

**Safeguarding Adults in Care Homes:  
Developing a preventive dimension to the quality of care**

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## **Abstract**

This paper will set out the findings of research conducted in the summer/autumn of 2008. It reviewed the opinions and experiences of participants in two recent initiatives to improve the quality of care homes and to raise the standards and consistency of Safeguarding Adults investigations in one local authority area. The paper will present an overview of the initiatives and of the progress made by the local authority, drawing upon the experiences of those involved to report some of the lessons learned during the course of these initiatives. On the whole, respondents identified substantial progress and a rise both in the standards of care and in awareness of the appropriate response to situations that might indicate abuse. All agreed that the care homes under the supervision of the local authority are better homes as a result of the initiatives. The paper will then go on to identify some of the continuing concerns of some participants. In particular, the response of some has been to overreact to the increased scrutiny and to refer every incident for investigation. This response has increased pressures and tensions in care homes and workloads among social work teams. The paper will advance some thoughts on conceptualising these issues and identifying some long-term solutions.

## **Introduction**

Recent years have seen a growing debate around risk in public services (see Beck, 1992; Blewett *et al.*, 2007). A key aim of policy making appears now to be to safeguard citizens from risk. In the policy area that this research is focused on, the issue is safeguarding adults from risk (in the same way in which, for example, the ultimate aim in policy making for children is children's safeguard). The *No Secrets* policy guidance (DoH and Home Office, 2000) refers to the risk to which adults are exposed when it defines the types of vulnerability adults may have, who can be at risk and who the perpetrators could be. In circumstances where they are unable to take care of themselves, they become prone to exploitation and significant harm from others. While 'others' can include anyone around the vulnerable person, a special category is 'institutional abuse' by professional neglect or omission (DoH and Home Office, 2000). This is the type of abuse that we will be concerned with here. The *No Secrets* policy document also introduces the requirement for local authorities to lead and develop multi-agency policies for protection of vulnerable adults. The agencies that are likely to be involved include health and social care providers and commissioners, their regulators and criminal justice agencies. These agencies form a Safeguarding Adults Board, a permanent partnership structure to monitor and debate the contribution of each of the agencies to the well being of vulnerable adults in the area. The challenge that comes with this wide responsibility is the lack of powers to enforce cooperation, which leads to inconsistent involvement, depending on organisational priorities and on the good will of the individuals (Fitzgerald, 2008).

A more fundamental addition that *No Secrets* brings to community care is, however, the introduction of the 'safeguarding adults' mindset, mirroring the latest developments in child protection where the shift in viewpoint towards the notion of 'safeguarding children' was made explicit in *Working Together* (HM Government 2006). While the notion has not been made explicit in any policy guidance with reference to adults, the fact that there are now Safeguarding Adults Boards in place signals the need to move from reacting to incidents of abuse to effectively preventing them. One practical implication of aiming to keep adults safe from potential risks, rather than from identified ones, is that professionals and agencies with a stake in adults' wellbeing must collaborate effectively rather than just to a level to which they would keep each other merely informed of their actions. Another practical implication is the issue of the risk threshold above which agencies and professional bodies (whether or not they reach a consensus about it) react to 'safeguard' their service users.

### **Quality of care in care homes**

The externalisation of long-term care for the elderly to the independent sector was intended to secure value for money, the provision of better quality public services and the development of a flourishing independent sector which could contribute to better choices for service users (Ware *et al.*, 2003). The providers of nursing and care homes typically belong to the private or to the non-profit sector (Chou, 2002) but, regardless of the provider, care should be 'high quality, reliable and sensitive support for individuals and families' (Ware *et al.*, 2003, pp.412).

The literature suggests that the ideal care home is one that gives the residents a feeling of being at home, rather than in a hospital. The philosophical approach to this is of a normalisation of life, rather than a form of isolation (Pearson *et al.*, 1993). The literature on nursing homes is particularly well developed in the United States where various views on what long-term care should be have been developed. Thomas (2007) and Baker (2007) bring interesting contributions in this respect. While the former seeks to restore dignity to old age, the latter sees this happening in a transformative type of care home, one that does not feel like a place where people are placed before their lives end, but where they feel as secure and comfortable as they felt at home. These views come primarily from the US, indicating a more advanced conceptualisation of old age than in the UK. Clearly, there are lessons to be learnt from their experiences with care and nursing homes, experiences that will be emphasized here wherever appropriate.

When assessing the quality of care in residential care homes, it is important to keep focused on the very purpose of this care: the well being of the beneficiaries. In the academic literature, this is referred to as the residents' quality of life. This is a broad concept, encompassing issues such as physical health, psychological and social function, as well as interaction with the environment (Nyman and Geyer, 1989; Gill and Feinstein, 1994). However, there is limited material translating these ideals into identifiable indicators of quality.

In a very recent literature review, Castle (2008) identified a strong positive link between the staffing levels and the quality of care in nursing homes. In a study intended to generate evidence about the kinds of indicators worth using when assessing care, Saliba *et al.* (2002) identified 19 from potential indicators previously identified from interviews with service users (residents and their families) and a review of academic literature. However, they tend to emphasise the physical performance of particular functions or the presence of particular facilities. As such, this represents a limited understanding of quality.

A further body of literature addresses the effect of home ownership type on the quality of service generally suggests that non-profit homes are superior in quality to for-profit homes (e.g. Weisbrod and Schlesinger 1985, Gertler 1989, Davis 1993, Zinn 1994). A limited number of studies, however, showed insignificant evidence to support such a claim (e.g. Nymann 1988).

Beyond these measures of control, however, there are also some accounts of aspects that are significantly more difficult to measure. An illustrative account of this comes from Baker (2007) who summarises her personal experience of researching nursing homes, following her experience as an informal carer, as follows:

'Every home I visited would describe itself as work-in-progress... Yet some are much farther on the road. (...) And while none claims to be perfect, to me the ones that had arrived at a meaningful way station on the journey were those that made me feel happy when I entered. (...) That quality cannot be measured or regulated. But it is powerful nonetheless.' (p.3)

One can look at this account and hear the author's voice as carer and a researcher, and it emphasises the degree to which quality is a judgement, and a very personal one at that. Indeed, the point is often made that the beneficiaries' (especially the residents') satisfaction is a key element in determining the quality of care and of life in such homes (Pearson *et al.*, 1993). Amongst the variables which influence resident satisfaction are:

- the size of the nursing home - the larger the nursing home, the more dissatisfied service users are (Townsend, 1962);
- the interactions between the nursing home staff and residents (Saliba and Schnelle, 2002); and
- the staffing levels (see the literature review in Castle, 2008)

However, the literature on quality indicators reveals a lack of thinking around the 'non-measurables', such as the 'happiness' one feels when entering a care home (Baker, 2007). It also suggests the need to find new ways of uncovering clues of quality, other than through formal inspections given that older people in care react to programmed, formal inspections with caution and can become protective towards the care staff they are in contact with.

An important issue signalled by various theorists in the field is that the scope for feedback on care services from service users is limited, for the elderly tend not to complain nor report dissatisfaction with the services they receive (Hardy *et al.*, 1999; Ware *et al.*, 2003). If they may occasionally complain about some aspects of their care, overall they rate it rather positively (Allen *et al.*, 1992). Hardy *et al.* (1999) attribute this to the fact that older people feel grateful for the service they receive, rather than acting as clients, as other service users do. Indeed, as Cambridge and Parkes (2004) maintain, current professional decision-making patterns contribute to the disempowerment of service users through paternalistic approaches to care provision (Williams and Keating, 1999; Parkes and Goodman, 2000), conferring perhaps even more vulnerability on the adults concerned by something Stewart calls 'an oppressive sense of obligation' (2005, p.313). This 'social administration approach' has a long history of not listening to the views of users (Croft and Beresford, 1999). The more recent policy developments include principles such as the 'personalisation of services' which is, in part at least, intended to tackle some of these issues.

In the absence of clear ways of judging care, particularly ones which engage service beneficiaries in the assessment, we have standards with which to work. The National Minimum Standards for Care Homes (Department of Health, 2003) detail what a minimum level of quality might look like in the UK under seven headings:

- Choice of home;
- Health and personal care;
- Daily life and social activities;
- Complaints and protection;
- Environment;
- Staffing; and
- Management and administration

The 38 standards that underpin these seven themes are, the guidance suggests, both qualitative and measurable. While some of them are clearly measurable (or, more often, open to a yes/no answer), the majority involve some degree of judgement. Locally, within the authority studied, a list of ten 'points of quality' within homes identifies:

- Case files: quality of recording; clarity of information required; accompanying documents including risk assessments and behaviour management plans.
- Environment: consideration for special needs, e.g. loop lines; health and safety; and understanding of accompanying legislation, e.g. COSHH.

- Quality and viability of activities: risk assessment and risk management; activities coordinator in post.
- Level of commitment to staff training.
- Opportunities for relatives, friends and relatives: consultation and participation in the running of the home; complaints procedure.
- DOLS signing and understanding of the Care Plan.
- Residents' opportunity to access their own money.
- Involvement in the community, inside and outside the home.
- Medication recording, ordering and disposal: required consent.
- Access to policy and procedures and legislation relating to homes.

As discussions of quality approach the frontline of service delivery, the less they focus upon the philosophical standpoint adopted and the more they focus upon the more prosaic matters of systems and forms. But the differences of understanding of quality at a more philosophical level will have consequences for the forms that services take and for the judgements we reach about those services. And the lack of clarity is then further aggravated by the almost all-encompassing scope of 'abuse' in government guidance. It is indeed conceivable in this context that what one might view as quality, another might regard as abuse.

### **Research design**

In 2007/08, the authority in our case study conducted two separate but related activities to address both quality and safety in care homes. The projects were in response to concerns about patterns of referrals to hospitals and to recognition that regular annual reviews for older people placed by the council were not up to date. At the same time, there were concerns about the quality standards in some homes. As a result, the two projects were set up:

- The Investigations Project, centralising and investing in Safeguarding Adults Investigations for older people in care homes; and
- The Review Project, involving a systematic review of all care homes and of all residents within those care homes.

Since these activities have ended, a new structure has been developed to take forward the issues of quality and safeguarding adults from abuse. A central Quality Assurance and Safeguarding team has been formed with one of its key purposes being to change the relationships between the council and its care home providers. The ambition has been to form a more constructive relationship with both parties committed to the provision of high quality and safe care to older people.

The research informing this paper had two initial key stages:

- Review of key documents from the safeguarding investigations and the review visits. Further material from the contracting and compliance team, CSCI and others was also analysed.
- Interviews with key participants in the investigations and inspections, and with others involved in nursing, contracting and the management of care homes.

As the work developed, and after discussion, the project was extended to include interviews with:

- the Commission for Social Care Inspection;
- social work team managers; and
- care home managers.

Involving these last two groups was intended to take discussions beyond the internal dynamics of the Quality Assurance and Safeguarding team and to ask how the ideas and processes that they are developing appear both to their social work colleagues and to the care home providers.

### **Findings**

The systems for monitoring quality and investigating Safeguarding concerns have been improved dramatically over the course of the two programmes. Where, in the past, there were good policies, there was now also the infrastructure and capacity to investigate and follow-up on referrals. The concerns highlighted by some should be read against that background, universally acknowledged, that the situation has been transformed in the authority concerned.

#### Understandings of Abuse and Risk

The examples and language that were used by different interviewees has been revealing at times of the problems of developing a shared view of the nature of services, of abuse and of quality. One defined Safeguarding Adults as distinct from Adult Protection. Others sought to illustrate the boundaries between care management and Safeguarding Adults as they saw it. Each recognised the need for judgements, but it was clear that they each made different judgements. One reviewer described abuse as needing to ask for liquids if a client were immobile, but not if that client were mobile. But whether a home short of staff constituted a safeguarding issue, a contracts issue or a quality issue, they could not say.

Throughout the course of the research, interviewees referred, in more or less detail, to an incident. While we are not clear that this was an actual incident or several different ones, the story illustrates some of the central concerns about understandings. Interviewees told of a resident who, after an interchange with another resident, threw a soft toy which hit the other resident. For some interviewees, this should prompt a safeguarding investigation. Was this a one-off incident? Are there more serious issues lying behind the incident? What if it had not been a soft toy that was thrown? For others, it is a minor matter and to treat it as more is to overreact. Whatever the 'right' response (and only hindsight can make that judgement in any definitive way), the story was told in support of different interpretations of what constitutes abuse.

These differences affect a number of key issues, to which we will return, including the attitude of care home staff and management to safeguarding, the response of area team managers to referrals and to the consistency of systems and reporting within the authority.

#### Management Issues

The relationship between the various interests/actors within local authority and the PCT were raised by a number of people throughout the course of this research. Closely related to questions of understanding and definition were concerns about how the organisational expressions of those understandings relate to each other. How do matters of quality relate to contracts? How do concerns about an individual uncovered in a review feed in to considerations of quality or of contracts/compliance? Reviewers are concerned largely with the standards of care – that the care set out for an individual is being provided to some minimum standard. The details of training, of finance etc. are not their concern and certainly not their area of expertise. At the same time, can contract staff make judgements on the standards of care provided? And at what point do care management issues become a safeguarding concern?

The links with the PCT also need further elaboration. While it might appear clear to some where the link with the nursing teams are, at the time of this research, there was little confidence of this among social work teams, the nursing team or the safeguarding team. And, just as the PCT is centralising functions to align with the Safeguarding Team, that work is being decentralised in the local authority.

Nor do the systems and frameworks necessarily clarify the boundary issues. The National Minimum Standards (Department of Health, 2003) are subject to interpretation, as we have already noted.

The locally produced Quality Assurance Framework, though still under development in partnership with local care home managers, appears to add to this without necessarily clarifying anything. It has been adapted from a Supporting People context and does not clearly fit the needs. Care home managers speak of it as just a further duplication without any clarity as to how it is actually used by/useful to the local authority or to them.

### Reviews

Reviews of care should take place every year for all clients placed by Social Services. They should be notified in advance to the family and involve the care home manager and staff. Feedback should then be provided to the care home and to the family. During the course of the Review Project, reviewers all mentioned cases of clients who had not had a recorded review for six years or even more. Some were careful to say 'recorded' review, recognising that there may have been reviews that had not been properly recorded on the Social Work Information System (SWIS). However, where reviews had been conducted, they described them as cursory, checking that the client was indeed there and on some very basic deprivation of liberty issues.

The process followed during the Review Project was to undertake 'screening reviews' of all homes except where there were known concerns (such as recent safeguarding investigations). In these cases, a full review was undertaken. Contact was made with the families of all clients in a home to inform them that a review would take place the following week. Some would attend, some would ask for alternative dates, but many would not raise any concerns and simply receive a copy of the report after the review. There was a check of all the files and of the stories told on those file. These stories were then checked against what the manager and staff said and the evidence from clients. Conducting a number of reviews at the same time allowed families to raise concerns that might then more easily be anonymised. At the same time, they made home managers nervous about possible hidden motives.

Those reviewers interviewed each identified different indicators that might prompt concerns or further enquiries. For some, paperwork was a good yardstick for the quality of care provided in a home. The absence of care plans and risk assessments, or examples of risk assessments that were little more than photocopies of standard examples, were serious issues for most reviewers. These suggested that care was not person-centred because there was no evidence of thought about the needs and risks associated with that person. In contrast, a detailed care plan with a clear risk assessment was evidence of a good quality home. Records were of such central importance because they not only indicated an attention to detail but also suggested a degree of continuity of care. Without thorough records, no handover can be effected properly.

At a tier removed from the client records were the internal management records. For instance, staff recruitment and training records, or evidence of supervision and communication with staff were important indicators for some reviewers. Where staff were from overseas, there might also be concerns over language, particularly familiarity with technical language and abbreviations associated with the work. And turnover is a big issue that aggravates the difficulties of managing care with any continuity and of developing staff.

For others, the physical condition of the premises would indicate problems. Items left lying around, particularly COSHH substances, were serious issues. Broken glass, or clear glass without any obvious signs, might also be dangerous and/or suggest neglect of the environment. Others identified blocked fire exits, lack of security (e.g. visitors not required to present ID or sign in) and windows open on a cold afternoon as indicators of carelessness. Other reviewers were concerned about the

quality of food, the smell of the place and evidence of activities beyond simply listening to the radio or watching television.

Finally, still other reviewers made early judgements on the attitudes of those staff they met upon entering the premises. They would refer to much more intangible indicators – things ‘don’t seem right’ or a ‘nervous’ reception by staff; or clients might not ‘look right’. If they see respect and dignity in the way people are treated, everything else will probably be fine. If the attitude is defensive, questioning or obstructive, for example refusing or delaying access to files, then there is cause for concern. If the attitude of staff is poor (‘I finish work here soon, so what do I care?’), the quality of care is likely to be of the same standard. If they are not happy working at an institution, what does that say about that institution? Where it is easy to find fault with files, for reviewers who drew on these subjective impressions, the sense of a home was more important. Poor paperwork was not an indicator of poor quality, and vice versa.

There is no evidence to suggest that one or other of these approaches is better than another. However, what reviewers all argued in common was that they could not rely upon paperwork alone but needed to get out of an office and into the open areas so that people could talk to them if they wished.

The response of a home’s manager to a critical review report is a further indicator of the quality of care provided. A positive response, open to the criticisms, and a clear action plan to address the concerns would suggest a good home. If they make good progress, then all well and good. But reviewers need to have this same attitude – constructive and helpful, in order to encourage the same from home managers. They must also be prepared to be corrected.

It should be noted that, at the outset, the intention was to conduct individual reviews for all residents. Following one review, and in response to a request, one report was written and shared with a care home manager, listing 6 or 8 things to look in to. These were home related, rather than client related, concerned with, for example, training, or with complaints/suggestion boxes, or with guidance on when to send someone to hospital and the procedures to follow. That is, they were issues that might not be a safeguarding matter but would not previously have been picked up as part of an individual care review. The notes made after each review and the different foci of each report underline the sense that each reviewer approached the work with different perspectives and using different evidence. To that extent, the process was not uniform and could appear to be contradictory to care home managers in a larger group or when compared with previous reports and inspection judgements.

All reviewers spoke of the work as enjoyable and rewarding. And as a result of undertaking them, they spoke of now increasingly looking at a home more broadly when doing individual reviews. Reviewers began to understand the differences in perceptions they could see in their colleagues or in those of contracts staff and nurses. A more deliberate and conscious sharing of judgements might further develop the awareness and skills of reviewing staff so that they could all begin to look for evidence or signs beyond their normal range.

### Investigations

In response to concerns about the condition of people discharged from hospitals to care homes identified by district nurses and others, procedures for Safeguarding Investigations were centralised. This reflected a further concern that area social work teams were not investigating cases thoroughly and consistently. For instance, they may not trace a problem back to the hospital or might treat a case as a normal care management review. This reflected the low profile given to the work

compared to other day-to-day pressures on social workers and a lack of confidence/competence in conducting investigations that might involve other professionals, including the police. In particular, more than one social worker might be involved in a case and so a case might fall between the gaps and receive little attention. The scale of any problems was unknown and, as a result of experience, the Safeguarding Investigations project, begun in 2007 and intended as a 3 month exercise, was extended to 12 months. The team grew from two investigators to five.

Interviewees described the process of conducting investigations using the image of concentric circles. Rather than a linear process of tracking back from an incident to find a cause or a problem, an investigation will, in many cases, uncover a range of issues, which may intersect, each needing following through. In that sense, they are different to reviews. They are not person-centred but might look at other people in the same home or pursue lines of inquiry into other settings, including hospitals.

In conducting investigations and interviews, they tend not to give advanced notice but will examine paperwork and speak to people involved after liaising with the police, where there may be a criminal offence involved. Where there are potential criminal offences, planning and early discussion with the police are key. There was some sense that staff have been nervous of calling the police for fear of seeming stupid and of being dismissed. Interviewees gave examples of cases which, when briefly summarised, appeared trivial to the police but, when examined in more detail and not in a quick phone call, might be more serious. Handling referrals to the police is something which takes experience. Some of the paperwork does not help here (police referral forms do not encourage more than brief notes that may not convey the concerns).

While there have been some cases of individuals abusing residents, most cases are more insidious. In particular, interviewees gave examples of homes in which poor practice had become routine. Homes specialising in mental health might not treat physical health matters with appropriate care. Sometimes, practises might be a matter or result of local (or national in the case of larger groups of homes) policies but, in other cases, managers might be unaware. In larger organisations, findings might conflict with CSCI where, for instance, a policy has been reviewed and approved by CSCI in another context or geographical location. With the declining role of CSCI as an investigatory agency, these conflicts and confusions should decline.

### Remedies

Following investigations and reviews, a range of remedies are available:

- Criminal proceedings – following investigations, individuals or managers might be pursued by the police;
- Decommissioning – where the management of and/or quality of care provided in a home is of a clearly and/or consistently low standard, a home might have its registered status withdrawn by CSCI;
- Suspended – no new placements might be made to a home where serious failings have been identified but where an action plan is in place to manage improvements; and
- Recommendations – a written report might detail failings and identify key issues to be addressed.

While the first three remedies might be taken as a result of a decision of the Quality Assurance Board, the last of the remedies is of a more routine nature. Until recently, there was some concern that recommendations might be made but not necessarily acted upon. More recently, systematic follow-up has become part of managing homes and of escalating remedies to a more serious level. All interviewees were clear, however, that a simple numerical count of investigations on-going in any

one home was no simple indicator of a serious problem. Indeed, where referrals are made by staff and managers, it could be an indicator of a positive attitude towards the safeguarding agenda.

More recently, a regular circular has been introduced to update social work teams as to the status of the various homes, particularly where they are suspended. As with all such communications, their effectiveness depends in large part on the way they are used. While some clearly found them useful, others described them as an additional communication that they did not read. However, none suggested a better way of circulating the information. Social work teams need to take some responsibility for the effective communication of this information and either use it or shape its format.

#### Current Management Systems and Coordination

Systems for managing Safeguarding Investigations in the local authority have been significantly improved as a result of the project launched in 2007. Procedures for Strategy Meetings, the reporting of cases and concerns to the Radar Group and the Quality Assurance Board have all been tightened up.

However, interviewees raised a number of concerns about recent changes and the decentralisation of responsibility for Safeguarding Investigations. While centralisation is not always the answer, and investigation of abuse is part of a social worker's professional practice, concerns centred upon the workload that Safeguarding Investigations now represent, the uniformity of approach to cases, the capacity of staff to conduct thorough investigations, the role of the new mentors and the follow-up of any conclusions and recommendations.

The workload that Safeguarding Investigations now represents has increased dramatically over the past eighteen months according to all those interviewed. In that sense, Community Services might be a victim of the success of the project. There is a heightened awareness of the importance of safeguarding issues among residents and their relatives and among the staff and managers of homes. Referrals have increased dramatically. While some of these might be readily handled in a day, others will be complex and take time and will be beyond the capacity of teams to handle in addition to other demands. At the same time, judgements about the way to manage the increased referrals lie with area team managers. In discussion with them, it was clear that there were some concerns about those judgements and the demands now placed upon them. In particular, there is a danger of inconsistencies re-emerging in the way similar referrals are handled across the authority.

A number of those interviewed suggested the need for cases to be escalated after initial investigation. Some social workers might feel vulnerable in handling more complex cases, perhaps involving contracts, nursing or the police, and there were some concerns at the lack of managerial oversight. The role of practice quality mentors appeared ill-defined to many, though all accepted that they were only recently in post and the role needed to develop with experience. There was widespread concern at the loss of the expertise developed during the period when investigations were centralised. This was expressed by a majority of interviewees from all of the groups engaged in the research. In particular, the expertise referred to was:

- Handling complex investigations;
- Gathering and retaining evidence suitable for a court case;
- Knowing when to turn to other expert colleagues, such as contracts or nurses;
- Handling the police; and
- Professionalism in dealing with the home managers.

Finally, some reference was made to recent investigations that were 'less than thorough', to inconsistencies and to the potential for confusion arising from a number of social workers investigating cases in the same home.

### The Care Home Perspective

All those care home managers interviewed as part of this work agreed that change in the processes of Safeguarding Adults had been necessary. Standards had declined to levels that they recognised were unacceptable in some instances. The comments recorded below were made against this background of general consensus.

At the heart of their concerns with the current processes was the lack of transparency in the way in which investigations were conducted. Interviewees described the process as a 'witch hunt' or in terms of 'dawn raids'. Staff, all staff, felt under suspicion and were kept in the dark as to the purpose or the subject of the investigation. Management were not kept informed and so levels of stress and anxiety among care home staff rose significantly, particularly during protracted investigations. Recently, with the decentralisation of investigations, several could conceivably be on-going under different investigators in the same home, aggravating the confusions.

In turn, the sense of being under surveillance was prompting an increase in referrals for investigation. The managers were clear that this increase was a response to the increased profile of investigations. Staff, residents and their families were better informed and were more aware of issues that should cause concern. As we have already noted, this is a good outcome of the recent activities in one sense. However, they also voiced concerns that things were going too far. Matters were now being referred for investigation that might be better dealt with locally. In the absence of trust, the tendency is now to refer to be on the safe side.

Managers also suspected political games were being played out in the way homes were investigated or monitored. The variations in reports submitted by social workers following a review suggested a lack of consistency between teams. The QAF was seen as an indication that the local authority did not trust the registration assessments of CSCI. Multi-agency meetings also seemed to be the focus for inter-agency tensions to be played out. While this is a matter of interpretation, it did lead home managers to describe feeling the passive victims of these tensions.

### Changing the Dynamic

The increased levels of referrals for investigation coming from staff and from home managers suggests that there has been some change of attitudes towards safeguarding adults in care homes. However, what is prompting this change is unclear. Area social work managers and care home managers were concerned that the referrals were, to some degree, a self-protection mechanism – if in doubt, refer – rather than a result of a more positive understanding and attitudinal change. Some described Safeguarding Investigations as 'aggressive' rather than 'assertive' and that this has raised awareness in homes and has had an impact. But it might also have resulted in cautiousness and a tendency to over-refer.

The intention is to get to a more collaborative relationship between social workers and the homes, so that each is concerned to raise standards. Getting the balance right, between trust and collaboration on the one hand and inspection and investigation on the other is key. While all agreed that quality and standards had improved as a result of interventions in recent months, for home managers, the management of investigations spoke of a lack of trust. They were slow, time consuming, intrusive, lacked transparency and destroyed staff morale.

The Quality Assurance team is beginning to develop a role somewhere between individual reviews, contracting and safeguarding. It will provide mentoring advice to social work teams, monitor standards, as revealed through other visits and investigations, and support the Radar system, Strategy meetings and the Quality Assurance Board. Where a number of concerns are raised about a home (from whatever sources), they will review the quality of care being provided. As such, the team sits between contracting (because it is interested in quality and not simply compliance), reviews (because it is interested in more than individual clients) and safeguarding (because it is proactive). However, this could be seen to complicate an already complicated and potentially confusing situation. To whom should concerns be referred? Is a poor physical environment in a home a quality issue, a contracting issue or a health and safety and, therefore, safeguarding matter? Some clarity will develop with time, but these issues will aggravate concerns about the changing arrangements, standards, consistency etc.

The introduction of the QAF approach, encouraging homes to self-assess as a means to clarify the standards expected of homes and to raise standards, is on a pilot exercise basis at present. Eight homes managers have been involved in the development and revision of the QAF. The principle underpinning the approach seems sound and makes sense to those interviewed within the local authority. Feedback from home managers suggests a degree of scepticism. Those familiar with it were concerned that it represented not simply a duplication of other information they are required to produce for other purposes (e.g. CSCI registration) but an additional burden because it takes a different form and requires additional information. Nor did they speak of it in terms of a self-assessment tool but simply as an additional bureaucratic instrument.

On a slightly different tack, care home managers referred to their experiences of other authorities. Safeguarding Investigations were conducted differently from one place to the next, but they identified a number of positive features to be found in other locations. While some had centralised teams, other authorities had lead social workers responsible for each home. A social worker might be responsible for more than one home, but the important point was that all reports, investigations etc. were coordinated through one point. The home had a single person to contact, messages were consistent and they could build up a relationship over time. Elsewhere, strategy meetings would always include the home management unless they were under some suspicion. Indeed, strategy meetings might be held in the care home so that all concerned got some sense of the setting of the alleged abuse. Some of the larger organisations, running a number of homes across the country, suggested that, in appropriate cases, the reports of internal investigations might take the place of Safeguarding Investigations. This would be an appropriate response to some of the increase in referrals. Any evidence or decisions made could be open to review by the Quality Assurance and Safeguarding team to ensure standards were being maintained. This, they recognised, required a level of trust and might also not be appropriate to smaller homes.

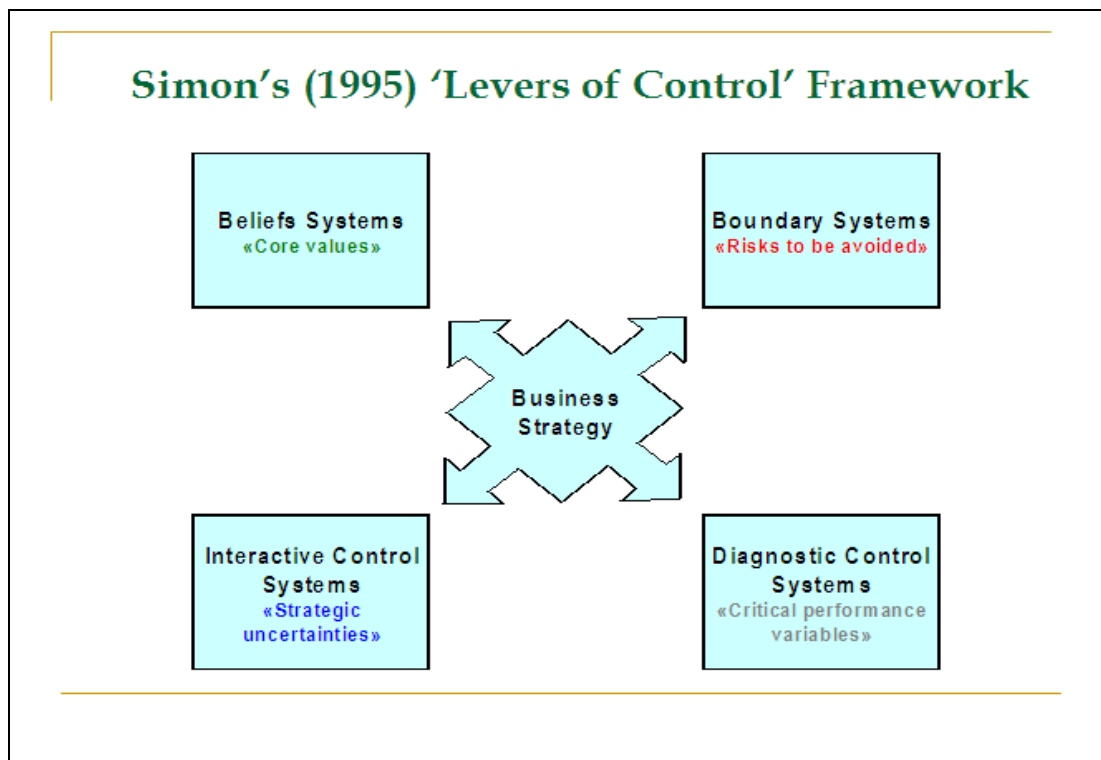
### **A Framework of Analysis**

In beginning to think about moving the relationship beyond the traditional 'mutual distrust and distance' (Walsh *et al.*, 1997, p.144), we must recognise that contracts, investigations and other arms-length control mechanisms are not adequate to the task. Given that quality is hard to establish and that choice and competition are imperfect in the context of care homes, some degree of self-enforcement is central to ensuring care is of the standard we expect (Walsh, 1995). Formal procedures in place to ensure accountability in human service contracting fail to provide an accurate image of just how effectively the users are being cared for (Dicke, 2002). Dicke argues that principal-agent models of accountability, emphasising external oversight, procedures and contracts, is inadequate to the social care context. Instead, what she calls a stewardship model offers a different way of thinking about relationships:

‘Stewardship theories provide a foundation for the development of internal accountability methods that are aimed at heightening or appealing to an agent’s sense of personal responsibility and shared value sets of parties in a contractual relationship.’ (p.457)

The two essential aspects of the model are that the main value guiding behaviour is public service and that there is such a thing as ‘motivational altruism’. That is the model relies on a shared value set which includes some sense of service to the public and not simple self-serving behaviour. While this is quite a leap from the models of accountability that dominate public services, it can help us to think about the way ahead in terms of challenging and changing the current relationships.

A useful framework for the analysis of the systems and processes in place to monitor care home standards is offered by Simons (1995). His theoretical contribution was originally concerned with management control systems and strategy in a commercial setting, but his ‘levers of control’ offers a simple way of organising thinking on the problems of quality in care homes.



The key systems for managing quality, adapted from this model, would be:

- Belief Systems – developing a shared understanding, across all partners, of quality and of the risks of abuse;
- Boundary Systems – defining roles and responsibilities in the provision of services, the management of quality and the investigation of concerns;
- Diagnostic Control Systems – developing indicators and reporting and accountability systems that monitor quality and performance; and
- Interactive Control Systems – processes for learning from experience, from interactions and from users and their relatives.

According to this model, a successful implementation of strategy requires organisations to strive towards a balance of these four systems. Thinking about these four dimensions might also then provide a framework for thinking about the further development of a preventive agenda in safeguarding adults.

### Belief Systems

One of the themes that emerged most clearly throughout this research has been the differences in perspective on the fundamental questions of: what constitutes quality; how to recognise it; and what constitutes abuse. Social work team managers differed amongst themselves and had very different perspectives to the Safeguarding Investigators. A number expressed concerns that the judgements of others were too strict or too loose. Beginning to open up these differences to discussion might be the start of a process for developing a shared view about the standards to which all aspire.

### Boundary Systems

The practical implications of aiming to keep adults safe from potential risks rather than from identified ones is that professionals and agencies with a stake in adults' wellbeing must collaborate effectively rather than just share information. In their analysis of decision-making in adult protection, Cambridge and Parkes (2004) develop a critical analysis of literature on institutional care and abuse (e.g. Martin, 1984; Morris, 1969; Robb, 1967; Townsend, 1962). In this review, they show how "fractures in accountability, the failure to share critical information, and the need for clarity on how and when to make important decisions of intervention and information-sharing surfaced as dominant correlates of abuse" (p.712). Recent initiatives in the local authority have addressed a number of weaknesses that were evident in the past. What has emerged in this research is a concern that, with a reversion to devolved responsibility for investigations, there is the potential for some lack of clarity and, as a result, for failures to re-emerge.

### Diagnostic Control Systems

We have already noted the weaknesses of simply relying upon contracts and other formal systems of accountability and oversight. Nevertheless, these are inevitable and, indeed, essential elements of an effective system. But the purpose of the elements that make up this element of the broader system must be clear. In what ways are care homes already accountable to CSCI, through contracts and compliance and case reviews? How might these be effectively brought together to avoid duplication, for all concerned, and to make the most of the information already available to statutory agencies. Again, the local authority has made some good progress in this area. However, some of the concerns expressed about the additional burdens of the QAF and about the lack of a clear oversight of the numerous messages communicated to each home suggest that the purpose of the system is still unclear.

### Interactive Control Systems

Perhaps the least effectively used system, in any organisation and not just this local authority, is the 'soft' data and intelligence we gather all the time. These include some of the judgements and opinions that are hard to define that social workers make as a matter of routine. But they might encompass the similar judgements and perspectives of care home managers and staff as allies in the understanding of quality care. And they might also include the more active engagement of families and friends in the monitoring and development of quality. This is more easily said than done, but examples do exist of the active recruitment of advocates for quality as scrutineers and advocates.

### **Reflections**

The local authority of our case study has made significant improvements in the monitoring of quality in care homes and in the investigation of concerns about the abuse of residents. This progress was recognised by all and any comments about further development should be read against that background. That this council, like perhaps so many others, are keen to improve standards is an important point. Unfortunately, however, the literature on management control systems indicates that diagnostic indicators, though relatively easy to implement, are not the only control system on

which decision-makers should rely. Interactive controls, while harder to pin down and subsequently manage, are important complements to diagnostic-type of controls.

Against this backdrop of significant progress with quality assurance in care homes, a number of deficiencies can be further addressed by taking an interactive approach to setting and enforcing quality standards. At the core of the deficiencies observed in this local authority area are issues of defining where the risk lies: over-estimating it places serious strains on the local authority's resources, while under-estimating it may cost the health or even lives of people that the local authority is there to protect. At present, and because understandings of risk are so different, there can be no confidence in the preventive dimension of this local authority's work. Similar cases are interpreted differently. Responses to referrals will vary from a care management review to a full-scale investigation. Focusing upon the first lever of control, the belief systems, is central to an effective response to the safeguarding agenda. It may seem that partnership working is too easy an answer for all social problems nowadays. However, it is also intuitive to say that investing in relationships and nurturing the active involvement of practitioners with the object of their work are effective ways in which to counteract the false safety that comes from practitioners ticking boxes without reflecting on the meanings of their actions. That the new developments led to people being over-cautious and resorting to referrals to avoid taking responsibility for their work is indicative of a chronic problem in public services: following processes as a means to manage workloads while avoiding difficult, complex and time-consuming judgements. In this context, the lack of attention to the underlying beliefs and understandings of key staff responsible for safeguarding vulnerable adults opens up the prospect of continuing risks and of crisis incubation.

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