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Exploring Perceptions and Approaches of Registered Managers Regarding Clinical Safety in Care Homes in the UK

RESEARCH

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ABSTRACT

Context: Around 400,000 people currently live in care homes with increasing complexity of care needs and comorbidities. Despite this, there is a paucity of research that asks questions about how the care and clinical safety of this vulnerable population are managed.

Objective: The aim of this research was to understand how registered care home managers approach clinical safety and what they feel helps or hinders them in this.

Methods: The research took a Heideggerian interpretative phenomenological approach, embracing the closeness of the researcher to the participants and the subject matter to uncover rich and detailed findings. Five registered managers of care homes owned by one provider participated in semi-structured interviews between March and May 2020. Three of the interviews took place in the managers' care homes, and, due to coronavirus restrictions, two were undertaken via video conferencing software.

Findings: Thematic analysis of the data generated unexpected findings demonstrating the significant impact on clinical safety in care homes caused not by the managers themselves, but by external forces, including regulation, shortcomings in the structure of the health and social care system in the UK and complex relationships between care homes and other agencies.

Limitations: The strengths (e.g., in-depth data) and limitations (e.g., only including care homes in one area) of this phenomenological qualitative study are discussed.

Implications: The findings led to recommendations that further research and reviews should be undertaken urgently to understand these factors in more detail. This would provide valuable guidance to inform system-wide reform to ensure better clinical safety for care home residents.

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INTRODUCTION

Clinical safety in UK care homes is undoubtedly of high importance, and yet there is a distinct paucity of research in this area. Clinical safety in these environments is complicated by the increasingly vulnerable resident population with complex levels of comorbidities. According to the Care Quality Commission (CQC) (2020), the independent regulator for health and social care in England, there are 457,686 care home beds in England, approximately 90% of which are occupied (Knight Frank Research, 2019), suggesting that approximately 411,000 people are currently living in care homes. Each of these residents relies on the expertise of social care staff to ensure their clinical safety and on the leadership skills of the managers appointed to oversee their care.

Given the difference in bed numbers in care homes and hospitals in the UK—457,686 care home beds (CQC, 2018b) versus 141,000 hospital beds (King's Fund, 2020)—there is a significant disparity between the evidence base hospital providers can draw on to inform how they meet CQC's criteria for the key domains they inspect against (safe, effective, responsive, caring and well led (CQC, 2018b)) and that available to adult social care providers. A literature search for 'safety culture' undertaken on 28 July 2020 on just one health care database (CINAHL complete) delivered 33 studies between 2015 and 2020 in UK hospitals compared to no studies in UK care homes. Eight studies were identified from outside the UK (Abusalem et al., 2019; Banaszak-Holl et al., 2017; Bondevik et al., 2017; Cappelen, Harris & Aase, 2018; Cappelen et al., 2017; Desmedt et al., 2018; Ree & Wiig, 2019; Sepp & Jarvis, 2019).

On reviewing CQC reports, safety in care homes appears to be a particularly difficult domain to achieve high ratings in. Whilst the use of CQC inspection reports to judge safety in care homes could be argued and viewed as problematic due to the complexity of the issues, this is the only statutory guide currently available. CQC inspections in 2019 found less than 0.5% of care homes attain an 'outstanding' rating in the 'safe' domain (CQC, 2019), and care homes accounted for 35.6% of section 42 safeguarding concerns concluded in 2017–2018 (NHS Digital, 2018). From the limited existing research (Abusalem et al., 2019; Banaszak-Holl et al., 2017; Bondevik et al., 2017; Cappelen, Harris & Aase, 2018; Cappelen et al., 2017; Desmedt et al., 2018; Ree & Wiig, 2019; Sepp & Jarvis, 2019), it seems that team culture and training are key factors in maintaining clinical safety in care homes. Without a broader evidence base, however, it is hard to demonstrate exactly what is required to improve clinical safety in care homes.

Orellana, Manthorpe and Moriarty (2017) completed a scoping review of the literature about care home managers in England and concluded that this professional group has been neglected in the research despite the importance of their role to a large number of older people.

Only five of the safety culture questionnaire studies identified explored the topic from the managers' point of view (Banaszak-Holl et al., 2017; Cappelan, Harris & Aase, 2018; Cappelan et al., 2017; Damery et al., 2019; Desmedt et al., 2018), and only one paper was identified that specifically investigated care home managers in the UK (Evans et al., 2018). Even this study failed to achieve its intended aim to focus on registered managers, due to recruitment difficulties, resulting in many of the participants being senior carers or deputy managers. Results may be very different for this staff group, not least because they are not required to be registered with CQC, so they carry a lower level of responsibility. Marshall et al. (2018) found significant issues with quality improvement intervention caused by the high turnover of managers, suggesting a need to understand how the management of clinical safety weighs on registered managers. In 2019, 22% of managers had left their role in the previous 12 months (Skills for Care, 2019)—a concerning statistic given how critical this role is considered to be for safe care. This demonstrates a need for more research into how managers feel about the burden of managing the complexities of clinical safety in their homes and why they feel that way.

MaGee-Rodgers (2018) also specifically researched managers, but their study was based in the United States. Their findings demonstrated that there is rich data to be found when exploring how managers of good care homes approach their work, making use of qualitative interviews to gather data, thereby being one of the closest methodologies to the planned approach of this research. With 19 participants, its findings provide important insight into management in care homes and demonstrate the value of further research in this area.

There are not only evidence gaps but also methodological ones, necessitating not only a need for research into how managers approach clinical safety in their homes but for such research to employ a qualitative, phenomenological approach to ensure in-depth rich data that authentically reflects managers' lived experience of the work they do. Throughout the remainder of this paper, the term 'manager' will be used to refer to any care home–registered manager, and the term 'participant' will be used to refer to those managers who participated in this research study.

RESEARCH AIM

The aim of this study was to explore registered managers' perceptions and approaches to clinical safety in their care homes.

METHODOLOGY

This research employed a Heideggerian interpretative phenomenological (HIP) approach, which aligns well with that utilised by many nursing researchers (Holloway & Galvin, 2017, p. 224; Weaver & Olson, 2006; Parahoo, 2014). HIP affords researchers a platform to make interpretations of social phenomena, placing importance on what is meaningful to the participants and embracing how the complexity and richness of their lived experience has impacted their response to clinical safety in care homes (Saunders, Lewis & Thornhill, 2019, p. 149). As per Heideggerian philosophy, it was considered important that the closeness of the lead researcher's (CK) professional role and experience as a nursing home deputy manager to the subject matter was not rejected but valued as integral to the process of data collection and interpretation (Lincoln & Guba, 2013, p. 41; Weaver & Olson, 2006). Lastly, as phenomenological enquiry, this research drew on the concept of *information power*, aiming for data sufficiency rather than data saturation, through high-quality conversational semi-structured interviews (LaDonna, Artino & Balmer, 2021; Malterud, Siersma & Gaussora, 2016; Sebele-Mpofu, 2020; Manen, 2016).

SAMPLING

Purposive sampling technique (Davies & Hughes, 2014, p. 207) was employed to recruit a sample of eight managers who worked in one care home group.

DATA COLLECTION

Eight managers were approached and five consented to participate in the study. Two were registered nurses, and managers of nursing homes. The remaining three managed residential homes and were not registered nurses.

Data collection was achieved through semi-structured individual interviews, which lasted between 50 and 70 minutes and took place between March and May 2020. The first three interviews were conducted face to face, and recorded on two encrypted devices. However, the COVID-19 pandemic began to affect UK care homes during the research thereby preventing all non-essential visits to care homes. The final two interviews were therefore conducted virtually online and recorded using video conferencing software.

To remain true to the HIP methodology of aiming to elicit individual subjective experiences (Manen, 2016), the interviews made use of less structured questions and a more 'conversational' approach to the interview. This created space for the participants to explore and voice their own interpretation of their experiences, leading to a more authentic understanding of their views (Munhall, 2013, p. 154). Notes were taken during the interview to aid deep understanding but kept to a minimum to reduce distraction and interruption of the flow of the participants' accounts (Holloway & Galvin, 2017, p. 97). To add richness, reflexivity and transparency to the process of interpreting the data, further in-depth notes were recorded as soon as possible after each interview (Bryman, 2016) and later dropped into the transcription for each participant.

DATA ANALYSIS

All interviews were completed and then transcribed verbatim. This approach adheres to HIP and aims to reduce the chance that later interviews could be influenced by themes identified through earlier interviews. A systematic thematic analysis approach was employed using the six-phase analytic process described by Terry et al. (2017). This was chosen due to its emphasis on the approach being iterative and nonlinear, corresponding with the methodological foundation upon which the research was built. Taking an inductive, data-led approach to the analysis also aimed to mitigate any potential negative impact on the data of the proximity of the researcher to the participants' roles (Terry et al., 2017).

ETHICS CONSIDERATIONS

Ethics approval was obtained from the University of Worcester ethics committee by proxy. Participation was entirely voluntary, and informed consent and permission were sought from participants as well as the 'gatekeeper' (the owner of the care homes), respectively. Participants were provided with the participant information sheet as well as the consent form to agree and sign on the interview day and return to the researcher either in person or by post for those participants who were interviewed remotely.

FINDINGS

Four themes were developed from the data: the manager and their team, skills and knowledge, regulation and external agencies. From the literature search, the first two themes were anticipated. However, the second two findings—the impact of regulation and external agencies—were unexpected.

THE MANAGER AND THEIR TEAM

The perceived impact the manager and their team made on clinical safety was central here. Participants talked about their leadership style, encompassing terms like 'integrity', 'authenticity', 'openness' and 'transparency'. For example, participant 2 (P2) was open and honest: 'I make mistakes just as much as everyone else, and showing that vulnerability to the team … gives them the strength to say, "Do you know what? No one here's perfect; we are all human." … I'll always apologise if I'm wrong.'

Being visible and present was reported by all participants to be important: firstly, by building the relationship between the manager and the staff: 'I'm part of the team and part of the solution, not the problem. … We're in this together' (P2). Secondly, by enabling the managers to understand what was happening 'on the floor': 'I would expect the manager to know pretty much everything about their residents' (P5). Thirdly, by acting as a resource, as P3 described, 'When they're care planning, … they'll be asking me questions, and … they're learning' (P3).

Participants reported finding the management of clinical safety challenging and frustrating at times, often feeling that their efforts to ensure their residents were clinically safe were thwarted by factors outside their control. Both P1 and P3 mentioned fear: '[I am] really scared. And sometimes I don't sleep' (P3); 'I think when you're legally responsible, it can be quite a scary place to be' (P1). The weight of this responsibility often led to feelings of guilt, overwhelm and stress. P2 described managers who had become ill with the stress of the role: '… and then they burn out and they leave' (P2).

Participants also reported positive feelings about clinical safety, universally describing being driven by wanting to make a positive impact on people's lives: 'When you see someone improving, it's brilliant!' (P4).

P2 described the task-centred and disengaged team culture she inherited when the home was new to the group as a significant barrier to clinical safety and worked on changing this: 'You can have really robust systems and procedures in place, but they won't work if the team don't get it and they don't follow it' (P2). Similar terms about culture emerged repeatedly through the interviews, no blame, openness and transparency, continuous learning, ownership, willingness to question and quality improvement, with participants describing the need to be proactive in developing these cultural attributes: 'We're trying to stop blame cultures in the care homes' (P3); 'I also know that … if they've got a question or a concern or they want to run it by someone, that they will always ring me or [the provider] and discuss it with us' (P4).

Communication within the team was mentioned by all the participants, particularly written communication, and they took various approaches to improve this, from extra training to including team members in investigations, so that they had firsthand experience of using documentation to build an accurate picture of events. Verbal communication was also valued, particularly handovers between shifts: 'It's really important that the handover is robust and it's bringing up relevant information' (P2).

P2 ensured either the manager or a deputy attended handovers frequently to improve and maintain a strong handover process. P1, P2 and P5 all explained the mid-shift 'huddle' they had introduced, where the team could discuss any concerns and plan so that the rest of the shift ran smoothly: 'The other thing I think contributed to clinical safety is having huddles, so we have a huddle at 11 … and we have one at 4' (P1).

SKILLS AND KNOWLEDGE

Participants all discussed the importance of staff, including the managers themselves, having relevant knowledge, skills and experience. The managers of the nursing homes felt having registered nurses onsite improved clinical safety: 'Clinical safety is embedded in your training' (P2). The residential home managers highlighted the barrier to clinical safety of not having staff with that background knowledge, particularly with the needs of their residents increasing: 'Something like stage 2 chronic kidney disease … [the carers will] happily write it in the notes but they don't actually understand … what that might mean for the person and what they need to look for' (P1); 'The expectation is that a [residential] home can run exactly the same as a nursing home, without that nurse support' (P3).

Training and developing staff were seen by all the participants as a key factor in improving and maintaining clinical safety. In the nursing homes, managers supported nurses to train carers in tasks that could be safely delegated, and this was felt to improve safety by reducing delays in time-sensitive care being given. The managers of the residential homes were keen to work with the clinical commissioning group (CCG) and community nursing teams to develop such a system within their homes.

Effective monitoring and governance were also valued by participants: 'It really is up to us as managers to make sure that we have as much information as we can' (P5). P1 and P2 both placed a strong emphasis on the skill of change management as pivotal in managing clinical safety. P2 explained that 'quick fixes' are rarely sustainable and saw one of a manager's strengths as 'looking at the bigger picture and seeing long term what will work and how [they] get there' (P2).

Three of the participants described the need for skilled balancing of conflicting priorities, particularly when limited time was a significant barrier: 'It's constantly juggling' (P3); 'Your list constantly gets longer' (P2).

REGULATION

Participants all referred to the impact of independent regulation. P2 and P3 both felt strongly that although they understood the need for regulation, its requirements for evidence frequently pulled them away from the work itself: '… and all that stuff takes you away from the real stuff' (P3); 'How are you going to pick up on [signs of deterioration in residents] if you haven't got time to be with them?' (P3).

These participants reported frustration at the resulting paradoxical impact of regulation on their ability to meet the regulations themselves. They also noted that whilst they strove to create a no-blame culture within their homes, this was not mirrored by their regulators: 'There's just this massive blame culture in the council, in safeguarding, in CQC. … As a home manager, you're constantly living under a blame culture' (P3). All participants reported a constant feeling of needing to 'cover their own backs' at times, with one feeling that 'they're always moving the goalposts' (P2).

EXTERNAL AGENCIES

Working with external agencies, including partners in the NHS (e.g., general practitioners (GP), hospitals, community and specialist nursing teams), partners in social care (e.g., social workers and safeguarding teams) and funding bodies (e.g., local authorities and NHS Continuing Healthcare), was reported as impactful on different levels. All participants were overwhelmingly appreciative of the positive impact a good working relationship with external agencies had on clinical safety: 'We've got great support from our GP surgery' (P5). Participants reported a sense that external health care professionals with whom they did not have that relationship often showed an automatic distrust of care home staff: 'They think we haven't got a clue, because we're a residential home' (P4). Several participants reported inappropriate admissions to hospital by paramedics due to poor communication as a result of this mistrust. P5 explained that 'it can take years to build up that kind of relationship' (P5), where staff skills and knowledge of residents are trusted. However, in an emergency or out of hours, there is no time to build that trust.

To mitigate this risk, all participants had introduced the use of the National Early Warning Score (NEWS2) and escalation communication tools. All participants reported examples where hospital staff had disregarded information provided by the home on admission and neglected to hand over effectively to the home on discharge, sometimes leading to poor outcomes for residents: 'You're given some information over the phone and then they'll be discharged, and it won't be anything like what you've been told has been happening' (P3).

Participants also reported frustration at the time taken away from caring for residents due to having to investigate unnecessary safeguarding referrals that could have been avoided by clearer communication: '… but before phoning and asking if we'd done an RCA [root cause analysis] and if we'd had any checks, if, you know, they just sent it straight to safeguarding before having a conversation with me. And actually, that put me through a lot of stress, whereas they could have just phoned and said, "Look, can we get a little bit of background of what's going on here?"' (P2).

Other weaknesses in the health and social care system were felt by participants to adversely affect the clinical safety of their residents. Firstly, low staffing levels in the NHS often resulted in poor continuity of care, for example, with different community nurses attending residential homes to dress wounds, as well as potentially dangerous delays in care, for example, the administration of insulin or administration of subcutaneous analgesia at end of life in residential homes: 'Often we have to wait, … but the person may not have time to wait if they require insulin or are in pain' (P1).

Secondly, disparities in local policy were a concern, particularly for homes close to the borders of two local authorities or CCGs. For example, P4 described how, when the new national treatment escalation plan (ReSPECT) forms were introduced in one region, paramedics from the neighbouring region did not recognise them and insisted on attempting resuscitation on a resident who had requested not to be resuscitated: 'We went in and they said, "You've got to commence CPR [cardiopulmonary resuscitation]." And we said, "She's got a DNAR [do not attempt resuscitation]." "Yeah, but you've got to commence CPR"' (P4).

Lastly, participants reported a sense of 'silo working' in the external agencies, affecting their ability to provide safe clinical care. P4 described a situation where a specialist nursing team was reluctant to help because they did not want to 'step on the district nurses' toes' (P4). These participants reported a sense of helplessness in such situations, as they knew the care their residents needed but had no influence to secure it: 'What does worry me is that if we need things like a syringe driver, which is probably the most common thing that will happen, um … we have to wait for a district nurse to come and put the syringe driver up and that … if that's at night, then often … we can't get a nurse for maybe a few hours, or so' (P1).

DISCUSSION

MANAGERS' PERCEPTIONS AND APPROACHES TO CLINICAL SAFETY

Following the 'Cavendish Review' (Cavendish, 2013), all carers and nurses in social care are now required to complete the national care certificate training. However, as the needs of people living in care homes have become more complex (NHS Scotland, 2016), this basic standard has not changed to meet the resulting increased demands on care home staff. The participants in this study all reported feeling that there was a need for their staff to have training over and above this basic standard. If managers do not recognise this and provide extra training, staff may still not have the skills and knowledge required to safely meet the needs of their residents.

CQC (2018b) now includes 'Are they well led?' in the five key questions they ask when inspecting a service, and there are special guidelines that inform inspectors' answers to this question (CQC, 2018c). Leadership in care homes has become a key issue in recent years, with leadership programmes developed (e.g., Skills for Care, n.d.) as a result of a recommendations made by the UK Government (Department of Health and Social Care, 2012) that set up 'leadership forums' to address issues they identified in this area. Although participants in this study all discussed areas of leadership as being important to clinical safety, including cultivating good teamwork and culture, as Orellana, Manthorpe and Moriarty (2017) and the literature review for this study found, there has been little research undertaken into this area.

UNEXPECTED INSIGHTS

Although we primarily set out to investigate managers' perceptions and approaches to clinical safety, and participants did indeed discuss these, the data analysis revealed that participants mainly focused on the external factors that frustrated the work they were doing to achieve clinical safety in their homes. The potential impact of this on the safety of care home residents suggests a valid need for further exploration of these factors.

Firstly, participants highlighted the impact of regulation on clinical safety. Blake (2020), an experienced CQC inspector and quality assurance manager, believes regulation does drive up standards, but only if providers engage: those who show low levels of engagement seem to need the carrot and stick approach of the ratings. The findings from this study corroborate this view, clearly demonstrating how the current regulation model can be a double-edged sword, potentially creating issues in safety and quality. These unintended negative consequences can range from the indirect long-term potential harm caused to care homes following the achievement of an 'outstanding' rating (Peart, 2019) to the direct short-term impact caused by managers being pulled away from their work to provide evidence for inspections. Burton (2017) describes examples of CQC inspections missing ongoing abuse within a service, adding weight to the argument that the current inspection and ratings model not only creates safety issues but also fails to pick up serious areas of concern. Although evidence is available to suggest that CQC's current approach has led to improvements for some care home residents (CQC, 2018a), a report by the King's Fund (2018) describes a less clear picture, suggesting a distinct need for current regulation models to be examined in order to learn how to mitigate the negative impact they can create.

Secondly, participants described the challenges precipitated by the complexity of the interface between the health and social care sectors. It is clear from the data that challenges of communication between care homes and other stakeholders exist, often resulting in perceived mistrust within the whole health and social care sector. Whether or not the mistrust is real, the perception itself produces a barrier to safe working relationships. This may be influenced by the competing forces at work in this complex relationship, such as the imperative in hospitals to discharge medically fit patients versus the capacity of social work teams, versus the need for care homes to ensure that they are able to meet each resident's individual needs before they can admit them to the home. This danger was highlighted by the coronavirus crisis, with care home managers being pressured to accept patients from hospitals without confirmation of COVID-19 status (Launder, 2020), putting other residents and care home staff at significant risk (Amnesty International, 2020) and causing potentially avoidable deaths (O'Dowd, 2021). Under normal circumstances, care homes rely on understaffed and overstretched NHS services for some clinical tasks, considered by participants to have a significant impact on clinical safety. The coronavirus crisis led to clinical tasks that had previously only been undertaken by district nurses or GPs being delegated to carers to complete. Participants felt these changes had improved safety in their homes and felt the commissioning of nursing care for all care home residents should be reviewed.

STRENGTHS AND LIMITATIONS

As a phenomenological qualitative study, the sample size of this research is acceptable when considering the level of information power afforded by the proximity of the lead researcher (CK) to the research area and the quality of the interviews (Baker & Edwards, 2012; LaDonna, Artino & Balmer, 2021; Malterud, Siersma & Gaussora, 2016; Sebele-Mpofu, 2020; Manen, 2016). The methodology of this study provided a richness and depth of data that may not have been possible with a larger sample size and enabled adequate meaning to be explored and captured. However, the findings suggest a need for larger studies in future that seek maximum variation by asking similar questions but of a broader range of managers.

A limitation of the study is that it only explored managers' views from one set of care homes in one local area. However, due to the substantial existing gaps in the literature, demonstrably useful findings were still drawn from this study that could inform and inspire much needed future studies. Despite the impact of the coronavirus crisis part way through the study, which could have affected the quality of data, the data obtained from the last two interviews were equally and sufficiently rich and in depth to have contributed to the overall quality of the findings.

RECOMMENDATIONS FOR FUTURE RESEARCH

Future quantitative research should determine the specific skills and knowledge held by current care home

staff and managers and should compare this to the increased complexity of the health needs of care home residents to establish if current training legislation is still fit for purpose.

Qualitative research with semi-structured individual interviews and a larger and more diverse sample should be undertaken to explore care home managers' backgrounds, experience, training and their preferred approaches to leadership.

In order to inform improvements in regulation methodology, a qualitative study employing focus groups and a larger and more diverse sample should explore in depth care home managers' thoughts and experiences of how current CQC inspection methodology impacts on the achievement of clinical safety for their residents.

Finally, we recommend that a large and thorough review of the health and social care sector, including the commissioning of nursing tasks in care homes and the complex interface between care homes and other stakeholders, should be undertaken urgently.

CONCLUSION

This study, inspired by a lack of evidence base to inform the management of clinical safety in care homes, has, through a HIP approach, yielded rich, in-depth and unexpected findings that highlighted managers' experiences of clinical safety in care homes. Although there was a glimpse in the literature review that possible negative implications of external regulation might emerge from the data, the fact that the participants all alluded to a sense that however skilled they were as managers or whatever they implemented in their own care homes, they would always be held back by external forces was a wholly unexpected finding. The deeper the data were analysed, the more significant this unexpected finding became, until it was clear that the systems within which care home managers must operate and which aim to ensure safe care for residents are, paradoxically, creating serious and critical barriers to clinical safety. These systems and relationships are unarguably where future research and even reform must urgently be focused to ensure the clinical safety of the most vulnerable of our population.

ETHICS AND CONSENT

The authors' academic institution approved the study protocol and declared that no further formal ethical approval was required.

All participants received verbal and written information about the aim of the study and the interview procedures and content, after which they signed an informed consent form and gave written permission to be interviewed and audiotaped. Data gathered in this study was treated confidentially and anonymously.

COMPETING INTERESTS

The authors have no competing interests to declare.

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