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Factors contributing to abuse in care homes and nursing homes

Review for the Department of Health

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The Social Care Institute for Excellence improves the lives of people of all ages by co-producing, sharing, and supporting the use of the best available knowledge and evidence about what works in practice. We are a leading improvement support agency and an independent charity working with organisations that support adults, families and children across the UK. We also work closely with related services such as health care and housing.

We improve the quality of care and support services for adults and children by:

- identifying and sharing knowledge about what works and what's new
- supporting people who plan, commission, deliver and use services to put that knowledge into practice
- informing, influencing and inspiring the direction of future practice and policy.

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Contents

Contents

Factors contributing to abuse in care homes and nursing homes 2
Contents 3
Key Findings 5
1. Introduction 1
1.1 Review questions 1
1.2 Search strategy 1
Additional searching 2
1.3 Screening process 2
1.4 Data coding and analysis 3
1.5 Overview of included literature 3
Distribution of evidence across key variables 3
Distribution of evidence across themes 5
2. Definitions of types of abuse and neglect in the literature 7
2.1 Definitions of abuse and neglect 7
2.2 Definitions of types of abuse 8
3. Why are adults abused in residential care settings? 12
3.1 Interpersonal theories 12
3.2 Socio-cultural theories 12
3.3 Ecological theories 13
3.4 Multi-system theories 14
4. Factors contributing to abuse in residential settings 17
4.1 Staff vulnerabilities and characteristics 17
Vulnerable groups 17
Types of abuse 19
4.2 Resident vulnerabilities and characteristics 19
Vulnerable groups 20
Types of abuse 21
4.3 Organisational culture and leadership 22
4.4 Institutional characteristics 23
4.5 Poor governance and accountability 24
4.6 Wider context 25
5. How do residential settings respond to or try to prevent abuse and neglect? 26
5.1 Staff education and training 26

5.2 Improving identification, reporting and documentation of abuse 29
5. 3 Improving policies and procedures 30
5.4 Improving organisational culture and leadership 32
5.5 Education and training for residents and older people 32
5.6 Post-abuse response and consequences for perpetrators of abuse 33
6. The use of CCTV to prevent/respond to abuse 34
7. Employing a human rights consideration to prevention of abuse 36
8. Evidence gaps 38
9. Conclusions 39
10. References 41
Appendix 1. Coding Framework 45
Full Text Coding Framework 45
Appendix 2: NICE safeguarding guidelines to prevent and respond to abuse 48

Key Findings

- The literature on abuse of adults in care homes is mainly focused on older people, with few reports focusing on other groups. Additionally, most of the research considers abuse an 'all inclusive' category with very few papers looking at specific types of abuse.
- The most common definition of abuse across the UK and European literature is that prescribed by the WHO. There were varying definitions of neglect but these were all similar and the key point made was that that whilst abuse refers to intentional or deliberate acts, neglect can be both intentional or unintentional.
- Staff characteristics are one of the key factors identified as increasing the risk of abuse. There was general consensus that staff burn-out, negative attitudes towards older people and a lack of knowledge or training about conditions such as dementia all increased the risk for abuse and neglect. Looking at abuse types, the staff characteristics that increase the risk for sexual abuse and financial abuse appear to be more specific.
- Another key risk factor is resident characteristics, with consensus that adults that demonstrate behaviour problems, have cognitive impairment and high levels of dependency are at increased risk for abuse and neglect.
- Organisational factors that increase the risk for abuse include adverse working conditions such as heavy workloads, staff working in isolation and a tacit tolerance for abuse on the part of managers by approving shortcuts to meet heavy workloads. Institutions with high staff turnover and those that rely heavily on agency staff also present more of a risk.
- The most popular intervention to prevent or reduce the risk for abuse is staff education and training, including psycho-educational training, recognising the risk factors for abuse, and education about dementia and how it progresses. Training styles should include interactive elements, address real-life problems and encourage participants to reflect on their practice.
- Some authors have argued that evaluations of staff education programmes have not been methodologically rigorous enough and that direct outcomes relating to prevention of abuse have not been reported. However, given that the risk factors for abuse and neglect are varied and that each residential setting represents a unique context, we would argue that whilst the methodological rigour of evaluations is important, it is also important for the approach and the outcomes assessed to be flexible and appropriate to the context.
- A culture of proper reporting and documentation, and clear whistleblowing policies and procedures are key to decreasing the risk for abuse in residential settings. There is a need to improve hiring practices to ensure that references are checked and people with the right values and motivations are employed. There is also an important role for leadership in implementing organisational change by modelling attitudes and behaviours and valuing and supporting staff.
- There are few legal consequences for perpetrators of financial and/or sexual abuse, with perpetrators usually subjected to fines, moved to other facilities, had their employment terminated or received psychiatric treatment.

- Most of the literature on CCTV focuses on outlining the debates and ethical issues and highlighting appropriate guidelines for its use. Adequate evidence is not available to determine whether the use of CCTV reduces abuse.
- The literature on using a human rights approach to preventing abuse focuses primarily on making the case for such an approach with very little evidence of its effectiveness.

1. Introduction

There have been a number of recent and concerning instances of abuse and neglect taking place in care homes in Northern Ireland, for example, at Muckamore Abbey Hospital and Dunmurry Manor care home. In response to these incidents the Department of Health has taken a number of steps, including the commissioning of an independent review, to understand and learn from these incidents. Abuse, as defined by the Department of Health, Social Services and Public Safety (2015), is 'a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to another individual or violates their human or civil rights.' [1]

In order to support the learning from the independent review and provide additional context, the Department has also commissioned SCIE to conduct a rapid review of evidence to explore why abuse in care homes is so prevalent, not only in Northern Ireland but globally.

The overall aim of this rapid evidence review is to understand the contributing factors, which allow abuse, neglect or exploitation of residents to occur in residential settings.

1.1 Review questions

The following research questions have been agreed for this review:

- How is abuse or neglect defined in the studies?
- What knowledge do we have about why adults are abused in residential or institutional settings?
- What knowledge do we have about the contributing factors which allow abuse of residents to occur in residential settings?
- How do contributing factors differ for different types of abuse, types of setting and resident groups?
- What do we know about how settings try to prevent or respond to abuse?
- What is the evidence in relation to the use of CCTV to prevent or reduce abuse in care settings?
- What consideration is given to Human Rights Based approaches in preventing or responding to abuse in care homes in the studies?
- What are the gaps in existing evidence?

1.2 Search strategy

We searched five databases (Medline, CINAHL, Social Care Online, Social Policy and Practice, CORE – open access research papers). We supplemented the search by carrying out focused web searches using Google and Google Scholar. In addition, we searched the

[1] Action on Elder Abuse: definition of abuse 1993 which can be accessed at: http://www.elderabuse.org.uk/Mainpages/Abuse/abuse.html. This was later adopted by the World Health Organisation - http://www.who.int/ageing/projects/elder_abuse/en/

Professional Standards Authority website as suggested by the reference group and added the reports that the reference group shared with us to the dataset.

We searched using search terms for the **setting** (aged care facilit*,assisted living, care home, homes for the aged, long term care, nursing home*, old age home*, residential care, secure hospitals) **AND population** (elder*, aged, old age*, resident*, geriatric*, alzheimer*, dementia*, older*, learning disab*, intellectual disab*) **AND phenomena of interest** (abuse*, assault*,bully*,CCTV,exploit*, harass*, harm, maltreat*, mistreat*, neglect*, rape*, rights, surveillance, violen*).

All the search results were loaded into EPPI Reviewer 4 database and after duplicates were removed we were left with **754** references to screen.

Additional searching

We completed an additional search as per the request from the reference group to add 'staff misconduct' as another search term. We carried out some additional focused searches within out dataset and in the same database sources for misconduct and abuse which resulted in identifying a small number (n=23) of new papers to screen.

An additional 5 references from the supplementary searches were added to the dataset to screen, which took the total number of references that were screened in this review to **759**.

1.3 Screening process

Screening of titles was based on a set of inclusion and exclusion criteria agreed with the Department of Health. These criteria describe the types of studies examined and the key factors looked for in terms of relevance. They are identified in the table below.

We used a two-stage screening process, first screening all the search results on title and abstract against the inclusion criteria. This resulted in **110 included** items. At the second stage we screened the full-text of studies included at stage one and identified **51 documents for inclusion**.

Criteria	INCLUDE
Scope	To understand the contributing factors which allow abuse of residents to occur in residential settings Include staff, visitors, volunteers and service users or other residents.
Evidence type	Document was produced using empirical research evidence, including cohort studies, cross-sectional studies, qualitative studies, randomised control trials or experimental designs or is a systematic review or scoping review that meets the scope of this review.
Setting	All forms of residential care including secure hospitals
Population	Adults accessing care and support in residential care

Location	Prioritise care settings and systems which are most analogous to Northern Ireland No exclusion limit placed on the location of studies
Language	English Language

1.4 Data coding and analysis

The 51 items that were identified for inclusion were coded as per our coding framework, which continued to evolve over the course of the review. This is attached in Appendix 1. We used EPPI reviewer 4 for both screening and coding. Upon the completion of coding, the data was analysed to identify key themes. Sub-group analysis looking specifically at the groups targeted for abuse and type of abuse was also conducted.

One document included in this review was the recently published guidance by NICE on safeguarding adults in care homes. However, it was decided with the Department of Health that guidance from this document relating to preventing or responding to abuse would be included as an appendix (Appendix 2), rather than integrated in the body of the text.

1.5 Overview of included literature

The following tables highlight the distribution of the included studies across the key variables that form part of the review

Distribution of evidence across key variables

Study type	**N**
Systematic review	5
Literature or research review	11
Independent review or report	6
RCT	1
Secondary data analysis	4
Cross-sectional studies	2
Mixed methods study or evaluation	6
Qualitative study	5
Book	2
Theoretical paper	7
Other	2

Country of publication	N
Northern Ireland	4
UK	17
USA	5
Multi-country	16
France	1
Switzerland	1
Australia	2
Norway	1
Republic of Ireland	1
Portugal	1
Japan	1
Italy	1

Abuse type	N
Sexual abuse	3
Aggression	1
Financial abuse	2
Negative verbal prompts	1
Neglect	4
Institutional abuse	1
Various types of abuse	40
Other	1

Type of Setting	N
Nursing home	23
Residential care	22
Institutional setting	4
Across settings	15

Groups targeted	N
People with learning disabilities	3
People with dementia	3
Older people	28
Staff	2
Various or unspecified	16
Other	1

Research question	N
Definitions of abuse	25
Why are adults abused?	13
Contributing factors	31
Responses to abuse	28
Use of CCTV to prevent or reduce abuse	4
Human rights considerations	5
Evidence gaps	13

Distribution of evidence across themes

Why are adults abused?	N
Interpersonal theories	6
Socio-cultural theories	4
Ecological theories	5
Multisystem theories	3
Other	2

Factors contributing to abuse	N
Staff vulnerabilities and characteristics	20
Resident vulnerabilities characteristics	12
Organisational culture and leadership	23
Institutional characteristics	8
Poor governance and accountability	3
Wider context	6

Responding to and preventing abuse	**N**
Staff education and training	19
Improving identification, reporting and documentation of abuse	9
Improving policies and procedures	14
Improving organisational culture and leadership	8
Education and training for residents and older people	2
Post abuse response and consequences for perpetrators	3
The use of CCTV to prevent/respond to abuse	4
Employing a human rights consideration to prevention of abuse	5

2. Definitions of types of abuse and neglect in the literature

2.1 Definitions of abuse and neglect

The concept of abuse that is covered the most in the literature reviewed relates specifically to 'elder abuse'. The most common definition across literature published in the UK and Europe is that **defined by the WHO of elder abuse** as "*a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person"* (WHO 2002a) (Baker et al, 2016; Blundell et al, 2020; Phelan, 2015).

However, a handful of papers (Araten-Bergman et al, 2017; COPNI, 2018; Drennan et al, 2012) adhere to the definition prescribed in *Protecting Our Future* (Working Group on Elder Abuse, 2002: 25) which retains a focus on human rights and defines abuse as '*a single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person or* ***violates their human or civil rights****.'* It is interesting to note that these papers tend to cover groups such as people with disabilities, dementia or care home residents in general, rather than older people specifically. Additionally, this definition is also commonly used in literature relating to safeguarding adults.

Some authors (Department of Health, Social Services and Public Safety in Northern Ireland ((DHSSPNI), 2015; Gil, 2019; Moore, 2016; Radermacher et al, 2018) are keen to point out some of the central tenets of these definitions as they relate to residential care setting: the relationship of trust within which the abuse occurs; the misuse of power and control by someone in a position of authority; and the existence of a formal contract for paid care.

Other definitions of abuse that are used primarily in America and in some international papers are those prescribed by the:

- American Medical Association (AMA): "an act of commission or omission that results in harm or threatened harm to the health or welfare of an older adult" (Castle et al, 2015)
- The Centers for Disease Control and Prevention (CDC): "an intentional act or failure to act by a caregiver or another person in a relationship involving an expectation of trust that causes or creates a risk of harm to an older adult."

Closely related to the concept of abuse is that of neglect. Many authors (Gil, 2019; Mileski et al, 2019) have highlighted that **whilst abuse refers to intentional or deliberate acts, neglect can be both intentional or unintentional-** it does not need to be a wilful act. Whilst there are a number of definitions of neglect in the literature, they are all very similar and can be represented by the definition provided by the Commission on Older People in Northern Ireland (COPNI) (2018) in their report on the Commissioners investigation into Dunmurry Manor Care Home:

> *'Neglect occurs when a person deliberately withholds, or fails to provide, appropriate and adequate care and support which is required by another adult. It may be through a lack of knowledge or awareness, or through a failure to take reasonable action given the information and facts available to them at the time. It may include physical neglect to the extent that health or well-being is impaired, administering too much or too little medication, failure to provide access to appropriate health or social care,*

withholding the necessities of life, such as adequate nutrition, heating or clothing, or failure to intervene in situations that are dangerous to the person concerned or to others particularly when the person lacks the capacity to assess risk.'

There are several reports that also use the terminology of **'mistreatment' and/or 'maltreatment',** and definitions for these tend to include concepts of neglect and/or abuse. However, these definitions also often refer to the 'loss of dignity' suffered by residents/patients (Bonnie, 2019; Lupton, 2019). For the most part, elder mistreatment or maltreatment and elder abuse are used interchangeably across the literature. (Liat et al, 2016; Mosqueda et al, 2015)

2.2 Definitions of types of abuse

There is general consensus on the different types of abuse and these tend to include: **physical abuse, psychological/emotional abuse, sexual abuse, and financial abuse/exploitation. However, some authors also include institutional abuse as an important sub-category** (COPNI, 2018; Moore, 2016).

The table below provides **a number of definitions of these different types of abuse. The content of these definitions is similar** - they tend to include a combination of a brief description of the abuse and/or its impact followed by a number of examples of the said abuse.

However, the fact that each category of abuse includes a number of definitions indicates that there has been a lack of consensus or agreement in the social care sector about these definitions. It is also interesting to note that only **financial abuse/exploitation is referred to as being 'illegal' or 'criminal'.**

Type of Abuse	Definition
Physical abuse	Pushing, striking or causing bodily injury, force feeding or improper use of physical restraints (Andela et al, 2018) Inflicting physical injury, pain or any unpleasant sensation (Araten-Bergman et. al, 2017) The use of physical force or mistreatment of one person by another, which may or may not result in actual physical injury. This may include hitting pushing, rough handling, exposure to heat or cold, force-feeding, improper administration of medication, denial of treatment, misuse or illegal use of restraint and deprivation of liberty. (COPNI, 2018; DHSSPNI, 2015) Includes hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions (Drennan et al, 2012) The infliction of pain or injury, physical coercion, physical/chemical restraint. Physical abuse may include hitting, slapping, pushing, kicking, spitting, misuse of medication, restraint or inappropriate sanctions; (O'Brien et al, 2016)
Psychological/ emotional abuse	Verbal or nonverbal insults, humiliation, infantilization or threats (Andela et al, 2018) Verbal assaults, threats, harassment, humiliation or intimidation. Failure to interact or acknowledge a person's presence. (Araten-Bergman et. al, 2017) Behaviour that is psychologically harmful or inflicts mental distress by threat, humiliation or other verbal/ non-verbal conduct. This may include threats, humiliation or ridicule, provoking fear of violence, shouting, yelling and swearing, blaming, controlling, intimidation and coercion (COPNI, 2018; DHSSPNI, 2015) Including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks. (Drennan et al, 2012) Negative prompts aimed at eating can assume the features of psychological abuse when they are delivered in a negative manner rather than providing positive reinforcements, e.g. making the patient feel guilty for not

	being able to eat alone or threatening to withhold the reward at the end of the meal, as coffee or sweets, if all the food has not been eaten (Palese et al, 2019)
Sexual abuse	Sexual activity with an adult who is unable to understand or who has been threatened, coerced or forced (Araten-Bergman et.al, 2017) Including rape and sexual assault or sexual acts to which the older adult has not consented, or could not consent, or into which he or she was compelled to consent. (Drennan et al, 2012) Any behaviour perceived to be of a sexual nature which is unwanted or takes place without consent or understanding. Sexual violence and abuse can take many forms and may include non-contact sexual activities, such as indecent exposure, stalking, grooming, being made to look at or be involved in the production of sexually abusive material, or being made to watch sexual activities. It may involve physical contact, including but not limited to non-consensual penetrative sexual activities or non-penetrative sexual activities, such as intentional touching (known as groping) (DHSSPNI, 2015) Non-consensual sexual contact of any kind with an older person (O'Brien et al, 2016) Non-consenting sexual contact of any kind. The definition of sexual abuse includes (but is not limited to) unwanted touching and all types of sexual assault or battery, such as rape, sodomy, coerced nudity, and sexually explicit photographing (Maldemal et al, 2015)
Financial abuse / Exploitation	Including theft, fraud, exploitation or the misuse or misappropriation of property or possessions (Drennan et al, 2012) Actual or attempted theft, fraud or burglary. It is the misappropriation or misuse of money, property, benefits, material goods or other asset transactions which the person did not or could not consent to, or which were invalidated by intimidation, coercion or deception. This may include exploitation, embezzlement, withholding pension or benefits or pressure exerted around wills, property or inheritance (DHSSPNI, 2015) The illegal or improper exploitation and/or use of funds or resources. This can include theft, coercion, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, misuse of power of attorney or the misuse or misappropriation or property, possessions or benefits; (O'Brien et al, 2016)

	Exploitation refers to the right of the resident to not have their property, assets, or resources used without their express permission. This generally refers to the use of the elder's assets for the benefit of someone else without their knowledge (Mileski et al, 2019) Financial or material exploitation is defined as the illegal or improper use of an elder's funds, property, or assets. Examples include, but are not limited to, cashing an elderly person's checks without authorization or permission; forging an older person's signature; misusing or stealing an older person's money or possessions; coercing or deceiving an older person into signing any document (e.g., contracts or will); and the improper use of conservatorship, guardianship, or power of attorney (Payne and Strasser, 2012).
Institutional abuse	Mistreatment or neglect of an adult by a regime or individuals in settings which adults who may be at risk reside in or use. This can occur in any organisation, within and outside the HSC sector. Institutional abuse may occur when the routines, systems and regimes result in poor standards of care, poor practice and behaviours, inflexible regimes and rigid routines which violate the dignity and human rights of the adults and place them at risk of harm. Institutional abuse may occur within a culture that denies, restricts or curtails privacy, dignity, choice and independence. It involves the collective failure of a service provider or an organisation to provide safe and appropriate services, and includes a failure to ensure that the necessary preventative and/or protective measures are in place. (COPNI, 2018) Where embedded institutional practices, rules, customs and actions of staff are direct and indirect causes of abuse (Moore, 2016)

3. Why are adults abused in residential care settings?

3.1 Interpersonal theories

A number of interpersonal theories have historically been used to explain why adults, and more specifically older people, are abused (Andela et al, 2018; Abolfathi et al, 2013).

The most popular such theory is the **caregiver stress theory** or situational theory, which is derived from child abuse and domestic violence theories. It is used to explain elder abuse where an **older person is often viewed as a source of stress upon the carer as a result of behaviours and dependency attributable to old age** and attendant physical and psychological decline. Without support, the carer may be unable to adequately manage their responsibilities and become overwhelmed and frustrated leading to abuse (Moore, 2016; O'Brien et al, 2016).

One adaptation of the caregiver stress theory is the **job demands-resources model** - This model is based on the idea that job strain can develop from a combination of high job demands that require sustained effort over time and lack of job resources. Specifically, job demands can result in psychological and physical costs, for example stress and exhaustion, while a lack of job resources, such as management and team support, can make it difficult for carers to meet their job demands. This can lead to carers disengaging or withdrawing from their work which can lead to depersonalisation and reduced quality of care (Andela et al, 2018).

Two other interpersonal theories that have often been cited include:

- **Social exchange theory** - explains interactions between people as a process of negotiated exchanges. Applying this theory to residential settings, resources may be food and fluids, warmth, and equipment to alleviate the effects of disability or illness; benefits may be the ability to provide assistance with physical care or to provide psychological support. These resources and benefits are those that are predominantly under the control of care home staff. As a result, there is likely to be an imbalance of exchange between the person who needs care and the caregiver, where one is dependent upon the other, and the dependent person has little or no access to resources (Moore, 2016; Mosqueda, 2017).
- **Social learning theory** - proposes that violent acts are a learned behaviour. A person has learned, through the process of modelling, to use violence in an earlier context to either resolve conflicts or obtain a desired outcome.

3.2 Socio-cultural theories

In addition to inter-personal theories there are also theories that try to draw from **the wider macro-level social or cultural context** to explain why adults, particularly older people, are abused (Abolfathi et al, 2013; Moore, 2016; O'Brien et al, 2016). These include:

- The **Political Economy Model** - This theory addresses that older people are gradually marginalised in their families and society. They are viewed as responsible for increasing healthcare and welfare costs, the increasing pressures on the health and social care system and for creating a future demographic crisis. These **ageist attitudes** create an ideology of economic and political exclusion. The theory therefore locates abuse within a macro-system socio-political context and considers the structural factors of poverty, gender, power, inequality and age prejudicial attitudes in abuse.

- **Power and Control theory** - This theory is grounded in domestic violence theory. In this theory violence and abuse is seen to stem from the unequal and oppressive power relation between women and men. Similarly, there is a **power differential between older people and younger people**. Moreover, the interaction between the older person and the younger trusted other is set within a context of factors that include status, rights and duties. If an older person is seen as incapable of making decisions, the person may be seen as less worthy of interaction. 'Malignant' positioning like this, can contribute to the creation of a climate that allows elder abuse to take place or a social environment that fails to prevent it.
- **Symbolic Interaction theory** - this theory relates to the way people react and view the world through their interactions with others. It is used to explain why elder abuse takes place and how culture plays an important role in the perception of abuse. According to this theory, every object has different meaning to each person, and everyone has his or her own way to find meaning. Cultural values and expectations influence what conduct is elder abuse. For example, in some cultures, sending elderly individuals to nursing homes is considered to be a form of abuse, whereas other cultures define it as a sign of caring

A number of authors have argued that interpersonal theories and socio-cultural theories tend to be too simplistic or one-dimensional. For example, they do not explain why some carers abuse and some do not when experiencing comparable circumstances. They have argued instead for the specification of potential mediating and moderating factors, specifically those relating to the wider social context, to be included in these theories and conceptual models (Castle et al, 2015; Moore, 2016; O'Brien et al, 2016).

3.3 Ecological theories

Over time researchers recognised that there was a need to move away from theories rooted in other disciplines or parallel abusive contexts, and to identify and **develop theories that are more closely related to the context and relationships that are unique to the residential care setting.**

One such theory that has been helpful in guiding researchers is Bronfenbrenner's Ecological Systems theory which was introduced in the field of violence in the late 1970s. This model considers the origin of abuse in terms of socio-cultural and social factors, and relationships between agent and environment. It was adapted in 2011 by Schiamberg et al to understand elder abuse in the context of a nursing home environment. The model is highlighted in the box below.

Ecological model of elder abuse

The Ecological model proposed by Schiamberg et al (2011) focuses on the interaction between the older resident and the institutional caregiver as the unit of interest and includes five **levels of analysis**:

1. The **microsystem** - focuses on individual characteristics such as biological and demographic factors that increase the likelihood of being a victim (cognitive impairment, functional status) or perpetrator (e.g., level of stress, level of training) of abuse.

2. The **mesosystem** - these effects can occur when both the institutional caregiver and the older adult resident are involved in several microsystems, which can multiply the likelihood for either the presence or absence of abuse.

3. The **exosystem** - examines institutional factors in which these relationships are embedded, for example caregiver supervision and training, staffing patterns and older people isolation/support

4. The **macrosystem** - explores larger societal factors such as cultural norms, ageism/sexism, and public policy/economy.

5. The **chronosystem** - the fifth and final level seeks to identify changes in the environment over time

A similar adaptation is the socio-ecological model outlined by Araten-Bergman et al (2017) to understand why abuse of people with learning disabilities occurs and persists. This framework is adapted from the conceptual model proposed by the World Health Organisation for exploring abuse in the lives of vulnerable populations. In this model abuse is conceptualised as an outcome of the complex interaction of factors at four levels of analysis:

- The individual level includes personal health and socio-demographic characteristics of the victim and perpetrator, and is associated with higher risk of exposure to abuse.
- The relational level includes characteristics and types of interaction between the individual and their immediate social network in personal and professional settings.
- The community level is the social context in which social relationships occur, such as disability services, neighbourhoods and workplaces.
- The broader societal context comprises the factors that influence whether violence is encouraged or inhibited in the society more widely, and the economic and social policies that maintain inequalities between people, and social and cultural norms such as those around disability.

The socio-ecological framework regards the interaction between factors at different levels with equal importance to the influence of factors within a single level. For example, in the context of an equal distribution of power in the relationships between carers and people being supported, other factors such as social isolation or the dehumanisation of individuals with learning disabilities can serve to allow abuse to continue.

3.4 Multi-system theories

Many authors have proposed multi-systems theories that, like the ecological and socio-ecological models discussed above**, operate at a number of levels or domains. However, these models also incorporate a range of risk factors for abuse that have been identified across the literature**. One such example is the Abuse Intervention Model proposed by Mosqueda et al (2016) to understand elder abuse by identifying risk factors across three domains:

- Domain 1: Vulnerable Older Adult **Vulnerability** - defined as financial, physical, or emotional dependence on others or impaired capacity for self-care or self-protection
- Domain 2: Trusted other - **Dependence** on the vulnerable older adult, mood or substance use disorders or pathological personality traits
- Domain 3: Context -The context in which an older adult and trusted other interact plays an important role in mitigating or exacerbating elder mistreatment

Another such conceptual framework has been developed by Hanley and Marsland (2014) to explain why abuse occurs in residential care settings. This model was developed through the

analysis of a number of enquiries, studies, reports and serious case reviews in addition to an analysis of the underpinning theoretical perspectives. It consists of three interrelated dimensions which the authors argue can combine to create relationships that are potentially unbalanced and risk-laden, thereby resulting in abuse:

- **Dimension 1: Non-mutual dependency** - Within residential settings people who are supported are totally dependent and reliant on the paid care provided by others. More importantly, a key difference between powerful and powerless people in these settings is that powerless people are impelled to have their care either met by other people, or bought for them. This type of dependency has been recognised as one of the key factors that is likely to lead to the abuse of adults.
- **Dimension 2: Isolation** – this includes the geographical isolation of residential settings as well as the isolation position that residents tend to be in within these settings. This kind of isolation can prevent outside influences from identifying or helping those within the institution to recognise that what is occurring is not acceptable.
- **Dimension 3: Unequal decision-making power** - Although concepts of choice and independence are now staples of policy and law in social care, there is also ample evidence care is not person centred and that people are fitted around services, rather than services being designed around them.

The authors also argue that these three dimensions are perpetuated by contextual factors that exist in residential settings, including institutional forces, the poor position of staff and an inadequate commissioning model. In addition, the relationships within these settings are maintained by the wider social context in which they exist, including the legal context that fails to prevent and perhaps even facilitates abuse in some contexts.

It is interesting to note that models discussed above and other similar models identified in the literature reviewed (Drennan et al, 2012; National Research Council, 2003) are focused **not only on the risk factors for abuse that exist across dimensions/levels but also on the fundamental power-laden relationship that exists between carers and people who are supported.** Moreover, the models discussed so far range from focusing on a particular vulnerable group, for example older people or people with learning disabilities to focusing on a particular setting, for example residential settings. This specificity of these conceptual frameworks is a big step from the initial interpersonal and sociocultural theories that framed the discussion about abuse for many years

However, Moore (2020) has argued that research in the field could go further in developing explicit discrete theories that explain the occurrence of **different types of abuse** against **specific vulnerable groups** in **specific environments**. He outlines one such theory to explain the **physical and psychological abuse** and neglect of **older people** in **care homes** in England, the majority of whom were living with **dementia**. He identified three factors that led to their abuse:

- 1. Older people, particularly those living with dementia are, or come to be regarded as less than fully human by those who should be providing for their care needs.
- 2. The care that is provided becomes routinised over time and fails to take account of the specific needs and wants of individuals, in greater part because they have ceased to be perceived as individuals.
- 3. Both macro-level societal institutions, and peers and managers at the micro-level of the care home give implicit and explicit permission through their attitudes and behaviours for

staff who should be providing care to engage in the abuse of the people who are no longer regarded as fully human.

The author concludes that it is the development and testing of discrete theories such as the one proposed above that will enable a fuller understanding of the social, intrapersonal and environmental factors that interact in the aetiology of different types of abuse in a range of diverse situations. In turn, this understanding will finally allow researchers to develop effective preventative strategies and interventions in specific circumstances.

4. Factors contributing to abuse in residential settings

In this section we will discuss a number of factors that increase the likelihood of the risk of abuse in residential settings. There was more evidence and greater consensus in the literature about some of these factors compared to others. They are presented below in order of strength of evidence, and include:

- Staff vulnerabilities and characteristics
- Resident vulnerabilities and characteristics
- Organisational culture and leadership
- Institution characteristics
- Governance and accountability
- Factors relating to the wider context

4.1 Staff vulnerabilities and characteristics

One of the key factors contributing to abuse relates to the specific vulnerabilities and characteristics of staff who work in residential care settings. The literature on this topic tended to focus mostly on vulnerable groups such as older people, with some coverage of people with dementia or Alzheimer's disease, and people with learning disabilities. Additionally, the vulnerabilities and characteristics of staff that can lead to abuse was also discussed in terms of different types of abuse: sexual abuse and financial abuse. The findings are therefore presented as relating to vulnerable groups and types of abuse.

Vulnerable groups

There are three key staff characteristics and vulnerabilities that are identified across the literature review that can increase the risk of abuse towards **older people**. These are:

- **Staff stress, exhaustion and burnout**. Several studies conducted found that there is a strong association between burnout and elder abuse. Additionally, there are several factors that can contribute to this stress and burnout, including staff working long hours, staff working on night duty, physical demands of the job, low pay and staff shortages (increased workload). Moreover, burnout is associated with a number of outcomes, including emotional exhaustion, depersonalisation, and reduced personal accomplishment all of which can increase the likelihood of abuse (Botngard et al, 2020; Castle et al, 2015; Drennan et al, 2012; Hyde et al, 2014; Moore, 2016, O'Brien et al, 2016).
- **High levels of conflict between staff and residents –** Several studies reported that that staff-resident conflicts and interactions are one of the critical variables in identifying factors relating to abuse of older people in residential settings. More specifically, studies have found that staff who have experienced physical abuse from residents were more likely to reciprocate with either physical and/or psychological abuse, whereas staff who experienced psychological mistreatment from residents tended to respond with psychological abuse (Castle et al, 2015; Drennan et al, 2012, Moore, 2016).

- **Staff holding negative attitudes towards older people** – Some studies highlighted the role of negative value judgments towards older people increasing the risk for abuse. Moore's study of abuse in care homes across the UK (2016) found that staff working in these settings tended to view older people as "*less than people", "not real people" or "not people".* Authors also argue that if staff do not positively value older people they are less likely to adhere to the training they have received and more likely to ignore policies, procedures and care plans, particularly when much of the intimate care required by residents is given beyond scrutiny, behind the closed door of bedrooms and bathrooms (Drennan et al, 2012; Hyde et al, 2014; Moore, 2016; Moore, 2019).

Other staff characteristics that are also mentioned in the literature, but where the evidence is less strong compared to the characteristics discussed above include:

- **Education, qualifications and training of staff** - a few studies reported that less educated staff, those with minimal training, and with low levels of professional knowledge and skills are at greater risk of perpetrating abuse and neglect. However, Botngard et al (2020) in their study on nursing staff in Norwegian nursing homes found that educated staff reported more incidents of all types of abuse. They speculate that more educated staff may reflect more critically on their practice and are therefore more likely to recognise and self-report abuse.
- **Low levels of job satisfaction** – Drennan et al (2020) report in their study of a survey of registered nurses and healthcare assistants from nursing homes in the Republic of Ireland that a number of previous studies have identified low levels of job satisfaction as a predictor of the abuse of older people. More specifically, in Drennan et al's (2020) study the survey indicated that staff who reported that they will probably/definitely leave the organisation were twice as likely to report that they had experienced acts of physical abuse when compared to respondents who stated that they probably/definitely will not leave.
- **Lack of knowledge about what constitutes abuse** – Radermacher et al (2017) in their rapid review of staff conceptualisations of abuse reported that there was one study that reported high levels of uncertainty for participants about what constituted abuse. Furthermore, there was more disparity in recognition and reporting some forms of abuse than others – for example, verbal and psychological an abuse was less well recognised compared to sexual and physical abuse.
- **Nationality of staff** - Drennan et al's (2020) survey of registered nurses and healthcare assistants from nursing' homes in the Republic of Ireland found that the staff that recorded their nationality as 'other-European' reporting significantly more incidents of physical abuse than non-European or Irish staff. They suggest that this result needs further exploration as the literature on the interactions between overseas workers and older people is only just beginning to emerge.

A few studies (Mileski et al, 2019; Moore, 2019) also reported on the staff characteristics that can increase the risk of abuse specifically for people with **dementia or Alzheimer's disease**. The key characteristic identified was a **lack of knowledge and limited training** about these diseases, how they affect people and about how to provide quality care. For example, Moore (2019) reports on a study by Schneider et al (2010) that found that care staff in residential settings believe that people with dementia deliberately tried to thwart their

efforts to provide care and were generally antisocial, without considering how the effects of residents' dementia may be influencing their behaviour.

Finally, a few studies (Araten-Bergman et al, 2017; Lawrence and Banerjee, 2010) reported on the staff characteristics that can increase the risk of abuse specifically for **people with learning disabilities**. **Having a history as a perpetrator** has been found to be associated with further incidents of abusing residents. Research has also consistently found that staff in care settings who have been abusive often **lacked qualifications**, professional skills and training. Finally, Lawrence and Banerjee (2010) also reported that importance of **staff attitudes** in the abuse of people with learning disabilities, suggesting that a process of dehumanisation, whereby people with learning disabilities are seen to have minimal rights and values, can lead to unacceptable behaviour.

Types of abuse

A few papers reviewed looked specifically at the sexual abuse of residents in nursing homes (Maldemal et al, 2015; McDonald et al, 2012; Smith et al, 2018). A higher likelihood of abuse was attributed to the following staff vulnerabilities and characteristics:

- Staff who have experienced "moderate to severe" trauma including high rates of sexual, physical and emotional trauma as a child
- Staff who were male, with a **criminal or sexual assault history** and substance abuse
- Prevalence of certain **personality disorders** including psychopathy, narcissism and sociopathy

One paper specifically reported on the staff characteristics related to financial abuse. Payne and Strasser (2013) in their study on financial exploitation of older people in care settings reported that occupation directors were more like to be involved in financial abuse cases than in physical abuse cases, where aides were usually identified as the offenders. Moreover, just over a quarter of the financial abusers were from other categories (e.g., laundry worker, bookkeeper, and so on), while just 7% of the physical abusers were from this category.

The findings discussed above highlight that across vulnerable groups there are some key staff vulnerabilities and characteristics that can increase the risk for abuse. These tend to include staff burnout, negative attitudes towards residents and a lack of knowledge or training about diseases and providing high quality care. Given that most of the literature focuses on older people and there is very little that specifically looks at other vulnerable groups, it is reassuring that the heavily evidenced findings for older people resonates well with the findings for other vulnerable groups. The staff characteristics that increase the risk for sexual abuse and financial abuse are on the other very specific to personal attributes of staff who conduct the abuse.

4.2 Resident vulnerabilities and characteristics

Another key factor contributing to abuse relates to the specific vulnerabilities and characteristics of residents in residential settings. The literature on this topic tended to focus mostly on vulnerable groups such as older people, with some coverage of people with

learning disabilities and finally staff working at residential homes who had experienced aggression / abuse from residents. Additionally, the vulnerabilities and characteristics of residents as a risk factor was also discussed in terms of different types of abuse: sexual abuse, financial abuse, physical abuse.

Vulnerable groups

There is considerable consensus across the literature about the vulnerabilities and characteristics of older people in care settings that can contribute to a higher likelihood of abuse (Drennan et al, 2012; Hyde et al, 2014; O'Brien, 2016; Radermacher, 2018). The three most commonly discussed vulnerabilities are:

- Older people with **cognitive impairments** such as dementia or Alzheimer's disease
- Older people that demonstrate **behaviour problems, communication problems, aggression** towards and non-cooperation with staff
- Older people with a **high level of dependency** who require assistance with daily activities

With regards to cognitive impairment being a key risk factor the National Research Centre (2003) have argued that that it is not the dementia or Alzheimer's disease that is the risk factor, but the resulting behaviours and difficulties. The authors argue that further research is needed into the relationship between cognitive impairments, such as dementia, and abuse which should differentiate the cognitive, functional, and behavioral effects of the impairment and examine the independent association between each and the risk for abuse.

Other characteristics or vulnerabilities of older people in care settings that have also been highlighted in the literature include:

- Gender - older women are at higher risk of abuse than older men
- Isolation – older people who have a poor social network or have become isolated from family and friends

There was only one piece of literature that looked specifically at vulnerabilities and characteristics of people with learning disabilities that could lead to abuse. Araten-Bergman et al's (2017) review of best practice in supports in disability services for the prevention of abuse of people with disability reported the following risk factors identified:

- The cognitive impairment associated with learning disability hampers the individual's ability to recognise and respond appropriately to situations where danger exists
- The **severity of cognitive impairments magnifies risk**; several studies have found that majority of people with learning disabilities exposed to abuse have severe or profound learning disability
- The lack of power over making decisions about their own lives and their reliance on others, over whom they have little or no control, to meet physical, psychological or economic needs

Other characteristics that increased the risk of abuse were similar to those of older people in similar settings:

- People with learning disabilities who have challenging behaviour and communication difficulties

- People with learning disabilities that have limited ability to undertake daily activities

The one other vulnerable group that received specific attention was staff working in residential settings. Ayako et al (2012) in their study on aggression exhibited by older adults with dementia toward staff in Japanese long-term care found that:

- Most aggressive residents were males and older (70-89 years) and many were suffering from paralysis, muscle contraction or aphasia
- Emotional pain or shame experienced during the provision of personal care triggered aggressive behaviour
- Older residents with dementia may exhibit aggressive behaviour in order to express their complaints about and/or reject the care that is provided to support them

The author argues that these findings indicate the importance of respecting resident dignity, paying heed to their emotional state, and ensuring that the care provided causes as little pain as possible.

Types of abuse

A few papers reviewed looked specifically at the sexual abuse of residents in nursing homes (Maldemal et al, McDonald et al, 2012; Smith et al, 2018). A higher likelihood of abuse was attributed to the following resident vulnerabilities and characteristics:

- **Residents who are predominantly female**, **older**, and Caucasian
- Residents with cognitive impairment due to dementia or other cognitive/neurological disorders, who have a psychiatric diagnosis, who are physically frail and who are nonambulatory
- Residents that require assistance in all activities of daily living

With regards to the gender of residents who are sexually abused, Maldemal et al (2015) report that caution is needed with regards to interpretation as the WHO states **that official statistics vastly underrepresent male victims of sexual abuse**. They argue that perhaps the older the age, the less significant the issue of gender, and other factors such as fragility, dependency, and cognitive decline become more important and conclude that more research on gender issues in elder abuse is needed.

One paper specifically reported on the resident vulnerabilities and characteristics related to financial abuse. Payne and Strasser (2013) in their study on financial exploitation of older people in care settings reported that:

- Two thirds of the residents were females and one third were males
- The average age was 82 years which was approximately 10 years higher than residents who had suffered physical abuse

Finally, Hutchinson and Kroese (2015) in their review of possible causes of abuse and neglect in adult residential care highlights the findings of a few studies that have focused specifically on physical abuse. In particular they highlight the resident vulnerabilities that increase the risk for physical abuse:

- In one study resident behavioural difficulties were correlated with physical abuse, and in another the level of cognitive function was correlated
- Another study identified resident age, aggression, communication problems, self-injurious behaviour and ambulation that were significant in differentiating between those who had been physically abused and those who had not.

The findings indicate that across abuse types and vulnerable groups, there are key resident vulnerabilities and characteristics that increase the risk for abuse: behavioural difficulties and cognitive impairment. It not surprising to note that the resident gender that is associated with resident to staff abuse staff tends to be male, whereas the gender tends to be female in relation to staff to resident abuse. However, it was also acknowledged that abuse against men may be underreported.

4.3 Organisational culture and leadership

A common theme across the literature was the influence of organisational culture and leadership on the risk for abuse and neglect in residential settings. One of the key factors identified in the literature was poor management and leadership (Andela et al, 2018; Hyde et al, 2014; Lawrence and Banerjee, 2010; Moore, 2016; Schiamberg et al, 2011). Some specific aspects of such **low-quality leadership** that have been found to be associated with incidents of abuse of residents in residential settings include:

- **Little continuity** in management, high changeover of managers, and unclear lines of accountability
- **Invisibility of managers**, managers that do not spend much time “on the floor”
- Overly bureaucratic and instructive management styles with a focus on external targets, or standardised rather than individual care, that leaves staff with little control over their work situation
- A lack of management scrutiny and vigilance with regards to care staff behaviour and/or complaints and lack of response to abusive or neglectful behaviour
- **Inconsistent or absent supervision** of staff and absence of staff appraisals
- Little support to help staff with workload pressures and everyday stresses of their job

These findings resonate with the findings of Muckamore Abbey Hospital Review Team’s (2020) review of leadership and governance at Muckamore Abbey Hospital. More specifically, the review found that the leadership team was dysfunctional, there was a lack of continuity and stability, and leadership was not visible.

Another key aspect of organisational culture that was identified in the literature as posing a significant risk to abuse in residential settings was the pervasiveness of **adverse working conditions** for staff (Araten-Bergman et al, 2017; Ayako et al, 2012; Drennan et al, 2010; Hyde et al, 2014; National Research Centre, 2003; Pickering et al, 201;). The adverse working conditions that were most associated with increased instances of abuse and neglect were:

- Staff working in isolation, absence of constructive teamwork, poor quality relationships with colleagues or factions within staff
- **Not enough staff on duty and working too many nights shifts**
- **Being in charge of too many residents, having heavy workloads, and a large number of high dependency residents**
- Experiencing workplace bullying which can normalise and rationalise such behaviours, leading staff to become desensitised

This also resonates with the findings of Muckamore Abbey Hospital Review Team's (2020) review of leadership and governance at Muckamore Abbey Hospital. The review found that there were significant staff shortages, particularly in relation to nursing staff, patient activities were restricted due to staffing deficits which resulted in boredom and heightened levels of challenging behaviours and medical staff were at times not available in sufficient numbers to support nursing staff or to drive up standards within wards.

There was moderate evidence about a third aspect of organisational culture that increases the risk for abuse and neglect is institutions that have **inadequate policies and procedures**. This includes policies relating to **safeguarding, complaints**, the management of incontinence and procedures relating to **poor record keeping** and a lack of clarity about how to report safeguarding concerns (Hyde et al, 2014; Manthorpe and Martineau, 2017). Finally, there was also moderate evidence (Moore, 2019; Radermacher et al, 2018) relating to risk posed by a certain level of **tolerance for or permission to abuse** from people in positions of higher authority and in the same peer group. This tended to present itself as a tacit approval to use shortcuts and workarounds in care delivery that could lead to neglect and/or abuse, in order to enable the volume of work to be completed. It is in this way that abusive routines often came to be regarded as normal behaviours and Moore (2019) has argued this this is one of the key reasons for why abuse has perpetuated in care homes across the country for so long.

4.4 Institutional characteristics

There was moderate evidence in the literature about some specific characteristics associated with the residential settings that could potentially result in higher levels of abuse and neglect. These included:

- Institutions with **high levels of staff turnover** which can **disrupt the quality of care delivered to people**
- Institutions that rely heavily on agency and **part-time staff** which can result in 'care without commitment'

Moreover, there are some institutional characteristics about which the literature is divided. For example, some studies across countries (Drennan et al, 2012; Gil, 2019; Hutchinson and Kroese, 2015) have found that complaints and reports about abuse and neglect are more common to **for-profit institutions rather than not-for-profit institutions**. However, Drennan et al (2012) report in their survey of staff-resident interactions in the Republic of Ireland that in their study that there was no statistically significant difference in the reported

prevalence of neglect or abuse, when the public or private residential homes were compared.

Similarly, there are also a few studies that report that **bigger institutions** with larger number of residents and beds are associated with a higher incidence of abuse and neglect (Drennan et al, 2012; Hyde, 2014; Hutchinson and Kroese, 2015). However, Drennan et al (2012) again report that in their study the strongest facility-related predictor of physical abuse was in fact working in a small-sized nursing home. They report that other available evidence is also variable, with larger nursing homes often offering better social supports for resident whereas the quality care is often higher in smaller nursing homes. The authors conclude there is a need for further research to fully explain their findings. Finally, the evidence reviewed on whether abuse and neglect are more likely to occur in settings in **rural or metropolitan** settings is also divided, with some reports reporting the former (Hyde et al, 2014) and others reporting the latter (Drennan et al, 2012; Hutchinson and Kroese, 2015).

4.5 Poor governance and accountability

There is also some discussion in the literature, particularly that relating to safeguarding reviews and investigations, about the role of poor governance and accountability in creating an atmosphere where abuse and neglect can flourish. For example, the Muckamore Abbey Hospital Review Team's (2020) review of leadership and governance at Muckamore Abbey Hospital reported that although the hospital had the appropriate governance structures in the form of an Executive Team and Trust Board, there was **little reporting of risks pertaining to safe and effective care to these bodies**. Instead, there was a high degree of autonomy afforded to Directors and senior managers who were able to exercise judgment and discernment about matters requiring escalation to these bodies. The location of the hospital at some distance from the Governance bodies meant that it operated outside their sightlines and under their radar.

Similarly, Flynn et al (2015) in their review of neglect in care homes as part of Operation Jasmine, reported that non-listed private care providers are not subject to the monitoring codes and legislative provisions that apply to listed public companies. In practice this means that a sole director is sufficient to run a company without external or independent scrutiny, which in the case of homes owned by Puretruce Healthcare Ltd resulted in gross negligence and the provision of a very poor standard of care by the owners.

Moore (2017) has also raised the issue of **poor contract monitoring** by local authorities, which is reported to **be superficial and reactive** and not designed to see past the façade constructed by staff recruitment checks, staff training records, files of policies and procedures and care plans. Additionally, many of the staff employed by local authorities and clinical commissioning groups to manage and monitor contracts, particularly those who monitor, often **lack the skills and experience** to do so. Finally, Moore (2017) also comments on changes to **the CQC's approach to inspections** announced in 2016 (in light of an anticipated 13% cut in budget) whereby a more 'risk-based' approach would mean that care homes with higher ratings would be inspected less often than those with lower ratings. He argues the risk posed by such an approach given that there is no discernible relationship between standards of care, as measured by statutory regulators, and the occurrence of physical abuse.

4.6 Wider context

The literature reviewed has also identified a few factors in the wider context of which residential homes operate which can increase the risk for abuse and neglect. For example, **financial pressures**, particularly efficiency savings, reduced provisions and lack of resources to provide adequate care were mentioned, as was significant organisational changes such restructuring, and changes in ownership (Hyde et al, 2014; O'Brien et al, 2016).

Some papers (Moore, 2016; O'Brien et al, 2016) also identified the important role played by **societal attitudes** towards older people in increasing their risk of abuse. O'Brien et al (2016) argued that in western cultures ageing is associated with negative connotations which can result in treating people from the older generation as not having the same rights as the rest of society. Negative social attitudes towards older adults are acknowledged as a permissive element for elder abuse and therefore social ageism permits elder abuse to happen as it creates a context or social space that makes the behaviour possible.

5. How do residential settings respond to or try to prevent abuse and neglect?

The literature reviewed has highlighted a number of different types of interventions, responses and approaches that can help reduce the risk for abuse in residential settings. They are presented below in order of strength of evidence, and include:

- Staff education and training
- Improving identification, reporting and documentation of abuse
- Improving policies and procedures
- Improving organisational culture and leadership
- Education and training for residents and older people
- Post abuse response and consequences for perpetrators

It is interesting to note that there were a number of systematic reviews and non-systematic reviews that looked at the effectiveness of interventions aimed at preventing abuse against older people or people with disabilities. However, the authors often reported that their most notable finding was that although there were a few thousand studies initially identified in the review, very few (ranging from 12-24) were actually included in the review due to strict inclusion standards relating to the methodological rigour of evaluations. However, our review was able to identify evaluations of studies that would not have been included in these reviews. These evaluations provide a rich insight into the design of interventions and the learning gained by participants.

It is also important to note that a number of authors have argued that what is needed is not just one type of response of intervention, but interventions that are multifactorial and multilevel to reflect the fact that the risk factors for abuse are varied and complex as are the interactions between them (Hyde, 2014; Schiamberg et al, 2011).

5.1 Staff education and training

Staff education and training is one of the most common preventative interventions highlighted in the literature with authors arguing that such training should be mandatory in order to lower residential settings risk for abuse and neglect. The literature reviewed highlights some key educational aspects that should be part of the **content of training** programmes. These include:

- **Psycho-education training** that includes training on constructive communication techniques with residents and effective techniques of modifying aggressive or non-cooperative resident behaviour in order to diffuse difficult situations and reduce staff-resident conflicts and thereby abusive behaviours by staff (Araten-Bergman et al, 2017; Drennan et al, 2012; National Research Centre, 2003).
- Training on **what constitutes abuse and neglect**, recognising the risk factors for abuse and how to report any perceived abuse or neglect (Drennan et al, 2012; Mileski et al, 2019; Phelan, 2015)

- Specific training on the ageing process, geriatric care, as well as education about the progress of **dementia and Alzheimer's disease**, their impact on behaviour and providing high quality care for people suffering from these diseases. Tadd et al (2012) report that this training should include an understanding of the significance of the Mental Capacity Act for day-to-day care practice (Mileski et al, 2019; Tadd et al, 2012)

Other aspects of training that were also mentioned in the literature included training that increases staff skills when dealing with residents that have cognitive deficits and education about their particular vulnerability to abuse, and training on how to use elder abuse protocols or screening tools as they can assist early identification and reporting of abuse.

In addition to the content of training programmes, the literature reviewed also offered insights into the **style of training** that is most likely to engage and have a positive impact on staff. For example, Drennan et al (2012) report on a popular programme of training developed by Pritchard (1996) on recognising and preventing abuse which successfully uses theory and **interactive exercises** to facilitate staff to think about and deal with abusive situations. They argue that staff should receive educational updates on the recognition and prevention of elder abuse throughout their careers due to the ongoing changes and developments related to the protection of older people and that there is also a need to continually evaluate and review the education and training that staff receive on elder abuse. Similarly, Tadd et al (2012) describe the format of the PEACH training programme which uses a vignette-based set of materials **that reflects the day-to-day realities of work** in residential settings. They argue that this approach promotes reflective practice, in contrast to a 'tick box', checklist approach to learning. Finally, one of the key recommendations of the CPEA (2020) safeguarding review of Dunmurry Manor was to establish Action Learning Sets with leaders from care homes, Adult Safeguarding Champions and care managers. The review team argued that such a format would be most effective as Action Learning Sets will allow certain types of situations and issues to be explored and probed with a view to taking purposeful action as opposed to focusing only on policies and procedures. What is clear from these papers that training works best when it includes interactive elements, addresses real-life problems and encourages participants to reflect on their practice.

There are also some **specific examples of staff education and training** interventions in the literature. One is the Croydon Care Home Support Team (CHST) (Lawrence and Banerjee, 2020) the detail of which are highlighted in the box below:

The Croydon Care Home Support Team (CHST)

This consists of a small, focused multi-disciplinary team comprising one district nurse, one community psychiatric nurse (CPN) and one social worker. Their work focuses on: promoting teamwork and professional development, underlining the importance of person-centred care and encouraging staff to examine existing care practices. The input of the CHST can be divided into four categories:

- Workshops – interactive sessions on topics such as person-centred care plans, record keeping and understanding dementia
- Facilitating access to e-learning - Safeguarding Vulnerable Adults (SVA), Mental Capacity Act (MCA) and Deprivation of Liberty (DoL).

- Community services and formal training - signpost to clinical nurse specialists in palliative care, continence specialist nurses and community dieticians; formal training including end of life care, support with literacy and advanced safeguarding vulnerable adults
- Audits – medication audits and care plan audits
- Managerial support - extensive face-to-face and telephone support.

A qualitative approach towards evaluation was used and data has been encouraging: care home staff and managers reported improved communication, skills, motivation, confidence and pride among staff. Evidence of increased competence in tasks, such as record keeping and managing clients with challenging behaviour coexisted with evidence of shifting attitudes and beliefs, with staff reporting that the way that they perceived and interacted with residents had changed.

Another intervention is a safety improvement intervention in care homes in England called PROSPER (Promoting Safer Provision of care for Elderly Residents) (Marshall et al, 2018), with details highlighted below:

PROSPER (Promoting Safer Provision of care for Elderly Residents)

This intervention tackled neglect specifically, and was designed to reduce the incidence of three common causes of harm among care home residents—falls, pressure ulcers and urinary tract infections—by improving the safety culture and working practices of participating care homes, It comprised of three complementary components:

- Training in quality improvement methods - provided for the care home staff, initially by quality improvement experts from the local academic/health service network, then using a train-the-trainers model by members of the local government quality improvement team
- Participating care homes were encouraged to collect their own data on the incidence of falls, pressure ulcers and urinary tract infections, which and fed back to the homes in graphical form by the evaluation team
- The prevailing safety culture of the homes was assessed using a version of the Manchester Patient Safety Framework (MaPSaF) adapted for use in care homes.

It was evaluated using a participatory approach to evaluation where the evaluator is an active member of the operational team. Participation in the programme appears to have led to notable changes in the value that care home staff place on resident safety and to changes in their working practices. Moreover, evidence also demonstrated that most of the care homes showed changes in their working practices, priorities and the ways in which they thought about their role with respect to safety. Care home staff of all levels of seniority described how they felt more empowered and more confident to suggest new ideas to improve resident safety and to implement change. The homes also described how, as a consequence of participating in the programme, they learnt how to work more effectively with the NHS, a relationship which had previously been fractious. In addition, they forged a more constructive and mutually appreciative relationship with their local councils. The authors conclude that the study provides robust qualitative evidence that well designed

improvement programmes can result in changes in what care home staff value and in their working practices.

Finally, there is also a discussion in the literature about the success and impact of staff training programmes. Some authors in their reviews of interventions aimed at preventing abuse in residential settings (Baker, 2016; Liat et al, 2016; Phelan, 2015) have argued that **evaluations of educational and training interventions have not been robust enough, with almost no studies using Random Control Trial methodologies**, or too many studies only conducting evaluations right at the point of delivery when staff are more sensitised to issues of abuse and neglect. **They also argue that these evaluations only tend to report an improvement in knowledge and attitudes towards abuse rather than any outcomes relating to the prevention or reduction of abuse.**

At the same time, some authors (National Research Centre, 2003; Tadd et al, 2012) describe abuse prevention programmes as having been 'successful' by demonstrating a number of positive outcomes, including the development of better attitudes towards older people, enhanced conflict coping strategies and a reduction in self-reported abusive behaviours. Other positive outcomes have included less conflict with residents after the training, as well as reductions in resident aggression towards staff.

Given that the risk factors for abuse and neglect are varied and that each residential setting represents a unique context, we would argue that whilst the methodological rigour of evaluations is important, it is also important for the approach and **the outcomes assessed to be flexible and appropriate to the context. It is hard to quantify 'prevention or reduction of abuse' or to apply experimental/quasi-experimental approaches to such evaluations. Therefore, using a rich mix of proxy measures** such as increased knowledge, better attitudes, reduction in self-reported abuse and fewer staff-resident conflicts is better suited to reflecting success and impact in these settings.

5.2 Improving identification, reporting and documentation of abuse

There is also notable evidence in the literature (Milkeski et al, 2019; Blundell et al, 2020) about the importance of leadership in residential settings ensuring that a **culture of proper reporting and documentation** is encouraged.

The importance of reporting was stressed by Maldemal et al (2015) in their review of sexual abuse of older nursing home residents. The review found that may nursing homes did not handle situations of sexual abuse in an adequate way. Many did not report further or delayed reporting to authorities, and there was also a lack of documentation. The authors concluded that developing good policies and reporting systems are an important step in seriously addressing sexual abuse against older persons. Similarly, Phelan (2015) reported that within serious case reviews there is evidence of reports of abuse being ignored or only getting a token response. They argue that policy needs to foster disclosure of poor care and ensure that this is within a culture of nonvictimization and appropriate, timely response follow-ups

More specifically, the literature identified the use of **elder abuse instruments/screening tools** as potentially playing an important role in the early identification and reporting of abuse (Albofathi et al, 2013: Blundell et al, 2020). The key points raised were:

- Instruments should include information about different types of abuse, risk factors, older people's right to self-determination, interagency collaboration, the broader category of family and domestic violence, and appropriate local laws and organizations
- It is important to consider the instrument's purpose and reliability and validity for the population studied. Some may not be appropriate cross culturally. **This signifies the importance of ensuring that instruments are localised and specific to context. It is important to use universal indicators as well as sub-indicators appropriate to specific contexts**
- Instruments must be supported by education and training, as well as organisational policies, procedures, and line management duties
- Organisations should ensure that there is monitoring and evaluation of instruments used to assess their effectiveness
- Initial screening/assessment of the resident is dramatically important as it sets the tone regarding the care plan of that resident and what is best for them

Another important point raised relating to the identification and reporting of abuse (Mileski et al, 2019; Drennan et al, 2012) was that residential settings must regularly **engage with residents** as they may choose to not share any information or may be unable to do so. Engaging with family and utilising outside resources such as advocates is just as important. In fact, Drennan et al (2012) argue that *'asking older people and their carers about abuse is probably the single most effective detection strategy.'*

The literature also makes some mention to interventions that aim to increase and improve the **documentation of abuse** (Mileski et al, 2019; Maldemal et al, 2015; Blundell, 2020). Such interventions need to highlight the importance of staff reporting and documenting immediately after an incident and the importance having an appropriate documentation process so that staff members can supply the details and get back to work.

5. 3 Improving policies and procedures

The literature clearly identifies the need for clear **whistle-blowing policies and procedures** to demonstrate residential settings have zero tolerance for neglect and abuse. Staff, residents and families should all know the different avenues for reporting concerns. Moreover, there is a need for management to **encourage disclosure of poor care by providing appropriate, timely response follow-ups**, rather than ignoring reports or providing only a token response as is often the case (Phelan, 2015; Flynn, 2012; Manthorpre, 2017). Investigations and reviews of cases of abuse at Winterbourne and Dunmurry manor (CPEA, 2020; Flynn, 2012) also identified the need for a whistle-blowing policy and clear **complaints management process**. They recommended that all registered health and social care employers should be required to advise their employees in their contracts to whom they can whistleblow, the response that the employee can anticipate from the employer and what to do if this is not forthcoming. They also identified the need for families to be involved early in the complaints process and to be well informed at all times of the next steps in the complaints process (COPNI, 2018).

The importance of having clear policies and protocols in place was also stressed by Tilse et al (2013) in their report on financial abuse in residential care facilities. The study found that

families of residents were the group most likely to financially abuse older people and that the residential settings tended to 'wing it' in their responses to suspected abuse. Having clear protocols would manage risk and protect residents and staff.

Finally, some authors have also stressed the importance of having **robust risk management systems** in place to identify, manage, and monitor risk of abuse and **neglect**. Phelan (2015) in her report on the need for policy to protect care homes residents from abuse suggests that risk management must occur on multiple levels:

- Regular risk management assessments for individual residents (based on personal characteristics)
- Risk management of the environment (physical setting, staff ratios, health, and safety)
- Maintaining and promoting residents' autonomy, rights, dignity, or social connectedness (family, community)

Moreover, Starns (2018) suggests a **similar systems approach towards safeguarding** that adopts a holistic view of the care home, taking into account the individual elements that contribute to the home functioning and how they relate to each other to provide safe care to all its residents. This would involve identifying the factors that act as inputs into care for residents. These inputs transform into the daily care delivered to adults, leading to the output of a safe good quality care environment. **When safeguarding events occur these should act as a feedback loop about how well the system is working**. A cumulative pattern of safeguarding concerns should act as a signifier to change an input before it causes a breakdown in the system leading to significant harm to residents. The time, number, nature and frequency of concerns should be recorded daily, with a review of this data taking place at least once a month. In this way adjustments can be made to the input of care that will prevent escalation to greater harm.

There is also some evidence in the literature that preventing abuse and neglect in residential homes requires these settings to re-think their **hiring procedures and practices**. There is evidence in the literature from staff at care homes in the UK that the interview process is often far from rigorous and there is a perceived **absence of any checks** being performed on references by prospective employers (Moore, 2017). On the other hand, staff who have worked in recruitment reported that it is difficult to determine the true motivations or attitudes of prospective employees during the hiring process. They reported that **staff often gave the 'right' responses at interview, but their behaviour changed after employment** and after their probationary period (Moore, 2016). Moreover, In the U.S, there is evidence that a high number of nursing assistants in care homes have criminal backgrounds or active substance abuse problems that are not picked up during the recruitment process (National Research Centre, 2003).

Authors have therefore argued that interventions that improve residential settings capacity to screen employees and determine individuals who are suited for caregiving work would be helpful, in particularly tools to assess potential employees' risk of abusive behaviour. Similarly, Moore (2017) has suggested that staff should be recruited on the basis of their personal value frameworks. One way to do this would be **though psychometric appraisal** which would objectively measure the knowledge, abilities, attitudes and personality traits of potential employees and therefore select staff more suitable for the work.

5.4 Improving organisational culture and leadership

Several authors have argued that a change in organisational culture is needed to ensure that residents receive good quality care from motivated and satisfied staff. One of the key factors stressed in the literature (Braaten et al, 2017; Drennan et al, 2013; DHSSPNI, 2015; PANICOA, 2013) is the need for residential settings to **embrace and commit to person centred care**. What this means in practice is:

- All care staff must put the **needs of the resident** first and work in such a way that maintains the residents' autonomy
- Care staff must move the focus from the disease (such as dementia, Alzheimer's disease) itself to see the person with the disease
- It is important to develop '**a sense of connectedness' between staff and residents** by ensuring that resident feel seen and recognised
- Involve residents as much as possible in decisions about their care and where this is not possible provide advocacy services

The **role of management and leadership** in improving the quality of care and implementing organisational change was also stressed in the literature (DHSSPNI, 2015; Mileski et al, 2019; PANICOA, 2013; Tadd et al, 2012), particularly, in investigations and reviews of specific abuse incidents such as Winterbourne and Dunmurry Manor (CPEA, 2020; Flynn, 2012). In particular leaders and managers need to:

- Promote and embed the principles and values of people's human rights and freedoms and the importance of a person-centred approach by modelling appropriate attitudes and behaviours
- **Value staff**, build their sense of self-efficacy, self-worth and personal accomplishment, celebrate their good work, ensure they are empowered, and supported in decision making by line managers
- Provide an environment for staff to work together and discuss successes to help in the **development of the staff** and give on-the-job training opportunities
- Develop a recognised career structure and pay structure for care workers which would help to promote a sense of accomplishment and increased self-esteem and ultimately reduce burnout
- Ensure that their normal place of work is one where they can become known to patients/service users and **are routinely visible and accessible for the staff** who are working 365 day rotas

5.5 Education and training for residents and older people

There is some evidence in the literature about the importance of ensuring **that older people and people with learning disabilities are able to recognise what abuse and neglect looks like. Moreover, they should also be educated about the steps they can take to protect themselves** from mistreatment.

For example, O'Brien et al (2016) report that psychological and social support interventions targeting at risk older people, were found to have the strongest evidence of efficacy. These

interventions included an educational video and booklet aimed at educating older people who were victims of crime (Acierno et al., 2004). In Italy and Ireland, the police developed leaflets aimed at educating older people on crime prevention. Finally, the Health Service Executive in Ireland developed an educational DVD “Open Your Eyes to Elder Abuse in your Community”, aimed at educating older people and the general public about elder abuse and how to prevent it.

Araten-Bergman et al (2017) in their review of abuse prevention interventions for people with learning disabilities reported on the results of a few training programmes involving people with mild to moderate learning disabilities. These included psycho education training and cognitively oriented decision-making training. The authors report that the studies demonstrated that people with mild to moderate learning disability may successfully acquire knowledge or skills to assist them with recognising an abusive situation and responding in an effective way. However, it is unclear to what extent such knowledge and skills are transferable or reflect a person’s ability to respond effectively in a real situation.

5.6 Post-abuse response and consequences for perpetrators of abuse

A few studies relating to financial and sexual abuse reported on the response to and consequences for perpetrators of abuse. For example, Maldemal et al (2015) in their review of sexual abuse of older people in nursing homes report that findings from the studies reviewed showed that only a few perpetrators were held responsible and that **the assault had no legal consequence, despite witnesses in several of the abuse situations. Where the perpetrators were staff members they were either terminated from employment, placed on leave, or transferred to other jobs**. Some had the assault included on their criminal records and very few were actually sentenced. Smith et al (2018) in their review of sexual assaults in nursing homes report similar findings. The studies reviewed reported that very few perpetrators were prosecuted and reasons given include insufficient evidence, victim unable/unwilling to prosecute, and attorneys decided not to prosecute. Perpetrators were relocated to another facility and received psychiatric treatment.

Finally, Payne and Strasser’s study (2012) on financial **exploitation of older adults in care settings found that fines were applied in the majority of cases, and probation was the next most common penalty**. Only about 12% of offenders were incarcerated in jail or prison. Comparing penalties awarded in financial and physical abuse cases found that physical abusers were more likely to be sentenced to jail (short-term stays) than financial abusers were, but financial abusers were more likely to be sentenced to prison (long-term stays). Comparing sentence lengths, financial abusers received longer probation sentences, shorter prison sanctions, and higher fines than physical abusers did.

6. The use of CCTV to prevent/respond to abuse

The use of CCTV in residential care settings to prevent abuse has come to the forefront of policy after the concerns raised about the quality of care at places like Winterbourne View Hospital in England and Dunmurry Manor care home and Muckamore Abbey Hospital in Northern Ireland. However, it is important to note that in all these cases CCTV did not lead to the identification of abuse, but rather it was used to explore concerns that had already been identified by family or staff members.

What is clear from this review is that the **use of CCTV in residential settings is a complex topic shrouded in debate with concerns from all parties involves**. The literature (Davidson et al, 2020; Fisk, 2015; Moore, 2017: SCIE, 2015) has identified the following key debates:

- **Rights based issues** – **the balancing of protection and privacy**. Consultation with staff working at care homes has unsurprisingly indicated that privacy for both staff and residents is the main concern with regards to the use of CCTV.
- **Legal debates** including issues of **capacity and consent** - There are ethical issues stemming from whether or not a person knows about, and gives their permission, or has the capacity to give their permission to be the subject of surveillance. The issue of consent to the use of surveillance in health and care settings relates not only to that of the person using the service, but also to families, carers, visitors and staff.
- **The benefits vs harm debate** – there are a number of potential benefits associated with using CCTV including the potential for CCTV to improve the quality of care, provide continuous real time data, and provide better information about high-risk behaviour. However, it can also create a culture of mistrust, have a negative impact on staff, a negative impact on recruitment of staff and public perception of care homes using CCTV.
- **Perspectives** of service users who live in care home settings, their family and friends, and staff who work in care home settings – there is a need to clarify who the intended beneficiaries are in relation to the use of CCTV, for example protection of service users, families' desire for reassurance, staff's concern about false allegations or service providers concerns about staff, residents and families.
- **Practical and economic perspectives** – complexities of installing, operating and monitoring CCTV and whether investment in CCTV is the best use of limited resources.

Given the debates around using CCTV in residential settings **a number of authors and organisations have developed very specific guidelines** for the use of CCTV in residential settings. This includes guidance published by The Regulation and Quality Improvement Authority (RQIA, 2016) and guidance published by the Care Quality Commission (2015) and the Information Commissioner's Office (ICO) (2014). Davidson et al (2020) sum up the general themes contained within these policies and guidance:

- that CCTV should be for a specific purpose (to promote care/prevent abuse)
- it is based on a comprehensive assessment
- there needs to be consultation with all involved

- issues of consent and capacity need to be addressed
- the relevant legal requirements need to be considered
- the associated need for training should be identified
- the wider practical and operational issues also need to be considered.

There is also **little evidence to support the use of CCTV** in care homes. Davidson et al (2020) in their review of the effectiveness of CCTV in care homes report that there are very few studies that actually tested the effectiveness of CCTV within care homes settings. Other studies that they included in their review tended to consider the use of 'Smart Home' technologies that can assist people to 'age in place' and types of monitoring often applied in residential care, and studies that have investigated attitudes towards surveillance within a healthcare setting**. Two of the most relevant papers identified argue that there is no clear evidence of camera surveillance being effective** in protecting the welfare of people in residential care. This is because:

- It was disliked by people and was regarded with suspicion by staff
- Its functionality was limited and the ethical challenges associated with its deployment were considerable
- It was expensive and difficult to trial
- Expectations of the use of CCTV often exceeded performance

Based on this rapid evidence assessment Davidson et al (2020) conclude that there is **insufficient research evidence to support the proposal to use CCTV in care home settings**. These findings are also echoed in a review by SCIE (2015) on electronic surveillance in health and social care settings. The authors reported on a few of studies that found **little evidence on the effectiveness of CCTV on preventing abuse and also noted that there is scarce literature on the topic**. On the other hand, the authors also report that there is some limited research that there may be potential benefits in terms of patient care such as:

- It has the potential to generate observational data on the movements and behaviours of carious people within the care facility to complement tradition observation techniques.
- Surveillance data can support professionals as they review incidents. Reviewing video footage can help to build a picture of what led to a negative event, such as an accident, occurring.

It is clear from the research that the issue of using CCTV as a means to prevent abuse remains a complex topic and one that must be approached with a considered mindset and in consultation with all the parties involved.

7. Employing a human rights consideration to prevention of abuse

A human rights-based approach to care establishes minimum standards of care that help to safeguard individuals, particularly those who are vulnerable. It has many **overlaps with a person-centred approach** but has the backbone afforded by the fact that it is a legal requirement to uphold the human rights of those in care.

A few papers reviewed have made the case for employing a human rights approach towards care for older people. For example, O'Brien et al (2016) have argued that **a human rights approach is a good example of a macro-level intervention**. However, they also report that whilst there is a growing awareness about the discrimination, poverty and abuse faced by older people, there is an unwillingness at government levels to provide a legal instrument that would actually protect older people's rights.

This has also been echoed by Phelan (2015) who argues that a human rights-based approach has very fundamental advantages in terms of policy articulation in care homes. Such an approach can illuminate inconsistencies in relation to care homes such as the right to liberty. For example, often, leaving the care home is not permitted without an accompanying person, even in the event of having full capacity to do so. **Other rights pertain to the right to privacy, the right to a family life, the right to be free from torture, and inhuman or degrading treatment or punishment**. A human rights lens can also be used for benchmarking care delivery against human rights standards and provides a way of ensuring that paternalistic and ageist practices are exposed**. Moreover, the use of a human rights lens can stimulate staff to question poor practice and discuss how rights can be promoted**. Phelan argues that this is particularly relevant in the context of dementia-related care, where decisions may be taken on behalf of the resident in a paternalistic way. Finally, the importance of applying a human rights lens towards safeguarding and care has been stressed in COPNI's (2018) investigation into Dunmurry Manor Care Home. This review included a series of human rights related recommendations for care homes, regulators and policy makers.

There was only one study in the literature reviewed that explored the use of a human rights-based approach and this was Kinderman et al's (2018) study on the impact of a human rights-based approach to **dementia care in inpatient ward** and care home settings. The intervention consisted of a 1-day training package for staff, the implementation of the 'Getting It Right' assessment tool and booster sessions to support the implementation. The 'Getting It Right' assessment tool was a person-centred care planning tool that explicitly linked the FREDA (Fairness, Respect, Equality, Dignity and Autonomy) principles to areas contributing to person-centred care. Overall, the study found that:

- There were no significant differences found in the reported quality of life of residents between the control and the intervention
- There was a significant **difference in both the human rights knowledge and attitudes**
- No improvements were seen in care
- There were **some changes in staff-reported decision-making strategies at follow-up where staff relied less on 'common sense' as a way of making clinical decisions and more on human rights strategies and person-centred care in guiding decision-making**

Staff found the approach to be simple and useful, but that they did not always apply it. It was found that **the level of management support was a major factor** in whether the approach was adopted. Kinderman et al (2018) conclude that the findings of the study do not support the hypothesis that increasing staff knowledge and attitudes towards human rights leads to improvements in the care and well-being of people living with dementia. They also argue that the study highlights that training alone in a traditional format is potentially not a good medium for bringing about cultural change and that instead, training must embrace models that allow learners to understand the material and apply it to their own work. This is consistent with our findings relating to effective styles of staff training in section 5.1.

8. Evidence gaps

One of the key gaps identified in the literature reviewed is that there is insufficient **high quality research about interventions** that are effective in preventing and reducing incidents of abuse in the residential sector. Whilst there is a large proportion of literature on elder abuse that describes programs for elder abuse, these tend to be brief, without a comparison, and in many cases, only report post-intervention descriptions of satisfaction with a program. **Several authors have argued that although these publications are useful to describe the processes of the interventions, they fail to meet the criteria to establish a causal relationship for abuse prevention** that policy makers and health professionals can use (Baker, 2016; Drennan et al, 2012).

The literature also identifies the need for further research into the relationships between **care workers from different cultural backgrounds and older people** in residential care. More specifically, research is needed to explore the problems and conflicts that arise when staff and residents from differing linguistic and cultural backgrounds interact and experience poor communication (Drennan et al, 2012; McDonald, 2012).

Some authors have also argued that there is little research that focuses **specifically on elder neglect** although this can often be the most common form of abuse. Similarly, others have argued that there is more research needed on risk factors for **specific types of abuse**, including neglect, psychological abuse, sexual abuse and financial abuse, as current studies have focused primarily on physical abuse (Liat et al, 2016; National Research Centre, 2003).

More specifically some authors (Drennan et al, 2012; Maldemal et al, 2015; Smith et al, 2018) have argued for the need for further **research into sexual abuse** which tends to be a taboo topic and is difficult to research. Moreover, much of the existing published research id from the United States and this does not adequately portray the characteristics of sexual assaults nationally or globally . Financial abuse is another area that that needs further research. More specifically, research on recognising and responding to **financial abuse** needs more attention (Tilse and Wilson, 2013).

There is also limited evidence about the effectiveness of programs to prevent abuse against **individuals with learning disabilities**. Although many interventions have been designed and implemented over the years, only a few interventions have been evaluated. Moreover, whilst there is data about the risk factors for abuse among individuals with mild learning disabilities, there is very little in respect of individuals with severe learning disabilities and communication difficulties (Araten Bergman et al, 2017). Finally, **there is a paucity of research that reports on the experience of neglect and abuse from the perspective of the older person receiving care. Whilst there are complexities involved in conducting research with group, there are innovative qualitative approaches** that could be used to give older people a voice on their experiences (Drennan et al, 2012).

In addition to the evidence gaps outlined above, this rapid review has found that the balance of literature on abuse of adults in care homes is focused on older people, with few reports focusing on other groups. Additionally, most of the research considers abuse an ‘all inclusive’ category with very few papers looking at specific types of abuse.

9. Conclusions

A key finding of this review has been that most of the literature identified for inclusion relates to older people and abuse in general, rather than to other vulnerable groups and specific types of abuse.

The review found that there is a consistency in terms of the definition of abuse used across the UK and European literature; that prescribed by the WHO. Whilst there were varying definitions of neglect, these were all similar and the key point made was that that whilst abuse refers to intentional or deliberate acts, neglect can be both intentional or unintentional. The review also found that historically, interpersonal and socio-cultural theories have been used to explain why people are abused – the most commonly used being the caregiver stress theory. However, over time researchers recognised the need to develop theories more closely related to unique context of residential care settings. A popular theory that emerged was the ecological theory which focused on the interaction between the older resident and the caregiver at different levels or systems. A number of other multi-system models have also been proposed, often specific to vulnerable groups and/or settings. The specificity of these conceptual frameworks is a big step from the initial interpersonal and sociocultural theories that framed the discussion about abuse for many years.

The literature reviewed revealed a number of factors that increase the likelihood of the risk of abuse in residential settings. Two of the key factors identified were staff characteristics and resident characteristics. With regards to the former, there was general consensus across vulnerable groups that staff burn-out, negative attitudes towards older people and a lack of knowledge or training about diseases such as dementia or Alzheimer's disease all increased the risk for abuse and neglect. On the other hand, the staff characteristics that increase the risk for sexual abuse and financial abuse are very specific to the personal attributes of staff who conduct the abuse. Similarly, the findings indicated that across abuse types and vulnerable groups, there are key resident vulnerabilities and characteristics that increase the risk for abuse. These include cognitive impairments such as dementia or Alzheimer's disease, residents that demonstrate behaviour problems, degree of cognitive impairment and high levels of dependency with regards to daily living activities.

Poor management and leadership was identified as the key aspect of organisational culture that increases the risk for abuse and neglect. This included little visibility of managers, absent supervision, little scrutiny of staff and overly bureaucratic management styles. Adverse working conditions including heavy workloads, staff working in isolation and insufficient staffing levels as well inadequate safeguarding policies, poor record keeping and a tacit tolerance for abuse by approving shortcuts to meet heavy workloads are also key organisational factors that increase the risk for abuse. Moreover, institutions with high staff turnover or those that tend to rely more on agency or part-time staff are also considered high risk settings.

The literature reviewed has highlighted a number of different types of interventions and approaches that can help reduce the risk for abuse in residential settings. The most popular intervention discussed is staff education and training, including psycho-educational training, recognising the risk factors for abuse and education about dementia and how it progresses. Moreover, the literature makes it clear that training styles should include interactive elements, address real-life problems and encourage participants to reflect on their practice. It is important to note that some authors have argued that evaluations have not been

methodologically rigorous enough and that direct outcomes relating to prevention of or reduction of abuse have not been reported. On the other hand, other authors describe abuse prevention programmes as having been ‘successful’ by demonstrating a number of positive outcomes on staff, such as less conflict with resident and better attitude towards older people.

There is also evidence that a culture of proper reporting and documentation is key to decreasing the risk for abuse in residential settings. More specifically, the use of elder abuse instruments/screening tools can potentially play a big role in the early identification and reporting of abuse. Additionally, there is also a need for clear whistle-blowing policies and procedures to ensure that staff, residents and families know the different avenues for reporting concerns. Robust risk management systems are also encouraged in order to identify, manage, and monitor risk of abuse and neglect. Finally, there is also an urgent need for a change in organisational culture where the focus is on providing person centred care such that all staff put the needs of the resident first and work in such a way that maintains the residents’ autonomy. There is also an important role for leadership and management in implementing organisational change by modelling attitudes and behaviours and valuing and supporting staff.

There is very literature on the effectiveness of CCTV in preventing abuse and neglect in residential settings. Most of the literature focuses on outlining the many debates and issues surrounding the topic and highlighting appropriate guidelines for its use. Similarly, the literature on using a human rights approach to preventing abuse is also limited and focuses primarily on making the case for such an approach with very little evidence of its effectiveness.

It is clear from this review that there is considerable consensus in the literature about the risk factors abuse, but less consensus about interventions and approaches to reduce the risk of or prevent abuse. With the latter, there are concerns about the dearth of evaluations of interventions and the methodological rigour of evaluations.

10. References

Abolfathi, M. Y., Hamid, T.A., and Ibrahim, R. (2013). Theories and measures of elder abuse. *Psychogeriatrics, 13*(3), pp.182-188.

Andela, M., Truchot, D., and Huguenotte, V. (2018). Job demands, emotional dissonance and elderly abuse: the moderating role of organizational resources. *Journal of Elder Abuse and Neglect, 30*(5), pp.368-384.

Araten-Bergman, T., Bigby, C., and Ritchie, G. (2017). Literature Review of Best Practice Supports in Disability Services for the Prevention of Abuse of People with Disability. Report for the Disability Services Commissioner. Living with Disability Research Centre, La Trobe University

Ayako, K.O., Kinuko, T., Yumi C., Hiroki F., Ayumi, I., Yukari, T., and Noriko, Y. M. (2012) Aggression Exhibited by Older Dementia Clients Toward Staff in Japanese Long-Term Care, *Journal of Elder Abuse & Neglect, 24:1*, 1-16, DOI: 10.1080/08946566.2011.608041

Ayalon, Li., Sagit, L., Ohad, G., and Uziel, N. (2016). A systematic review and meta-analysis of interventions designed to prevent or stop elder maltreatment. *Age and Ageing, 45*, pp.216-227.

Baker. P. R. A., Francis, D. P., Hairi, N. N., Othman, S., and Choo, W. Y. (2018) Interventions for preventing abuse in the elderly*. Cochrane Database of Systematic Reviews 2016, Issue 8*. Art. No.: CD010321. DOI: 10.1002/14651858.CD010321.pub2.

Blundell B., Warren A., and Moir, E. (2020). Elder abuse protocols: identifying key features and establishing evidence for their use and effectiveness. *Journal of Elder Abuse & Neglect*, DOI: 10.1080/08946566.2020.1736225.

Botngard, A., Eide, A. H., Mosqueda L., and Malmedal, W. (2020). Elder abuse in Norwegian nursing homes: a cross-sectional exploratory study. *BMC health services research, 20*(1), pp.9.

Castle N., Ferguson-Rome, J., C., and Teresi, J. A. (2015). Elder Abuse in Residential Long-Term Care: An Update to the 2003 National Research Council Report. *Journal of Applied Gerontology, 34,* pp.407-443.

Commissioner for Older People for Northern Ireland. (2018). Home truths: a report on the Commissioner's investigation into Dunmurry Manor Care Home. Belfast: Commissioner for Older People for Northern Ireland.

CPEA. (2020). Paper 1-Adult Safeguarding-Dunmurry Manor Review Team September 2020. [online] Department of Health. Northern Ireland. Available at: https://www.health-ni.gov.uk/publications/paper-1-adult-safeguarding-dunmurry-manor-review-team-september-2020.

Davidson, G., McCartan, C., and Best, P. (2020). A review of the international evidence of the effectiveness of the use of CCTV in care home settings: a rapid evidence assessment: full report. Belfast: Queens University Belfast. Available at: https://www.rqia.org.uk/guidance/guidance-for-service-providers/a-review-of-the-effectiveness-of-the-use-of-cctv-i/

Department of Health, Social Services, and Public Safety Northern Ireland. (2015). Adult safeguarding: prevention and protection in partnership. Belfast: Northern Ireland. Department of Justice. Available at: https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/adult-safeguarding-policy.pdf.

Drennan, J., Lafferty, A., Treacy, M. P., Fealy, G., Phelan, A., Lyons, I., and Hall, P. (2012). Older people in residential care settings: Results of a national survey of staff-resident interactions and conflicts. NCPOP, University College Dublin.

Flynn M. (2015). In search of accountability: a review of the neglect of older people living in care homes investigated as Operation Jasmine. Cardiff: Welsh Government.

Flynn, M. (2012). Winterbourne View Hospital: a serious case review. Yate: South Gloucestershire Safeguarding Adults Board.

Gil, A. P. (2019). Quality procedures and complaints: nursing homes in Portugal. *The Journal of Adult Protection*, **https://doi.org/10.1108/JAP-09-2018-0018**

Hanley. J., and Marsland, D. (2014). Unhappy anniversary?. *Journal of Adult Protection, 16*(2), pp.104-112.

Hutchison, A., and Kroese, B. S. (2015). A review of literature exploring the possible causes of abuse and neglect in adult residential care. *Journal of Adult Protection, 17*(4), pp.216-233.

Hyde, P., Burns, D., Killett, A., Kenkmann, A., Poland, F., and Gray, R. (2014). Organisational aspects of elder mistreatment in long term care. *Quality in Ageing and Older Adults, 15*(4), pp.197-209.

Kinderman, P., Butchard, S., Bruen, A. J., Wall, A., Goulden, N., Hoare, Z., et al. A randomised controlled trial to evaluate the impact of a human rights based approach to dementia care in inpatient ward and care home settings. *Health Services Delivery Research, 2018, 6*(13).

Lawrence, V., and Banerjee, S. (2010). Improving care in care homes: a qualitative evaluation of the Croydon care home support team. *Aging & mental health, 14*(4), pp.416-24.

Lupton C. (2013). Respect and protect: the experience of older people and staff in care homes and hospitals: the PANICOA report. Comic Reliefg

Malmedal, W., Iversen, M. H., and Kilvik, A. (2015). Sexual abuse of older nursing home residents: a literature review. *Nursing research and practice, 2015*, pp.902515.

Manthorpe, J., and Lipman, V. (2015). Preventing abuse through pre-employment checks: an international review. *Journal of Adult Protection, 17*(6), pp.341-350.

Manthorpe, J., and Martineau, S. (2017). Engaging with the new system of safeguarding adults reviews concerning care homes for older people. *British Journal of Social Work, 47*(7), pp.2086-2099.

Marshall, M., Pfeifer, N., Silva, D. , Wei, L., Anderson, J., Cruickshank, L., James, K. A., and Shand, J. (2018). An evaluation of a safety improvement intervention in care homes in England. *Journal of the Royal Society of Medicine, 2018, Vol. 111(11)* 414–421

McDonald, L., Beaulieu, M., Harbison, J., Hirst, S., Lowenstein, A., Podnieks, E., and Wahl, J. (2012). Institutional abuse of older adults: what we know, what we need to know. *Journal of Elder Abuse and Neglect, 24*(2), pp.138-160.

Mileski, M., Lee, K., Bourquard, C., Cavazos, B., Dusek, K., Kimbrough, K., Sweeney, L., and McClay R. (2019). Preventing The Abuse Of Residents With Dementia Or Alzheimer's Disease In The Long-Term Care Setting: A Systematic Review. *Clinical interventions in aging, 14*, pp.1797-1815.

Moore, S. (2016). The abuse of older people in private sector care homes: Why does it occur? Why does it endure?. University of Birmingham.

Moore, S. (2018). Assumption, the mother of all foul ups: a fundamental reason for the continuing abuse of adults at risk. *Journal of Adult Protection, 20*(3/4), pp.129-143.

Moore, S. (2019). Paths to perdition: exploring the trajectories of care staff who have abused older people in their care. *Journal of Adult Protection, 21*(3), pp.169-189.

Moore, S. (2020). Sharpening Occam's razor: developing theory to explain the persistent abuse of older people living in care homes. *Working with Older People, 24*(1), pp.49-60.

Moore, St. (2017). If you always do what you have always done, you will always get what you have always got: commissioning and regulating care homes to prevent abuse. *Journal of Adult Protection, 19*(6), pp.418-430.

Mosqueda, L., Burnight, K., Gironda, M. W., Moore, A. A., Robinson, J., and Olsen, B. (2016). The Abuse Intervention Model: A Pragmatic Approach to Intervention for Elder Mistreatment. *Journal of the American Geriatrics Society, 64*, pp.1879-1883.

Muckamore Abbey Hospital Review Team. (2020). A Review of Leadership & Governance at Muckamore Abbey Hospital. Department of Health. Northern Ireland. Available at: https://www.health-ni.gov.uk/publications/mah-review.

National Institute for Health and Care Excellence. (2020). Safeguarding adults in care homes: draft for consultation. London: National Institute for Health and Care Excellence.

National Research Council. (2003). Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America. Panel to Review Risk and Prevalence of Elder Abuse and Neglect. Richard J. Bonnie and Robert B. Wallace, Editors. Committee on National Statistics and Committee on Law and Justice, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press.

Nordstrom K., and Wangmo, T. (2018). Caring for elder patients: Mutual vulnerabilities in professional ethics. *Nursing ethics, 25,* pp.1004-1016.

O'Brien, M., O'Brien-Olinger, S., Boccaletti, L., Milianta, S., Caciula, I., Laurola, H., Perttu, S., Kadzik-Bartoszewska, A, Canning, K., and Quinn, S. (2016). Elder abuse context and theory: Finland, Ireland, Italy and Romania. Erasmus.

Palese, A., Gonella, S., Kasa, T., Caruzzo, D., Hayter, M., and Watson, R. (2019). Negative prompts aimed at maintaining eating independence. *Nursing ethics, 26*, pp.2158-2171.

Payne, B. K., and Strasser, S. M. (2012). Financial exploitation of older persons in adult care settings: comparisons to physical abuse and the justice system's response. *Journal of Elder Abuse and Neglect, 24*, pp.231-250.

Phelan, A. (2015). Protecting care home residents from mistreatment and abuse: on the need for policy. *Risk management and healthcare policy, 8*, pp.215-223.

Pickering, C. E. Z., Nurenberg, K., and Schiamberg, L. (2017). Recognizing and Responding to the "Toxic" Work Environment: Worker Safety, Patient Safety, and Abuse/Neglect in Nursing Homes. *Qualitative Health Research, 27*(12), pp.1870-1881.

Radermacher, H., Toh, Y. L., Western, D., Coles, J., Goeman, D., and Lowthian, J. (2018). Staff conceptualisations of elder abuse in residential aged care: A rapid review. *Australasian Journal on Ageing, 37*, pp.254-267.

Schiamberg, L. B., Gia, G. B., Oehmke, J., Zhang, Z., Griffore, R. J., WEatherill, R. P., Heydrich, L., and Post, L. A. (2011). Elder abuse in nursing homes: an ecological perspective. *Journal of Elder Abuse and Neglect, 23*(2), pp.190-211.

Smith, D., Lyndal, B., Cunningham, N., and Ibrahim, J.E. (2018). A systematic review of sexual assaults in nursing homes. *Gerontologist, 58*(6), pp.e369-e383.

Social Care Institute for Excellence. (2015). Electronic surveillance in health and social care settings: a brief review. London: Social Care Institute for Excellence.

Starns, B. (2018). Moving to a systems approach to safeguard adults in residential care. *Practice: Social Work in Action, 30*(3), pp.157-161.

Tadd W., Woods, R., O'Neill, M., Windle, G., Read, S., Seddon, D., Hall, C., and Bayer, T. (2012). Promoting excellence in all care homes: PEACH. London: Prevention of Abuse and Neglect in the Institutional Care of Older Adults.

Tilse, C., and Wilson, J. (2013). Recognising and responding to financial abuse in residential aged care. *Journal of Adult Protection, 15*(3), pp.141-152.

Appendix 1. Coding Framework

Full Text Coding Framework

Full Text - Coding of Report Descriptors	
Publication/ study type	Select one: • Systematic Review • Literature or research review • Independent review or report • Randomised control trial • Secondary analysis of data • Cross-sectional study • Mixed methods study or evaluation • Qualitative studies • Theoretical papers • Books
Location	Select one: • Northern Ireland • UK • USA • France • Switzerland • Australia • Norway • Republic of Ireland • Italy • Japan • Portugal • Multi-country
Type of abuse	• Sexual abuse • Aggression • Financial abuse • Negative verbal prompts • Neglect • Institutional abuse • Various types of abuse • Other
Type of setting	• Nursing home • Residential care • Institutional setting • Across settings

Groups targeted	Select as many as apply: • People with learning disabilities • People with Dementia • Older people • Staff • Other • Various or unspecified
Full text extraction for review and analysis - Research questions	
Definition of abuse	Abuse Neglect Mistreatment/ maltreatment Sexual abuse Financial abuse / exploitation Institutional abuse
Why are adults abused in these settings?	Interpersonal theories Socio-cultural theories Ecological theories Multisystem theories Other
Factors contributing to abuse	Staff vulnerabilities and characteristics Resident vulnerabilities characteristics Organisational culture and leadership Institutional characteristics Poor governance and accountability Wider context
How do settings respond to or try to prevent abuse?	Staff education and training Improving identification, reporting and documentation of abuse Improving policies and procedures Improving organisational culture and leadership

	Education and training for residents and older people Post abuse response and consequences for perpetrators The use of CCTV to prevent/respond to abuse Employing a human rights consideration to prevention of abuse
What are the gaps in existing evidence?	
Additional information	
Research gaps identified	Code relevant text
Key conclusions of study	Code relevant text

Appendix 2: NICE safeguarding guidelines to prevent and respond to abuse

This section highlights the relevant guidance from the NICE safeguarding adults in care homes guidance that is currently in the process of being finalised. The guidance has been structured in accordance with the findings presented in section 5. The full text can be found here: https://www.nice.org.uk/guidance/gid-ng10107/documents/draft-guideline

5.1 Staff education and training

The national guidance by NICE on safeguarding adults in care homes (2020) has highlighted the following topics, at a minimum, for inclusion in mandatory safeguarding training for staff:

- Safeguarding and legal principles under the Care Act 2014 3, the 6 core principles of safeguarding
- How to recognise different forms of abuse and neglect, including organisational abuse and neglect
- The care homes whistleblowing policy and procedure, including what support and information is available in this situation
- How to act on and report suspected abuse or neglect and how to raise safeguarding concerns within the care home, and with local authorities and through multi-agency reporting
- How to talk about and share information about safeguarding with residents, their families, and carers
- Confidentiality and data protection, the duty of candour, and being open and honest when things go wrong

Further training could cover: how to ask about abuse and neglect in a sensitive and non-judgemental manner, how frequently to assess and ask about abuse and neglect, the wide range of situations and circumstances in which abuse and neglect can potentially occur, less obvious indicators of abuse and neglect, and more complex safeguarding concerns (for example organisational abuse and neglect.

An approach to training has also been detailed by the guidance including tailoring training for individual staff roles, assessing staff's before and after training, requesting feedback on training methods, and refreshing training annually.

5.2 Improving identification, reporting and documentation of abuse

The national guidance by NICE on safeguarding adults in care homes (2020) has also highlighted the importance of documentation and reporting of abuse and recommends that staff must gather information as soon as possible about suspected abuse or neglect. They should:

- Write down what happened, when it happened, where it happened and who was involved (the person at risk and the alleged abuser).
- Give the resident the chance to speak freely about what has happened. Use simple and open questions, and ask in a non-leading way.
- Report suspected abuse and neglect to a senior member of staff and the safeguarding lead as soon as practical. Abuse can also be reported to the local authority or the Care Quality Commission or a whistleblowing helpline, if available

5.3 Improving policies and procedures

The national guidance by NICE on safeguarding adults in care homes (2020) has provided detailed guidance related to policies and procedures including but not limited to:

Safeguarding policies, which should be:

- Clearly written and in line with accessibility requirements, be easy to find, so that all residents, staff, visitors and service providers can read it when they need to,
- Include clear and transparent arrangements for identifying, responding to and managing safeguarding concerns, and involve residents (and their families and carers) in designing and reviewing these arrangements,
- Explain how to respond to safeguarding concerns, and how to report suspected abuse or neglect

Systems and procedures:

- To track and monitor incidents, accidents, disciplinary action, complaints and safeguarding concerns, to identify patterns of potential harm.
- For preserving evidence from reported safeguarding concerns, including care records, as these may be required in future (for example for police investigations).
- For recording and sharing information (in line with current data protection laws) about safeguarding concerns

Care homes should also have a **whistleblowing policy** that staff are aware of, and should consider using an external whistleblowing service. They must ensure that whistleblowers are not victimised as a result of reporting or disclosing a safeguarding concern

5.4 Improving organisational culture and leadership

The national guidance by NICE on safeguarding adults in care homes (2020) also echoes much of the same when it comes to care home managers and line managers, who should:

- Make sure there are regular opportunities for all staff to share best practice in safeguarding, including learning from Safeguarding Adults Reviews, challenge poor practice or discuss uncertainty around practice, discuss the differences between poor practice (which is not necessarily a safeguarding issue) and abuse or neglect (which are safeguarding issues)

- Make particular efforts to involve staff who work alone or who get very little supervision in these opportunities for learning
- Should ask for feedback about safeguarding from residents (and their families, friends and carers) and other people working in care homes including their experience of safeguarding concerns and how these have been identified, reported, managed and resolved and then respond to feedback and tell people about any changes made in response to their comments
- Lead by example in maintaining up-to-date knowledge on safeguarding
- Promote reflective supervision to help staff understand how to identify and respond to potential abuse and neglect in care homes.
- Should provide positive feedback through supervision and appraisals acknowledging how staff have learned from their experience of identifying, reporting and managing safeguarding concerns.
- Should encourage staff to discuss care home culture, learning and management in relation to safeguarding in exit interviews when leaving employment with the care home.
- Be aware of the potential for under-reporting of safeguarding concerns by staff who may be afraid of losing their job (for example staff who have their housing or work permit linked specifically to their current role).



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