National Institute for Health and Care Excellence

Safeguarding adults in care homes

[H] The effectiveness and acceptability of safeguarding training

NICE guideline <tbc>

Evidence reviews

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Contents

1 The effectiveness and acceptability of
2 safeguarding training

3 This evidence review supports recommendations 1.2.3, 1.2.4, 1.2.5, 1.2.6, 1.2.7, 1.2.8, 1.2.9,
4 1.2.10, 1.2.11, 1.2.12, 1.2.13, 1.2.14, 1.2.15, 1.2.16, 1.2.17, 1.2.18, 1.2.19, 1.2.20.

5 Review question

6 This evidence report contains information on 2 reviews relating to different models of training
7 for safeguarding.

8 • What is the effectiveness of different models of training for safeguarding in care homes?

9 • What is the acceptability of different models of training for safeguarding in care homes?

10 Introduction

11 **Evidence review H: The effectiveness and acceptability of safeguarding training**

12 Safeguarding adults at risk is a fundamental responsibility of all people employed in care
13 homes. In line with the Care Act Statutory Guidance (paragraph 4.29) and the requirements
14 of the Care Certificate, Manager Induction Standards and National Occupational Standards
15 for health and social care, all staff working in care homes should receive safeguarding train-
16 ing. Safeguarding training should be a mandatory part of induction training for all new staff
17 and be delivered on a regular ongoing basis, tailored to particular job roles.

18 Current practice is that training is provided via a variety of different modes, including e-
19 learning, such as that offered by SCIE; 'traditional' face-to-face training delivered by a quali-
20 fied trainer (sometimes including the use of virtual platforms); cascaded training (where one
21 member of a team attends a traditional training course and then repeats the content to other
22 staff as part of a team meeting); DVDs and video-based training; and individual learning and
23 reflection through supervision and appraisal processes. However, although training is man-
24 datory, no specified modes of delivery of training are required by the Care Act Statutory
25 Guidance, the Care Quality Commission, Skills for Care or other bodies.

26 It is important that both the effectiveness and acceptability of different training methods are
27 evaluated in terms of their outcomes on staff knowledge, skills and understanding. Anecdotal
28 evidence has suggested that group discussions of different scenarios relevant to particular
29 care settings and training delivered with the involvement of people with lived experience may
30 be the most impactful forms of training, but this has not been tested in a way which demon-
31 strates improved outcomes for people living in care homes (e.g. improved management of
32 safeguarding concerns, people feeling 'safe', staff confident to speak up about any con-
33 cerns).

34 Summary of the protocol

35 See Table 1 for a summary of the Population, Intervention, Comparison and Outcome (PI-
36 CO) characteristics of this review.

37 **Table 1: Summary of the protocol (PICO table)**

Population	
	• Adults (aged over 18 years) accessing care and support in care homes.
	• People working in care homes.
	• People working with care homes.
	• People visiting care homes.

Interven-tion/exposure/test	Intervention 1 Safeguarding training designed specifically for care home managers and safeguarding leads/ champions in care homes. Intervention 2 Safeguarding training delivered in different formats - Face-to-face (group or 1 to 1). - Remote (including e-learning). - Self-directed (including e-learning). - Theatre based training. - Training through supervision. - One off, single session training. Intervention 3 Safeguarding training focussed on specific populations - People living with dementia. - High risk referrals. - All people accessing care and support, regardless of risk. - People with learning disabilities. - People with mental health issues. - Older adults (using the study definition). Intervention 4 Training delivered by people with lived experience or which incorporates components delivered by people with lived experience.
Comparison	Comparison 1 - Usual practice. 'Natural history' (no service) control. - Safeguarding training for care workers. Comparison 2 - Usual practice. 'Natural history' (no service) control. - Different training formats compared with each other. Comparison 3 - Usual practice. 'Natural history' (no service) control. - Safeguarding training focussed on adult care home residents, in general. Comparison 4 - Usual practice. 'Natural history' (no service) control. - Training delivered by people without specific lived experience. Different types of each intervention will not be compared with each other. They have been conceived because of different aspects of training (audience, focus, mode of delivery) about which the committee is interested in data on effectiveness and they are not considered to be mutually exclusive.

Outcomes	For part a) assessing effectiveness
	Critical
	• Workforce skills in safeguarding (as defined by the studies but examples include knowledge and skills for identifying a safeguarding concern and attitudes towards reporting).
	• Healthcare contacts related to suspected safeguarding concerns (for example, A&E, hospital admissions).
	• Reports of proven safeguarding cases.
	Important
	• Unnecessary transfer of care home residents between settings (for example, care home to hospital).
	For part b) assessing acceptability
	Qualitative themes will be identified from the available literature. The committee agreed the following potential themes although they are aware that data may not be located for all of them and that additional themes may be identified:
	• Satisfaction with the safeguarding training.
	• Perceived appropriateness of the training model or mode of delivery.
	• Positive and negative aspects of the safeguarding training.
	• Ideas for improvement in the content, organisation or delivery of safeguarding training.
	• Perception about the impact of the training on safeguarding procedures and practices within the care home.
	• Perception about the impact of the training on achieving the Making Safeguarding Personal outcomes.

1 *A&E: accident and emergency*

2 For further details see the review protocol in appendix A.

3 Methods and process

4 This evidence review was developed using the methods and process described in Develop-
5 ing NICE guidelines: the manual. Methods for this review question are described in the re-
6 view protocol in appendix A and the methods document.

7 Evidence

8 Included studies

9 The objectives of this review were to establish the effectiveness of different models of safe-
10 guarding training for care homes and to ascertain the acceptability of different training mod-
11 els by exploring the views and lived experiences of everyone involved.

12 The review was designed as a mixed-methods review with parallel synthesis of data from
13 both qualitative and quantitative studies. However insufficient data were identified and it was
14 therefore not possible to synthesise both data types. Instead, the qualitative and quantitative
15 data were synthesised and presented separately and the committee used the evidence as
16 the basis for discussions and making recommendations.

1 As per the protocol, because of insufficient UK based studies being available (both qualita-
2 tive and quantitative), studies from Europe (including the Republic of Ireland), and Australia
3 and Canada were also considered for inclusion. However only 2 further studies were identi-
4 fied which met all other inclusion criteria. These were both conducted in Canada (Du Mont
5 2017, Storey 2018) and report quantitative data, as described below.

6 A total of 7 studies were included. Six of these provided quantitative data on the effective-
7 ness of different models of training (Campbell 2014, Cooper 2012, Du Mont 2017, Kinderman
8 2018, Ochieng 2018, Storey 2018) and 1 provided qualitative data on the acceptability of dif-
9 ferent models of training and on training more generally (Tadd 2012).

10 The included studies are summarised in Table 2.

11 ***Quantitative component of the review***

12 For the quantitative part of the review, we looked for systematic reviews, randomised con-
13 trolled trials (RCTs) and observational studies.

14 One RCT was identified and included in the evidence review (Kinderman 2018). Five further
15 studies reporting quantitative data were included, all of which used a before and after design,
16 the majority of which used online questionnaires to assess knowledge and competence be-
17 fore delivery of a training intervention and after delivery of the intervention. The studies in-
18 cluded in the quantitative component of the review all evaluated individual interventions ra-
19 ther than training models; and there were no papers identified which focused specifically on
20 the effectiveness of training mode (as defined in the protocol), for example, audience, focus,
21 or method of delivery.

22 Four of the quantitative studies reported research conducted in the UK (Campbell 2014,
23 Cooper 2012, Kinderman 2018, Ochieng 2018), 2 studies reported research conducted in
24 Canada (Du Mont 2017, Storey 2018). The study populations included community nurses,
25 doctors on psychiatry or general practice training programs, Sexual Assault Nurse Examin-
26 ers, care home/nursing home staff and managers, people living with dementia in care homes
27 and NHS inpatient wards (and their carers), staff nurses and matrons working in primary and
28 secondary care, ward managers, and adult protection workers.

29 Campbell (2014) reported on a 1-day training course designed to improve participants' un-
30 derstanding of the Adult Support and Protection (Scotland) Act 2007 and practice relating to
31 this; Cooper (2012) evaluated the impact of a 'brief' educational seminar on UK psychiatric
32 trainees' knowledge about the detection and management of suspected abuse of older peo-
33 ple; Du Mont (2017) evaluated the impact of the 'Elder Abuse Nurse Examiner Curriculum'
34 on Sexual Assault Nurse Examiner (SANE)s' knowledge of abuse of older people and com-
35 petence in delivering care to abused older adults; Kinderman (2018) evaluated the impact of
36 applying a human rights based approach in dementia inpatient wards and care homes;
37 Ochieng (2018) assessed the impact of a continuing professional development intervention
38 (SOVA-CPD) for nurses working in both primary and secondary care settings; and Storey
39 (2018) evaluated the impact of the 're:act curriculum' on Adult Protection workers.

40 The following types of outcomes were identified through analysis of the included quantitative
41 studies:

42 • Service user and carer outcomes.

43 • Competence, expertise, and knowledge.

44 • Perceived knowledge, confidence.

45 • Ability to identify abuse and neglect.

1 •   Acceptability and satisfaction with training interventions.

2 ***Qualitative component of the review***

3 For the qualitative part of the review, we looked for studies that collected and analysed data
4 using qualitative methods (including focus groups, interviews, thematic analysis, framework
5 analysis and content analysis). Surveys restricted to reporting descriptive data that were ana-
6 lysed quantitatively were excluded.

7 One study, conducted in the UK, reported qualitative data (Tadd 2012). This focused on
8 training for care home staff and the design of the PEACH (Promoting Excellence in all Care
9 Homes) training package.

10 Data collection methods in studies with a qualitative design included focus groups, inter-
11 views, and surveys.

12 The following concepts were identified through analysis of the included qualitative studies:

13 • views on the status of current training in the care sector

14 • accessibility of training interventions.

15 As shown in the theme map (

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32 Figure 1), the concepts from the qualitative studies have been explored in a number of cen-
33 tral themes and sub-themes. The overarching theme is shown below in green, central
34 themes in blue and sub-themes in orange.

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16   **Figure 1: Theme map**

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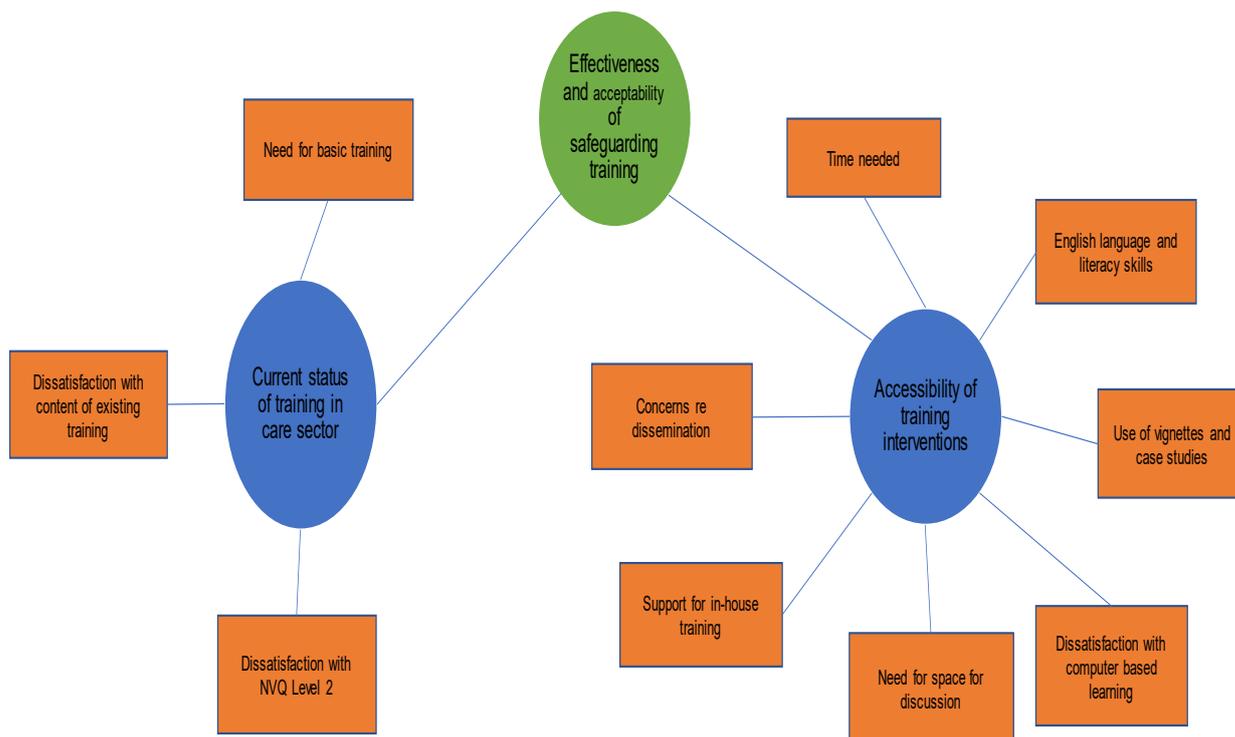
Excluded studies

Studies not included in this review are listed, and reasons for their exclusion are provided in appendix K.

Summary of studies included in the evidence review

Summaries of the studies that were included in this review are presented in Table 2 and

CSQ: **Caregiver Scenario Questionnaire; DCM: Dementia Care Mapping assessment; FREDA: Fairness, Respect, Equality, Dignity and Autonomy; IDEA: Identity, Dignity, Equality and Autonomy; KMA: Knowledge and Management of Abuse questionnaire; SANE: Sexual Assault Nurse Examiner; SD: standard deviation; SOVA-CPD: safeguarding of vulnerable adults – continued professional development.**

Table 3.

Table 2: Summary of included quantitative studies

Study	Population	Intervention/comparison	Outcomes
Campbell 2014 **Study design:** Before and after study using online questionnaire. **Aim of the study** To "…measure nurses' knowledge about Adult	**Sample size** Community nurses: N=18. **Characteristics** Sex: Male n=3; female n=15. Age: Range = 30-61; mean = 44.	One-day training session focusing on the Adult Support and Protection (Scotland) Act 2007.	• Perceived knowledge, confidence: o Knowledge of the Adult Support and Protection Act and its

Study	Population	Interven-tion/comparison	Outcomes
Support and Protection (Scotland) Act 2007 before and after a one-day training course using participants' favoured methods of training activities." (p 17) United Kingdom			implementation (measured using bespoke questionnaire)
Cooper 2012 **Study design:** Before and after study using questionnaires administered both in person and remotely. **Aim of the study** To test the hypothesis that "… a brief educational seminar would improve knowledge about the detection and management of suspected elder abuse by UK psychiatric trainees." (p. 1448) United Kingdom	**Sample size** Trainee doctors: N=40. **Characteristics** Participants were doctors on psychiatry or general practice training programs, currently working in psychiatry in 2 NHS trusts covering inner city London and suburban areas of outer London, Middlesex, and Essex in the UK. The trusts provide all NHS hospital and community secondary psychiatric care to those living in their catchment areas. Sex: Male n=19 (47.5%). Ethnicity: Asian or Asian British n=23 (57.5%); White, British n=7 (17.5%); White, other n=5 (12.5%); Other or mixed ethnicity n=5 (12.5%).	20 minute slide presentation focusing on: • definitions • prevalence and risk • detection and early intervention • Mental Capacity Act • asking about and screening for abuse in routine appointments • documentation • confidentiality • local reporting procedures.	• Ability to identify abuse and neglect: o identification of abuse (measured using CSQ). o Staff-applied knowledge and practice regarding identification and management of potentially abusive situations (measured using KMA).
Du Mont 2017 **Study design:** Before and after study using questionnaires administered in person. **Aim of the study** "To pilot and evaluate a novel Elder Abuse Nurse Examiner Curriculum and its associated training materials for their efficacy in improving Sexual Assault Nurse Examiner (SANE)s' knowledge of elder abuse and competence in delivering care	**Sample size** Sexual Assault Nurse Examiners: N=18. **Characteristics** Age group (years): 19 to 24 n=1 (6%); 25 to 34 n=4 (22%); 35 to 44 n=2 (11%); 45 to 60 n=9 (50%); 60 plus n=2 (11%). Ethnicity: White n=18 (100%).	An 8-hour training session covering the content of the 'Elder Abuse Nurse Examiner Curriculum' and associated materials. The curriculum focuses on: • overview of 'older adults and abuse' • documentation, legal and legislative issues • interviewing older adults,	• Competence, expertise, and knowledge: o Overall knowledge and expertise related to abuse of older people (measured using bespoke questionnaires and surveys).

Study	Population	Interven-tion/comparison	Outcomes
to abused older adults." P. 71 Canada		their care-givers, and other rele-vant con-tacts • assess-ment • medical and foren-sic exami-nation • case summary, discharge plan, and follow-up care.	
Kinderman 2018 **Study design:** RCT **Aim of the study** To evaluate the impact of applying a human rights based approach in de-mentia inpatient wards and care homes on the quality of care delivered and the well-being of the person living with dementia. United Kingdom	**Sample size** 8 NHS dementia specif-ic wards and 12 care homes recruited in north-west of England. People living with de-mentia: N=439 (n=213 training, n=226 no train-ing) Staff recruited: n=245. **Characteristics** Service users, that is, people with dementia (at baseline) Age (years): Mean (SD) - no training n=81.2 (8.0), training n=82.2 (7.3), total n=81.7 (7.7) Gender: Female no training n=93 (57.1%), training n=103 (60.9), total n=196 (59.0), Male no training n=70 (42.9), training n=66 (39.1), total n=136 (41.0).	A 1-day training session focusing on a human rights based approach to care and the imple-mentation of the 'Getting It Right' assessment tool, plus booster ses-sions to support the im-plementation. The 'Getting It Right' assessment tool is a person-centred care planning tool that explic-itly links the FREDA principles to areas con-tributing to person-centred care.	• Service user and carer out-comes: o Subjective well-being of service user/person with dementia (measured us-ing measured using QOL-AD). o Extent to which service users felt that their human rights were being up-held (measured using IDEA questionnaire). o Human rights knowledge (measured us-ing bespoke questionnaires). o Human rights attitudes (measured us-ing bespoke questionnaires). o Quality of care provided (measured us-ing DCM).
Ochieng 2018	**Sample size** Nurses working in primary and	SOVA-CPD training for nurses.	• Per-ceived

Study	Population	Intervention/comparison	Outcomes
Study design: Before and after study using online questionnaires. **Aim of the study** "The broad aim of this project was to assess the effect of safeguarding of vulnerable adults continuing professional development (SOVA-CPD) training on nurses working in primary and secondary care." P. 31 United Kingdom	secondary care: N=71. **Characteristics** Sex: Male n=10; female n=41. Age group: 25-44 years n=27; 45-65 years n=24.	The main aims of the course are to - improve leadership skills and interdisciplinary working in safeguarding adults; enable uptake of local and national safeguarding multidisciplinary guidelines; improve adult safeguarding policy and practice in the organisations in which participants were employed; and to enable sustainable improvements in adult safeguarding practice.	knowledge, confidence: o Perceived acquisition of knowledge and skills (measured using bespoke questionnaire). o Perceived changes in practice (measured using bespoke questionnaire).
Storey 2018 **Study design:** Cross-sectional comparative study - compares outcomes between completers and non-completers of curriculum (knowledge assessed using an online survey). **Aim of the study** To evaluate the re:act basic curriculum "… to determine if learners who complete the basic curriculum demonstrate more of the five core competencies of the curriculum than those who have not completed the basic curriculum." (p. 47) Canada	**Sample size** Adult protection workers: N=157. **Characteristics** Profession: Social workers n=84, (54%), nurses n=54 (34%), occupational therapists n=5 (3%), other n=14 (9%) (n=14) for example, physical therapists, case managers. Time in profession: Average of 6.5 years in profession (SD = 5.57, range: 0–32). Previous training in abuse of older people or had experience using the Adult Guardianship Act to protect vulnerable adults in British Columbia: n=107 (86%).	Training on the re:act Adult Protection Worker Curriculum. The curriculum was designed to ensure that Designated Responders understand how to follow-up reports of alleged abuse or neglect and are competent (as defined by the requirements of the Adult Guardianship Act).	• Ability to identify abuse and neglect: o Self-rated knowledge in identifying, reporting, and investigating cases of suspected abuse, neglect, and self-neglect of vulnerable adults (measured using bespoke questionnaire). • Competence, expertise, and knowledge: o Perceived competence and knowledge about material covered in the curriculum (measured using bespoke questionnaire). o Actual competence and

Study	Population	Intervention/comparison	Outcomes
			knowledge (measured using bespoke questionnaire). o Knowledge application (measured using bespoke questionnaire).

1 CSQ: Caregiver Scenario Questionnaire; DCM: Dementia Care Mapping assessment; FREDA: Fairness,Respect,
2 Equality, Dignity and Autonomy; IDEA: Identity, Dignity, Equality and Autonomy; KMA: Knowledge and
3 Management of Abuse questionnaire; SANE: Sexual Assault Nurse Examiner; SD: standard deviation; SOVA-
4 CPD: safeguarding of vulnerable adults – continued professional development.

5 **Table 3: Summary of included qualitative study**

Study and aim of the study	Participants	Methods	Themes
Tadd 2012 **Study design:** Qualitative – Described as multi-method – included interviews, focus groups, workshops, surveys and direct observation/ethnographic research. **Aim of the study** To "… explore the needs, knowledge and practices of the care home workforce in relation to abuse, neglect and loss of dignity and to provide a preliminary evaluation of an evidence-based training package." (p. 7) United Kingdom	**Sample size** N=255 (estimate – numbers not reported clearly). Interviews (n=33 care home staff), focus groups (n=29 care home managers and trainers, and n=15 residents and relatives), workshops (n=85 – background unclear), surveys (n=37 care home managers, n=56 care home workers), and direct observation (n=8 care homes). **Characteristics** Sex: Female n=27 (82%); male n=6. No qualifications: n=11 (33%) Been in post for less than a year: n=7 (21%).	**Setting** Care homes in in a range of locations across England (urban and rural). **Sample selection** Sampling process not reported. **Data collection** Interviews, focus groups, workshops, surveys, and direct observation in care homes. **Data analysis** Inductive and comparative methods.	• Current status of training in care sector: o need for basic training o dissatisfaction with content of existing training o dissatisfaction with NVQ Level 2. • Accessibility of training interventions: o time needed o English language and literacy skills o use of vignettes and case studies o dissatisfaction with computer based training. o need for space for discussion. o support for in house training. o concerns re dissemination.

6 See the full evidence tables in appendix D. No meta-analyses were conducted due to the va-
7 riety of outcome measures used in each study and the heterogeneity of interventions and
8 comparators (and so there are no forest plots in appendix E).

1 Quality assessment of studies included in the evidence review

2 Outcomes using data from RCTs were assessed using GRADE methodology. When before
3 and after studies were included, outcomes using data from these studies were analysed
4 where possible using modifications of the GRADE principles intended for RCTs. As per
5 GRADE methodology outcomes including data from these studies were automatically rated
6 as low quality.

7 A summary of the strength of evidence for quantitative studies, assessed using GRADE and
8 modified GRADE, is presented according to the outcomes identified:

9 • Service user and carer outcomes. All outcomes were assessed to be of high quality.

10 • Competence, expertise, and knowledge. All outcomes were assessed to be of very low
11 quality.

12 • Perceived knowledge, confidence. All outcomes were assessed to be of very low quality.

13 • Ability to identify abuse and neglect. All outcomes were assessed to be of very low quality.

14 • Acceptability and satisfaction with training interventions. All outcomes were assessed to
15 be of very low quality.

16 A summary of the strength of evidence for qualitative studies, assessed using GRADE-
17 CERQual, is presented according to the main themes:

18 ***Acceptability of safeguarding training***

19 • Current status of training in the care sector:

20   o Need for training. Overall, methodological concerns were considered to be serious for
21   this sub-theme and the overall confidence in this sub-theme was judged to be very low.

22   o Dissatisfaction with existing training - content. Overall, methodological concerns were
23   considered to be serious for this sub-theme and the overall confidence in this sub-
24   theme was judged to be very low.

25   o Dissatisfaction with existing training – NVQ Level 2. Overall, methodological concerns
26   were considered to be serious for this sub-theme and the overall confidence in this
27   sub-theme was judged to be very low.

28 • Accessibility of training interventions:

29   o Time needed. Overall, methodological concerns were considered to be serious for this
30   sub-theme and the overall confidence in this sub-theme was judged to be very low.

31   o Consideration of literacy and English language levels. Overall, methodological con-
32   cerns were considered to be serious for this sub-theme and the overall confidence in
33   this sub-theme was judged to be very low.

34   o Power case studies and vignettes. Overall, methodological concerns were considered
35   to be serious for this sub-theme and the overall confidence in this sub-theme was
36   judged to be very low.

37   o Dissatisfaction with computer based programmes. Overall, methodological concerns
38   were considered to be serious for this sub-theme and the overall confidence in this
39   sub-theme was judged to be very low.

40   o Opportunities for discussions and reflection rather than 'getting the right answer'. Over-
41   all, methodological concerns were considered to be serious for this sub-theme and the
42   overall confidence in this sub-theme was judged to be very low.

43   o Support for in-house training. Overall, methodological concerns were considered to be
44   serious for this sub-theme and the overall confidence in this sub-theme was judged to
45   be very low.

1   o Dissemination and implementation. Overall, methodological concerns were considered
2   to be serious for this sub-theme and the overall confidence in this sub-theme was
3   judged to be very low.

4   Evidence is summarised in GRADE tables for quantitative studies and in GRADE-CERQual
5   tables for the qualitative study. See the evidence profiles in appendix F for details.

6 Economic evidence

7 Included studies

8   One relevant study was identified in a literature review of published economic evidence on
9   this topic (Kinderman 2018; see appendix H and appendix I for summary and full evidence
10   tables).

11   The analysis adopted the perspective of the UK public sector and multi-agency perspective.

12 Excluded studies

13   A global search of economic evidence was undertaken for all review questions in this guide-
14   line. However, no economic studies relating to this question were considered as full texts and
15   so there is no list of excluded studies.

16 Summary of studies included in the economic evidence review

17   Kinderman (2018) considered the costs and consequences of human rights training for staff
18   caring for people with dementia in hospital and care home settings, compared with usual pa-
19   tient management.

20   The study evaluated a training intervention designed to be delivered to all grades and pro-
21   fessions of care unit staff (for example, ward manager, registered nurses, support workers,
22   domestic staff, occupational therapists and physiotherapists). The analysis was a cost-
23   consequences analysis embedded in a cluster RCT measuring consequences in terms of
24   health-related quality of life and well-being of people with dementia, well-being of their family
25   carers, and overall quality of care. The primary outcome to assess the consequences was
26   well-being of people with dementia.

27   The base-case results suggested that the provision of a training intervention designed to be
28   delivered to all grades and professions of health and social care professionals caring for
29   people with dementia (for example, from ward manager to occupational therapists and phys-
30   iotherapists; from care home managers to care home assistants) would cost £101 per pro-
31   fessional. The analysis of consequences did not show any evidence of a difference in quality
32   of life between groups (training intervention versus standard of care).

33   The base-case incremental cost-effectiveness ratio (ICER) was not estimated and was not
34   estimable for the primary outcome (that is, patient-reported well-being). Uncertainty on the
35   robustness of study results was not assessed by either deterministic or probabilistic sensitivi-
36   ty analyses.

37   Being a UK study and meeting most applicability criteria, this study was deemed to be direct-
38   ly applicable to the context of the guideline. The study failed to meet most methodological
39   quality requirements of an adequate economic evaluation (such as a, model structure inap-
40   propriate to the decision problem; a lack of reporting of an appropriate incremental analysis,
41   no reporting of a sensitivity analysis) and this was highly likely to change the conclusions
42   about the economic findings. Therefore, it was deemed as having very serious limitations

1   (see https://www.nice.org.uk/Media/Default/About/what-we-do/our-programmes/developing-
2   NICE-guidelines-the-manual.pdf - appendix H).

3 **Economic model**

4   In the absence of any economic or comparative effectiveness evidence comparing alterna-
5   tive approaches in the delivery of safeguarding training for those looking after adults in care
6   homes, a "what-if" cost-utility analysis was developed to compare e-learning with face-to-face
7   training for safeguarding adults in care homes. It was intended that this analysis would sup-
8   port the research recommendation made by the committee which reflected the lack of evi-
9   dence available to make recommendations on these alternative approaches which are both
10   used in current practice. The model is summarised below with full details in appendix J.

11   Figure 2 shows the basic model structure which was for the population of care home workers
12   and managers relevant to this guideline. In the absence of evidence, the model posited a re-
13   lationship between effective safeguarding training and improved safeguarding practice which
14   in turn offered a mechanism to improve the well-being of adult residents in care homes, as-
15   sessed in terms of Quality Adjusted Life Years (QALYs). The costs of the alternative training
16   courses were taken from that publicly advertised by providers in the social care sector. The
17   analysis did not consider the potential impact on future costs and savings from improved
18   safeguarding. There was no available data to inform model inputs relating to the comparative
19   effectiveness of e-learning and face-to-face training and therefore a "what-if" approach was
20   used, in which the model was run many times with different input values, to assess cost-
21   effectiveness under a number of alternative scenarios. This allowed the impact of optimistic
22   and pessimistic states to be compared in addition to suggesting threshold values for cost-
23   effectiveness of a number of key model parameters.

Figure 2: Model decision tree
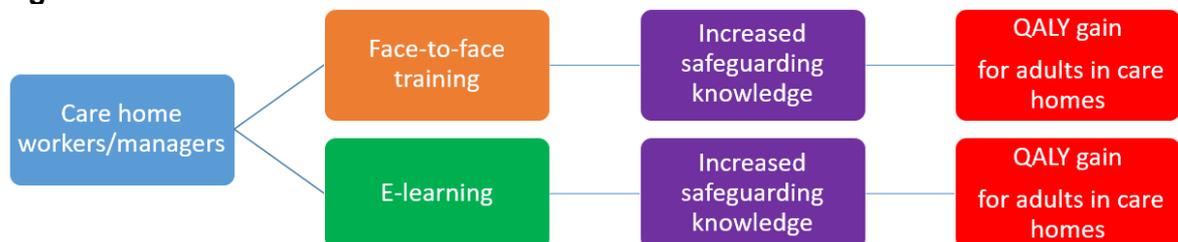
24   The results for an illustrative set of model inputs (see appendix J) were that face-to-face
25   training had ICERs relative to e-learning of £8,200 per QALY for a home care worker doing
26   the training and £9,560 per QALY for a home care manager doing the training. In both those
27   scenarios face-to-face training would be cost-effective relative to e-learning as the ICER was
28   less than a cost-effectiveness threshold of £20,000 per QALY.

29   The "what-if" analyses suggested that the cost-effectiveness of face-to-face training relative
30   to e-learning would depend on the additional costs, the gains in knowledge and the extent to
31   which those gains in knowledge translated into better outcomes for care home users.

32   Research is needed to confirm whether the perceived advantages of face-to-face training
33   over e-learning for safeguarding training for adults in care homes translate into cost-effective
34   provision given its higher cost.

1 The committee's discussion of the evidence

2 Interpreting the evidence

3 *The outcomes that matter most*

4 For the quantitative component of the review, workforce skills in safeguarding (as defined by
5 the studies but examples include knowledge and skills for identifying a safeguarding concern
6 and attitudes towards reporting), healthcare contacts related to suspected safeguarding con-
7 cerns (for example, A&E, hospital admissions) and reports of proven safeguarding cases
8 were considered to be critical outcomes. Unnecessary transfer of care home residents be-
9 tween settings (for example, care home to hospital) was identified to be an important out-
10 come. Quantitative evidence was identified in relation to the critical outcome workforce skills
11 in safeguarding. None of the studies reported on healthcare contacts related to suspected
12 safeguarding concerns, reports of proven safeguarding cases, or unnecessary transfer of
13 care home residents between settings.

14 For the qualitative component of the review, the committee could not specify in advance the
15 data that would be located. Instead they identified the following main themes to guide the re-
16 view. However, not all the themes may be found in the literature and the list was not exhaus-
17 tive so additional themes may have been identified:

18 • Satisfaction with the safeguarding training.

19 • Perceived appropriateness of the training model or mode of delivery.

20 • Positive and negative aspects of the safeguarding training.

21 • Ideas for improvement in the content, organisation or delivery of safeguarding train-
22 ing.

23 • Perception about the impact of the training on safeguarding procedures and practices
24 within the care home.

25 • Perception about the impact of the training on achieving the Making Safeguarding
26 Personal outcomes.

27 The qualitative studies included in this part of the review provided data regarding stakeholder
28 views on training provision and accessibility. However, the included studies provided only
29 limited detail.

30 *The quality of the evidence*

31 The quality of the quantitative evidence contributing to each outcome was assessed using
32 GRADE methodology. The majority of the outcomes were assessed to be of very low quality,
33 although a small number were determined to be of high quality (as they were based on data
34 from one RCT assessed as having a low risk of bias and were not assessed to have limita-
35 tions with regards to consistency, directness, or imprecision). Outcomes assessed as being
36 of very low quality were all downgraded on the basis of design/risk of bias as the 5 studies on
37 which these were based were not randomised (as per GRADE methodology). These studies
38 all used a before and after design, with participants completing questionnaires and surveys
39 before and after delivery of an intervention and the data available from these meant that it
40 was not possible to calculate absolute effects. Outcomes were further downgraded on the
41 basis of imprecision as sample sizes were very small (i.e. below 200. One study was includ-
42 ed in the qualitative component of the review. The overall confidence in the qualitative evi-
43 dence was assessed using GRADE-CERQual methodology and was determined to be of
44 very low quality for all themes, mainly as a result of the adequacy of the data which were as-
45 sessed as thin. Confidence in the findings was generally downgraded because of the rele-

1 vance and adequacy of the findings; the single study reported limited data addressing vari-
2 ous topics, not exclusively relevant to safeguarding.

3 In terms of population subgroups specified in the protocol, it was not possible to report find-
4 ings separately because the studies did not provide this level of detail.

5 The committee recognised the limitations of the evidence, including the use of indirect evi-
6 dence from other care settings which required extrapolation to a care home setting, and this
7 prevented the committee from reaching firm conclusions. However, the committee felt strong-
8 ly about the issues identified from the evidence and they therefore drew on their own experi-
9 ences and expertise to make recommendations to ensure that health and social care profes-
10 sionals and organisations meet the standards set by the Care Act 2014 and other statutory
11 requirements to provide best practice; ultimately protecting care home residents from harm
12 and ensuring they receive the best quality care.

13 **Synthesis of quantitative and qualitative data**

14 Although the review was designed as a mixed-methods review, insufficient data were identi-
15 fied to enable synthesis of qualitative and quantitative data; as a result, the two sets of data
16 were presented separately to the committee. Although the committee made use of the quan-
17 titative evidence, the majority of the outcomes presented were assessed as low quality, and
18 the committee did not believe that it was appropriate to make recommendations solely on the
19 basis of these data. Their recommendations were instead guided by findings from the quali-
20 tative data which they agreed aligned with their own experiences and knowledge of current
21 safeguarding training provision.

22 *Benefits and harms*

23 *Induction and training in care homes*

24 **Induction and mandatory training**

25 No quantitative evidence was identified which was relevant to induction and mandatory train-
26 ing specifically. Although the strength of the qualitative evidence presented was considered
27 very low, it indicated the need for basic training for all care home staff to enable them to un-
28 derstand the role of safeguarding in their work and allow them to carry out this work confi-
29 dently and effectively. This aligned with the committee's own knowledge and expertise with
30 regards to induction and mandatory training and requirements of the Care Act, 2014. The
31 committee therefore agreed that it was important to emphasise the need for mandatory train-
32 ing. Based on consensus they made a recommendation highlighting that mandatory training
33 should be completed by all staff (including contract and temporary staff) as a priority and no
34 later than 6 weeks from the start (in accordance with guidance such as Adult Safeguarding:
35 Roles and competencies for Health Care Staff 2018).

36 The committee also made a recommendation for Safeguarding Adults Boards to consider
37 organising mandatory training for staff on a multi-agency basis, working together with related
38 service providers and other health and social care organisations. This was based on the lim-
39 ited evidence highlighting the benefits of training groups of staff together so that they com-
40 plete training over a shorter period of time and to also provide them with the opportunity to
41 engage with each other. The committee agreed that an important potential benefit of this ap-
42 proach would be associated cost savings. Based on their own expertise, the committee were
43 also keen to emphasise that staff knowledge should be refreshed regularly. The committee
44 agreed that it was appropriate to specify that this happens annually as a means of ensuring
45 that good practice is embedded throughout the care home without the risk of unsustainable
46 costs.

1   In their discussions on what training should be provided and whether this differed by role, the
2   committee were mindful of the competency framework outlined in the intercollegiate docu-
3   ment Adult Safeguarding: Roles and competencies for Health Care Staff 2018. The commit-
4   tee therefore agreed that it was not necessary to make detailed recommendations regarding
5   what further training should be provided to certain roles and on what timescales.

6   The limited evidence also highlighted some dissatisfaction among care home staff with cer-
7   tain training methods such as e-learning. The committee therefore agreed that it is important
8   to identify how effective training is in enhancing staff understanding of safeguarding and
9   whether there are areas that may need improvement or whether other training methods may
10 be more appropriate and effective. This was reflected in their recommendation to assess
11 staff understanding of safeguarding before and after induction and mandatory safeguarding
12 training to identify any changes and areas for improvement.

13 Based on their expertise and experience, the committee were aware that there may be con-
14 straints on staff time to complete safeguarding training and they highlighted the need for pro-
15 tected time to enable staff to fully engage with induction and mandatory training materials
16 and to improve their confidence, which should in turn enhance learning and the transfer of
17 knowledge and skills into daily practice. The committee also recognised, based on their own
18 expertise, that there may be potential harms (or disadvantages) in terms of resources (that
19 is, use of staff time), but on balance they considered that the benefits achieved through staff
20 training and engaging with other professionals are likely to outweigh the potential harms; in-
21 creasing staff safeguarding skills and competency, and this should in turn be reflected in dai-
22 ly practice.

23 The committee made further recommendations in relation to induction and mandatory train-
24 ing based on the evidence presented for evidence review B: barriers and facilitators to identi-
25 fying abuse and neglect and evidence review I: the effectiveness and acceptability of em-
26 bedding organisational learning. Details of the committee's discussion and rationale for these
27 recommendations are included in both reviews.

28 **What mandatory training should cover**

29 The quantitative evidence suggested that training interventions may have a positive effect on
30 workforce skills such as knowledge and attitudes regarding human rights based approaches
31 and competence in identifying and investigating, and managing and reporting abuse, neglect,
32 or self-neglect. However, the evidence also suggested that potential improvements in prac-
33 tice did not lead to better quality of care or service-user wellbeing and the quality of the evi-
34 dence was very low. Based on their knowledge about the importance of human rights in this
35 context the committee were nevertheless keen to recommend training about the relationship
36 between safeguarding and human rights and in this sense used their own experiential
37 knowledge to support and strengthen the very low quality quantitative data. In light of discus-
38 sions about this evidence the committee also agreed it was crucial for other specific areas to
39 be covered and therefore made a recommendation highlighting the need for mandatory safe-
40 guarding training to cover the following: the Care Act 2014 and the 6 core principles of safe-
41 guarding; the Making Safeguarding Personal framework; specific responsibilities and ac-
42 countabilities for safeguarding in the care home; how to recognise different forms of abuse
43 and neglect (including organisational abuse and neglect) and differences between poor prac-
44 tice and abuse and neglect; and to cover whistleblowing (including what support and infor-
45 mation is available in this situation). The committee were also keen to emphasise the need
46 for training to cover how to talk about and share information about safeguarding with resi-
47 dents and their families and carers because they were aware, from the evidence and their
48 own expertise and experience, that safeguarding needs to be discussed in a sensitive and
49 non-judgemental manner.

1   However, the committee were aware, from the evidence and their own expertise and experi-
2   ence, that there may be potential difficulties with communication, for example English may
3   not be the first language for some staff, or staff may have low levels of literacy or numeracy
4   skills. The committee therefore made a recommendation designed to highlight the need for
5   training to address these areas to promote the understanding of language and literacy, which
6   in turn should result in more effective learning.

7   On balance the committee considered that the benefits are likely to outweigh any potential
8   harms associated with these recommendations such as increased costs or staff time, as
9   providing training to all care home staff in accessible formats should promote greater under-
10   standing of safeguarding which in turn is likely to ensure greater consistency and improve-
11   ments in the identification of abuse and neglect. The committee made further recommenda-
12   tions in relation to what safeguarding training should cover based on the evidence presented
13   for evidence review B: barriers and facilitators to identifying abuse and neglect and evidence
14   review E: support and information needs.

15   **Further training**

16   The quantitative evidence reported on how often participants were asking older people about
17   abuse and whether they considered abuse during assessments of older people and whether
18   consideration of this issue increased after delivery of a training intervention. Although the
19   quality of this evidence was considered to be very low, and no qualitative evidence was iden-
20   tified which covered this issue the committee agreed that all stages of training should include
21   learning on how to ask about abuse and neglect in a sensitive and non-judgmental manner,
22   the importance of frequently considering the possibility of abuse and neglect, and the practi-
23   cal nature of safeguarding. Based on their own expertise and consensus, the committee
24   were also keen to reflect the need for further training to cover risk assessments and their re-
25   lationship to safeguarding, and this was reflected in their recommendation. The benefits from
26   covering a range of safeguarding topics in further training should help to keep staff
27   knowledge up-to-date, and promote reflective learning to ensure that best practice is embed-
28   ded within their daily activities.

29   Based on their discussions and drawing on their own expertise, the committee reached con-
30   sensus about the need for training to incorporate recognition of abuse and neglect, including
31   less obvious indicators of abuse and neglect and more complex safeguarding concerns, for
32   example, organisational level abuse and neglect. In addition, they agreed to reflect the fact
33   that practitioners should be taught that abuse and neglect can happen in any setting or situa-
34   tion within the care home.

35   On balance the committee considered that the benefits are likely to outweigh the potential
36   harms; providing training to all care home staff to cover different aspects of safeguarding
37   should promote greater understanding of what abuse and neglect look like and enhance re-
38   flective learning. This in turn is likely to ensure staff keep up-to-date with safeguarding issues
39   and should ensure greater consistency and improvements in the identification of abuse and
40   neglect.

41   **How to conduct training**

42   The qualitative evidence highlighted the dissatisfaction of care home managers and staff with
43   the content of existing training which was often perceived to be a 'tick box exercise' which
44   has little relevance to day-to-day practice. Although the overall confidence in the qualitative
45   evidence was considered to be very low, and no quantitative evidence was identified which
46   covered this issue, the committee were keen to emphasise that training should be directly
47   applicable to the responsibilities and daily practices of the staff being trained and also to the
48   care and support needs of the residents they are working with. The evidence also highlighted
49   positive views towards case studies and vignettes, which were seen as a powerful learning
50   and assessment tool. Based on the evidence and their own expertise and knowledge, the

1   committee were keen to recommend the use of case studies in training because this can
2   provide the trainer with the opportunity to evaluate whether the person is learning and can
3   apply the lessons into a practice context. Based on the evidence and their own expertise, the
4   committee also recognised the benefits of learning from Safeguarding Adults Reviews
5   (SARs) to promote good practice and they were therefore keen to recommend incorporating
6   recommendations and other information from SARs into training as soon as possible after
7   publication of the reports. The committee also felt it important to highlight the need for train-
8   ing designed to encourage reflective learning and discussions with colleagues to identify
9   what good practice looks like, and this was reflected in their recommendation to include case
10   studies and reflective practice at the team and organisational level (for example, at team
11   meetings and handovers). The committee discussed the disadvantages and challenges as-
12   sociated with different modes of training. Although no quantitative evidence was identified
13   which compared the effectiveness of different modes of training (e.g. individual e-learning
14   versus group sessions), the committee were in agreement that there were risks associated
15   with a reliance on e-learning particularly because this method relies on staff having good lit-
16   eracy and computer skills. The committee also noted that e-learning programmes provided
17   without any checks can lead to difficulties in determining whether staff have really under-
18   stood the content. Face-to-face training was viewed positively in the evidence (based on
19   group or 1-to-1 training) but the committee recognised that not all care homes will have the
20   resources to provide face-to-face safeguarding training. This was reflected in the recommen-
21   dations made by the committee, which suggest that, wherever possible, mandatory safe-
22   guarding training should be delivered face-to-face, and e-learning should only be used if
23   face-to-face training is not possible. Based on the evidence and their own expertise and
24   knowledge, the committee were keen to make recommendations to ensure the limitations of
25   e-learning were acknowledged, and also to consider providing appropriate training to incor-
26   porate different levels of staff literacy and computer skills. The committee also recognised
27   that there was an absence of effectiveness evidence to demonstrate the superiority of face-
28   to-face training over e-learning and therefore they, for the purposes of their recommenda-
29   tions, used a slightly broader definition of face-to-face training than would conventionally be
30   employed. They believed that this would allow training to incorporate what they considered to
31   be the key advantages of that approach (interactive contact between the trainer and partici-
32   pants) without necessarily always requiring the more resource intensive physical proximity of
33   traditional face-to-face training. They agreed that within the guideline face-to-face training
34   would be defined as including the use of virtual platforms such as video or teleconferencing.

35   Providing training that is appropriate to different staff should ensure that staff still receive the
36   training in a way that promotes learning. The committee were keen to highlight the benefits of
37   ensuring that learning from training is reflected in daily practice to promote best practice.
38   They therefore made a recommendation to reflect that care home managers should ensure
39   that staff are learning from training, for example, through random quality-checking and sam-
40   pling, follow-up conversations with staff, and ensuring that training is completed on-site and
41   within a specific timeframe.

42   Overall, the committee considered that the benefits are likely to outweigh the potential
43   harms; delivering training using alternative methods to incorporate different staff skill levels,
44   and tailoring training to the particular responsibilities and daily tasks of the person being
45   trained and to the needs of the people they are working with, should in turn promote staff en-
46   gaging with training and enhancing the implementation of effective training into daily practice.

47   The committee made further recommendations in relation to how safeguarding training
48   should be delivered and what kinds of training work best, based on the evidence presented
49   for evidence review I: the effectiveness and acceptability of embedding organisational learn-
50   ing.

51   **Evaluating training**

1   The committee made recommendations based mainly on quantitative evidence which sug-
2   gested improvements in staff knowledge and understanding of safeguarding after delivery of
3   a training intervention. The committee acknowledged that the quality of the data were very
4   low and that these interventions had only been evaluated in the short-term. However, since
5   their experiences supported the findings they were able to integrate their own experiential
6   knowledge with the results to make recommendations. Based on their own expertise the
7   committee also agreed to emphasise the importance of evaluating training programmes and
8   evaluating improvements in practice resulting from these as means of ensuring that training
9   remains relevant and effective. The committee agreed that evaluations should take place
10 both in the short and the long-term. The committee therefore made a recommendation to re-
11 flect that care home managers should evaluate changes in understanding and confidence
12 before and after training, including immediately after training and on an ongoing basis (that
13 is, annually and in regular long-term evaluations such as supervision sessions) to identify
14 any changes and areas for improvement. The committee were also keen to emphasise the
15 need to ensure that any positive outcomes are recognised and acknowledged by line man-
16 agers in care homes and shared with colleagues, and this was reflected in their recommen-
17 dations. This should promote the positive effects of training and continued positive effects
18 achieved by staff, which should in turn enhance embedding learning within daily practice.

19 The committee believed that the potential benefits from highlighting the positive outcomes
20 that can be achieved through effective safeguarding training should outweigh the potential
21 disadvantages; improving staff knowledge and recognition of abuse and neglect and increas-
22 ing confidence in managing safeguarding concerns, which should in turn ensure the safety
23 and quality of care of care home residents.

24   Cost effectiveness and resource use

25 The committee recognised that basic training is a mandatory and Clinical Quality Care com-
26 mission requirement. Given that context the committee did not consider that their recom-
27 mendations on training would have a significant resource impact.

28 One economic study (Kinderman 2018) based on the "Getting it Right" assessment tool was
29 included in the review of economic evidence. However, given the costs of this training inter-
30 vention, and the fact that the study did not find evidence that improved knowledge and atti-
31 tudes about human rights led to improvements in the well-being of people living with demen-
32 tia in an inpatient hospital or care home setting, the committee did not consider that this
33 could be used to make any recommendations.

34 Based on their own expertise and knowledge, the committee recognised that e-learning may
35 be a more cost-effective or affordable option for some care homes despite what they consid-
36 ered to be some important limitations when compared with face-to-face training (including
37 that delivered via virtual platforms). However, no economic evidence was found with respect
38 to the cost-effectiveness of alternative approaches in the delivery of safeguarding training for
39 those looking after adults in care homes. Furthermore, the quantitative review undertaken for
40 this guideline did not find any comparative effectiveness data on which it would have been
41 possible to base original economic modelling comparing face-to-face and e-learning ap-
42 proaches. Given the lack of evidence focusing on the mode of training, the committee agreed
43 to address the gaps in the evidence and made a research recommendation to inform future
44 guidelines. A hypothetical economic model was developed in support of this research rec-
45 ommendation.

46 The committee made recommendations on the content of training but did not think these in-
47 volved making choices between competing alternatives with implications for opportunity cost.
48 They considered that their recommendations for evaluating training would not involve signifi-
49 cant resource use and would therefore be likely to be cost-effective as they would help rein-
50 force the positive effects of training

1 **Other factors the committee took into account**

2 Given the limitations of the evidence, the committee drew on their own experience and ex-
3 pertise to make social value judgements about what health and social care professionals and
4 organisations should provide to ensure the safety of care home residents, which then in-
5 formed the recommendations. The committee also made recommendations to address the
6 gaps in the evidence relating to mode of training to inform future guidelines.

7 When making the recommendations, the committee also aimed to respect individual needs
8 and basic human rights, at the same time aiming to provide the most benefit for the greatest
9 number of people. The committee were aware that care home residents include a wide varie-
10 ty of people with individual needs (including, for example, people with dementia or learning
11 difficulties) and they were therefore aware of the need to eliminate discriminations when
12 making the recommendations. The committee were also aware that safeguarding adults in-
13 volves a wider range of individuals and organisations (including the care homes and care
14 home providers, individual health and social care practitioners who work with care home res-
15 idents, and also local authorities and commissioners). The committee were also aware of the
16 need to consider the inequalities that exist between different agencies to ensure fairness and
17 least impact on resources. For example, different care homes will have varying levels of
18 staffing and finances. Whilst the committee agreed to be prescriptive regarding topics that
19 should be covered in mandatory and further training programmes, the points at which these
20 should take place and the importance of protected time for training; they recognised that a
21 more flexible approach to delivery could help to mitigate inequalities in the care sector. For
22 example, the committee agreed to adopt a broader definition of face-to-face training that in-
23 cludes programmes that are provided via virtual platforms on the condition that they include
24 interactive elements, such as the opportunity to ask questions, and have discussions with
25 other trainees.
26
27 As this review did not identify evidence directly relating to the effectiveness of specific modes
28 of training the committee agreed to draft a research recommendation addressing this. The
29 committee were particularly interested in the effectiveness of training-learning and noted
30 concerns regarding its suitability as a means of enabling best practice on a day to day basis.
31 As a result, the committee agreed to draft a research recommendation focusing on the effec-
32 tiveness and cost-effectiveness of e-learning in comparison to face to face training.
33

34 **References**

35 **Campbell 2014**

36 Campbell, M., Adult protection training for community nurses: evaluating knowledge following
37 delivery using participant-favoured training methods. Journal of Adult Protection 16, 17-28,
38 2014

39 **Cooper 2012**

40 Cooper, C., Huzzey, L., Livingston, G., The effect of an educational intervention on junior
41 doctors' knowledge and practice in detecting and managing elder abuse. International Psy-
42 chogeriatrics 24, 1447-1453, 2012

43 **Curtis 2019**

44 Curtis, Lesley A. and Burns, Amanda Unit Costs of Health and Social Care 2019. Unit Costs
45 of Health and Social Care. PSSRU, Kent, UK, 176 pp. ISBN 978-1-911353-10-2, 2019.

46 **Department of Health and Social Care 2014**

1 Department of Health and Social Care. Care and support statutory guidance [online; ac-
2 cessed May 2020]

Du Mont 2017

4 Du Mont, J., Kosaa, D., Yang, R., Determining the effectiveness of an Elder Abuse Nurse
5 Examiner Curriculum: A pilot study Nurse. Education Today 55, 71–76, 2017

Kinderman 2018

7 Kinderman, P., Butchard, S., Bruen, A., A randomised controlled trial to evaluate the impact
8 of a human rights based approach to dementia care in inpatient ward and care home set-
9 tings. Health Services and Delivery Research 6, 2018.

Local Government Association 2020

11 Local Government Association. Making Safeguarding Personal [online; accessed May 2020]

Ochieng 2018

13 Ochieng, B. and Ward, K., Safeguarding of vulnerable adults training: assessing the effect of
14 continuing professional development. Nursing Management 2018.

Storey 2018

16 Storey, J. and Prashad, A., Recognizing, reporting, and responding to abuse, neglect, and
17 self-neglect of vulnerable adults: an evaluation of the re:act adult protection worker basic cur-
18 riculum. Journal of Elder Abuse and Neglect 30, 42-63, 2018

Tadd 2012

20 Tadd, W., Woods, R., O'Neill, M., Promoting Excellence in Care Homes. Centre for Mental
21 Health and Society: Wrexham, 2012

1 Appendices

2 Appendix A – Review protocol

3 Review protocol for review questions H:

4 • What is the effectiveness of different models of training for safeguarding in care homes?

5 • What is the acceptability of different models of training for safeguarding in care homes?

6 Table 4: Review protocol

ID	Field (based on PRISMA-P)	Content
0.	PROSPERO registration number	CRD42020170988
1.	Review title	Effectiveness and acceptability of safeguarding training.
2.	Review question	a) What is the effectiveness of different models of training for safeguarding in care homes? b) What is the acceptability of different models of training for safeguarding in care homes?
3.	Objective	• To assess the effectiveness of different models of training for promoting safeguarding practices within the care home context for practitioners working in care homes, family/friends of people living in or using care homes, and people accessing care and support in care homes. • To explore the views/perceptions/lived experiences of commissioners, practitioners working in care homes, family/friends of people living in or using care homes, and people accessing care and support in care homes regarding the effectiveness and acceptability of different training models within the care home context.
4.	Searches	The following databases will be searched: • Cochrane Database of Systematic Reviews (CDSR) • Cochrane Central Register of Controlled Trials (CENTRAL) • MEDLINE & Medline in Process • Embase • CINAHL

ID	Field (based on PRISMA-P)	Content
		- PsycINFO - ASSIA - IBSS - Social Policy and Practice - Social Science Database - Social Services Abstracts - Sociological Abstracts. Searches will be restricted by: - date limit - 2008 onwards (see rationale under Section 10) - English language - human studies. Other searches: Additional searching may be undertaken if required (for example, reference or citation searching). With the agreement of the guideline committee the searches will be re-run 6 weeks before final submission of the review and further studies retrieved for inclusion. The full search strategies for MEDLINE database will be published in the final review.
5.	Condition or domain being studied	For part a) Models of training aimed at increasing knowledge and awareness about adult safeguarding and promoting safeguarding practices in care homes. For part b) Views, perceptions, and/or lived experiences of people working in, working with, visiting and accessing care and support, family/friends of people living in or using care homes, and people living in or using care homes about safeguarding training within the adult care home context.
6.	Population	- Adults accessing care and support in care homes. - People working in care homes. - People working with care homes. - People visiting care homes.
7.	Intervention/Exposure/Test	Intervention 1 Safeguarding training designed specifically for care home managers and safeguarding

ID	Field (based on PRISMA-P)	Content
		leads/ champions in care homes. Intervention 2 Safeguarding training delivered in different formats • Face-to-face (group or 1 to 1). • Remote (including e-learning). • Self-directed (including e-learning). • Theatre based training. • Training through supervision. • One off, single session training. Intervention 3 Safeguarding training focussed on specific populations • People living with dementia. • High risk referrals. • All people accessing care and support, regardless of risk. • People with learning disabilities. • People with mental health issues. • Older adults (using the study definition). Intervention 4 Training delivered by people with lived experience or which incorporates components delivered by people with lived experience.
8.	Comparator/Reference standard/Confounding factors	Comparison 1 • Usual practice. • 'Natural history' (no service) control. • Safeguarding training for care workers Comparison 2 • Usual practice. • 'Natural history' (no service) control. • Different training formats compared with each other.

ID	Field (based on PRISMA-P)	Content

		Comparison 3
		      • Usual practice.
		      • 'Natural history' (no service) control.
		      • Safeguarding training focussed on adult care home users, in general.
		
		Comparison 4
		      • Usual practice.
		      • 'Natural history' (no service) control.
		      • Training delivered by people without specific lived experience.
		
		Different types of each intervention will not be compared with each other. They have been conceived because of different aspects of training (audience, focus, mode of delivery) about which the committee is interested in data on effectiveness and they are not considered to be mutually exclusive.

9.	Types of study to be included	For part 'a' about the effectiveness of safeguarding training: Experimental studies (where the investigator assigned intervention or control) including:
		      • Randomised controlled trials.
		• Non-randomised controlled trials (for example, case control, case series [uncontrolled longitudinal study]).
		• Before and after study or interrupted time series.
		      • Observational studies (where neither control nor intervention were assigned by the investigator) including:
		   o Prospective cohort studies.
		   o Retrospective cohort studies.
		   o Cross-sectional study.
		   o Review on associations.
		   o Before and after study or interrupted time series.
		      • Systematic reviews of studies using the above designs.
		
		For part 'b' about the acceptability of safeguarding training:
		      • Systematic reviews of qualitative studies.
		      • Studies reporting semi-structured and structured interviews, focus groups, observations.

ID	Field (based on PRISMA-P)	Content
		• Surveys using open ended questions and a qualitative analysis of responses including, including Carers UK Survey, Health and Digital Behaviours Survey 2017 (Teva Pharmaceutical Industries), and Think Local Act Personal (TLAP) Care Act 2014 survey. Also, surveys conducted by Action on Elder Abuse and Age UK.
10.	Other exclusion criteria	• Conference abstracts. • Papers that do not include methodological details will be excluded because they do not provide sufficient information to evaluate risk of bias/quality of study. Examples include editorials and opinion pieces. • Non-English language articles.
11.	Context	• Articles published before 2008. • Only studies conducted in care homes will be included. This excludes other congregate care settings and acute hospital settings. • Only studies conducted in the UK will be included. If insufficient* UK based studies are available for any of the interventions then studies from the following high income (according to the World Bank) countries, will be considered: Europe, including the Republic of Ireland, Australia and Canada. *For part a (quant) this means at least 5 studies with a sample size of 50 or more. *For part b (qual) this means a total of at least 10 studies providing rich data and which cover all the populations of interest.
12.	Primary outcomes (critical outcomes)	For part a) assessing effectiveness: • Workforce skills in safeguarding (as defined by the studies but examples include knowledge and skills for identifying a safeguarding concern and attitudes towards reporting). (MID: statistically significant difference) • Healthcare contacts related to suspected safeguarding concerns (for example, A&E, hospital admissions). (MID: statistically significant difference) • Reports of proven safeguarding cases. (MID: statistically significant difference) The interpretation of data on 'healthcare contacts' and 'reports of proven safeguarding cases' will be informed by the research objectives and scale direction reported by the individual studies. For part b) assessing acceptability:

ID	Field (based on PRISMA-P)	Content
		Qualitative themes will be identified from the available literature. The committee agreed the following potential themes although they are aware that data may not be located for all of them and that additional themes may be identified: • Satisfaction with the safeguarding training. • Perceived appropriateness of the training model or mode of delivery. • Positive and negative aspects of the safeguarding training. • Ideas for improvement in the content, organisation or delivery of safeguarding training. • Perception about the impact of the training on safeguarding procedures and practices within the care home. • Perception about the impact of the training on achieving the Making Safeguarding Personal outcomes.
13.	Secondary outcomes (important outcomes)	For part a) assessing effectiveness: Unnecessary transfer of care home residents between settings (for example, care home to hospital).
14.	Data extraction (selection and coding)	Screening on title and abstract and full text will be conducted by the systematic reviewer using the criteria outlined above. Because this question was prioritised for health economic analysis formal dual weeding (title and abstract) of 10% of items will be undertaken. Any discrepancies will be resolved through discussion between the first and second reviewers or by reference to a third person, for example topic advisor or senior systematic reviewer. The systematic reviewer will also carry out data extraction, which will be recorded on a standardised form (see Developing NICE guidelines: the manual section 6.4). NGA STAR software will be used for study sifting, data extraction, recording quality assessment using checklists and generating bibliographies/citations. Overall quality control will be done by the senior systematic reviewer.
15.	Risk of bias (quality) assessment	The methodological quality of each study will be assessed using a preferred checklist. For full details please see section 6.2 of Developing NICE guidelines: the manual.
16.	Strategy for data synthesis	Part a) If pairwise meta-analyses are undertaken, they will be done using Cochrane Review Manager (RevMan).

ID	Field (based on PRISMA-P)	Content	
		'GRADEpro' will be used to assess the quality of evidence for each outcome. 6.1b Confidence in each of the review findings will be evaluated using an adaptation of the 'Grading of Recommendations Assessment, Development and Evaluation - Confidence in the Evidence from Reviews of Qualitative Research (GRADE-CERQual)' developed by the international GRADE working group https://www.cerqual.org Where data allow, the quantitative and qualitative evidence will be integrated for presentation to the committee. The aim will be to provide a synthesis of data about what works in terms of safeguarding training and what is and is not acceptable about those approaches. For a full description of methods see supplementary material A.	
17.	Analysis of sub-groups	Part a: Subgroup analysis will be conducted wherever possible if the issue of heterogeneity appears relevant, for example in relation to: • Conceptually different training models. • Modes of delivery (for example, face-to-face or remote). • Intensity (for example, 1-off or ongoing programme). • Different groups of service users, for example, people with and without a dementia diagnosis, different age groups, people with severe physical disabilities. Note that as an alternative, if sufficient data are located, we will instead consider conducting meta-regression. The purpose of this would be to investigate the contribution of different intervention components to the overall effect size of the intervention. Part b: Because this is a qualitative review subgroup analysis is not possible. However, if data allow, the review will include information regarding differences in views held between certain groups or about different training, focussed on different groups and delivered via different modes.	
18.	Type and method of review	☒	Intervention
		☐	Diagnostic

ID	Field (based on PRISMA-P)	Content		
		☐	Prognostic	
		☒	Qualitative	
		☐	Epidemiologic	
		☐	Service Delivery	
		☐	Other (please specify)	
19.	Language	English		
20.	Country	England		
21.	Anticipated or actual start date	June 2019		
22.	Anticipated completion date	October 2020		
23.	Stage of review at time of this submission	Review stage	Started	Completed
		Preliminary searches	☐	☑
		Piloting of the study selection process	☐	☑
		Formal screening of search results against eligibility criteria	☐	☑
		Data extraction	☐	☑
		Risk of bias (quality) assessment	☐	☑
		Data analysis	☐	☑
24.	Named contact	**5a. Named contact** National Guideline Alliance **5b Named contact e-mail** SafeguardingAdults@nice.org.uk **5c Organisational affiliation of the review** National Institute for Health and Care Excellence (NICE) the National Guideline Alliance		
25.	Review team members	From the National Guideline Alliance: • Jennifer Francis [Technical lead]		

Safeguarding adults in care homes: evidence reviews for the effectiveness and acceptability of safeguarding training DRAFT (September 2020)

ID	Field (based on PRISMA-P)	Content
		• Ted Barker [Technical analyst] • Fiona Whiter [Technical analyst] • Paul Jacklin [Health economist] • Elise Hasler [Information scientist]
26.	Funding sources/sponsor	This systematic review is being completed by the National Guideline Alliance which receives funding from NICE.
27.	Conflicts of interest	All guideline committee members and anyone who has direct input into NICE guidelines (including the evidence review team and expert witnesses) must declare any potential conflicts of interest in line with NICE's code of practice for declaring and dealing with conflicts of interest. Any relevant interests, or changes to interests, will also be declared publicly at the start of each guideline committee meeting. Before each meeting, any potential conflicts of interest will be considered by the guideline committee Chair and a senior member of the development team. Any decisions to exclude a person from all or part of a meeting will be documented. Any changes to a member's declaration of interests will be recorded in the minutes of the meeting. Declarations of interests will be published with the final guideline.
28.	Collaborators	Development of this systematic review will be overseen by an advisory committee who will use the review to inform the development of evidence-based recommendations in line with section 3 of Developing NICE guidelines: the manual. Members of the guideline committee are available on the NICE website: https://www.nice.org.uk/guidance/indevelopment/gid-ng10107/documents
29.	Other registration details	NA
30.	Reference/URL for published protocol	https://www.crd.york.ac.uk/prospero/display_record.php?RecordID=170988
31.	Dissemination plans	NICE may use a range of different methods to raise awareness of the guideline. These include standard approaches such as: • Notifying registered stakeholders of publication. • Publicising the guideline through NICE's newsletter and alerts. • Issuing a press release or briefing as appropriate, posting news articles on the NICE website, using social media channels, and publicising the guideline within NICE.
32.	Keywords	Abuse of adults/ elder abuse/ care homes/ safeguarding training/ views and experiences
33.	Details of existing review of same topic by same authors	NA

ID	Field (based on PRISMA-P)	Content	
34.	Current review status	☐	Ongoing
		☒	Completed but not published
		☐	Completed and published
		☐	Completed, published and being updated
		☐	Discontinued
35.	Additional information	NA	
36.	Details of final publication	www.nice.org.uk	

1 *A&E: accident and emergency; CDSR: Cochrane Database of Systematic Reviews; CENTRAL: Cochrane Central Register of Controlled Trials; DARE: Database of Abstracts*
2 *of Reviews of Effects; GRADE: Grading of Recommendations Assessment, Development and Evaluation; HTA: Health Technology Assessment; MID: minimally important dif-*
3 *ference; NGA: National Guideline Alliance; NHS: National health service; NICE: National Institute for Health and Care Excellence; RCT: randomised controlled trial; RoB: risk*
4 *of bias; SD: standard deviation*
5

1 Appendix B – Literature search strategies

2 Literature search strategies for review questions H:

3   A combined search was conducted for the following 2 review questions:

4 • **What is the effectiveness of different models of training for safeguarding in**
5   **care homes?**

6 • **What is the acceptability of different models of training for safeguarding in**
7   **care homes?**
8
9   **Database(s): Medline & Embase (Multifile)**
10   Last searched on **Embase Classic+Embase** 1947 to 2019 September 04, **Ovid MED-**
11   **LINE(R) Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MED-**
12   **LINE(R) Daily and Ovid MEDLINE(R)** 1946 to September 04, 2019
13   Date of last search: 4th September 2019
14   *Multifile database codes: emczd = Embase Classic+Embase; ppez= MEDLINE(R) and Epub Ahead of*
15   *Print, In-Process & Other Non-Indexed Citations and Daily*

#	Searches
1	Elder Abuse/ use ppez
2	(elder abuse/ or elderly abuse/) use emczd
3	((elder$ or aged or old-age$ or older adult$ or old people$ or older people$ or geriatric$ or resident$) adj (abus$ or mistreat$ or neglect$ or self-neglect$)).mp.
4	((elder$ or aged or old-age$ or older adult$ or old people$ or older people$ or geriatric$ or resident$) adj3 (abus$ or mistreat$ or neglect$ or self-neglect$)).tw.
5	((vulnerable$ adult$ or vulnerable people$ or vulnerable patient$ or incompetent$ or incapacitat$ or older adult$ or older people$) adj4 (safeguard$ or protect$)).mp.
6	((abuse$ or neglect$ or self-neglect$ or violen$ or safeguard$) adj5 (dementia$ or alzheimer$ or learning disab$ or learning impair$ or learning disorder$ or intellectual disab$ or intellectual impair$ or mentally-ill or mentally ill or mentally-disabl$ or mentally disabl$ or disabl$ adult$ or disabl$ people$ or disabl$ person$ or disabl$ population$)).tw.
7	((adult adj safeguard$) or (safeguard$ adj adult$) or (adult adj protection$) or (protect$ adj adult$)).mp.
8	(adult$ social$ care$ or adult$ protective$ service$ or elder$ protective$ service$).mp.
9	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8
10	"Organization and Administration"/ use ppez
11	clinical supervision/ use emczd
12	(supervision$ adj4 (staff$ or work$ or peer or training or education or handling or risk$ or right$)).mp.
13	(supervision$ and training).mp.
14	(supervision$ adj (program$ or session$)).mp.
15	((clinical$ or professional$ or restorativ$) adj supervision$).mp.
16	(teamcoach$ or team-coach$ or team coach$ or teamlearn$ or team-learn$ or team learn$).mp.
17	(team$ adj5 intervention$).mp.
18	(practice adj supervis$).mp.
19	(supervision$ and (training or good practi?e or learning or development or quality assurance)).mp.
20	sub$ group$.mp.
21	Clinical Competence/ use ppez
22	clinical competence/ use emczd
23	(reflective$ adj (practice$ or learning or process$ or approach$ or framework$ or intervention$ or question$ or point$ or assignment$ or exercise$ or journal$ or essay$ or review$ or account$ or analy$ or online)).mp.
24	((critical$ or case$) adj reflect$).mp.
25	*Education/ or Education, Continuing/ or Education, Medical/ or Education, Nursing/ or Education, Medical, Continuing/ or Education, Nursing, Continuing/
26	25 use ppez
27	*education/ or continuing education/ or medical education/ or nursing education/
28	27 use emczd
29	Health Knowledge, Attitudes, Practice/ use ppez
30	training/ use emczd
31	"education and training".mp.
32	"learning and development".mp.
33	"knowledge and training".mp.
34	(organi?ation$ adj learn$).mp.
35	((training or education$ or competenc$ or skill or skills) adj3 (model$ or program$ or workshop$ or framework$ or

#	Searches
	module$ or curricul$ or intervention$ or need or needs or requirement$)).mp.
36	embed$.mp.
37	"core competenc$".mp.
38	coaching.mp.
39	capacity building.mp.
40	((one-to-one or face-to-face) adj3 training).mp.
41	(elearn$ or e-learn$).mp.
42	learning/
43	*Leadership/ use ppez
44	*leadership/ use emczd
45	Personnel Management/ use ppez
46	personnel management/ use emczd
47	Organizational Culture/ use ppez
48	organizational culture/ use emczd
49	leadership.mp.
50	(staff adj (educat$ or learn$ or train$ or develop$)).mp.
51	(workforce$ adj2 (educat$ or learn$ or train$ or develop$ or transform$)).mp.
52	"well-led".mp.
53	(awareness adj train$).mp.
54	(train adj3 trainer$).mp.
55	lived experience.mp.
56	(safeguard$ adj2 train$).mp.
57	(supervis$ or competenc$ or reflect$ or educat$ or knowledge$ or train$ or skills or awareness).m_titl.
58	10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 26 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41 or 42 or 43 or 44 or 45 or 46 or 47 or 48 or 49 or 50 or 51 or 52 or 53 or 54 or 55 or 56 or 57
59	9 and 58
60	limit 59 to english language
61	limit 60 to yr="2008 -Current" General exclusions filter applied.

1

2 **Database(s): Cochrane Library**
3 Last searched on **Cochrane Database of Systematic Reviews**, Issue 9 of 12, Sept 2019
4 **Cochrane Central Register of Controlled Trials**, Issue 9 of 12, Sept 2019
5 Date of last search: 9th September 2019

#	Searches
#1	MeSH descriptor: [Elder Abuse] this term only
#2	(((elder* or aged or old-age* or "older adult*" or "old people*" or "older people*" or geriatric* or resident*) NEAR/3 (abus* or mistreat* or neglect* or self-neglect*))):ti,ab,kw
#3	((("vulnerable* adult*" or "vulnerable people*" or "vulnerable patient*" or incompetent* or incapacitat* or "older adult*" or "older people*") NEAR/4 (safeguard* or protect*))):ti,ab,kw
#4	(((abuse* or neglect* or self-neglect* or violen* or safeguard*) NEAR/5 (dementia* or alzheimer* or "learning dis-ab*" or "learning impair*" or "learning disorder*" or "intellectual disab*" or "intellectual impair*" or mentally-ill or "mentally ill" or mentally-disabl* or "mentally disabl*" or "disabl* adult*" or "disabl* people*" or "disabl* person*" or "disabl* population*"))):ti,ab,kw
#5	((("adult safeguard*") or ("safeguard* adult*") or ("adult protection*") or ("protect* adult*"))):ti,ab,kw
#6	(("adult* social* care*" or "adult* protective* service*" or "elder* protective* service*")):ti,ab,kw
#7	#1 OR #2 OR #3 OR #4 OR #5 OR #6 Publication Year from 2008 to current

6

7 **Database(s): Cinahl Plus**
8 Date of last search: 9th September 2019

#	Searches
S46	S45 Limiters - Publication Year: 2008-2019; English Language
S45	S7 AND S44
S44	S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21 OR S22 OR S23 OR S24 OR S25 OR S26 OR S27 OR S28 OR S29 OR S30 OR S31 OR S32 OR S33 OR S34 OR S35 OR S36 OR S37 OR S38 OR S39 OR S40 OR S41 OR S42 OR S43
S43	TI (supervis* or competenc* or reflect* or educat* or knowledge* or train* or skills or awareness)
S42	TI (safeguard* N2 train*) OR AB (safeguard* N2 train*)
S41	TI "lived experience" OR AB "lived experience"
S40	TI (train N3 trainer*) OR AB (train N3 trainer*)
S39	TI (awareness N1 train*) OR AB (awareness N1 train*)
S38	TI "well-led" OR AB "well-led"
S37	TI (workforce* N2 (educat* or learn* or train* or develop* or transform*)) OR AB (workforce* N2 (educat* or learn* or train* or develop* or transform*))
S36	TI (staff N1 (educat* or learn* or train* or develop*)) OR AB (staff N1 (educat* or learn* or train* or develop*))
S35	TI leadership OR AB leadership
S34	(MH "Organizational Culture")

Safeguarding adults in care homes: evidence reviews for the effectiveness and acceptability of safeguarding training DRAFT (September 2020)

#	Searches
S33	(MH "Personnel Management")
S32	(MM "Leadership")
S31	(MH "Learning")
S30	TI (elearn* or e-learn*) OR AB (elearn* or e-learn*)
S29	TI ((one-to-one or face-to-face) N3 training) OR AB ((one-to-one or face-to-face) N3 training)
S28	TI "capacity building" OR AB "capacity building"
S27	TI coaching OR AB coaching
S26	TI "core competenc*" OR AB "core competenc*"
S25	TI embed* OR AB embed*
S24	TI ((training or education* or competenc* or skill or skills) N3 (model* or program* or workshop* or framework* or module* or curricul* or intervention* or need or needs or requirement*)) OR AB ((training or education* or compe-tenc* or skill or skills) N3 (model* or program* or workshop* or framework* or module* or curricul* or intervention* or need or needs or requirement*))
S23	TI (organi?ation* N1 learn*) OR AB (organi?ation* N1 learn*)
S22	TI ("education and training") OR ("learning and development") OR ("knowledge and training") OR AB ("education and training") OR ("learning and development") OR ("knowledge and training")
S21	(MH "Education, Continuing") OR (MM "Education") OR (MH "Education, Medical") OR (MH "Education, Medical, Continuing") OR (MH "Education, Nursing") OR (MH "Education, Nursing, Continuing")
S20	TI ((critical* or case*) N1 reflect*) OR AB ((critical* or case*) N1 reflect*)
S19	TI (reflective* N1 (practice* or learning or process* or approach* or framework* or intervention* or question* or point* or assignment* or exercise* or journal* or essay* or review* or account* or analy* or online)) OR AB (reflective* N1 (practice* or learning or process* or approach* or framework* or intervention* or question* or point* or assignment* or exercise* or journal* or essay* or review* or account* or analy* or online))
S18	(MH "Clinical Competence")
S17	TI ("sub* group*") OR AB ("sub* group*")
S16	TI (supervision* and (training or "good practi?e" or learning or development or "quality assurance")) OR AB (supervi-sion* and (training or "good practi?e" or learning or development or "quality assurance"))
S15	TI (practice N1 supervis*) OR AB (practice N1 supervis*)
S14	TI (team* N5 intervention*) OR AB (team* N5 intervention*)
S13	TI (teamcoach* or team-coach* or "team coach*" or teamlearn* or team-learn* or "team learn*") OR AB (teamcoach* or team-coach* or "team coach*" or teamlearn* or team-learn* or "team learn*")
S12	TI ((clinical* or professional* or restorativ*) N1 supervision*) OR AB ((clinical* or professional* or restorativ*) N1 supervision*)
S11	TI (supervision* N1 (program* or session*)) OR AB (supervision* N1 (program* or session*))
S10	TI (supervision* and training) OR AB (supervision* and training)
S9	TI (supervision* N4 (staff* or work* or peer or training or education or handling or risk* or right*)) OR AB (supervi-sion* N4 (staff* or work* or peer or training or education or handling or risk* or right*))
S8	(MH "Clinical Supervision")
S7	S1 OR S2 OR S3 OR S4 OR S5 OR S6
S6	TI ("adult* social* care*" or "adult* protective* service*" or "elder* protective* service*") OR AB ("adult* social* care*" or "adult* protective* service*" or "elder* protective* service*")
S5	TI ((adult N1 safeguard*) or (safeguard* N1 adult*) or (adult N1 protection*) or (protect* N1 adult*)) OR AB ((adult N1 safeguard*) or (safeguard* N1 adult*) or (adult N1 protection*) or (protect* N1 adult*))
S4	TI ((abuse* or neglect* or self-neglect* or violen* or safeguard*) N5 (dementia* or alzheimer* or "learning disab*" or "learning impair*" or "learning disorder*" or "intellectual disab*" or "intellectual impair*" or mentally-ill or "mentally ill" or mentally-disabl* or "mentally disabl*" or "disabl* adult*" or "disabl* people*" or "disabl* person*" or "disabl* popula-tion*")) OR AB ((abuse* or neglect* or self-neglect* or violen* or safeguard*) N5 (dementia* or alzheimer* or "learn-ing disab*" or "learning impair*" or "learning disorder*" or "intellectual disab*" or "intellectual impair*" or mentally-ill or "mentally ill" or mentally-disabl* or "mentally disabl*" or "disabl* adult*" or "disabl* people*" or "disabl* person*" or "disabl* population*"))
S3	TI (("vulnerable* adult*" or "vulnerable people*" or incompetent* or incapacitat* or "older adult*" or "older people*") N3 (safeguard* or protect*)) OR AB (("vulnerable* adult*" or "vulnerable people*" or incompetent* or incapacitat* or "older adult*" or "older people*") N3 (safeguard* or protect*))
S2	TI ((elder* or aged or old-age* or "older adult*" or "old people*" or "older people*" or geriatric* or resident*) N3 (abus* or mistreat* or neglect* or self-neglect*)) OR AB ((elder* or aged or old-age* or "older adult*" or "old people*" or "old-er people*" or geriatric* or resident*) N3 (abus* or mistreat* or neglect* or self-neglect*))
S1	(MH "Elder Abuse")

1

2 **Database(s): Social Policy and Practice, PsycINFO** 1806 to August Week 4 2019

3 Date of last search: 4th September 2019

#	Searches
1	((elder$ or aged or old-age$ or older adult$ or old people$ or older people$ or geriatric$ or resident$) adj (abus$ or mistreat$ or neglect$ or self-neglect$)).mp.
2	((elder$ or aged or old-age$ or older adult$ or old people$ or older people$ or geriatric$ or resident$) adj3 (abus$ or mistreat$ or neglect$ or self-neglect$)).tw.
3	((vulnerable$ adult$ or vulnerable people$ or vulnerable patient$ or incompetent$ or incapacitat$ or older adult$ or older people$) adj4 (safeguard$ or protect$)).mp.
4	((abuse$ or neglect$ or self-neglect$ or violen$ or safeguard$) adj5 (dementia$ or alzheimer$ or learning disab$ or learning impair$ or learning disorder$ or intellectual disab$ or intellectual impair$ or mentally-ill or mentally ill or men-

#	Searches
	tally-disabl$ or mentally disabl$ or disabl$ adult$ or disabl$ people$ or disabl$ person$ or disabl$ population$)).tw.
5	((adult adj safeguard$) or (safeguard$ adj adult$) or (adult adj protection$) or (protect$ adj adult$)).mp.
6	(adult$ social$ care$ or adult$ protective$ service$ or elder$ protective$ service$).mp.
7	1 or 2 or 3 or 4 or 5 or 6
8	(supervision$ adj4 (staff$ or work$ or peer or training or education or handling or risk$ or right$)).mp.
9	(supervision$ and training).mp.
10	(supervision$ adj (program$ or session$)).mp.
11	((clinical$ or professional$ or restorativ$) adj supervision$).mp.
12	(teamcoach$ or team-coach$ or team coach$ or teamlearn$ or team-learn$ or team learn$).mp.
13	(team$ adj5 intervention$).mp.
14	(practice adj supervis$).mp.
15	(supervision$ and (training or good practi?e or learning or development or quality assurance)).mp.
16	sub$ group$.mp.
17	(reflective$ adj (practice$ or learning or process$ or approach$ or framework$ or intervention$ or question$ or point$ or assignment$ or exercise$ or journal$ or essay$ or review$ or account$ or analy$ or online)).mp.
18	((critical$ or case$) adj reflect$).mp.
19	"education and training".mp.
20	"learning and development".mp.
21	"knowledge and training".mp.
22	(organi?ation$ adj learn$).mp.
23	((training or education$ or competenc$ or skill or skills) adj3 (model$ or program$ or workshop$ or framework$ or module$ or curricul$ or intervention$ or need or needs or requirement$)).mp.
24	embed$.mp.
25	"core competenc$".mp.
26	coaching.mp.
27	capacity building.mp.
28	((one-to-one or face-to-face) adj3 training).mp.
29	(elearn$ or e-learn$).mp.
30	leadership.mp.
31	(staff adj (educat$ or learn$ or train$ or develop$)).mp.
32	(workforce$ adj2 (educat$ or learn$ or train$ or develop$ or transform$)).mp.
33	"well-led".mp.
34	(awareness adj train$).mp.
35	(train adj3 trainer$).mp.
36	lived experience.mp.
37	(safeguard$ adj2 train$).mp.
38	(supervis$ or competenc$ or reflect$ or educat$ or knowledge$ or train$ or skills or awareness).m_titl.
39	8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 26 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38
40	7 and 39
41	limit 40 to english language
42	limit 41 to yr="2008 -Current"

Databases ASSIA, IBSS, Social Science Database, Social Services Abstracts and Sociological Abstracts were also searched.

Date of last search: 10th September 2019

Grey literature databases HMIC, OpenGrey and PsyEXTRA were also searched.

Date of last search: 4th September 2019

Economics Search

Database(s): Medline & Embase (Multifile)

Embase Classic+Embase 1947 to 2019 December 03, **Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily** 1946 to December 03, 2019

Date of last search: 4th December 2019

Multifile database codes: emczd = Embase Classic+Embase; ppez= MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily

#	Searches
1	*Long-Term Care/ use ppez
2	*long term care/ use emczd
3	((long term$ or long-term$) adj care).tw.
4	Respite Care/ use ppez

Safeguarding adults in care homes: evidence reviews for the effectiveness and acceptability of safeguarding training DRAFT (September 2020)

#	Searches
5	respite care/ use emczd
6	(respite$ adj care).tw.
7	institutional practice/ use ppez
8	institutional care/ use emczd
9	exp Nursing Homes/ use ppez
10	Group Homes/ use ppez
11	nursing home/ use emczd
12	residential facilities/ use ppez
13	residential home/ use emczd
14	homes for the aged/ use ppez
15	home for the aged/ use emczd
16	(nursing adj home$1).tw.
17	(care adj home$1).tw.
18	((elderly or old age) adj2 home$1).tw.
19	((nursing or residential) adj (home$1 or facilit$)).tw.
20	(home$1 for the aged or home$1 for the elderly or home$1 for older adult$).tw.
21	residential aged care.tw.
22	("frail elderly" adj2 (facilit$ or home or homes)).tw.
23	(residential adj (care or facilit$ or institution$ or setting$ or service$ or provider$)).tw.
24	((long-term or long term) adj2 (facility or facilities)).tw.
25	((mental health or mental-health) adj (facilit$ or institution$ or setting$ or service$)).tw.
26	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25
27	Physical Abuse/ use ppez
28	physical abuse/ use emczd
29	Restraint, Physical/ use ppez
30	*Violence/ use ppez
31	*violence/ use emczd
32	emotional abuse/ use emczd
33	Sex Offenses/ use ppez
34	Rape/ use ppez
35	sexual abuse/ use emczd
36	rape/ use emczd
37	neglect/ use emczd
38	Domestic Violence/ use ppez
39	domestic violence/ use emczd
40	Spouse Abuse/ use ppez
41	Intimate Partner Violence/ use ppez
42	partner violence/ use emczd
43	exp Human Rights Abuses/ use ppez
44	exp human rights abuse/ use emczd
45	self neglect/ use emczd
46	abuse/ use emczd
47	patient abuse/ use emczd
48	((physical$ or emotional$ or sexual$ or psychological$ or financial$ or organi?tional$ or institutional$ or discriminat$ or depriv$) adj abus$).tw.
49	(domestic$ adj violen$).tw.
50	(modern$ adj3 slave$).tw.
51	(neglect or self-neglect or self neglect).tw.
52	((significant$ or persistent$ or deliberat$ or inflict$ or unexplained or non-accident$ or nonaccident$ or non-natural$) adj (injur$ or trauma$)).tw.
53	(safeguard$ or safe-guard$ or safe guard$).mp.
54	27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41 or 42 or 43 or 44 or 45 or 46 or 47 or 48 or 49 or 50 or 51 or 52 or 53
55	Elder Abuse/ use ppez
56	(elder abuse/ or elderly abuse/) use emczd
57	((elder$ or aged or old-age$ or older adult$ or old people$ or older people$ or geriatric$ or resident$) adj (abus$ or mistreat$ or neglect$ or self-neglect$)).mp.
58	((elder$ or aged or old-age$ or older adult$ or old people$ or older people$ or geriatric$ or resident$) adj3 (abus$ or mistreat$ or neglect$ or self-neglect$)).tw.
59	(adult$ social$ care$ or adult$ protective$ service$ or elder$ protective$ service$).mp.
60	(adult$ adj3 (safeguard$ or safe-guard$ or safe guard$ or protection$)).mp.
61	((vulnerable$ adult$ or vulnerable people$ or incompetent$ or incapacitat$ or older adult$ or older people$) adj3 protect$).mp.
62	((abuse$ or neglect$ or self-neglect$ or violen$ or safeguard$) adj5 (dementia$ or alzheimer$ or learning disab$ or learning impair$ or learning disorder$ or intellectual disab$ or intellectual impair$ or mentally-ill or mentally ill or mentally-disabl$ or mentally disabl$ or disabl$ adult$ or disabl$ people$ or disabl$ person$ or disabl$ popula-tion$)).tw.
63	(family adj violence$).tw,kw.

Safeguarding adults in care homes: evidence reviews for the effectiveness and acceptability of safeguarding training DRAFT (September 2020)

#	Searches
64	55 or 56 or 57 or 58 or 59 or 60 or 61 or 62 or 63
65	(elderly or old age or aged or older adult$ or frail or vulnerabl$ or mental health or mental-health or residential or institution$ or respite$ or long term$ or long-term$ or nursing home$1 or care home$1 or home care$).m_titl.
66	(abuse$ or restrain$ or violen$ or rape or neglect$ or selfneglect$ or self-neglect$ or slave$ or safeguard$ or safe-guard$ or mistreat$ or protect$ or harm$).m_titl.
67	Economics/ use ppez
68	Value of life/ use ppez
69	exp "Costs and Cost Analysis"/ use ppez
70	exp Economics, Hospital/ use ppez
71	exp Economics, Medical/ use ppez
72	Economics, Nursing/ use ppez
73	Economics, Pharmaceutical/ use ppez
74	exp "Fees and Charges"/ use ppez
75	exp Budgets/ use ppez
76	health economics/ use emczd
77	exp economic evaluation/ use emczd
78	exp health care cost/ use emczd
79	exp fee/ use emczd
80	budget/ use emczd
81	funding/ use emczd
82	budget*.ti,ab.
83	cost*.ti.
84	(economic* or pharmaco?economic*).ti.
85	(price* or pricing*).ti,ab.
86	(cost* adj2 (effective* or utilit* or benefit* or minimi* or unit* or estimat* or variable*)).ab.
87	(financ* or fee or fees).ti,ab.
88	(value adj2 (money or monetary)).ti,ab.
89	or/67-88
90	26 and 54 and 89
91	64 and 89
92	54 and 65 and 89
93	26 and 66 and 92
94	90 or 91 or 92 or 93
95	limit 94 to yr="2014 -Current"
96	Quality-Adjusted Life Years/ use ppez
97	Sickness Impact Profile/
98	quality adjusted life year/ use emczd
99	"quality of life index"/ use emczd
100	(quality adjusted or quality adjusted life year*).tw.
101	(qaly* or qal or qald* or qale* or qtime* or qwb* or daly).tw.
102	(illness state* or health state*).tw.
103	(hui or hui2 or hui3).tw.
104	(multiattibute* or multi attribute*).tw.
105	(utilit* adj3 (score*1 or valu* or health* or cost* or measur* or disease* or mean or gain or gains or index*)).tw.
106	utilities.tw.
107	(eq-5d* or eq5d* or eq-5* or eq5* or euroqual* or euro qual* or euroqual 5d* or euro qual 5d* or euro qol* or eu-roqol*or euro quol* or euroquol* or euro quol5d* or euroquol5d* or eur qol* or eurqol* or eur qol5d* or eurqol5d* or eur?qul* or eur?qul5d* or euro* quality of life or european qol).tw.
108	(euro* adj3 (5 d* or 5d* or 5 dimension* or 5dimension* or 5 domain* or 5domain*)).tw.
109	(sf36 or sf 36 or sf thirty six or sf thirtysix).tw.
110	(time trade off*1 or time tradeoff*1 or tto or timetradeoff*1).tw.
111	Quality of Life/ and ((quality of life or qol) adj (score*1 or measure*1)).tw.
112	Quality of Life/ and ec.fs.
113	Quality of Life/ and (health adj3 status).tw.
114	(quality of life or qol).tw. and Cost-Benefit Analysis/ use ppez
115	(quality of life or qol).tw. and cost benefit analysis/ use emczd
116	((qol or hrqol or quality of life).tw. or *quality of life/) and ((qol or hrqol* or quality of life) adj2 (increas* or decreas* or improv* or declin* or reduc* or high* or low* or effect or effects or worse or score or scores or change*1 or impact*1 or impacted or deteriorat*)).ab.
117	Cost-Benefit Analysis/ use ppez and cost-effectiveness ratio*.tw. and (cost-effectiveness ratio* and (perspective* or life expectanc*)).tw.
118	cost benefit analysis/ use emczd and cost-effectiveness ratio*.tw. and (cost-effectiveness ratio* and (perspective* or life expectanc*)).tw.
119	*quality of life/ and (quality of life or qol).ti.
120	quality of life/ and ((quality of life or qol) adj3 (improv* or chang*)).tw.
121	quality of life/ and health-related quality of life.tw.
122	Models, Economic/ use ppez
123	economic model/ use emczd
124	care-related quality of life.tw,kw.

Safeguarding adults in care homes: evidence reviews for the effectiveness and acceptability of safeguarding training DRAFT (September 2020)

#	Searches
125	((capability$ or capability-based$) adj (measure$ or index or instrument$)).tw,kw.
126	social care outcome$.tw,kw.
127	(social care and (utility or utilities)).tw,kw.
128	96 or 97 or 98 or 99 or 100 or 101 or 102 or 103 or 104 or 105 or 106 or 107 or 108 or 109 or 110 or 111 or 112 or 113 or 114 or 115 or 116 or 117 or 118 or 119 or 120 or 121 or 122 or 123 or 124 or 125 or 126 or 127
129	26 and 54 and 128
130	64 and 128
131	54 and 65 and 128
132	26 and 66 and 128
133	129 or 130 or 131 or 132
134	95 or 133

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2 **Database(s): CRD: NHS Economic Evaluation Database (NHS EED), HTA Database**

3 Date of last search: 4th December 2019

Line	Search
1	MeSH DESCRIPTOR Long-Term Care EXPLODE ALL TREES
2	((((long term* or long-term*) NEAR1 care)))
3	MeSH DESCRIPTOR Respite care EXPLODE ALL TREES
4	((respite* NEAR1 care))
5	MeSH DESCRIPTOR institutional practice EXPLODE ALL TREES
6	MeSH DESCRIPTOR Nursing Homes EXPLODE ALL TREES
7	MeSH DESCRIPTOR Group Homes EXPLODE ALL TREES
8	MeSH DESCRIPTOR residential facilities EXPLODE ALL TREES
9	MeSH DESCRIPTOR homes for the aged EXPLODE ALL TREES
10	((nursing NEAR1 home*))
11	((care NEAR1 home*))
12	(((elderly or old age) NEAR2 home*))
13	(((nursing or residential) NEAR1 (home* or facilit*)))
14	((home* for the aged or home* for the elderly or home* for older adult*))
15	(residential aged care)
16	(("frail elderly" NEAR2 (facilit* or home or homes)))
17	((residential NEAR1 (care or facilit* or institution* or setting* or service* or provider*)))
18	(((long-term or long term) NEAR2 (facility or facilities)))
19	(((mental health or mental-health) NEAR1 (facilit* or institution* or setting* or service*)))
20	#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19
21	MeSH DESCRIPTOR Physical Abuse EXPLODE ALL TREES
22	MeSH DESCRIPTOR Restraint, Physical EXPLODE ALL TREES
23	MeSH DESCRIPTOR Violence EXPLODE ALL TREES
24	MeSH DESCRIPTOR Sex Offenses EXPLODE ALL TREES
25	MeSH DESCRIPTOR Rape EXPLODE ALL TREES
26	MeSH DESCRIPTOR Domestic Violence EXPLODE ALL TREES
27	MeSH DESCRIPTOR Spouse Abuse EXPLODE ALL TREES
28	MeSH DESCRIPTOR Intimate Partner Violence EXPLODE ALL TREES
29	MeSH DESCRIPTOR Human Rights Abuses EXPLODE ALL TREES
30	(((physical* or emotional* or sexual* or psychological* or financial* or organisational* or organizational* or institutional* or discriminat* or depriv*) NEAR1 abus*))
31	((domestic* NEAR1 violen*))
32	((modern* NEAR3 slave*))
33	((neglect or self-neglect or self neglect))
34	(((significant* or persistent* or deliberat* or inflict* or unexplained or non-accident* or nonaccident* or non-natural*) NEAR1 (injur* or trauma*)))
35	((safeguard* or safe-guard* or safe guard*))
36	#21 OR #22 OR #23 OR #24 OR #25 OR #26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32 OR #33 OR #34 OR #35
37	MeSH DESCRIPTOR Elder Abuse EXPLODE ALL TREES
38	(((elder* or aged or old-age* or older adult* or old people* or older people* or geriatric* or resident*) NEAR3 (abus* or mistreat* or neglect* or self-neglect*)))
39	((adult* social* care* or adult* protective* service* or elder* protective* service*))
40	((adult* NEAR3 (safeguard* or safe-guard* or safe guard* or protection*)))
41	(((vulnerable* adult* or vulnerable people* or incompetent* or incapacitat* or older adult* or older people*) NEAR3 protect*))
42	(((abuse* or neglect* or self-neglect* or violen* or safeguard*) NEAR5 (dementia* or alzheimer* or learning disab* or learning impair* or learning disorder* or intellectual disab* or intellectual impair* or mentally-ill or mentally ill or mentally-disabl* or mentally disabl* or disabl* adult* or disabl* people* or disabl* person* or disabl* population*)))
43	((family NEAR1 violence*))
44	#37 OR #38 OR #39 OR #40 OR #41 OR #42 OR #43
45	((elderly or old age or aged or older adult* or frail or vulnerabl* or mental health or mental-health or residential or

Safeguarding adults in care homes: evidence reviews for the effectiveness and acceptability
of safeguarding training DRAFT (September 2020)

Line	Search
	institution* or respite* or long term* or long-term* or nursing home* or care home* or home care*)):TI
46	((abuse* or restrain* or violen* or rape or neglect* or selfneglect* or self-neglect* or slave* or safeguard* or safe-guard* or mistreat* or protect* or harm*)):TI
47	#20 AND #36
48	#20 AND #46
49	#36 AND #45
50	#44 OR #47 OR #48 OR #49
51	* IN NHSEED, HTA
52	#50 AND #51
53	((care-related quality of life)) IN NHSEED, HTA
54	((((capability* or capability-based*) NEAR1 (measure* or index or instrument*)))) IN NHSEED, HTA
55	((social care outcome*)) IN NHSEED, HTA
56	((social care NEAR (utility or utilities))) IN NHSEED, HTA
57	#52 OR #53 OR #54 OR #55 OR #56

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Safeguarding adults in care homes: evidence reviews for the effectiveness and acceptability of safeguarding training DRAFT (September 2020)

1 Appendix C – Evidence study selection

2 **Study selection for review questions H:**

3 • **What is the effectiveness of different models of training for safeguarding in**
4 **care homes?**

5 • **What is the acceptability of different models of training for safeguarding in**
6 **care homes?**

7 **Figure 3:   Study selection flow chart**

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   │  Full copies retrieved│          │  Excluded, N=3021        │
   │  and assessed for eli-│          │  (not relevant population,│
   │  gibility, N=62       │          │  design, intervention, com-│
   │                       │          │  parison, outcomes, unable│
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│ Publications │ │ Publications     │
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│ N=7          │ │ (refer to excluded│
│              │ │ studies list)    │
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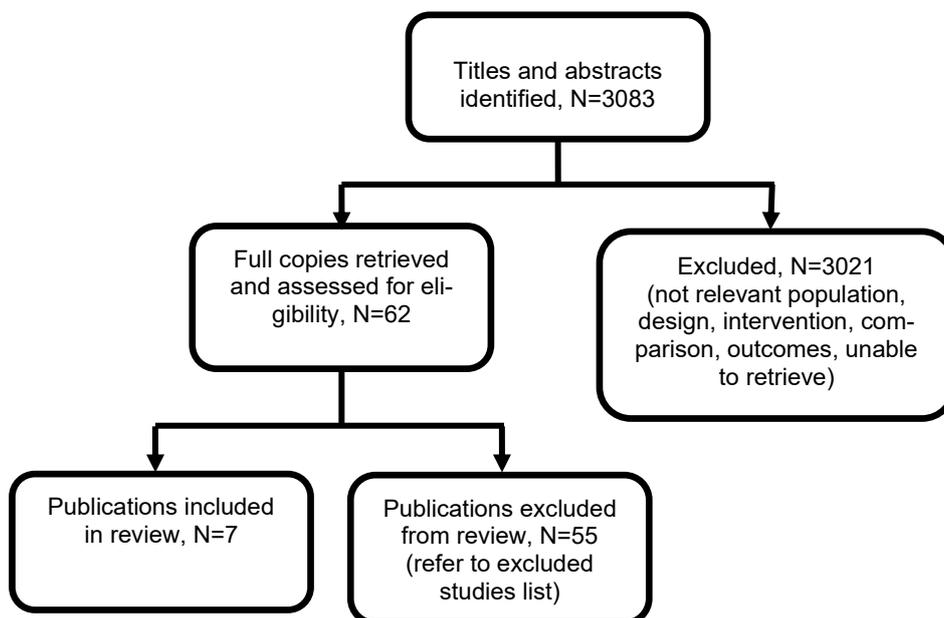
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1 Appendix D – Evidence tables

2 Evidence tables for review questions H:

3 • **What is the effectiveness of different models of training for safeguarding in care homes?**

4 • **What is the acceptability of differet models of training for safeguarding in care homes?**

5 **Table 5: Evidence tables**

Study details	Participants	Intervention/control	Methods	Outcomes and results	Comments
Full citation Campbell, M., Adult protection training for community nurses: evaluating knowledge following delivery using participant-favoured training methods. Journal of Adult Protection 16, 17-28, 2014 **Ref Id** 1107410 **Aim of the study** To "…measure nurses' knowledge about Adult Support and Protection (Scotland) Act 2007 before and after a one-day training course using participants' favoured methods of training activities." (p	**Sample size** Community nurses recruited through negotiation with area Clinical Nurse Managers. (self-selecting): N=22; 18 took part in all stages of the research (the training needs analysis, training preferences questionnaire, attendance at the training day, completion of the pre- and post-training knowledge questionnaire and evaluation form). **Characteristics** Participants were community nurses working in 1 NHS area (with an estimated population of around 500,000) recruited from a range of	**Intervention** One day training session focusing on the Adult Support and Protection (Scotland) Act 2007. No further details regarding the content of the training are provided. The authors note that the first half hour of the session provided a summary of staff responsibilities in order "… to meet the mandatory requirement set by NHS authority for all staff to attend Adult Support and Protection training …" (p 21). They also note that the methods used were based on participants expressed training preferences identified through a survey ad-	**Data collection** Participants completed an online 40 item questionnaire under test conditions (1 hour limit, but no restriction on access to written materials or other sources of external information). The questionnaire included both multiple choice questions and true/false questions. **Outcomes** Knowledge of the Adult Support and Protection Act and its implementation (measured under test conditions pre and post training, maximum score 100).	Knowledge of the Adult Support and Protection Act and its implementation (pre versus post training): Z = 3.738, *p* = 0.000). Mean average: Pre-training 51.2, SD 7.8; post-training 65.6, SD 8.6. Median score: Pre-training 52.5; post-training 67.5. Range of scores: Pre-training 32.5-60; post-training 45-75. All participants showed individual improvement in scores at T2 when compared with T1. Individual increases ranged from 2.5 to 27.5 per cent.	**Limitations (assessed using the ROBINS-I 'risk of bias' checklist for non-randomised studies of interventions)** **Pre-intervention** **Bias because of confounding:** Serious risk of bias. No consideration of confounders. **Bias in selection of participants into the study:** Low risk of bias. **Bias in classification of interventions:** Low risk of bias. **Post-intervention** **Bias because of devi-**

Study details	Participants	Intervention/control	Methods	Outcomes and results	Comments
17) **Country/ies where study carried out** Scotland. **Study type** Before and after study. **Study dates** Not reported. **Source of funding** Queens Nursing Institute Community Project.	disciplines. From learning disability, mental health and general adult. Of the 18 participants who took part in all stages: Sex: Male n=3; female n=15. Age: Range = 30-61; mean = 44. Previous experience of post-registration training in Adult Support and Protection (half day session): n=17. Professional remits as follows: Community Learning Disability Nurses n=9; Community Psychiatric Nurses (Older People) n=2; Inpatient Services; n=1; District Nurse n=1; Community Psychiatric Nurse (Adult) n=1; Primary Care Mental Health n=1; Community Health Partnership n=1; Accident and Emergency n=1; Team Leader Community Learning Disability Team n=1. Reasons for withdrawal	ministered in advance of the session.	**Follow-up** Interval between measurements not reported. **Statistical analysis** Wilcoxon signed-rank test.	There was no relationship between the time taken to complete the knowledge questionnaire and final scores.	ations from intended **interventions:** Serious risk of bias. No consideration of preparatory phase of intervention, and test conditions for pre and post measures allowed access to external resources. **Bias because of missing data:** Low risk of bias. **Bias in measurement of outcomes:** Moderate risk of bias. No details re scoring methods for the questionnaire used are provided. **Bias in selection of the reported result:** Low risk of bias. **Overall risk of bias:** Critical.

Study details	Participants	Intervention/control	Methods	Outcomes and results	Comments
	given included: increased workload, lack of allowance of work time to complete the project, staff shortages, failure to read e-mails in time, and illness. **Inclusion criteria** Not reported. **Exclusion criteria** Not reported.				
Full citation Cooper, C., Huzzey, L., Livingston, G., The effect of an educational intervention on junior doctors' knowledge and practice in detecting and managing elder abuse. International Psychogeriatrics 24, 1447–1453, 2012 **Ref Id** 942910 **Aim of the study** To test the hypothesis that "… a brief educational seminar would improve knowledge about the detection and management of suspected elder abuse by	**Sample size** Trainee doctors: N=40. **Characteristics** Participants were doctors on psychiatry or general practice training programs, currently working in psychiatry in 2 NHS trusts covering inner city London and suburban areas of outer London, Middlesex, and Essex in the UK. The trusts provide all NHS hospital and community secondary psychiatric care to those living in their catchment areas. Sex: Male n=19 (47.5%).	**Intervention** 20-minute education session described by the authors as a "… didactic standardised slide presentation, tailored to trainee doctors …" (p 1448). The content covered – definitions, prevalence and risk factors for abuse of older people; detection and early intervention; the MCA; asking about abuse and screening for abuse sensitively during routine consultations; keeping clear and timely documentation; 'the limits of confidentiality'; and local reporting procedures.	**Data collection** Data collected via a number of questionnaires administered in person and via email. **Outcomes** Identification of abuse measured using the Caregiver Scenario Questionnaire. The CSQ focuses on strategies for managing challenging behaviour in a person with dementia. A vignette is provided with a list of 14 possible management strategies. Four of these are defined as abusive by the World Health Organisation Centre for Interdiscipli-	**Identification of abuse measured using (CSQ)** Number of definitely abusive strategies identified: n=39, pre-intervention score median = 3.3 (1.2 IQR), post-intervention score = 4.0 (1.0 IQR), Wilcoxon signed rank test = 3.0, df 38, p = 0.003. Number of possibly abusive strategies identified: n=40, pre-intervention score mean 4.0 (3.5 SD), post-intervention score 5.6 (4.1 SD), paired t-test 2.1, df 39, p = 0.043.	**Limitations (assessed using the ROBINS-I 'risk of bias' checklist for non-randomised studies of interventions)** **Pre-intervention** **Bias because of confounding:** Serious risk of bias. No consideration of confounders. **Bias in selection of participants into the study:** Low risk of bias. **Bias in classification of interventions:** Low risk of bias. **Post-intervention**

Study details	Participants	Intervention/control	Methods	Outcomes and results	Comments
UK psychiatric trainees." (p 1448) **Country/ies where study carried out** United Kingdom. **Study type** Before and after study. **Study dates** Not reported. **Source of funding** Not reported.	Ethnicity: Asian or Asian British n=23 (57.5%); White, British n=7 (17.5%); White, other n=5 (12.5%); Other or mixed ethnicity n=5 (12.5%). Age: n=23 between ages of 24 and 34 (57.5%); n=15 (37.5%) between ages of 35 and 44, n=2 (5%) between the ages of 45 and 54. Trainee status: n=21 (52.5%) in first 3 years of specialist psychiatric training; n=13 (32.5%) were 'more experienced trainees …'; n=4 (10%) General Practice trainees; n=2 (5%) pre-registration doctors working in first psychiatry post; n=26 (65%) had previously undertaken a 6 month post in Old Age Psychiatry. Previous training in abuse of older people: n=6 (15%) participants recalled prior training on abuse of older people. The authors report	The session also included the use of an 8-minute film produced by Action on Elder Abuse promoting awareness of abuse. The intervention was scheduled within mandatory academic teaching for junior trainees.	nary Gerontology, 5 are defined as possibly abusive, and 5 as not abusive. Participants are asked to rate each strategy on a 6-point Likert scale. Possible responses are: 'Good idea and helpful; possibly useful; not sure; unlikely to help; bad idea but not abusive; abusive.' Knowledge regarding abuse and management of potentially abusive situations measured using the Knowledge and Management of Abuse questionnaire. This measures staff-applied knowledge and practice regarding identification and management of potentially abusive situations. The wording of this was modified slightly to make the scenarios more applicable to trainee doctors. Trainees were asked to describe how they would manage each of 6 scenarios and their responses were marked using a	Staff-applied knowledge and practice regarding identification and management of potentially abusive situations (KAMA): n= 40, pre-intervention score mean 13.1 (4.2 SD), post-intervention score 15.3 (4.8 SD), paired t-test 3.4, df 39, p = 0.002. Frequency with which participants were considering abuse when assessing older people (pre versus post): Wilcoxon signed rank test, z = 2.8, p = 0.006 Reported level of confidence in managing abuse (pre versus post): z = 3.7, p < 0.001 Frequency with which participants reported that they were asking older people and their carers about abuse (pre versus post): z = 1.2, p = 0.24. Reasons given for not routinely asking about	**Bias because of deviations from intended interventions:** Serious risk of bias. Before and after study which is unlikely to be able to account for factors such secular trends, regression to the mean, and differences in the experiences of participants apart from the intervention of interest. **Bias because of missing data:** Low risk of bias. **Bias in measurement of outcomes:** Low risk of bias. **Bias in selection of the reported result:** Low risk of bias. **Overall risk of bias:** Critical.

Study details	Participants	Intervention/control	Methods	Outcomes and results	Comments
	that there was no significant difference in their baseline KAMA scores compared to those who did not report earlier training (mean 14.0 (SD 3.7) versus 12.9 (4.3), t = 0.57, df = 38, p = 0.57). **Inclusion criteria** Not reported. **Exclusion criteria** Not reported.		structured marking scheme. Higher scores indicate that respondents gave more correct answers, demonstrating more knowledge. (ICC = 0.98.) Participants' answers regarding why they did not consider or ask about abuse routinely (recorded qualitatively) **Follow-up** Baseline, immediately post-intervention, and 3 months post-intervention. **Statistical analysis** Paired t-tests and Wilcoxon signed rank tests.	abuse (n=8): Reluctance to ask 'without evidence' for suspicion (n=4); fear of offending someone or eliciting a 'bad reaction' (n=3); concerns re negative effect on doctor's relationship with patient/carer (n=2); participants level of knowledge of abuse in older people (n=2); reported difficulties in communicating with people with dementia (n=1).	
Full citation Du Mont, J., Kosaa, D., Yang, R., Determining the effectiveness of an Elder Abuse Nurse Examiner Curriculum: A pilot study Nurse. Education Today 55, 71–76, 2017 **Ref Id** 980098 **Aim of the study**	**Sample size** Sexual Assault Nurse Examiners: N=18. **Characteristics** Participants worked at 1 of 5 Sexual Assault and Domestic Violence Treatment Centres serving Ontario. Age group (years): 19 to 24 n=1 (6%); 25 to	An 8-hour training session covering the content of the Elder Abuse Nurse Examiner Curriculum and associated materials. The training was co-delivered by 2 experienced SANEs with expertise on abuse of older people who had	**Data collection** Questionnaires and surveys using 5 point Likert scales. **Outcomes** Overall knowledge/ expertise related to abuse of older people. **Follow-up** Immediately post-	Overall knowledge and expertise related to abuse of older people: pre-training mean rating 2.36; post-training mean rating 3.45; p = 0.0014. Total overall scores were calculated based on individual items assessing participants'	**Limitations (assessed using the ROBINS-I 'risk of bias' checklist for non-randomised studies of interventions)** **Pre-intervention** **Bias because of confounding:** Serious risk of bias. No consideration of confounders.

Study details	Participants	Intervention/control	Methods	Outcomes and results	Comments
"To pilot and evaluate a novel Elder Abuse Nurse Examiner Curriculum and its associated training materials for their efficacy in improving Sexual Assault Nurse Examiner (SANE)s' knowledge of elder abuse and competence in delivering care to abused older adults." p 71 **Country/ies where study carried out** Canada (included as per protocol, insufficient UK studies were included. **Study type** Before and after study. **Study dates** 2015 **Source of funding** Women's Xchange Grant: MAR15L1.	34 n=4 (22%); 35 to 44 n=2 (11%); 45 to 60 n=9 (50%); 60 plus n=2 (11%). Ethnicity: White n=18 (100%) Provide direct clinical care to clients 65 or older: Yes n=12 (71%); No n=5 (29%). Type of clinical care provided to clients 65 or older: Emergency medical care n=12 (100%); consultation with other health providers or community members n=10 (83%); follow-up care n=7 (58%); crisis counselling n=6 (50%); other n=2 (17%). NB Categories are not mutually exclusive. **Inclusion criteria** Not reported. **Exclusion criteria** Not reported.	earlier reviewed and provided feedback on the curriculum as part of its development. At the end of each section, participants answered a series of multiple choice questions. The answers to these were collated across the group and the results were displayed to enable discussion on the questions. The curriculum has 6 domains (based on 47 consensus based competencies developed using Delphi methods). These are -overview of 'older adults and abuse'; documentation, legal and legislative issues; interviewing older adults, their caregivers, and other relevant contacts; assessment; medical and forensic examination; and case summary, discharge plan, and follow-up care.	intervention. **Statistical analysis** t tests.	agreement to statements regarding self-reported knowledge and perceived skills-based competence (for example, I am able to assess for indicators of neglect, physical, sexual, psychological, and financial abuse) on a 5-point Likert scale (1 = strongly disagree, 2= disagree, 3= neither agree nor disagree, 4 =agree, 5= strongly agree, NA = not applicable). Knowledge and Skills-based Competence Pre- and Post-training (mean content domain scores) Older Adults and Abuse: pre-intervention mean score 3.53 (0.68 SD); post-intervention mean score 4.61 (0.47 SD); n=17; p < 0.0001). Documentation, legislative, and legal issues: pre-intervention mean score 2.70 (0.68 SD); post-intervention mean score 4.17 (0.52); n=18; p < 0.0001).	**Bias in selection of participants into the study:** Low risk of bias. **Bias in classification of interventions:** Low risk of bias. **Post-intervention** **Bias because of deviations from intended interventions:** Serious risk of bias. Before and after study which is unlikely to be able to account for factors such as secular trends, regression to the mean, and differences in the experiences of participants apart from the intervention of interest. **Bias because of missing data:** Low risk of bias. **Bias in measurement of outcomes:** Low risk of bias. **Bias in selection of the reported result:** Low risk of bias.

Study details	Participants	Intervention/control	Methods	Outcomes and results	Comments
				Interview with the older adult, caregiver, and other relevant contacts: pre-intervention mean score 3.40 (0.49 SD); post-intervention mean score 4.24 (0.42 SD); n=18; p < 0.0001).

Assessment: pre-intervention mean score 3.28 (0.83 SD); post-intervention mean score 4.17 (0.51); n=18; p= 0.0018).

Medical and forensic examination: pre-intervention mean score 3.83 (0.40 SD); post-intervention mean score 4.41 (0.46 SD); n=18; p = 0.0001).

Case summary, dis-charge plan, and fol-low-up care: pre-intervention mean score 3.37 (0.48 SD); post-intervention mean score 4.04 (0.49); n=17; p < 0.0001.

Satisfaction with the Elder Abuse Nurse Ex-aminer Curriculum | **Overall risk of bias:** Critical. |

Study details	Participants	Intervention/control	Methods	Outcomes and results	Comments
				training overall: Comprehensiveness of the curriculum in addressing the critical issues of abuse of older people (mean Likert rating of 4.22) Extent to which the curriculum contained the right amount of practical information (4.00) Appropriateness of materials/protocols/tools/information for level of experience and knowledge (4.28). Clarity of PowerPoint presentation and associated materials (4.28) Time allotted for the scope of material presented (4.00) Clarity of manual, protocol, and clinical tools (4.00).	
Full citation Kinderman, P., Butchard, S., Bruen, A., 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 and Delivery Research	**Sample size** Randomised sites: N=22 (n=2 withdrew because of a change in management who decided against participation, n=10 training, n=10 no training) n=439 people living with dementia (n=213 training, n=226 no	**Intervention** A 1-day training session focusing on a human rights based approach to care and the implementation of the 'Getting It Right' assessment tool, plus booster sessions to support the implementation.	**Randomisation** Web based randomisation, 1:1 ratio. **Allocation concealment** Remote and independent randomisation process and blinded allocation report.	Subjective well-being of service user/person with dementia (measured using QOL-AD): [$F(1,16.51) = 3.63$; p = 0.074]. Because it was found that proxy reports rated quality of life significantly lower than did	**Risk of bias assessed using Cochrane risk of bias tool** **Random sequence generation:** Low risk of bias. **Allocation concealment:** Low risk of bias.

Study details	Participants	Intervention/control	Methods	Outcomes and results	Comments
6, 2018 **Ref Id** 1107835 **Country/ies where the study was carried out** England **Aim of the study** To evaluate the impact of applying a human rights based approach in dementia inpatient wards and care homes on the quality of care delivered and the well-being of the person living with dementia. **Study dates** 2014-2016 **Source of funding** National Institute for Health Research	training) n=245 staff recruited. Average of 8.8 staff per unit received training (28.7%). Proportions of staff ranged from 11.6-52.4% at each site. 8 staff per site interviewed because of difficulties achieving initial aim of interviews with 50% at each site. **Characteristics** People living with dementia, their carers and the staff of NHS inpatient dementia wards and care homes. ('Carers' "... referred to family members, or significant others, of the people living with dementia"). Sites n=8 NHS dementia specific wards and 12 care homes recruited in north-west of England. Number of beds ranged from 11 to 89. Total number of staff ranged from 16 to 91. Number of day staff ranged from 16 to 73. Average number of	The 'Getting It Right' assessment tool is a person-centred care planning tool that explicitly links the FREDA (Fairness, Respect, Equality, Dignity and Autonomy) principles to areas contributing to person-centred care. The training was delivered by the joint developer of the programme (a clinical psychologist and teacher). The training is based on 'dilemma-based learning' and uses scenarios that often occur in dementia services. It includes direct learning about a human rights based approach to care as well as information regarding its practical application using the person-centred assessment tool ('Getting It Right'). The aim of the assessment tool is to create a person-centred care plan that is clearly	**Blinding** Service users, outcomes assessors and trial statistician were all blinded. **Attrition** Declined, n = 15 (9), In hospital, n = 4 (3); unavailable, n = 1 (1); death, n = 56 (16); discharged, n = 94 (62); moved to another care home, n = 2; staff felt that it was not appropriate, n = 4 (3); on home leave, n = 1 (1); no longer at care home, n = 1; no longer on respite, n = 1 **Statistical analysis** Linear mixed model. **Follow-up** 4 months post-intervention. **Outcomes** Subjective well-being of service user/person with dementia (measured using QOL-AD) Subjective well-being of carer (measured using QOL-AD) Extent to which service users felt that their hu-	self-reports, the data from these 2 sources were analysed separately. 149 service users completed measure and 256 proxies. (Baseline - Group 1 self-report n=57, proxy n=72; group 2 self-report n=45, proxy n=91; follow-up - Group 1 self-report n=56, proxy n=99; group 2 self-report n=37, proxy n=95)" Subjective well-being of carer (measured using QOL-AD): md 11.576, df 6.440, F1.850, p = 0.219, 95% CI 31.587 to 38.814, effect size 0.04. Extent to which service users felt that their human rights were being upheld (IDEA questionnaire: md –0.002, df 9.758, F 1.130, p = 0.313, 95% CI 34.492 to 39.288, effect size – 0.08. Human rights knowledge [t(30) = –7.02; p < 0.001]	**Blinding of participants and personnel:** Moderate risk of bias. Unblinding of some investigators occurred at progress meetings. **Blinding of outcome assessment:** Low risk of bias. **Incomplete outcome data:** Low risk of bias. **Selective reporting:** Low risk of bias. **Overall risk of bias:** Low.

Study details	Participants	Intervention/control	Methods	Outcomes and results	Comments
	staff on shift ranged from 4 to 22. Service users, i.e. people with dementia (at baseline) Age (years): Mean (SD) - no training n=81.2 (8.0), training n = 82.2 (7.3), total n= 81.7 (7.7) Gender: Female no training n=93 (57.1%), training n= 103 (60.9), total n=196 (59.0), Male no training n=70 (42.9), training n= 66 (39.1), total n=136 (41.0). Type of dementia: Alzheimer's disease no training n=55 (33.7), training n=67 (39.6), total n=122 (36.7); Vascular dementia no training n=46 (28.2), training n=45 (26.6), total n=91 (27.4); Dementia with Lewy bodies - no training n=7 (4.3), training n=2 (1.2); total n=9 (2.7); Mixed - no training n=19 (11.7), training n=14 (8.3), total n=33 (9.9), Fronto-temporal dementia - no training n=2 (1.2), training n= 0 (0.0), total n=2	linked to the FREDA principles. Each site received multiple copies of the tool following the session and were asked to use tool for both new and with both new and existing residents. The package also included the offer of 3 monthly booster sessions delivered by the original trainer. These were based around consultation with staff in order to discuss issues they had in using the assessment tool. No training: Treatment as usual. The authors acknowledge that this is likely to vary considerably across sites.	man rights were being upheld (IDEA questionnaire Human rights knowledge Human rights attitudes Quality of care provided, audited using Dementia care mapping (DCM).	Human rights attitudes $[t(55) = -53.87; p < 0.001]$ Quality of care provided, audited using Dementia care mapping (DCM): md 1.960, df 18.138, F 1.149, p = 0.298, SE 1.041, 95% CI 42.580 to 46.930, effect size 0.12.	

Study details	Participants	Intervention/control	Methods	Outcomes and results	Comments
	(0.6); Other - no training n=29 (17.8), training n=41 (24.3), total n=70 (21.1); Missing no training n=5 (3.1), training n=0 (0.0), total n=5 (1.5). Staff Age (years): Mean (SD) no training n=39.3 (12.3), training n=39.5 (12.0), total n=39.1 (12.6) Gender: Female no training n=94 (76.4), training n=100 (80.6), total n=194 (78.5), Male no training n=29 (23.6), training n=24 (19.4), total 53 (21.5). Ethnicity: White/white British no training n=104 (83.9), training n=113 (91.1), total n=217 (87.5), Black/black British no training n=5 (4.0), training n=0 (0.0), total n=5 (2.0), Asian/Asian British no training n=6 (4.8), training n=1 (0.8), total n=7 (2.8), Mixed no training n=3 (2.4), training n=1 (0.8), total n=4 (1.6), Other no training n=4 (3.2), train-				

Study details	Participants	Intervention/control	Methods	Outcomes and results	Comments
	ing n=4 (3.2), total n=8 (3.2), Missing no training n=2 (1.6), training n=5 (4.0), total n=7 (2.8)				
	Qualified member of staff?: Yes no training n=21 (16.9), training n=19 (15.3), total n=40 (16.1); No no training n=102 (82.3), training n= 103 (83.1), total n=205 (82.7), missing data no training n=3 (0.8), training n=2 (1.6), total n=3 (1.2)				
	Researchers report that there "… was good comparison between the groups at baseline in relation to age, gender and type of dementia diagnosed."				
	Inclusion criteria Sites: NHS dementia specific wards and care homes where caring for people with dementia is a part of the facility's 'core business' and with enough residents with dementia to fulfil study requirements.				

Safeguarding adults in care homes: evidence reviews for the effectiveness and acceptability of safeguarding training DRAFT (September 2020)

Study details	Participants	Intervention/control	Methods	Outcomes and results	Comments
	Service users: Diagnosis of dementia (no further details provided). **Exclusion criteria** Sites: Not reported. Service users: Did not have capacity to consent or a proxy.				
Full citation Ochieng, B., Ward, K., Safeguarding of vulnerable adults training: assessing the effect of continuing professional development. Nursing Management, 2018. **Ref Id** 1107889 **Aim of the study** "The broad aim of this project was to assess the effect of safeguarding of vulnerable adults continuing professional development (SOVACPD) training on nurses working in primary and secondary care." p 31 **Country/ies where study carried out** England.	**Sample size** Nurses working in primary and secondary care (recruited): N=71. **Characteristics** Sex: Male n=10; female n=41. Age group: 25-44 years n=27; 45-65 years n=24. Staff nurses and matrons working in primary and secondary care, clinical leadership and development managers, complex discharge planning nurses, ward managers, nursing home managers, and tissue viability nurses. Length of service in current role: 10 months to 21 years (range).	**Intervention** SOVA-CPD (safeguarding of vulnerable adults continuing professional development) training for nurses. The main aims of the course are to - improve leadership skills and interdisciplinary working in safeguarding adults; enable uptake of local and national safeguarding multidisciplinary guidelines; improve adult safeguarding policy and practice in the organisations in which participants were employed; and to enable sustainable improvements in adult safeguarding practice. The content focused on – safeguarding in clini-	**Data collection** Online self-administered questionnaire (closed and open ended questions). **Outcomes** Perceived acquisition of knowledge and skills; percentage of respondents. Perceived changes in practice. **Follow-up** Not reported. **Statistical analysis** Descriptive statistics only.	Perceived acquisition of knowledge and skills; percentage of respondents - Question: Following the course, to what extent were you able to do the following? Improve your competence in your current role: Not at all 0%; a little 20%; to a fair extent 40%; to a greater extent 40%. Improve skills: Not at all 0%; a little 15%; to a fair extent 25%; to a greater extent 60%. Have a greater understanding of the underlying knowledge: Not at all 0%; a little 0%; to a fair extent 24%; to a greater extent 76%. Address work-related issues in this area bet-	**Limitations (assessed using the ROBINS-I 'risk of bias' checklist for non-randomised studies of interventions)** **Pre-intervention** **Bias because of confounding:** Serious risk of bias. No consideration of confounders. **Bias in selection of participants into the study:** Low risk of bias. **Bias in classification of interventions:** Low risk of bias. **Post-intervention** **Bias because of deviations from intended interventions:** Serious risk of bias. Before and after study which is un-

Study details	Participants	Intervention/control	Methods	Outcomes and results	Comments
Study type Before and after study. **Study dates** 2015. **Source of funding** Not reported.	**Inclusion criteria:** Not reported. **Exclusion criteria:** Not reported.	cal practice, the MCA (2005) and the MHA (2007); learning disabilities; Serious Case Reviews; legal and ethical issues; leadership; and discharge planning.		ter: Not at all 0%; a little 0%; to a fair extent 30%; to a greater extent 70%. Gain familiarity with relevant legislation: Not at all 0%; a little 0%; to a fair extent 40%; to a greater extent 60%. Perceived changes in practice - Question: Since completing the course, to what extent do you do things differently as a result of the course? Not at all: 2012 class n=0; 2013 class n=0; 2014 class n=0; percentage of participants responding 0%. A little: 2012 class n=0; 2013 class n=0; 2014 class n=0; percentage of participants responding 0%. To a fair extent: 2012 class n=10; 2013 class n=4; 2014 class n=13; percentage of participants responding 53%.	likely to be able to account for factors such, secular trends, regression to the mean, and differences in the experiences of participants apart from the intervention of interest. **Bias because of missing data:** Low risk of bias. **Bias in measurement of outcomes:** Low risk of bias. **Bias in selection of the reported result:** Low risk of bias. **Overall risk of bias:** Critical.

Study details	Participants	Intervention/control	Methods	Outcomes and results	Comments
				To a greater extent: 2012 class n=4; 2013 class n=5; 2014 class n=15; percentage of participants responding 47%.	
Full citation Storey, J., Prashad, A., Recognizing, reporting, and responding to abuse, neglect, and self-neglect of vulnerable adults: an evaluation of the re:act adult protection worker basic curriculum. Journal of Elder Abuse and Neglect 30, 42-63, 2018 **Ref Id** 1007298 **Aim of the study** To evaluate the re:act basic curriculum "… to determine if learners who complete the basic curriculum demonstrate more of the five core competencies of the curriculum than those who have not completed the basic curriculum." (p 47) **Country/ies where study carried out**	**Sample size** Adult protection workers: N=157. **Characteristics** Profession: Social workers n=84, (54%), nurses n=54 (34%), occupational therapists n=5 (3%), other n=14 (9%) (n = 14) for example, physical therapists, case managers. Time in profession: Average of 6.5 years in profession (SD = 5.57, range: 0–32). Previous training in abuse of older people or had experience using the Adult Guardianship Act to protect vulnerable adults in British Columbia: n=107 (86%) **Inclusion criteria** Not reported.	**Intervention** Training on the re:act Adult Protection Worker Curriculum. The curriculum was designed to ensure that Designated Responders understand how to follow-up reports of alleged abuse or neglect and are competent (as defined by the requirements of the Adult Guardianship Act. The curriculum is based on 'adult learning principles' and is designed to be delivered in person to inter-disciplinary groups using the Train-the-Trainer approach. There are 6 basic modules in the curriculum - • Mandatory pre-requisite online module defining	**Data collection** Online survey. **Outcomes** Self-rated knowledge in identifying, reporting, and investigating cases of suspected abuse, neglect, and self-neglect of vulnerable adults. Perceived competence and knowledge about material covered in the curriculum. Respondents were asked to rate themselves on 7 aspects of their confidence and knowledge using a 10-point Likert scale, where 0 represented 'no' competence or knowledge, 5 represented 'some' competence or knowledge and 10 represented 'a great deal of' competence or knowledge.	Total average score (calculated on basis of scores for 9 questions pertaining to the vignette): Completers = 21.60 (SD = 10.64, range 0–53), non-completers = 22.25 (SD = 8.95, range 3–41), t(153) = −.37, p = .714. Knowledge about indicators of abuse, neglect and self-neglect: Completers mean 9.17 (SD 1.42), non-completers mean 6.94 (SD 1.97), t = 8.03*, df = 155, 95% CI 2.79 to 1.69, d = 1.29. Knowledge about dynamics of abuse, neglect and self-neglect: Completers mean 9.02 (SD 1.45), non-completers mean 6.77 (SD2.05), t = 7.86*, df = 155, 95% CI 2.81 to 1.68, d = 1.26.	**Limitations (assessed using the ROBINS-I 'risk of bias' checklist for non-randomised studies of interventions)** **Pre-intervention** **Bias because of confounding:** Serious risk of bias. No consideration of confounders. **Bias in selection of participants into the study:** Low risk of bias. **Bias in classification of interventions:** Moderate risk of bias. Only minimal details are provided in relation to how participants were classified as 'completers' or 'non-completers'. **Post-intervention** **Bias because of devi-**

Study details	Participants	Intervention/control	Methods	Outcomes and results	Comments
Canada (included as per protocol, insufficient UK studies were included. **Study type** Cross sectional comparative study. **Study dates** 2014 and 2015 **Source of funding** Not reported.	**Exclusion criteria** Not reported.	different types of abuse and neglect according to the Adult Guardianship Act; identification of risk factors, role of the Designated Agency and how to proceed if an employee suspects abuse, neglect or self-neglect. • Overview of the health authorities abuse and neglect policy, recommended response process and clinical tools available.	Actual competence and knowledge about material covered in the curriculum. Based on 20 multiple choice questions, 18 of which had 4 response options and 2 of which had 2 response options. Knowledge application. Assessed using vignettes. Respondents were given 1 of 2 vignettes involving the abuse, neglect, or self-neglect of a vulnerable adult. Respondents were then prompted to answer 9 questions related to how they would investigate, assess and care plan in the situation presented. Application of knowledge was assessed through respondents' answers to 9 questions about the vignette. The questions reflected the process of investigating, assessing and care planning for a vulnerable adult. Overall competence was	Knowledge about factors that make adults vulnerable to abuse: Completers mean 9.29 (SD 1.42), non-completers mean 7.32 (SD 2.04), t = 6.91*, df = 153, 95% CI 2.53 to 1.45, d = 1.12. Knowledge about documenting adult protection cases: Completers mean 7.86 (SD 2.37), non-completers mean 5.13 (SD 2.72), t = 6.37*, df = 155, 95% CI 3.59 to 1.89, d = 1.02. Competence at assessing an individual's risk for harm as a result of abuse, neglect or self-neglect: Completers mean 8.64 (SD 1.66), non-completers mean 6.58 (SD 2.56) t = 5.99*, df = 154, 95% CI 2.73 to 1.38, d = .97. Competence at conducting investigation of abuse neglect and self-neglect in accordance with the Adult Guardianship Act: Completers	**ations from intended interventions:** Serious risk of bias. No consideration of other factors that may have impacted upon results. For example, no consideration of crossover. **Bias because of missing data:** Low risk of bias. **Bias in measurement of outcomes:** Moderate risk of bias. **Bias in selection of the reported result:** Low risk of bias. **Overall risk of bias:** Critical.

Study details	Participants	Intervention/control	Methods	Outcomes and results	Comments
		• Overview of the investigation process and the influence of legislation on this, as well as the influence of family relationships, other factors to keep in mind, and the use of screening tools. • Self-neglect - legal definitions, indicators, and use of clinical tools. • Financial abuse and its dynamics, how to proceed on the basis of whether the person	graded out of 5 with 1 point given for evidence of each competency. **Follow-up** Not reported **Statistical analysis** Independent samples t-tests, chi-square analyses.	mean 7.94 (SD 2.04), non-completers mean 4.90 (SD 2.81) t = 7.61*, df = 154, 95% CI 3.83 to 2.25, d = 1.23. Competence at developing a support and assistance plan for vulnerable adult experiencing abuse, neglect or self-neglect: Completers mean 7.28 (SD 2.25), non-completers mean 4.98 (SD 2.80) t = 5.46*, df = 155, 95% CI 3.13 to 1.47, d = .88. * p < .001 Number of questions answered correctly: Completers (m = 14.91, SD = 2.59, range 7–20), non-completers (m = 12.46, SD = 2.18, range 8–18), t(155) = 5.72, p < .001, d = .92. Incorrect statements included in responses: On average Completers (M = .41, SD = .77, range: 0–4) and Non-completers (M = .38, SD = .73, range: 0–3) included less than 1 incorrect statement in	

Study details	Participants	Intervention/control	Methods	Outcomes and results	Comments
		has capacity, legislative options and when to refer to the Office of the Public Guardian and Trustee, and use of clinical tools. • Overview of care planning and care planning legislation, how to proceed if the person refuses the offer of a care plan. Each module takes around 3.5 hours to complete. Because of concerns regarding the length of time needed to complete the curriculum (17.5 hours) a condensed version was developed (13 hours).		their responses. There was no significant difference between Completers and Non-completers in the amount of incorrect information given, $t(155) = -.29$, $p = .774$.	

Study details	Participants	Intervention/control	Methods	Outcomes and results	Comments
		The authors also note that 'multi-modal learning activities were incorporated including lectures and group discussions and activities, as well as role play, reflective writing, case studies, quizzes, and video content.			

1   *CI: confidence interval; CSQ: Caregiver Scenario Questionnaire; DCM: Dementia Care Mapping tool; d: Cohen's d; df: degrees of freedom; ICC: Intraclass coefficient; IQR:*
2   *Interquartile range; KAMA: Knowledge and Management of Abuse questionnaire; MCA: Mental Capacity Act; MD: mean difference; MHA: Mental Health Act; NHS: National*
3   *Health Service; NVQ: National Vocational Qualification; QOL-AD: Quality of Life in Alzheimer's Disease scale; RoB 2: Revised Cochrane risk-of-bias tool for randomised ran-*
4   *domised trials; ROBINS-I: The Risk Of Bias In Non-randomised Studies – of assessment tool; SD: Standard deviation; SE: Standard error; SOVA-CPD: Safeguarding of Vul-*
5   *nerable Adults Continuing Professional Development.*

1

Study details	Participants	Intervention/control	Methods	Findings	Limitations
Full citation Tadd, W., Woods, R., O'Neill, M., Promoting Excellence in Care Homes. Centre for Mental Health and Society: Wrexham, 2012 **Ref Id** 853891 **Aim of the study** To "… explore the needs, knowledge and practices of the care home workforce in relation to abuse, neglect and loss of dignity and to provide a preliminary evaluation of an evidence-based training package." (p 7) **Country/ies where study carried out** United Kingdom. **Study type** Described as multi-method – included interviews, focus groups, workshops, surveys and direct observation/ethnographic research. **Study dates** Not reported.	**Sample size** N=255 (estimate – numbers not reported clearly). Interviews (n=33 care home staff), focus groups (n=29 care home managers and trainers, and n=15 residents and relatives), workshops (n=85 – background unclear), surveys (n=37 care home managers, n=56 care home workers), and direct observation (n=8 care homes). **Characteristics** Sex: Female n=27 (82%); male n=6. No qualifications: n=11 (33%) Been in post for less than a year: n=7 (21%) **Inclusion criteria** Not reported. **Exclusion criteria** Not reported.	**Intervention**: PEACH (Promoting Excellence in All Care Homes). The content of the vignette based training package covers the following topics: • Independence & control. • physical well-being / behaviour • risk and fun • disrespectful practice • impact of staff shortage on fundamental care • dealing with relatives • disrespectful communication and feeding • medication and challenging behaviour • team work • end of life care. This approach is described as promoting reflective practice through discussion with colleagues, in contrast to 'tick box', approaches to learning.	**Setting** Care homes in in a range of locations across England (urban and rural). **Sample selection** Sampling process not reported. **Data collection** Interviews, focus groups, workshops, surveys, and direct observation in care homes. **Data analysis** Inductive and comparative methods.	The authors reported data about the following themes and sub-themes: • Current status of training in the care sector: ○ Need for training – participants discussed the need for some level of basic training for care home staff. For example: "I mean training as well, like some of them haven't got the training, some – they know how to care, but not communicate with the residents, I mean training did me good with like Dementia Awareness, so I know how to respond to whatever they say, but some people are just – I mean they just don't know how to respond basically and just come off their communication and just sit down somewhere or something." (Interview with a Care assistant, Care home 7, p. 234)	**Limitations (assessed using the CASP checklist for qualitative studies)** **Clear statement of aims and appropriate methodology** Yes. **Was the research design appropriate to address the aims of the research?** Yes. **Was the recruitment strategy appropriate to the aims of the research?** Yes. An appropriate level of detail is provided with regards to the recruitment process however this is sometimes not very clearly described. **Were the data collected in a way that addressed the research issue?** Unclear. Only minimal details are provided in relation to the data collection methods and processes. Whilst the authors report that they used, interview and observational guides

Study details	Participants	Intervention/control	Methods	Findings	Limitations
Source of funding Department of Health Policy Research Programme and Comic Relief under the PANICOA initiative.		The training package also includes material and exercises relating to attitudes to ageing and conceptions of dignity. No further details are provided.		o Dissatisfaction with existing training – content – training is too focused on tasks. Training should be more 'hands on' and directly relevant to the everyday work care home staff need to do. For example, "End of life care, because in care homes we don't get that, we're not taught how to deal with end of life care. It's not just looking after the residents, looking after the families as well. We've got palliative care training coming up, which is long distance, but that's just paperwork. We need more hands on, we don't deal a lot with nurses either when they're coming in to deal with the resident, when they're on their last few hours. That's the only thing really is looking after them when they're dying." (Interview with a Care assistant, Care home 6, Tadd 2012, pp. 233)	only minimal details are provided regarding the content of these. **Has the relationship between researcher and participants been adequately considered?** Yes. **Have ethical issues been taken into consideration?** Yes. **Was the data analysis sufficiently rigorous?** Unclear. The authors description of the analysis process is not very clear and discussion of important issues such as data saturation, dealing with contradictory data and understanding the role of the researcher in this process are only briefly mentioned. **Is there a clear statement of findings?** Unclear. Whilst the authors discuss issues such as participant feedback and triangulation (albeit briefly), the findings in not clearly set out and are somewhat repetitive.

Study details	Participants	Intervention/control	Methods	Findings	Limitations
				o Dissatisfaction with existing training – NVQ Level 2 – care home managers feel that NVQ Level 2 does not meet the requirements of the care home. For example, Respondent 1: "Mmmm very disappointed when the new NVQ, the what's it called, er what, whatever it's going to be, we'll end up with a diploma. Why can't we have a degree? Hairdressers have a degree, the pharmacists …you can get degrees, but there's no degree…" Respondent 2: "The new credit…" Respondent 3: "…for care" Respondent 2: "…The new credit framework." (Focus Group with Care home owners and managers, London, 29/09/2009, p. 94) • Accessibility of training interventions: o Time needed for training – whilst care home staff and	**Value of research: (1. Contribution to literature and 2. Transferability)** 1. The authors do not discuss their findings in the context of existing literature. 2. The authors briefly discuss transferability but this is not very detailed. **Overall methodological concerns:** Serious. **Other information** N/A

Study details	Participants	Intervention/control	Methods	Findings	Limitations
				managers were on the whole receptive to new training initiatives, there were concerns regarding the ability to find time to attend these sessions. For example, "Not long enough."; "Insufficient time to peruse all of the material."; "Would have liked it to be slightly longer as there were good topics of conversation to be discussed.", "The time given is not enough to discuss other scenarios." (p. 242) ○ English language and literacy skills – care home managers believe that it is important that training packages take into consideration the language skills of participants. 'Text-based learning' is not always appropriate or accessible to staff. For example, "I had a specific incidence of a lady, a mature lady who	

Study details	Participants	Intervention/control	Methods	Findings	Limitations
				had worked in care for a number of years, came to us about three years ago and she was a typical lady with very poor literacy, good communication skills, but poor literacy and numeracy. The sort of classic scenario, very disjointed education and came out of school with no formal qualifications and she was supported to do her NVQ2, she did her basic literacy, numeracy, did fantastically well, achieved her Level 1, achieved her Level 2 in health and social care, went on and did dementia training and she blossomed … She had never been given the support or encouragement to experiment and explore those avenues and I think there's lots and lots of different areas, but there's still an awful lot of those people who have, you know, have never been given the opportunity. So, it can be that somebody has, you know, that's coming in with other challenges on commu-	

Study details	Participants	Intervention/control	Methods	Findings	Limitations
				nication, but if you know, it's looking at everybody individually. Very, very much so, isn't it, but I don't know, it's such a minefield isn't it. Such a minefield." (Focus Group with Care home managers, London, 07/07/2010) [Quote: Tadd 2012, pp. 221) o Use of case studies and vignettes – care home managers and staff reportedly find case studies and vignettes to be a useful way of learning. "Because you give people the knowledge of what you're putting over in the training…you give them the tools and then to see if they've taken it all in, you give them a scenario and see what – you know, their answers are going to be, what their thoughts are. If you're teaching, person-centred care away from task-orientated care… you can say everything, but then at the end of the training and I think it's right, I think scenari-	

Study details	Participants	Intervention/control	Methods	Findings	Limitations

				os are brilliant as assessment tools…they can provoke discussions." (Focus Group with Training Managers, Birmingham, 02/07/2010, p. 237]
				
				  o Dissatisfaction with computer based programmes – some care home staff do not enjoy e-learning sessions and prefer face-to-face and group based training.
				  o Space for discussion and uncertainty – care home managers reportedly feel that group based training that provides an opportunity for discussion and reflection is an effective learning method for care home staff.
				
				For example, "Because like in many things, sometimes things are more right than others, or more wrong than others, but not necessarily black and white, and you've got to help peo-	

Study details	Participants	Intervention/control	Methods	Findings	Limitations
				ple to cope and accept that, because often – and especially the peo-ple, and I say this with-out meaning to be de-rogatory at all, often these people like black and white. The people working the sector, they want to know what the right thing to do is, and sometimes helping them to accept uncertainty, and possibility is very important for their per-sonal development." (Focus Group with Care Home Managers, Lon-don, 07/07/2010, p. 237) ○ In house training – viewed positively because it can be arranged more flexi-bly and at a lower cost than external courses. For example, "I like in-house training myself … Because you can get quite a few staff there at one go … whereas if you're using outside like we do with our partner-ship with social services, you can't afford to send more than one or two at	

Study details	Participants	Intervention/control	Methods	Findings	Limitations
				a time. If it's mandatory training, then you could take quite a long time for all your staff to finish that mandatory training … whereas if you did it in-house in two goes, you're done. Your moving and handling, you've done your basic food hygiene, but you have to pay for that." (p. 236) o Dissemination and implementation – care home managers and staff reportedly have concerns regarding sharing learning from training packages.	

1   *NVQ: National Vocational Qualification; PEACH: Promoting Excellence in All Care Home).*

2

3

4 Appendix E – Forest plots

5 **Forest plots for review questions H:**

6 • **What is the effectiveness of different models of training for safeguarding in**
7 **care homes?**

8 • **What is the acceptability of different models of training for safeguarding in**
9 **care homes?**

10 No meta-analysis was undertaken for these 2 review questions and so there are no forest
11 plots.

12

1 Appendix F – GRADE tables

2 GRADE tables for review questions H:

3 • **What is the effectiveness of different models of training for safeguarding in care homes?**

4 • **What is the acceptability of different models of training for safeguarding in care homes?**
5

6 **Table 6: Evidence profile for comparison: training versus no training**

Quality assessment							Number of participants		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Before training	After training	Relative (95% CI)	Absolute[4]		
Subjective well-being of service user/person with dementia as measured by QOL-AD at 16 weeks (possible range 13-52, better indicated by higher values)												
1 (Kinderman 2018)	randomised trials	Low risk of bias	no serious inconsistency	no serious indirectness	serious[1]	none	213	226	-	MD 1.48 higher (7.86 lower to 10.82 higher)	HIGH	CRITICAL
Extent to which service users felt that their human rights were being upheld as measured by IDEA at 16 weeks (possible range 29-87, better indicated by lower values)												
1 (Kinderman 2018)	randomised trials	Low risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	213	226	-	MD 0.002 lower (95% CI0.002 lower to 0.006 higher)	HIGH	CRITICAL
Quality of care provided as measured by DCM at 16 weeks (scale range not clearly reported, better indicated by higher values)												
1 (Kinderman 2018)	randomised trials	Low risk of bias	no serious inconsistency	no serious indirectness	serious[1]	none	213	226	-	MD 1.960 higher (95% CI1.737 lower to 5.657 higher	HIGH	CRITICAL
Knowledge of the Adult Support and Protection Act as measured by online questionnaire at post-intervention (interval between assessments not reported)												
1 (Campbell 2014)	Before and after study	very serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	18		-	Median score - pre-training 52.5 (range 32.5-60); median score post-training 67.5 (range 45-75), $p < 0.001$	VERY LOW	CRITICAL

No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Before training	After training	Relative (95% CI)	Absolute[4]	Quality	Importance
			Quality assessment				Number of participants		Effect			
Staff-applied knowledge and practice regarding identification and management of potentially abusive situations as measured by KAMA at 3 months post-intervention (scale range not reported, better indicated by higher values)												
1 (Cooper 2012)	Before and after study	very serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	40	-		Pre-intervention mean 13.1 (4.2 SD); post-intervention mean 15.3 (4.8 SD), p = 0.002.	VERY LOW	CRITICAL
Human rights knowledge (pre versus post in intervention group) as measured by bespoke questionnaire at 16 weeks (possible range and direction of effect not reported)												
1 (Kinderman 2018)	Before and after study (as part of an RCT)	very serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	213	-		MD 2.13 lower (2.75 lower to 1.51 lower)	VERY LOW	CRITICAL
Human rights attitudes (pre versus post in intervention group) as measured by bespoke questionnaire at 16 weeks (possible range and direction of effect not reported)												
1 (Kinderman 2018)	Before and after study (as part of an RCT)	very serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	213	-		MD 3.00 lower (4.02 lower to 1.98 lower)	VERY LOW	CRITICAL
Overall competence in identifying, reporting, and investigating cases of suspected abuse, neglect, and self-neglect of vulnerable adults (range 0-5, better indicated by higher values)												
1 (Storey 2018)	Cross sectional comparative study study	very serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	109	48	-	Total average score training = 21.60 (SD = 10.64, range 0–53) versus no -training = 22.25 (SD = 8.95, range 3–41, p = .714.	VERY LOW	CRITICAL
Self-reported level of confidence in managing abuse (measured at 3 months post-intervention)												
1 (Cooper 2012)	Before and after study	very serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	40	-		p < 0.001	VERY LOW	CRITICAL
Self-reported knowledge/expertise related to abuse of older people as measured by a content evaluation of the Elder Abuse Nurse Examiner Curriculum (immediately post-training)												
1 (Du Mont 2017)	Before and after study	very serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	17	-		pre-training mean rating 2.36; post-training mean rating 3.45; p = 0.0014	VERY LOW	CRITICAL

No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Before training	After training	Relative (95% CI)	Absolute[4]	Quality	Importance
			Quality assessment				Number of participants		Effect			
Perceived acquisition of knowledge and skills, as percentage of respondents (follow-up not reported)												
1 (Ochieng 2018)	Before and after study	very serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	42	-	-	Question: Following the course, to what extent were you able to do the following? Improve your competence in your current role: Not at all 0%; a little 20%; to a fair extent 40%; to a greater extent 40%. Improve skills: Not at all 0%; a little 15%; to a fair extent 25%; to a greater extent 60%. Have a greater understanding of the underlying knowledge: Not at all 0%; a little 0%; to a fair extent 24%; to a greater extent 76%. Address work-related issues in this area better: Not at all 0%; a little 0%; to a fair extent 30%; to a greater extent 70%. Gain familiarity with relevant legislation: Not at all 0%; a little 0%; to a fair extent 40%; to a greater extent 60%.	VERY LOW	CRITICAL
Perceived changes in practice (follow-up not reported)												
1 (Ochieng 2018)	Before and after study	very serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	42	-	-	Question: Since completing the course, to what extent do you do things differently as a result of the course? Not at all: 2012 class n=0; 2013 class n=0; 2014 class n=0; percentage of participants responding 0%. A little: 2012 class n=0; 2013 class n=0; 2014 class n=0; percentage of participants responding 0%. To a fair extent: 2012 class n=10; 2013 class	VERY LOW	CRITICAL

Safeguarding adults in care homes: evidence reviews for the effectiveness and acceptability of safeguarding training DRAFT (September 2020)

No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Number of participants		Effect		Quality	Importance
							Before training	After training	Relative (95% CI)	Absolute[4]		
									-	n=4; 2014 class n=13; percentage of participants responding 53%. To a greater extent: 2012 class n=4; 2013 class n=5; 2014 class n=15; percentage of participants responding 47%.		
Identification of abuse measured using CSQ at 3 months post-intervention - Number of definitely abusive strategies identified												
1 (Cooper 2012)	Before and after study	very serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	40	-	-	Number of definitely abusive strategies identified: pre-intervention score median = 3.3 (1.2 IQR), post-intervention score = 4.0 (1.0 IQR), p = 0.003.	VERY LOW	CRITICAL
Identification of abuse measured using CSQ at 3 months post-intervention - Number of possibly abusive strategies identified												
1 (Cooper 2012)	Before and after study	very serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	40	-	-	Number of possibly abusive strategies identified: pre-intervention score mean 4.0 (3.5 SD), post-intervention score 5.6 (4.1 SD), p = 0.043.	VERY LOW	CRITICAL
Frequency with which participants were considering abuse when assessing older people (at 3 months post-intervention)												
1 (Cooper 2012)	Before and after study	very serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	40	-	-	p = 0.006	VERY LOW	CRITICAL
Frequency with which participants reported that they were asking older people and their carers about abuse (at 3 months post-intervention)												
1 (Cooper 2012)	Before and after study	very serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	40	-	-	p = 0.24	VERY LOW	CRITICAL
Reasons given for not routinely asking about abuse (at 3 months post-intervention)												
1 (Cooper 2012)	Before and after study	very serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	40	-	-	N=8 participants reported not routinely asking about abuse. Reluctance to ask 'without evidence' for suspicion (n=4); fear of offending someone or eliciting a 'bad reaction' (n=3); concerns re negative	VERY LOW	CRITICAL

No of studies	Quality assessment						Number of participants		Effect		Quality	Importance
	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Before training	After training	Relative (95% CI)	Absolute[4]		
										effect on doctor's relationship with patient/carer (n=2); participants level of knowledge of abuse of older people (n=2); reported difficulties in communicating with people with dementia (n=1).		
Satisfaction with the Elder Abuse Nurse Examiner Curriculum Training (immediately post training)												
1 (Du Mont 2017)	Before and after study	very serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	17	-		Comprehensiveness of the curriculum in addressing the critical issues of abuse of older people (mean Likert rating of 4.22); Extent to which the curriculum contained the right amount of practical information (4.00); and the appropriateness of materials/protocols/tools/information for level of experience and knowledge (4.28). Clarity of PowerPoint presentation and associated materials (4.28) Time allotted for the scope of material presented (4.00) Clarity of manual, protocol, and clinical tools (4.00).	VERY LOW	CRITICAL

1   CSQ: Caregiver Scenario Questionnaire; DCM: Dementia Care Mapping; IDEA: Identity, Dignity, Equality and Autonomy questionnaire; IQR: inter-quartile range; KAMA:
2   Knowledge and Management of Abuse questionnaire; MD: mean difference; QOL-AD: Quality of life in Alzheimer's disease; SD: standard deviation.
3   1 Evidence was downgraded by 1; 95% confidence interval crossed 1 default MID (-0.5 SD control, +0.5 SD control).
4   2 Evidence was downgraded by 2 because of very serious risk of bias in the evidence as per ROBINS-I.
5   3 Very serious imprecision, sample size below 200
6   4 For outcomes using data from before and after studies it was not possible to calculate absolute effect, therefore summary statistics or narrative results are reported.

1 **GRADE CERQual tables for review questions H:**

2 • **What is the effectiveness of different models of training for safeguarding in care homes?**

3 • **What is the acceptability of different models of training for safeguarding in care homes?**

4 **Overarching theme H1 – training interventions**

5 **Table 7: Evidence summary (GRADE-CERQual) theme H1.1: current status of training in the care sector**

Study information	Description of theme or finding	CERQUAL Quality Assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
Sub-theme H1.1.1- Need for training						
1 study • Tadd 2012 Interviews (n=33 care home staff), focus groups (n=29 care home managers and trainers, and n=15 residents and relatives), workshops (n=85 – background unclear), surveys (n=37 care home managers, n=56 care home workers), and direct observation (n=8 care homes).	Data from 1 study indicate that there is a general acknowledgement amongst care home staff and managers that basic training is required for all staff. For example: "I mean training as well, like some of them haven't got the training, some – they know how to care, but not communicate with the residents, I mean training did me good with like Dementia Awareness, so I know how to respond to whatever they say, but some people are just – I mean they just don't know how to respond basically and just come off their communication and just sit down somewhere or something." (Interview with a Care assistant, Care home 7) [Quote: Tadd 2012, pp. 234]	Serious concerns[1]	No concerns	Serious concerns[2]	Serious concerns[3]	VERY LOW
Sub-theme H1.1.2 – Dissatisfaction with existing training - content						
1 study	Data from 1 study indicate that	Serious con-	No concerns	Serious con-	Serious	VERY LOW

Study information	Description of theme or finding	CERQUAL Quality Assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
• Tadd 2012 Interviews (n=33 care home staff), focus groups (n=29 care home managers and trainers, and n=15 residents and relatives), workshops (n=85 – background unclear), surveys (n=37 care home managers, n=56 care home workers), and direct observation (n=8 care homes).	care home staff and care home managers are dissatisfied with the content of training which is often excessively task-focused. This is perceived by some as a 'tick box exercise' that has little relevance to the day to day work of care home staff. Holistic topics such as end of life care and dementia care were suggested as key. For example, "End of life care, because in care homes we don't get that, we're not taught how to deal with end of life care. It's not just looking after the residents, looking after the families as well. We've got palliative care training coming up, which is long distance, but that's just paperwork. We need more hands on, we don't deal a lot with nurses either when they're coming in to deal with the resident, when they're on their last few hours. That's the only thing really is looking after them when they're dying." (Interview with a Care assistant, Care home 6) [Quote: Tadd 2012, pp. 233]	cerns[4]		cerns[5]	concerns[6]	
Sub-theme H1.1.3 – Dissatisfaction with existing training – NVQ Level 2						
1 study • Tadd 2012 Interviews (n=33 care home staff), focus groups (n=29 care	Data from 1 study indicate that care homes managers felt that NVQ Level 2 did not meet their requirements. For exam-	Serious concerns[7]	No concerns	Serious concerns[8]	Serious concerns[9]	VERY LOW

Study information	Description of theme or finding	CERQUAL Quality Assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
home managers and trainers, and n=15 residents and relatives), workshops (n=85 – background unclear), surveys (n=37 care home managers, n=56 care home workers), and direct observation (n=8 care homes).	ple, Respondent 1: "Mmmm very disappointed when the new NVQ, the what's it called, er what, whatever it's going to be, we'll end up with a diploma. Why can't we have a degree? Hairdressers have a degree, the pharmacists …you can get degrees, but there's no degree…" Respondent 2: "The new credit…" Respondent 3: "…for care" Respondent 2: "…The new credit framework." (Focus Group with Care home owners and managers, London, 29/09/2009) [Quote: Tadd 2012, pp. 94]					

1 Serious concerns about methodological limitations of the evidence as per CASP qualitative checklist.
2 Serious concerns about the relevance of data, which relate to training covering – but not limited to – safeguarding topics.
3 Serious concerns about the adequacy of data; 1 study supported the review's findings (offering thin data).
4 Serious concerns about methodological limitations of the evidence as per CASP qualitative checklist.
5 Serious concerns about the relevance of data, which relate to training covering – but not limited to – safeguarding topics.
6 Serious concerns about the adequacy of data; 1 study supported the review's findings (offering thin data).
7 Serious concerns about methodological limitations of the evidence as per CASP qualitative checklist.
8 Serious concerns about the relevance of data, which relate to training covering – but not limited to – safeguarding topics.
9 Serious concerns about the adequacy of data; 1 study supported the review's findings (offering thin data).

Table 8: Evidence summary (GRADE-CERQual) theme H1.2: accessibility of training interventions

Study information	Description of Theme or Finding	CERQUAL Quality Assessment				
		Methodological Limitations	Coherence of findings	Relevance of evidence	Adequacy of Data	Overall Confidence
Sub-theme H1.2.1 – Time needed						
1 study • Tadd 2012 Interviews (n=33 care home	In relation to PEACH (Promoting Excellence in All Care Homes), the authors report	Serious concerns[1]	No concerns	Serious concerns[2]	Serious concerns[3]	VERY LOW

Study information	Description of Theme or Finding	CERQUAL Quality Assessment				
		Methodological Limitations	Coherence of findings	Relevance of evidence	Adequacy of Data	Overall Confidence
staff), focus groups (n=29 care home managers and trainers, and n=15 residents and relatives), workshops (n=85 – background unclear), surveys (n=37 care home managers, n=56 care home workers), and direct observation (n=8 care homes).	that most of the negative feedback received at the pilot stage related to the length of the training sessions. For example, "Not long enough." "Insufficient time to peruse all of the material." "Would have liked it to be slightly longer as there were good topics of conversation to be discussed." "The time given is not enough to discuss other scenarios." [Quote: Tadd 2012, pp. 242]					
Sub-theme H1.2.2 – consideration of literacy and English language levels						
1 study • Tadd 2012 Interviews (n=33 care home staff), focus groups (n=29 care home managers and trainers, and n=15 residents and relatives), workshops (n=85 – background unclear), surveys (n=37 care home managers, n=56 care home workers), and direct observation (n=8 care homes).	Data from 1 study indicate that care home managers believe that literacy levels should be considered when designing or planning training sessions or programmes that includes safeguarding content. For example, "I had a specific incidence of a lady, a mature lady who had worked in care for a number of years, came to us about three years ago and she was a typical lady with very poor literacy, good communication skills, but poor literacy and numeracy. The sort of classic scenario, very disjointed education and came out of school with no formal qualifications and she was supported to do her NVQ2, she did her basic literacy, numeracy,	Serious concerns[1]	No concerns	Serious concerns[2]	Serious concerns[3]	VERY LOW

Study information	Description of Theme or Finding	CERQUAL Quality Assessment				
		Methodological Limitations	Coherence of findings	Relevance of evidence	Adequacy of Data	Overall Confidence
	did fantastically well, achieved her Level 1, achieved her Level 2 in health and social care, went on and did dementia training and she blossomed … She had never been given the support or encouragement to experiment and explore those avenues and I think there's lots and lots of different areas, but there's still an awful lot of those people who have, you know, have never been given the opportunity. So, it can be that somebody has, you know, that's coming in with other challenges on communication, but if you know, it's looking at everybody individually. Very, very much so, isn't it, but I don't know, it's such a minefield isn't it. Such a minefield." (Focus Group with Care home managers, London, 07/07/2010) [Quote: Tadd 2012, pp. 221] Similar concerns were also reportedly raised regarding care home staff for whom English was not their first language. [No relevant quotes provided by Tadd 2012].					
Sub-theme H1.2.3 – Power of case studies and vignettes						
1 study • Tadd 2012 Interviews (n=33 care home	Data from 1 study indicate that care home managers and staff view the use of case studies	Serious concerns[1]	No concerns	Serious concerns[2]	Serious concerns[3]	VERY LOW

Study information	Description of Theme or Finding	CERQUAL Quality Assessment				
		Methodological Limitations	Coherence of findings	Relevance of evidence	Adequacy of Data	Overall Confidence
staff), focus groups (n=29 care home managers and trainers, and n=15 residents and relatives), workshops (n=85 – background unclear), surveys (n=37 care home managers, n=56 care home workers), and direct observation (n=8 care homes).	and vignettes positively. These were reportedly seen as a powerful learning and assessment tool by participants involved in the pilot stage of the PEACH programme. For example, "Because you give people the knowledge of what you're putting over in the training…you give them the tools and then to see if they've taken it all in, you give them a scenario and see what – you know, their answers are going to be, what their thoughts are. If you're teaching, person-centred care away from task-orientated care… you can say everything, but then at the end of the day if you're given a scenario and they say, "Well, no, breakfast is at nine" …they go to the toilet at three, you know, you haven't got anywhere…with them, but if they're thinking outside of the box by answering a scenario at the end of the training and I think it's right, I think scenarios are brilliant as assessment tools…they can provoke discussions." (Focus Group with Training Managers, Birmingham, 02/07/2010) [Quote: Tadd 2012, pp. 237]					
Sub-theme H1.2.4 – Dissatisfaction with computer based programmes						
1 study	Data from 1 study indicate that	Serious con-	No concerns	Serious con-	Serious	VERY LOW

Study information	Description of Theme or Finding	CERQUAL Quality Assessment				
		Methodological Limitations	Coherence of findings	Relevance of evidence	Adequacy of Data	Overall Confidence
• Tadd 2012 Interviews (n=33 care home staff), focus groups (n=29 care home managers and trainers, and n=15 residents and relatives), workshops (n=85 – background unclear), surveys (n=37 care home managers, n=56 care home workers), and direct observation (n=8 care homes).	care home staff do not find e-learning to be an enjoyable or useful way of learning about safeguarding. Participants reportedly felt that this was a way for care home managers to fulfill requirements on training whilst saving money. Whilst some care home staff appreciated that e-learning could be useful as a refresher tool most felt that face-to-face and group based training was more appropriate. [No relevant quotes provided by Tadd 2012]	cerns[1]		cerns[2]	concerns[3]	
Sub-theme H1.2.5 – opportunities for discussion and reflection rather than 'getting the right answer'						
1 study • Tadd 2012 Interviews (n=33 care home staff), focus groups (n=29 care home managers and trainers, and n=15 residents and relatives), workshops (n=85 – background unclear), surveys (n=37 care home managers, n=56 care home workers), and direct observation (n=8 care homes).	Data from 1 study indicate that care home managers feel that it is important that training for care home staff does not excessively focus on ensuring that trainees get 'the right answer' and instead should enable staff to reflect on their practice, recognise the importance of discussion with and become more comfortable with the uncertainty and variety that can be inherent in some aspects of care home work. For example, "Because like in many things, sometimes things are more right than others, or more wrong than others, but not necessarily black and white, and you've got to help people to cope and accept	Serious concerns[1]	No concerns	Serious concerns[2]	Serious concerns[3]	VERY LOW

Study information	Description of Theme or Finding	CERQUAL Quality Assessment				
		Methodological Limitations	Coherence of findings	Relevance of evidence	Adequacy of Data	Overall Confidence
	that, because often – and especially the people, and I say this without meaning to be derogatory at all, often these people like black and white. The people working the sector, they want to know what the right thing to do is, and sometimes helping them to accept uncertainty, and possibility is very important for their personal development." (Focus Group with Care Home Managers, London, 07/07/2010) [Quote: Tadd 2012, pp. 237]					
Sub-theme H1.2.6 – Support for in-house training						
1 study • Tadd 2012 Interviews (n=33 care home staff), focus groups (n=29 care home managers and trainers, and n=15 residents and relatives), workshops (n=85 – background unclear), surveys (n=37 care home managers, n=56 care home workers), and direct observation (n=8 care homes).	Data from 1 study indicate that care home managers believe that in-house programmes are an effective way of delivering training because it is less expensive and can be provided on a more flexible basis. For example, "I like in-house training myself … Because you can get quite a few staff there at one go … whereas if you're using outside like we do with our partnership with social services, you can't afford to send more than one or two at a time. If it's mandatory training, then you could take quite a long time for all your staff to finish that mandatory training … whereas if you did it in-house in two goes, you're	Serious concerns[1]	No concerns	Serious concerns[2]	Serious concerns[3]	VERY LOW

Study information	Description of Theme or Finding	CERQUAL Quality Assessment				
		Methodological Limitations	Coherence of findings	Relevance of evidence	Adequacy of Data	Overall Confidence
	done. Your moving and handling, you've done your basic food hygiene, but you have to pay for that." [Quote: Tadd 2012, pp. 236]					
Sub-theme H1.2.7 – Dissemination and implementation						
1 study • Tadd 2012 Interviews (n=33 care home staff), focus groups (n=29 care home managers and trainers, and n=15 residents and relatives), workshops (n=85 – background unclear), surveys (n=37 care home managers, n=56 care home workers), and direct observation (n=8 care homes).	Data from 1 study indicate that whilst care home managers and staff were on the whole receptive to new training opportunities and initiatives to improve practice with regards to safeguarding, there were concerns regarding how learning could be shared. Making materials available online; helping smaller care homes to access new training packages, offering booster sessions, and providing materials free of charge were reportedly suggested as key mechanisms.	Serious concerns[1]	No concerns	Serious concerns[2]	Serious concerns[3]	VERY LOW

1 *1 Serious concerns about methodological limitations of the evidence as per CASP qualitative checklist.*
2 *2 Serious concerns about the relevance of data, which relate to training covering – but not limited to – safeguarding topics.*
3 *Serious concerns about the adequacy of data; 1 study supported the review's findings (offering thin data).*

1 Appendix G – Economic evidence study selection

2 **Economic evidence study selection for review questions H:**

3 • **What is the effectiveness of different models of training for safeguarding in**
4 **care homes?**

5 • **What is the acceptability of different models of training for safeguarding in**
6 **care homes?**

7 A global economic literature search was undertaken for safeguarding adults in care homes.
8 This covered all 16 review questions, which were reported in 9 evidence reports in this guide-
9 line. As shown in Figure 4 below, no economic evidence was identified which was applicable
10 to this evidence review.

11

Figure 4: Economic study selection flowchart

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1 Appendix H – Economic evidence tables
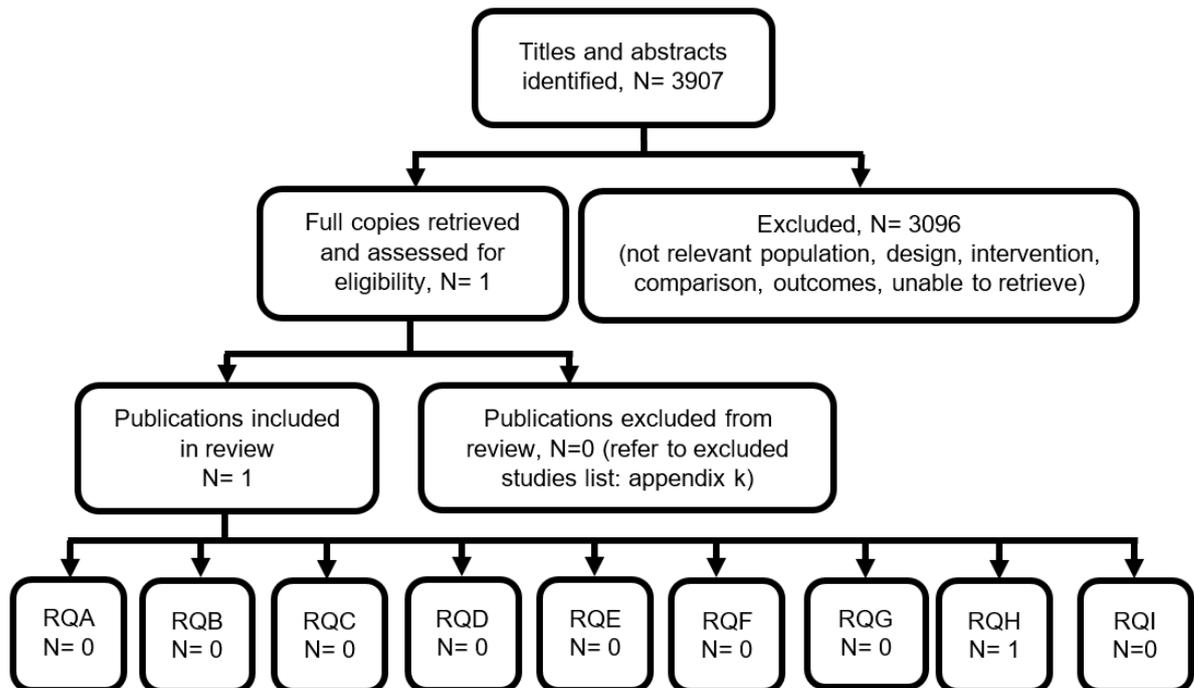
2 Economic evidence tables for review questions H:

3 • **What is the effectiveness of different models of training for safeguarding in care homes?**

4 • **What is the acceptability of different models of training for safeguarding in care homes?**

5 Table 9: Economic evidence tables for training versus no training (pre versus post)

Study details	Treatment strategies	Study population, design and data sources	Results	Comments
Author & year: Kinderman 2018 **Country:** UK **Type of economic analysis:** Cost-consequences analysis embedded in a cluster RCT **Source of funding:** This study was funded by the NIHR Health Services and Delivery Research programme	**Interventions in detail:** Human right based training intervention. Its delivery was organised in 3 parts: 1-day training delivered to staff caring for people with dementia, based on dilemma-based learning, utilising clinical scenarios that commonly occur in dementia service implementation of 'Getting It Right' assessment tool (please see Appendix D for further details) booster sessions to support the implementation. Standard of care Treatment as usual. The authors acknowledge that this is likely to vary considerably across sites.	**Population characteristics:** This study was a cluster RCT involving a population of: N=22 clusters randomised (including NHS dementia specific inpatients ward sites and care homes caring for people with dementia [n=10 training, n=10 no training][1]) N=439 people within clusters (that is people living with dementia [n=213 training, n=226 no training]) N=245 professionals[2]. **Modelling approach:** No modelling was used for the cost–consequences analysis carried-out alongside a cluster RCT. **Source of QoL and effectiveness data:**	**QALYs** No estimates of QALYs were reported. **Incremental costs with the staff training intervention:** £101 per staff member **Incremental QALYs with the staff training intervention:** No estimates of QALYs were reported. **ICER:** Not estimable **Deterministic or probabilistic sensitivity analysis:** No sensitivity analyses were reported on the robustness of the study results to methodological limitations.	**Perspective:** UK public sector and multi-agency **Currency:** GBP **Cost year:** 2014-2015 **Time horizon:** 4 months **Discounting:** Not applicable **Applicability:** This study was deemed as directly applicable to the context of the guideline.

Study details	Treatment strategies	Study population, design and data sources	Results	Comments
		Estimates of QoL and effectiveness data were obtained from a cluster RCT, with a 4 months follow-up after intervention completion, and included: people with dementia well-being (QOL-AD) family carers' well-being (WEMWBS and ZBI) people with dementia quality of care (ASCOT, and EQ-5D-3L) **Source of cost data:** Cost data were obtained from a cluster RCT, with a 4 months follow-up after intervention completion, and included: Costs associated with the staff training intervention (distinguishing between set-up/training costs and running costs)3 Healthcare resource use (for example, frequency of contacts of people with dementia with selected health and social services). These were collected using collected service use data using an adapted Client Service Receipt Inventory, at baseline and follow-up Medication usage of people with dementia Costs were all inflated to 2014-		**Limitations:** The study failed to meet most methodological quality criteria (i.e. model structure inappropriate to reflect the decision problem; lack of reporting of an appropriate incremental analysis, lack of reporting of a sensitivity analysis) and this was highly likely to change the conclusions about the economic findings. Therefore, it was deemed as having very serious limitations.

Study details	Treatment strategies	Study population, design and data sources	Results	Comments
		2015 Pound Sterling		

1   *ASCOT: Adult Social Care Outcomes Toolkit; EQ-5D-3L: 3-level version of EuroQol 5 Dimension; GBP: Pound Sterling; ICER: incremental cost-effectiveness ratio;*
2   *NIHR: National Institute for Health Research; QALY: quality adjusted life year; QoL: quality of life; QOL-AD: Quality of Life in Alzheimer's disease; RCT: ran-*
3   *domised controlled trial; WEMWBS: Warwick-Edinburgh Mental Well-being Scale; ZBI: Zarit Burden Interview.*

4

1 Appendix I – Economic evidence profiles

2 **Economic evidence profiles for review questions H:**

3 • **What is the effectiveness of different models of training for safeguarding in care homes?**

4 • **What is the acceptability of different models of training for safeguarding in care homes?**

5 **Table 10: Economic evidence profile for training versus no training (pre versus post)**

Study and country	Limitations	Applicability	Other comments	Incremental costs	Incremental effects	ICER	Uncertainty
Author & year: Kinderman 2018 **Country:** UK **Interventions:** Human right based training intervention versus standard of care	Very serious limitations[1]	Directly applicable[2]	**Type of economic analysis:** Cost-consequences analysis alongside a cluster RCT **Time horizon:** 4 months **Primary measure of outcome:** People with dementia wellbeing (QOL-AD)	£ 101 per professional	Not reported/estimable	Not reported/estimable	No sensitivity analyses were reported on the robustness of the study results to methodological limitations.
National Guideline Alliance model	Very serious limitations[3]	Directly applicable[4]	**Type of economic analysis:**	**Base case analysis (home care**	**Base case analysis (home care worker)**	**Base case analysis (home care worker)**	The results just represent various "what-if" scenarios and

Study and country	Limitations	Applicability	Other comments	Incremental costs	Incremental effects	ICER	Uncertainty
"What-if" cost-utility analysis of e-learning and face-to-face training for delivering training in the safeguarding of adults			"What-if" cost-utility analysis **Time horizon:** 1 day costs Not specified for hypothetical benefits **Primary measure of outcome:** Incremental cost per QALY	**worker)** Face-to-face training: £205 **Base case analysis (home care manager)** Face-to-face training: £239	Face-to-face training: 0.025 QALYs **Base case analysis (home care manager)** Face-to-face training: 0.025 QALYs	£8,200 per QALY **Base case analysis (home care manager)** £9,560	give no estimate of the actual ICER

1 *ICER: incremental cost-effectiveness ratio; QOL-AD: Quality of Life in Alzheimer's disease; RCT: randomised controlled trial.*
2 *1 The study failed to meet most methodological quality criteria (i.e. model structure inappropriate to reflect the decision problem; lack of reporting of an appropriate incremental*
3 *analysis, lack of reporting of a sensitivity analysis) and this was highly likely to change the conclusions about the economic findings. Therefore, it was deemed as having very*
4 *serious limitations.*
5 *2 Being a UK study and meeting most applicability criteria, this study was deemed as directly applicable to the context of the guideline*
6 *3 The study results are based on hypothetical effectiveness of training on improving knowledge and a hypothetical relationship between knowledge and improved well-being of*
7 *adult care home users*
8 *4 The model was devised to represent a population in whom the guideline recommendations would apply*
9

10

11

1 Appendix J – Economic analysis

2 **Economic analysis for review questions H:**

3 • **What is the effectiveness of different models of training for safeguarding in**
4 **care homes?**

5 • **What is the acceptability of different models of training for safeguarding in**
6 **care homes?**

7 **A "what-if" economic analysis to compare training for safeguarding in care**
8 **homes using either a face-to-face approach or e-learning**

9 Introduction

10 A systematic review of the economic literature found a single study which compared a specif-
11 ic training tool with treatment as usual in the context of improving the well-being of people
12 with dementia in hospital or care home settings. However, no economic evidence was found
13 with respect to the cost-effectiveness of alternative approaches in the delivery of safeguard-
14 ing training for those looking after adults in care homes. Furthermore, the quantitative review
15 undertaken for this guideline also failed to find any comparative effectiveness data on which
16 it would have been possible to base original economic modelling comparing face-to-face and
17 e-learning approaches.

18 Nevertheless, the guideline committee were of the view, based on their own expertise and
19 experience that face-to-face training (including the use of virtual platforms) offered a number
20 of number of advantages over e-learning. These advantages include the opportunities pro-
21 vided for reflective learning, to learn from the shared experience of other care home staff and
22 the ability to interact with trainers and ask supplementary questions that help reinforce
23 knowledge and learning objectives. In addition, face-to-face training is considered to be less
24 dependent on good computer skills and literacy. Although e-learning is often utilised in prac-
25 tice for safeguarding training due to its convenience and lower cost. Therefore, the commit-
26 tee made a research recommendation in order to assess the effectiveness and cost-
27 effectiveness of face-to-face training and a "what-if" economic analysis was undertaken to
28 support this research recommendation and to serve as an exemplar of how a future econom-
29 ic analysis might be approached. It does this by indicating the quantitative data that would be
30 needed from research to populate such an analysis, rather than relying on hypothetical val-
31 ues, and by showing important linkages between various outcomes.

32 Methods

33 *Setting and population*

34 The model was for a social care setting in England and the population was care home work-
35 ers and managers with responsibility for safeguarding adults in care homes.

36 *Model structure*

37 A decision analytic model was developed in Microsoft Excel® to hypothetically compare the
38 costs and cost-utility of face-to-face training and e-learning for safeguarding adults in care
39 homes. A simple schematic of the model is shown in Figure 5**Error! Reference source not**
40 **found.**. In the absence of any comparative effectiveness data, the model used a "what-if"
41 approach to ascertain cost-effectiveness for a given incremental gain in knowledge from

1   face-to-face training relative to e-learning. Underlying the model was an assumption that the
2   knowledge and skills imparted through training would translate into improved safeguarding
3   practice in care homes and that this in turn would result in improved well-being for adult resi-
4   dents in care homes. Whilst there was no evidence available to quantify this mechanism to-
5   wards improved outcomes, it is consistent with the purpose of training as stated by Health
6   Education England (2017) which "exists for one reason only: to support the delivery of excel-
7   lent healthcare and health improvement to the patients and public of England by ensuring
8   that the workforce of today and tomorrow has the right numbers, skills, values and behav-
9   iours, at the right time and in the right place".

10   In the absence of quantitative evidence, a hypothetical relationship was postulated in the
11   model between increased knowledge and the quality of life of those adults cared for in care
12   homes. The committee considered that is was reasonable to assume such a relationship be-
13   tween increased knowledge and improved quality of life as part of a hypothetical model.
14   Quality of life in the model was quantified in terms of QALYs to make it consistent with
15   NICE's preferred outcome measure in economic evaluation and to make assessments about
16   the hypothetical cost-effectiveness using a cost-effectiveness threshold of £20,000 per
17   QALY.

18   Costs were attached to training and staff time and travel in attending training. This analysis
19   did not explicitly consider "downstream" cost savings that could occur as a result of improved
20   safeguarding but these would be relevant if there was data. Sensitivity analysis was used to
21   address the possibility that not all costs were explicitly captured by the model costing such as
22   the possible need to backfill posts whilst staff attend training.

23   A time horizon was not explicitly specified in the model as it is not fundamental to the "what-
24   if" approach taken with respect to the benefits of training. This aimed to assess the cost-utility
25   of the discounted QALYs over whatever timeframe the training would continue to provide
26   benefits to the well-being of adults in care homes. Clearly the longer any benefits of in-
27   creased knowledge persist the greater the potential QALY gain from effective training. This
28   does not negate the possibility that the benefits of training can diminish over time.

Figure 5: A schematic of the model decision tree

29 **Effectiveness outcomes**

30   The effectiveness outcomes incorporated into the model are listed below:
31   i.   Safeguarding knowledge
32   ii.   QALY gain for each percentage point gain in knowledge.

33   It was assumed that those undertaking training have some baseline knowledge that will be
34   enhanced by training. This knowledge was measured on a percentage scale and so can be
35   considered as the hypothetical improvement that would be achieved in test scores as a result
36   of training. The model varied the hypothetical gain in knowledge from face-to-face training as
37   part of the "what-if" approach.

1　However, improved knowledge, whilst potentially easier to measure, is only an intermediate
2　measure of effectiveness. The real outcome of interest is the improved well-being and safety
3　of adults in care homes. Therefore, this analysis used a hypothetical relationship between
4　knowledge and QALYs which was again varied in a "what-if" manner in order to determine
5　those scenarios when face-to-face training is likely to be cost-effective.

6 *Training effectiveness*

7　Table 11 shows illustrative values used for effectiveness in the economic analysis. It is im-
8　portant to recognise that these values have no greater legitimacy than any other "what-if"
9　values in this hypothetical analysis. In selecting an illustrative QALY it was recognised that a
10　single care home worker or manager will have responsibility for a number of adults and was
11　intended to represent a total discounted QALY gain across all those they care for. The illus-
12　trative value was chosen to generate a moderately cost-effective result given the model's
13　other illustrative inputs. It should also be noted that it is the incremental knowledge gain from
14　face-to-face training that drives the estimate of cost-effectiveness. The illustrative values
15　were not based on any evidence or opinion but an incremental 5 percentage point gain from
16　face-to-face training relative to e-learning was not considered so large as to be implausible.
17　The baseline knowledge was included to illustrate that it is expected that there would also be
18　some knowledge gain from e-learning. Theoretically it would be possible to compare no train-
19　ing against e-learning and face-to-face training but as much training is mandatory then it
20　seemed unreasonable to posit no training as part of the decision set. The inclusion of an il-
21　lustrative value for baseline knowledge had no impact on the model results which was only
22　based on an incremental comparison of face-to-face training relative to e-learning.

23　**Table 11: Hypothetical effectiveness inputs**

Variable	Value
Baseline knowledge	30%
Knowledge after e-learning	65%
Knowledge after face-to-face	70%
QALY gain from each percentage point gain in knowledge	0.005

24

25 *Costs*

26　Costing was undertaken from the perspective of the English social care sector. The costs
27　included the costs of marketed training, the costs of staff time in attending the training and
28　travel costs for face-to-face training. The model was also developed so that the analysis
29　could be based on either a home care worker or home care manager attending. The costs
30　and resource inputs utilised in the model are given in Table 12.

31　**Table 12: Costs and resource use associated with safeguarding training**

Variable	Value	Source
Provider cost of e-learning	£11	Safeguarding Adults Level 3 eLearning https://www.skillsplatform.org/courses/7326-safeguarding-adults-level-3-elearning (accessed 24/02/2020)
Provider cost of face-to-face training	£120	Safeguarding of Vulnerable Adults (SOVA) Level 3 Training – Skills for Health CSTF Aligned https://www.skillsplatform.org/courses/4244-safeguarding-of-vulnerable-adults-sova-level-3-training-skills-for-health-cstf-aligned (accessed 24/02/2020)
Staff time to complete	3	Safeguarding Adults Level 3 eLearning

Variable	Value	Source
e-learning (hours)		https://www.skillsplatform.org/courses/7326-safeguarding-adults-level-3-elearning (accessed 24/02/2020)
Staff time to undertake face-to-face training (hours)	5	Safeguarding of Vulnerable Adults (SOVA) Level 3 Training – Skills for Health CSTF Aligned plus assumption of 2 hours travel time https://www.skillsplatform.org/courses/4244-safeguarding-of-vulnerable-adults-sova-level-3-training-skills-for-health-cstf-aligned (accessed 24/02/2020)
Travel costs for face-to-face training	£50	Assumption
Accommodation costs for face-to-face training	£0	Assumption
Other costs for e-learning	£0	Assumption
Other costs for face-to-face learning	£0	Assumption
Employment cost of home care worker per hour	£23	Unit Costs of Health and Social Care 2019 (Curtis, 2019)
Employment cost of home care manager per hour	£40	Unit Costs of Health and Social Care 2019 (Curtis, 2019)

1 All costs are incurred on the day of training and as "downstream" costs/savings were not in-
2 cluded there were no future costs to discount.

3 To assess cost-effectiveness a cost-effectiveness threshold of £20,000 per QALY was uti-
4 lised as that is consistent with advisory thresholds used in other NICE guidance.

5 *Sensitivity analysis*

6 As befits a "what-if" analysis a number of one-way and two-way sensitivity analyses are pre-
7 sented to explore how cost-effectiveness would vary under different scenarios.

8 Inputs for the following variables were varied as part of these sensitivity analysis:

9 i. Incremental costs of face-to-face training
10 ii. Incremental gain in knowledge from face-to-face training compared to e-learning
11 iii. QALY gain per percentage point gain in knowledge.

12 The range for the values varied in the sensitivity analysis are given in Table 13.

13 **Table 13: Ranges for variables assessed in sensitivity analysis**

Variable	Illustrative value	Lowest value	Highest value
Incremental costs of face to face training	£205 [a]	£10	£1,000
Incremental percent-age point gain in knowledge from F2F compared to e-learning	5	0.5	10
QALY gain per per-	0.0050	0.0005	0.0100

Variable	Illustrative value	Lowest value	Highest value
centage point gain in knowledge			

1 (a) *This is the illustrative value for the analysis based on a home care worker. The illustrative value for a home*
2   *care manager is £239*

3

4 Illustrative results (based on Table 11 and Table 12) are presented for a home care worker
5 undergoing training and for a home care manager undergoing training. However, sensitivity
6 analyses are just presented for a home care worker and are intended to show how cost-
7 effectiveness interacts with changes to model variables.

8 Results

9   i.   Home care worker undertaking safeguarding training

10 Illustrative results for a home care worker are summarised in Table 14. An ICER of £8,200
11 per QALY suggests that face-to-face training would be cost-effective given the hypothetical
12 scenario represented by the illustrative inputs at a cost-effectiveness threshold of £20,000
13 per QALY. The table also shows that the threshold incremental QALY gain for face-to-face
14 training to be cost-effective is 0.01025 QALYs. This suggests that, given the incremental
15 costs of face-to-face training reported in this scenario, that either a lower rate of knowledge
16 gain and/or a lower QALY gain per percentage point increase in knowledge could still be
17 compatible with face-to-face training being cost-effective. With these illustrative inputs and
18 the relationship between the QALY gains per percentage point increase in knowledge, the
19 model suggested that an incremental 2.05 percentage point gain in knowledge would be
20 needed in order for face-to-face training to be cost-effective relative to e-learning. This is less
21 than the hypothetical 5 percentage point increase in knowledge derived from the illustrative
22 values from Table 11.

23 **Table 14: Analysis for a home care worker attending safeguarding training for adults in**
24 **care homes**

Training mode	Cost	QALY	Incremental cost	Incremental QALY	ICER [a]	QALY gain needed	Knowledge gain needed [b]
e-learning	£80	0.175	N/A	N/A	N/A	N/A	N/A
Face-to-face	£285	0.200	£205	0.025	£8,200	0.0103	2.05%

25 (a) *ICER = incremental cost-effectiveness ratio*
26 (b) *This is measured as the percentage point change rather than percentage change*

27

28   ii.   Home care manager undertaking safeguarding training

29 This analysis was undertaken from the perspective of a home care manager undertaking the
30 safeguarding training. The results are given in Table 15. As the hourly costs of staff time
31 were higher there was a small increase in the incremental costs of training and consequently
32 the ICER is also higher at £9,560 per QALY given that no additional effectiveness is as-
33 sumed. However, under such a scenario face-to-face training remains cost-effective relative
34 to e-learning at a cost-effectiveness threshold of £20,000 per QALY.

101
Safeguarding adults in care homes: evidence reviews for the effectiveness and acceptability
of safeguarding training DRAFT (September 2020)

1   **Table 15: Analysis for a home care manager attending safeguarding training for adults**
2   **in care homes**

| Training mode	Cost	QALY	Incremental cost	Incremental QALY	ICER [a]	QALY gain needed	Knowledge gain needed [b]
e-learning	£131	0.175	N/A	N/A	N/A	N/A	N/A
Face-to-face	£370	0.200	£239	0.025	£9,560	0.01195	2.39%

3   *(a) ICER = incremental cost-effectiveness ratio*
4   *(b) This is measured as the percentage point change rather than percentage change*

5   iii.   One-way sensitivity analysis varying the incremental costs of face-to-face training for
6   a home care worker attending safeguarding training for adults in care homes

7   In this sensitivity analysis the incremental costs of face-to-face training are varied between
8   £10 and £1,000. All other model inputs were held constant and the analysis was for a home
9   care worker attending safeguarding training for adults in care homes. The results are shown
10   in Figure 6 and indicate that face-to-face training would be cost-effective relative to e-
11   learning providing the incremental costs of face-to-face training were no greater than £500.
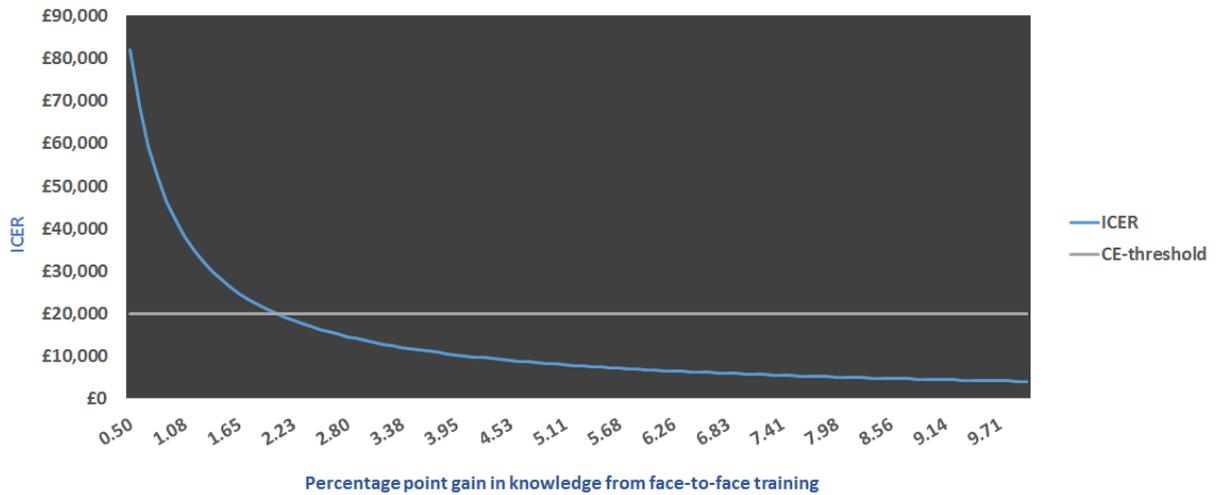
Figure 6:   One-way sensitivity analysis varying the incremental costs of face-to-face training
            relative to e-learning for a home care worker
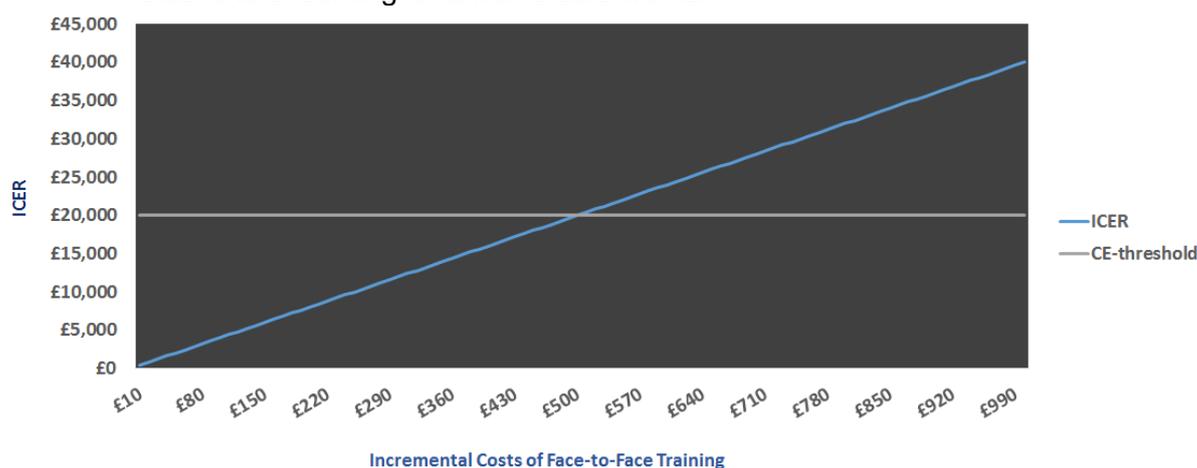
12   iv.   One-way sensitivity analysis varying the incremental gain in knowledge from face-to-
13   face training relative to e-learning

14   In this sensitivity analysis, depicted in Figure 7, the incremental gain in knowledge from face
15   to training relative to e-learning was varied between 0.5 and 10 percentage points, holding
16   other model inputs constant and for a home care worker attending safeguarding training for
17   adults in care homes. Figure 7 graphs the same threshold for the required incremental
18   knowledge gain for face-to-face training to be cost-effective relative to e-learning as reported
19   in Table 14, given the assumed hypothetical relationship between knowledge gain and QAL-
20   Ys.

102
Safeguarding adults in care homes: evidence reviews for the effectiveness and acceptability
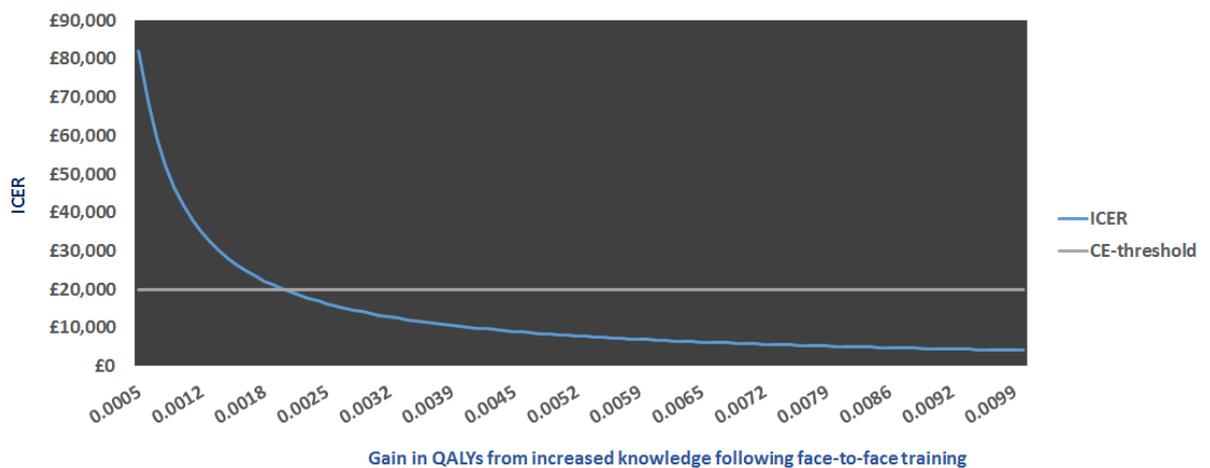of safeguarding training DRAFT (September 2020)

Figure 7: One-way sensitivity analysis varying the incremental percentage point gain in knowledge from face-to-face training relative to e-learning for a home care worker

1   v.   One-way sensitivity analysis varying the gain in QALY from each percentage point in-
2   crease in knowledge

3   Figure 8 displays the relationship between the ICER and QALY gain from increased
4   knowledge, when the QALY gain per percentage point in knowledge is varied between
5   0.0005 and 0.01 QALY. This suggests that face-to-face training will be cost-effective relative
6   to e-learning providing the QALY gain per percentage point gain in knowledge is 0.0021
7   QALYs or greater, holding the other model inputs constant and for a home care worker at-
8   tending safeguarding training for adults in care homes.

Figure 8: One-way sensitivity analysis varying the QALY gain from each percentage point gain in knowledge for a home care worker

9   vi.   Two-way sensitivity analysis varying the incremental costs and the incremental gain
10   in knowledge from face-to-face training relative to e-learning
11

12   In this two-way sensitivity analysis both the incremental costs of face-to-face training relative
13   to e-learning and the percentage point increase in knowledge from face-to-face learning are

103
Safeguarding adults in care homes: evidence reviews for the effectiveness and acceptability
of safeguarding training DRAFT (September 2020)

1   varied, whilst holding other model inputs constant and for a home care worker attending
2   safeguarding training for adults in care homes. The analysis is illustrated in Figure 9. It
3   shows which combinations of input values for these variables are cost-effective. It can also
4   be used to determine the threshold value for cost-effectiveness for one of the variables for
5   any given value of the other variable. The shading of the cost-effective regions confirms the
6   intuitive view that the effectiveness of training (as measured by percentage point increase in
7   knowledge) has to increase with higher training costs in order for face-to-face training to be
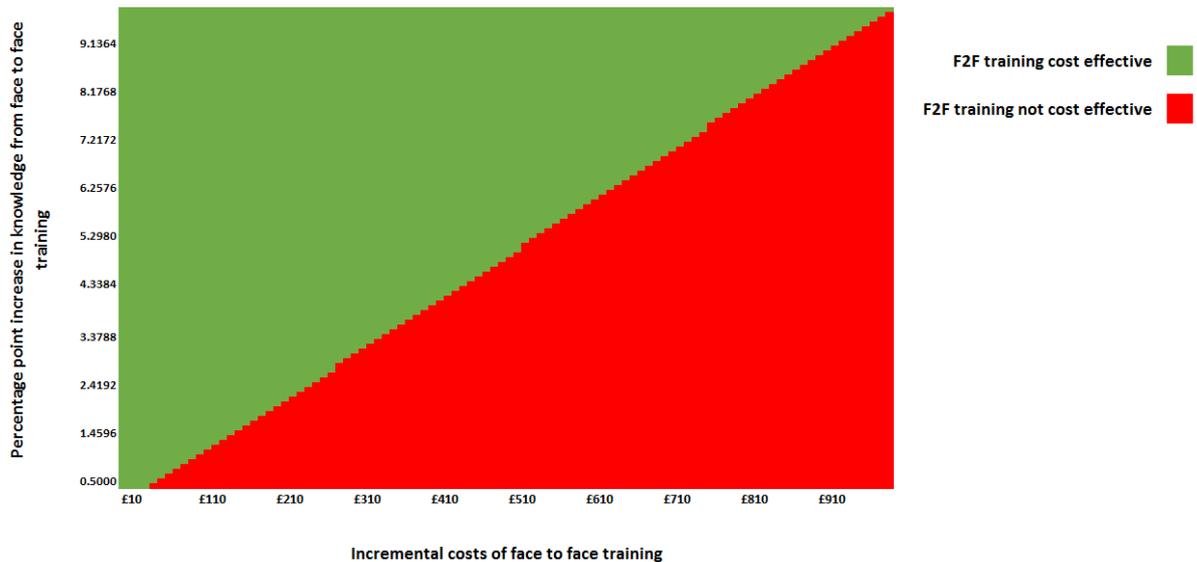8   cost-effective relative to e-learning.
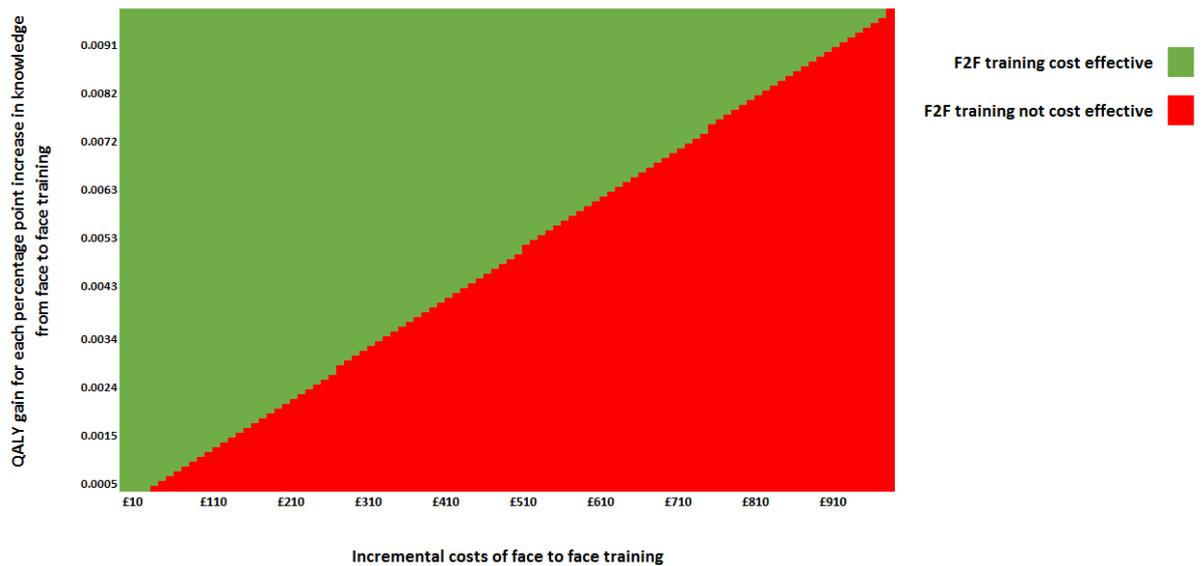
Figure 9: Two-way sensitivity analysis varying the incremental costs and the incremental
           percentage point gain in knowledge from face-to-face training for a home care
           worker

9   vii.   Two-way sensitivity analysis varying the incremental costs of face-to-face training rel-
10   ative to e-learning and the QALY gain from each percentage point increase in
11   knowledge

12   Figure 10 illustrates a two-way sensitivity analysis where the incremental costs of face-to-
13   face training relative to e-learning are varied along with the QALY gain from each percentage
14   point increase in knowledge. All other model inputs are held constant (including the incre-
15   mental gain in knowledge from face-to-face training) and the analysis is for a home care
16   worker attending training. Again this analysis shows that a higher QALY gain per percentage
17   point increase in knowledge is required for face-to-face training to remain cost-effective rela-
18   tive to e-learning as the incremental costs of face-to-face training rise.

104
Safeguarding adults in care homes: evidence reviews for the effectiveness and acceptability
of safeguarding training DRAFT (September 2020)

Figure 10:Two-way sensitivity analysis varying the incremental costs of face-to-face training and the QALY gain from a percentage point gain in knowledge for a home care worker

1   viii.   Two-way sensitivity analysis varying the incremental gain in knowledge from face-to-
2   face training relative to e-learning
3

4   In this two-way sensitivity analysis both the effectiveness of training (as measured by the
5   percentage point increase in knowledge) and the QALY gain from a percentage point change
6   in knowledge are varied. Figure 11 shows how the QALY gain needed from each percentage
7   point increase in knowledge declines as the incremental effectiveness of face-to-face training
8   increases relative to e-learning increases.

Figure 11:Two-way sensitivity analysis varying the incremental percentage point gain in knowledge from face-to-face training and the QALY gain from a percentage point gain in knowledge for a home care worker
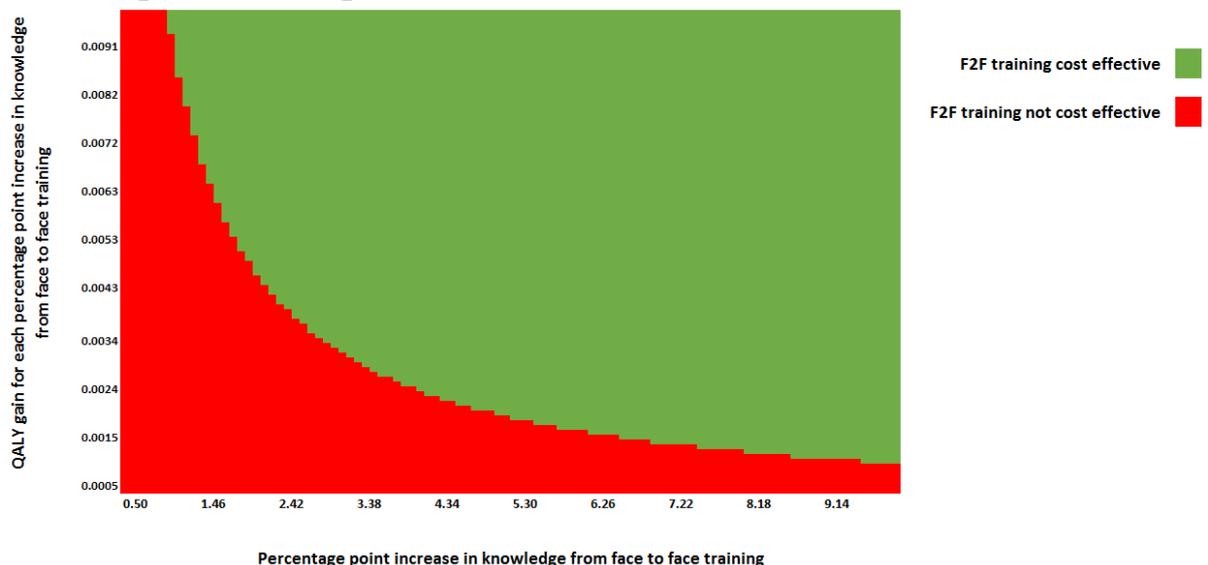
1

2 Discussion

3 The committee identified a number of reasons why face-to-face training might be more cost-
4 effective than e-learning, in some circumstances at least. Some of these reasons were re-
5 flected in the qualitative evidence reviewed for this guideline. In particular, the committee
6 noted that good literacy and computer skills were required for e-learning; and the positive
7 experience of face-to-face learning reported in the evidence. However, the committee recog-
8 nised that scarce resources were an important consideration in decisions about how training
9 should be delivered and that face-to-face training was a more resource intensive approach.

10 The base case results, using illustrative model inputs, both depict hypothetical scenarios
11 where face-to-face training for safeguarding adults in care homes is cost-effective relative to
12 e-learning but it is important to note that this is not based on any real effectiveness data. In-
13 deed, the illustrative QALY values were selected to generate such a finding. Better evidence
14 is needed in order to determine the relative cost-effectiveness of different training approach-
15 es for safeguarding adults in care homes. Sensitivity analyses showed how cost-
16 effectiveness would be expected to vary with changes in key model parameters.

17 The sensitivity analyses showed, as expected, that increases in costs would lead to higher
18 ICERs and reduced cost-effectiveness. Conversely, the sensitivity analysis showed that in-
19 creases in knowledge or the QALY gain from a percentage point increase, which would both
20 increase the well-being of adults in care homes, would result in lower ICERs and improved
21 cost-effectiveness.

22 It should be noted that whilst the cost-effectiveness results depend on hypothetical effective-
23 ness data the costs of face-to-face and e-learning training used in the model were based on
24 an example of what is currently available in the market place. Whilst exact costs vary
25 amongst providers they do tend to fall within a similar range. For example, the Social Care
26 Institute of Excellence (SCIE) reports (personal communication, 2020):

27   i.   £150 for face-to-face training at SCIE
28   ii.   £20 for e-learning with discounts available for multiple purchase

29 It is reflected in the model variables but the effectiveness of safeguarding training has 2 ele-
30 ments. First, it relates to an improvement in terms of the "knowledge" needed to provide
31 safeguarding for adults in care homes. However, this improved "knowledge" is only ultimately
32 of benefit if it leads to better safeguarding in practice and therefore better outcomes for
33 adults in care homes.

34 Ideally, any future research should aim to measure both of these elements as it is not inevi-
35 table that increases in "knowledge" would translate into better safeguarding in care homes
36 with improved well-being. In other words, research should aim to assess the comparative ef-
37 fectiveness of face-to-face training and e-learning in terms of increasing knowledge about
38 safeguarding adults in care home and, in addition, the impact that increased knowledge has
39 on improved well-being for adult residents in care homes as a result of better safeguarding
40 practice.

41 However, it should be recognised that the well-being or quality of life of adults in care homes
42 is multi-factorial and this "noise" may make it difficult to discern the impact of training on
43 these end-points of interest. Therefore, future research may as a minimum be limited to mak-
44 ing an assessment using more intermediate measure of effect such as increased knowledge.
45 That could then be supplemented by some "what-if" assumptions to make a more qualitative
46 assessment as to whether any incremental gains in knowledge from face-to-face training,

106
Safeguarding adults in care homes: evidence reviews for the effectiveness and acceptability
of safeguarding training DRAFT (September 2020)

1 assuming the evidence establishes this, would be likely to deliver the improvements in well-
2 being necessary for cost-effectiveness to be achieved.

3 **Conclusion**

4 Whilst face-to-face training is likely to confer advantages over e-learning in the provision of
5 safeguarding training for adults in care homes, its higher cost means that research is needed
6 in order to determine the relative cost-effectiveness of these approaches. The committee
7 used a broader definition of face-to-face training in framing their recommendations so that,
8 what they considered the key advantages of face-to-face training could be utilised without
9 necessarily incurring the costs associated with physical proximity.

10

107
Safeguarding adults in care homes: evidence reviews for the effectiveness and acceptability
of safeguarding training DRAFT (September 2020)

1 Appendix K – Excluded studies

2 Excluded studies for review questions H:

3 • **What is the effectiveness of different models of training for safeguarding in**
4 **care homes?**

5 • **What is the acceptability of different models of training for safeguarding in**
6 **care homes?**

7 **Table 16: Excluded studies and reasons for their exclusion**

Study	Reason for exclusion
Alon, S., Berg-Warman, A., Treatment and prevention of elder abuse and neglect: where knowledge and practice meet-a model for intervention to prevent and treat elder abuse in Israel, Journal of Elder Abuse & Neglect, 26, 150-71, 2014	Does not provide effectiveness or acceptability data re training models/interventions.
Alt, K. L., Nguyen, A. L., Meurer, L. N., The Effectiveness of Educational Programs to Improve Recognition and Reporting of Elder Abuse and Neglect: A Systematic Review of the Literature, Journal of Elder Abuse and Neglect, 23, 213-233, 2011	Systematic review - included studies checked for relevance.
Anderson, A., NURSES' SELF-EFFICACY FOR MANAGING ELDER ABUSE, Nurses' Self-Efficacy for Managing Elder Abuse, 1-1, 2015	Dissertation.
Ayalon, L., Lev, S., Green, O., Nevo, U., A systematic review and meta-analysis of interventions designed to prevent or stop elder maltreatment, Age & Ageing, 45, 216-27, 2016	Systematic review - included studies checked for relevance.
Baker, P. R., Francis, D. P., Hairi, N. N., Othman, S., Choo, W. Y., Interventions for preventing abuse in the elderly, Cochrane Database of Systematic Reviews, CD010321, 2016	Systematic review - included studies checked for relevance.
Bern-Klug, M., Sabri, B., Nursing home social services directors and elder abuse staff training, Journal of gerontological social work, 55, 5-20, 2012	Does not provide effectiveness or acceptability data re training models/interventions.
Braaten, K. L., Malmedal, W., Preventing physical abuse of nursing home residents- as seen from the nursing staff's perspective, Nursing OpenNurs, 4, 274-281, 2017	Does not provide effectiveness or acceptability data re training models/interventions
Clawson, R., Kitson, D., Significant Incident Learning Process (SILP) - the experience of facilitating and evaluating the process in adult safeguarding, Journal of Adult Protection, 15, 237-245, 2013	Descriptive/non-empirical.
Connell-Carrick, K., Scannapieco, M., Adult protective services: state of the workforce and worker development, Gerontology & Geriatrics Education, 29, 189-206, 2008	Study conducted in the US.

108
Safeguarding adults in care homes: evidence reviews for the effectiveness and acceptability
of safeguarding training DRAFT (September 2020)

Study	Reason for exclusion
Davis, R. C., Medina, J., Avitabile, N., Reducing repeat incidents of elder abuse: results of a randomized experiment: final report, 2001	Study conducted in the US.
DeHart, D., Webb, J., Cornman, C., Prevention of elder mistreatment in nursing homes: competencies for direct-care staff, Journal of Elder Abuse & NeglectJ Elder Abuse Negl, 21, 360-78, 2009	Does not present effectiveness or acceptability data re training models/interventions.
Desy, P. M., Prohaska, T. R., The Geriatric Emergency Nursing Education (GENE) Course: An Evaluation, Journal of Emergency Nursing, 34, 396-402, 2008	Participants not relevant - emergency department nurses; study conducted in the US.
Ellis, Julie M., Ayala Quintanilla, Beatriz Paulina, Ward, Louise, Campbell, Fergus, Hillel, Stav, Downing, Carolyn, Teresi, Jeanne, Ramirez, Mildred, A systematic review protocol of educational programs for nursing staff on management of resident to resident elder mistreatment in residential aged care homes, Journal of Advanced Nursing, 74, 2018	Systematic review protocol.
Ellis, J. M., Ayala Quintanilla, B. P., Ward, L., Campbell, F. (2019) Implementation and evaluation of an education programme for nursing staff on recognising, reporting and managing resident-to-resident elder mistreatment in aged care facilities. Journal of Advanced Nursing 75: 187-196	Study protocol only.
Embregts, P. J., Heestermans, M., van den Bogaard, K. J., A training course for psychologists: Learning to assess (alleged) sexual abuse among victims and perpetrators who have intellectual disabilities, Sexuality and Disability, 35, 39-44, 2017	Study conducted in The Netherlands, sufficient UK studies identified for part a of this evidence review.
Garma, C. T., Influence of health personnel's attitudes and knowledge in the detection and reporting of elder abuse: An exploratory systematic review, Psychosocial Intervention, 26, 73-91, 2017	Systematic review - included studies checked for relevance.
Goulding, H., Riordan, S. A., What kind of support and training do junior qualified nurses working with women with learning disabilities in a secure setting require when dealing with violence and aggression, Journal of Intellectual Disabilities and Offending Behaviour, 7, 140-150, 2016	Does not report acceptability/effectiveness data on safeguarding training models/interventions.
Harries, P., Davies, M., Gilhooly, K., Gilhooly, M., Tomlinson, C. (2014) Educating novice practitioners to detect elder financial abuse: a randomised controlled trial BMC medical education 14: 21	Participants were student clinicians/not yet qualified.
Hirst, S. P., Penney, T., McNeill, S., Boscart, V. M., Podnieks, E., Sinha, S. K., Best-Practice Guideline on the Prevention of Abuse and Neglect of Older Adults, Canadian Journal on Aging, 35, 242-60, 2016	Systematic review - included studies checked for relevance.

Safeguarding adults in care homes: evidence reviews for the effectiveness and acceptability of safeguarding training DRAFT (September 2020)

Study	Reason for exclusion
Hsieh, H. F., Wang, J. J., Yen, M., Liu, T. T., Educational support group in changing caregivers' psychological elder abuse behavior toward caring for institutionalized elders, Advances in Health Sciences Education, 14, 377-86, 2009	Study conducted in Taiwan.
Humphries, R., Adult safeguarding: early messages from peer reviews, JOURNAL OF ADULT PROTECTION, 13, 89-99, 2011	Does not provide effectiveness or acceptability data re training models/interventions.
Hunter, S., When self-directed support meets adult support and protection: findings from the evaluation of the SDS test sites in Scotland, JOURNAL OF ADULT PROTECTION, 14, 206-215, 2012	Does not provide effectiveness or acceptability data re training models/interventions.
Imbody, B., Vandsburger, E., Elder Abuse and Neglect: Assessment Tools, Interventions, and Recommendations for Effective Service Provision, Educational Gerontology, 37, 634-650, 2011	Narrative review/non-empirical.
Irct20160814029349N,, Effect of nurses' education on recognition of the phenomenon of elder abuse by Family caregivers, http://www.who.int/trialsearch/Trial2.aspx?TrialID=IRCT20160814029349N3, 2018	Trial registry record, not a published study.
Irct20170223032742N,, bbasnef model and abuse towards the elderly, http://www.who.int/trialsearch/Trial2.aspx?TrialID=IRCT20170223032742N1, 2018	Trial registry record, not a published study.
Isrctn,, I-NEED: improving Nurses dEtection and managEment of elDer abuse and neglect, http://www.who.int/trialsearch/Trial2.aspx?TrialID=ISRCTN47326902, 2014	Trial registry record, not a published study.
Kim, K. K., Development of a web-based education program for nurses working in nursing homes on human rights of older adults, Journal of Korean Academy of Nursing, 40, 463-472, 2010	Study conducted in Korea.
Lambley Sharon, A semi-open supervision systems model for evaluating staff supervision in adult care settings: a conceptual framework, European Journal of Social Work, 21, 389-399, 2018	Non-empirical.
Lambley Sharon, A semi-open supervision systems model for evaluating staff supervision in adult-care organisational settings: the research findings, British Journal of Social Work, 49, 391-410, 2019	Does not provide effectiveness or acceptability data re training models/interventions.
Lawrence, V., Banerjee, S., Improving care in care homes: a qualitative evaluation of the Croydon care home support team, Aging & mental health, 14, 416-24, 2010	Does not provide effectiveness or acceptability data re training models/interventions.
Loh, D. A., Choo, W. Y., Hairi, N. N., Othman, S., Mohd Hairi, F., Mohd Mydin, F. H., Jaafar, S. N., Tan, M. P., Mohd Ali, Z., Abdul Aziz, S., Ramli, R., Mohamad, R., Lal Mohammad, Z., Hassan, N., Brownell, P., Bulgiba, A., A cluster	Study protocol, study conducted in Malaysia.

Safeguarding adults in care homes: evidence reviews for the effectiveness and acceptability of safeguarding training DRAFT (September 2020)

Study	Reason for exclusion
randomized trial on improving nurses' detection and management of elder abuse and neglect (I-NEED): study protocol, Journal of Advanced Nursing, 71, 2661-2672, 2015	
Luz, C., Mickus, M., Rostant, O., Macomber, C., ADULT ABUSE AND NEGLECT PREVENTION: EVALUATION OF A TRAINING PROGRAM FOR DIRECT ACCESS STAFF, The Gerontologist, 48, 640, 2008	Conference abstract.
Manthorpe J., Making Safeguarding Personal: developing responses and enhancing skills, Journal of Adult Protection, 16, 96-103, 2014	Does not provide effectiveness or acceptability data re training models/interventions.
Manthorpe, J., Martineau, S., 'In our experience': chairing and commissioning Serious Case Reviews in adult safeguarding in England, Journal of Social Work, 12, 84-99, 2012	Does not provide effectiveness or acceptability data re training models/interventions.
Manthorpe, J., Martineau, S., Serious case reviews in adult safeguarding, 2009	Does not provide effectiveness or acceptability data re training models/interventions.
Manthorpe, J., Martineau, S., Serious case reviews in adult safeguarding in England: an analysis of a sample of reports, British Journal of Social Work, 2011	Does not provide effectiveness or acceptability data re training models/interventions.
Manthorpe, J., Martineau, S., Engaging with the new system of safeguarding adults reviews concerning care homes for older people, British Journal of Social WorkBr J Soc Work, 47, 2086-2099, 2017	Does not provide effectiveness or acceptability data re training models/interventions.
Mills, W. L., Roush, R. E., Moye, J., Kunik, M. E., Wilson, N. L., Taffet, G. E., Naik, A. D., An Educational Program to Assist Clinicians in Identifying Elder Investment Fraud and Financial Exploitation, Gerontology and Geriatrics Education, 33, 351-363, 2012	Study conducted in the US.
Moore, C., Browne, C., Emerging Innovations, Best Practices, and Evidence-Based Practices in Elder Abuse and Neglect: a Review of Recent Developments in the Field, Journal of Family ViolenceJ Fam Violence, 32, 383-397, 2017	Does not provide effectiveness or acceptability data re training models/interventions.
Moore, S., 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?, The Journal of Adult Protection, 19, 297-308, 2017	Does not provide effectiveness or acceptability data re training models/interventions.
Pickering, C. E. Z., Ridenour, K., Salaysay, Z., Reyes-Gastelum, D., Pierce, S. J., EATI Island - A virtual-reality-based elder abuse and neglect educational intervention, Gerontology & geriatrics education, 39, 445-463, 2018	Study conducted in the US.
Rixon, A., Ward, R., What Difference Does It Make?: Social Work Practice and Post-Qualifying Awards, Practice (09503153), 24, 147-159, 2012	Does not provide effectiveness or acceptability data re training models/interventions.
Romain-Glassey, N., Mangin, P., Schwab, P. D. R., An innovative interdisciplinary training about elder abuse, Revue Medicale Suisse, 13, 716-	Non-empirical.

Safeguarding adults in care homes: evidence reviews for the effectiveness and acceptability of safeguarding training DRAFT (September 2020)

Study	Reason for exclusion
718, 2017	
Rosen, T., Elman, A., Dion, S., Delgado, D., Demetres, M., Breckman, R., Lees, K., Dash, K., Lang, D., Bonner, A., Burnett, J., Dyer, C. B., Snyder, R., Berman, A., Fulmer, T., Lachs, M. S., National Collaboratory to Address Elder Mistreatment Project, Team, Review of Programs to Combat Elder Mistreatment: Focus on Hospitals and Level of Resources Needed, Journal of the American Geriatrics SocietyJ Am Geriatr Soc, 67, 1286-1294, 2019	Does not provide effectiveness or acceptability data re training models/interventions.
Smith, M. K., Davis, B. H., Blowers, A., Shenk, D., Jackson, K., Kalaw, K., Twelve important minutes: introducing enhanced online materials about elder abuse to nursing assistants, Journal of continuing education in nursing, 41, 281-288, 2010	Non-empirical.
Social Care Institute For, Excellence, Faulkner Alison, Sweeney Angela, Prevention in adult safeguarding: a review of the literature, 59p., bibliog., 2011	Does not provide effectiveness or acceptability data re training models/interventions.
Stevens, E. L., How does leadership contribute to safeguarding vulnerable adults within healthcare organisations? A review of the literature, The Journal of Adult Protection, 17, 258-272, 2015	Does not provide effectiveness or acceptability data re training models/interventions.
Sugita, J. A., Garrett, M. D., Elder abuse and oral healthcare providers: an intervention to increase knowledge and self-perceived likelihood to report, Journal of elder abuse & neglect, 24, 50-64, 2012	Study conducted in the US.
Teresi, J. A., Ramirez, M., Ellis, J., Silver, S., Boratgis, G., Kong, J., Eimicke, J. P., Pillemer, K., Lachs, M. S. (2013) A staff intervention targeting resident-to-resident elder mistreatment (R-REM) in long-term care increased staff knowledge, recognition and reporting: results from a cluster randomized trial. International Journal of Nursing Studies 50: 644-56	Study conducted in the US.
Teresi, J. A., Burnes, D., Skowron, E. A., Dutton, M. A., Mosqueda, L., Lachs, M. S., Pillemer, K., State of the science on prevention of elder abuse and lessons learned from child abuse and domestic violence prevention: Toward a conceptual framework for research, Journal of elder abuse & neglect, 28, 263-300, 2016	Does not provide effectiveness or acceptability data re training models/interventions.
Teresi, J. A., Ramirez, M., Fulmer, T., Ellis, J., Silver, S., Kong, J., Eimicke, J. P., Boratgis, G., Meador, R., Lachs, M. S., Pillemer, K., Resident-to-Resident Mistreatment: Evaluation of a Staff Training Program in the Reduction of Falls and Injuries, Journal of Gerontological Nursing, 44, 15-23, 2018	Does not provide effectiveness or acceptability data re training models/interventions.
Unison Community Care, Staff support and the quality of care in children's and adults' residential care, 16, 2016	Does not provide effectiveness or acceptability data re training models/interventions.

Study	Reason for exclusion
University Of, Sussex, University Of, Bedford-shire, A scoping study of workforce development for self-neglect work, 2013	Does not provide effectiveness or acceptability data re training models/interventions. Focuses on the concept of self-neglect with a clear emphasis on people living in their own homes.
Wagenaar, D. B., Rosenbaum, R., Herman, S., Page, C., Elder abuse education in primary care residency programs: a cluster group analysis, Family Medicine, 41, 481-6, 2009	Does not provide effectiveness or acceptability data re training models/interventions; study conducted in the US.
Wagenaar, D. B., Rosenbaum, R., Page, C., Herman, S., Elder abuse education in residency programs: How well are we doing?, Academic Medicine, 84, 611-618, 2009	Does not provide effectiveness or acceptability data re training models/interventions; study conducted in the US.

1 **Economic studies**

2 No economic evidence was identified for this review.

3

1 Appendix L – Research recommendations

2 Research recommendations for review questions H:

3 • **What is the effectiveness of different models of training for safeguarding in**
4 **care homes?**

5 • **What is the acceptability of different models of training for safeguarding in**
6 **care homes?**

7 **Research question**

8 What is the effectiveness, cost-effectiveness and acceptability of e-learning safeguarding
9 training compared with face-to-face training?

10 **Why this is important**

11 The review on safeguarding training in the context of adults in care homes found no research
12 evidence directly relating to the effectiveness of different modes of safeguarding training,
13 specifically the effectiveness of e-learning in comparison to face-to-face (including the use of
14 virtual platforms). Anecdotal evidence from experts within the committee demonstrated con-
15 cerns about the e-learning and whether it can provide a meaningful level of understanding of
16 safeguarding which enhances the quality of care provided in the care home setting. The
17 committee therefore agreed that there is a need to determine the most effective modes of
18 delivering safeguarding training and to clarify whether e-learning can meet the standards re-
19 quired for best practice. The committee agreed that such research should measure the im-
20 pact on longer-term outcomes rather than evaluate improvements in knowledge in the short-
21 term as the studies included in this review did. Suggested longer-term outcomes include im-
22 provements in staff skills, understanding and knowledge with regard to safeguarding; impact
23 on quality of life of adults using care homes; increases and/or decreases in safeguarding re-
24 ferrals with attention focused upon reasons for such; improved quality of care as noted within
25 Care Quality Commission inspection reports; and evaluation data from those providing safe-
26 guarding training.

27 **Table 17: Research recommendation rationale**

Research question	What is the effectiveness, cost-effectiveness and acceptability of e-learning safeguarding training compared with face-to-face, group, multi-disciplinary and single discipline training?
Why is this needed	
Importance to the population	Care home residents deserve the best trained staff across all specialisms with an up to date thorough understanding of all aspects of safe-guarding, the risks and indicators of abuse and neglect, and a sound reflective approach to as-sessing situations proactively. If different modes of training are demonstrated to produce differing levels of ultimate working knowledge and under-standing across all staff working with care home residents, this may impact directly upon the quali-

114
Safeguarding adults in care homes: evidence reviews for the effectiveness and acceptability
of safeguarding training DRAFT (September 2020)

Research question	What is the effectiveness, cost-effectiveness and acceptability of e-learning safeguarding training compared with face-to-face, group, multi-disciplinary and single discipline training?
	ty of care experienced.
Relevance to NICE guidance	Evidence about the efficacy of e-learning versus other modes of training is important for future NICE guidelines to ensure best practice in this important area. Research which balances the costs of training with final outcomes for care home residents will enable NICE to make firm recommendations in future about how that training should be provided.
Relevance to social care and the NHS	If research favoured more expensive training modes (for example, one to one and face to face) then incorporating this best practice could potentially increase costs. However, the higher upfront costs may be outweighed by the training being potentially more impactful, resulting in better care, more appropriate safeguarding referrals, enhanced awareness of what constitutes a safeguarding concern and a general increase in standards within care homes, contracting and inspection regimes. Potentially higher initial investment would therefore be balanced with cost savings and improved outcomes linked with fewer safeguarding incidents, complaints and investigations.
National priorities	The guideline committee took the view that work is needed to standardise approaches to safeguarding practice in care homes. This research could provide evidence which would encourage greater standardisation across the country to ensure best practice is available to all regardless of postcode.
	The Care Act 2014 and Statutory Guidance is clear about the responsibility on organisations to always promote the adult's wellbeing in their safeguarding arrangements and that 'safety measures' should always take account of individual well-being. For this to happen to best effect all training around safeguarding needs to be impactful and assimilated, something there is as yet no research evidence available to demonstrate.
	The Care Act 2014 guidance also clearly states the importance of safeguarding training at all levels of the organisation, with no staff members excluded. It also states that training should be provided on a rolling basis and that organisations have a responsibility to train their own staff. However the guidance does not stipulate how that training should be provided and much inconsistency exists, with growing unease about the

Research question	What is the effectiveness, cost-effectiveness and acceptability of e-learning safeguarding training compared with face-to-face, group, multi-disciplinary and single discipline training?
	quality of some modes of delivery.
Current evidence base	There is currently no published evidence about the effectiveness, cost- effectiveness or acceptability of different modalities of training in relation to safeguarding adults in care homes.
Equality	There were concerns about the accessibility of training to those with lower IT skills, poor literacy skills, English as a second language – and the potential for staff to complete e-learning programmes on behalf of each other. The committee believed that research into the effectiveness of e-learning versus other training modes might evidence which approaches would lead to the best outcomes across all abilities in terms of learning and understanding achieved.
Feasibility	Research into the effectiveness of various training methods has been undertaken in other fields of learning and as such should be able to be replicated with appropriate adjustments for the specificity of training related to safeguarding in care homes. There are large numbers of care homes, local authorities, health authorities and voluntary sector organisations which could be approached to create feasible sample sizes across all areas working in care homes. There are research modalities in both qualitative and quantitative approaches which should be affordable in addressing this research question. In addition, research funding across social policy, social work, health and other related fields may be available to support this research question.
Other comments	University departments or centres such as the Social Policy Research Unit at the University of York might be a useful starting point for identifying standard 'care' (or standard training) as they already host CPD workshops based on recent research for social workers and related professionals, including symposia on safeguarding and related topics.

1   *CPD: continued professional development; IT: information technology.*

2   **Table 18:   Research recommendation modified PICO table**

Criterion	Explanation
Population	• Adult care home residents (18 years of age or older) • Staff working in care homes including care workers, social workers, other care support staff, voluntary sector roles working directly with care home residents (such as independent advocates and contracted advocacy

Criterion	Explanation
	service staff), care and health management and commissioning staff, care home users and their own informal carers/family.
Intervention	E-learning safeguarding programmes. Defined as: Induction, training and assessment that is undertaken individually using an e-learning package on a computer or mobile device, and does not involve interaction with others.
Comparator	Face to face safeguarding programmes. Defined as: Induction, training and assessment that is performed one-to-one, or in groups led by either in-house staff experts, managers or external trainers. It may take place with participants and trainers all in the same room, or by using virtual platforms such as video or telephone conferencing. It may include the use of online materials, but staff participants should have the opportunity to ask questions, discuss, reflect on current practice and use case studies and examples. This type of training includes an exploration of how safeguarding relates to the particular role of the person being trained, and to the personalised care and support needs of residents.
Outcomes	• workforce skills relating to identification of and responses to abuse and neglect (including self-neglect) • workforce skills relating to understanding and knowledge of safeguarding practice • quality of life of adult care home residents • quality of care • changes in numbers and frequency of safeguarding referrals with attention focused upon reasons for such • Satisfaction (workforce) • Acceptability (workforce)
Study design	Randomised controlled trial with process evaluation. Follow-up would ideally measure outcomes in the short-term (immediately after intervention, the medium-term, and the long-term i.e. one-year post-intervention). In addition, economic analysis to establish the value for money of the various modes of training.
Timeframe	There is no formal timeframe applicable to this research in relation to guideline development at this stage. However, the sooner this research is undertaken the sooner it may be possible to update the current guideline regarding the recom-

Criterion	Explanation
	mendations related to training and learning.
Additional information	None

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Safeguarding adults in care homes: evidence reviews for the effectiveness and acceptability
of safeguarding training DRAFT (September 2020)