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The Journal of Adult Prot

'It's that gut feeling isn't it': General Practitioner experiences of safeguarding in care homes for older people

Journal:	*The Journal of Adult Protection*
Manuscript ID	JAP-02-2024-0009.R3
Manuscript Type:	Research Paper
Keywords:	Care homes, General practitioners, Safeguarding, Elder abuse, Neglect, Multi-disciplinary Relationships

'It's that gut feeling isn't it': General Practitioner experiences of safeguarding in care homes for older people.

Abstract

Purpose: General Practitioners (GPs) play an important role in adult safeguarding. However, their experiences of this role have received scant attention in the UK and internationally. This study explored their experiences of safeguarding within care homes (CHs) for older adults where, as they are among the practitioner groups most frequently visiting, they are well-positioned to contribute to bringing abuse and neglect to light.

Methodology: This study involved qualitative methods. Semi-structured interviews were undertaken with 12 GPs to explore their experiences of safeguarding in CHs. This included the issues that prompted their concerns, actions taken in response, difficulties and dilemmas experienced, CH safeguarding during the COVID-19 pandemic. Thematic analysis was undertaken, taking an inductive approach to the analysis.

Findings: GPs seldom witnessed what they considered clear signs of abuse/neglect, but instead more frequently observed 'softer', more ambiguous signs. They undertook a range of actions in response to these, in addition to formally reporting concerns. They experienced difficulties and dilemmas in respect of the hidden nature of abuse, uncertainty about the legitimacy of their concerns and thresholds for reporting, as well as dilemmas associated with the need to preserve essential working relationships with CHs, yet avoiding collusion with staff.

Originality: Although GPs play an important role in identifying signs of abuse/neglect, this role has been little explored to date. Their safeguarding role within CHs has been especially neglected, and we are aware of no other studies which have explored GPs' roles and experiences in this context, within or outwith the UK.

Keywords

General Practitioners; Care Homes; Safeguarding; Elder abuse; Neglect.; Multi-disciplinary Relationships

Background

Research, reports and inquiries demonstrate that the abuse and neglect of older people living in care homes (CHs) is a significant and ongoing issue internationally. Estimates of the prevalence of abuse in such settings vary widely, due to differing definitions and methodologies, sources of data, and types of abuse considered, with under-reporting acknowledged (Yon *et al*., 2019; Hirt et al., 2022). However, significant physical and emotional health impacts for older people who are abused are documented (Yunus et al., 2019), therefore this is an important policy and practice issue.

Uncovering (and therefore responding to) abuse and neglect is however challenging. Residents may experience difficulties complaining about abuse or neglect, due to cognitive impairments, communication difficulties or fear (Cooper et al., 2013; Prang & Jelsness-Jørgensen, 2014). Therefore, they may need those in their support networks to be vigilant and raise concerns on their behalves. Families often monitor care when visiting, but may experience hostility or defensive responses when raising concerns or may avoid doing so due to anxieties about consequences (Baumbusch & Phinney, 2014; Yon et al., 2019; Saga et al., 2021). Furthermore, not all residents have families/friends, and some may experience difficulties visiting the home frequently (for example, due to illness, other caring responsibilities, distance), and monitoring care from afar

appears challenging (White et al., 2020; White et al., 2024). Visiting practitioners are well placed to identify and report concerns (Marsland et al., 2015). GPs (based on pre-COVID data) are among the professional groups most frequently visiting CHs (Handley et al., 2014; Kinley et al., 2014; Victor et al., 2018). Accordingly, they are particularly well-positioned to contribute towards resident safeguarding.

Research has demonstrated that GPs encounter abuse and poor care in care homes (Gleeson et al., 2014; O'Brien et al., 2014; White & Alton, 2022). However, while they considered abuse in these settings as concerning, they perceived elder abuse as difficult to address in comparison to domestic or child abuse, and a lack of confidence was indicated (O'Brien et al., 2014). Insufficient attention to abuse of older people within UK undergraduate medical training has been highlighted, and CHs are neglected within GP training (Gordon et al., 2014; Ruaux & Chadborn, 2023). There appears to have been no research within the UK or internationally which explores how GPs manage their safeguarding roles and the specific challenges and facilitators to identifying and responding to signs of abuse and neglect in care homes. A survey undertaken prior to this research (White & Alton, 2022) explored GP experiences of working in CHs; this found that 39.6% of participants had witnessed clear signs of abuse and neglect, and 42.6% had observed things which prompted concern about possible abuse or neglect. Participants also highlighted challenges encountered in CH settings, some of which are pertinent to their safeguarding roles; including reliance on others for information, and the need to foster effective working relationships with multiple partners (residents, staff, families, other professionals), who may have competing perspectives and priorities.

In England, responsibilities and actions in respect of abuse and neglect are underpinned by the Care Act 2014 and associated guidance (Department of Health and Social Care, 2024). Within the Act abuse and neglect are not defined (instead a range of abuses are recognised, including physical, psychological, sexual and financial abuses, and neglect). The guidance to the Act highlights the importance of lowering risks and preventing abuse and neglect, and those in contact with adults with care needs are charged with being vigilant for signs of abuse and reporting concerns. Primary care staff, especially GPs, are recognised as having important roles in observing such signs. The focus on prevention means that signs of possible abuse or neglect should be attended to, in addition to clear signs of abuse.

This study aimed to explore GPs' experiences of observing and responding to signs of possible abuse or neglect in care homes for older people. It sought to explore the things GPs notice and which prompt their concerns; the actions they take in response; any difficulties and dilemmas experienced. The research was underpinned by a recognition that abuse may be signalled by clear and relatively unambiguous signs, but also by more subtle signs which have a range of underlying causes (including, but not restricted to abuse), often referred to as 'softer signs'. While we use this language to differentiate the array of signs and certainties encountered, we stress that such 'softer signs' can signal abuse, neglect and other difficult experiences, and we do not seek to minimise their importance or impact.

Methods

Participant recruitment

GPs were recruited from an English Clinical Commissioning Group (CCG) which funded the research. They were eligible to participate if their roles had included CH visiting within the previous year. GPs were informed about the research at safeguarding training; in a GP newsletter; via a flyer with information about the study, circulated by practice safeguarding leads.

Data collection

Interviews were conducted from October 2020 – March 2021. They included questions about GPs' experiences of working in CHs; whether they see clear signs of abuse/neglect within these settings; whether they see things that worry them, but which they are uncertain are indicative of abuse or neglect; their responses to signs observed; any concerns or dilemmas experienced. GPs discussed experiences before and during the COVID-19 pandemic, and were asked about their perceptions of how COVID-19 had impacted on safeguarding in CHs. Interviews were conducted online or by phone, and lasted 25 minutes - 1.25 hours, were audio recorded and transcribed verbatim. Ahead of interview participants were given a written Participant Information Sheet (PIS), which was discussed, and were asked to sign a consent form. The PIS informed participants that if they discussed evidence of abuse or significant concerns which had not been appropriately reported, the researchers might have to report this information. EA undertook to follow up on any such issues post-interview in her capacity as Named GP for Safeguarding; however, this was not required in practice.

Data analysis

Thematic analysis was selected as an analytic approach which provides a 'robust, systematic framework' for coding and identifying key themes in qualitative data, which is well suited to applied research, and enables the reporting of findings in ways which are accessible to academic and non-academic audiences alike (Braun & Clarke, 2014:1).

Open coding was undertaken by one researcher (CW) with inductive codes derived from the data. Both researchers reviewed these, enabling them to bring their different professional backgrounds and perspectives (social care research and general practice) to the data. Following initial coding, themes and sub-themes were identified and thematic tables developed into which the data was sorted, to give a detailed view of each theme.

Ethics

Ethical approval for the study was given by The University of Hull Faculty of Health Sciences Research Ethics Committee.

After interview, participants were given an information sheet detailing sources of support and reminding them where to report safeguarding issues, in case participation prompted distress or concerns.

Permission was sought for the use of anonymised quotes. These have been amended to incorporate gender neutral language to further protect anonymity.

Results

Twelve GPs participated in the study. Most were GP partners or salaried doctors. 25% qualified before 2000 and 50% between 2000 – 2009 (25% missing data), indicating that participants were established, experienced practitioners.

GPs' experiences of care home safeguarding varied. Some had observed signs of abuse/potential abuse and neglect, and reflected in-depth on their experiences; others had more limited experience of safeguarding in CHs, and drew on experiences in other settings (e.g. the community), as well as their knowledge of CHs, to identify potential difficulties and challenges.

Six themes were identified:

- GP experiences of detecting possible abuse and neglect

- GP actions in response to signs of abuse and neglect
- Uncertainties within care home safeguarding
- The paradox of relationships
- Factors which hinder recognition and responses to potential abuse
- Changing patterns of care home visiting

GP experiences of detecting possible abuse and neglect

GPs were asked whether they had observed signs which they considered clear and unambiguous signs of abuse or neglect, and/or 'softer signs', which caused them concern, but which they were less certain signified abuse or neglect.

Clear signs of abuse and neglect

Most participants reported that they had not seen signs which they considered clearly indicated abuse or neglect. Those signs they had seen primarily related to medical matters to which the home had not responded appropriately, with sufficient attention or in a timely manner, such as failing to request help when there were changes to residents' health or clear signs of injury:

People who'd had a fall, bumped their head with…significant bruising and…they become drowsy, which was out of character…….but they weren't calling us (GP1).

Less clear signs

GPs more frequently reported seeing 'softer' signs of abuse or neglect, with a greater diversity of signs noted. These included: the 'feel' of the home (*'a finance first business rather than a care home' GP10*); CHs not making decisions, taking responsibility or problem solving, instead relying on external practitioners; lack of leadership; staff lacking knowledge of individual residents or demonstrating negative attitudes towards them:

When [staff member] was talking about patients….the way they spoke about them was disrespectful and arrogant….I felt like they didn't care…..the language….a bit derisory….they would assume they were lying or they were making a fuss ….actually sometimes they were quite ill…. when you saw the patient, Jeez, this person is actually…they're dying and [staff member is] talking like they're being a fuss pot (GP1).

Signs observed also related to the quality of care delivered and documented and included: residents appearing unkempt, dirty and smelling of urine/sitting in wet clothing; a lack of cleanliness in the home; poor record keeping and reporting; concerns about the adequacy of medication management/recording; neglect of 'basic' care, and failing to address concerns raised previously:

You've been to review a patient who is clearly dry and that cup of juice is on the table and they can't reach it and so you've said to the carers…..you really need to be going in, you need to hand them the cup - and then you go back the next week to review them and they're still dry and they've still got the cup on the side (GP9)

Concerns raised by other people

Concerns also came to light as a result of others (such as family members, other practitioners) raising issues with the GP, rather than through direct observation. In these circumstances it could be challenging to identify the legitimacy of the concerns raised, and what actions, if any, should follow.

GP actions in response to signs of abuse and neglect

GPs reported undertaking a range of responses when they saw signs which concerned them.

Formal reporting

Participants were aware of the requirement to formally report abuse or neglect to Adult Safeguarding Teams, in line with local multi-agency Adult Safeguarding policies and the Care Act; they also had recourse to other services such as a Medication Management team for concerns regarding medication matters, and a CCG safeguarding team where concerns could be discussed. Some had made formal reports or approached the safeguarding team to discuss concerns, enabling collation of their concerns with those from other sources. Some reported difficult experiences associated with formal reporting, including anxiety about making mistakes and the consequences of reporting, and responses perceived as defensive or unhelpful. The lack of feedback about outcomes was also noted, *it feels like it goes into a big abyss (GP1).*

Where GPs had witnessed clear signs of abuse, they appeared confident of the required actions; how to respond to less clear signs was associated with greater uncertainty, and a wider range of responses.

Responses to less clear concerns

Participants reported discussing concerns with other GPs, the Named GP for Safeguarding, and other health colleagues, and taking concerns to practice meetings. This enabled consideration of further actions and collation of wider concerns, and drawing on colleagues' knowledge and experience was valued:

It can be sad and scary sometimes. You need the team (GP10).

GPs also kept a watchful eye and monitored CHs where they had concerns, to check how situations progressed, and whether a safeguarding referral was subsequently warranted or issues resolved:

You have to be a bit of a detective to try and put everything together and it takes more of an effort from your side then to monitor it, to sometimes do impromptu home visits and things like that, just turn up at the door (GP10).

Participants also sometimes sought to work with care homes to address concerns, and described raising issues with managers, formally writing to CHs to raise concerns, and giving prompts to staff when they felt additional support for residents was required:

If it was a home that I knew very well and I felt it was very much a one-off incident, it was something that I wouldn't expect of that care home, I would speak to the senior carer, try and establish what the problem was (GP9).

Uncertainties within care home safeguarding

GPs described multiple uncertainties which challenged the process of identifying and responding to abuse and potential abuses.

The language employed when discussing signs of possible abuse indicated how the things GPs saw could be intangible, and open to interpretation, in which it was difficult to pinpoint and define precisely what was wrong. Words and phrases such as 'gut feeling', 'can't quite put your finger on it' and 'subtle' were used to describe the things which prompted concern, so that *sometimes all you have is something that you just feel slightly uncomfortable about (GP7).*

Participants expressed uncertainty about thresholds and precisely what should be considered a safeguarding matter. For example, one GP described a situation which they considered to *verge on neglect (GP1)* and another questioned:

At what level do you call it neglect? You've maybe left a care home saying 'oh by the way Mrs So and So's trousers are wet or her pad's wet', you assume that that will be changed, it's only when…next time you go and you think oh, her pad - that was wet last time (GP9).

There could be multiple underlying causes of the things seen, and participants appeared to question the legitimacy of their concerns and whether they would be shared by others, with judgement required to determine whether:

This is something that is pervasive and potentially dangerous…or if you're being overly sensitive about something (GP5).

Situations involving subjective judgements, personal feelings and emotions may be especially difficult to disentangle, as highlighted by this GP who experienced concerns about the attitudes of a staff member. Although they formally reported concerns relating to medical matters, they did not report those associated with staff attitudes, despite their concerns:

I think it seemed prejudiced to, because it seemed personal….I have to admit, I didn't like them….I needed fact and evidence and not feelings, and so I felt it wasn't professional (GP1).

Consequently, important information may have been lost.

The uncertain landscape experienced by GPs within this context and the challenges of interpreting many of the signs observed meant that:

You always have some doubt as to….whether your conclusions are right (GP4).

The paradox of relationships

Participants highlighted the importance of establishing good professional relationships with staff which facilitated their work. Some perceived that such relationships could ease discussion of concerns. However, GPs were also aware of the risks to these relationships when responding to the softer signs which signalled possible abuse (although there was no evidence that significant concerns or signs of abuse were overlooked):

I knew I had to go in every week, I had to work with these people and you spend a lot of time trying to be nice to the staff to get a working relationship, because if they have concerns and they think you're a stroppy, demanding, not very nice doctor, they're not going to tell you stuff and then they won't do what you suggest (GP1).

Therefore, when they had concerns they appeared to navigate these carefully, to manage social awkwardness and avoid damaging relationships and upsetting others:

You don't want to offend friends….the difficulty is to raise the concern without it feeling personal to the other person and them being personally offended, so keeping it factual…and saying it in a way that they are likely to be receptive about the issue (GP5).

Furthermore, they expressed reluctance to *get anyone else in trouble (GP11).*

While valuing working relationships with staff/managers, and working to cultivate these, GPs were aware of the risks of blurred boundaries and collusion with staff perspectives:

I go in regularly, I'm quite friendly with the staff, and I think then you cross over to colluding because I don't want them to be fearful of me going in, I want to see, I don't want….them to hide things (GP1).

Factors which hinder recognition and responses to potential abuse

GPs' accounts highlighted factors which impacted on their abilities to recognise and respond to signs of potential abuse clearly and confidently.

Barriers to witnessing signs of abuse or neglect

Abuse is often hidden, with overt acts of abuse unlikely to occur in the presence of external practitioners, who are often accompanied by staff when visiting. Participants observed that residents are not always able to clearly report abusive or neglectful experiences, and the necessity of relying on information from others can be problematic:

The vast majority of patients in care homes are…elderly…with some level of short term memory problem….dementia, confusion and you…are probably never going to be….wholly reliant on, on their history…..you're going to probably… take it from….the carers and therefore that is maybe going to hugely….sway your independence (GP4).

Empathy for the challenges of the staff role

Participants perceived that CH staff have physically and emotionally challenging roles, are poorly paid and often experience staff shortages, while supporting residents who have diverse needs and could experience distress or become aggressive. Staff were perceived to be doing the best they could under such circumstances; one particpant recognised that they are *doing a really tough job that the rest of us aren't doing (GP1),* and questioned their own ability to manage better:

I don't know how I'd manage it and that's what I am often thinking, well I don't know what I'd do (GP1).

Interpretations of the underpinning reasons for abuse and neglect

Although only mentioned by a few participants, there was some suggestion that whether actions were framed as abusive or neglectful depended on whether GPs believed these to be caused by deliberate intent or systemic factors:

Sometimes it's the very minor things that you think well is that neglect or is it that the carers are too busy? (GP9)

The reason that the people are lying in wee, generally I don't think it's because they're really lazy, they were busy sorting out something else and just hadn't had a chance to go to that room for two hours say and so I can see the reasons behind it are not malicious, they're about resources (GP1).

However, this apparent distinction between deliberate intent and systemic factors, coupled with their recognition of the challenging working environment, in which staff were felt to be trying their best, means there is a risk that signs of possible abuse or neglect may not be perceived as such or their seriousness diminished, with a consequent lack of appropriate action:

You don't want to knock [staff] when they're trying their very best but actually we probably should be reporting it because what it shows is they need more resources but I don't want them to personally be being told off and disciplined and having safeguarding scary social workers come down because… that feels unsupportive (GP1).

It is not clear in the quote above whether the perception of safeguarding social workers as 'scary' is widely held, and whether this reflects the view of the GP or care home staff. However, it offers a further indication that safeguarding processes may be anxiety provoking for the practitioners involved, and that there is a reluctance to get others 'into trouble', as previously noted.

Changing patterns of care home visiting

Participants reported changes to their working patterns which appear to reduce the frequency of visits. These changes reflected the risks of spreading COVID and the need to rationalise GP time. They include increased use of technology and phone calls to conduct consultations remotely, and greater use of non-medical practitioners such as Advanced Nursing Practitioners (ANPs) and Advanced Care Practitioners (ACPs) to attend care homes. Such practitioners appear to undertake many routine care home calls, with GP visits limited to the most complex circumstances. These new ways of conducting visits save GP time, but concerns were also noted in respect of technical difficulties and associated missed information, and loss of relationship continuity and direct contact with patients. Participants noted the potential for *lost clues (GP3)* in which signs associated with the individual, their environment and the care home culture may be lost. This contrasted with the opportunities afforded by in-person visits to *get the vibes of the general atmosphere (GP2)* and for:

Informal chit-chat with the staff…..building a relationship with the team….it's the small talk as you go to the patient that you're picking up lots of information, including the attitude of the carer….It's all those little interactions as they walk along the corridor and they interact with the residents and you see how the residents are sat in the lounge. You see what the staff are doing, we've got none of that information now (GP1).

Discussion

This study contributes to the currently limited research evidence about GPs' safeguarding roles, both in the UK and internationally, which has been especially neglected in the context of care homes.

The findings demonstrate that GPs observe things which cause them concern when visiting care homes. Their experiences of witnessing signs which they considered clear and unambiguous were rare, but provided clarity in respect of formal reporting requirements. However, more frequently, they observed 'softer' signs; these were less clear, attributable to multiple possible causes, and subjective, requiring practitioner judgement. In these instances, GPs employed a diverse range of responses, including monitoring, discussing with colleagues, and informal discussions, prompts and encouragement during care home visits, intended to improve practice and resident support. These alternative practices are also reflected within the wider whistleblowing literature, in which recourse to a range of informal strategies for situations assessed as 'less serious', in addition to formally reporting, has been reported by CH staff (Jones & Kelly, 2014). However, Jones and Kelly (2014, 996) note that *little attention has been given to these informal ways of raising concerns or of monitoring practices* and that *by their very nature these interactions remain unrecorded and invisible to external oversight*. Yet it is in this informal, less certain context that much GP safeguarding appears to rest.

The findings suggest that there are some significant challenges for GPs in bringing abuse to light in care home contexts. These include the inherent challenges and uncertainties in confidently recognising signs of possible abuse and neglect, the relational nature of the care home space, and interpreting the causes of the signs they see.

Uncertainties associated with signs of abuse

Abuse usually occurs in private spaces, away from the scrutiny of outsiders. It is therefore unsurprising that GPs seldom reported seeing clear signs, with their concerns instead often prompted by less tangible, subtle signs, and gut feelings. Gut feelings have important roles in social work practice, in which they can alert practitioners to signs which require further exploration, and can assist in making sense of complex dynamics and environments, along with more analytic thinking (Cook, 2017). Similarly, gut feelings play a significant role in GPs' clinical practice, highlighting signs of significant disease which may require investigation (Green et al., 2015; Smith et al., 2021). Within care homes, visiting practitioners have been found to recognise sometimes intangible signs that 'something is wrong' in a service, before abuse comes to light, although they may lack confidence in the legitimacy of their concerns (Marsland et al., 2007). Together this evidence highlights the importance of subtle signs, intuition and gut feelings in alerting visiting practitioners to potential abuse and neglect, although they also need to be mindful of the risks of bias and unwarranted assumptions which might underpin these (Cook, 2017). Further, it demonstrates that, within the clinical context, GPs are adept at employing gut feelings, and such skills could be incorporated into their safeguarding practice. This suggests that safeguarding training could usefully incorporate an awareness of 'softer signs' of abuse as legitimate and important alarm bells, alongside training to identify clear, but less frequently encountered, signs. In this the work of Marsland et al (2012, 2015) which identified 'early indicators of abuse' may provide a useful framework to support practitioners' understanding, observations and judgements, and decisions about the most appropriate responses.

GPs also highlighted difficulties in determining when their concerns meet thresholds for formal reporting. This reflects the difficulties reported elsewhere in distinguishing between abuse and poor practice, and judging thresholds of seriousness and what should be reported (Brown, 1999; Prang & Jelsness-Jørgensen, 2014; Fyson & Patterson, 2020). However, the importance of recognising and collating evidence of 'low level' harms and attending to emerging patterns of concerns across whole services, rather than solely responding to individual concerns, have been highlighted (Manthorpe & Martineau, 2017; Starns, 2018). Ensuring that there are systems in place which facilitate the reporting and collation of these signs, which collectively highlight a need for greater scrutiny and close examination of practices and dynamics within care homes, is an important element of adult safeguarding. It is therefore important that GPs, as well as other practitioners, are able to report such concerns and are confident that this evidence will be taken seriously, documented and collated with any concerns from other sources.

Care homes as relational spaces

As external practitioners GPs occupy ambiguous positions within care homes. Like others on the periphery of the care team they bring important perspectives which may enable them to question practices and behaviours which may have become established and embedded within CH cultures (Jones & Kelly, 2014; Marsland et al., 2015). However, CHs are relational spaces, in which breaching social and relational codes may be problematic. Like those on the inside of the service, who may fear loss of working /social relationships (Prang & Jelsness-Jørgensen, 2014; Lund et al., 2023), GPs are also dependent on positive working relationships to enable them to deliver good support to residents (Badger et al., 2012; Robbins et al., 2013; Kinley et al., 2014; White & Alton, 2022). Traditional professional hierarchies may be disrupted within the care home context (Ruaux & Chadborn, 2023), in which, although GPs may have power conferred by their role and expertise, they are also dependent upon staff, and may adjust the ways they work alongside them to ensure that vital relationships remain functional and cordial. GP responses highlighted the importance of these working relationships, and the social awkwardness of raising concerns or prompting staff when practice is poor and residents need additional support. The findings suggest GPs may be concerned

that if relationships deteriorate, staff may be less willing to follow their advice (which could impact on resident care) and might be more guarded in the things they say, closing down communication and consequently awareness of practice and standards. In these circumstances, when GPs had concerns (rather than clear evidence of abuse or neglect), they were aware of the risks to their professional relationships and in some instances sought to address issues in ways which reduced risks of conflict and damage. However, alongside acknowledgement of these difficulties, they were also aware of the delicate balance between the preservation of professional relationships and the risk of colluding with staff. In our previous research (White & Alton, 2022) we highlighted this paradox in which relationships with staff both facilitate GPs' work, but also place them at risk of collusion with staff perspectives and of marginalising residents' voices. Similar difficulties have been identified by practitioners working with families (Hodges & Northway, 2019) who were reluctant to disrupt positive relationships and therefore acted on concerns without recourse to formal reporting, while recognising that maintaining these relationships also risked compromising practice. These findings demonstrate the challenges for practitioners in managing the relationships which facilitate their work, and the potential damage to these when there are concerns. Training and supervision for GPs (and other visiting practitioners) could usefully acknowledge the complexities of managing professional relationships and boundaries, and explore the skills required to reduce risks of collusion and compromising safeguarding practice.

Factors which shape GP interpretations

There are multiple and complex reasons why abuse and neglect may occur in care homes. Abuse and neglect have been attributed both to resident characteristics and the failings of individual staff, which may be rooted in occupational or personal stress, psychopathology or deviance (Burns et al., 2013; Eliasson & DeHart, 2024). However, these factors risk victim blaming and do not take into consideration the wider pressures which may impact on the way care is given and support provided. The role of factors such as care cultures, which may shape the ways in which otherwise well-intentioned staff behave, organisational factors and lack of resources, also appear to play important roles in creating the climate in which abuse and neglect may thrive (Cooper et al., 2013; Marsland et al., 2015; Pickering et al., 2017; Eliasson & DeHart, 2024). Although mentioned by relatively few, some participant accounts hinted that GPs might be more comfortable in defining actions as abusive when they are perceived to be underpinned by individual failings and malicious intent. Policy recognises that abuse may arise intentionally or unintentionally (Department for Health and Social Care, 2024). However, GPs' apparent reluctance to frame as abuse acts which are non-intentional and underpinned by workplace conditions, alongside their reluctance to get staff into trouble, risks overlooking the harms done to individuals and groups, and failing to ensure that appropriate actions are undertaken.

Further, GPs appear aware of the challenges care home staff experience, which include poor staffing levels, high turnover, poor remuneration and time pressures (Prang & Jelsness-Jørgensen, 2014; Vandrevala et al., 2017; Kupeli et al., 2018; Puthenparambil, 2023), and they appear to develop empathy for staff working in these conditions. Their perceptions of the pressures on care home staff, who some recognised were doing difficult jobs well, in challenging circumstances, apparently prompted them to adopt encouraging and motivating approaches when working with staff, in which they sought to model and shape practice with subtlety and without conflict. Such empathetic responses may help foster the relationships which support GPs' practice, but may contribute to the apparent challenges in labelling actions which may arise from workplace conditions as abusive or neglectful.

Changed patterns of care home visiting

This research took place during the COVID-19 pandemic which drove the adoption of online consultations with CH residents. These enabled time and cost savings for external practitioners who would otherwise have visited, and are perceived as valuable tools beyond the pandemic, although limitations have been noted, in which they have been experienced as unsuitable for difficult consultations and challenging for some residents (Warmoth et al., 2022). GPs' reflected on their experiences and perceptions of online contact with CHs. They observed that online consultations could restrict their abilities to develop a rapport with the wider care team and to notice concerns associated with the environment, organisational culture and quality of care. Similarly, safeguarding practitioners have reported concerns about missing visual and sensory cues, the quality of information available virtually, and experiencing barriers to exercising professional curiosity (Pritchard-Jones et al., 2022). In some areas GPs' care home roles are being adopted by other practitioners (Evans et al., 2020). How these new patterns of visiting and examining residents impact on the development of professional relationships and the ability to observe signs of abuse and neglect are important areas for future research. ANP/ACP experiences, training and supervision needs require further exploration, to ensure that they are able to contribute to identifying concerns of possible abuse and neglect.

Implications for practice

This research has explored GPs' experiences of safeguarding in care homes, and has identified some significant challenges that they and other visiting practitioners may experience. These include the subtle signs that prompt their concerns, the complex relational environments in which they are working, and the apparent difficulties in labelling as abusive (or as safeguarding issues) actions or omissions which do not appear to stem from deliberate intent. This suggests that those delivering support, guidance and training to GPs (and other practitioners) need to acknowledge the complexities and uncertainties of safeguarding in care homes, and the difficulties GPs may have in being certain of the significance of the things they see. A nuanced approach which acknowledges that there may not be clear, unambiguous signs that residents are being abused or are at significant risk, and which supports GPs to engage with the uncertain signs they perceive, alongside the imperative to develop professional relationships with the very staff whose practices may cause concern, appear important elements of safeguarding training and support. Further, as already noted, it is important that safeguarding systems recognise the importance of the softer signs more typically observed by practitioners and collate these, in order to highlight any growing patterns of concern suggesting service deterioration and risks to residents.

Strengths and Limitations

This was a small-scale study within a single geographic area. The small sample size meant that not all types of abuse were reported (for example, no GP discussed concerns about sexual or financial abuses or abuses carried out by other residents). Further, we did not explore the level of safeguarding training received by GPs. Therefore, while this study underscores the importance of GPs' safeguarding roles, it also signals the need for further research incorporating participants from a wider geographic area and inclusive of greater diversity.

The different professional backgrounds of the researchers is a strength, bringing experiences of general practice and social care to the study. The involvement of the Named GP for Safeguarding, who conducted some of the interviews and who was known to GPs (through safeguarding training and discussion of safeguarding concerns), appeared to facilitate recruitment and may have encouraged participation for some. However, we also acknowledge that the involvement of a senior

safeguarding practitioner may have meant that others were reluctant to participate or were guarded in respect of the accounts they gave of their safeguarding practice and experiences.

Conclusion

This paper explored GPs' experiences of safeguarding in care homes for older people. While GPs play significant roles in supporting residents, their role in care home safeguarding has been largely absent from the research literature internationally. This study highlighted the importance of GPs in detecting and responding to abuse and neglect. However, they seldom reported witnessing clear signs of abuse. The softer signs they more typically report have an ambiguous place in adult safeguarding and are often unclear, intangible and hard to pin down. While GPs may recognise that these are potentially important signifiers of harm, their subjectivity and associated lack of clarity, along with relational dynamics and empathy for the challenges experienced by staff, meant that they could also disappear from view and could be shrouded in uncertainty. There is a need for further research to explore the GP safeguarding role in care homes, the challenges and dilemmas experienced, and approaches to mitigate these.

Acknowledgements

We would like to thank the GPs who participated in this study and reflected on their safeguarding practice, during the exceptional demands and pressures imposed by the COVID-19 pandemic. The study was funded with support from the former East Riding of Yorkshire CCG.

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