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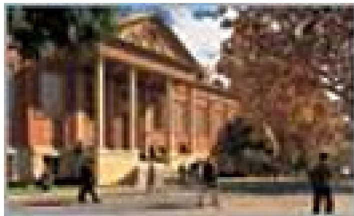

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You can lead a horse to water but you can't make it drink: how effective is staff training in the prevention of abuse of adults?

Steve Moore

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Abstract

Purpose – *The purpose of this paper is to present findings from a research project designed to determine the qualifications held by those staff who had perpetrated abuse in private sector care and nursing homes for older people during a 12-month period.*

Design/methodology/approach – *A self-completion, postal questionnaire was issued to the safeguarding teams of all local authorities in England with adult social care responsibilities to determine the qualifications held by staff who were proven to have perpetrated abuse in these facilities.*

Findings – *Though findings with respect to qualified nurses who had perpetrated abuse when considered in isolation were inconclusive in numerical terms, the proportion of all nursing and care staff who had perpetrated abuse, and who held either a professional or vocational qualification was high.*

Research limitations/implications – *Responses to the postal questionnaire represented 21.8 per cent of local authorities with social services responsibilities, yet the data secured suggests that care providing staff who have received recognised training are disproportionately represented among those proven to have perpetrated abuse.*

Originality/value – *Findings indicate that recognised training for those who provide care in care and nursing homes is of limited efficacy in the prevention of abuse.*

Keywords *Abuse, Policy and practice, Care and nursing homes, Older adults at risk, Staff training and qualifications, Staff values*

Paper type *Research paper*

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Introduction

The author of this paper conducted semi-structured interviews from December 2011 to July 2013 with a range of private sector care home staff ($n = 36$) as part of a PhD research project supervised by the University of Birmingham. A recurring perception among respondents, comprising care home proprietors, care managers and care staff, was that qualifications and training alone do not produce caring staff or caring behaviour. Rather, respondents identified that it was often the inherent, personal value frameworks held by these staff, and their subsequent attitudes and behaviours, that tended to influence how they acted towards those in their care, irrespective of any training they received (Moore, 2017).

Prompted by these assertions from members of all groups of respondents during the research project, the author subsequently decided to explore if there was any discernible relationship between staff proven to have perpetrated abuse in private sector care and nursing homes, and the absence or presence of recognised qualifications among them. Any relationship that might be determined was perceived to have utility both in terms of supporting or refuting the claims of interview respondents during the preceding research project and, perhaps more importantly, by informing future preventative strategies to protect adults at risk. The research was inductive in

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nature in that it did not seek to test any particular hypothesis, but might contribute to building new theory concerning the fundamental reasons why staff in care homes sometimes abuse the people in their care.

Care homes are those registered with the statutory regulator, the Care Quality Commission to provide exclusively personal care, nursing homes are those registered to provide nursing and personal care.

Reviewing the literature

Training for staff who provide care in care and nursing homes and many other settings, which may or may not be in the form of nationally recognised qualifications, has been frequently offered as a solution to the occurrence of poor quality care and abuse (Tadd, Woods, O'Neill, Windle, Read, Sedden, Hall and Bayer, 2011; Faulkner, 2012; Cavendish, 2013; West Sussex Adult Safeguarding Board, 2014), including, amongst other subject areas, respecting and valuing those who require care, treating them with dignity, maintaining self-awareness as a care giver and managing personal stress (Skills for Care, 2014).

Registered nurses are currently required to ensure that they demonstrate their continued ability to practice safely and effectively to the Nursing and Midwifery Council through prescribed "revalidation" processes. Revalidation includes the requirement for nurses to obtain practice related feedback from their nurse peers, managers or patients (Nursing and Midwifery Council, 2017) and, once registered and subsequently periodically "revalidated", it is therefore reasonable to expect that nurses remain competent and knowledgeable to treat those in their care well and in a manner that is free from abuse of any kind. Though there is no equivalent requirement for staff who provide care who are not registered nurses, extensive training in the form of National Vocational Qualifications (NVQ)[1] has been available for care staff in England for over 20 years. Attainment of these skill-based certifications of practical competence is significant, with 44 per cent of direct care staff in England holding an NVQ at levels 2, 3 and 4 (Skills for Care, 2016, p. 6). In many local authorities, this figure is higher than that quoted by Skills for Care because the fees paid by them as purchasers of services to care and nursing homes have been positively titrated with reference to higher levels of NVQ certification amongst the care staff that the homes employ (Laing and Buisson, 2014, p. 321). In addition, care staff in English care and nursing homes are all required to undertake the Care Certificate induction training[2], prescribed by Skills for Care, including in addition to the basic principles of providing care a module specifically on safeguarding adults who may be at risk from abuse (Skills for Care, 2014, p. 7).

Moreover, by means of statutory regulation and the purchase of services from care and nursing homes by local authorities and Clinical Commissioning Groups under the terms of legally binding contracts, minimum levels of training and instruction, including Care Certificate induction training and written policies and procedures, are stipulated by both regulators and commissioners. Thus, regulators and commissioners will require providers to have in place both comprehensive training programmes and ever-present guidance for their staff, including, as just one example among many others, training to ensure that staff treat those in their care with respect whilst ensuring that they are protected from abuse. Largely as a result of this scrutiny from external agents, care providing organisations are more likely to provide training to their staff than are organisations in other, comparable industry sectors (Joseph Rowntree Foundation, 2014, p. 32).

However, a review of the entirety of social care provision in England found that any indications of a relationship between the acquisition of qualifications and the quality of care services were "inconclusive" (Wanless *et al.*, 2006, p. 134). Similarly, Manthorpe *et al.* (2011) maintain that despite the large amounts of money expended on adult protection training, little is known about what kind of training works and for whom, and the Institute of Public Care/Skills for Care (2013, p. 68) have pointed out the lack of evaluation of the effectiveness of different types of staff training on protecting people who are at risk of abuse. In a similar vein, the Independent Safeguarding Authority (2012, p. 54) found no specific evidence to suggest a shortfall in the levels of training among those referred to its vetting and barring list to protect those at risk of abuse (adults and children). Of additional concern are the findings of Tadd *et al.* (2006) and Tadd, Woods, O'Neill, Windle, Read, Sedden, Hall and Bayer (2011) who determined that

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codes of practice, that, like training, are expected to positively influence staff conduct, frequently have only limited impact on the consequent behaviours of some staff in both hospitals and care homes; as a result of these characteristics in the areas studied, the quality of care provided to residents was reduced. Additionally, research into social work practices has also established that organisational intentions expressed through training and policies are not always reflected in the practices of individual staff at a micro-level (Healy and Wint, 1998; Hughes and Wearing, 2007). Though there is some acknowledgement of a need to ensure training is transferred into practice, and that this requires a receptive organisational culture to be effective (Pike *et al.*, 2010, 2011), little consideration is given to the significance of the value frameworks of individual members of staff and how this may influence their behaviour when caring for people when they have left the "classroom", particularly when working beyond the scrutiny of their peers and managers (Moore, 2017).

Furthermore, despite the extensive professional and vocational training provided to nursing and care staff in care homes, data collated by the NHS Information Centre and its successor, The Health and Social Care Information Centre, over four successive years repeatedly demonstrated that 36 per cent of all referrals concerned abuse that was alleged to have occurred within care and nursing homes (all resident age groups) in each of four consecutive annual periods from 2011 to 2015 (The NHS Information Centre, 2013; The Health and Social Care Information Centre, 2014a, b, 2015). Though there is a possibility that these figures may be influenced by increased reporting of abuse since the advent of the formal safeguarding policy of "No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse" (Department of Health, 2000), this seems unlikely given that this policy had been in place from 12 to 15 years prior to the collection of this data, and given that the levels of referrals from care homes seems to have remained more or less constant over the four annual periods from which the data was extracted. Further, if assertions that only somewhere between one in every four or five cases and one in every 15 cases of abuse are reported (all settings) are accurate (Wolf, 2000, p. 7; Bonnie and Wallace, 2003, p. 9; Cooper *et al.*, 2008, p. 1; World Health Organisation, 2008, p. 1) these figures are but a proportion of the abuse that is actually taking place.

Consequently, the continuing mantra among practitioners and policy makers of ensuring care home staff receive adequate and appropriate training, and have access to policies and procedures in order to prevent abuse, though both have a place in prevention, also has a falsely reassuring sense of legitimacy that tends to deter any questioning of the true effectiveness of these measures.

Method

The aim of the research was to identify the qualifications, if any, of care providing staff who had perpetrated abuse of older people in private sector care and nursing homes by accessing data from historical records of substantiated or partially substantiated[3] abuse that had occurred during a one-year period.

A postal questionnaire was sent to the adult safeguarding teams of 151 of the 152 local authorities with adult social services responsibilities in England to establish the numbers of substantiated or partially substantiated occurrences of abuse of older people in private sector care and nursing homes in the period 1 April 2014 to 31 March 2015. The questionnaire also sought to determine whether or not the perpetrators of abuse possessed either registered nursing qualifications, or NVQ or QCF (Qualifications and Credit Framework) certification in health and social care. The type of qualification recorded for those who were proven to have carried out abuse was limited to these three categories of qualification because their content is prescribed at a national level in terms of how people should be looked after, and each includes a module concerned specifically with the protection of adults who may be at risk of abuse. Although it is acknowledged that there is a plethora of other training available in the care and nursing home sector, including safeguarding training, its calibre is almost infinitely variable and its inclusion would thus introduce a completely uncontrolled variable.

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The nature of the primary type of recorded abuse was also requested for each case using the classifications within "No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse" (Department of Health, 2000). These categories were employed given the time period of 2014 to 2015 from which data were requested from local authorities, and the minimal difference in any case between them and the categories of abuse stipulated in the Care Act 2014, the most significant perhaps being the re-categorisation of "psychological abuse" to "emotional abuse". The category of "institutional abuse" ("organisational abuse" in Care Act 2014 terminology) was not included as a discrete category of abuse on the questionnaire because the research here is concerned with the actions and qualifications of individual staff members. Further, though data collected by The NHS Information Centre (2013) and its successor The Health and Social Care Information Centre (2014a, b, 2015) determined that 36 per cent of adult protection referrals emanated from within care and nursing homes, only 4 per cent in 2012, 2013 and 2014, and 3 per cent in 2015 were recorded as institutional abuse (all ages). There is then perhaps some deficiency in the mechanisms and skills available to those who record abuse when it comes to identifying what is abuse perpetrated by individual staff members as being a reflection of, or distinctly different from, "institutional abuse".

Potential respondents were informed in the request sent to them that they were not required to identify the perpetrators of abuse by name or the care and nursing homes in which the abuse occurred, but were asked to assign a numeric code to each case. They were also reassured that their employing local authorities would not be identified by name or otherwise in any reports or publications arising from the study. The name and role of the person completing the questionnaire was requested for the purposes of discussion should this be necessary for clarification of content. Though this was not required due to the simplicity of the questionnaire, 26 questionnaires were returned from local government officers working within informatics functions, and seven were from senior managers within the safeguarding functions of the local authority.

The questionnaire was not piloted prior to being issued to local authorities because of its perceived simplicity. Ethical approval was not required from the author's employer for this study as this is only necessary if client specific information is sought, or clients themselves are research participants, neither of which was the case.

Results

Postal questionnaires, including a postage paid return envelope, were issued to the 151 local authorities during May 2015 with a return deadline of six weeks from the date of receipt to allow respondents to collate the requested data. A reminder and duplicate questionnaire was sent to the authorities that had not responded within four weeks, including an extended deadline for return of an additional four weeks to maximise overall responses.

Of the 151 questionnaires distributed, 57 local authorities did not respond, 61 responded but advised that they did not record and/or could not access all of the required information, and 33 returned completed questionnaires containing the required data, representing a return rate of 21.8 per cent.

Results are shown in Table I.

As can be seen from Table I, both the proportions of all staff, and of unregistered care staff only, who possessed a recognised qualification in care and who were proven to have perpetrated abuse, was significantly high for all types of abuse reported.

Discussion

The number of questionnaires completed and returned by local authorities was low at 21.8 per cent of the number sent out, representing an "unacceptable" rate of returns according to Mangione's (1995, p. 60) classification of postal questionnaire responses. However, as Bryman (2004, p. 136) maintains many postal questionnaire methods result in similarly low response rates, and social researchers should not be disheartened by this. Instead, they should

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Table I Numbers and qualifications of staff proven to have perpetrated abuse of older people in care and nursing homes during 2014-2015 in 33 English local authority areas							
Type of abuse perpetrated	*Physical*	*Psychological*	*Neglect*	*Financial*	*Sexual*	*Discriminatory*	*Total*
Registered nurses	4	7	7	0	0	0	18
Unregistered care staff with in this sample with NVQ or QCF at levels 2 or 3	181	268	306	6	2	0	763
Unregistered care staff in this sample without any NVQ or QCF qualification	33	52	83	1	0	0	169
Percentage of Reg' nurses and unregistered care staff in this sample with a qualification who perpetrated abuse	84.9	84.1	79.0	85.7	100	0	82.2
Percentage of unregistered care staff only in this sample with a qualification who perpetrated abuse	84.5	83.8	77.3	85.7	100	0	81.9

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acknowledge the consequent implications and potential limitations of their research. Nonetheless, as a result of the low number of returns in this research, the author intends to repeat the method described here with what may be a more robust strategy, employing a freedom of information request to each of the local authorities in England at a later time.

Yet what is important to recognise from the results above, despite the limitations arising from the low response rate, is that in each of the 33 local authorities that did return completed questionnaires, the numbers of all staff who possessed recognised qualifications, and who were confirmed to have perpetrated abuse of older people in care homes (82.2 per cent overall), consistently and significantly exceeded numbers of staff who had perpetrated abuse, but did not possess such qualifications (17.8 per cent).

Notably, though the numbers of qualified nurses who had perpetrated abuse when considered in isolation were inconclusive in purely numerical terms[4], the percentages of care staff only proven to have perpetrated abuse (all types) and holding a recognised NVQ or QCF qualification (81.9 per cent overall) consistently exceeded the percentage of care staff recorded as possessing such qualifications at levels 2 and 3 in England as cited by Skills for Care (2016, p. 6) at 44 per cent. Even allowing for higher percentages of staff in some local authorities holding such qualifications as a result of financial incentives offered to care home providers by commissioners, it seems unlikely that in excess of 80 per cent of care staff, as determined for those proven to have perpetrated physical and psychological abuse, would have achieved this level of qualification (shown in Table I above).

Unfortunately, due to a poor response rate from local authorities to which the questionnaire was sent, the results must be treated with some caution, but nonetheless care staff who hold recognised qualifications are significantly over-represented among those found guilty of perpetrating abuse against older people in care and nursing homes in this limited sample, indicating that factors other than their training alone are key determinants of whether they will abuse those in their care or not. Though it may also be subsequently surmised that training provided to care staff by means of the now outmoded NVQ methods, and the more contemporary QCF structure, is inadequate and poorly designed and/or delivered, more likely is the explanation that despite training provided to staff that is generally of good calibre, staff are either choosing, or being forced, either occasionally or consistently, to abandon the methods and principles that they have learned because other imperatives are achieving dominance within the care homes in which they work. The dominance or otherwise of these other imperatives is also likely to be influenced by the personal value frameworks held by individual staff members towards those in their care that may not always be congruent with the job that they do of looking after older people with significant physical and cognitive needs (Moore, 2017).

Some of these likely competing demands that lead staff to abandon or temporarily suspend the principles of training they have received are discussed here, though the author's personal view is that none of these factors excuse the perpetration of abuse by any member(s) of staff. What are described here can essentially only be mitigated by the actions of care home proprietors and managers, and by policy and regulation that governs the market of care home provision.

The imbalance between time and task

There are ample references in the available literature concerning the imbalance between the time available to staff and the number and range of tasks they are required to be complete in institutional care settings, particularly those for very vulnerable people. The research that has led to these conclusions has been undertaken primarily in hospitals, predominantly in relation to the care of older people (Schneider *et al.*, 2010; Tadd, Hillman, Calman, Calman Bayer and Read, 2011), but also includes care and nursing homes for older people (Brechin, 2000; Killett *et al.*, 2011; Tadd, Woods, O'Neill, Windle, Read, Sedden, Hall and Bayer, 2011; Tadd, Hillman, Calman, Calman Bayer and Read, 2011).

Though these studies were not linked directly to the occurrence of abuse, but to quality of care, Tadd, Woods, O'Neill, Windle, Read, Sedden, Hall and Bayer (2011), Tadd, Hillman, Calman, Calman Bayer and Read, 2011, pp. 78, 246) assert that the ever-present pressures on staff time when caring for older people are critical to the adoption of a task oriented and largely reactive approach to patients/residents in NHS hospitals and care and nursing homes. In circumstances where insufficient time was available to staff to complete the tasks required of them, Tadd, Woods, O'Neill, Windle, Read, Sedden, Hall and Bayer (2011), Tadd, Hillman, Calman, Calman Bayer and Read (2011) found that the quality of care and the dignity of those requiring care was compromised. Schneider *et al.* (2010, p. 67) similarly determined that care staff in hospitals chose against applying the principles of person centred care on dementia wards in the interests of fulfilling required daily routines that were designed to maximise available time for task completion, a phenomenon termed a "pragmatic relationship" by Schneider *et al.* This pragmatic relationship was characterised by a paucity of interaction and communication between staff and patients, and by poor quality care, often amounting to neglect and active abuse.

Though the continued presence of an imbalance between time and task in care and nursing homes has long been recognised in existing literature and, more recently, in a number of serious case reviews (SCRs)[5], it has not yet been addressed and rectified by contemporary policy, practice or regulation. For example, the minimum numbers of qualified nurses and care staff required to be on duty at any given time in care and nursing homes is not prescribed in clear numerical terms by the statutory regulator of the sector.

Stress experienced by staff

Research in care and nursing homes has also frequently identified the presence of significant stress upon staff as a result of undertaking care tasks within limited time, linked in some circumstances to shortages of staff and material resources (Killett *et al.*, 2011; Tadd, Woods, O'Neill, Windle, Read, Sedden, Hall and Bayer, 2011; Tadd, Hillman, Calman, Calman Bayer and Read, 2011). Sources of stress upon staff have also been found to include the demanding behaviours of residents and patients, their illnesses, and the suffering and death of many of those who are being cared for (Schneider *et al.*, 2010, p. 43; Tadd, Woods, O'Neill, Windle, Read, Sedden, Hall and Bayer, 2011, p. 177). To compound these sources of stress, the ever-increasing morbidity and dependency of older people in care and nursing homes as a progenitor of stress has also been acknowledged in the literature (Killett *et al.*, 2013). Lievesley *et al.* (2011, p. 31), for example, found that residents with cognitive limitations due to dementia living in care and nursing homes were two and a half times more likely to exhibit behaviour that challenges the provision of care than those without such illness, an attribute likely to place higher levels of stress upon staff. Some studies have confirmed that staff members who perpetrate physical and psychological abuse in care and nursing homes were both physically exhausted and "burned out" (Duffy *et al.*, 2009; Tadd, Woods, O'Neill, Windle, Read, Sedden, Hall and Bayer, 2011), with Duffy *et al.* (2009) detecting "burnout" to be present among 68.6 per cent of care staff in care homes for older people with dementia.

Stress has also been found to be a contributory factor to circumstances in which the individuality of those receiving care in hospitals can "become obscured" (Schneider *et al.*, 2010, p. 10), and, in both hospitals and care homes, where "desensitisation" and "depersonalisation" leading to a lack of appropriate emotional responses from care staff may occur (Schneider *et al.*, 2010, p. 43; Tadd, Woods, O'Neill, Windle, Read, Sedden, Hall and Bayer, 2011, p. 9). Brodaty *et al.* (2005)

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determined that physical isolation and emotional withdrawal from the people in need of care, and sometimes anger towards them (amongst other emotions), was an adaptive strategy among staff working in the stressful environments of nursing homes. Schneider *et al.* (2010) similarly concluded that the desensitisation towards patients that they found among the staff they studied in hospital settings was a protective mechanism to negate the stressful, distressing sights, sounds and smells of the work, minimise the fear of verbal and physical attacks upon them from patients, and lessen the emotional impact of the deaths they encountered. These phenomena seem to be consistent with the earlier, seminal work of Menzies Lyth (1988, p. 46) who suggested that care work in hospitals requiring close contact with dependency, pain and death would inevitably give rise to anxieties within the care giving staff. Consequently, Menzies Lyth asserted that a social system arises to defend staff against these unpleasant, anxiety provoking experiences that in turn leads to failures to acknowledge the humanity and individuality of those receiving care, whereupon they may be treated poorly and abused. These same factors are also likely to be present in contemporary care and nursing homes, particularly given the ever-increasing prevalence of physical and cognitive illness among those being cared for (Fossey and James, 2008; Royal College of Nursing, 2010, 2011).

But again, the recognised factors that precipitate detrimental levels of stress among those working in care and nursing homes, such as insufficient staff and the increasing needs of residents that perpetuate the time/task imbalance, have not been effectively addressed by contemporary policy or regulation of the sector.

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Power imbalance

Williams and Keating (1999, p. 131) define abuse as, "[…] the use of power to serve self-interest or group interest […]" and the imbalance of power often present between those providing care and the recipients of care has long been recognised in the literature as a causal factor of abuse. Whittaker (1997, p. 37), for example, maintains that abuse can only occur between two people in any relationship when a power imbalance exists between them; one person perceives and is perceived by the other as more powerful, and the other perceives and is perceived by the other as less powerful.

Empirical power-dependence theory (Emerson, 1962) states that the power of person A over person B is directly proportional to the degree of dependence of person B upon person A. Emerson (1962, p. 32) posits that one person's power resides in the others dependency, and this is a potentially significant factor given the current tendency towards increasing needs in both physical and psychological terms among older people being admitted to care and nursing homes (Cooper *et al.*, 2008) that renders them particularly frail and often relatively powerless in terms of power-dependence theory. They are therefore particularly reliant upon the staff employed to look after them, and their only other sources of advocacy are usually relatives whose degrees of contact and awareness of care home life may be limited and sporadic.

If staff in care and nursing homes are competing with the ever-present pressures of insufficient time to provide care, and the high levels of stress as a result of this and myriad other factors, they are perhaps more likely to exercise the inordinate power they possess in comparison to those they look after, creating fertile conditions in which a propensity to abuse those people requiring care may take root, despite the training they may have received. This will be particularly likely if staff do not value positively the people in their care.

Compounding factors

Private sector care and nursing homes are required to generate sufficient profit to continue in business, including reinvestment of some of that profit into the home itself and the staff who work there. However, in a business environment where the fees paid to private sector care and nursing homes are, in the estimations of providers at least, too low, one result is that the numbers of staff employed to provide direct care are often insufficient to meet residents' needs effectively. As a consequence of this most obvious method of cost containment exercised by care home providers, the time/task imbalance referred to above remains unaddressed and perhaps deteriorates, stress among staff endures and possibly increases, and thus the likelihood of abuse occurring, irrespective of staff training, policies and procedures, remains significant.

Current regulation of the care and nursing home sector does not prescribe the numbers of staff required to look after specified numbers of residents who have specific degrees of need, leaving it to the judgements of providers and individual regulatory staff.

Additionally, though care homes are required by commissioners and regulators to provide training in certain areas to their staff, the calibre of the training purchased or accessed is not scrutinised diligently by the agents external to the care home. Thus, there can be no guarantee that the training that is taking place is of a nature and quality that may be effective, particularly given that care home owners or managers may, as another method of cost containment, select cheaper training providers.

Further, even if the training purchased by care and nursing homes for their staff is of the required quality, it is less likely to be put into practice, or abandoned, either temporarily or permanently, by those staff who do not positively value the people who are reliant upon their care (Moore, 2017). Currently, the personal value bases among staff working and being constantly recruited to work in care homes is barely considered by policy makers, regulators or employers, and the concept of "values" is often confused, without consideration of what the word "values" actually means. For example, Skills for Care (2013, 2017) talk of recruiting staff based on values, and go on to list, among others, the values of "dignity and respect", "working together" and "commitment to quality support", but do not consider that it is individual staff member will confer upon these "values" their own value judgements. As Moore (2017) also points out, the "values" that Skills for Care (and others) cite are better described as "principles of care" or "principles of practice", or even personal attributes, and that the individual, personal evaluations of these principles and characteristics applied by staff members to them, that may be either positive or negative, are ignored. Moreover, the assertions of Skills for Care referred to above assume, like other policy documents that ostensibly talk of "values" applied to care provision, that these "values" (or rather "principles of care and practice") can simply be imposed upon staff, when long established psychological theory asserts that this is not the case (Verplanken and Holland, 2002; Kasser and Kanner, 2004).

Conclusions

The research outlined in this paper has demonstrated that in the data extracted from the limited number of responses, staff who possess formal qualifications are significantly over represented among those who have abused older people in private sector care and nursing homes for older people. Though further research into this finding is clearly warranted, results from the study presented here indicate that it cannot be assumed that once staff have received training they will not perpetrate abuse. However, the requirement for care homes to repeat or augment the training they provide to their staff as an outcome of safeguarding enquiries and SCRs[6] continues to be common, though the occurrence of abuse may frequently be, in part, as a result of other factors operating within the care home that may lead to the principles of training to be set aside, by individual or collective groups of staff. Insufficient time and high levels of stress among care staff who are in a powerful position when compared to that of residents, as discussed above, are but some examples of the factors that are often left unaddressed.

Though further research into the multiple factors likely to be involved in the occurrence of abuse of older people in care and nursing homes is clearly indicated, until national policy addresses the uneasy tension between providing care in residential and nursing homes, and the necessary pursuit of profit by their operators in a business environment where fees paid to them by public sector purchasers are perceived by providers as too low, it remains likely that abuse will continue, despite the plethora of staff training that is available. It would also make eminent good sense for all local authorities to record the qualifications of those staff who have been found to be responsible for abuse so that further determination of the effectiveness or otherwise of training as a preventative measure may be achieved.

Yet more important is the conceptual leap that needs to be made by many safeguarding practitioners and commissioners of care home services that will enable them to acknowledge that despite the wealth of staff training that is currently deployed in care and nursing homes (amongst other measures), abuse clearly continues without any reduction. They may then realise that other factors are therefore likely to be responsible for the enduring abuse in these homes, not least of

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which are the fundamental value bases of the care providing staff that are employed. Until this difficult problem requiring fundamental policy driven action, this "wicked issue" (Rittel and Webber, 1973, p. 160), is addressed at a national level so that staff are recruited who at least already possess personal value frameworks commensurate with the sometimes difficult work of providing care, abuse in care homes will continue, and sometime during 2017 we will no doubt view more covertly obtained footage of older people being abused in what has become their home, the last home that they will have before they die.

Notes

1. National Vocational Qualifications were replaced in 2011 by the Qualification and Credit Framework (QCF).
2. Previously "Common Induction" training (that also included a module on protecting vulnerable people), replaced on 1 April 2015 by the "Care Certificate".
3. In that abuse of some type and to some degree had been proven to have occurred.
4. Though it remains of concern that trained, qualified and registered professionals are sometimes the perpetrators of abuse.
5. See, for example, "In Search of Accountability – A review of the neglect of older people living in care homes investigated as Operation Jasmine" by Flynn (2015).
6. Serious Case Reviews are now termed as Safeguarding Adults Reviews.

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Further reading

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About the author

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