–103. Available at: <https://doi.org/10.1093/ageing/afu077>
- Hanratty, B., Burton, J.K., Goodman, C., Gordon, A.L. and Spilsbury, K.** (2020) 'Covid-19 and lack of linked datasets for care homes', *BMJ*, 369, m2463. Available at: <https://doi.org/10.1136/bmj.m2463>
- Hanratty, B., Wolters, A.T., Towers, A.M., Spilsbury, K., Meyer, J., Killelt, A., Jones, L., Gordon, A., Burton, J.K., Akdur, G., Irvine, L., Warmoth, K., Liddle, J. and Goodman, C.** (2023) 'Data collection in care homes for older adults: A national survey in England', *Journal of Long-Term Care*, 2023, pp. 288–296. Available at: <https://doi.org/10.31389/jltc.199>
- Hollnagel, E., Wears, R.L. and Braithwaite, J.** (2015) *From Safety-I to Safety-II: A White Paper*. Available at: <https://www.england.nhs.uk/signuptosafety/wp-content/uploads/sites/16/2015/10/safety-1-safety-2-white-papr.pdf> (Accessed 2 January 2026).
- Johnston, L., Hockley, J., Henderson, D.A. and Shenkin, S.D.** (2020) 'The Development of a Care Home Data Platform in Scotland: Insights from the Care Home Innovation Partnership, Lothian', *medRxiv Preprint server*. Available at: <https://doi.org/10.1101/2020.08.17.20176503>
- Marshall, M., Cruickshank, L., Shand, J., Perry, S., Anderson, J., Wei, L., Parker, D. and de Silva, D.** (2017) 'Assessing the safety culture of care homes: a multimethod evaluation of the adaptation, face validity and feasibility of the Manchester Patient Safety Framework', *BMJ Quality and Safety*, 26(9), pp. 751–759. Available at: <https://doi.org/10.1136/bmjqs-2016-006028>
- McCarthy, E.P., Ogarek, J.A., Loomer, L., Gozalo, P.L., Mor, V., Hamel, M.B. and Mitchell, S.L.** (2020) 'Hospital transfer rates among US nursing home residents with advanced illness before and after initiatives to reduce hospitalizations', *JAMA Internal Medicine*, 180(3), p. 385. Available at: <https://doi.org/10.1001/jamainternmed.2019.6130>
- NHS Digital.** (2019) *NHS Long Term Plan Implementation Framework*. Available at: <https://sw.leadershipacademy.nhs.uk/wp-content/uploads/sites/33/2022/07/nhs-long-term-plan-version-1.2.pdf> (Accessed 2 January 2026).
- NHS England.** (2016) *Burden reduction plan 2016–17*. Department of Health. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/519652/Burden_Reduction_Plan.pdf (Accessed 2 January 2026).
- O'Brien, B., Harris, I., Beckman, T., Reed, D. and Cook, D.** (2014) 'Standards for Reporting Qualitative Research: A Synthesis of Recommendations', *Academic Medicine*, 89(9), pp. 1245–1251. Available at: <https://doi.org/10.1097/ACM.0000000000000388>
- Office for National Statistics.** (2023) *Care homes and estimating the self-funding population, England: 2022 to 2023*. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/articles/carehomesandestimatingtheselffundingpopulationengland/2022to2023> (Accessed 2 January 2026).
- Oliver, D., Foot, C. and Humphries, R.** (2014) *Making our health and care systems fit for an ageing population*. The King's Fund. Available at: https://assets.kingsfund.org.uk/f/256914/x/7a8ed1e67a/making_health_care_systems_fit_ageing_population_2014.pdf (Accessed 2 January 2026).
- QSR International.** (2020) *NVivo qualitative data analysis software [software] Version 13 (R1)*.
- Rand, S., Smith, N., Jones, K., Dargan, A. and Hogan, H.** (2021) 'Measuring safety in older adult care homes: A scoping review of the international literature', *BMJ Open*, 11(3). Available at: <https://doi.org/10.1136/bmjopen-2020-043206>
- Richardson, E., Walshe, K., Boyd, A., Roberts, J., Wenzel, L., Robertson, R. and Smithson, R.** (2019) 'User involvement in regulation: A qualitative study of service user involvement in Care Quality Commission inspections of health and social care providers in England', *Health Expectations*, 22(2), pp. 245–253. Available at: <https://doi.org/10.1111/hex.12849>
- Shenkin, S.D., Johnston, L., Hockley, J. and Henderson, D.A.G.** (2022) 'Developing a care home data platform in Scotland: a mixed methods study of data routinely collected in care homes', *Age and Ageing*, 51(12). Available at: <https://doi.org/10.1093/ageing/afac265>
- Smith, N., Damant, J., Jasim, S., McLeod, H., Prato, L., Taylor, J., Ferguson Montague, A., Fitzpatrick, R., Forder, J., Giebel, C., Knapp, M., Toma, M., Towers, A. and Wright, L.** (2024) 'Care planning in older adult care homes: a qualitative study of care staff experiences and views', *International Journal of Care and Caring*, 10(3). Available at: <https://doi.org/10.1332/23978821Y2024D000000092>

- Smith, N., Rand, S., Morgan, S., Jones, K., Hogan, H. and Dargan, A.** (2023) 'The scope of safety in English older adult care homes: a qualitative analysis of Safeguarding Adult Reviews', *Journal of Adult Protection*, 25(1), pp. 3–13. Available at: <https://doi.org/10.1108/JAP-03-2022-0006>
- The Organisation for Economic Co-operation and Development.** (2025) *Health at a Glance 2025: OECD Indicators*. Paris: OECD Publishing. Available at: <https://doi.org/10.1787/8f9e3f98-en>
- Towers, A.-M.** (2022) 'Using linked health and social care data to understand service delivery and planning and improve outcomes', *Age and Ageing*, 51(3). Available at: <https://doi.org/10.1093/ageing/afac070>
- Towers, A.-M., Gordon, A., Wolters, A.T., Allan, S., Rand, S., Webster, L.A., Crellin, E., Brine, R.J., De Corte, K., Akdur, G., Irvine, L., Burton, J., Hanratty, B., Killelt, A., Meyer, J., Jones, L. and Goodman, C.** (2023) 'Piloting of a minimum data set for older people living in care homes in England: protocol for a longitudinal, mixed-methods study', *BMJ Open*, 13(2), e071686. Available at: <https://doi.org/10.1136/bmjopen-2023-071686>
- UK Government.** (2014) *Care Act 2014*.
- Vincent, C., Burnett, S. and Carthey, J.** (2014) 'Safety measurement and monitoring in healthcare: a framework to guide clinical teams and healthcare organisations in maintaining safety', *BMJ Quality and Safety*, 23, pp. 670–677. Available at: <https://doi.org/10.1136/bmjqs-2013-002757>
- Waterson, P.** (2014) *Patient safety culture: theory, methods and application*. London: Ashgate.
- World Health Organization.** (2021) *Global Patient Safety Action Plan 2021–2030*. The World Health Organization. Available at: <https://iris.who.int/server/api/core/bitstreams/a28c34c0-089c-4f5d-a0b1-5d9c35a3cd67/content> (Accessed 25 August 2026).

TO CITE THIS ARTICLE:

Smith, N., Rand, S., Palmer, S., Jones, K. and Hogan, H. 2026. The Measurement of Safety in Older Adult Care Homes: A Qualitative Study of the Perspectives of Strategic-Level Health and Social Care Professionals. *Journal of Long-Term Care*, (2026), pp. 294–304. DOI: <https://doi.org/10.31389/jltc.559>

Submitted: 04 January 2026 **Accepted:** 06 August 2026 **Published:** 07 September 2026

COPYRIGHT:

© 2026 The Author(s). This is an open-access article distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International License (CC BY-NC-ND 4.0), which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited. See <https://creativecommons.org/licenses/by-nc-nd/4.0/>.

Journal of Long-Term Care is a peer-reviewed open access journal published by LSE Press.