National Institute for Health and Care Excellence

FINAL

Safeguarding adults in care homes

[H] The effectiveness and acceptability of safeguarding training

NICE guideline NG189

Evidence reviews

February 2021

Final

These evidence reviews were developed by the National Guideline Alliance which is part of the Royal College of Obstetricians and Gynaecologists

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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, 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, 1.2.21, 1.2.22, 1.2.23.

Review question

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

- What is the effectiveness of different models of training for safeguarding in care homes?
- What is the acceptability of different models of training for safeguarding in care homes?

Introduction

Evidence review H: The effectiveness and acceptability of safeguarding training

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

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

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

Summary of the protocol

See Table 1 for a summary of the Population, Intervention, Comparison and Outcome (PICO) characteristics of this review.

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.

Intervention/expo-sure/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

1　therefore not possible to synthesise both data types. Instead, the qualitative and quantitative
2　data were synthesised and presented separately and the committee used the evidence as
3　the basis for discussions and making recommendations.

4　As per the protocol, because of insufficient UK based studies being available (both qualita-
5　tive and quantitative), studies from Europe (including the Republic of Ireland), and Australia
6　and Canada were also considered for inclusion. However only 2 further studies were identi-
7　fied which met all other inclusion criteria. These were both conducted in Canada (Du Mont
8　2017, Storey 2018) and report quantitative data, as described below.

9　A total of 7 studies were included. Six of these provided quantitative data on the effective-
10　ness of different models of training (Campbell 2014, Cooper 2012, Du Mont 2017, Kinderman
11　2018, Ochieng 2018, Storey 2018) and 1 provided qualitative data on the acceptability of dif-
12　ferent models of training and on training more generally (Tadd 2012).

13　The included studies are summarised in Table 2.

14　*Quantitative component of the review*

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

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

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

32　Campbell (2014) reported on a 1-day training course designed to improve participants' un-
33　derstanding of the Adult Support and Protection (Scotland) Act 2007 and practice relating to
34　this; Cooper (2012) evaluated the impact of a 'brief' educational seminar on UK psychiatric
35　trainees' knowledge about the detection and management of suspected abuse of older peo-
36　ple; Du Mont (2017) evaluated the impact of the 'Elder Abuse Nurse Examiner Curriculum'
37　on Sexual Assault Nurse Examiner (SANE)s' knowledge of abuse of older people and com-
38　petence in delivering care to abused older adults; Kinderman (2018) evaluated the impact of
39　applying a human rights based approach in dementia inpatient wards and care homes;
40　Ochieng (2018) assessed the impact of a continuing professional development intervention
41　(SOVA-CPD) for nurses working in both primary and secondary care settings; and Storey
42　(2018) evaluated the impact of the 're:act curriculum' on Adult Protection workers.

43　The following types of outcomes were identified through analysis of the included quantitative
44　studies:

45　•　　Service user and carer outcomes.

46　•　　Competence, expertise, and knowledge.

1   •   Perceived knowledge, confidence.

2   •   Ability to identify abuse and neglect.

3   •   Acceptability and satisfaction with training interventions.

4 ***Qualitative component of the review***

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

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

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

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

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

16 • accessibility of training interventions.

17 As shown in the theme map (

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

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22   **Figure 1: Theme map**

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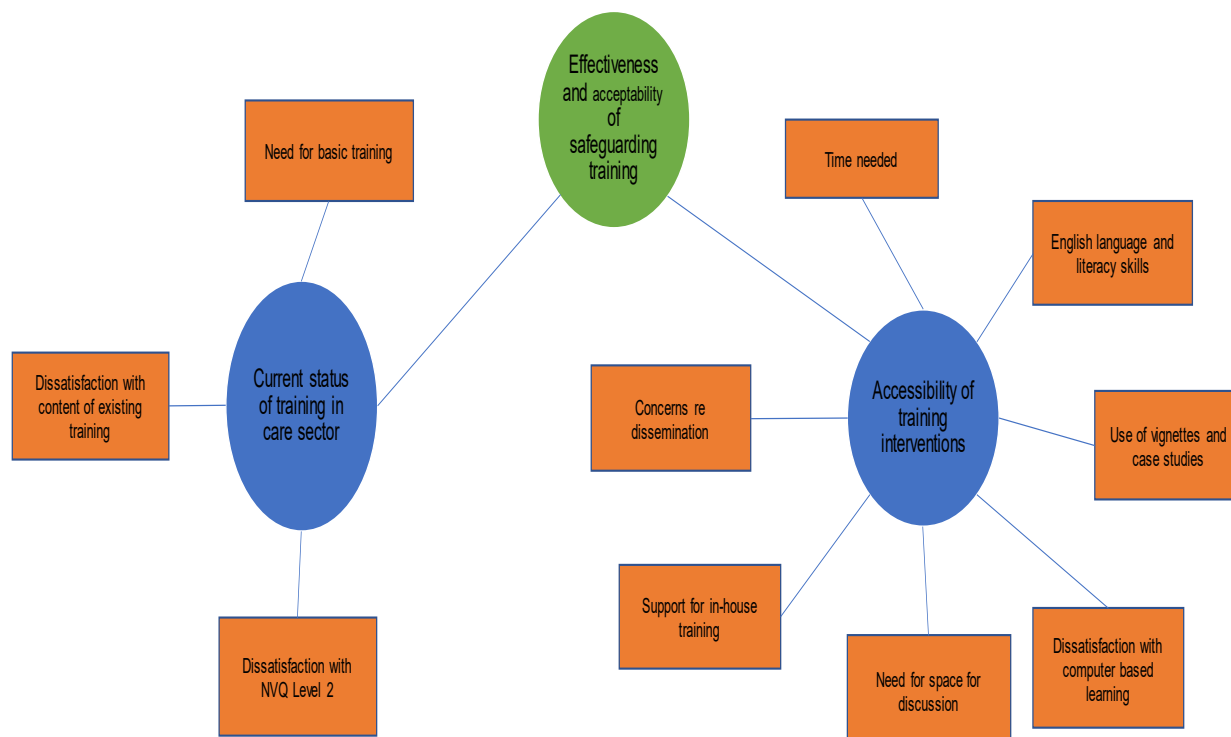
Excluded studies

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

Summary of studies included in the evidence review

6 Summaries of the studies that were included in this review are presented in Table 2 and
7   CSQ: **Caregiver Scenario Questionnaire; DCM: Dementia Care Mapping**
8   **assessment; FREDA: Fairness,Respect, Equality, Dignity and Autonomy;**
9   **IDEA: Identity, Dignity, Equality and Autonomy; KMA: Knowledge and**
10   **Management of Abuse questionnaire; SANE: Sexual Assault Nurse**
11   **Examiner; SD: standard deviation; SOVA-CPD: safeguarding of vulnerable**
12   **adults – continued professional development.**

13 **Table 3**.

14 **Table 2: Summary of included quantitative studies**

Study	Population	Intervention/compari-son	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.	• Per-ceived knowle dge, confi-dence: ○ Knowledge of the Adult Support and Pro-tection Act and

Study	Population	Intervention/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			its 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	**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	• Competence, expertise, and knowledge: o Overall knowledge and expertise related to abuse of older people (measured using bespoke questionnaires and surveys).

Study	Population	Intervention/comparison	Outcomes
elder abuse and competence in delivering care to abused older adults." P. 71 Canada		• interviewing older adults, their caregivers, and other relevant contacts • assessment • medical and forensic examination • 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 dementia 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 specific wards and 12 care homes recruited in north-west of England. People living with dementia: N=439 (n=213 training, n=226 no training) 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 implementation of the 'Getting It Right' assessment tool, plus booster sessions to support the implementation. The 'Getting It Right' assessment tool is a person-centred care planning tool that explicitly links the FREDA principles to areas contributing to person-centred care.	• Service user and carer outcomes: ○ Subjective well-being of service user/person with dementia (measured using measured using QOL-AD). ○ Extent to which service users felt that their human rights were being upheld (measured using IDEA questionnaire). ○ Human rights knowledge (measured using bespoke questionnaires). ○ Human rights attitudes (measured using bespoke questionnaires).

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Study	Population	Intervention/comparison	Outcomes
			o Quality of care provided (measured using DCM).
Ochieng 2018 **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	**Sample size** Nurses working in primary and secondary care: N=71. **Characteristics** Sex: Male n=10; female n=41. Age group: 25-44 years n=27; 45-65 years n=24.	SOVA-CPD 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.	• Perceived 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

Study	Population	Intervention/comparison	Outcomes
			knowledge about material covered in the curriculum (measured using bespoke questionnaire). o Actual competence and 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.

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Study and aim of the study	Participants	Methods	Themes
			o concerns re dis-semination.

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

4 ## Quality assessment of studies included in the evidence review

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

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

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

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

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

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

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

19 A summary of the strength of evidence for qualitative studies, assessed using GRADE-CER-
20 Qual, is presented according to the main themes:

21 ***Acceptability of safeguarding training***

22 • Current status of training in the care sector:

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

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

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

31 • Accessibility of training interventions:

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

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

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

- o Dissatisfaction with computer based programmes. Overall, methodological concerns were considered to be serious for this sub-theme and the overall confidence in this sub-theme was judged to be very low.
- o Opportunities for discussions and reflection rather than 'getting the right answer'. Overall, methodological concerns were considered to be serious for this sub-theme and the overall confidence in this sub-theme was judged to be very low.
- o Support for in-house training. Overall, methodological concerns were considered to be serious for this sub-theme and the overall confidence in this sub-theme was judged to be very low.
- o Dissemination and implementation. Overall, methodological concerns were considered to be serious for this sub-theme and the overall confidence in this sub-theme was judged to be very low.

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

Economic evidence

Included studies

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

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

Excluded studies

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

Summary of studies included in the economic evidence review

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

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

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

The base-case incremental cost-effectiveness ratio (ICER) was not estimated and was not estimable for the primary outcome (that is, patient-reported well-being). Uncertainty on the

1   robustness of study results was not assessed by either deterministic or probabilistic sensitiv-
2   ity analyses.

3   Being a UK study and meeting most applicability criteria, this study was deemed to be di-
4   rectly applicable to the context of the guideline. The study failed to meet most methodological
5   quality requirements of an adequate economic evaluation (such as a, model structure inap-
6   propriate to the decision problem; a lack of reporting of an appropriate incremental analysis,
7   no reporting of a sensitivity analysis) and this was highly likely to change the conclusions
8   about the economic findings. Therefore, it was deemed as having very serious limitations
9   (see https://www.nice.org.uk/Media/Default/About/what-we-do/our-programmes/developing-
10 NICE-guidelines-the-manual.pdf - appendix H).

11 Economic model

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

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

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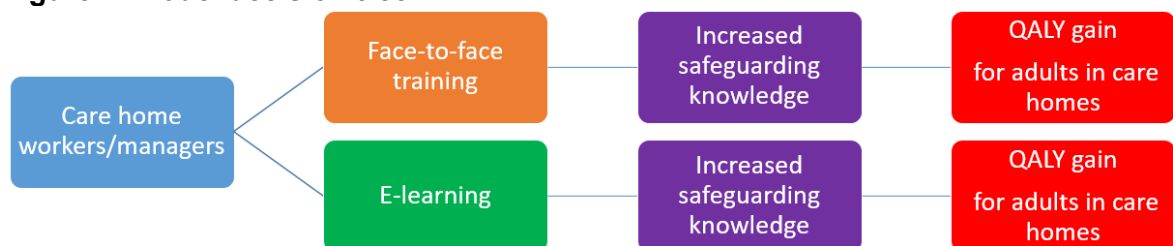
32 The results for an illustrative set of model inputs (see appendix J) were that face-to-face
33 training had ICERs relative to e-learning of £8,200 per QALY for a home care worker doing
34 the training and £9,560 per QALY for a home care manager doing the training. In both those
35 scenarios face-to-face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

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

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

7   The committee's discussion of the evidence

8   Interpreting the evidence

9   *The outcomes that matter most*

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

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

24   •   Satisfaction with the safeguarding training.

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

26   •   Positive and negative aspects of the safeguarding training.

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

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

31   •   Perception about the impact of the training on achieving the Making Safeguarding
32   Personal outcomes.

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

36   *The quality of the evidence*

37   The quality of the quantitative evidence contributing to each outcome was assessed using
38   GRADE methodology. The majority of the outcomes were assessed to be of very low quality,
39   although a small number were determined to be of high quality (as they were based on data
40   from one RCT assessed as having a low risk of bias and were not assessed to have limita-
41   tions with regards to consistency, directness, or imprecision). Outcomes assessed as being
42   of very low quality were all downgraded on the basis of design/risk of bias as the 5 studies on
43   which these were based were not randomised (as per GRADE methodology). These studies

1 all used a before and after design, with participants completing questionnaires and surveys
2 before and after delivery of an intervention and the data available from these meant that it
3 was not possible to calculate absolute effects. Outcomes were further downgraded on the
4 basis of imprecision as sample sizes were very small (i.e. below 200. One study was in-
5 cluded in the qualitative component of the review. The overall confidence in the qualitative
6 evidence was assessed using GRADE-CERQual methodology and was determined to be of
7 very low quality for all themes, mainly as a result of the adequacy of the data which were as-
8 sessed as thin. Confidence in the findings was generally downgraded because of the rele-
9 vance and adequacy of the findings; the single study reported limited data addressing vari-
10 ous topics, not exclusively relevant to safeguarding.

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

13 The committee recognised the limitations of the evidence, including the use of indirect evi-
14 dence from other care settings which required extrapolation to a care home setting, and this
15 prevented the committee from reaching firm conclusions. However, the committee felt
16 strongly about the issues identified from the evidence and they therefore drew on their own
17 experiences and expertise to make recommendations to ensure that health and social care
18 professionals and organisations meet the standards set by the Care Act 2014 and other stat-
19 utory requirements to provide best practice; ultimately protecting care home residents from
20 harm and ensuring they receive the best quality care.

21 **Synthesis of quantitative and qualitative data**

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

30 ***Benefits and harms***

31 ***Induction and training in care homes***

32 **Induction and mandatory training**

33 No quantitative evidence was identified which was relevant to induction and mandatory safe-
34 guarding training specifically. Although the strength of the qualitative evidence presented
35 was considered very low, it indicated the need for basic training for all care home staff to en-
36 able them to understand the role of safeguarding in their work and allow them to carry out
37 this work confidently and effectively. This aligned with the committee's own knowledge and
38 expertise with regards to induction and mandatory training and requirements of the Care Act,
39 2014 and related statutory guidance. The committee therefore agreed that it was important to
40 emphasise the need for mandatory training. Based on consensus they made a recommenda-
41 tion highlighting that mandatory training should be completed by all staff (including contract
42 and temporary staff) as a priority and no later than 6 weeks from their start in a care home (in
43 accordance with guidance such as the Royal College of Nursing's Adult Safeguarding: Roles
44 and competencies for Health Care Staff 2018).

45 The committee also made a recommendation for Safeguarding Adults Boards to seek assur-
46 ances from their partners that mandatory training for staff takes a multi-agency perspective.
47 This was based on the limited evidence highlighting the benefits of training groups of staff to-
48 gether so that they complete training over a shorter period of time and to also provide them

1 with the opportunity to engage with practitioners working in a range of settings. The commit-
2 tee agreed that an important potential benefit of this approach would be associated cost sav-
3 ings. The committee also agreed that it was appropriate to specify that staff knowledge
4 should be assessed annually and refreshed if needed as a means of ensuring that good
5 practice is embedded throughout the care home without the risk of unsustainable costs.

6 In their discussions on what training should be provided and whether this differed by role, the
7 committee were mindful of the competency framework outlined in the intercollegiate docu-
8 ment Adult Safeguarding: Roles and competencies for Health Care Staff 2018. The commit-
9 tee therefore agreed that it was not necessary to make detailed recommendations regarding
10 what further training should be provided to certain roles and across what timescale training
11 should take place.

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

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

29 The committee made further recommendations in relation to induction and mandatory train-
30 ing based on the evidence presented for evidence review B: barriers and facilitators to identi-
31 fying abuse and neglect and evidence review I: the effectiveness and acceptability of embed-
32 ding organisational learning. Details of the committee's discussion and rationale for these
33 recommendations are included in both reviews.

34 **What mandatory training should cover**

35 The quantitative evidence suggested that training interventions may have a positive effect on
36 workforce skills such as knowledge and attitudes regarding human rights based approaches
37 and competence in identifying and investigating, and managing and reporting abuse, neglect,
38 or self-neglect. However, the low quality evidence did not provide clarity on whether improve-
39 ments in practice lead to better quality of care or service-user wellbeing low. Based on their
40 knowledge about the importance of human rights in this context the committee were never-
41 theless keen to recommend training about the relationship between safeguarding and human
42 rights and in this sense used their own experiential knowledge to support and strengthen
43 findings from the very low quality quantitative data. In light of discussions about this evidence
44 the committee also agreed it was crucial that mandatory safeguarding training should cover
45 the following: the Care Act 2014 and the 6 core principles of safeguarding; the Making Safe-
46 guarding Personal framework; specific responsibilities and accountabilities for safeguarding
47 in the care home; how to recognise different forms of abuse and neglect (including organisa-
48 tional abuse and neglect) and differences between poor practice and abuse and neglect; and
49 to whistleblowing (including what support and information is available in this situation). The
50 committee were also keen to emphasise the need for training to cover how to talk about and

23

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1   share information about safeguarding with residents and their families and carers, because
2   they were themselves aware, of the need to discuss safeguarding related issues in a sensi-
3   tive and non-judgemental manner, an issue that was also suggested by some of the evi-
4   dence included in the review.

5   However, the committee were also aware, as a result of the evidence and their own experi-
6   ence, that there may be potential difficulties in communication around safeguarding, for ex-
7   ample, staff for whom English is not their first language, or those with lower levels of literacy;
8   may find this difficult. The committee therefore made a recommendation designed to high-
9   light the need for care home managers to consider these areas, and to ensure that training is
10 meets the needs of all staff working in the care home.

11 On balance the committee considered that the benefits are likely to outweigh any potential
12 harms associated with these recommendations such as increased costs or staff time, as
13 providing training to all care home staff in accessible formats should promote greater under-
14 standing of safeguarding which in turn is likely to ensure greater consistency and improve-
15 ments in the identification of abuse and neglect and improved outcomes for care home resi-
16 dents. The committee made further recommendations in relation to what safeguarding train-
17 ing should cover based on the evidence presented for evidence review B: barriers and facili-
18 tators to identifying abuse and neglect and evidence review E: support and information
19 needs.

20 **Further training**

21 The quantitative evidence reported on how often participants asked older people about
22 abuse and whether they considered abuse during assessments after delivery of a training in-
23 tervention. Although the quality of this evidence was considered to be very low, and no quali-
24 tative evidence was identified on this issue the committee agreed that all levels of training
25 should include details regarding how to ask about abuse and neglect in a sensitive and non-
26 judgmental manner, the importance of considering the possibility of abuse and neglect. The
27 committee were also keen to reflect the need for further training to cover risk assessment
28 and its relationship to safeguarding, and agreed to draft a consensus based recommendation
29 covering this. The benefits from covering a range of safeguarding topics in further training
30 should help to keep staff knowledge up-to-date, and promote reflective learning to ensure
31 that best practice is embedded within their daily activities.

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

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

44 **How to conduct training**

45 The qualitative evidence highlighted the dissatisfaction of care home managers and staff with
46 the content of existing training which was often perceived to be a 'tick box exercise' that has
47 little relevance to day-to-day practice. Although the overall confidence in the qualitative evi-
48 dence was considered to be very low, and no quantitative evidence was identified which cov-

1   ered this issue, the committee were keen to emphasise that training should be directly appli-
2   cable to the responsibilities and daily practices of the staff being trained and also to the care
3   and support needs of the residents they are working with. The evidence also highlighted pos-
4   itive views towards case studies and vignettes, which were seen as a powerful learning and
5   assessment tool. Based on the evidence and their own expertise and knowledge, the com-
6   mittee were keen to recommend the use of case studies in training because this can provide
7   the trainer with the opportunity to evaluate whether the person is learning and can apply the
8   lessons into a practice context. Based on the evidence and their own expertise, the commit-
9   tee also recognised the benefits of learning from Safeguarding Adults Reviews (SARs) to
10 promote good practice and they were therefore keen to recommend incorporating recom-
11 mendations and other information from SARs into training as soon as possible after this be-
12 comes available. The committee also felt it important to highlight the need for training de-
13 signed to encourage reflective learning and discussions with colleagues to identify what good
14 practice looks like, and this was reflected in their recommendation to include case studies
15 and reflective practice at the team and organisational level (for example, at team meetings
16 and handovers). The committee discussed the disadvantages and challenges associated
17 with different modes of training. Although no quantitative evidence was identified which com-
18 pared the effectiveness of different modes of training (e.g. individual e-learning versus group
19 sessions), the committee were in agreement that there were risks associated with a reliance
20 on e-learning particularly because this method relies on staff having good literacy and com-
21 puter skills. The committee also noted that e-learning programmes provided without any
22 checks can lead to difficulties in determining whether staff have really understood the con-
23 tent. Face-to-face training was viewed positively in the evidence (based on group or 1-to-1
24 training) but the committee recognised that not all care homes will have the resources or abil-
25 ity to provide face-to-face safeguarding training, particularly given the impact which Covid-19
26 has had on the care home sector. This was reflected in the recommendations made by the
27 committee, which suggest that, wherever possible, mandatory safeguarding training should
28 be delivered face-to-face, and e-learning should only be used if face-to-face training is not
29 possible. Based on the evidence and their own expertise and knowledge, the committee
30 were keen to make recommendations to ensure the limitations of e-learning were acknowl-
31 edged, and also to consider providing appropriate training to incorporate different levels of
32 staff literacy and computer skills. The committee also recognised that there was an absence
33 of effectiveness evidence to demonstrate the superiority of face-to-face training over e-learn-
34 ing and therefore they, for the purposes of their recommendations, used a slightly broader
35 definition of face-to-face training than would conventionally be employed. They believed that
36 this would allow training to incorporate what they considered to be the key advantages of that
37 approach (interactive contact between the trainer and participants) without necessarily al-
38 ways requiring the more resource intensive physical proximity of traditional face-to-face train-
39 ing. They agreed that within the guideline face-to-face training would be defined as including
40 the use of virtual platforms such as video or teleconferencing.

41 Providing training that is appropriate to different staff should ensure that staff still receive the
42 training in a way that promotes learning. The committee were keen to highlight the benefits of
43 ensuring that learning from training is reflected in daily practice to promote best practice.
44 They therefore made a recommendation to reflect that care home managers should ensure
45 that staff are learning from training, for example, through random quality-checking and sam-
46 pling, follow-up conversations with staff, and ensuring that training is completed and within
47 an agreed timeframe.

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

25

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

5 **Evaluating training**

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

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

29 **Cost effectiveness and resource use**

30 The committee recognised that basic training is a mandatory and a Care Quality Commission
31 requirement. Given this context the committee did not consider that their recommendations
32 on training would have a significant resource impact.

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

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

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

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

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

12 When making the recommendations, the committee also aimed to respect individual needs
13 and basic human rights, at the same time aiming to provide the most benefit for the greatest
14 number of people. The committee were aware that care home residents include a wide vari-
15 ety of people with individual needs (including, for example, people with dementia or learning
16 difficulties) and they were therefore aware of the need to eliminate discriminations when
17 making the recommendations. The committee were also aware that safeguarding adults in-
18 volves a wider range of individuals and organisations (including the care homes and care
19 home providers, individual health and social care practitioners who work with care home resi-
20 dents, and also local authorities and commissioners). The committee were also aware of the
21 need to consider the inequalities that exist between different agencies to ensure fairness and
22 least impact on resources. For example, different care homes will have varying levels of
23 staffing and finances. Whilst the committee agreed to be prescriptive regarding topics that
24 should be covered in mandatory and further training programmes, the points at which these
25 should take place and the importance of protected time for training; they recognised that a
26 more flexible approach to delivery could help to mitigate inequalities in the care sector. For
27 example, the committee agreed to adopt a broader definition of face-to-face training that in-
28 cludes programmes that are provided via virtual platforms on the condition that they include
29 interactive elements, such as the opportunity to ask questions, and have discussions with
30 other trainees.
31
32 As this review did not identify evidence directly relating to the effectiveness of specific modes
33 of training the committee agreed to draft a research recommendation addressing this. The
34 committee were particularly interested in the effectiveness of training-learning and noted con-
35 cerns regarding its suitability as a means of enabling best practice on a day to day basis. As
36 a result, the committee agreed to draft a research recommendation focusing on the effective-
37 ness and cost-effectiveness of e-learning in comparison to face to face training.
38

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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

ID	Field (based on PRISMA-P)	Content
		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.
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.

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ID	Field (based on PRISMA-P)	Content
		• Studies reporting semi-structured and structured interviews, focus groups, observations. • 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.

ID	Field (based on PRISMA-P)	Content
		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.
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)

ID	Field (based on PRISMA-P)	Content
		If pairwise meta-analyses are undertaken, they will be done using Cochrane Review Manager (RevMan). '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

Safeguarding adults in care homes: evidence reviews for the effectiveness and acceptability of safeguarding training FINAL (February 2021)

ID	Field (based on PRISMA-P)	Content		
		certain groups or about different training, focussed on different groups and delivered via different modes.		
18.	Type and method of review	☒	Intervention	
		☐	Diagnostic	
		☐	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		

ID	Field (based on PRISMA-P)	Content
		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] • 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.

ID	Field (based on PRISMA-P)	Content	
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	
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*
3   *difference; 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.

#	Searches
35	((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$)).mp.
36	embed$.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 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*"))):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

#	Searches
S34	(MH "Organizational Culture")
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 su-pervision*)
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 "older 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.

#	Searches
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 mentally-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

#	Searches
3	((long term$ or long-term$) adj care).tw.
4	Respite Care/ use ppez
5	respite care/ use emczd
6	(respite$ 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

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#	Searches
	mentally-disabl$ or mentally disabl$ or disabl$ adult$ or disabl$ people$ or disabl$ person$ or disabl$ population$)).tw.
63	(family adj violence$).tw,kw.
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 safeguard$ 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 euroqol*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.

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#	Searches
122	Models, Economic/ use ppez
123	economic model/ use emczd
124	care-related quality of life.tw,kw.
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*)))

Line	Search
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 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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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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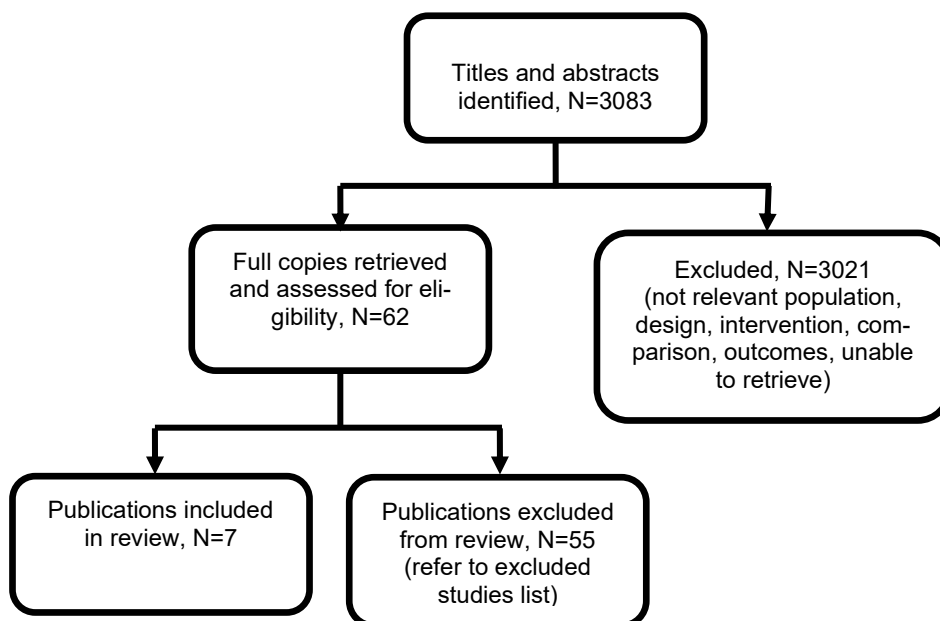
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1 Appendix D – Evidence tables

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 different 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	**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	**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**

Study details	Participants	Intervention/control	Methods	Outcomes and results	Comments
training activities." (p 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; In-patient 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.	through a survey administered 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.	**Bias because of deviations 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
	Reasons for withdrawal 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	**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.	**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	**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.

Study details	Participants	Intervention/control	Methods	Outcomes and results	Comments
management of suspected elder abuse by 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.	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%). 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	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.	Interdisciplinary 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	**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 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
	on abuse of older people. The authors report 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**	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.	Immediately post-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, discharge plan, and follow-up care: pre-intervention mean score 3.37 (0.48 SD); post-intervention mean score 4.04 (0.49); n=17; p < 0.0001.	**Overall risk of bias:** Critical.

Study details	Participants	Intervention/control	Methods	Outcomes and results	Comments
				Satisfaction with the Elder Abuse Nurse Examiner Curriculum 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	**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)	**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	**Randomisation** Web based randomisation, 1:1 ratio. **Allocation concealment** Remote and independent randomisation process and	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	**Risk of bias assessed using Cochrane risk of bias tool** **Random sequence generation:** Low risk of bias.

Study details	Participants	Intervention/control	Methods	Outcomes and results	Comments
and care home settings. Health Services and Delivery Research 6, 2018 **Ref Id** 1107835 **Country/ies where the study was carried out** England **Study type** Randomised controlled trial (cluster). **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	n=439 people living with dementia (n=213 training, n=226 no 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.	support the implementation. 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	blinded allocation report. **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	quality of life significantly lower than did 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]	**Allocation concealment:** Low risk of bias. **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
	Number of day staff ranged from 16 to 73. Average number of 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 | person-centred care plan that is clearly 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. | carer (measured using QOL-AD)
Extent to which service users felt that their human 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
	n=33 (9.9), Frontotemporal dementia - no training n=2 (1.2), training n= 0 (0.0), total n=2 (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				

Study details	Participants	Intervention/control	Methods	Outcomes and results	Comments
	no training n=3 (2.4), training n=1 (0.8), total n=4 (1.6), Other no training n=4 (3.2), training 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				

Study details	Participants	Intervention/control	Methods	Outcomes and results	Comments
	enough residents with dementia to fulfil study requirements. 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	**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 manag-	**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.	**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	**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
Country/ies where study carried out England. **Study type** Before and after study. **Study dates** 2015. **Source of funding** Not reported.	ers, nursing home managers, and tissue viability nurses. Length of service in current role: 10 months to 21 years (range). **Inclusion criteria:** Not reported. **Exclusion criteria:** Not reported.	The content focused on – safeguarding in clinical practice, the MCA (2005) and the MHA (2007); learning disabilities; Serious Case Reviews; legal and ethical issues; leadership; and discharge planning.		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%. 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%.	**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
				To a fair extent: 2012 class n=10; 2013 class n=4; 2014 class n=13; percentage of partici-pants responding 53%. 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 vulnera-ble adults: an evalua-tion of the re:act adult protection worker basic curriculum. Journal of Elder Abuse and Ne-glect 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	**Sample size** Adult pro-tection workers: N=157. **Characteristics** Profession: Social workers n=84, (54%), nurses n=54 (34%), oc-cupational therapists n=5 (3%), other n=14 (9%) (n = 14) for exam-ple, physical therapists, case managers. Time in profession: Av-erage of 6.5 years in profession (SD = 5.57, range: 0–32). Previous training in abuse of older people or had experience us-ing the Adult Guardian-	**Intervention** Training on the re:act Adult Protection Worker Curriculum. The curric-ulum was designed to ensure that Designated Responders under-stand how to follow-up reports of alleged abuse or neglect and are competent (as de-fined by the require-ments of the Adult Guardianship Act. The curriculum is based on 'adult learning princi-ples' and is designed to be delivered in person to inter-disciplinary groups using the Train-the-Trainer approach. There are 6 basic mod-ules in the curriculum -	**Data collection** Online survey. **Outcomes** Self-rated knowledge in identifying, reporting, and investigating cases of suspected abuse, neglect, and self-ne-glect of vulnerable adults. Perceived competence and knowledge about material covered in the curriculum. Respond-ents were asked to rate themselves on 7 as-pects of their confi-dence and knowledge using a 10-point Likert scale, where 0 repre-sented 'no' competence or knowledge, 5 repre-	Total average score (calculated on basis of scores for 9 questions pertaining to the vi-gnette): Completers = 21.60 (SD = 10.64, range 0–53), non-com-pleters = 22.25 (SD = 8.95, range 3–41), t(153) = −.37, p = .714. Knowledge about indi-cators of abuse, ne-glect and self-neglect: Completers mean 9.17 (SD 1.42), non-com-pleters mean 6.94 (SD 1.97), t = 8.03*, df = 155, 95% CI 2.79 to 1.69, d = 1.29. Knowledge about dy-namics of abuse, ne-glect and self-neglect: Completers mean 9.02	**Limitations (assessed using the ROBINS-I 'risk of bias' checklist for non-randomised studies of interven-tions)** **Pre-intervention** **Bias because of con-founding:** Serious risk of bias. No considera-tion of confounders. **Bias in selection of participants into the study:** Low risk of bias. **Bias in classification of interventions:** Mod-erate risk of bias. Only minimal details are pro-vided in relation to how

Study details	Participants	Intervention/control	Methods	Outcomes and results	Comments
who have not completed the basic curriculum." (p 47)

Country/ies where study carried out 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. | ship Act to protect vulnerable adults in British Columbia: n=107 (86%)

Inclusion criteria Not reported.

Exclusion criteria Not reported. | • Mandatory pre-requisite online module defining 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, | sented 'some' competence or knowledge and 10 represented 'a great deal of' competence or knowledge.

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 | (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.

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. | participants were classified as 'completers' or 'non-completers'.

Post-intervention
Bias because of deviations 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
		recommended response process and clinical tools available. • 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	reflected the process of investigating, assessing and care planning for a vulnerable adult. Overall competence was 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.	Competence at conducting investigation of abuse neglect and self-neglect in accordance with the Adult Guardianship Act: Completers 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:	

Study details	Participants	Intervention/control	Methods	Outcomes and results	Comments
		its dynamics, how to proceed on the basis of whether the person 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		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 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
		complete. Because of concerns regarding the length of time needed to complete the curriculum (17.5 hours) a condensed version was developed (13 hours). 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 Vulner-
5   able Adults Continuing Professional Development.

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 only minimal details are

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)	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.

Safeguarding adults in care homes: evidence reviews for the effectiveness and acceptability of safeguarding training FINAL (February 2021)

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	**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
				home staff and 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) o 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	

Study details	Participants	Intervention/control	Methods	Findings	Limitations
				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, 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	

Study details	Participants	Intervention/control	Methods	Findings	Limitations
				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) 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	

Study details	Participants	Intervention/control	Methods	Findings	Limitations
				it's right, I think scenarios 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	

Study details	Participants	Intervention/control	Methods	Findings	Limitations
				you've got to help people to cope and accept 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, p. 237) o In house training – viewed positively because it can be arranged more flexibly 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 partnership with social services, you can't afford to send	

Study details	Participants	Intervention/control	Methods	Findings	Limitations
				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 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		Qual-ity	Im-portance
No of studies	Design	Risk of bias	Incon-sistency	Indirect-ness	Impre-cision	Other consid-erations	Before train-ing	After train-ing	Rela-tive (95% CI)	Absolute[4]		Qual-ity	Im-portance
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 (Kinder-man 2018)	randomised trials	Low risk of bias	no serious incon-sistency	no seri-ous indi-rectness	serious[1]	none	213	226	-	MD 1.48 higher (7.86 lower to 10.82 higher)		HIGH	CRITI-CAL
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 (Kinder-man 2018)	randomised trials	Low risk of bias	no serious incon-sistency	no seri-ous indi-rectness	no seri-ous im-preci-sion	none	213	226	-	MD 0.002 lower (95% CI0.002 lower to 0.006 higher)		HIGH	CRITI-CAL
Quality of care provided as measured by DCM at 16 weeks (scale range not clearly reported, better indicated by higher values)													
1 (Kinder-man 2018)	randomised trials	Low risk of bias	no serious incon-sistency	no seri-ous indi-rectness	serious[1]	none	213	226	-	MD 1.960 higher (95% CI1.737 lower to 5.657 higher		HIGH	CRITI-CAL
Knowledge of the Adult Support and Protection Act as measured by online questionnaire at post-intervention (interval between assessments not reported)													

Quality assessment							Number of participants		Effect		Qual-ity	Im-portance
No of studies	Design	Risk of bias	Incon-sistency	Indirect-ness	Impre-cision	Other consid-erations	Before train-ing	After train-ing	Rela-tive (95% CI)	Absolute[4]		
1 (Camp-bell 2014)	Before and after study	very seri-ous[2]	no serious incon-sistency	no seri-ous indi-rectness	very se-rious[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	CRITI-CAL
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 seri-ous[2]	no serious incon-sistency	no seri-ous indi-rectness	very se-rious[3]	none	40	-		Pre-intervention mean 13.1 (4.2 SD); post-intervention mean 15.3 (4.8 SD), $p = 0.002$.	VERY LOW	CRITI-CAL
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 (Kinder-man 2018)	Before and after study (as part of an RCT)	very seri-ous[2]	no serious incon-sistency	no seri-ous indi-rectness	very se-rious[3]	none	213	-		MD 2.13 lower (2.75 lower to 1.51 lower)	VERY LOW	CRITI-CAL
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 (Kinder-man 2018)	Before and after study (as part of an RCT)	very seri-ous[2]	no serious incon-sistency	no seri-ous indi-rectness	very se-rious[3]	none	213	-		MD 3.00 lower (4.02 lower to 1.98 lower)	VERY LOW	CRITI-CAL
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 compara-tive study study	very seri-ous[2]	no serious incon-sistency	no seri-ous indi-rectness	very se-rious[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	CRITI-CAL
Self-reported level of confidence in managing abuse (measured at 3 months post-intervention)												

Quality assessment						Number of participants			Effect		Qual-ity	Im-portance
No of studies	Design	Risk of bias	Incon-sistency	Indirect-ness	Impre-cision	Other consid-erations	Before train-ing	After train-ing	Rela-tive (95% CI)	Absolute[4]		
1 (Cooper 2012)	Before and after study	very seri-ous[2]	no serious incon-sistency	no seri-ous indi-rectness	very se-rious[3]	none	40	-		p < 0.001	VERY LOW	CRITI-CAL
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 seri-ous[2]	no serious incon-sistency	no seri-ous indi-rectness	very se-rious[3]	none	17	-		pre-training mean rating 2.36; post-training mean rating 3.45; p = 0.0014	VERY LOW	CRITI-CAL
Perceived acquisition of knowledge and skills, as percentage of respondents (follow-up not reported)												
1 (Ochieng 2018)	Before and after study	very seri-ous[2]	no serious incon-sistency	no seri-ous indi-rectness	very se-rious[3]	none	42	-		Question: Following the course, to what extent were you able to do the follow-ing? 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 ex-tent 60%. Have a greater understanding of the underlying knowledge: Not at all 0%; a lit-tle 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 ex-tent 40%; to a greater extent 60%.	VERY LOW	CRITI-CAL
Perceived changes in practice (follow-up not reported)												
1 (Ochieng 2018)	Before and after study	very seri-ous[2]	no serious incon-sistency	no seri-ous indi-rectness	very se-rious[3]	none	42	-		Question: Since completing the course, to what extent do you do things differ-ently as a result of the course? Not at all: 2012 class n=0; 2013 class n=0; 2014 class n=0; percentage of par-ticipants responding 0%.	VERY LOW	CRITI-CAL

No of studies	Design	Risk of bias	Incon-sistency	Indirect-ness	Impre-cision	Other consid-erations	Before train-ing	After train-ing	Rela-tive (95% CI)	Absolute[4]	Qual-ity	Im-portance
										A little: 2012 class n=0; 2013 class n=0; 2014 class n=0; percentage of partici-pants responding 0%. To a fair extent: 2012 class n=10; 2013 class n=4; 2014 class n=13; percent-age of participants responding 53%. To a greater extent: 2012 class n=4; 2013 class n=5; 2014 class n=15; per-centage of participants responding 47%.		

(header spanning cells: "Quality assessment" spans Design–Other considerations; "Number of participants" spans Before/After training; "Effect" spans Relative (95% CI) / Absolute[4])

Identification of abuse measured using CSQ at 3 months post-intervention - Number of definitely abusive strategies identified

No of studies	Design	Risk of bias	Incon-sistency	Indirect-ness	Impre-cision	Other consid-erations	Before train-ing	After train-ing	Rela-tive (95% CI)	Absolute[4]	Qual-ity	Im-portance
1 (Cooper 2012)	Before and after study	very seri-ous[2]	no serious incon-sistency	no seri-ous indi-rectness	very se-rious[3]	none	40		-	Number of definitely abusive strategies identified: pre-intervention score me-dian = 3.3 (1.2 IQR), post-intervention score = 4.0 (1.0 IQR), p = 0.003.	VERY LOW	CRITI-CAL

Identification of abuse measured using CSQ at 3 months post-intervention - Number of possibly abusive strategies identified

No of studies	Design	Risk of bias	Incon-sistency	Indirect-ness	Impre-cision	Other consid-erations	Before train-ing	After train-ing	Rela-tive (95% CI)	Absolute[4]	Qual-ity	Im-portance
1 (Cooper 2012)	Before and after study	very seri-ous[2]	no serious incon-sistency	no seri-ous indi-rectness	very se-rious[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	CRITI-CAL

Frequency with which participants were considering abuse when assessing older people (at 3 months post-intervention)

No of studies	Design	Risk of bias	Incon-sistency	Indirect-ness	Impre-cision	Other consid-erations	Before train-ing	After train-ing	Rela-tive (95% CI)	Absolute[4]	Qual-ity	Im-portance
1 (Cooper 2012)	Before and after study	very seri-ous[2]	no serious incon-sistency	no seri-ous indi-rectness	very se-rious[3]	none	40		-	p = 0.006	VERY LOW	CRITI-CAL

Frequency with which participants reported that they were asking older people and their carers about abuse (at 3 months post-intervention)

No of studies	Design	Risk of bias	Incon-sistency	Indirect-ness	Impre-cision	Other consid-erations	Before train-ing	After train-ing	Rela-tive (95% CI)	Absolute[4]	Qual-ity	Im-portance
1 (Cooper 2012)	Before and after study	very seri-ous[2]	no serious incon-sistency	no seri-ous indi-rectness	very se-rious[3]	none	40		-	p = 0.24	VERY LOW	CRITI-CAL

Reasons given for not routinely asking about abuse (at 3 months post-intervention)

| Quality assessment | | | | | | | Number of participants | | Effect | | Qual-ity | Im-portance |
No of studies	Design	Risk of bias	Incon-sistency	Indirect-ness	Impre-cision	Other consid-erations	Before train-ing	After train-ing	Rela-tive (95% CI)	Absolute[4]		
1 (Cooper 2012)	Before and after study	very seri-ous[2]	no serious incon-sistency	no seri-ous indi-rectness	very se-rious[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 effect on doc-tor'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).	VERY LOW	CRITI-CAL
Satisfaction with the Elder Abuse Nurse Examiner Curriculum Training (immediately post training)												
1 (Du Mont 2017)	Before and after study	very seri-ous[2]	no serious incon-sistency	no seri-ous indi-rectness	very se-rious[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 infor-mation (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	CRITI-CAL

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						

Study information	Description of theme or finding	CERQUAL Quality Assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
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 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]	Serious concerns[4]	No concerns	Serious concerns[5]	Serious concerns[6]	VERY LOW
Sub-theme H1.1.3 – Dissatisfaction with existing training – NVQ Level 2						
1 study • Tadd 2012	Data from 1 study indicate that care homes managers felt that NVQ Level 2 did not meet	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
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).	their requirements. 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) [Quote: Tadd 2012, pp. 94]					

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

10 **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	In relation to PEACH (Promoting Excellence in All Care	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
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).	Homes), the authors report 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,	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
	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 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 | | | | | | |

Study information	Description of Theme or Finding	CERQUAL Quality Assessment				
		Methodological Limitations	Coherence of findings	Relevance of evidence	Adequacy of Data	Overall Confidence
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 and staff view the use of case studies 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	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
	Training Managers, Birmingham, 02/07/2010) [Quote: Tadd 2012, pp. 237]					
Sub-theme H1.2.4 – Dissatisfaction with computer based programmes						
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 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]	Serious concerns[1]	No concerns	Serious concerns[2]	Serious concerns[3]	VERY LOW
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	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
	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 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,	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
	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." [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

12

13

14

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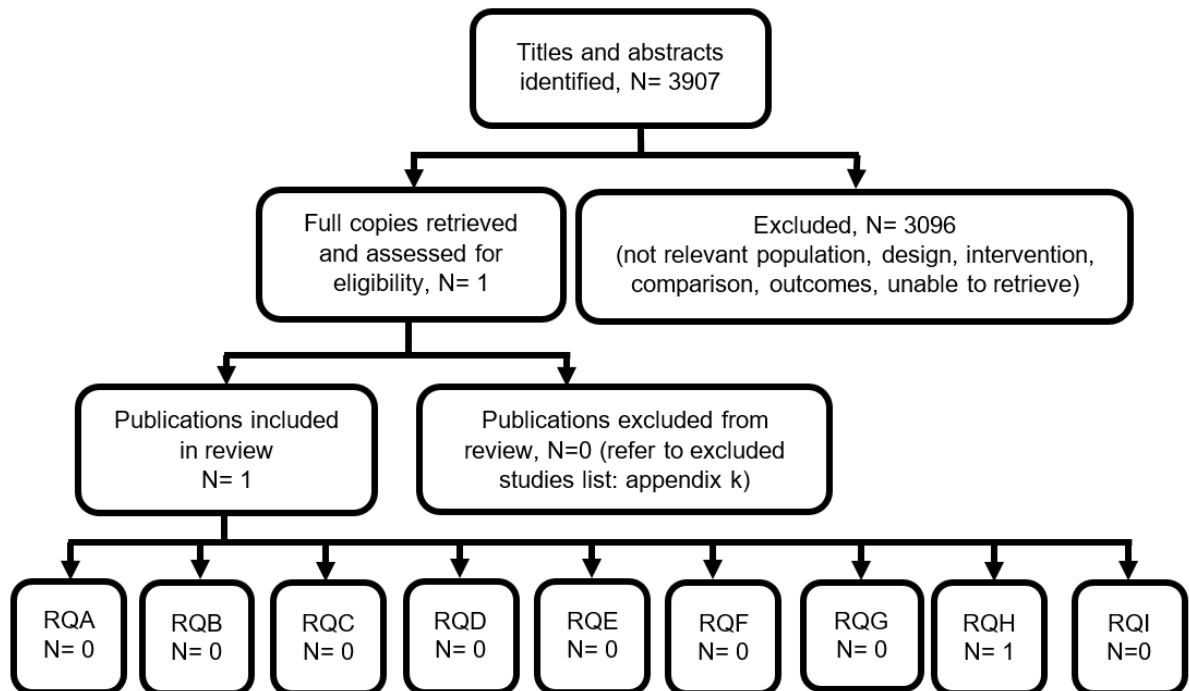
2 **Economic evidence tables for review questions H:**

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 2014-2015 Pound Sterling		**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.

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 well-being (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:** "What-if" cost-utility analysis	**Base case analysis (home care worker)**	**Base case analysis (home care worker)**	**Base case analysis (home care worker)**	The results just represent various "what-if" scenarios and give no estimate of the actual ICER

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			**Time horizon:** 1 day costs Not specified for hypothetical benefits **Primary measure of outcome:** Incremental cost per QALY	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	

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 spe-
11 cific 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-effec-
27 tiveness of face-to-face training and a "what-if" economic analysis was undertaken to support
28 this research recommendation and to serve as an exemplar of how a future economic analy-
29 sis 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" ap-
41 proach to ascertain cost-effectiveness for a given incremental gain in knowledge from face-

1   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" val-
9 ues 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 in-
27 cluded 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-learn-ing	£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-vul-nerable-adults-sova-level-3-training-skills-for-health-cstf-aligned (accessed 24/02/2020)
Staff time to complete e-learning (hours)	3	Safeguarding Adults Level 3 eLearning

Variable	Value	Source
		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 percentage point gain in knowledge from F2F compared to e-learning	5	0.5	10

Variable	Illustrative value	Lowest value	Highest value
QALY gain per percentage point gain in knowledge	0.0050	0.0005	0.0100

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-ef-
7　fectiveness 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.

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

| Training mode	Cost	QALY	Incre-mental cost	Incremen-tal QALY	ICER [a]	QALY gain needed	Knowledge gain needed [b]
e-learn-ing	£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-learn-
11 ing providing the incremental costs of face-to-face training were no greater than £500.
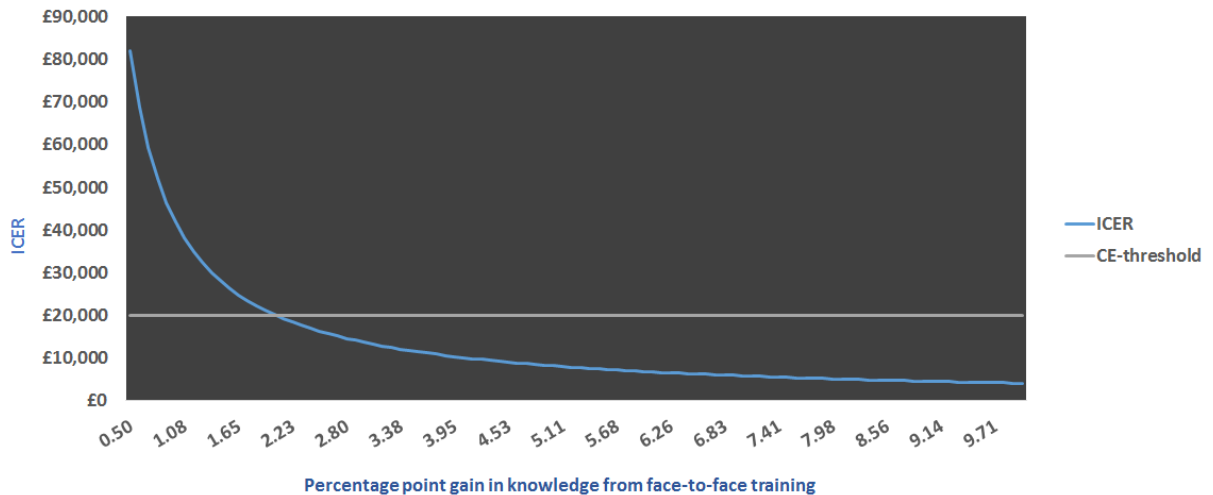
Figure 6: One-way sensitivity analysis varying the incremental costs of face-to-face training
            relative to e-learning for a home care worker
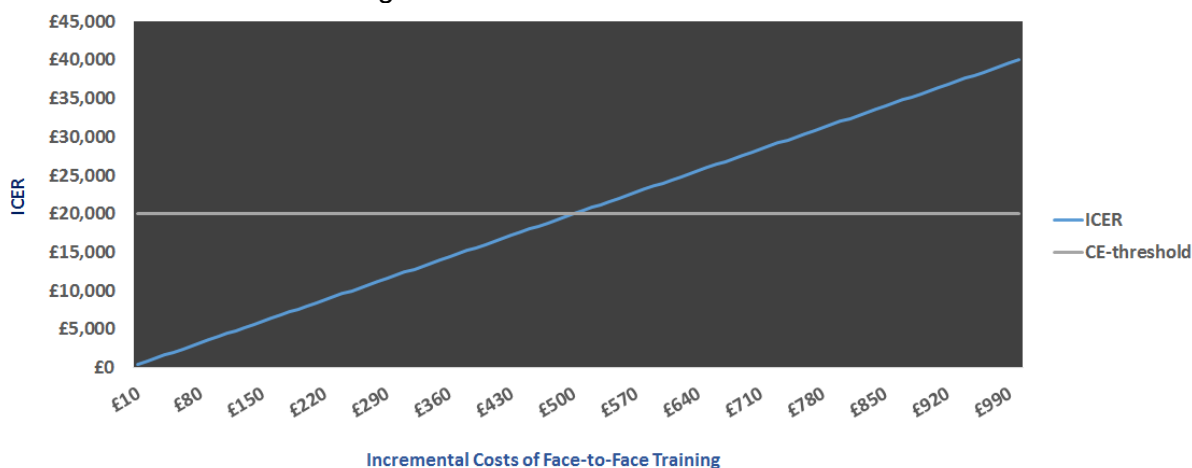
12   iv.   One-way sensitivity analysis varying the incremental gain in knowledge from face-to-
13   face training relative to e-learning

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
20 QALYs.

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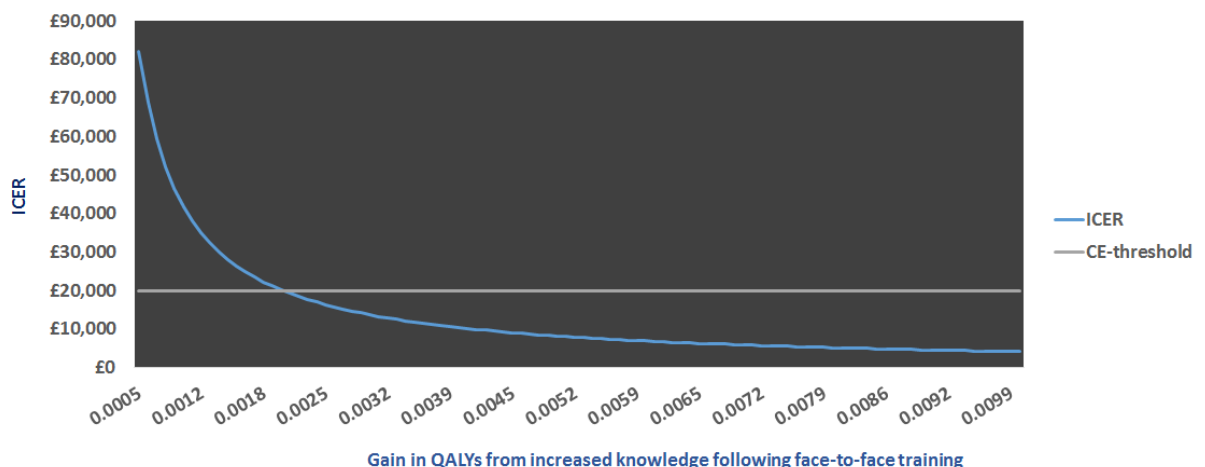of safeguarding training FINAL (February 2021)

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

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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
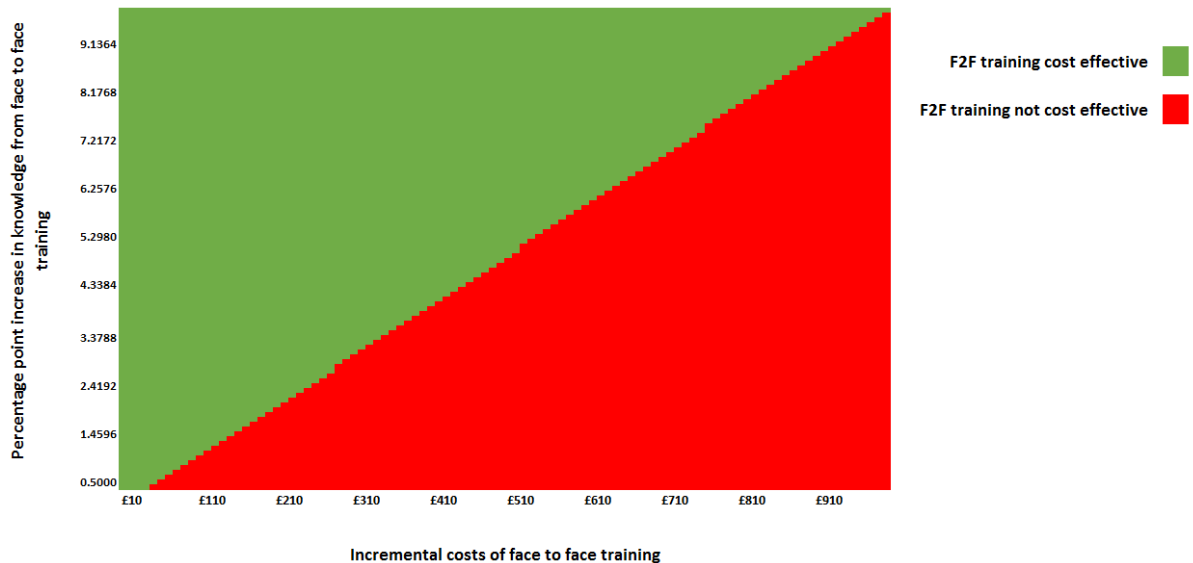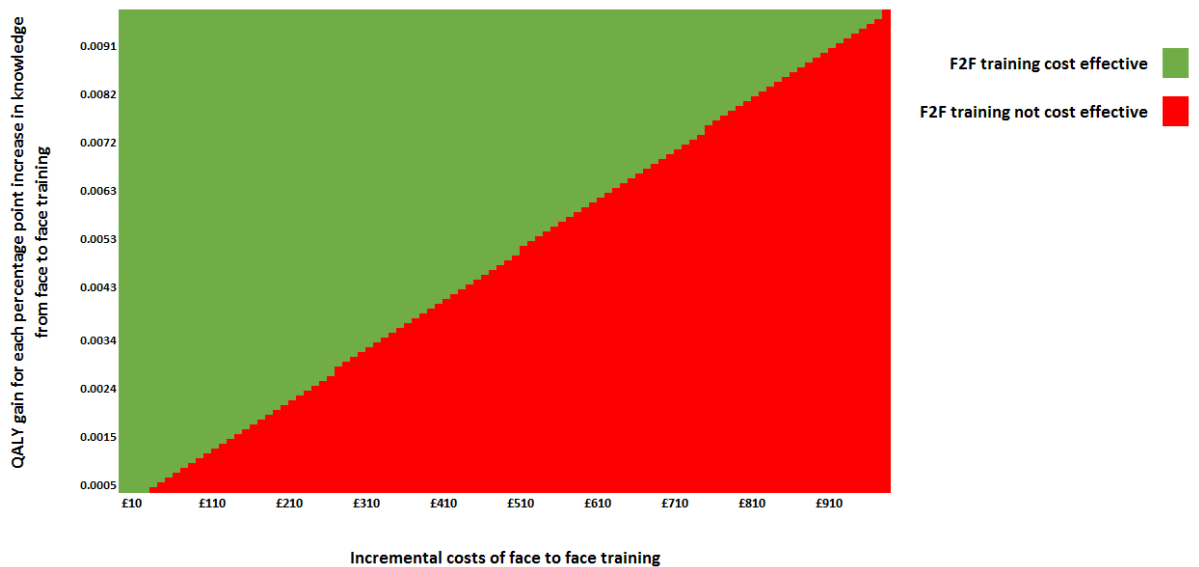8 cost-effective relative to e-learning.

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.

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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
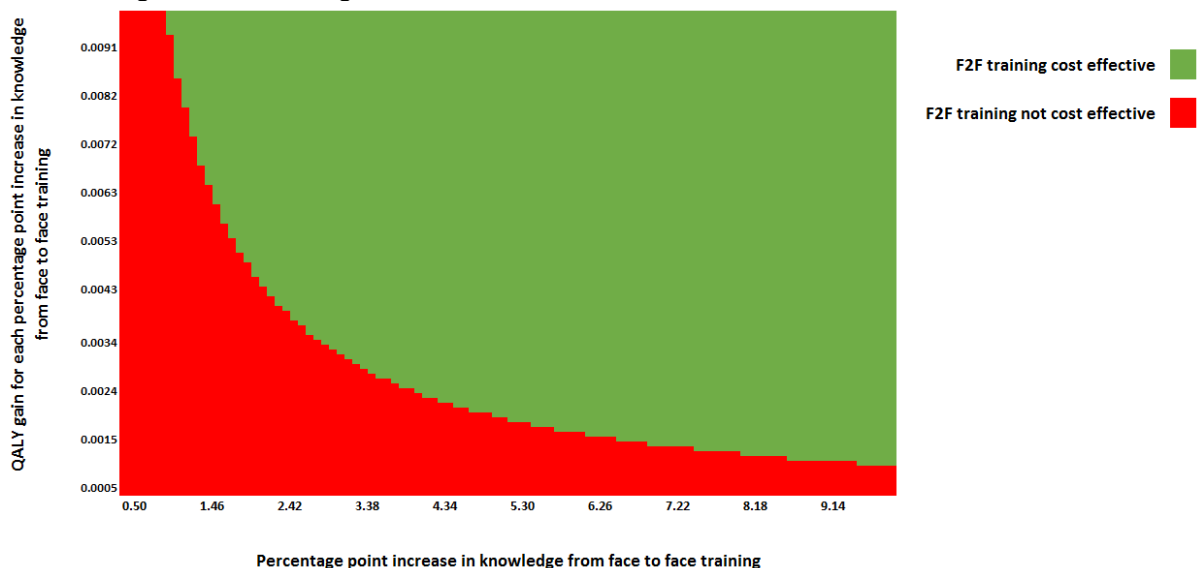
1

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 ex-
7 perience 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 ap-
15 proaches for safeguarding adults in care homes. Sensitivity analyses showed how cost-effec-
16 tiveness 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 inevita-
35 ble that increases in "knowledge" would translate into better safeguarding in care homes with
36 improved well-being. In other words, research should aim to assess the comparative effec-
37 tiveness of face-to-face training and e-learning in terms of increasing knowledge about safe-
38 guarding adults in care home and, in addition, the impact that increased knowledge has on
39 improved well-being for adult residents in care homes as a result of better safeguarding prac-
40 tice.

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

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1 assessment as to whether any incremental gains in knowledge from face-to-face training, as-
2 suming the evidence establishes this, would be likely to deliver the improvements in well-be-
3 ing necessary for cost-effectiveness to be achieved.

4 **Conclusion**

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

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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.

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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.

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.,	Study protocol, study conducted in Malaysia.

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Study	Reason for exclusion
Ramli, R., Mohamad, R., Lal Mohammad, Z., Hassan, N., Brownell, P., Bulgiba, A., A cluster 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.

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Study	Reason for exclusion
Romain-Glassey, N., Mangin, P., Schwab, P. D. R., An innovative interdisciplinary training about elder abuse, Revue Medicale Suisse, 13, 716-718, 2017	Non-empirical.
Rosen, T., Elman, A., Dion, S., Delgado, D., De-metres, 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 Mis-treatment 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 litera-ture, 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 in-crease 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 tar-geting 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 concep-tual 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.

Study	Reason for exclusion
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.
University Of, Sussex, University Of, Bedfordshire, 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.

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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 de-
18 livering 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 train-ing?
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 qual-ity of care experienced.

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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?
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 quality of some modes of delivery.

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?
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 service staff), care and health management and

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

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