Patient Safety Culture in Homecare in England: An Exploratory Study

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Thesis submitted to The University of Nottingham for the degree of Doctor of Philosophy (PhD)

June 2024

Acknowledgements

I would like to express my great gratitude to my supervisors, Dr Simon Bishop and Professor Carl Macrae, for their valuable time, patience, kind support and helpful guidance throughout the course of conducting this PhD research. Thank you for your trust and encouragement. This PhD thesis would not have been possible without your support and insightful feedback.

I would also like to thank the University of Nottingham for their generous funding, which has provided me with the opportunity to dedicate myself to full-time research, an experience that has been both enriching and rewarding. I am also thankful to the Business School's professional and academic staff, who have helped me throughout my PhD journey with their support and expertise.

To all of the participants that took part in this study, I would like to dedicate my thanks and appreciation for your participation and openness. Your insights have been both inspiring and enlightening, contributing significantly to this research and its potential impact on future developments in homecare research and practice.

To all my friends, thank you for being part of my life during this journey and for making it exceptional. I would also like to extend my gratitude to my fellow PhD colleagues at the Business School for their support and friendship.

Finally, I wish to express my heartfelt gratitude to my dear family, especially my mum, for their love, encouragement, and support. Your constant belief in me has been a source of strength and motivation that helps me overcome challenges and stay focused on my goals. Your sacrifices and understanding have made this journey possible, and I am forever grateful for everything you have done.

Abstract

Background: In the health and social care sector, patient safety culture is a key priority. However, research on patient safety culture has extensively focused on hospitals, with very few studies examining safety culture in homecare. Homecare is a crucial part of the health and social care system in England, and there has also been an increase in demand for homecare services due to the aging population and the impact of the COVID-19 pandemic. Consequently, the UK government has made significant efforts and strategic commitments to reform adult social care and highlight the importance of research in homecare.

Aims: This PhD thesis aims to explore the patient safety culture in homecare in England. The research seeks to identify the foundational factors that constitute high-quality and safe homecare, examine the prevalent safety issues in the sector, and address the fundamental challenges in delivering such care services. Additionally, the study aims to understand approaches to safety and investigate the role of HRM practices in shaping and strengthening homecare safety culture.

Methodology: This study adopts an interpretivist epistemology to explore the rich meanings of safety culture in homecare. Using an inductive approach, this study collects qualitative data to develop theoretical concepts from detailed interpretations of social actors. The research strategy employs narrative inquiry and triangulation, incorporating semi-structured interviews and documents for data collection. Thematic analysis is used for interview data, while qualitative content analysis is applied to written documents.

Findings: The study reveals a number of significant findings. First, safe homecare consists of several foundational factors of high-quality care, person-centred care, and the engagement of family members and informal support networks (e.g., friends, neighbours). Second, safety incidents are categorised into four types: medication safety, physical and health safety, emotional and social safety, and functional safety. Third, fundamental challenges that serve as barriers to high-quality care and act as risk factors leading to safety issues relate to the institutional context, organisational management, work environment, teams, individual staff, tasks, service users, and informal support networks. Fourth, initiatives and practices that have been made to improve

care quality and safety culture include collaborations and partnerships, inclusive and personalised care service, strong leadership and staff support, digital technology integration, and effective HRM practices.

Discussions: The insightful findings help answer the research questions, achieve the primary research aim, and develop theoretical frameworks. First, the interconnected fundamental challenges framework depicts how homecare challenges are interconnected and function as barriers to high-quality care and risk factors for safety incidents. This is useful for identifying safety issues, understanding their origins, and proposing measures to minimise errors and risks, which is in line with the Safety-1 approach. Second, the homecare safety framework, which incorporates both Safety-1 and Safety-2 approaches, illustrates the link between best practices, fundamental challenges, and safety incidents. These frameworks offer a detailed, sector-specific approach to high-quality and safe care and present tailored insights for developing a robust safety culture in homecare organisations.

Contributions: This research contributes to the literature by offering sector-specific insights into homecare safety culture. The study also contributes to the literature on the link between effective HRM practices and organisational positive outcomes, especially in the context of homecare providers in England and during the COVID-19 pandemic. Furthermore, the frameworks developed in this research make a theoretical contribution to the field of safety approach and management in healthcare.

Implications: This research provides practical implications for stakeholders in homecare, emphasising continuous staff development, genuine care, clear communication, patient-centred approaches, and family engagement. It highlights the need for collaboration, personalised care, strong leadership, digital integration, and effective HRM practices to enhance safety culture and care quality, with frameworks providing sector-specific guidelines for risk mitigation and continuous improvement.

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Conference Presentations

'Patient Safety Culture in Homecare: A Conceptual Framework', presented in:

- 2024 Nottingham University Business School Tri-Campus Conference, University of Nottingham, UK.

'Human Resource Management in Home Care: Managing People for Safe Care at the Frontline of the Pandemic', presented in:

- 2023 Homecare Research Forum, National Institute for Health and Care Research (NIHR), UK.

- 2022 Organisational Behaviour in Health Care (OBHC) Conference, Society for Studies in Organising Healthcare, UK: 'Wellbeing in Practice' session.

- 2022 European Group for Organizational Studies (EGOS) Colloquium, Vienna, Austria: 'Human Resources and Resilience in Health Care Organizations' session.

- 2022 European Health Management Association (EHMA) Conference, Brussels, Belgium. Best Poster Award

Publication

Le, T., Bishop, S. & Macrae, C. (2024) Human resource management in homecare in England: managing people for safe care during crisis. *BMC Health Service Research*, 24(1589), pp.1-13. https://doi.org/10.1186/s12913-024-11842-y

Le, T. (2025) Human Resource Management in Homecare in England: Challenges and Implications. In: Exworthy, M., Ferguson, J., Waring, J., & Zurynski, Y. (eds) Organising the Healthcare Workforce: Challenges And Dilemmas.

Chapter 1.

Introduction

1. Introduction

1.1. Research Background and Research Aims

In the health and social care sector, patient safety culture stands out as a priority among care organisations, to prevent harms and improve care quality. This focus is driven by numerous reports that highlight the risks and preventable harm associated with unsafe medical practices in the early 2000s (e.g., Institute of Medicine, 2000; 2004; World Health Organization, 2009; 2012). Since then, research in healthcare and organisational studies has increasingly focused on quality-of-care services and patient safety, making care quality improvement and patient safety key objectives in healthcare organisational performance (Katz-Navon, Naveh and Stern, 2005).

However, for over two decades, since the early 2000s, research on patient safety culture has extensively focused on ensuring high quality of care and safety for patients in hospitals, with very few studies examining safety culture in social care settings, including care homes (Gartshore, Waring and Timmons, 2017; Marshall et al., 2018) and domiciliary care or homecare (Berland and Bentsen, 2017). Overall, social care has not received the same level of research focus as acute care. As the demand for social care rises due to ageing populations and shifts in care preferences, understanding safety culture in these settings is essential to mitigate risks and enhance care quality. Moreover, social care often serves vulnerable populations who may experience health inequities, making it imperative to explore safety culture to inform equitable and effective care strategies (CQC, 2023). By addressing these gaps, research can provide valuable insights to policymakers, care providers, and stakeholders, fostering a culture of safety that aligns with the growing importance of social care within the broader healthcare landscape. Within the field of adult social care, the available evidence for homecare is possibly even less robust compared to that for care homes (O'Rourke and Beresford, 2022; Vincent and Amalberti, 2016). As a result, there is a significant knowledge gap about safety in homecare settings, highlighting an important need for evidence on homecare to be made available to government agencies, policymakers, homecare commissioners, providers, and caregivers, as well as service users and their families.

Homecare, or home care, or domiciliary care, is an important component of the health and social care sector, aimed at helping individuals live independently in their own homes. For consistency, this research will use the term 'homecare' throughout and define homecare as the care provided to individuals in their own homes, incorporating varying levels of informal and professional support. In England, the sector is growing rapidly due to the ageing population (Wittenberg, Hu and Hancock, 2018). There has also been an increase in demand for homecare services since the COVID-19 pandemic, which exacerbated challenges related to accessing adult social care (e.g., restrictions on care home visitation, reduction in care homes, individuals opting to stay at home for extended periods rather than transitioning into residential care, etc.) (CQC, 2022). As a consequence, the provision of homecare has had to adapt and expand to meet the increased demand and evolving needs of service users.

Since the COVID-19 pandemic, the UK government has also made significant efforts and strategic commitments to reform adult social care and highlight the importance of research in homecare. Research plays a vital role in identifying and addressing challenges, ensuring that care systems remain resilient and adaptive to unprecedented pressures, and enabling homecare services to provide high-quality and safe care. However, in the context of England, research into the specific topic of safety culture in homecare is currently limited. Research priorities for homecare have primarily centred upon a diverse array of themes, including understanding and defining homecare; exploring the homecare population, providers, and workforce; investigating funding and management aspects; examining engagement and decision-making processes; and exploring homecare's role as both a health and social intervention (O'Rourke and Beresford, 2022). However, it is crucial to recognise that patient safety culture remains relatively underexplored within the homecare context, and it should be regarded as a primary research priority, particularly considering the sector's growing importance within the broader health and social care landscape in England. In homecare, patients may also be referred to as service users, individuals, persons, or clients. This research will use these terms interchangeably to refer to homecare patients and will focus on individuals who are either living independently or receiving support in their homes from professional caregivers and family members.

Given the above contexts, this PhD thesis aims to explore the patient safety culture in homecare. The purpose of this exploration is to fill the research gap

in the literature on patient safety culture in homecare, specifically within the context of England. This study also aims to provide evidence to policymakers, homecare commissioners, providers, and caregivers, as well as service users and their families. By doing so, it supports the UK government's efforts and strategic commitments to reform adult social care.

To achieve the primary aim of exploring the patient safety culture in homecare, this research will first identify the foundational factors that constitute high-quality and safe homecare. It will then examine the prevalent safety issues in the sector, as well as the fundamental challenges in delivering high-quality and safe care services. The findings will be critical for developing strategic measures to address these challenges and improve safety in homecare. This approach is in line with the Safety-1 perspective, which focuses on understanding safety incidents and how they have occurred in order to develop mitigation strategies (Smith and Plunkett, 2019).

Nevertheless, perspectives on safety in the healthcare sector are shifting from Safety-1 to Safety-2, which emphasises an understanding of the routine processes and practices that lead to successful outcomes (Smith and Plunkett, 2019). The Safety-2 approach encourages care organisations to examine, reinforce, and replicate the conditions that lead to successful patient care, thereby enhancing organisational resilience and adaptability in changing scenarios, ensuring consistent safety culture (Hollnagel, 2014). Both Safety-1 and Safety-2 perspectives offer valuable insights, and this thesis argues that homecare safety culture can be strengthened by combining both approaches. By examining both successes and failures, we can draw lessons from effective practices as well as from shortcomings. Therefore, as part of the main aim of exploring the patient safety culture in homecare, this research seeks to understand these approaches to safety in homecare and integrate them to develop a comprehensive framework for enhancing safety culture in this care setting.

Additionally, this research argues that it is also important to take into account human factors, including individual and group values, attitudes, perceptions, competencies, and behaviours that foster a strong safety culture in care organisations. Previous research has emphasised that organisational safety culture encompasses shared values, beliefs, norms, customs, behaviours, and attitudes that shape the way people within an organisation interact with each

other and with external stakeholders (Cox and Cox, 1991; U.K. Health and Safety Commission, 1993). Therefore, organisations in the health and social care sector have actively sought ways to define, shape, and reform the patient safety culture in their settings through various people management or human resource (HR) management initiatives (Sammer et al., 2010).

Consequently, the important link between human resource management (HRM) and quality and safety of care has gained increased attention in the fields of organisational science and healthcare (Bartram et al., 2007; Grimshaw, Rubery and Marchington, 2010; Mayo, Myers and Sutcliffe, 2021; Shipton et al., 2016). In the context of acute care settings, there has been an abundance of evidence supporting the use of HRM practices in hospitals to promote healthcare organisations' performance outcomes, particularly in preventing adverse events, enhancing care quality, and improving patient safety. Nonetheless, these studies have tended to focus on acute hospitals, whereas other care settings such as domiciliary care or homecare, have been overlooked (Berland and Bentsen, 2017).

In homecare research, HRM has been a key focus and recognised for its important role in ensuring high-quality care and improving patient safety (Berland and Bentsen, 2017; Ree and Wiig, 2020). Although there is limited research on the positive link between HRM and the organisational performance of homecare providers, a number of reports and studies on patient safety in homecare found HRM challenges to be major barriers to care quality and patient safety (Berland and Bentsen, 2017; CQC, 2019; Lang, Edwards and Fleiszer, 2007; The King's Fund, 2018). These HRM challenges are related to a wide range of issues, including workforce well-being, staff recruitment and retention (Cooke and Bartram, 2015), performance management (McCann et al., 2015), training and development (Gospel, 2015), compensations and recognition (Rubery et al., 2015), and employment relations (Brown and Korczynski, 2017). Hence, it is critical to examine HRM practices, patient safety, and care quality in homecare to fill the gaps in the literature. This thesis aims to explore safety culture in homecare by investigating how HRM practices shape and strengthen this culture.

To summarise, the main objective of this study is to explore the patient safety culture in homecare in England. This includes seeking to identify the foundational factors that constitute high-quality and safe homecare, examine

the prevalent safety issues in the sector, and address the fundamental challenges in delivering such care services. Additionally, the study aims to understand and integrate the approaches to safety in homecare to develop a comprehensive framework for enhancing safety culture. It also investigates the role of HRM practices in shaping and strengthening this safety culture.

In other words, this PhD thesis aims to explore the patient safety culture in homecare in England by addressing the following research questions:

(1) What are the key foundational factors that constitute high-quality and safe homecare?
(2) What are the prevalent safety issues in homecare?
(3) What are the fundamental challenges in delivering high-quality and safe care?
(4) What approaches and practices have been implemented to enhance care quality and safety in homecare?
(5) How can HRM contribute to creating and sustaining a safety culture in homecare?

1.2. Research Contribution

A PhD research project demonstrates a researcher's independent and original contribution to knowledge and establishes an understanding of appropriate research methods in their chosen field of study (Bourke and Holbrook, 2013). This PhD thesis contributes to the health and social care sector by addressing an important gap in the literature on patient safety culture, specifically within homecare settings in England. It extends the existing body of knowledge in several ways.

First, for over two decades, the focus of patient safety culture research has predominantly been on hospital settings, with limited attention given to social care environments, including homecare. This thesis contributes to the shift of focus to homecare to address the lack of evidence in this area and aims to provide a comprehensive examination of patient safety culture within this context. By focusing on homecare, this research contributes to the broader fields of organisational science and healthcare. It offers new insights into the role of safety culture in non-acute care settings, expanding the scope of patient safety research beyond hospitals and acute care facilities.

Second, the study aims to identify the key foundational factors that constitute high-quality and safe homecare. It also examines prevalent safety issues and the fundamental challenges in delivering high-quality and safe care services in homecare. These insights are critical for developing strategic measures to address these challenges, ultimately enhancing safety and care quality in homecare settings. Furthermore, the study explores how HRM practices shape and strengthen the safety culture in homecare. It highlights the critical link between HRM and patient safety, addressing challenges related to workforce well-being, recruitment, and retention, performance management, training and development, compensation and recognition, and employment relations. This examination provides a nuanced understanding of how HRM can contribute to creating and sustaining a safety culture in homecare.

Third, by exploring patient safety culture in homecare, this research provides evidence for policymakers, homecare commissioners, providers, caregivers, service users, and their families. This evidence supports informed decision-making and policy development, aligning with the UK government's efforts to reform adult social care and improve service quality. The findings of this thesis support strategic reforms and innovations in the homecare sector in the UK. Additionally, by providing evidence-based recommendations for improving safety culture, the research aligns with current efforts to adapt and expand homecare services to meet the growing demand and evolving needs of an aging population, particularly in the wake of the COVID-19 pandemic.

1.3. Summary of Chapters

This section provides a brief summary of each subsequent chapter in the thesis. It aims to offer a clear overview of the content and structure, which can help clearly demonstrate the main points and progression of the research.

Chapter 2 presents a literature review on a number of broad topics that are relevant to the research aims. These include the organisational culture, safety culture, and patient safety culture within healthcare settings. It also presents an overview of homecare in England, including the regulation and assessment of care quality, as well as background information on service users and caregivers in the sector.

Chapter 3 reviewed more focused literature specifically on the topic of patient safety culture in homecare. It reveals a number of key themes within the topic of patient safety culture in homecare. These include the involvement of different stakeholders in the safety culture, understanding safety enablers and barriers, and recognising safety issues and associated risk factors. In this chapter, the research also examines the literature on safety approaches in homecare through the lens of Safety-1 and Safety-2 perspectives.

Chapter 4 examines the literature on HRM and safety culture in homecare. It reviews previous studies on the link between HRM and organisational performance, as well as HRM and healthcare organisational performance. As the study was conducted during the COVID-19 pandemic, which resulted in a number of emerging findings and challenges in health and social care, this chapter also provides a contextual background of the HRM challenges faced during the crisis. This context is important, as it highlights the role of HRM practices in helping organisations adapt to unprecedented and disruptive changes to ensure high-quality and safe care during the COVID-19 pandemic.

Chapter 5 presents the research methodology of the study. The chapter begins with the research philosophy that underpins the study's theoretical framework. It then justifies the research approach and strategy in relation to the research aims. This is followed by an explanation of the research design and data collection methods. The chapter also discusses data management and data analysis, and reviews ethical considerations during the research process. Finally, the chapter reflects on the impact of COVID-19, detailing the necessary adaptations in data collection and analysis processes due to the pandemic.

Chapter 6 reveals a number of significant findings about the foundations of safe homecare and critical safety incidents. The first part of the chapter presents the subthemes that emerged as critical components of safe homecare: the essence of high-quality and safe homecare, person-centred care, and the role of family members and informal support networks (e.g., friends, neighbours). The second part of the chapter demonstrates various safety incidents and categorises them into four types: medication safety issues, physical and health safety issues, emotional and social safety issues, and functional safety issues.

Chapter 7 presents important findings regarding fundamental challenges in homecare. These challenges serve as barriers to high-quality care and pose

risk factors leading to safety issues and potential harm to service users. The chapter demonstrated a number of contributary factors that influence safety incidents, and they relate to the institutional context, organisational and management, work environment, teams, individual staff, tasks, and patients. Additionally, a new emerging theme related to challenges in involving family members and informal support networks was incorporated into the analysis.

Chapter 8 provides findings about initiatives and practices that have been made to improve care quality and safety culture in homecare. The chapter illustrates five significant themes: collaborations and partnerships, inclusive and personalised care service, strong leadership and staff support, digital technology integration, and strengthening HRM practices.

Chapter 9 discusses the foundational factors of high-quality and safe homecare, the safety issues, and fundamental challenges in the sector. These discussions aim to answer the first three research questions. This chapter presents two important conceptual frameworks. First, a conceptual framework for high-quality and safe homecare aims to offer significant insights into the crucial dimensions of delivering these services. Second, the framework on interconnected fundamental challenges act as barriers to high-quality care and pose risk factors for safety incidents. This framework helps identify the components of high-quality and safe care, recognise the challenges that impede high-quality care, and highlight the safety incidents and risk factors associated with homecare.

Chapter 10 discusses the initiatives and practices for enhancing homecare safety culture. The discussion helps answer the remaining research questions, which are to explore the initiatives and approaches to safe care and to examine the role of HRM practices in creating and sustaining a safety culture. Importantly, the chapter discusses the role of HRM practices in the unique context of the COVID-19 pandemic. Finally, it examines the findings with reference to the Safety-1 and Safety-2 approaches and develops a safety framework that incorporates both perspectives and is tailored specifically to the homecare sector.

Chapter 11 discusses the implications, limitations, directions for future research, and summarises key takeaways. First, it outlines the contributions to research and implications of practice. It details how the research addresses

gaps in the existing literature by providing sector-specific insights into homecare safety culture. Then, it discusses the practical implications for government agencies, policymakers, homecare commissioners, providers, caregivers, service users, and their families by offering guidelines to enhance care quality and safety. Next, the chapter highlights possible limitations regarding generalisability, the capture of the full complexities and nuances of homecare settings, and the applicability of the developed frameworks. Consequently, it suggests directions for future research to address these limitations and further explore the emerging critical findings of the thesis. Finally, this chapter provides a final, cohesive narrative that ties together the entire thesis with the aim to reinforce the original research aims and highlight the study's overall contribution to knowledge.

Chapter 2.

Safety Culture and Homecare

2. Safety Culture and Homecare

Chapter Overview

This chapter provides a literature review on a number of broad topics that are relevant to the research aims. These include the organisational culture, safety culture, and patient safety culture within healthcare settings. It also presents an overview of homecare in England, including the regulation and assessment of care quality, as well as background information on service users and caregivers in the sector. This information helps to identify gaps in the existing literature, justify the development of research questions, and inform the methodology, all of which establish a foundation for the research. It also helps to situate the current study within the broader field and demonstrate how the study will contribute to the existing body of knowledge.

2.1. Organisational Culture, Safety Culture, and Patient Safety Culture within Healthcare Settings

Organisational culture is a crucial concept that has received extensive research in organisation studies. There is no consensus on the notion of organisational culture, and often its definition is closely linked with the researchers' views of the world and their preferred methodology (Ogbonna, 1992). Two contrasting broad schools of thought on organisational culture can be identified: (1) culture as a metaphor for describing an organisation rather than something separable from the organisation itself; and (2) culture as a variable or a functional measure that can be isolated, described and managed in the pursuit of wider organisational objectives (Martin, 2002). Although studies of culture as a metaphor help us understand an organisation's history and the processes of social construction at work, they offer limited insights in terms of how culture can be a potential attribute that helps organisations achieve their objectives. Therefore, this thesis adopts the functionalist viewpoint of organisational culture, considering culture as an organisational variable that can be shaped, managed, and leveraged to achieve organisational outcomes.

Organisational culture can be formally defined as the shared values, beliefs, norms, customs, behaviours, and attitudes that shape the way people within an organisation interact with each other and with external stakeholders (Ogbonna, 1992). To unravel the different components of organisational

culture, three layers can be identified: the visible artifacts (superficial and observable aspects), espoused values (explicitly stated beliefs, philosophies, and values), and the basic assumptions (underlying, often unconscious, beliefs and values) (Schein, 2004). The concepts of organisational culture and its levels are important for understanding how organisations manage and treat culture as a tool for improving management effectiveness. For example, for the past few decades, organisations in the health and social care sector have actively sought ways to define, shape, and reform various desired cultures and subcultures that contribute to improved care quality and performance (Mannion and Davies, 2018). These cultures include patient-centred care (Hower et al., 2019), an empowered workforce (Armstrong, Laschinger and Wong, 2009), innovation and adaptability, and most notably, the patient safety culture (Sammer et al., 2010).

Safety culture first gained prominence following the Chernobyl nuclear power disaster in 1986. Since then, it has remained a central focus in high-risk industries such as aviation, nuclear energy, and petrochemicals (Institute of Medicine, 2000). By definition, safety culture can be described as "the product of individual and group values, attitudes, perceptions, competencies, and patterns of behaviour that determine the commitment to, and the style and proficiency of, an organization's health and safety management" (U.K. Health and Safety Commission, 1993, p.10). Examples of the three levels of safety culture can be observed in various aspects, including (1) visible artifacts, such as statements, meetings, inspection reports, dress codes, personal protective equipment, posters, etc.; (2) espoused values, which encompass attitudes, policies, training manuals, procedures, formal statements, bulletins, accident and incident reports, job descriptions, and meeting minutes; and (3) fundamental assumptions that can be inferred from both artifacts and espoused values, as well as through direct observation (Guldenmund, 2000). Organisations that possess a robust safety culture are known for fostering effective communication among employees, cultivating mutual trust, and sharing a collective understanding of the significance of safety and the efficacy of precautionary actions (Cox and Cox, 1991). However, in healthcare organisations, safety culture has only been an important priority for patients and for organisations to build a stronger health system since the early 2000s (Wolfe, 2001).

In the healthcare sector, the focus on patient safety culture as a crucial priority came to the forefront following reports by the U.S. Institute of Medicine and World Health Organization highlighting the risks and harm associated with unsafe medical practices (e.g., Institute of Medicine, 2000; 2004; World Health Organization, 2009; 2012). For example, the Institute of Medicine (2000)'s report estimated between 44,000 and 98,000 deaths annually in American hospitals due to medical errors, a number that increased to over 251,000 deaths by 2016, making medical errors the third leading cause of death in the United States (Makary and Daniel, 2016). The World Health Organization (2019) also reported that one in ten patients experiences harm due to preventable medical accidents in European hospitals. In the United Kingdom, the National Health Service (NHS) (2022) counted over 2 million patient safety incidents resulting in harm to patients under NHS care. Therefore, patient safety stands out as a critical priority for healthcare organisations to mitigate harm and enhance care quality.

It is important to understand how safety culture for patients is defined within healthcare settings. While the concept of safety culture, as put forth by the U.K. Health and Safety Commission (1993), has been widely accepted by many empirical studies on patient safety in healthcare (e.g., Halligan and Zecevic, 2011; Lee et al., 2019), this definition remains somewhat elusive. There is a growing consensus that safety culture and its characteristics should be tailored to the specific context of healthcare organisations (Sammer et al., 2010). Key aspects of patient safety culture should include the patient-centred approach, leadership commitment, teamwork and collaboration, evidence-based practices, open and transparent communication, coordinating learning and knowledge sharing, fairness and justice (Sammer et al., 2010, Macrae, 2022), patient and family engagement (Vincent et al., 2017), shared beliefs among staff (Halligan and Zecevic, 2011), and staff participation in patient safety (Macrae, 2008). Over the past two decades, research on patient safety has focused extensively on the quality of care and safety for patients in hospitals. Thus, the definition of patient safety in healthcare originally emerged from acute care contexts and it has been defined as reducing the risk of preventable harm related to healthcare to an acceptable minimum (Runciman et al., 2009). The definition of patient safety culture is also often debated about whether it can be interchangeable with patient safety climate. While most publications have defined safety culture and safety climate as the same concept (Halligan and Zecevic, 2011), some scholars have taken a holistic view and defined both

terms. For example, Fleming (2005) and Weaver et al. (2013) explained that a safety climate consists of the surface and observable elements of the safety culture. Guldenmund (2000) described that safety climate usually refers to the measurable components of organisations; meanwhile, safety culture is often determined phenomenologically and difficult to quantify. Therefore, the difference between culture and climate is usually reduced to a difference in methodology, with studies of safety culture involving a qualitative approach and research into safety climate including quantitative measures (Weaver et al., 2013). Although the precise meanings of safety culture and safety climate are different, these two concepts have been used interchangeably in practice and in previous studies (e.g., Singer et al., 2007; Lee et al., 2019).

The construct of patient safety culture was measured using different questionnaires in hospital settings. The most adopted evaluation tool to assess patient safety culture is the Hospital Survey on Patient Safety Culture (HSOPSC), which was developed by the U.S. Agency for Healthcare Research and Quality (Halligan and Zecevic, 2011). The HSOPSC comprises 42 items that are grouped into 12 composite measures using a five-point Likert scale (Famolaro et al., 2016). Another popular measurement method evaluating the construct of patient safety culture is the Safety Attitudes Questionnaire (SAQ), which comprises 60 questions categorised into seven dimensions: (1) teamwork climate, (2) job satisfaction, (3) perceptions of management, (4) safety climate, (5) working conditions and (6) stress recognition (Relihan et al., 2009). Similar to the HSOPSC, the SAQ uses a Likert scale ranging from strongly disagree to strongly agree. Patient safety culture is an important concept in healthcare, and there are various measurement tools to evaluate this construct. The HSOPSC and SAQ are the most widespread instruments that help researchers understand how hospital staff perceive and respond to the safety culture. However, it is suggested that both questionnaires must be carefully tested for validity and reliability and amended to fit the local contexts before applying them to measure the construct (Etchegaray and Thomas, 2012).

Although numerous literature reviews on patient safety culture in healthcare have been published, the majority of studies have predominantly focused on acute care hospitals, with limited research dedicated to exploring safety culture in other healthcare settings, including care homes (Gartshore, Waring and Timmons, 2017; Marshall et al., 2018) and domiciliary care or homecare

(Berland and Bentsen, 2017). Overall, social care has not received the same level of research focus as acute care. Additionally, within the field of adult social care, the available evidence for homecare is possibly even less robust than that for care homes (O'Rourke and Beresford, 2022; Vincent and Amalberti, 2016). As a result, there is a significant knowledge gap about safety in these care settings, highlighting a critical need for high-quality evidence on homecare to be available to policymakers, homecare commissioners, providers, caregivers, service users, and their families.

2.2. Homecare Overview

Homecare (or home care, or domiciliary care) is an important part of the health and social care sector. Homecare is a term that is used to describe "a range of care and support programmes that aim to help people live in their own homes and maintain their independence" (CQC, 2013, p.7). The purposes of homecare can be curative, supportive, palliative, and rehabilitative (Schildmeijer et al., 2018). In the UK, the core service provided by the majority of local authorities revolves around providing personal care to individuals with long-term care needs (The King's Fund, 2018). This includes a wide range of personal care and support activities, such as assisting with getting in and out of bed, washing, dressing, cooking, providing medical care, and helping with household tasks, such as cleaning and shopping (CQC, 2019). Homecare also extends to reablement services for people leaving hospital or receiving crisis interventions to avoid hospital attendance in the first place (The King's Fund, 2018).

In this thesis, homecare is defined as the care provided to individuals in their own homes, incorporating varying levels of informal and professional support. The research focuses on individuals with illnesses, typically chronic conditions, who are either living independently or receiving support in their homes from professional caregivers and family members.

Overall, the homecare market is rapidly growing due to the aging population in England (Wittenberg, Hu and Hancock, 2018). However, the sector is fragmented and varies in quality. The great majority of homecare service are delivered by independent providers, including commercial (for-profit) and charity sectors; meanwhile, a small amount is provided by local councils or the NHS's Clinical Commissioning Groups (Homecare Association, 2020). There is also a growing self-funded market in which service users privately pay for and

manage their own care. Nevertheless, this sector receives less attention from the government when compared to state-funded care, and data availability is limited (Homecare Association, 2020).

In the UK, homecare can take the form of hourly visits and live-in (Homecare Association, 2020). Visiting homecare involves caregivers or home health aides who visit the service user's home for a specific period; meanwhile, live-in homecare involves a caregiver who resides in the service user's home on a full-time basis, providing around-the-clock care and support (Homecare Association, 2020). In the past decade, several emerging organisations, both for-profit and not-for-profit, have introduced innovative models of homecare services. These models encompass a wide range of approaches, including community-based, family-based, preventative, integrated care, and the integration of technology to enhance care delivery, representing a significant shift in the landscape of homecare (Bennet, Honeyman and Bottery, 2018; Zimpel-Leal, 2021).

Since the COVID-19 pandemic, the UK health and social care systems have been under strain and have faced significant challenges. In December 2021, the government released a policy paper titled 'People at the Heart of Care: Adult Social Care Reform', demonstrating its commitment to reforming the adult social care system in England by setting out a ten-year vision putting people at its heart. It revolves around three objectives: (1) People have choice, control, and support to live independent lives; (2) people can access outstanding-quality tailored care and support; and (3) people find adult social care fair and accessible (Department of Health & Social Care, 2021). Following this, the government published the 'Next steps to put People at the Heart of Care' implementation plan in April 2023, outlining their strategy for further advancing adult social care reform by implementing the highest-impact proposals, along with some new commitments, including providing additional funding and support to homecare service (Department of Health & Social Care, 2023a). These significant efforts and strategic commitments made by the UK government to reform adult social care, particularly in the wake of the COVID-19 pandemic, highlight the importance of research in homecare. Research plays a vital role in identifying and addressing challenges and ensuring that care systems remain resilient and adaptive to unprecedented pressures. Therefore, this study is essential for informed policy-making and the continuous

improvement of homecare services, ensuring they effectively meet the needs of the population.

2.3. Regulating and Assessing Quality of Care in Homecare

In the UK, the Care Act 2014 (Care Act) established a legal framework that mandates local authorities and their delivery partners to protect from harm people who use social care, requiring them to ensure the provision or arrangement of services, facilities, or resources aimed at preventing, delaying, or reducing the development of care and support needs (Department of Health & Social Care, 2023b). Also, in England, the Care Quality Commission (CQC) serves as an autonomous regulatory body that independently reviews and assesses the performance of local authorities in delivering their adult social care functions. The local authorities are required to collaborate with the CQC in addressing and investigating concerns related to substandard care provided by organisations. Moreover, the Health and Care Act 2022, which came into effect in April 2023, introduced an augmented support and monitoring framework. The UK Secretary of State will now have enhanced intervention powers under this Act, allowing intervention in cases where authorities fail to fulfil Care Act functions to an acceptable standard, such as instances involving serious and persistent risks to patient safety or insufficient support to drive improvements (Department of Health & Social Care, 2023b).

Homecare is a part of adult social care in England. Therefore, the CQC operates as an independent regulatory body with the responsibility of overseeing health and homecare services. This oversight encompasses the registration of care providers and the inspection of services. When conducting inspections, the regulator considers five fundamental questions: whether the service is safe, effective, caring, responsive to individual needs, and well-led (CQC, 2022). Each question gets a rating, as does the service as a whole, on a scale from 'Inadequate', 'Requires Improvement', and 'Good' to 'Outstanding'. The Care Quality Commission (CQC, 2022) inspected 8,518 homecare agencies in 2021-2022 and found that 5% were outstanding, 82% were good, 13% required improvement and 1% were inadequate. In addition to evaluating the quality of homecare services, the CQC also assesses the financial performance and sustainability of homecare providers. They also collaborate with local authorities, offering guidance and assistance when substantial concerns arise. These responsibilities for both local authorities and the regulatory body aim to

proactively prevent large failures of care, both financially and in terms of clinical quality (CQC, 2023).

Quality of care in homecare has been defined as "an ongoing process that depends on having the 'right competence,' and the ability to cooperate with other professional groups that places the patient at the center of all activities" (Aase et al., 2021, p.10). High-quality homecare refers to services that are effective, safe, secure, user-centred, coordinated and continuous, efficiently utilising resources, and evenly distributed (Aase et al., 2021). Similarly, in England, reports in the homecare sector from the CQC (2022), Homecare Association (2020) and The King's Fund (2018) found strong common themes with regard to what is considered a high quality of care. These consist of (1) the patient-centred care approach, (2) family caregivers' involvement, (3) the continuity of care, (4) manner of staff, (5) development and skills of staff, (6) adequate information about service and choices, and (7) the focus on well-being, prevention, promoting independence and connection to communities (Bennet, Honeyman and Bottery, 2018).

Compared to the literature on patient safety culture, both high-quality care and safety culture share common goals, such as patient-centredness, family involvement, staff development and collaboration; however, they differ in their specific focuses. High-quality care concentrates on service delivery aspects and service user experience; meanwhile, safety culture emphasises organisational practices, leadership, and collective efforts to ensure patient safety. This study argues that a strong safety culture that maintains a lower risk of safety incidents is essential for achieving high-quality care (Idsøe-Jakobsen et al., 2024). In other words, without a safety culture, high-quality care cannot be accomplished. Therefore, analysis and discussions with references to safety culture in this thesis will inherently include considerations of high-quality care.

2.4. Homecare Service Users and Carers

Care and support needs can arise for anyone in their own home, and the approach taken may vary based on the individual's specific care requirements, their residential location, and their household composition (Home Office and Department of Health and Social Care, 2023). In this study, individuals who receive homecare services will be referred to as service users, patients, individuals, or persons, depending on the context. The Homecare Association

(2020) reported that over 500,000 individuals used state-funded homecare services through local authorities, while approximately 150,000 service users received private homecare services in the UK between 2018 and 2019. As of March 2020, it is estimated that approximately 814,000 individuals were receiving homecare services in England (National Audit Office, 2021). The majority of those with care and support needs are older people. In England, it is estimated that 63% of homecare service users are aged 65 or above (Homecare Association, 2020).

The number of individuals receiving care in their own homes is expanding, and this trend is expected to significantly increase in the future to accommodate the demographic pressures of aging populations (Wittenberg, Hu and Hancock, 2018). There has also been an increase in demand for homecare services since the COVID-19 pandemic, which exacerbated challenges related to accessing adult social care (e.g., restrictions on care home visitation, reduction in care homes, individuals opting to stay at home for extended periods rather than transitioning into residential care, etc.) (CQC, 2022). As a result, the number of homecare providers has significantly increased in recent years. The Care Quality Commission reported approximately 9,528 homecare services in 2018-19, marking a 23% increase over the six-year period from 2014 to 2019 (CQC, 2019). As of June 2024, there are more than 12,000 registered homecare providers in England (CQC, 2024). Therefore, it is crucial to the longstanding strategic goal of enabling individuals to receive care as close to home as possible, aligning with the NHS's (2019) long-term plan to support frail and older individuals in maintaining health and independence, while minimising unnecessary hospital visits whenever feasible.

The Care Act (2014, section 10.10) defined a carer as 'an adult who currently provides or plans to provide care for another adult.' In homecare settings, caregivers encompass a wide spectrum, including individuals with personal relationships (e.g., family members, intimate partners, or civil partners), unpaid carers (e.g., neighbours or friends), paid carers (e.g., employed care workers or personal assistants), and volunteers (Home Office and Department of Health and Social Care, 2023), with these categories not being mutually exclusive. In the homecare sector across England, there were approximately 570,000 paid carers, with the majority, around 550,000, employed in the independent sector, while 19,400 were in local authorities (Skills for Care, 2022).

Chapter Summary

To summarise, the chapter presents a review of the literature on a number of topics. Organisational culture is an important concept in organisational studies with diverse definitions that reflect researchers' perspectives. Two main views include (1) culture as a metaphor for describing an organisation and (2) culture as a variable that can be managed to achieve organisational goals. This thesis adopts the latter approach. Organisational culture encompasses shared values, beliefs, norms, and behaviours, with three layers: visible artefacts, espoused values, and basic assumptions. Similarly, safety culture is defined as the product of individual and group values, attitudes, perceptions, competencies, and behaviours regarding health and safety management.

In health and social care, shaping cultures, such as patient safety culture, has been crucial for ensuring high-quality and safe care. Despite extensive research in acute care hospitals, there is a significant gap in understanding safety culture in homecare. This highlights the need for research in this area to inform policymakers, providers, caregivers, and service users.

Homecare, or domiciliary care, is an important component of the health and social care sector and is aimed at helping individuals live independently in their own homes. The sector is growing rapidly due to the ageing population in England. Despite its importance, the sector is fragmented and varies in quality. Quality of care in homecare is regulated by the CQC, which inspects services based on safety, effectiveness, caring nature, responsiveness to individual needs, and leadership. Both high-quality care and safety culture share common aims, including patient-centredness, family involvement, staff development, and collaboration. However, high-quality care focuses on service delivery and user experience, while safety culture concentrates on organisational practices, leadership, and collective efforts to ensure safety. This study argues that a strong safety culture that maintains a lower risk of safety incidents is essential for achieving high-quality care. In other words, without a safety culture, high-quality care cannot be accomplished. Therefore, analysis and discussion with references to safety culture in this thesis will inherently include considerations of high-quality care.

Chapter 3.

Patient Safety Culture in Homecare

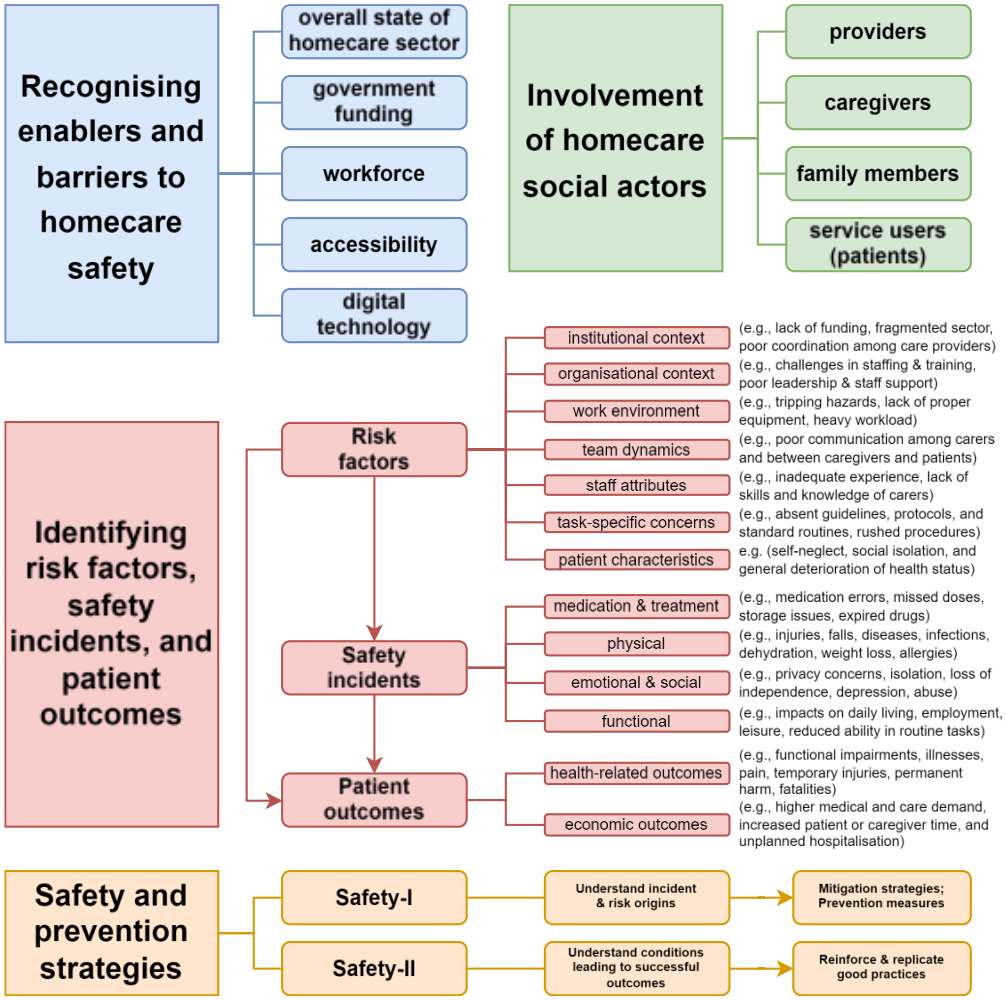
3. Patient Safety Culture in Homecare

Chapter Overview

The previous chapter provides a literature review on a number of broad topics that are relevant to the research aims, which helps to establish a foundation for the research. The following chapter presents a more focused topic on patient safety culture in the homecare sector.

There has not been a specific definition of patient safety within the context of homecare, as the term was predominantly used in acute hospital settings. It is essential to adapt the organisational safety culture and its defining features to extend the patient safety agenda to include homecare services (Lang et al., 2006). In the context of England, research into the specific topic of safety culture in homecare is currently limited. Research priorities for homecare have primarily centred around a diverse array of themes, including understanding and defining homecare, exploring the homecare population, providers, and workforce, investigating funding and management aspects, examining engagement and decision-making processes, and exploring homecare's role as both a health and social intervention (O'Rourke and Beresford, 2022). However, it is crucial to recognise that patient safety culture remains relatively underexplored within the homecare context, and it should be regarded as a primary research priority, particularly considering the sector's growing importance within the broader health and social care landscape in England. This chapter presents four key themes in patient safety culture in homecare, with each theme detailed in the following subsections. Figure 3.1 provides an overview of these themes.

Figure 3.1 Patient Safety Culture: Key Themes in the Literature



3.1. Involvement of Social Actors in Homecare

First of all, the active participation of homecare providers, managers, and caregivers is fundamental to shaping a safety culture. Traditionally, safety culture arises from the collective and individual values, attitudes, perceptions, skills, and behavioural patterns that influence an organisation's dedication to managing health and safety (U.K. Health and Safety Commission, 1993). In the homecare sector, numerous studies have adopted the organisational approach to examine the safety culture, offering recommendations revolving around enhancing the skills and knowledge of caregivers (Leverton et al., 2021b; Sutcliffe et al., 2021; Tudor Car et al., 2017), cultivating effective leadership and work engagement (Ree and Wiig, 2020), optimising teamwork and communication (Lang, Edwards and Fleiszer, 2007), and recognising care staff's challenges and providing support (Backhouse and Ruston, 2022; Yeh et

al., 2019). These studies highlight the crucial roles and responsibilities of homecare providers in shaping and managing a safety culture, with an emphasis on the importance of effective leadership and management. Homecare managers and decision-makers, therefore, need to consider how they can develop strategies to encourage learning and improvement among professional care staff, provide continuous support, and stay updated on best practices in homecare safety.

Second, care staff's experience and perceptions of safety are critical in creating and maintaining a safe homecare environment. Caregivers who deal firsthand with various care situations bring great insights and experiences to safety practices (Taylor and Donnelly, 2006). For example, they can recognise problems that lead to safety threats and propose solutions (Tudor Car et al., 2017). Caregivers can also provide feedback on the practicality and effectiveness of safety protocols (Möckli et al., 2021), and help design more relevant and effective training programmes (Cunningham et al., 2020). Therefore, safety culture in homecare is dependent on care staff's knowledge and understanding of safety risks, and their proactive approach to deal with safety concerns, as well as the ability to effectively communicate and collaborate within interdisciplinary teams (Ekstedt et al., 2022; Silverglow et al., 2022). Hence, the engagement of care staff in safety culture is indeed important in preventing adverse events and maintaining a safe care environment.

Third, to establish a safety culture, it is crucial to incorporate the experiences of homecare service users during care delivery and assessment. Person-centred healthcare has always been a strategic focus in health and social care policy, as well as in research and professional practice (Department of Health & Social Care, 2021). Studies in homecare have emphasised that person-centred care, which focuses on the individual's specific care needs, is a necessary component of ensuring safety in homecare (e.g., Anker-Hansen et al., 2018; Lang et al., 2009; Leverton et al., 2021a; Talabani et al., 2020; Turjamaa et al., 2014). The person-centred care approach allows homecare providers and carers to gain a deeper understanding of service users' perspectives, needs, and available resources, which facilitates the delivery of individually designed care (Turjamaa et al., 2014). Additionally, preventive safety measures in a service user's home require true patient involvement, taking their values and integrity into consideration (Schildmeijer et al., 2018).

Nevertheless, to provide and enact person-centred care at home for people with dementia or intellectual or learning disabilities can pose significant challenges, as it can be difficult to identify their specific needs and interpret challenging behaviours (Hedman, Sandman, and Edvardsson, 2022; Ericson Lidman and Antonsson, 2022). In such cases, it is crucial for homecare providers to invest in specialised training and education for their care staff and include open communication among service users and care partners (caregivers, families, friends, and other dedicated individuals involved in providing care) so that the identified needs can be addressed in a more comprehensive, organised, and person-centred manner (Anker-Hansen et al., 2018).

Fourth, including family members' experiences and perspectives is important to create a safety culture for service users in homecare. In acute hospital care settings, the aspect of family kinship is not usually incorporated into the patient safety culture, as families and friends are often regarded as unregulated caregivers who offer informal support to patients (Levine, 2011; Park and Giap, 2020). However, family engagement is gradually becoming a prominent priority in establishing patient safety (Park and Giap, 2020). In homecare, family dynamics unquestionably play a pivotal role in shaping a safety culture, with family caregivers taking on great responsibility for ensuring patient safety by actively and consistently committing to safety practices (Haltbakk et al., 2019; Schaepe and Ewers, 2018). Family carers can bring invaluable knowledge about the service users' values, resources, and needs (Lang et al., 2009). Nevertheless, there are challenges when family members, who are often untrained, may not consistently follow the care staff's instructions to perform nursing and medical tasks, or when they provide continuous care and become fatigued, thus increasing the risk of errors (Lang et al., 2009; Schaepe and Ewers, 2018). Additionally, family caregivers often perceive their role as lonely, exhausting, and burdensome (Søvde et al., 2019). Therefore, although it is crucial to involve family members in decision-making and care planning to ensure a safe care environment, homecare providers and managers must pay attention to building relationships with service users' families, providing training and support to family caregivers and ensuring consistent communication between care professionals and families (Glomsås et al., 2022; Schaepe and Ewers, 2018; Tudor Car et al., 2017).

To conclude, establishing a safety culture in homecare requires the active involvement of different stakeholders, and each contributes their unique perceptions and experiences. Caregivers, who are at the frontlines of care delivery, need to acquire knowledge and understanding of safety risks, and proactively deal with safety concerns, as well as effectively communicate and collaborate with service users and other stakeholders. Homecare providers and managers play key roles in shaping the safety culture through effective leadership, communication, teamwork, training, and providing support. Furthermore, incorporating the experiences and preferences of service users is integral to providing person-centred care and ensuring that their needs are met. Family members, while key contributors to safety, also present challenges that call for efficient communication, training, and support from homecare providers to ensure consistent and safe care practices. In the evolving landscape of homecare, an integrated approach that embraces the perspectives of all stakeholders is essential for fostering a culture of safety that prioritises the well-being of both caregivers and service users.

3.2. Recognising Enablers and Barriers to Safety Culture in Homecare

Within the literature on patient safety culture in homecare, another key theme focuses on the different factors that can either facilitate or hinder the attainment of safe care at home. These factors relate to the overall state of the homecare sector, government funding, homecare workforce, accessibility to homecare services, and the use of technology in homecare settings.

First, the overall state of the homecare sector is often fragmented and varied in quality, which can pose challenges to the establishment of safety culture (Ganann et al., 2019; Glendinning, 2012). Issues such as unregulated and uncontrolled settings, lack of collaboration and communication among care providers, and the lack of national standards governing the physical environment (in contrast to the stringent requirements imposed on healthcare institutions such as hospitals) are some of the factors contributing to the fragmentation of the homecare market (Lang, Edwards and Fleiszer, 2007). The variability and lack of standardisation in routines, procedures, and guidelines within the homecare sector present an additional challenge for homecare staff in effectively addressing various care scenarios, potentially impacting the overall safety culture (Berland et al., 2012; McKenna, Hasson and Keeney, 2004).

Second, the state's funding of the homecare sector appears to be a critical and pressing concern that can impact safety culture. Lack of resources and funding has been reported as one of the main barriers to providing homecare services globally (Brant et al., 2019; Ganann et al., 2019; Y. Song et al., 2023). In England, underfunded homecare often leads to difficulties in staff retention and individuals' access to services, potentially resulting in adverse effects on the continuity and quality of care (Glendinning, 2012; Yeh et al., 2019). Meanwhile, the homecare market could benefit significantly from increased public funding, making "homecare a right for all" (Mercille and O'Neill, 2021, p.614-615). Therefore, it is important to increase and maintain state-level funding to offer better support and resources to homecare providers and service users, thereby ensuring a high standard of care and fostering a culture of safety (Bandini et al., 2021).

Third, a prominent challenge to patient safety in homecare revolves around the care workforce, which stands out as a central focus within the homecare research literature. For instance, the challenges associated with personnel shortages, retaining care staff, or facing high turnover rates can impede the continuity of care, leading to reduced time spent with patients and lower quality of patient care (Brant et al., 2019; Johannessen et al., 2020). Unskilled care workers and inadequate education or training of carers are seen as key problems to patient safety (Berland et al., 2012; Masotti, McColl and Green, 2010). Homecare workers who lack sufficient training are often unable to carry out health-related tasks and provide safe and effective care (Leverton et al., 2021b). Other variables that are related to human resource management, such as leadership, work engagement, and employees' perceptions of job demands, guidelines, and job resources, have an impact on patient safety culture (Berland et al., 2012; Ree and Wiig, 2020). Hence, workforce management or human resource management is crucial to the patient safety culture in homecare. Numerous recommendations highlighted the importance of improving recruitment practices, oversight, and working conditions of professional caregivers, alongside the implementation of various strategies to enhance home safety (Tudor Car et al., 2017).

Fourth, accessibility to homecare services is another important factor that can contribute greatly to patient safety culture. The demand for homecare services is on the rise; however, there are a number of barriers hindering individuals

from accessing care. For example, isolated individuals who live in rural areas that require long travel times often have difficulty accessing professional support (Lang, Edwards and Fleiszer, 2007; Ohta et al., 2020). Financial constraints or difficulties in accessing funded support further aggravate the accessibility issue, potentially disrupting the continuity of care (Macdonald et al., 2013). Furthermore, the lack of effective promotion of homecare services, resulting in limited access to information about available options, can present obstacles to accessing homecare services (Lang, Edwards and Fleiszer, 2007). The lack of accessibility to care can indeed have a significant impact on patient safety, as it can result in delays in treatment, missed opportunities for preventive care, and challenges in managing health conditions effectively. Addressing barriers to care access is essential to ensure patient safety and improve overall healthcare outcomes.

Fifth, the integration of technology applications in homecare represents a promising factor for enhancing care quality and ensuring patient safety. Extensive research has found that the appropriate use of technology for care work planning, care delivery, and communication (e.g., electronic health records, telehealth, e-health information) can optimise homecare services and increase accessibility to homecare, and ultimately result in a higher quality of care for service users (Ganann et al., 2019; Hamblin, Burns and Goodlad, 2023; Lindberg et al., 2013). Nevertheless, certain challenges in implementing technology can serve as barriers to achieving a culture of safety in homecare. For instance, the effective use of technology requires staff training and education to increase competency, mitigate technological errors, and maximise the benefits (Ganann et al., 2019). This, in turn, can add to the workload and responsibilities of homecare workers (Hamblin, Burns and Goodlad, 2023). Furthermore, in some cases, the use of technology for care provision, such as telehealth, may not statistically differ significantly when compared to traditional homecare (McFarland, Coufopolous and Lycett, 2021), and the readiness level for integrating smart home and home health monitoring technologies remains relatively low (Liu et al., 2016). Therefore, homecare providers need to thoroughly research the technology and prioritise staff training to ensure the successful integration of technology into patient care.

In conclusion, the literature on patient safety culture in homecare underscores a number of factors that influence the attainment of safe care at home. The state of the homecare sector, government funding, the homecare workforce,

accessibility, and the integration of technology all play significant roles in shaping the safety culture within this context. Recognising and addressing the challenges related to these factors, such as improving sector-wide coordination, increasing funding, developing relevant strategic workforce plans, promoting accessibility, and leveraging technology effectively, is crucial to fostering a culture of safety in homecare.

3.3. Identifying Safety Issues and Risk Factors

The third key theme in the homecare patient safety literature is the identification of preventable safety issues and risk factors. There are a number of safety issues that can be categorised to different ways. This thesis highlights four key categories of safety issues, which are related to medication and treatment-related events, physical safety, emotional and social well-being, and functional safety. Such concerns can emerge from various risk factors, including institutional context, organisational management, the work environment, team dynamics, individual staff attributes, task-specific concerns, and characteristics of service users (McGraw, Drennan and Humphrey, 2008).

First of all, issues with medication management stand out as a prominent challenge in the homecare setting (Berland and Bentsen, 2017; Masotti, McColl and Green, 2010; Schildmeijer et al., 2018). These concerns include a spectrum of problems, including medication errors, such as the administration of incorrect medication or dosage, missed doses, improper medication storage, the use of expired medication, and the absence of medication reconciliation, among others (Lang, Macdonald, et al., 2015).

Second, physical safety concerns encompass a wide range of risks, from musculoskeletal injuries and trip hazards to communicable diseases, both in terms of immediate experiences and potential (Tong, Sims-Gould and Martin-Matthews, 2016). Falls represent the most frequent and serious physical incident in homecare in England, as every year, about one in three people over the age of 65 suffer a fall that causes serious injury or even death (McGlade and Dening, 2020). Other physical health concerns include infections, pressure ulcers, wounds, dehydration, weight loss, nutrition-related issues, and allergic reactions (Schildmeijer et al., 2018).

Third, emotional and social safety issues encompass a range of concerns. These include home privacy and security, feelings of isolation and loneliness, the sense of losing independence, the experience of depression and anxiety, abuse, and various other emotional and social challenges arising from interactions between clients and their family members and/or their homecare workers (Lang et al., 2015; Tong, Sims-Gould and Martin-Matthews, 2016).

Fourth, functional safety refers to service users' health conditions or provision of care affecting activities of daily living, employment, or leisure activities (Lang, Toon, et al., 2015). General deterioration in the health status of the service users can reduce their ability to perform everyday activities in their homes and communities, such as driving, shopping, banking, gardening, working, and other tasks they would typically manage or enjoy (Lang et al., 2015; Strømme, Aase and Tjoflåt, 2020).

Homecare service users can be at risk from any of these types of harm as a result of the care they receive, and often they are preventable (Sears et al., 2013). The health consequences of these safety harms can vary from subtle observable occurrences to severe cases with significant health and economic costs. For example, health-related outcomes can include functional impairments, illnesses, temporary pain or injuries, permanent harm, and even fatalities, whereas economic consequences might include increased demand for medical treatment or care, increased patient or caregiver time, and unplanned hospitalisation (Masotti, McColl and Green, 2010).

Safety issues can arise from various risk factors, spanning institutional context, organisational and management, the work environment, team dynamics, individual staff attributes, task-specific concerns, and characteristics of service users (McGraw, Drennan and Humphrey, 2008). For example, risks within the institutional context, such as inadequate government funding, fragmented homecare sector, or poor coordination among care providers, can impede a strong patient safety culture (Ganann et al., 2019). Organisational and management-related issues often involve challenges of recruiting and retaining care staff, as well as ensuring that they are adequately trained and supported (Johannessen et al., 2020; Leverton et al., 2021b). Factors related to the work environment refer to the spatial aspects of service users' homes, the availability of proper equipment and supplies, the level of staff training, and conditions related to workload and work settings (Tong, Sims-Gould and Martin-Matthews,

2016; Tudor Car et al., 2017). As for team dynamics and individual staff risks, these mainly involve the lack of communication among caregivers and between caregivers and patients, as well as inadequate experience, knowledge, and skills of care staff (Masotti, McColl and Green, 2010; Schildmeijer et al., 2018). Task-specific challenges can be seen in the form of absent guidelines, protocols, and standard routines, such as those for incident reporting or for the preparation and administration of medications (Berland and Bentsen, 2017). Finally, service user-related risks can include their health conditions, treatments, decisions, and interactions with caregivers, as seen in challenges such as self-neglect, social isolation, and general deterioration of health status (McGraw, Drennan and Humphrey, 2008; Tudor Car et al., 2017).

To conclude, there are a number of safety issues and their associated risk factors in homecare. This study emphasises four key safety categories: medication and treatment incidents, physical safety, emotional and social safety, and functional safety. These challenges can arise from a range of risk factors, such as institutional context, organisational and managerial issues, work environment, team dynamics, individual staff attributes, task-specific challenges, and service user characteristics. Recognising and addressing these concerns are crucial to establishing a strong safety culture in homecare settings.

3.4. Approaches to Safety Culture in Homecare

Three themes of patient safety culture in homecare have been presented: recognising safety issues and risk factors, identifying the facilitators and barriers to safety, and involving all stakeholders in improving homecare safety. All of these aspects are important to create a patient safety culture in the homecare settings. The literature on patient safety in homecare has predominantly followed the approach of identifying safety issues, understanding their origins, and proposing measures to minimise errors and risks, in line with the Safety-1 approach (Smith and Plunkett, 2019). For example, Lang, Edwards, and Fleiszer (2007) argued that maintaining a safety culture required consistent efforts in error reduction, risk mitigation, management and treatment of unsafe acts, and management of consequences of system failures. Harrison et al.'s (2013) evidence synthesis highlighted a number of harmful incidents, instigating factors, and prevention strategies, including management of risks and screening for risks. Research by Tudor Car

et al. (2017) pinpointed a range of challenges leading to patient safety threats in homecare, analysed these issues, and suggested essential solutions. Similarly, Backhouse et al. (2022) systematic review on homecare identified safety risks, while also highlighting mitigation measures. These mitigation strategies often fall into the following key categories: organisational system change (e.g., making adjustments, changes, and adaptations to provide safe care), education and knowledge sharing (e.g., providing adequate training for care staff, using assistive technology), stakeholder engagement (e.g., family involvement, patient-centred care), effective management and leadership (e.g., support for staff, communication, reviewing and screening hazardous behaviours and environments), and in some cases, harsh interventions (e.g., restraint use, psychotropic medication) (Backhouse et al., 2022; Harrison et al., 2013; Lang et al., 2009; Tudor Car et al., 2017).

The Safety-1 approach, which focuses on safety incidents and how they have arisen, has been essential to patient safety. Nevertheless, this approach is limited by its reactive nature, focus on failures, linear thinking, potential to foster a blame culture, limited adaptability, and underemphasis on the positive contributions of human performance and resilience (Hollnagel, 2014). In recent years, the healthcare sector has been experiencing a shift from this traditional perspective to Safety-2, which emphasises understanding the routine processes and practices that lead to successful outcomes (Smith and Plunkett, 2019). Safety-2 encourages care organisations to examine, reinforce, and replicate the conditions that lead to successful patient care, thereby enhancing organisational resilience and adaptability in changing scenarios, ensuring a consistent safety culture (Hollnagel, 2014). However, the limitations of the Safety-2 approach include its focus on process and system-related interventions rather than on empowering and supporting individuals to create resilience, and its failure to address the necessary mindset changes among employees, as well as pre-existing values, beliefs, and attitudes that may hinder the implementation of these approaches (Homann et al., 2022). As safety culture is defined as "the product of individual and group values, attitudes, perceptions, competencies, and patterns of behaviour that determine the commitment to, and the style and proficiency of, an organization's health and safety management" (U.K. Health and Safety Commission, 1993, p.10), it is indeed important to take into account the human factors and organisational mindset essential for fostering a comprehensive safety culture.

Both Safety-1 and Safety-2 offer valuable insights, and this thesis argues that homecare safety culture can be achieved by combining both perspectives, examining both successes and failures, and drawing lessons from effective practices as much as from shortcomings. Therefore, the research aims to integrate these dual perspectives to develop a comprehensive framework for enhancing safety culture in homecare settings. In the literature, two crucial paradigms that underpin both Safety-1 and Safety-2 approaches to shape patient safety culture are the model of cultural maturity, and high-reliability organisation theory. In the next paragraphs, the research critically examines these paradigms to gain a thorough understanding, which will be critical for analysing how homecare safety culture is shaped and reinforced through various initiatives and practices. This examination will help facilitate the development of a homecare safety framework.

Firstly, in the cultural maturity model, safety cultures evolve through five stages: from pathological (least mature), to reactive, calculative, proactive, and finally, generative (most mature) (Ashcroft et al., 2005). At the pathological level, safety is seen as a problem, and blame is placed on individuals serving those in power. Reactive organisations only respond to safety after major harm. Calculative ones are rule-bound and may dismiss safety incidents without deep inquiry. Proactive organisations anticipate safety issues by involving various stakeholders. Generative ones consistently seek insights into their safety performance, focusing on underlying conditions of incidents, not just immediate causes (Fleming and Wentzell, 2008). Each level in the cultural maturity model indicates a safety culture stage, helping organisations to diagnose their current maturity, identify strengths and weaknesses, and take actions to advance to the next stage, making it widely adopted in care organisations to improve patient safety culture (Goncalves Filho and Waterson, 2018). However, the model has its limitations: it can oversimplify the complex processes of achieving safety culture, might not be universally applicable, and may sometimes lead organisations to focus too much on progressing to the next stage, rather than adapting to their specific circumstances (Goncalves Filho and Waterson, 2018).

Secondly, high reliability organisation (HRO) theory refers to organisations that have sustained low rates of harm over time, despite operating in challenging and uncertain environments (Dwyer, Karanikas and Sav, 2023). In healthcare settings, the idea of becoming a HRO to improve patient safety and enhance

care quality outcomes has been widely accepted. HRO theory offers healthcare organisations a framework with key principles that can improve and enhance patient safety, focusing on both the reduction of adverse events and strengthening of best practices that lead to successful outcomes (Riley, 2009). These key principles include: (1) preoccupation with failure (identifying and acting on minor errors as indicators of potential larger problems), (2) reluctance to oversimplify (counteracting the tendency to minimise problems by integrating various perspectives, and considering innovative approaches), (3) sensitivity to operations (being aware of how work operations are linked, monitoring real-time changes, and recognising how issues in one area can impact others), (4) commitment to resilience (building organisation's capacity to address unforeseen challenges and prevent escalation), and (5) deference to expertise (valuing expertise based on situational demands rather than strict hierarchies) (Rotteau et al., 2022). Nevertheless, shortcomings of HRO theory include the inconsistent and conflicting interpretations and practices concerning its five key principles, and the lack of detailed guidance or step-by-step process for becoming a HRO, which might pose challenges for organisations wishing to adopt and adapt the HRO approach to their specific needs and situations (Dwyer, Karanikas and Sav, 2023; Myers and Sutcliffe, 2022).

Chapter Summary

In conclusion, the literature of patient safety culture in homecare is grounded in three primary themes: involvement of different stakeholders, understanding enablers and barriers, and recognising safety issues and associated risks.

First, establishing a safety culture in homecare requires active involvement from all stakeholders. Caregivers must understand and address safety risks and communicate effectively with service users and others. Homecare providers and managers shape the safety culture through leadership, communication, teamwork, training, and support. Incorporating service users' experiences and preferences ensures person-centred care. Family members, while crucial to safety, need effective communication, training, and support to maintain safe care practices.

Second, key factors that can act as facilitators or barriers to high-quality and safe care are the state of the homecare sector, government funding, workforce, accessibility, and technology integration. Recognising and addressing the

challenges related to these factors, such as improving sector-wide coordination, increasing funding, developing relevant strategic workforce plans, promoting accessibility, and leveraging technology effectively, is crucial to fostering a culture of safety in homecare.

Third, various types of safety incidents include medication and treatment incidents, physical safety, emotional and social safety, and functional safety. These safety incidents can arise from a range of risk factors, such as institutional context, organisational and managerial issues, work environment, team dynamics, individual staff attributes, task-specific challenges, and service user characteristics. Recognising and addressing these concerns is crucial to establishing a strong safety culture in homecare settings.

The literature review also reveals that, while the majority of homecare safety research adopts the Safety-1 approach, focusing on incident origins, the shift towards Safety-2 emphasises the promotion of practices leading to positive outcomes. Both perspectives are underpinned in the cultural maturity model and the high-reliability organisation theory. The cultural maturity model, illustrating the evolution of safety cultures, provides guidance for organisations to diagnose and improve their safety maturity levels, but may sometimes oversimplify the complicated processes involved. High-reliability organisation theory promotes an understanding of how organisations maintain low harm rates in complex settings and offers principles to improve patient safety. However, its application may be hindered by inconsistencies and the absence of a clear roadmap for its implementation. Both safety paradigms underscore the need for a holistic, adaptable approach to ensure safety in homecare settings.

Understanding the approaches to safety is critical for developing strong safety cultures. It is also important to take into account human factors, including individual and group values, attitudes, perceptions, competencies, and behaviours that foster a comprehensive safety culture in care organisations. In this context, HRM plays a pivotal role by implementing practices that support and enhance these human factors. Therefore, this thesis also aims to explore how HRM can be leveraged to strengthen safety culture in homecare. The next chapter will present a review of the literature on this topic.

Chapter 4.

HRM and Safety Culture in Homecare

4. HRM and Safety Culture in Homecare

Chapter Overview

Previous chapters highlighted the importance of patient safety culture in healthcare organisations, particularly within the homecare sector. A strong safety culture is necessary for achieving high-quality care, which is a critical measure of organisational performance in health and social care.

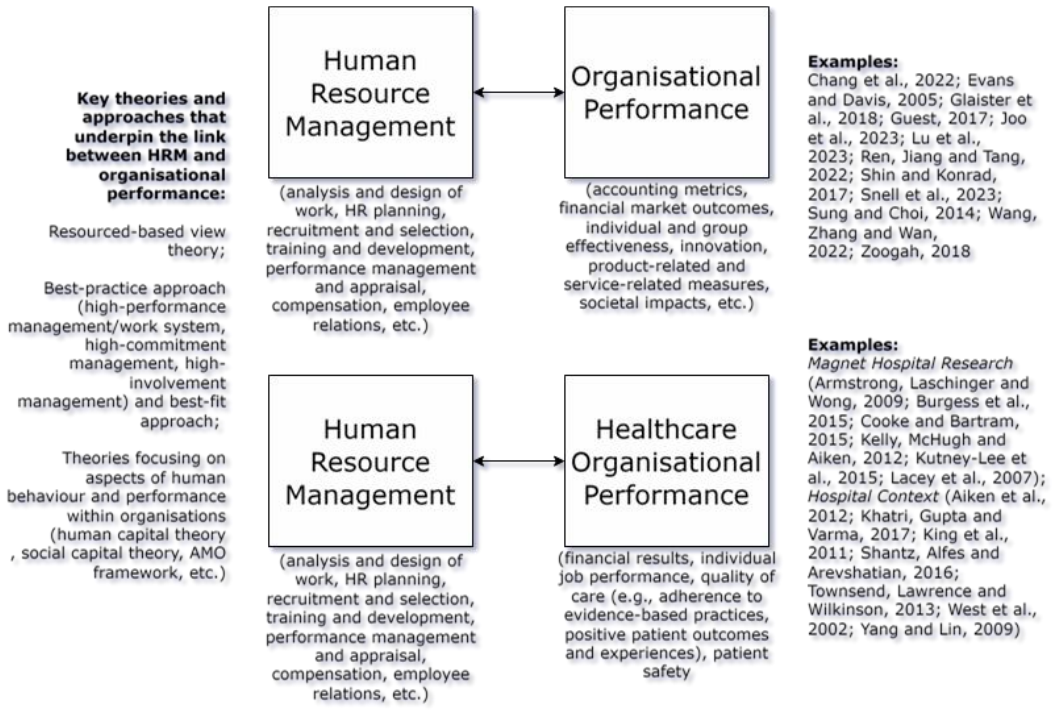
Safety cultures are established through the promotion of values, attitudes, perceptions, competencies, and behaviours that enhance an organisation's health and safety management. Therefore, HR professionals can play a crucial role in developing and nurturing this aspect of the organisation, and healthcare professionals have long recognised the importance of strategic HRM to organisational success (Palmieri et al., 2010).

However, the HRM and organisational safety literatures rarely connect, and they are almost existing as two separate fields, which makes this intersection a key argument to establish the thesis's contribution. This chapter presents the literature review on the link between HRM and organisational performance, especially in the context of healthcare and with a focus on the organisational performance measures of care quality and patient safety. A summary of the key findings from the literature is shown in Figure 4.1 below.

In the literature, studies have shown that HRM practices are closely linked to the quality of care and patient safety in acute care hospitals. However, in homecare, the focus on HRM remains underdeveloped. This further explains why the research aims to explore the role of HRM in the development of safety culture in homecare.

Additionally, this study was conducted during the COVID-19 pandemic, which resulted in a number of emerging findings and challenges in healthcare. Therefore, this chapter also provides a contextual background on the HRM challenges faced during the crisis. This context is important as it highlights the role of HRM practices in helping organisations adapt to unprecedented and disruptive changes to ensure high-quality and safe care during the COVID-19 pandemic.

Figure 4.1 HRM and Organisational Performance Literature Summary



4.1. HRM and Organisational Performance

4.1.1. The Link between HRM and Organisational Performance

Since the early 1990s, traditional personnel management has shifted from operating solely administrative functions to including more strategic components within HR roles and incorporating HR practices with other organisational strategies (Fisher, 1989; Wright and Rudolph, 1994). Over the past three decades, a shared consensus has defined HRM as a strategic process comprising different practices that support the organisation's goals and performance (Storey, Wright and Ulrich, 2019). These practices include analysis and design of work, HR planning, recruitment and selection, training and development, performance management and appraisal, compensation, and employee relations (Storey and Wright, 2023). The main purpose of HRM is to effectively manage the human resources in implementing business strategies and achieving the strategic goals of organisations (Schuler, 1992; Martell and Carroll, 1995). Therefore, the effective management of HR plays a key role in an organisation's efforts to operate its business, as well as to help its workforce adapt to disruptive changes and crises (Collings, McMackin, et al., 2021).

Extensive HRM research has consistently shown a strong link between effective HR practices and beneficial outcomes in terms of both employees' and an organisation's performance (McDermott et al., 2013; Sanders, Guest and Rodrigues, 2021). The view that HRM enhances the performance of an organisation is widespread; however, the specific aspects of performance that are important and the methods for their measurement are not clearly defined (Beardwell, 2017). In business and management research, the concept of organisational performance has predominantly centred on accounting metrics such as turnover, profits, return on investment, sales, and market share, as well as financial market outcomes like market value and stock price (Richard et al., 2009). Nevertheless, recent studies have expanded this perspective and included a broader range of indicators such as individual and group effectiveness (e.g., labour productivity, firm productivity) (Shin and Konrad, 2017), innovation, product- and service-related measures (e.g., number of products sold, product reliability, safe service, etc.), and societal impacts (e.g., environmental sustainability and social welfare) (Aguilera et al., 2024). The central theme of these studies is that certain combinations of HRM practices, particularly when tailored and adapted to specific organisational contexts, can lead to measurable improvements in organisational performance.

Key elements of HRM that positively influenced the organisation's performance include, but are not limited to, talent management, training and development, compensation, performance appraisal, and staff involvement and voice (Beardwell, 2017). For example, Glaister et al. (2018) found that talent management, when focused on a set of practices designed to build workforce networks and social capital, could increase firms' profit growth and profit margins. Sung and Choi (2014) discovered that HR training and development could enhance both employee commitment and competence, which in turn determined the financial performance of the organisation. McDermott et al. (2019) found that formative cross-functional performance monitoring in performance management contributed to improved outcomes for both employees and patients. Additionally, Chang et al. (2022) found that there is a positive relationship between employee relations system (e.g., employee involvement, strong retirement benefits, etc.) and firm financial performance. Research on high-performance work systems, which are conceptualised as a system of HR practices, also revealed a positive correlation to organisational performance (Shin and Konrad, 2017), through different mediating factors such

as internal social structure (Evans and Davis, 2005), staff well-being, employee commitment, work engagement, employee resilience (Lu et al., 2023; Wang, Zhang and Wan, 2022), and gender diversity (Joo et al., 2023). More contemporary approaches to HRM, such as green HRM (adopting HR practices for environment-centred decisions and corporate environmental sustainability behaviours) (Ren, Jiang and Tang, 2022; Zoogah, 2018), well-being-oriented HRM (Guest, 2017), and the use of digital online platforms and artificial intelligence management systems (Snell et al., 2023), have all positively impacted the organisation's performance.

Nonetheless, criticism of HRM and organisational performance has highlighted the lack of consensus about which HR practices should be included and how HRM and organisational performance are measured, as well as the inconsistencies in results in terms of whether the link is positive, negative, or non-significant (Beardwell, 2017). Other criticisms are related to the focus on the association between HRM and organisational performance, which could overlook other measures of managerial effectiveness (e.g., top management support, IT support), potentially overstating the impact of HRM (Mitchell, Obeidat and Bray, 2013). Despite ongoing debates over consensus and measurement challenges, research in the field of HRM and organisational performance continues to expand as the findings consistently indicate positive links. This growth underscores the need for conceptual frameworks of HRM practices and outcomes, as well as the relations between them. The next subsection critically examines theories that underpin the link between HRM and firm performance.

4.1.2. HRM and Organisational Performance Theories

A number of key conceptual theories and approaches that underpin the link between HRM and firm performance include resourced-based view theory, best-practice and best-fit approaches, as well as theories focusing on aspects of human behaviour and performance within organisations.

First, the link between HRM and performance can be supported by the resource-based view theory (Wright, Gardner and Moynihan, 2003), which suggests that organisations strive to maximise their internal resources through creating valuable, rare, inimitable, and irreplaceable resources that are both socially complex and causally ambiguous (Barney, 1991; Barney and Wright,

1998). Kinnie and Swart's (2017) approach to the impact of HRM on a firm's performance proposed that a collection of HRM policies, practices, and procedures can together provide the organisation with a competitive advantage.

Second, research into the link between HR practices and organisational performance can also be categorised into two approaches of best-practice and best-fit (Kinnie and Swart, 2017). In terms of best-practice, HRM encourages employee engagement, and commitment can improve performance regardless of the external and internal contexts of the organisation (Beardwell, 2017). Underpinning the best-practice approach, research employs various terms, such as high-performance management/work system, high-commitment management, and high-involvement management; however, all of these concepts convey a shared message that incorporates different bundles of HRM practices that are aimed at improving employees' abilities, motivations, and opportunities to make positive contributions to organisational performance (Appelbaum et al., 2000; Armstrong, 2021). In other words, these approaches attempt to recognise a distinctive set of effective HR practices that can be applied to all organisations, regardless of their context. In terms of the best-fit approach, there is no one-size-fits-all solution, and HRM should be customised to fit the specific circumstances of each organisation. The central theme among studies supporting the best-fit approach is that specific combinations of HRM practices, especially when adapted and customised to match specific organisational contexts, can result in measurable improvements in organisational performance (Beardwell, 2017).

Third, theories focusing on aspects of human behaviour and performance within organisations can also support the relationship between HRM and firm performance (Jiang and Li, 2019). For example, human capital theory views individuals as valuable assets and posits that investments in human capital can lead to increased productivity (Becker, 1964). Human capital theory involves the development of HR practices in areas like recruitment, selection, training, and team building, to ensure organisations hire top employees and equip them with the skills necessary for improved collective human capital and economic gains (Kinnie and Swart, 2017). Moreover, social capital theory adds focus to employee social relationships with the internal and external stakeholders of the organisations (Leana and Van Buren, 1999), which can bring certain benefits for organisations (Jiang and Li, 2019). For instance, network-building HRM

practices for the top management teams have been found to be positively associated with the internal and external networks, boosting firm performance (Collins and Clark, 2003). Finally, the AMO framework suggests that when employees have the necessary abilities (A), high motivation (M), and favourable opportunities (O), they are more likely to perform at their best, which contributes to organisational success, including improved productivity, job satisfaction, and overall performance (Appelbaum et al., 2000; Boxall and Purcell, 2016). The AMO framework forms the basis for both best-practice and best-fit approaches (Beardwell, 2017).

4.2. HRM and Healthcare Organisational Performance

Key measures of organisational performance in the healthcare sector typically include financial results, individual job performance, and quality of care (e.g., adherence to evidence-based practices, positive patient outcomes and experiences) (Mayo, Myers and Sutcliffe, 2021). In recent years, an important trend in research within healthcare and organisational studies is the increasing emphasis on the quality-of-care services and patient safety. This focus has only been an important priority for care organisations since the early 2000s (Katz-Navon, Naveh and Stern, 2005), following a significant number of preventable incidents resulting from unsafe care practices. Since then, care quality improvement and patient safety emerged as key objectives in healthcare organisational performance (McDermott and Fitzgerald, 2017).

Consequently, the important link between HRM and quality and safety of care has gained increased attention in the fields of organisational science and healthcare (Bartram et al., 2007; Grimshaw, Rubery and Marchington, 2010; McDermott and Fitzgerald, 2017; Mayo, Myers and Sutcliffe, 2021; Shipton et al., 2016). In the context of acute care settings, there has been an abundance of evidence supporting the use of HRM practices in hospitals to enhance healthcare organisational performance outcomes, particularly in preventing adverse events, enhancing care quality, and improving patient safety. One prominent example is the extensive research on hospital outcomes using the Magnet Recognition Program, a model developed by the American Nurses Credentialing Centre in the United States to organise and support nursing staff in a professional work environment (Armstrong, Laschinger and Wong, 2009; Cooke and Bartram, 2015; Kelly, McHugh and Aiken, 2012).

The original Magnet study took place in 1981 when 41 hospitals from across the United States were selected to participate based on their already known reputation as being exceptional places for nurses to work. The criteria were hospital recruitment and retention records with a low nurse turnover rate (American Academy of Nursing, 1983). Over the years, research on the Magnet hospitals has demonstrated how improving the work environment through HRM practices can result in better outcomes for patients, nurses, and organisations.

For instance, Lacey et al. (2007) discovered that in Magnet hospitals, the quality of patient care is positively correlated with nursing training, encouragement of autonomy in nursing practice, and adequate staffing levels. Armstrong, Laschinger and Wong (2009) reported, from their study on 300 nurses in a Magnet hospital in Canada, that improving the quality of the work environments in terms of empowerment in the workplace could improve patient safety culture. Kelly, McHugh and Aiken's (2012) study on United States hospitals found that Magnet hospitals had considerably better work environments (e.g. better nurse staffing, lower levels of job dissatisfaction and burnout) when compared with non-Magnet hospitals. Similarly, Kutney-Lee et al.'s (2015) longitudinal research from 1997 to 2007 on 136 hospitals in Pennsylvania, USA showed that Magnet hospitals demonstrated greater improvements in their work environments than non-Magnet hospitals in terms of lower mortality and failure-to-rescue rates.

Nevertheless, one criticism of the Magnet hospitals study is that there is no consensus in the literature regarding whether Magnet hospitals have better outcomes or ways of working than non-Magnet counterparts. For example, Goode et al. (2011) found that some non-Magnet hospitals had better nurse staffing (e.g. higher skill mix) and better clinical outcomes (e.g. lower rates of infections) than Magnet hospitals. A study by Trinkoff et al. (2010) found no significant difference in schedules and working conditions between nurses in Magnet and non-Magnet hospitals. The authors investigated the factors of long work hours and intense work demand, which can adversely affect nurse health and patient outcomes, and found no real differences between Magnet and non-Magnet hospitals (Trinkoff et al., 2010). Another criticism of the research into Magnet hospital in terms of patient outcomes is that it has been specifically and predominantly directed at registered nurses in acute hospital settings and does not pay sufficient attention to other professions and occupations involved in the health and care service (Armstrong, 2005). McClure (2005) and

Bumgarner and Beard (2003) argued that the effective use of the Magnet model must require the cooperation of all staff, departments, and disciplines within the institution. Similarly, Vila (2016) pointed out the importance of physician engagement and that communication among nurses, physicians, and administrative staff is integral to the success of the Magnet programme. Critics of the Magnet programme have also raised concerns about hospital's primary concentration on the organisational outcomes rather than on the individual nurse (McNeely, 2005). For instance, hospitals might use Magnet designation as a tool for marketing opportunities (Bumgarner and Beard, 2003; Vila, 2016) and to achieve certain financial implications such as return on investment or revenues (Drenkard, 2022). This does not actually focus on the individual nurse but places high demands on them (Trinkoff et al., 2010).

Besides Magnet research, other studies of HRM practices and the quality of care have also taken place predominantly in acute hospital settings. For example, Yang and Lin (2009) identified that effective HR practices in Taiwanese hospitals, including recruitment and selection, training and development, performance appraisal and compensation, are critical for attracting and retaining skilled employees, thereby enhancing organisational performance. Similarly, Aiken et al. (2012) examined the impact of these HRM practices on patient safety and care quality in hospitals in Europe and United States. Their findings highlighted that those hospitals with good levels of nurse staffing (using the ratio of patients to nurse) and good work environments are significantly related to patient satisfaction, patient safety, and quality of care. Townsend, Lawrence, and Wilkinson (2013) further corroborated this in their research of Australian hospitals, revealing that the efficient functioning of HRM processes significantly impacts the continuity of quality patient care, and that HR practices such as strategic planning, recruitment, performance management, training and development, industrial relations and staff support, are positively associated with the continuity of quality patient care. Additionally, Khatri, Gupta and Varma (2017) emphasised the importance of HR capabilities, noting a positive correlation between patient care quality and HR capabilities, which include support from chief executives, the competence of HR heads, and the professionalism of HR personnel and departments.

In the UK, studies on the link between HRM and hospital performance show similar results. For instance, West et al. (2002) found that HR practices, including employee appraisal, training, and teamwork in English hospitals, were

strongly related to the quality of care in terms of patient mortality. King et al. (2011) demonstrated that managing and valuing diversity can impact patient civility and, consequently, enhances organisational performance. Furthermore, Burgess et al.'s (2015) study on leadership and healthcare quality in the UK emphasises the importance of HR practices as a space and opportunity for care managers to facilitate knowledge management, and the cultivation of social connections, ensuring high-quality patient care. Similarly, Shantz, Alfes and Arevshatian (2016) identified a positive link between HR and work engagement practices (including training, development, participation in decision making, and communication) and care quality, based on their research of NHS nurses and administrative staff in the UK.

While a significant amount of research has demonstrated common findings that HRM is one of the crucial determinants to achieving successful healthcare quality programmes, they have tended to focus on acute hospitals, whereas other care settings such as domiciliary care or homecare have been overlooked (Berland and Bentsen, 2017). Critics have also pointed out that much research in HRM and patient safety has been specifically and predominantly directed at registered nurses in hospital settings and does not pay sufficient attention to other healthcare professions (Mayo, Myers and Sutcliffe, 2021).

In social care, the effective management of HRM practices and initiatives is important for individual and organisational performance (Cooke and Bartram, 2015; Kessler, Heron and Spilsbury, 2017). In homecare research, HRM has been a key focus and recognised for its important role in ensuring high-quality care and improved patient safety (Berland and Bentsen, 2017; Ree and Wiig, 2020). Although there is limited research on the positive link between HRM and organisational performance of homecare providers, a number of reports and studies on patient safety in homecare found HRM challenges to be major barriers to care quality and patient safety (Berland and Bentsen, 2017; CQC, 2019; Lang, Edwards, and Fleiszer, 2007; The King's Fund, 2018). These HRM challenges are related to a wide range of issues including workforce well-being, staff recruitment and retention (Cooke and Bartram, 2015), performance management (McCann et al., 2015), training and development (Gospel, 2015), compensations and recognition (Rubery et al., 2015), and employment relations (Brown and Korczynski, 2017). Therefore, it is critical that this thesis looks into the role of HRM in creating and sustaining a safety culture in homecare to fill the gaps in the literature.

4.3. HRM in the Context of COVID-19 Pandemic

4.3.1. HRM Challenges during the Pandemic

In December 2019, the discovery of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and its rapid global spread prompted the World Health Organization to declare a pandemic on 12 March 2020 (Ciotti et al., 2020). Since then, this coronavirus disease 19 (COVID-19) has resulted in millions of fatalities and has profoundly impacted the global landscape (Wise, 2023). Various countries worldwide had to initiate lockdowns to restrict movement and safeguard borders to curb the disease's spread; however, these lockdowns, while effective in controlling the pandemic, also significantly altered people's lifestyles through mobility restrictions, promoting remote work, and prohibiting mass gatherings (Onyeaka et al., 2021). In many organisations, the lockdown experience has redefined how organisations operate, particularly in altering workplace dynamics with significant shifts towards remote work, virtual teams, and virtual leadership (Minbaeva and Navrbjerg, 2023). In May 2023, the World Health Organization declared that COVID-19 is no longer a global health emergency; however, it still remains a global health threat (Wise, 2023).

The effective management of HRM practices plays a key role in an organisation's efforts to operate its businesses and help its workforce adapt to disruptive changes and crises (Collings, McMackin, et al., 2021; Kim, Vaiman and Sanders, 2022). Despite this significance, many organisations struggled to efficiently implement HRM practices in response to the major disruption of COVID-19 (Butterick and Charlwood, 2021). Recent research has highlighted a range of HRM challenges during this period, including staff turnover and job losses (Johnstone, 2024; Stuart et al., 2021), concerns over employee well-being (Adisa et al., 2022; Bolino, Henry, and Whitney, 2024; Mihalache and Mihalache, 2022), difficulties in training delivery and addressing skills gaps (Kuijper et al., 2022; Leverton et al., 2023; Q. Song et al., 2023), as well as a decline in employee performance and productivity (Park and Koch, 2024). HR practitioners, therefore, have been under considerable pressure to adapt and transform HRM processes in response to the difficulties intensified by the

COVID-19 crisis (Branicki, Kalfa and Brammer, 2022; Minbaeva and Navrbjerg, 2023).

COVID-19 has also brought further HRM challenges that organisations have been struggling to overcome. One of the most noticeable difficulties involves shifting to a remote work environment or altering workplace conditions during a time of crisis (Adisa et al., 2022; Leonardi, 2021). Managers and HR practitioners had to find new ways to ensure their staff had suitable equipment and the digital skills to work from home, as well as supporting their employees' well-being, keeping them motivated, and maintaining social connections and communication (Collings, Nyberg, et al., 2021; Bolino, Henry, and Whitney, 2024). Nevertheless, for other industries such as manufacturing, construction, and healthcare support, remote working is not a viable option (Collings, Nyberg, et al., 2021). As a result, health and social care organisations face significant obstacles in finding alternatives and adapting to new work arrangements.

4.3.2. HRM Challenges in Healthcare Sector during the Pandemic

There has been a scarcity of research focusing on the role of HRM and HRM-related challenges within healthcare organisations, with an even more pronounced lack of attention paid to the social care sector during the COVID-19 crisis, despite it being severely impacted by the pandemic (Lintern, 2020; Perry, 2021). Social care has been on the receiving end of many of the policy and organisational changes made to cope with the pandemic, with staff, patients, and access to resources affected in the push to shore up acute care (Marshall et al., 2021). Particularly striking is the limited number of studies on homecare or domiciliary care services. Prior to the pandemic, HRM challenges were major barriers to care quality and patient safety in homecare. The pandemic has brought long-present challenges in HRM in homecare to the fore, while adding a host of new ones. Therefore, this thesis aims to examine HRM challenges in the homecare sector during the COVID-19 crisis and explore how homecare organisations adapted their HRM strategies to ensure the safety of patients amidst the pandemic's challenges.

The COVID-19 crisis exacerbated HRM issues in the health and social care sector, placing considerable pressure on care providers. During this period, the major HRM challenges in healthcare were related to staff turnover and

retention (Nyashanu, Pfende, and Ekpenyong, 2020; Peng et al., 2023), training and skill gaps (Leverton et al., 2023; Kuijper et al., 2022), communication (Aughterson et al., 2021), and managing staff and supporting their well-being (Chaudhry et al., 2021; Rapp, Hughey, and Kreiner, 2021). Nevertheless, despite the health and social care sector being heavily impacted by COVID-19, there have been limited studies exploring the role of HRM and HRM-related issues in health organisations. Furthermore, most of these studies have merely reported the HRM challenges encountered during the crisis, without investigating further how these challenges can act as barriers to care quality and impact patient safety. Other research has also been calling for further qualitative studies looking into the impact of HRM challenges on patients' experiences (Moynihan et al., 2021). Therefore, we aim to fill in this literature gap by investigating how HRM challenges can influence homecare patient safety by discovering the responses of homecare providers during the pandemic.

4.3.3. The Role of HRM in Responding to the Pandemic

Since COVID-19, the pressure on health and social care organisations has intensified, highlighting HRM's crucial role in ensuring the continuity of the care service, managing staff, helping them to cope with the crisis, and safeguarding the safety of patients and staff (Kuijper et al., 2022; Q. Song et al., 2023). While effective HRM practice management is key for organisational functioning and workforce adaptation during crises (Collings, McMackin, et al., 2021; Kim, Vaiman and Sanders, 2022), many health and social care providers struggled to efficiently implement HRM practices in response to the major disruptions of the pandemic.

HRM within healthcare organisations is crucial in effectively responding to the pandemic (Liu et al., 2020). Health and social care providers have developed a number of HRM innovations, focusing on new ways of managing, ways of working, and work roles (Kessler, Heron and Spilsbury, 2017). One of the most salient approaches has been to make use of digital technology to transition to virtual forms of recruitment, selection, training, and online meetings (Akkermans, Richardson and Kraimer, 2020; Mazurenko et al., 2022; Q. Song et al., 2023). COVID-19 might have brought opportunities for changing work arrangements and skill upgrades with respect to the use of technology (Akkermans, Richardson and Kraimer, 2020); however, the digital transition

approach has been seen to create difficulties concerning technology-related stress and exhaustion, as employees can be expected to constantly be available and respond to emails or online meetings (Aleksić, Černe and Batistič, 2024). Workload and working hours can be increased, resulting in stress and burnout among staff (Aughterson et al., 2021); therefore, organisations must take into consideration how their employees experience and feel about the virtual tools in times of the pandemic (Adisa et al., 2022).

Besides using digital technology, care providers have responded to the HRM challenges through a mix of adaptation measures. For example, to increase care staff capacity, organisations recruited and redirected staff from other areas, including hiring and training unemployed individuals, encouraging retired carers to return to work, and recruiting the military, medical students, and civilian nurses (Kuijper et al., 2022). Nonetheless, there might be a potential limitation in terms of adopting non-standard employment, which is that the staff might not be familiar with the new roles due to their lack of experience in incident response (Tekeli-Yesil and Kiran, 2020). Furthermore, relocating staff to work during COVID-19 might pose potential risks, cause distress and conflicts, and raise other ethical concerns for professionals (Danielis et al., 2021; Dunn et al., 2020; Schuurmans et al., 2023). As a result, healthcare providers must be able to justify the process of staff reallocation and carefully prepare guidelines for non-standard employees (Dunn et al., 2020; Tekeli-Yesil and Kiran, 2020). Once again, it is noteworthy that most studies investigating HRM issues in healthcare organisations during COVID-19 have been conducted primarily in acute care hospitals, and very little research has focused on homecare, revealing a significant gap in the literature. Additionally, the majority of these research have only explored the issues pertaining to HRM and did not investigate further the impact of these issues on care quality and patient safety. Such an extensive list of emerging HRM-related issues caused by the pandemic requires further discussion regarding their influence on the quality-of-care service and patient experience, especially in homecare settings.

Chapter Summary

This chapter presents a review of the literature on the topic of HRM and quality-of-care. Effective HRM plays a key role in achieving organisational goals and adapting to changes. Despite some debate over specific HR practices and their

measurement, the positive link between HRM and organisational performance is well supported. In the healthcare sector, recent studies have emphasised quality-of-care services and patient safety as key measures of organisational performance. As a result, the link between HRM and the quality and safety of care has gained attention, with extensive evidence showing that effective HRM practices in hospitals improve outcomes such as patient safety and care quality. However, research in homecare settings is limited. Therefore, the thesis aims to address this gap by exploring HRM practices, patient safety, and care quality in homecare, recognising the significant role HRM plays in overcoming challenges and ensuring high-quality care.

The research was conducted during the COVID-19 pandemic, which resulted in a number of emerging findings and challenges in healthcare. Effective HRM is crucial in managing organisational operations and helping workforces adapt to disruptive changes. However, many organisations struggled to implement HRM practices efficiently during the pandemic. In healthcare, major HRM challenges included staff turnover and retention, training and skill gaps, communication, and managing staff well-being. The pandemic also brought long-present challenges in HRM in homecare to the fore, while adding a host of new ones. Health and social care providers had to develop HRM innovations, focusing on new management methods, work arrangements, and roles. Nevertheless, the research has mainly focused on acute care hospitals, with little attention paid to homecare. This gap necessitates further investigation into the impact of HRM challenges on care quality and patient safety in homecare settings, especially given the extensive list of emerging HRM-related issues caused by the pandemic.

Chapter 5.

Research Methodology

5. Research Methodology

Chapter Overview

The methodology chapter provides a detailed account of the methods and procedures used to conduct the research. It begins with the research philosophy that underpins the study's theoretical framework. Next, the chapter justifies the research approach and strategy with reference to the research aims. Then, the chapter elaborates on the research design and data collection methods, which are tailored to the research questions that guide the investigation. The management of data and data analysis are also discussed. Furthermore, ethical considerations are reviewed to ensure the entire research process adheres to ethical standards. Finally, the researcher reflects on the impact of COVID-19 on the research methodology by detailing how the pandemic required adaptations in data collection and analysis processes.

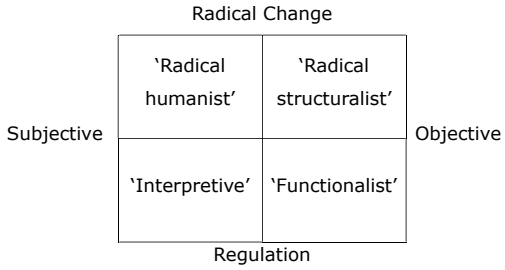
5.1. Research Philosophy

The ontological assumption underpinning this thesis is that it studies the social and cultural phenomenon of people's behaviours and interactions with one another. Therefore, the research's ontological position is in line with constructivism and subjectivism (Grix, 2002), which support the idea that social phenomena and its meanings are remarkably complex and in a constant state of construction and reconstruction by social actors (Bryman, 2012).

The ontological position behind the research also falls into the interpretive paradigm in the four paradigms of Burrell and Morgan (1979), as illustrated in Figure 5.1. It is because the research seeks to understand the social phenomena within the existing structures and contexts at the level of subjectivity. Ontologically speaking, interpretivism seeks for meanings, realities, and interpretations of the complex social world from the point of view of the actors involved in the social process (Saunders, Lewis and Thornhill, 2019). As the study investigates the safety culture through social actors' understandings of events, it is the interpretive assumption that underlies this research.

Figure 5.1 Four paradigms for the social theory analysis

(Burrell and Morgan, 1979, p.22)



Epistemology refers to the theory of knowledge, the process of gathering knowledge, developing new theories of social reality, and validating the acceptable knowledge (Grix, 2002). A common epistemological concern involves the question of what is considered as acceptable knowledge in doing research (Bryman, 2012). There are two popular contrasting epistemological assumptions relating to the perspectives of positivism and interpretivism (Grix, 2002). The epistemological assumptions behind this study are central to the perspective of interpretivism. It is because the purpose of the research is to explore the complex and rich meanings of the social phenomenon of safety culture and fundamental challenges affecting the quality of care in homecare. Saunders, Lewis and Thornhill (2019) argued that rich insights and understandings would be lost if such complexity of the social cultural phenomena is concentrated into a series of law-like causal generalisations in a positivist perspective. In addition, because the nature of the research topic of safety culture in homecare is insufficiently investigated, an exploratory stance to interpret the social phenomenon using a qualitative strategy is preferable (Bryman, 2012, p.41). Typical methods in the epistemological position of interpretivism are inductive with small samples, in-depth investigations, and using qualitative approach of analysis (Saunders, Lewis and Thornhill, 2019).

While these methods can help obtain in-depth interpretations, meanings, and perceptions from the social actors, there are potential limitations, such as generalisability issue or possible bias. For example, regarding the concern of generalisation in interpretivism using a qualitative approach (Williams, 2000), the research does not intend to generalise findings to the wider population, to those who are not within the home care settings, or not in England. This constraint arises because the research is shaped by the specific cultural, regulatory, and organisational contexts of the English homecare system, which may differ significantly from those in other regions or countries. Qualitative

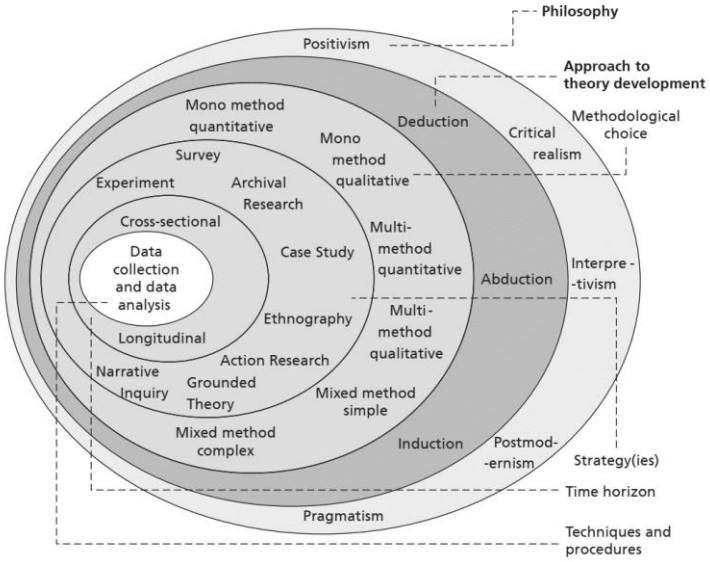
research is also often criticised as being too subjective or biased when researchers focus too much on their own views or close relationships with the participant studied (Bryman, 2012). Therefore, this research took a cautious approach to minimise the influence of subjective views, personal biases, and relationships on the study. To achieve this, the researcher carefully selected a sampling method, defined an optimal sample size, and applied robust analytical techniques to mitigate the limitations of interpretivism in qualitative research. These considerations will be elaborated upon in the following subsections.

5.2. Research Approach

The previous section has demonstrated a clear and consistent set of assumptions, establishing the key research philosophy for the study. This philosophy underpins the researcher's methodological approach, strategy, data collection methods, and analysis procedures (Saunders, Lewis and Thornhill, 2019). By setting out an interrelation between what the researcher thinks can be research (ontological assumptions) and how the researcher come to know about it (epistemological assumptions), this study has identified the impact of these assumptions to the research approach and research methods. Using the 'research onion' model (Figure 5.2) developed by Saunders, Lewis and Thornhill (2019, p.130), the researcher can identify the stages of developing the research methodology which are influenced by the ontological and epistemological assumptions.

Figure 5.2 The 'research onion'

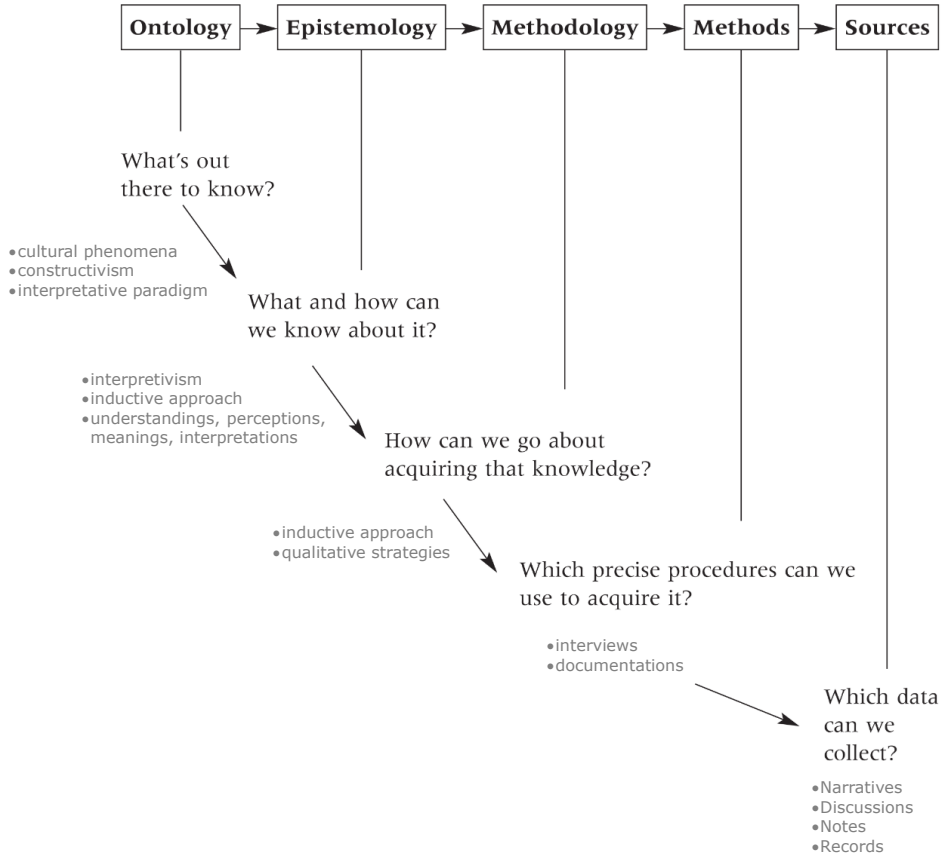
(Saunders, Lewis and Thornhill, 2019, p.130)



The 'research onions' contains six layers including: (1) philosophy, (2) approach to theory development, (3) methodological choice, (4) strategies, (5) time horizon, and (6) techniques and procedures. The ontological and epistemological assumptions discussed in previous sections reveal the first layer of philosophy which is the interpretivism. This perspective influences the inductive approach to theory development and methodological choice using qualitative strategies. Additionally, to illustrate the influence of the ontological and epistemological assumptions on the research approach, the researcher has adapted the diagram of 'The interrelationship between the building blocks of research' (Figure 5.3) developed by Hay (2002), as cited in (Grix, 2002, p.180).

Figure 5.3 The interrelationship between the building blocks of research

(adapted from Hay, 2002, cited in Grix, 2002, p.180)



This research took an inductive approach, which is a process of using detailed readings of data to build theories, concepts, themes, or models through

interpretations made from data by the researcher (Saunders, Lewis and Thornhill, 2019); Thomas, 2006). The purpose of this research is to explore the subject of patient safety in England. Therefore, the data collection is used to explore these matters and to identify themes and patterns, then create conceptual frameworks for patient safety in homecare, for which it is appropriate to take an inductive stance (Saunders, Lewis and Thornhill, 2019).

5.3. Research Strategy

This thesis adopts the research strategy of a narrative inquiry. The narrative approach involves gathering information, in the form of storytelling by the research participants, for the purpose of understanding a phenomenon (Edmonds and Kennedy, 2017). This study's strategy is to recruit participants who can share their perspectives on homecare and recount specific safety incidents, as well as practices that can enhance the quality-of-care services.

The narrative research is suitable for exploring a phenomenon which detailed stories help understand (Creswell and Poth, 2016) and for grasping how people create meaning from their experience (Edmonds and Kennedy, 2017). In this case, narrative research strategy helps to explore the patient safety in homecare and the approach to safety through stories from different groups of participants. The strategy also enables reviewing the stories with the participants to help validate the meaning and interpretation of patient safety in homecare from different perspectives.

This thesis also employs a strategic process of triangulation, meaning that it investigates the research topics from multiple points of view to develop a comprehensive understanding of the phenomena (Neuman, 2014). In the study, there are two types of triangulations. First, the triangulation of methods allows the researcher to take multiple measures of data collection about the same phenomenon (Carter et al., 2014). The data collection methods of interviews and keeping documents for this research are discussed in the next section. Second, data source triangulation consists of the process of collecting data from different types of persons, groups, families, and communities, to obtain multiple views and validation of data (Carter et al., 2014). Neuman (2014) argued that multiple observers can bring alternative perspectives, which can reduce the limitations of any biased view. Triangulation also has been

considered as a qualitative research strategy to test validity through the convergence of information from multiple sources (Carter et al., 2014).

5.4. Research Design and Data Collection Methods

The research philosophy and research approach have guided the adoption of qualitative data collection methods for a narrative research strategy. The narrative stories can be gathered through many different forms of data, for example, interviews, observations, documents, pictures, and other sources of qualitative data (Creswell and Poth, 2016). The data collection method for this research of patient safety in homecare is the semi-structured individual interviews. Another method of collecting data for this research is to obtain documents and official reports, which are written materials that people leave behind (Esterberg, 2002).

5.4.1. Interviews

The first data collection method for this research was the semi-structured individual interview. The rationale for using qualitative interviews is because it is the most flexible qualitative method that can allow the researcher to address the research questions with broader issues and to explore in depth different aspects of the topic (King, 2004). On top of that, the semi-structured interview allows the participants to talk about other matters rather than precisely following a set of identical questions, which is useful for obtaining in-depth insights into their opinions (Patten and Newhart, 2018). The interview questions were designed based on key themes identified in the literature review, which served as the foundational framework for the semi-structured interviews. Three sets of questions were prepared: one for homecare workers, one for service users, and one for family members (Appendix F).

The interviews were individual, which allows the interviewer to access a good source of available knowledge and lead the conversation in a way that is useful for interviewer's research interests (Brinkmann, 2014). Additionally, online and/or phone interviews were conducted for data collection. These were selected by asking participants which way they preferred after they agreed to participate in the study. Before the interview, each participant received a set of instructions, including a request to minimise any disturbing factors to ensure a high-quality environment for the interview. For the online interview, Microsoft

Teams was selected, and each participant received an invitation link to join via web browser/ web or mobile application. It was made clear to the participants that the interview would be audio recorded only. Each participant had the option to open/close their cameras during the interview.

5.4.2. Interview Participants

One of the research strategies of this study is data source triangulation (Carter et al., 2014). In this study, the researcher conducted interviews with different groups of participants, including homecare workers, service users, and family members. In the literature review, previous studies have highlighted the importance of the roles of service users and their family members in ensuring patient safety. For example, Schaepe and Ewers (2018) investigated how family members contribute to safety of home care patients in Germany and discovered that family caregivers had significant responsibility for the safety of service users in home care by being actively and constantly dedicated to safety work. Turjamaa et al. (2014) and Schildmeijer et al. (2018) argued that the standard of safety in home care must include service users' perspectives, needs, and involvement. In addition, Lang et al. (2009) found that the meaning of safety was not uniform for care workers, service users, and family members, as they see safety in homecare differently. Therefore, the conceptualisation and promotion of safety in home care must include the responsibilities and perspectives of the social actors involved, including care workers, service users, and their caregivers (Tong, Sims-Gould and Martin-Matthews, 2016).

In this research, it is important to explore and investigate the meaning of high-quality and safe care, the safety issues, the fundamental challenges, as well as the safety approaches from the perspectives of care workers, service users, and family members:

- **Homecare workers** selected for this study were those who had worked and had been working in the setting of homecare. This included home care staff, team leaders, home care managers, social workers, and homecare transition practitioners. In this study, home care staff will also be referred to as care workers, support workers, carers, and caregivers.

- **Homecare service users** included in the study were adults who had used and had been using the homecare support service. The study did not include service users who were accessing care services primarily for mental health issues. Participants must be mentally sound, capable of giving informed consent, and able to make their own decisions.

- **Family members or family caregivers** were those who were involved in providing care and support for homecare service users, either by living with them or being actively engaged in their care with the service user's consent. The family caregivers included in this study were parents, siblings, partners, or other relatives of the service users. To be eligible for participation, caregivers had to be at least 18 years old and play a role in supporting the care recipient, regardless of whether they lived with them. This criterion was established to ensure that participants had direct experience with caregiving responsibilities.

5.4.3. Sampling and Recruitment

The sampling methods used for this research were opportunistic and snowball samplings. The research collected the narratives, stories, thoughts, and experiences of participants about safety in homecare. The data was analysed in parallel with the data collection process. By using early analysis, the researcher was able to revise interview guides and make changes for the next interviews (Hoonaard and Hoonaard, 2008, p.186).

As this research aims to explore the safety culture in homecare, the targeted participants were mostly homecare workers with a few service users and family caregivers. This research emphasises gaining in-depth insights from caregivers' perspectives. Therefore, the majority of participants were homecare workers, while the remainder consisted of other relevant social actors.

Opportunistic sampling (also known as convenience sampling or accidental sampling) allows the researcher to reach participants who are available for the interview and easy to be contacted, which helps save time and resources (Koerber and McMichael, 2008). The study was published on online platforms

including callforparticipants.com, bepartofresearch.nihr.ac.uk, and peopleinresearch.org. These platforms promote various types of research to relevant individuals who can then sign up to participate if they meet the criteria. Designed for recruiting participants for academic research, these platforms helped the study find suitable participants.

This research also uses snowball sampling, as it allows the researcher to access more informants through contact information that is provided by other participants (Noy, 2008, p.330). In the study, the researcher enlisted the help of the homecare team leaders in identifying potential additional participants for the research project. The researcher contacted and interviewed two homecare team leaders who were happy and voluntarily introduced their homecare staff to participate in this study. The team leaders were asked to circulate study information to potential participants, along with the researcher's contact details (phone/email address).

Then, the potential participants would discuss further about the study and their participation with the researcher before giving their consent to take part in the interviews. The team leaders were not responsible for their staff participation. They simply passed on information about the study to their home care staff and let them decide whether they want to take part in the study and contact the researcher. The researcher ensured that agreeing to contact others was not an obligation to participate in the research, and there would not be a reward for recruiting research participants. However, there was a thank-you payment for the participant's time offered to every participant who completed the interview at the end. The thank-you payment was a £5 gift card for each participant who agreed to participate and complete the interview.

Between March 2021 and June 2022, there were thirty-one participants who were interviewed in this study (Table 5.1). All participants in the research were provided with an explanation of the aims and further details about the study, and each participant was provided with a sheet and a consent form. The consent process sought to ensure participants understood the research, who was carrying out the study, what they would be asked to do, what would happen to the information they provide, and their rights to withdraw from or complain about the research before agreeing to take part in the study. Written or oral informed consent to participation was obtained before the interviews took

place. The participant information sheet and consent form are attached to this document in the appendices.

Table 5.1 List of interview participants

Interviews (I)	Roles	Regions	Types of care provided/received
I.01	Homecare Transition Practitioner	Yorkshire & the Humber	Hospital-to-home transition
I.02	Homecare Transition Practitioner	Yorkshire & the Humber	Hospital-to-home transition
I.03	Homecare worker (Carer)	London	Basic supportive care
I.04	Homecare worker (Carer)	South West	Basic supportive care
I.05	Homecare worker (Carer)	Yorkshire & the Humber	Basic supportive care
I.06	Homecare worker (Carer)	East Midlands	Basic supportive care
I.07	Homecare worker (Carer)	London	Basic supportive care
I.08	Homecare worker (Carer)	North West	Basic supportive care
I.09	Homecare worker (Carer)	East Midlands	Basic supportive care
I.10	Homecare worker (Carer)	Yorkshire & the Humber	Basic supportive care
I.11	Homecare worker (Carer)	West Midlands	Basic supportive care
I.12	Homecare worker (Social worker)	East Midlands	Care services coordination
I.13	Family member	West Midlands	Supportive care, assistance
I.14	Service user	London	Basic supportive care
I.15	Homecare worker (Carer)	West Midlands	Basic supportive care
I.16	Service user	East Midlands	Basic supportive care
I.17	Homecare worker (Carer)	South West	Basic supportive care
I.18	Homecare worker (Carer)	East of England	Basic supportive care
I.19	Homecare worker (Carer)	East of England	Basic supportive care
I.20	Homecare worker (Carer)	Yorkshire & the Humber	Basic supportive care
I.21	Homecare worker (Carer)	Yorkshire & the Humber	Basic supportive care
I.22	Homecare worker (Carer)	Yorkshire & the Humber	Basic supportive care
I.23	Homecare worker (Carer)	East Midlands	Basic supportive care
I.24	Homecare worker (Carer)	North East	Basic supportive care
I.25	Homecare worker (Carer)	North East	Basic supportive care
I.26	Homecare worker (Carer)	London	Basic supportive care
I.27	Service user	Yorkshire & the Humber	Basic supportive care
I.28	Homecare worker (Social worker)	East Midlands	Care services coordination
I.29	Homecare worker (Carer)	London	Basic supportive care
I.30	Family member	East Midlands	Supportive care, assistance
I.31	Service user	London	Basic supportive care

5.4.4. Interview Design

As the qualitative strategy of this research takes the stance of narrative study, the interview questions were designed to be open-ended to gain the views,

thoughts, and experiences of the research participant and see how their stories of specific events related to homecare safety unfold over time (Creswell and Poth, 2016). The interviews were unstructured and conducted by phone or online through a Microsoft Teams meeting. Participants were given the option to choose which type of interview they preferred. The interviews lasted between 45 and 60 minutes and were audio recorded. The interview questions were designed and developed to be in line with the literature review. There were three sets of questions for home care workers, service users, and family members. The interview topic guide is attached in the appendices.

5.4.5. Documents and Reports

In addition to interviews, this research employed the method of collecting data through documents and reports, which are written materials left behind by individuals (Esterberg, 2002). This approach was also a key method for gathering qualitative data, which can offer a deeper contextual understanding of the findings (Hennink, Hutter and Bailey, 2011).

In this research, the document analysis was combined with the interview method for triangulation, which helped corroborate findings across data sets and minimised potential biases in the study (Bowen, 2009). There are different approaches to examine the documents. Prior (2008) suggested a typology for the ways in which documents can be considered in social research (see Table 5.2).

Table 5.2 Approaches to the study of documents

(Prior, 2008)

Focus of research approach	**Document as resource**	**Document as topic**
Content	(1) Approaches that focus almost entirely on what is "in" the document.	(2) "Archaeological" approaches that focus on how document content comes into being.
Use and Function	(3) Approaches that focus on how documents are used as a resource by human actors for purposeful ends.	(4) Approaches that focus on how documents function in, and impact on schemes of social interaction and social organization.

Each type of approach influences how documents are analysed and coded for what they encompass in terms of descriptions, reports, images, representations, and accounts (Prior, 2008). In this study, the focus of collecting documents is to use them as evidence to explore and highlight the findings that are relevant to safety culture and approaches to safety in homecare in England. These documents and reports are treated as resources, with the research focusing on their contents. Therefore, the data analysis strategy for documents in this research concentrates on what is in the texts through various forms of content analysis (Prior, 2008).

In this research, the process of finding and selecting relevant documents for homecare safety in England involved using Google search with specific keywords and Boolean operators. By entering terms such as "homecare," "adult social care," "England," and a custom date range from 1 January 2018 to 31 December 2023, the search was refined to come up with specific results. The results were then narrowed by language (English), region (United Kingdom), file type (pdf). This method ensures the retrieval of recent and relevant documents, reports, and studies. Once the search results were generated, each document was reviewed for relevance based on its title and content. Documents that provided substantial information on safety culture, safety practices, and quality improvement in homecare were selected for further analysis. Table 5.3 summarises all the documents and reports that were selected for the research analysis.

Table 5.3 List of documents selected for the research

Documents (D)	Type	Title	Data analysed
D.01	White Paper	"People at the Heart of Care: Adult Social Care Reform White Paper" (Department of Health & Social Care, 2021)	High-quality safe homecare; Homecare fundamental challenges; Approaches to high-quality and safe homecare
D.02	Report	"The state of health care and adult social care in England 2021/22" (CQC, 2022)	High-quality safe homecare; Homecare fundamental challenges; Approaches to high-quality and safe homecare
D.03	Report	"Home care in England: Views from commissioners and providers" (The King's Fund, 2018)	High-quality safe homecare; Homecare fundamental challenges; Approaches to high-quality and safe homecare

D.04	Report	"Safe Care at Home Review" (Home Office and Department of Health and Social Care, 2023)	Safety issues in homecare; Homecare fundamental challenges; Approaches to high-quality and safe homecare
D.05	Report	"Care Provision and Workforce Survey 2023" (Homecare Association, 2023)	Homecare fundamental challenges; Approaches to high-quality and safe homecare
D.06	Report	"Home care market dynamics in England" (Allan, 2021)	High-quality safe homecare; Homecare fundamental challenges
D.07	Report	"Homecare Association Impact Report 2021-2022" (Homecare Association, 2022)	Homecare fundamental challenges
D.08	Briefing	"Adult social care funding (England)" (House of Commons Library, 2023)	Homecare fundamental challenges
D.09	Report	"The State of Health and Care of Older People in England 2023" (AgeUK, 2023)	Homecare fundamental challenges
D.10	Report	"Workforce Intelligence Summary Domiciliary care services in the adult social care sector 2021/22" (Skills for Care, 2022)	Homecare fundamental challenges
D.11	Report	"Health and social care workers' quality of working life and coping while working during the COVID-19 pandemic 24th November 2021 – 4th February 2022: Findings from a UK Survey" (Gillen et al., 2022)	Homecare fundamental challenges; Approaches to high-quality and safe homecare; COVID-19 contextual data
D.12	Report	"Retaining homecare workers in the independent and voluntary sector" (Talent for Care and UKHCA, 2020)	Homecare fundamental challenges; Approaches to high-quality and safe homecare
D.13	Report	"Care and support workers' perceptions of health and safety issues in social care during the COVID-19 pandemic" (Hayes, Tarrant and Walters, 2020)	COVID-19 contextual data
D.14	Report	"Professionalisation at work in adult social care: Report to the All-Party Parliamentary Group on Adult Social Care, July 2019" (Hayes, Johnson and Tarrant, 2019)	COVID-19 contextual data

5.5. Managing Data

All data collected and generated for this research was managed, stored, and organised following the guidance of the University of Nottingham Research Data Management Policy and the General Data Protection Regulation (GDPR).

Data Planning: Before collecting the data, the researcher created a data management plan, which was included in the Research Ethics Review Application. The application was given a favourable opinion by the Nottingham University Business School Research Ethics Committee (see appendix). The plan explained what types of data would be collected, why the researcher was collecting data, how long the data would be kept for, where the data was stored, and provided privacy information for research participants.

Data Collection: Data was collected, captured, and created in accordance with the Code of Research Conduct and Research Ethics, the Data Protection Policy, and the Handling Restricted Data Policy of the University of Nottingham. Data collected for this research included interview records and documents. The researcher ensured that appropriate agreements for the responsibilities associated with the data collection (e.g., information for participants, informed consent, research participant privacy notice) were established and agreed in oral form and/or in writing by all parties before any research commenced.

Data Storage and Processing: The data collected was safely stored and processed in OneDrive using the researcher's University of Nottingham login credentials and was also synchronised with local data storage of the internal computer hard drive of the researcher. The purpose of this was to protect the data against loss and corruption, unauthorised access, and modification, and to comply with relevant legal, ethical, regulatory, and standards of information security. Each research participant was assigned a code to identify each transcript which was recorded on a password-protected spreadsheet and kept on secure servers of the University's managed environment in a password-protected folder (OneDrive). Transcripts themselves were password-protected and stored on university servers.

Data Archiving: Original interview recordings were deleted from all devices once the interview had been transcribed and made anonymous, as well as checked for accuracy. Research data deposited for archive will be retained and preserved for a period set out in the University's Records Retention Schedule, a minimum of 7 years after closure and up to 25 years.

5.6. Data Analysis

In qualitative research, data analysis generally consists of arranging and organising the data, summarising the data into themes through a process of coding and codes condensing, and then presenting the data in figures, tables, and discussion (Creswell and Poth, 2016).

In this research, thematic analysis was used for analysing data collected from the interviews and interview notes. Thematic analysis is a strategy that ensures qualitative data is separated, categorised, summarised, and reconstructed in a way that represents important concepts and meaningful patterns within the dataset (Ayres, 2008, p.867). Using thematic analysis, the researcher first read through the transcriptions, then sorted related ideas and patterns into various key categories using a list of codes, which were reviewed and arranged into organising themes (Lune and Berg, 2017, p.196). The interviews were transcribed and identifying information was pseudonymised in this process. The analysis was performed in English and the software Nvivo 11 was used to organise, manage, and analyse data. The thematic analysis began after the first interview with repeated reading of the first transcripts to identify key themes related to the review of the literature. Then, the data was coded, and there were three forms of coding.

First, open coding was used during a first read-though of recently collected data, then the researcher attempted to assign initial codes by condensing the mass of data into categories (Neuman, 2014). The researcher remained open to create new themes and to change the initial codes during the analysis. During this stage, a number of open codes were developed from the interview data, and they were also created based on insights from the literature review.

Then, the second stage of coding data was axial coding in which the researcher focused on organising the codes, linking them, finding about relationships such as causes, consequences, conditions, and interactions among the categories (Benaquisto, 2008a). During this stage, the open codes were organised into themes and sub-themes. The key seven themes were identified: (1) Meaning of Safety in Homecare, (2) Safety Enablers and Barriers, (3) Safey Issues, (4) Risk Factors, (5) Initiatives Implemented to Improve Safety, (6) HRM and Quality of Homecare Services, and (7) Challenges related to COVID-19.

Themes (2), (3) and (4) were also developed based on insights from the literature review.

Finally, selective coding was a late phase of analysis that involved reading through all the data and previous codes, examining selectively relevant themes, making comparisons, and selecting data that support the central conceptual themes or major categories (Neuman, 2014). These core themes or central categories were linked and presented in an attempt to develop a theoretical framework to better understand and explain the phenomenon (Benaquisto, 2008b). During this process, the research finalised the central themes by merging theme (6) into theme (5), and then amalgamating theme (2), theme (4), and theme (7) into one category, namely 'Fundamental Challenges,' due to their overlapping issues and shared characteristics. The purpose of this was to present a coherent and cohesive narrative that addresses the research questions and support the development of relevant theoretical frameworks.

In this study, qualitative content analysis was also used to analyse the documents. It is a process of categorising qualitative data into clusters of similar entities, or conceptual categories, to identify consistent patterns and relationships between themes (Julien, 2008). This study uses conventional content analysis, which involves coding categories that have been derived directly and inductively from the raw data to describe a phenomenon (Hsieh and Shannon, 2005). The code categories reflect the categories of meaning used by the study subjects (Lune and Berg, 2017). From this perspective, the researcher gathered documents from online sources relevant to the identified themes and codes. This qualitative content analysis was conducted in parallel with the axial and selective coding of the thematic analysis.

Both thematic analysis and content analysis share the same purpose of examining narrative materials by breaking the text into relatively small units of content, and both are suitable for answering research questions (Vaismoradi, Turunen and Bondas, 2013). Thematic analysis is a flexible and useful research analysis that provides a rich, detailed, and complex account of the data; meanwhile, content analysis can be suitable for a simple reporting of common issues mentioned in data (Vaismoradi, Turunen, and Bondas, 2013).

By the end of the data analysis process, the research identified four significant themes: (1) Foundations of Safe Homecare, (2) Homecare Safety Issues, (3) Fundamental Challenges, and (4) Enhancing Safety in Homecare: Initiatives and Practices. These themes are presented in Chapters 6, 7, and 8.

5.7. Ethical Considerations

During the whole process of researching, researchers need to consider what ethical issues might surface during the study and to plan how these issues need to be addressed. Ethics in research are a collection of principles that represent and exemplify what is good or right or allow the researchers to identify what is bad or wrong (Hammersley and Traianou, 2012).

There are four common types of ethical principles: beneficence (responsibility to do good), non-maleficence (cause no harmful consequences), autonomy (issues of voluntariness, informed consent, privacy, confidentiality, and anonymity), and justice (the importance of the research subjects being treated equitably) (Hammersley and Traianou, 2012; Patten and Newhart, 2018; Wiles, 2013). This research examines these ethical issues which might occur prior to conducting the study, at the beginning of the study, during data collection, during data analysis, in reporting the data, and in publishing a study (Creswell and Poth, 2016). The study also presents possible solutions to these ethical issues. Table 5.4 presents the ethical considerations in each stage of the research process, and how the researcher addresses them.

Table 5.4 Ethical considerations of the research process

(Adapted from Creswell and Poth, 2016)

Research process	Ethical considerations	Ethical principles	How the researcher addressed the issue
Prior to conducting the study	Seek Ethics Review Confirmation from the Business School	Beneficence, Non-maleficence, Autonomy, Justice	Research Ethics Review Application was revised and submitted to the NUBS Ethics Committee between 09/11/2020 and 04/12/2020. A favourable ethical opinion for this research was obtained on 05/02/2021.
	Familiarise with professional codes of ethics	Beneficence	Examined standards for ethical conduct of research available from professional organisations, for example, the British Sociological Association (BSA): Statement of Ethical Practice, or Social Research Association (SRA): Ethical Guidelines.

Beginning to conduct the study	Disclose the purpose of the study and refrain from pressure for participants into signing consent forms	Autonomy (voluntariness, informed consent)	The researcher ensured that potential participants understood the purpose of the research, who was conducting the study, what they would be asked to do, how the information they provided would be used, and their rights to withdraw from or complain about the research before agreeing to participate. Participants were also assured that their involvement was voluntary. Each participant had the opportunity to make an individual decision about whether to take part in the study and contacted the researcher after being provided with comprehensive information about the study.
Collecting data	Respect the participants, avoid deceiving participants, and respect potential power imbalances and exploitation of participants	Beneficence, Non-maleficence, Autonomy, Justice	The researcher acknowledged the power dynamics involved in recruiting homecare service users and family members, who might feel pressured to participate due to a sense of duty or dependence on their care workers. Additionally, discussing patient safety could provoke anxiety and distress when participants spoke about their experiences (Wiles, 2013). To minimise the risk, interview questions were designed to be open and non-provocative, and participants were thoroughly informed about the research. They were also assured that they could decline to answer questions or withdraw from the interview at any time without explanation (Wiles, 2013). Service users and family members might expect further help or care to be available during the interview (therapeutic encounter) or after sharing their stories or concerns (follow-up care). This could potentially lead to exploitation and harm if participants disclosed more information than they had anticipated when consenting to the study. Therefore, to reduce the potential for distress, exploitation, and coercion, the researcher clearly outlined his professional background as a PhD student (not a healthcare professional) and his role boundaries. The researcher avoided asking sensitive questions and ensured that participants understood that the research was not intended to be therapeutic or an adjunct to their medical care. Participants were also reassured that refusal to participate would in no way jeopardise their healthcare services or relationships.
	Respect the privacy of the participants	Autonomy (privacy, confidentiality, anonymity)	Efforts were made to ensure that service user participants could take part in interviews in a private setting, safeguarding the confidentiality of their responses. This included scheduling interviews at times when carers or other family members were not present and re-confirming at the start of each interview that participants felt fully comfortable to proceed. Participants were also reassured that their anonymity would be strictly maintained at all times.
	Snowballing ethical issues	Beneficence, Non-maleficence, Autonomy, Justice	One potential ethical issue of the snowballing method was to engage participants as research helpers, who were "enlisted to help find other potential respondents, they become de facto research assistants" (Biernacki and Waldorf, 1981, p.153). In this study, the researcher enlisted the help of homecare team leaders to identify potential additional participants. This approach raised ethical considerations, including whether respondents might feel obligated to participate or take responsibility for their referrals (autonomy), how to ensure fairness in the roles of those providing referrals (justice), and how to prevent potential harm to both referrers and referral recipients when individuals who did not meet the study criteria were excluded (non-maleficence) (Biernacki and Waldorf, 1981; Wiles, 2013). Therefore, the researcher clarified that team leaders were not responsible for staff participation, contacting others was voluntary, and no incentives were offered for recruiting participants. The researcher ensured that respondents' participation in assisting was voluntary and that no psychological harm occurred during the sampling process.

	Store data and materials using appropriate security measure	Autonomy (privacy and confidentiality)	All data collected and generated for this research were managed, stored, and organised following the guidance of the University of Nottingham Research Data Management Policy and the General Data Protection Regulation (GDPR). The researcher ensured that all data handling processes adhered to the highest standards of confidentiality and integrity, safeguarding the privacy and rights of participants throughout the study.
Analysing data	Respect the privacy, confidentiality of the participants	Autonomy (privacy, confidentiality, anonymity)	Personal information concerning research participants was kept confidential. Identifying details were pseudonymised during the transcription and analysis of interviews, and all identifying information was removed to ensure personal anonymity. Organisation names were excluded from the research output, and locations were disclosed only at the regional level to maintain participants' privacy.
	Avoid bias, siding with participants, and disclosing only favourable results	Non-maleficence, Justice	The researcher ensured that multiple perspectives and a comprehensive view of safety culture and safety approaches in homecare were reported. All viewpoints were treated equitably, with a consistent focus on representing diverse perspectives in the final report.
Reporting data	Avoid falsifying authorship, evidence, data, findings, and conclusions.	Non-maleficence	The researcher maintained records of consent forms and ensured that the ownership of the original data was acknowledged, cited, and referenced appropriately.
	Avoid disclosing information that would harm participants.	Non-maleficence, Autonomy (privacy, confidentiality, anonymity)	Individual participants were assigned codes, which were used in the research outputs. Organisation names were omitted, and locations were disclosed only at the regional level to maintain participants' anonymity and confidentiality.
	Communicate in clear, straightforward, appropriate language and do not plagiarise	Beneficence, Non-maleficence	The researcher ensured clear and appropriate communication tailored to the intended audiences of the study. Plagiarism was avoided by adhering to proper citation practices and obtaining necessary permissions to reference other works in the research.
Publishing study	Complete proof of compliance with ethical issues and lack of conflict of interest	Beneficence, Non-maleficence	The researcher signed letters of compliance with ethical practices, disclosed sources of funding, and declared no conflicts of interest regarding the results and publications of the study.

5.8. The Impact of COVID-19 on Research Methodology

In March 2020, the World Health Organisation declared COVID-19 a pandemic and, since then, restrictions on social life, work, and study, including social distancing, working from home, and quarantine requirements have been implemented. These measurements impact significantly on the researcher, the research progress, and research methodology. This section highlights the challenges of COVID-19 in research approach, research design, and methods.

Methodological adaptation: The initial research plan focused on conducting a single case study using an ethnographic approach. This design was chosen to gain in-depth, contextualised insights into patient safety in homecare, as

ethnography allows for prolonged immersion within a naturalistic setting (Edmonds and Kennedy, 2017). The aim was to directly observe and interact with participants in their work environments in order to capture the lived experiences and organisational dynamics relevant to the study. However, the onset of the COVID-19 pandemic presented unprecedented challenges, including restricted access to organisational settings and concerns over participant safety. Consequently, it became necessary to adapt the methodological approach to ensure the research could proceed while respecting public health guidelines and ethical considerations.

To address these constraints, the study was restructured as an interview-based investigation. Semi-structured interviews were employed as the primary data collection method to facilitate remote engagement with participants. This approach ensured that rich qualitative data could still be gathered, while also allowing flexibility in exploring participants' perspectives and experiences. Document analysis was also incorporated to complement and triangulate the interview data, providing an additional layer of depth to the study. This decision was driven by the recognition that organisational documents often contain valuable insights into the formal policies, practices, and narratives that shape organisational culture and practices. Furthermore, these documents offered a stable and readily accessible source of data during a time when direct observational methods were not feasible.

Accessibility issue: In-person interviews and field work have been halted since March 2020, according to the University research guidelines and the Business School Ethics Committee. Therefore, the researcher could only collect data remotely through phone/online interviews. The research methods have changed from in-person interviews and on-site observation to only accessing participants who have mobile phone/ internet access for communication and interviews. The accessibility issue lowers the chance of reaching more participants as the research cannot recruit those who do not use emails or do not have internet access. During the pandemic, it has been also difficult to source respondents due to the potential participant's perspective on sensitive research topics or care workers' busy work schedules. To address this issue, the researcher published the study on online platforms to reach a wider population and call for their participation. To establish trust and rapport, the researcher explained the topic, stressed the relevance of the research, and ensured that the participation was voluntary (Patel, Doku and Tennakoon,

2003). The researcher also provided small incentives as a thank-you payment for taking part in and completing the interviews to encourage more participants.

Engagement challenges: It could be difficult for the participants to remain engaged for extended periods of time when participating in online/phone interviews. The researcher also found it difficult to engage participants without seeing them during telephone interviews. The research design therefore has been adjusted in terms of making the questions short, clear, and relevant to the point when undertaking the interviews remotely. Technical issues and background noises during the online/phone interviews have also affected the engagement of the participants and the quality of the interview. There were occasions when the respondents could not connect to the online calls due to poor internet connection, or the interviews were distracted or interrupted due to background noises (baby crying, vehicles driving, people talking). When this happens, the researcher asks the respondents whether they could find a private place to talk or would like to reschedule the interviews at a convenient time for them.

Technical issues during online interviews: Online/phone interview was the one of the two methods of collecting data in this research. The researcher had adapted and taken extra steps to plan, set up, and test the interviews using online technology (Microsoft Teams meeting). For example, before the online interviews, the researcher sends the respondents the meeting link, advises them to check the internet connection, and to find a quiet and private place to do the interview. The researcher himself also makes sure that his interview tech and internet connection work to support an effective interview. However, there are multiple occasions when the internet connection was poor, and what respondents have said could not be fully captured. When that happened, the researcher suggested changing to a phone interview if possible. If the participants choose not to be interviewed by phone, the researcher politely asks them to speak more slowly so what they say could be captured correctly. The researcher also asks for clarifications and checks with the participants the ideas or stories they have shared to indicate that the researcher has understood correctly.

Challenges in analysing data: Some recordings are poor in quality due to bad internet/phone connections, and it was not possible to transcribe them

word for word. The researcher had to write down the answers and check with the participant by emails to ensure that everything was understood accurately.

Chapter Summary

The ontological assumption of this thesis is constructivist, which emphasises that social phenomena and their meanings are complex and continually shaped by social actors. This also aligns with the interpretive paradigm, which aims to understand social phenomena within existing structures through the perspectives of those involved. The research adopts an interpretivist epistemology, which focuses on exploring the rich meanings and findings of safety culture and safety approaches in homecare. Therefore, the study takes an inductive approach to collect qualitative data to capture detailed interpretations from social actors, which thereby helps build theoretical concepts based on the researcher's interpretations.

Regarding research strategy, the study adopts the narrative inquiry that gathers information through storytelling by participants to understand the phenomenon of homecare safety. It also employs triangulation to investigate research topics from multiple perspectives, using both method triangulation (interviews and document analysis) and data source triangulation (collecting data from caregivers, service users, family members). This comprehensive strategy aims to validate findings and reduce bias by incorporating diverse viewpoints.

The data collection methods for this research are the semi-structured individual interviews and obtaining documents and records. The data was used to identify themes and patterns, and to create conceptual frameworks for patient safety and safety approaches in homecare. All data for this research is managed, stored, and organised according to the University of Nottingham Research Data Management Policy and GDPR guidelines, with a detailed data management plan, secure data collection and storage practices, and archiving procedures that ensure data protection and compliance.

In terms of data analysis, this study uses thematic analysis for interview data, involving the steps of open coding, axial coding, and selective coding to identify key themes and develop a theoretical framework. Additionally, qualitative content analysis is used for written documents. Both thematic and content

analysis aim to examine materials by breaking text into smaller units, with thematic analysis providing a rich and detailed account, and content analysis suitable for simple reporting of common issues.

In this study, the researcher considers potential ethical issues throughout their study and details a plan how to address them. Four common ethical principles include beneficence (doing good), non-maleficence (avoiding harm), autonomy (ensuring voluntariness, informed consent, privacy, confidentiality, and anonymity), and justice (treating research subjects equitably). This study examines these ethical issues at all stages, from planning to data collection, analysis, reporting, and publishing, and proposes solutions for addressing them.

Finally, the researcher reflects on the impact of the COVID-19 pandemic on research methodology. The pandemic necessitated a methodological adaptation, shifting the study from an ethnographic case study to an interview-based design. This shift allowed the research to proceed remotely, ensuring compliance with public health guidelines and ethical considerations. However, the move to remote data collection introduced several challenges, including limited participant accessibility, engagement difficulties, technical issues during online interviews, and obstacles in data analysis due to poor recording quality.

Chapter 6.

Foundations of Safe Homecare and Critical Safety Incidents

6. Foundations of Safe Homecare and Critical Safety Incidents

Chapter Overview

This chapter presents a number of significant findings. First of all, it demonstrates the essence of homecare, which comprises a wide range of personalised activities that support individuals' daily routines, overall well-being, and independence. Next, it presents the varied interpretations of safe care, emphasising the importance of safeguarding and securing environments for both service users and caregivers. Then, the significance of person-centred care is highlighted, focusing on personalised care and service user involvement in care plans and decision-making. Additionally, the chapter examines the critical role of family and informal support networks in collaborating on care plan development and providing additional support.

These insights are expected to be important components of safe and high-quality homecare provision, which often presents an ideal standard for homecare services. However, practical implementation often encounters different fundamental challenges that impede the delivery of such care, resulting in various safety issues. The second part of this chapter presents these safety incidents (also referred to as safety issues or concerns) to provide context and underscore the urgency surrounding these issues, ensuring a clear understanding of these concerns.

6.1. Foundations of Safe Homecare

The foundations of safe care in homecare refer to high-quality care, safe services, person-centred care, and the integration of families and support networks. In this study, the findings reveal that high-quality and safe care requires providing practical support, companionship, emotional support, and promoting independence. Additionally, it involves safeguarding individuals from harm, ensuring their well-being, creating a safe living environment, and respecting their privacy and confidentiality. Meanwhile, person-centred care includes personalised attention and the active involvement of service users in their care plans and decision-making. Additionally, leveraging the support of families and friends enhances care through collaborative planning and reassurance, thereby creating a comprehensive and supportive homecare

environment. These findings are presented in detail in the following subsections.

6.1.1. The Essence of High-quality Homecare

Homecare includes a comprehensive range of activities that are tailored to individual needs. These activities are offered to assist service users with their daily routines and to ensure their overall well-being. Examples include the provision of household chores, domestic tasks, and practical support, such as cleaning, meal preparation, shopping, and medication assistance:

> *Generally, it's about helping them with daily stuff – keeping their place tidy, cooking, personal care reminders (I.23, Transition practitioner).*

> *Go to the shops with them, […] and yeah, I do occasionally do some cleaning (I.24, Carer).*

> *I assist clients with daily tasks like household chores, medication administration, and personal care (I.15, Carer).*

Care workers also revealed an important part of homecare service, which is companionship and emotional support. For instance, one carer highlighted the critical role of providing company to clients, stating it "is one of the most important things, making sure that they don't feel alone at all" (I.17, Carer). Other carers reinforced this point, noting that a substantial part of their roles involves offering emotional and mental support, engaging in activities that promote bonding and enjoyment:

> *And a big part is just being there for emotional and mental support (I.22, Carer).*

> *A lot of the rest of the time is just laughing with the clients, watching TV, having fun, activities, doing arts, doing puzzles, just bonding (I.04, Carer).*

Another integral part of homecare services is the promotion of independence among service users, an expectation commonly placed upon caregivers. From an organisational perspective, providing such autonomy allows individuals to make decisions that are meaningful to them, fostering a sense of independence and dignity:

> *Genuine choice and control about personalised care and support can enhance quality of life and promote independence in a way that matters to individuals (D.01, p.7).*

Homecare workers emphasise the importance of being mindful of service users' independence in their daily interactions. For example, research participants highlighted that a significant part of their work involves maintaining an awareness of each client's need for independence. The following excerpts demonstrate instances in which carers consult with service users on even minor decisions, such as meal choices, daily activities, or television preferences. By involving clients in these choices, carers help ensure that their needs and preferences are respected:

> *I mean I would say that every day like a big aspect of the work I do is with most clients is kind of being aware of their independence (I.11, Carer).*

> *Something that is very important for the elderly people is just giving them their independence. So, I always consult. I mean it can be something as little as what they want to eat for lunch or like, what they want to do for the day, or what's on television (I.19, Carer).*

> *I've got in and I just sat on the sofa, and I waited to chat to her [service user], and she made me a cup of tea. […] She was quite excited, and said, "Can I make you a cup of tea?" and I said, "That'd be fantastic." She made me a cup of tea and brought it over to me, and I think that was them taking really good pride in their own home, promoting their own independence (I.05, Carer).*

Homecare workers, therefore, are required to be well trained and skilled staff to be able to handle the diverse and complex needs of service users. They need specialised knowledge, skills, adaptability, as well as a genuine passion for care-giving to manage various scenarios effectively:

> *[…] home care workers take care of people who are mentally ill, physically challenged […]. They provide professional and accountable care (I.03, Carer).*

> *[…] when you have that mental health training as a professional, you can go in there with an open mind with no attachment to their individual, but strong attachment to their care needs and how you can meet those (I.05, Carer).*

> *Working in home care requires a strong dedication and the ability to adapt to various situations. It's not just a job; it's a calling that demands strength, patience, and a genuine passion for helping others (I.15, Carer).*

From a broad perspective, other important parts of high-quality care provision include continuity of care and adequate information about care services and choice. For example, various documents and reports highlighted the need for careful management of the homecare sector to balance consumer choice, promote continuous improvement, and ensure the stability required for continuity of care:

> *[Homecare] markets need to be carefully managed if they are to a) provide choice to the consumer, b) create a market with continuous improvement, and c) be able to provide continuity of care without providers being driven out of the market (D.06, p.7).*

> *Care and support should be accessible. Everyone – whether that be people who already, or may need to, draw on care and support, their families, or unpaid carers – should be able to access the right information and advice at the right time to understand the different options available to them that best meet their preferences and circumstances, including options for where care and support would best be delivered, and costs they may need to meet (D.01, p.19).*

To summarise, homecare comprises a broad spectrum of personalised activities aimed at assisting individuals with their daily routines and overall well-being. This includes practical tasks such as household chores, meal preparation, and medication assistance, ensuring a comfortable living environment. Additionally, caregivers play a critical role in providing companionship and emotional support. Promoting independence among service users is another important aspect, with caregivers emphasising the significance of allowing individuals to make meaningful decisions. Therefore, providing high-quality care service at home requires well-developed and skilled staff to ensure that caregivers are well equipped to handle the diverse and complex needs of service users. It also requires continuity of care and adequate information about services and choices, with careful management of the homecare sector to balance consumer choice, promote continuous improvement, and ensure stability.

6.1.2. Safe Homecare: Views from Caregivers and Service Users

In homecare, the meaning of safe care can vary, depending on how the nature of homecare is understood and the degree to which stakeholders place high importance on care. From an organisational standpoint, safe care involves safeguarding service users from abuse and neglect while also promoting their overall well-being:

> *Whilst safety, protection from abuse and neglect, and delivering the appropriate standards of care are vitally important, services must go beyond these basic requirements, and promote an individual's wider well-being (D.01, p.17).*

Similarly, caregivers and service users participating in the study define safe care as prioritising the best interests of the individual, prevention of harm, and the promotion of individuals' health and well-being. This involves addressing the personal needs of the service user, prioritising their health, and ensuring a secure environment free from harm:

> *Safety care means acting in the best interest of the resident. It's about meeting their personal needs and ensuring their well-being is always prioritised (I.08, Carer).*

> *Providing safe care involves ensuring that the client's environment is secure and that their health is not compromised. It means being attentive to their specific health needs and being prepared for any emergencies (I.25, Carer).*

> *It's not just about absence of physical harm. Ideally, homecare should enhance people's well-being and if it doesn't then I would say its unsafe (I.14, Service user).*

Caregivers also place the importance of protecting themselves from harm, focusing on an environment where both the service user and carer feel safe. One care worker highlights the unique challenges of homecare, where there are no immediate medical resources or security measures available:

> *I think, homecare, the safety really has to be a level playing field between both the support worker [carer] and the individual receiving the care. Being in their home, it'll be a typically one-to-one or two-to-one basis, you haven't got that safety blanket around you. There's no doctors, no CCTV. There's no alarm button*

> *on site to receive extra care, so it is quite a vulnerable environment. So being safe means levelling the playing field, ensuring that both support worker and the individual receiving the support feels safe in their environment (I.05, Carer).*

Safety, in this context, means creating an equitable environment where both the carer and the client feel secure and supported, despite the absence of traditional safety measures like on-site medical assistance or alarm systems. This is an important finding as it sheds light on the solitary nature of homecare work, with carers often working alone with service users.

Service users, meanwhile, stress the importance of privacy and confidentiality when receiving care in their own homes. They expect carers to prioritise fulfilling their needs while respecting their privacy. Ensuring safe care involves respecting privacy, maintaining confidentiality, and delivering high-quality care service:

> *They [carers] shouldn't violate anyone's privacy and should primarily do what they are there to do, what the client needs them to do (I.14, Service user).*

> *Safe care, to me, means that my privacy is respected, and I am assured of receiving the highest quality healthcare (I.16, Service user).*

> *[…] ensuring that I receive the best possible treatment and keeping my personal information confidential (I.31, Service user).*

These above findings reflect the important aspect of homecare: the promotion of service users' independence. Respecting their privacy and confidentiality is essential for developing a sense of comfort and control within their living environment, which can improve their overall independence and well-being.

In brief, the interpretation of safe care can differ based on the understanding of homecare and the extent to which participants prioritise the importance of care. From an organisational perspective, safe care involves safeguarding service users from abuse and neglect, while promoting their well-being. Both caregivers and service users define safe care as prioritising individual interests, preventing harm, and promoting health and well-being, with a focus on addressing personal needs and ensuring a secure environment. However, carers specifically emphasise the need for a safe working environment that

protects both themselves and the service user. Service users, on the other hand, connect safety with the respect for their privacy and the confidential nature of the care they receive.

6.1.3. Person-centred Care: Placing Individuals at the Heart of Homecare

Previous sections have highlighted the personalised nature of homecare activities which aim at meeting individuals' specific needs, promoting their overall well-being and independence, protecting them from harm, and ensuring a secure environment tailored to their requirements. Overall, these findings illustrate the importance of person-centred care, which prioritises respecting service users' autonomy, dignity, and preferences.

Indeed, person-centred care emerged as a prominent theme in homecare safety. Service users should be able to actively involve in their own health plan and in all decisions about their health. In December 2021, the UK Department of Health and Social Care (2021) introduced a policy paper setting out reforms on adult social care, highlighting the three key themes of person-centred care that centre on people:

> *Our vision puts people at its heart and revolves around three objectives: 1. People have choice, control, and support to live independent lives. 2. People can access outstanding quality and tailored care and support. 3. People find adult social care fair and accessible (D.01, p.7).*

In homecare, insights from many support workers show similar findings. They talked about how it is important to involve service users in the care plan, listen to their needs, and offer personalised support. This aims to enable choice, control, and support for service users:

> *I tend to involve the person I support quite a lot in creating their care plans because I think it's really important for them to be involved in that planning, and with it being in their home, the care plan is already quite an invasive piece of work to have in somebody's own personal home. So, for them to be involved in that process, I think is quite important (I.02, Transition practitioner).*

> *I am regularly in contact with the individual, finding out what their likes, what their dislikes are, and this [information] is coming from the individual (I.06, Carer).*

> *It's super important they get a say in what's happening. It's all about making plans that really fit their unique needs and wants (I.21, Carer)*

The implementation of person-centred care can include different aspects. For example, homecare staff said that they engaged in open discussions with individuals regarding their dietary preferences, living arrangements, emotional well-being, and community engagement, ensuring to accommodate preferences and take into account their unique requirements:

> *When it comes to meal preparation, I always discuss their dietary preferences and restrictions to ensure that their nutritional needs are met (I.15, Carer).*

> *[…] discussing with them where they would like to go live, whether they've got a preference of area that they would like to live, and there have been occasions where I discussed how to support them when they're feeling unsettled or anxious at any point and working with them to find the best ways to build skills (I.24, Transition practitioner).*

> *In terms of food intake, we've made decisions in their best interest, like restricting food intake but providing plenty of choices. We also support them in going out, using public transport, and visiting new places like country parks, taking into account their diagnosis and needs (I.10, Carer).*

Person-centred care also involves service users in decision-making processes and the adaptation of care plans based on their preferences and needs. Service users expressed the appreciation for having a say in their care, from scheduling appointments to decisions about treatment and medication:

> *It has just been adapted to rescheduling. Me having a say in what days they [carers] come, also, the prior notice if someone isn't coming (I.14, Service user).*

> *They [carers] take my opinions into account, particularly when making decisions about my treatment and care plan (I.16, Service user).*

> *In the initial stages of my care, I discussed with my doctor about gradually reducing my medication. He listened to my concerns and agreed with the decision. It was a collaborative process (I.27, Service user).*

The findings above reflect a sense of empowerment, autonomy, and respect for the service user's choices and preferences, demonstrating the principles of person-centred care. They also illustrate a collaborative approach between individuals and their homecare support workers, where communication is key to ensuring a person-centred care approach. When asked about how the homecare service can be improved, many respondents expressed the importance of personalised and collaborative communication in the provision of care. For example, one service user said:

> *I think communication is everything. The provider checking in regularly with the client to ensure they are happy with the care and who is providing the care from the provider, and I don't think that should just be questionnaires or surveys. I think it should be, you know, more personalised checking in, so someone from the care provider or local authority, depending on the client preference by coming into the home or remote meeting, to have a chat with them about how they are finding the care, what the problems are (I.31, Service user).*

In summary, person-centred care emerged as a central theme in homecare safety, echoing the U.K. Department of Health and Social Care's (2021) emphasis on placing individuals at the heart of adult social care reforms. In practice, homecare workers prioritise involving service users in care plans, tailoring support to individual needs, and fostering choice and control. This approach extends to open discussions on dietary preferences, living arrangements, emotional well-being, and community engagement. In addition, the findings show that service users value their involvement in decision-making processes and appreciate the empowerment, autonomy, and respect afforded to their choices. This collaborative approach between service users and homecare workers highlights the importance of personalised communication in enhancing the provision of care.

6.1.4. Family and Informal Support Networks in Homecare

Besides involving service users in their care plans, integrating family and informal support networks in homecare can further enhance the support and well-being of individuals. In this section, the research will highlight the critical role of social networks of the homecare service users, involving their families and friends in caregiving.

Firstly, various documents and reports have consistently emphasised the significant contribution of family, friends, and other members of the service user's circle of support in delivering care. For example, one document acknowledged the significance of families and friends in caregiving, while another survey reported that about 80% of people who used care services found it easy to get help from close family, friends, and neighbours:

> *We want to acknowledge the important role of families and friends in caring for one another, whilst also enabling those who provide unpaid care to a friend or loved one to be supported to achieve their own life goals (D.01, p.7).*

> *Social networks were important – the survey showed about 4 in 5 people who had used health and social care services found it easy to get help from a close family member, friends, and neighbours, if they needed it (D.02, p.112).*

Exemplary support models, such as 'Shared Lives', circles of support, asset-based community development, and local area coordination, can be considered to leverage the resources of the service user's family and social networks for better care:

> *The main models we considered were Shared Lives, in which individuals are supported by a paid carer in his or her home, and approaches such as circles of support, asset-based community development and local area co-ordination – all of which aim to harness the resources of a person's family and community to support them more effectively (D.03, p.30).*

Secondly, research participants have provided deeper insights and understanding in this context. For example, the role of family members is invaluable in building individual support plans as they often possess intimate knowledge about the individual, which is essential for effective support. Their close relationship with the service users provides a sense of familiarity and comfort, which can enhance the overall support experience:

> *My current role is to build an individual support plan, working with the individual as well as the family members, and as the family members know more information about the individual, they're important when it comes to supporting the individual, as the individual may find them important to them as they are close family connections, it's someone that's close to or they know, and they feel familiar around (I.06, Carer).*

Therefore, regularly updating care plans in consultation with family members is important, and effective communication channels help keep everyone informed and coordinated. Research findings have shown an emphasis on collaboration with families to build and update care plans, as well as communication; moreover, involving neighbours or community members can provide additional layers of support and reassurance:

> *We always had to chat with the families to keep the care plans up to date (I.01, Transition practitioner).*

> *It was all about keeping the good communication lines open. I mean, I had the names of the carers on my mobile phone so that we could communicate by text, so you know, that was good (I.30, Family member).*

> *[…] just having a neighbour who, you know, is keeping a watch out, that can be very reassuring (I.13, Family member).*

However, it is important to note that the level of family engagement in caregiving varies depending on the service user's needs and circumstances. For example, with younger service users, the caregiver often needs to liaise closely with parents who serve as primary guardians, whereas with elderly individuals, interaction with their children may occur but less frequently. This research also found that service users who have been heavily involved in mental health services sometimes have fragile or unstable relationships with family members. Therefore, family involvement in caregiving in these cases is limited and contingent upon the service user's permission:

> *Usually, when you are really involved in a mental health service in the way I am, an individual who has spent a large proportion of their life in mental health services often has quite fragile unstable relationships with family members. I do engage with family members where I have consent from the person receiving support, but again, it is very few and far between, but I do engage*

with them where I have the permission to do so from the person (I.21, Carer).

The above excerpt shows an example of variability in family engagement, highlighting the level of involvement depends on the specific needs and circumstances of the service user. Another example of this is when a service user chose to withhold certain information from their family, limiting their involvement in care discussions. This indicates that family engagement may be selective, based on personal preferences and comfort levels:

There's certain information I feel comfortable sharing with my doctor, which I might not necessarily share with my family members (I.27, Service user).

To sum up, this section presents the integral role of family and other informal support networks in providing care for individuals living at home, placing an emphasis on the collaboration in care plan development, communication, and extra support. However, the extent of family involvement varies with the service user's needs and circumstances, with factors such as age and mental health history influencing the extent of involvement.

6.2. Homecare Safety Issues

The findings thus far have revealed insights regarding important components of safe and high-quality homecare provision, which often presents an ideal standard for homecare services. Nevertheless, practical implementation frequently encounters challenges that impede the delivery of such care, leading to various safety incidents. This section presents these safety incidents (also referred to as safety issues or concerns) and categorises them into four types related to medication safety, physical and health safety, emotional and social safety, and functional safety. The aim of this is to provide context, ensure a clear understanding, and highlight the urgency surrounding these issues.

6.2.1. Medication Safety Issues

Medication errors stand out as a prominent safety concern, which can negatively impact the well-being of service users in homecare. There were medication concerns associated with improper administration or self-medication, particularly among elderly individuals or those with health issues. For example, the incident described below highlights the potential dangers of

medication mismanagement, such as unintentional overdosing, which can lead to serious consequences:

> *There was one occasion we did have a crisis where he [service user] kept taking his medication through the night. This was before the carer did the administration when he was in control of his own medication. He kept on taking it through the night, and I was terrified because there were painkillers involved (I.13, Family member).*

Incidents of medications being over-administered, under-administered, or mixed up raise a critical safety concern for service users. For example, caregivers have administered more medication than necessary or missed doses altogether. Errors also include inaccurate recording of medication administration and confusion between different dosage strengths, leading to either underdosing or overdosing of service users:

> *There has been many, too many [incidents] where the medications are overprescribed [sic]. The support staff have been given in excess of what the daily prescription allows out of medication. There have been a few instances of where the medications have been given less than what should have been given, for example, they missed a tablet or got a tablet mixed up (I.07, Carer).*

> *There's been recording errors, you know, medications have not been recorded accurately when it's been given, how it is being given (I.18, Carer).*

> *There has been an instance where [a service user] was kind of been under medicated because he has a medication but comes in two different tablets, one is 250 milligrams ones are 500 milligrams. And you know, he should have been given a 500 milligram, but he was given a 250 milligrams tablet, so he had been under dosed that day (I.29, Carer).*

In brief, medication errors pose a significant safety concern in homecare. This research has identified some incidents including medication mismanagement, overprescribing, under prescribing, and recording inaccuracies. Overprescribing, where service users are given more medication than necessary, and under prescribing, where insufficient medication is provided, are prevalent issues. Additionally, recording inaccuracies, where medication

details are incorrectly documented, further exacerbate the risk of harm to patients. These errors can lead to serious health consequences, which requires the need for stringent medication management practices in homecare settings.

6.2.2. Physical and Health Safety Issues

The research findings also showed a range of physical and health safety incidents within homecare. There were instances of homecare service users exhibiting unpredictable and challenging behaviours, which can cause physical harm to both the service users and caregivers. For example, care staff often encounter individuals with dementia who may hit, scratch, spit, or scream during personal care, making the situation particularly difficult:

> *People with dementia can become very aggressive. When providing personal care to aggressive individuals, it's not easy. They might hit, scratch, spit, or scream, which is challenging for us (I.08, Carer).*

Self-harm is another critical concern that caregivers often witness. There were instances where individuals were self-harming, and caregivers were often unable to intervene, leading to feelings of helplessness and concern for the individuals' physical safety and well-being:

> *There has been an occasion whereby an individual was incredibly heightened. They were physically harming themselves through the method of banging their head (I.05, Carer).*

> *I remember a case where someone was self-harming, and I couldn't step in physically because of legal limits. It was hard to just watch and then have to report it without being able to do much in the moment (I.02, Transition practitioner).*

Other physical safety incidents that were reported in the study revolves around slips and falls. These incidents are common and can lead to serious injuries. For example, a family member recounted multiple incidents where their relative experienced falls, leading to hospitalisation each time; meanwhile, a caregiver describes an incident involving a service user with mobility issues who insisted on bathing alone for privacy reasons, resulting in a slip in the bathroom:

> *He had a fall, and he went into hospital. […] There was yet another fall. Each time something happened, it seemed to be as a result of a fall (I.13, Family member).*

> *There was an instance with a client who had mobility issues and insisted on bathing alone for privacy reasons. Unfortunately, she slipped in the bathroom (I.15, Carer).*

Moreover, caregivers, during the interviews, highlighted further instances of health and safety risks including the risk of physical harm from handling sharp objects or navigating stairs, as well as fire hazards resulting from heavy smoking. Caregivers stressed their responsibility to identify and address these health and safety concerns to protect both themselves and the individuals under their care. The following excerpts describe the precautions and considerations caregivers must take to mitigate health and safety risks for individuals:

> *If there is someone who is maybe wanting to handle a knife, who wouldn't be able to handle it without hurting themselves, or wants to go up and down the stairs, it is a risk of tripping, or even come outside and it's raining, then I will have to say no and kind of make a decision before that person (I.04, Carer).*

> *The service user is a heavy smoker, so we have to ensure that fire alarms work, and the ashtrays are being emptied so that it's not becoming a fire risk (I.06, Carer).*

Finally, data highlight health and safety concerns related to the vulnerability of individuals to COVID-19. The findings highlighted the challenges faced by caregivers and families in balancing the need for assistance and support with concerns about COVID-19 transmission and the safety of vulnerable individuals, such as diabetic patients:

> *She was concerned because diabetic patients, like her, are more vulnerable to COVID-19. Despite my efforts to perform household chores and assist with her medication, she was reluctant to receive help due to her fear of contracting the virus (I.23, Carer).*

> *The family members didn't want agency [carers] in, because of the fears of bringing coronavirus in the household (I.20, Carer).*

To sum up, this sub-section analysed physical and health safety incidents within homecare. These include unpredictable behaviours causing harm to service users and caregivers, self-harm, slips and falls. Additionally, caregivers signify their responsibility to identify safety risks and address these concerns to protect both themselves and those under their care. Moreover, COVID-19

emerges as a significant theme, which poses as a health safety concern for individuals who fear contracting the virus due to their vulnerability.

6.2.3. Emotional and Social Safety Issues

As discussed in the first section of this chapter, many caregivers highlighted the importance of companionship and emotional support as key aspects of their roles in providing homecare. This is a significant aspect of the role of care workers, particularly for service users who may experience feelings of isolation:

> *Homecare worker is someone that supports an individual within their own homes and provides personal care or emotional support (I.06, Carer).*

> *I also provide companionship, which I think is important for clients who might feel isolated (I.25, Carer).*

Challenges related to emotional and social safety were reported by carers, with issues such as inconsistency in staff causing distress and anxiety for service users. In this study, research participants revealed that many service users prefer to know when caregivers will arrive, and unexpected changes or receiving a caregiver they dislike can lead to heightened anxiety and discomfort. The excerpt below illustrates this issue:

> *The inconsistency with staff members can cause a lot of distress and anxiety for the individual. Some individuals like to know when people are coming home, and if the individual doesn't know who's coming on, getting someone that they don't like or not very keen on for that day, it can cause a lot of anxieties for the individual (I.06, Carer).*

In addition, instances were recounted where service users experienced emotional distress and challenging behaviour due to forgetfulness or changes in mood. These emotional safety concerns often stem from the fundamental challenge associated with homecare service users' attributes, such as age, mental illness, cognitive capacity, disability, or dementia. This finding is significant as it provides valuable insights into the attributes of homecare service users, which will be further analysed in the next chapter.

Moreover, findings from the "Safe Care at Home Review" document revealed concerning instances of abuse and neglect experienced by service users,

particularly among vulnerable groups such as older people or those with disabilities. Stakeholders also shared examples of individuals with disabilities being exploited, further emphasising the vulnerability of certain populations within the homecare setting:

> *[…] people with care and support needs may experience abuse and neglect, sometimes under the guise of 'care'. Older people, or people with disabilities, may be particularly vulnerable to harm because of their dependence on others and the complexity of their care needs (D.04, p.5).*

> *Stakeholders shared the example of individuals with disabilities being 'groomed' to provide sexual favours or financial payments (D.04, p.48).*

In summary, various emotional and social safety issues were reported in homecare. Inconsistency in staff can cause distress and anxiety for service users who prefer predictable caregiver schedules. Emotional distress and challenging behaviour were linked to forgetfulness or mood changes, often due to service users' attributes such as age, cognitive capacity, disability, or dementia. Additionally, there were concerning instances of abuse and neglect, particularly among vulnerable groups such as older adults and those with disabilities.

6.2.4. Functional Safety Issues

Functional safety refers to service users' health conditions or provision of care affecting their ability to perform everyday activities in their homes and communities. Specifically, the general deterioration in the health status of service users, notably those with dementia, can significantly impact their ability to manage routine tasks independently. Instances were recounted where individuals with dementia refused to eat or drink, presenting challenges in ensuring proper nutrition and hydration:

> *In a past role, I had a service user in a dementia unit who wouldn't eat or drink (I.02, Transition practitioner).*

> *An individual there had got to the stage of their dementia that [they] refused to eat and drink, and there's no restrictions in place. You know, you can't force somebody to eat and drink. It was a real case of prompting encouragement, but there was a real*

> *nutrition concern there, but they did not want to engage in food or drink and had got to quite a challenging stage of their dementia so that was quite hard for them, I think, from a safety perspective (I.05, Carer).*

> *He'd been a wonderful cook and he cooked everything from raw so he would make stews and curries, broths, that sort of thing, and then all of a sudden it changed where he would heat up a quiche in the oven, you know, that kind of meal (I.13, Family member).*

Moreover, the impact of external factors, such as the COVID-19 pandemic, further exacerbated challenges related to functional safety. Restrictions imposed due to the pandemic limited service users' ability to engage in activities that contribute to their well-being, potentially affecting their emotional and mental health. The findings revealed the impact of the pandemic on service users' participation in health-promoting activities, such as exercise groups and social clubs, with a significant proportion reporting reduced participation compared to pre-pandemic levels:

> *Sometimes if they feel like they cannot do, they cannot go out or they cannot go to shop or cinema, it could affect their emotional health or mental health (I.22, Carer).*

> *Our survey also highlights the impact of the pandemic on people's use of activities that contribute to their health and wellbeing, such as exercise groups, clubs or religious institutions. Across all respondents, a fifth (20%) were participating less often than before the pandemic (D.02, p.55).*

In essence, functional safety issues in homecare refer to the service users' inability to carry out daily tasks. Particularly, the decline in health status, notably among those with dementia, can hinder their independence in managing routine activities. Instances were cited where individuals with dementia refused to eat or drink, posing challenges to ensuring proper nutrition and hydration. Additionally, external factors such as the COVID-19 pandemic exacerbated functional safety challenges, as restrictions limited individuals' engagement in health-promoting activities like exercise groups and social clubs. This type of safety issue could also impact their emotional and mental well-being.

Chapter Summary

This chapter explores the complex nature of homecare, with a focus on two main themes including foundations of safe care and homecare safety incidents. Each theme comprises different subthemes and codes, which are summarised in the table below.

Table 6.1 Foundations of Safe Homecare and Critical Safety Incidents

Themes	Sub-themes	Codes
Foundations of safe care	The essence of high-quality and safe homecare	- Providing practical support - Offering companionship and emotional support - Promoting independence - Safeguarding from harm - Promoting overall well-being - Ensuring a secure environment - Respecting privacy and confidentiality
	Person-centred care	Personalised care, and service user involvement in care plans and decision-making
	Families and informal support networks:	Leveraging the support of families and friends for enhanced care, collaborative planning, and additional reassurance.
Homecare safety incidents	Medication safety issues	Improper administration, over prescribing, under prescribing, and inaccurate recording of medications
	Physical and health safety issues	Self-harm, physical aggression, COVID-19 related health risks, slips and falls
	Emotional and social safety issues	Emotional distress, anxiety, mood changes, abuse, neglect
	Functional safety issues	Service users' refusal to eat or drink, decline in daily task ability, reduced participation in leisure activities

This chapter has highlighted some critical aspects that contribute to effective care service delivery. Homecare refers to a wide range of personalised activities aimed at supporting individuals in their daily routines and overall well-being. This includes practical tasks such as household chores, meal preparation, and medication assistance, alongside providing companionship, emotional support, and promoting independence among service users.

The concept of safe care in homecare is interpreted differently based on perspectives and priorities aligned with respondents' position in the care relationship. From an organisational standpoint, safe care primarily involves protecting service users from abuse and neglect while promoting their well-being. Caregivers and service users emphasise the importance of addressing personal needs and preventing harm. While caregivers additionally highlight the necessity of a secure home environment that protects both carers and service users, service users themselves prioritise safety through the lens of privacy and confidentiality.

Person-centred care is identified as a central theme in homecare safety. This approach involves actively engaging service users in their care plans, tailoring support to their specific needs, and promoting choice and control. The chapter also signifies the essential role of family and informal support networks in homecare, highlighting their collaboration in care plan development, communication, and additional support. However, the level of family involvement varies based on the service user's needs and circumstances, with factors such as age and mental health history playing a significant role.

These findings provide great insights of crucial aspects in providing safe and high-quality care, presenting an ideal standard for homecare services. Nevertheless, practical implementation often faces various fundamental challenges and risks that obstruct the delivery of such care, leading to a number of safety incidents. These incidents are associated with medication safety, physical safety, emotional and social well-being, and functional safety.

This chapter has provided rich understanding of these safety issues in homecare and briefly reveal some underlying causes, which is useful to identify, analyse and develop measures to avoid and mitigate these issues. However, there are many other challenges and associated risk factors that can contribute to homecare safety concerns. The next chapter will present and analyse these risks and challenges.

Chapter 7.

Fundamental Challenges

7. Fundamental Challenges

Chapter Overview

There are various challenges that not only serve as barriers to high-quality care but also as risk factors leading to safety issues and potential harm to service users. This chapter aims to demonstrate these difficulties to provide a comprehensive understanding of the fundamental challenges and how safety incidents might occur. Presenting these findings will allow for the creation of a comprehensive framework of safety issues and associated risks in the specific context of homecare in England, which will be discussed in Chapter 9. The findings in this chapter will be useful for identifying, mitigating, and addressing the unique challenges to ensure the provision of safe and high-quality care.

This thesis adopts the framework of contributory factors influencing clinical practice (FFICP), introduced by Taylor-Adams and Vincent (2004), to present and categorise these challenges. This model has been proven useful in defining the conditions of safe and unsafe practice, both in hospital and homecare settings (McGraw, Drennan and Humphrey, 2008). There are seven types of contributary factors that influence safety incidents, and they relate to the institutional context, organisational and management, work environment, teams, individual staff, tasks, and patients. The initial key themes were identified in relation to the FFICP framework. However, as the analysis progressed, some of the themes were amalgamated to produce a coherent story and provide a more cohesive understanding of the data. Additionally, a new emerging theme was incorporated into the analysis. These findings are presented in the following subsections. A summary can be viewed in Table 7.1 at the end of this chapter.

7.1. Institutional Challenges

There are a number of challenges and risk factors associated with institutional contexts that can cause harm and adversely impact the safety of homecare service users. First of all, the increasing demand for homecare services in England is a significant challenge due to the strain it places on resources, infrastructure, and staffing within the social care system. In recent years, English homecare providers have seen a significant increase in demand for homecare, with nearly three-quarters (74%) of providers reporting an increase

since the start of 2022, as revealed in a recent survey of 343 homecare providers (D.05, p.2). The research discovered a number of reasons for this increase, such as the avoidance of residential care, hospital aiming to discharge patients to the community more rapidly, and the increase in hospital discharge services:

> *I certainly see some increases in request for homecare, as people perhaps didn't want to be in residential care, and hospitals were wishing to discharge people to the community more quickly. So, I think that absolutely has put pressure on the homecare market (I.28, Social worker).*

> *Homecare providers have also seen a significant increase in demand for hospital discharge services […] there has been a rise in the quantity of care packages for people who were being discharged from hospital (D.05, p.3).*

The high demand for homecare has put pressure on care providers, complicating their ability to support individuals and making access to care services challenging for individuals who need support. For example, many providers and individuals have reported difficulties in accessing care:

> *The impact of the pressures on the health and care system is being felt by those who need healthcare, with 85% of providers saying that the people they support were finding it more difficult to access healthcare than this time last year [2022] (D.05, p.3).*

> *Some of the challenges have really been working to make sure that people getting the right support at the right time and that people's wishes and rights to live a live a good life (I.28, Social worker).*

Secondly, the lack of government funding is a prominent institutional issue. In England, a number of documents and reports have described the challenge of inadequate national funding for adult social care, including homecare sector:

> *There is no national government budget for adult social care in England. Instead, publicly funded social care is mostly financed through local government revenue (D.08, p.9).*

> *[…] the home care market was significantly exposed to challenges in public funding, and overall, the total amount of home care*

delivered fell by 3 million hours between 2015 and 2018 (D.09, p.37).

This challenge can lead to a number of safety concerns. For example, a decline in homecare services which can result in inaccessibility to care is a prominent example due to the insufficient funding to provide continuous and adequate support. One report showed that over 1.6 million people requiring homecare are unable to access it due to inadequate funding (D.07, p.6). Additionally, reduced funding and the lack of commissioned care services can pose as barriers to homecare safety. For instance, the two excerpts below illustrate notable impacts such as reduced care, difficulty accessing care, and disruptions in the continuity of homecare services due to insufficient funding:

[…] as a result of such funding pressures, some local authorities have adjusted their threshold for support, meaning that where an at-risk individual who might have once qualified for care and support, may now be less likely to be offered it (D.04, p.35).

One client I've worked with through the Council. The Council, they're always very keen to cut funds, so they didn't want this particular boy [homecare service user] to have care at all times, and so they were trying to prove that he was more independent than what he was. They, for example, like had him cut things with a knife when he has no motor and no spatial awareness because of his condition. He has very limited, very distorted spatial awareness, and you know, mobility. They wanted him to walk through the supermarket on his own. Again, no spatial awareness and also, he's had leg operation so he has that bad limb and so he requires someone to hold onto. Yeah, and they had them like do all these things, which obviously the parents weren't there at the time. It was only me with my colleague and I felt really uncomfortable (I.04, Carer).

The lack of funding can also result in an unstable homecare market, where a number of workforce issues such as low wages, high turnover rates, and inadequate staffing capacity are prominent. For instance, one document reported:

Uncertainty over future funding stifles provider investment and, along with low fee rates, can result in poor workforce conditions, inadequate quality care, market fragility and pose a threat to continuity of care (D.01, p.26).

In terms of low wages, a number of reports highlight the issue of underpayment and disparities in pay within homecare sector. For example, some homecare staff are paid below the National Living Wage, with recommendations suggesting hourly rates equivalent to Band 3 healthcare assistants in the NHS, yet the average national rate for homecare services falls well below these benchmarks, underscoring ongoing concerns about underpayment and low wages:

> *Our research found concerns that rates of pay in some parts of the home care industry are below the minimums set by the National Living Wage (D.03, P.8).*
>
> *[…] to enable them [care providers] to pay a fair price for care, so that care workers can receive wages equivalent to Band 3 healthcare assistants in the NHS with 2+ years' experience. […] this would require an hourly fee rate of at least £28.44 (D.05, p.3).*
>
> *The Homecare Association says that the minimum hourly rate for homecare services should be £23.20. However, the average national rate that commissioners pay for homecare is £18 an hour (D.02, p.49).*

Homecare sector in England has also been experiencing high turnover and inadequate staff capacity, which constitute another institutional challenge. For example, one report described that the openings and closures of homecare providers are above the national average for all businesses (D.06, p.62). Another document reported a sharp decline in filled positions, an increase in vacant posts, and a high turnover rate in the homecare market:

> *Between 2020/21 and 2021/22, domiciliary care services saw a decrease of around 19,000 filled posts and an increase of around 22,500 vacant posts […]. The turnover rate for domiciliary care services was 31.2% […]. This equates to an estimated 159,000 workers leaving their role in the previous 12 months (D.10, pp.1,2).*

Workforce challenges in the homecare sector have adversely impacted the continuity of care, potentially leading to wider effects on care quality. For example, between January and March 2022, more than 2.2 million hours of homecare services went undelivered due to insufficient workforce capacity (D.02, p.35). Findings from documents and interviews revealed that high

turnover within the homecare sector not only disrupts the continuity of care but also raises concerns about the quality of care being delivered, especially regarding inconsistent caregivers, potentially impacting emotional safety for service users:

> *High turnover, of providers and staff, which has negative impacts on continuity of care and potentially wider effects on care quality (D.03, p.37).*

> *41% of homecare providers said that workforce challenges have had a negative impact on the service they deliver (D.02, p.10).*

> *The turnover in the sector can sometimes mean that people won't have a consistent person coming into their homes (I.12, Social worker).*

The study also found other institutional challenges related to the homecare structure and systems. For example, limited choice in providers, alongside poor information and fragmented support systems, have created challenges for individuals looking for homecare information and advice, thereby becoming a barrier to safe homecare. These institutional challenges can lead to individuals receiving inappropriate or insufficient support and conflicting advice, potentially affecting their overall well-being:

> *People often do not know where to start when looking for information and advice, while others find that the volume of information available is overwhelming and poorly tailored to their own circumstances. A lack of knowledge and understanding can result in people drawing on the wrong type or amount of support, which may impact on their wellbeing (D.01, p.28).*

Furthermore, complex bureaucratic processes and delays in care also hinder the efficiency of service delivery. This research found that prolonged wait times and administrative burden make it difficult for individuals to access care. For instance, one document reported many individuals are waiting for too long for care support, meanwhile, a family member shared their experience of transitioning to a new provider, which involved a significant amount of paperwork for their service user:

> *Many people are still waiting for the health and social care support and treatment they need, and many are waiting too long (D.02, p.7).*

> *I did find that there was an awful lot of form filling, and particularly when we get got the new provider. I had to sit with a senior carer and go through what was probably a care plan. There was quite a lot of administration in the early days when we changed provider (I.30, Family member).*

To sum up, the increasing demand for homecare services in England has strained resources, infrastructure, and staffing, making it challenging for providers to support service users adequately. Insufficient government funding has also exacerbated these issues, leading to an unstable homecare market, where a number of workforce issues such as low wages, high turnover rates, and inadequate staffing capacity are prominent. All can lead to safety concerns such as inaccessibility to care, reduced care, and disruptions in the continuity of homecare services. Additionally, limited provider choices, fragmented support systems, and complex bureaucratic processes hinder efficient service delivery and affect overall care quality.

7.2. Organisational and Management Challenges

Within the organisational and management context, the research discovered challenges that revolves around financial resources (e.g., funding constraints), leadership roles, policy standards, and the human resource management issues. For example, the lack of funding, as discussed in the previous chapter, has led to significant challenges for homecare providers across the UK in sustaining their businesses. In addition, one document reported that the inconsistency in organisational leadership and culture can impacts the quality and choice of services available for individual (D.01, p.26). Particular examples include a lack of workforce support, lack of resources, and limited information sharing and learning:

> *Frontline professionals often lack the necessary tools and resources to allow them to best protect and support people with care and support needs (D.04, p.52).*

> *There is limited sharing of information and learning from best practice and failures (D.04, p.65).*

A family member reveals an example of organisational challenge in adhering to essential safety and care standards, such as conducting risk assessments,

managing medication properly, and maintaining hygiene standards, which are critical for the well-being of the service user:

> *I would hope that a homecare provider would have things like safety and risk assessments. They would have had, you know, a basic knowledge about medication administration and, you know, standards for keeping my uncle [service user] clean (I.13, Family member).*

Meanwhile, this study found that the most significant and fundamental challenge within the organisational and management context is associated with human resource management issues. These involve various difficulties in HR practices such as staffing, training and development, compensation, as well as the way staff members are recognised and supported. These issues are fundamental challenges to safe care and can result in different safety issues as they directly impact the quality, continuity, and reliability of care services. In England, one report on the state of healthcare and adult social care in 2021/22 revealed a number of workforce challenges faced by homecare providers had had a negative impact on the service they deliver (D.02, p.8). The following sub-sections present these difficulties.

7.2.1. Staffing Challenges

Staffing issues within the organisation, such as staff shortages, can lead to difficulties in delivering care to service users, negatively affecting the quality and availability of homecare services. This issue is closely linked to the institutional challenge of workforce problems, which were discussed in the previous section. This is because staffing issues within homecare organisations stem from broader systemic difficulties, such as insufficient funding, high turnover rates, insufficient staffing capacity within the whole adult and social care sector. In homecare, a shortage of staff can lead to difficulties in delivering care to clients, affecting the quality and availability of homecare services. For example, one research participant shared a situation where a surge in client demand coincided with a significant shortage of staff:

> *There was one time when many clients needed services, and we faced a challenge because many team members, especially the older ones, were not available or had resigned. This created a shortage of staff for client care, making service delivery more difficult but understandably so (I.03, Carer).*

Indeed, during the COVID-19 pandemic, the research found that shortage of staff has been a significant challenge to homecare providers. Findings from both research participants and documents reveal that homecare workplaces experienced high turnover and staff shortages during the time of crisis due to staff burn-out, fear of virus, lack of support from the care providers, and staff isolating with confirmed COVID-19 or with suspected infection:

> *Skills for Care has received feedback from employers in the sector about staff and registered managers experiencing 'burn-out' due to the pressures of the pandemic and that there's a risk of staff leaving as a result (D.10, p.3).*

> *[…] the pandemic has caused significant challenges in terms of staff absence, either because of COVID-19 infection or the need to self-isolate (D.02, p.94).*

> *There's obviously a certain number of people working in homecare would have had COVID as well, but at that time, it obviously posed challenges to them. […] They would need to self-isolate and wouldn't be able to go into people's homes (I.12, Social worker).*

The COVID-19 Insight report by CQC (2020a) showed that staff absence rates due to COVID-19 among homecare providers across England were between 8% and 10%. These high figures reflected the significant impact of COVID-19 on the staffing issue in homecare settings considering average absence in all sectors in the U.K. was only 1.8% in 2020 (Office for National Statistics, 2021). Care worker turnover rate within homecare providers was also reported relatively high during the time of COVID-19:

> *The turnover rate for domiciliary care services was 31.5% […] This equates to an estimated 166,000 workers leaving their role in the previous 12 months. Care workers had a turnover rate of 35.6%, which equates to an estimated 143,000 leavers (D.10, p.3).*

> *Nearly two thirds (63%) of homecare providers are experiencing higher staff turnover than before the pandemic (D.07, p.7).*

Since COVID-19, homecare providers have also experienced additional staffing hurdles related to recruitment and retention of staff. In recent years, a significant number of social care staff have been leaving the sector, presenting significant challenges for providers in recruiting care workers, directly affecting

care service (D.01, p.4). For example, one report revealed that staff absence due to COVID-19 posed "a significant challenge in maintaining continuity of care" (D.02, p.37). Similarly, research respondents reported that because there was not enough staff, service users might have to receive less care than normal:

> *In the event that too many staff became ill with COVID and there wasn't anyone there to support, certain individuals will be given less care, less hours than what they are being funded (I.20, Carer).*

> *There was one time when many clients needed services, and we faced a challenge because many team members, especially the older ones, were not available or had resigned. This created a shortage of staff for client care, making service delivery more difficult (I.03, Carer).*

> *Before the pandemic, my doctor used to visit five days a week. During the pandemic, this was reduced to three days a week, and currently, we are considering reducing it further to two days a week (I.27, Service user).*

In addition, staff turnover can create a harmful cycle where increased vacancies can disrupt scheduling and strain front-line staff, leading to further turnover. This can result in individuals not having a consistent caregiver, leading to disruptions in care continuity, and potentially impacting the quality of care received:

> *Staff turnover can generate a negative spiral, leading to increased vacancies that, in turn, disrupt rotas and put additional pressure on front-line staff, further increasing turnover (D.12, pp.9,10).*

> *The turnover in the sector can sometimes mean that people won't have a consistent person coming into their homes, so this challenge for the home carers and the providers themselves will be relatively short periods of time to work with people from the amount that they're paid as well, so I think it can be a challenge of recruiting people into the sector, then retaining them (I.12, Social worker).*

The study found a number of causes for this issue. For instance, in certain rural or high-employment areas, competition with other sectors offering higher wages, more stable employment, or easier working conditions poses a

significant challenge to recruit; meanwhile, pressure to maintain high care standards, coupled with inadequate funding from county councils, makes it challenging for homecare companies to recruit enough care workers:

> *In some rural areas or areas of high employment, the challenge is to recruit enough workers in competition with other sectors paying higher wages, offering more stable employment or easier working conditions (D.03, p.36).*

> *We are unable to recruit enough care workers, [while] the pressure we get to provide the care at very high standards and the pay rates from county councils are ridiculous. [It] is not cost effective to keep a care company anymore. […] Not being able to recruit staff required to complete care plans and risk assessments [makes] it unsafe to take on new work (D.05, p.10).*

7.2.2. Training and Development Challenges

Issues around the lack of training and development present additional challenges to safe care within the organisational and management context. For example, some care workers shared that there were a lack of comprehensive formal training and practical knowledge for carers and insufficient opportunities for development. This issue may leave caregivers without the essential tools and resources needed to effectively protect and support clients, thereby increasing the risk of harm:

> *Frontline professionals often lack the necessary tools and resources to fully protect and support people with care and support needs who are, or are at risk of being, abused in their own home by the person providing their care (D.04, p.68).*

> *There was a situation where the service user exhibited violence. We hadn't received in-depth training on handling such situations, so I felt unprepared. I managed to protect myself but felt I lacked the training to handle it appropriately (I.10, Carer).*

Additionally, without appropriate training, homecare staff might find it difficult handling challenging situations, which could potentially lead to errors and cause harm to service users. There were instances where care workers have been disciplined for unnecessarily restraining or shouting at service-users due to inadequate training in managing escalating behaviour:

> *We were told of instances where care workers have been disciplined for unnecessarily restraining or shouting at a service-user in circumstances where they have not received adequate training in how to deal with escalating behaviour. […] They need to be trained in order to feel confident in how to identify and prevent behaviour escalation. This is an important part of ensuring service-users and staff feel safe (D.14, p.13).*

Another prominent example of training challenges is the inadequate training provided by care providers during the COVID-19 pandemic. For instance, a caregiver described they only received one brief training session online about how to use personal protective equipment (PPE); meanwhile, another care worker expressed how their care agency only sent out government guidelines, newsletters, and online resources through emails but offered no specific training:

> *They were sending out weekly newsletters informing staff about mental health or looking after yourself, then some updates on the government guidelines, and other things, and they're kind of expected us to read through and learn it by ourselves (I.26, Carer).*

Some carers reported that care providers did not know much about the virus and therefore, were slow to respond. They were also dependent on the government guidelines which were confusing and frequently changed. Indeed, official guidance for preventing transmission and protecting homecare workers from the COVID-19 pandemic have been inconsistent:

> *Official guidance has said no PPE is needed in certain situations, but evidence from care workers suggests this has created confusion and they believe lack of PPE is putting them, and others, at risk. Official guidance is not addressing the specifics of potential virus transmission in residential and homecare settings (D.13, p.6).*

> *I think there's been a lot for providers to interpret. My observation is that the guidance has changed fairly quickly […] I think no matter what sector we've worked in, the sheer amount of guidance that has come through has been absolutely challenging to keep up with (I.12, Social worker).*

This lack of clarity about PPE requirements could increase infection risks among homecare service users, seriously affecting their safety. Furthermore, a member of care staff expressed that they were not guided by her employer on how to handle the situation when the service users feeling stressed and wanting to go out during the national lockdown, raising concerns about emotional, social, and functional safety:

> *There is the challenge of helping them understand why they can't, for instance, going to the cinema, or go to a recreational activity within the community. If they feel like they cannot go out or they cannot go to shop or cinema, it could affect their emotional health or mental health (I.22, Carer).*

> *[…] the service user can get quite frightened, can get quite scared when something that's not been explained to them (I.21, Carer).*

The findings also highlight instances where homecare providers offered comprehensive and detailed training for their staff; nevertheless, there's still a notable limitation in opportunities for further career development. For instance, one research participant highlighted a lack of progression and development opportunities within the company, indicating limited support for further advancement or skill development after initial training:

> *The actual training you receive to take part in your specific role within this company is incredibly thorough, incredibly detailed, and really good. So, we had, you know, the care, certificate training, and personality disorders, individualised training. But progression and development, not so much. So, I think once you've had the training to get into your role, we've got it, and that's when they leave here. I don't actually know if I don't request any further training, so I guess if you don't ask, you don't get (I.05, Carer).*

7.2.3. Compensation Challenges

This research identified various organisational and management challenges related to compensation. Low pay emerged as a significant issue. In the study, caregivers expressed frustration over the low salary rates, which they see as insufficient and disproportionate to the level of responsibility and effort required in their roles. For example, one carer expressed their frustration over

feeling undervalued as they were only paid between £12 to £14 an hour for the homecare role in London:

> *It is a bit underappreciated; I think. You know, you work for families which are sometimes very wealthy. They make a lot of money and are very happy to brag to you about all the money they have made, and they still won't pay you more than £12 to £14 an hour. That makes it really difficult to stay in the role, I think. […] I see online that the minimum hourly pay for care, especially in London where I live, should be between £20 to £25, and I've never experienced that. My pay is maybe £12 to £14 an hour. A senior carer might earn £18 an hour, but that is very far from what I have experienced, and that's not a lot of money (I.04, Carer).*

Some other participants also voiced their concerns over being paid unfairly compared to their peers, leading to feelings of unfairness, frustration, and financial insecurity among caregivers. The excerpts below highlight disparities in pay among homecare team staff members, with instances where individuals received lower compensation compared to peers, raising concerns about fairness and organisational oversight:

> *When I was a team leader in homecare, I felt I wasn't paid as fairly as I could have been. To elaborate, there was another team leader from a different area who got paid more to manage a single household, that is, one individual and their team. However, I managed three different teams but was paid less. The reason given to me was because of the area that I lived in. However, there wasn't a great deal of distance between where I supported and where the staff member who got paid more was located (I.06, Carer).*

> *There were issues in the past where I was paid less than my peers, which were eventually addressed (I.10, Carer).*

> *I'm aware of colleagues who have experienced being underpaid, which is troubling. It seems like a lack of organisation, given that it shouldn't be difficult to calculate correct payments. It's especially concerning when people rely on this income for their bills and necessities. It can be quite disheartening for care workers who put in long hours to not receive their rightful earnings (I.17, Carer).*

These compensation issues within organisations are closely related to the institutional challenge of lack of funding, which often results in lower wages for homecare workers, as providers struggle to cover their operational costs while still delivering essential services. This also perpetuates a cycle where low wages hinder the recruitment and retention of skilled caregivers, exacerbating staffing shortages and compromising the quality of care provided, as discussed previously.

To conclude, in organisational and management contexts, key challenges include financial constraints, leadership roles, and human resource management problems. For instance, insufficient funding has significantly challenged UK homecare providers in maintaining their businesses. Meanwhile, inconsistent leadership and culture can impact service quality, with examples such as inadequate workforce support and limited resource availability. Furthermore, human resource management issues, particularly staffing, training, compensation, and support, are identified as the most significant challenges, exacerbated by the COVID-19 pandemic, directly affecting the quality and safety of care services.

7.3. Work Environment Challenges

Challenges within the work environment in homecare refer to various issues related to the physical space of service users' homes, working conditions, and task-related difficulties. In terms of the physical space of service users' homes, many are poorly designed to accommodate changing care and support needs. One document reported that approximately 1.9 million households in England are home to someone with a health condition that needs an adaptation to their home to support everyday tasks (D.01, p.30). Instances were recounted where poor air quality, environmental problems, and unsafe living conditions resulted in safety issues such as trips, falls, and other health concerns:

> *Well, it may not always be in my control, but the living conditions of the patients can sometimes be hazardous. Issues like poor air quality or environmental problems can impact their health (I.03, Carer).*

> *There was an issue with the landlord not maintaining the property safely, particularly the stairs. It took significant effort from our management to address this (I.10, Carer).*

> *There are hazards like food being on the floor or drinks being spilled. If the patient were to walk near the spillage, they could slip and fall (I.17, Carer).*

Regarding working conditions, the research discovered significant issues of excessive workload, lack of breaks, and job insecurity. For example, one participant expressed frustration with the lack of consideration for homecare workers' personal lives, highlighting how their hours can become excessively long without notice, impacting their work-life balance (I.04, Carer). Another care worker felt burdened by their workload, particularly when they were asked to undertake tasks that were outside the scope of their job responsibilities (I.10, Carer). During the pandemic, carers also indicated that they experienced occupational stress attributed by poor communication and management. The findings reveal that homecare staff have had to adapt their lives around the pandemic and co-ordinate work through any means possible, detrimentally affected their mental health. For instance, two homecare transition practitioners in this study expressed their frustrations when their transition tasks were suspended, and they were required to take on-call shifts and deliver care to service users, which are not their duties before COVID-19 (I.01, Transition practitioner; I.02, Transition practitioner). One of them decided to leave the role soon after due to this reason (I.01, Transition practitioner). Similarly, other official reports documented the feeling of burnout or stress as reasons of homecare care staff leaving, resulting in low staff morale and not willing to take on additional hours or do more to provide care for service users:

> *Much of the workforce suffers from poor mental health and burnout, especially following the huge sacrifices they made during the COVID-19 pandemic (D.01, p.27).*

> *[…] many respondents feeling exhausted, reporting staff morale to be low, and burnout to be at higher levels than it was in pre-pandemic times (D.11, p.71).*

These are significant issues which can negatively impact the care quality. One carer said that "fatigue can hinder your ability to perform well" and emphasised the importance of maintaining sound well-being to deliver high-quality service (I.03, Carer). Furthermore, other concerns about working conditions can lead to an unskilled, unmotivated workforce, stress, exhaustion, burnout among workers, and low staff morale, thereby compromising the quality and safety of care in the homecare sector:

> *Concerns were also raised that working conditions in domiciliary care (wages, job insecurity, etc) could lead to an unskilled and unmotivated workforce, with resulting quality implications (D.03, p.17).*

> *Increasing work demand and increasing staff shortages, which for some created a vicious cycle of long working days, regular overtime, an inability to take breaks and holidays, and, as a result, led to stress, exhaustion and burnout (D.11, p.42).*

> *Increased pressure on management and staff, leading to low staff morale (D.12, p.1).*

> *[…] concerns around safety where employees were working such long hours, and also discussed greater costs associated with staff sickness that may arise due to poor work–life balance (D.03, p.10).*

In terms of task-related challenges, inadequate duration of homecare visits appears to be a prominent issue. Documentation and reports reveal that, on many occasions, homecare visits are short and time-restricted, which is considered inadequate for providing quality care. For example, issues with the commissioning of homecare services in 15-minute calls, deemed unviable by providers, leading to rushed or substandard service:

> *Some providers were still being commissioned to deliver 15-minute calls – something they described as 'not viable' (D.03, p.17).*

> *Local authorities that commission homecare in 15-minute blocks, which can lead to rushed or poor care (D.02, p.46).*

Meanwhile, local authorities paying for care by the minute exacerbate these problems by neglecting to account for travel time, a practice criticised as unfair to both carers and providers:

> *The council are paying for care by the minute. There is no provision in the fee rate for travel time. This is a scandal. [It is] not fair on carers and not fair on providers (D.05, p.10).*

Additionally, the solitary nature of homecare work, with carers often working alone with service users, can pose a significant challenge. Findings show that homecare work often involves one-on-one interactions with individuals,

requiring caregivers to be self-reliant and capable of independently managing various situations:

> *I work on my own, when I am working, I am alone with the client and unless it's for swapping shifts. […] I swap over the shift with them [other carers] and maybe see them for like 5 minutes, but I don't work with two people at once (I.04, Carer).*

> *When I was working within the home, it was one to one basis. You've got to be a kind of a bit more initiative and be able to manage situations on your own (I.06, Carer).*

Research participants reveal that the one-on-one arrangement can be difficult when providing care service. For example, one caregiver highlighted that in homecare settings, immediate medical resources or security measures are often unavailable. Consequently, managing challenging behaviour from service users without support from other caregivers can be both difficult and potentially unsafe:

> *There're occasions when the individual becomes physically aggressive and is lone working that can sometimes be a challenge to manage as sometimes you don't get any indication that they're going to be becoming physically aggressive, so it's responding proportionate to the incident, and following correct steps to ensure that they are safe, but also, you're safe that can be quite difficult (I.06, Carer).*

In brief, challenges within the homecare work environment include issues related to the physical space of service users' homes, working conditions, and task-related difficulties. Many service users' homes are poorly designed to meet changing care needs, resulting in safety hazards such as trips, falls, and health concerns due to poor air quality and unsafe living conditions. Working conditions are also problematic, with excessive workloads, lack of breaks, and job insecurity leading to stress and burnout among caregivers. The COVID-19 pandemic exacerbated these issues, causing high turnover rates and further strain on mental health of care staff. Task-related challenges include inadequate homecare visit durations, often limited to 15-minute blocks, which are insufficient for quality care. Additionally, the solitary nature of homecare work requires caregivers to independently manage various situations without immediate support. These challenges collectively impact the quality and safety of care provided.

7.4. Team and Individual Staff Challenges

In homecare, one of the risk factors at team levels that this research discover is the inconsistency of team members. This can negatively impact the care quality as service users can get upset and anxious not knowing who the carer will be coming to their homes. For example, research participants explained:

> *Some of the challenges can sometimes be for people [service users] is not having a consistent home carer (I.28, Social worker).*

> *The inconsistency with staff members, so it can cause a lot of distress and anxiety for the individual. Some individuals like to know when people are coming to the home. If the individual doesn't know who's coming or getting someone that they don't like or not very keen on for that day, it can cause a lot of anxieties for the individual (I.06, Carer).*

However, the main challenge at the team level is associated with communication issues. For example, home caregivers expressed challenges that they encountered in getting promptly responses from their supervisors or managers, especially in the context of remote work during the pandemic and lone working in homecare, where timely replies are often crucial:

> *I have occasions where you're required an immediate response from your line managers, especially nowadays where it's working from home, and it can be quite difficult sometimes to get in contact with them. I've had incidents that required on call but there's been no answer from on calls (I.06, Carer).*

> *In homecare, individuals often work alone, so not being able to reach a manager can be problematic for the service users. […] During summer, I faced a delay in response when inquiring about shifts, which was a bit frustrating, especially when I was readily available. Prompt communication is key in this field, and such lapses, even if rare, can be inconvenient (I.17, Carer).*

The challenges in communication such as delayed responses can create obstacles for homecare workers in delivering timely and appropriate services to service users. For example, a caregiver described difficulties in communicating with the head office, including delayed responses or being

passed between departments, can hinder their ability to perform duties effectively and may impact the safety and well-being of service users:

> *Communication with the head office can be challenging due to delayed responses or being passed between departments. […] Delayed responses can hinder my ability to do my job effectively, which might indirectly impact service user safety (I.10, Carer).*

Furthermore, within teams, there were many instances of a lack of attention and support from care managers. One document reported that mental health problems among care staff were exacerbated by a perceived decline in support from employers and managers since the beginning of the pandemic:

> *Mental health problems were further impacted by a perceived deterioration in communication between employers and managers with respondents indicating reduced levels of support from line managers since the beginning of the pandemic. Managers and HR staff also indicated that overall support for the sector declined across the pandemic, making it harder for them to cope and to support their staff (D.11, p.72).*

Similarly, caregivers noted a lack of proactive support and involvement from their care agency, and another felt undermined by their supervisors, leading to a sense of isolation and feeling unsupported:

> *They [agency] are quite relaxed. They place you with the client, and then you just go on and do your thing. If there is an issue, I raise with them, but other than that, they don't really interfere with your day-to-day work unless, I guess, the employer reaches out to them to bring something up (I.04, Carer).*

> *There was an incident where I felt undermined by a supervisor and director. They didn't communicate effectively, and it seemed like they were taking advantage of weaknesses. Everyone has weaknesses, and it felt like they were exploiting mine for their purposes, which was quite demeaning, especially when I was just starting out in this role. That was a difficult experience for me (I.03, Carer).*

In terms of individual care staff attributes, the findings of this study reveal that poor communication and non-compliance with company procedures from care staff can lead to disruptions in care provision, such as staff not showing up on time or failing to inform others about their absence due to sickness. These

communication issues can cause gaps in care delivery, potentially leaving service users without needed support:

> *It could be the communication issue, you know, somebody didn't report or didn't show up on time. It could be concerning for service user (I.28, Social worker).*

> *There would have been an occasion where an individual that I supported 4 hours care a day, and a staff member didn't follow company policies and procedures, and was off sick, but they didn't contact anyone to let them know, and in doing so, no covered staff was contacted because no one was aware of the sickness (I.06, Carer).*

These above findings also reveal challenges related to individual staff attributes, specifically in terms of skills, knowledge and attitudes towards safety, posing a risk to safe care at home. For example, the study found several individual staff factors leading to medication errors in homecare. One factor is the lack of training and understanding among care staff who might not fully comprehend the correct dosages or the importance of accurate medication administration. Additionally, individual neglect can play a role, where caregivers may not pay sufficient attention to the details of medication instructions:

> *It could be due to like lack of training, lack of understanding. It could also be to do with individual neglect, and from my experience, when you train someone in medication, that trainer has to be there, and they should never let someone give medication without prior training (I.09, Carer).*

Indeed, the research found that the primary cause of medication safety incidents is human error, often stemming from staff negligence, inattention, and a poor attitude towards safety culture. For instance, there were incidents when care staff repeated errors after further training was provided, administered the wrong does due to a lack of careful attention to detail, or cut corners such as delaying the recording:

> *From my experience, we train all staff on giving medication so that they could do it independently. If they were then to make mistakes, well, they will be given further training, and if they make any further mistakes, then it's clearly neglect from the individual [carer], or lack of concentration, or just a poor attitude towards it (I.29, Carer).*

An incident involved an agency staff member administering the wrong medication dose due to similar packaging (I.10, Carer).

It's when people skip or cut corners is when those mistakes be made, so, for example, as soon as you prepare medication and administrate, you record straight away, whereas some people might think, "you know what, I'll record it later on," and then you'll forget, and then the next person [carer] comes in and think they [service user] have not got medication yet, then he [carer] goes and gives it, and that's where the mistakes can be made (I.09, Carer).

To summarise, homecare team-level challenges include inconsistent team members, communication issues, and lack of support from team managers. Inconsistent team members can lead to anxiety among service users. Communication issues, such as difficulties in receiving timely responses and poor communication, along with a lack of attention and support from care managers, can create gaps in service provision and hinder homecare workers in delivering timely and appropriate services. Additionally, several individual staff factors, including lack of skills, knowledge and poor attitudes toward safety, such as non-compliance with procedures and individual neglect, can contribute to unsafe care environments.

7.5. Service User, Family, and Informal Support Network Challenges

Homecare service users' attributes and characteristics is one of the fundamental challenges in providing safe care. For example, there are situations when service users exhibit challenging behaviours. These issues, stemming from factors such as age, mental illness, mental capacity, disability, or dementia, can hinder the delivery of safe and high-quality care:

Clients that are vulnerable because of different reasons. Be it age, elderly clients or disabilities (I.04, Carer).

As some caregivers noted, providing care for individuals with dementia presents considerable difficulty, often involving managing physical aggression or other dilemmas such as persuading individuals to eat or drink when they refuse:

It's part of the job to handle such situations. People with dementia can become very aggressive. When providing personal care to

> *aggressive individuals, it's not easy. They might hit, scratch, spit, or scream (I.08, Carer).*

> *An individual there had got to the stage of their dementia that refused to eat and drink, and there's no restrictions and placed it. You know, you can't force somebody to eat and drink. It was a real case of prompting encouragement, but there was a real nutrition concern there, but they did not want to engage in food or drink and got quite a challenging stage of their dementia so that was quite hard for them, I think, from a safety perspective (I.05, Carer).*

Additionally, instances of sudden mood swings, violent outbursts, or memory lapses highlight challenges associated with the attributes of individuals receiving homecare services. These behaviours can be unpredictable and may pose risks to both the service users and the caregivers:

> *There was an incident where a service user was having significant problems. They became violent, which was unexpected and challenging for us to handle (I.19, Carer).*

> *That's one incident I've had where the patients forgotten the conversation and completely changed her mood. Obviously, it's not her fault, but that, yeah, that that's one incident I've come across. It's quite sad to see (I.17, Carer).*

> *There are instances with clients who are not cooperative. This can be challenging, and it might make you feel bad (I.03, Carer).*

The above narratives also depict the emotional strain experienced by caregivers when faced with challenging situations while providing care. These circumstances highlight feelings of sadness and helplessness among caregivers as they navigate these difficult circumstances.

In terms of family members and other informal support networks, the first chapter emphasised the crucial role of families, friends, and neighbours in providing significant support to homecare service users. However, there are also various challenges and issues associated with integrating informal support networks into homecare. The study found an example where a carer faced difficulties in dealing with service user's family when providing care, citing issues such as lack of respect and scheduling disorganisation:

> *You can actually be emotionally abused by the family. I've left working with some clients because the situation was just so toxic, the family around it was so toxic and just that there was no mutual respect and there was a lot of messing around with hours and a lot of uncertainty. I think that's the biggest problem that I've experienced with families (I.04, Carer).*

Another issue with involving families and friends is that they are seen as informal carers who are often unpaid, may lack professional training, and might fail to meet established care standards. For example, concerns were raised by carer organisations regarding the potential stigmatisation faced by informal and unpaid carers, who may not always receive recognition for their efforts despite doing their best to provide care:

> *The review heard from carer organisations who are concerned that informal and unpaid carers might be stigmatised for not providing 'good care' when they are doing their best (D.04, p.45).*

Meanwhile, caregivers reported challenges with non-immediate family members who might not fully understand service users' needs, leading to a relaxed approach that could compromise the quality of care, or challenges with family members who lack training, resulting in unintended errors due to unfamiliarity with caregiving practices:

> *Sometimes, I see people who are not family members, maybe like partners of parents, who don't fully understand the person and the care they require, so they are maybe a little too relaxed with the things that they think they can do with this person (I.18, Carer).*

> *It's incredible challenging whereby they [family members] don't have the training. They can often say wrong thing. They've got the right intention but the wrong way of verbalising it (I.05, Carer).*

To sum up, providing safe care in homecare is fundamentally challenged by the attributes and characteristics of service users, such as age, mental illness, mental capacity, disability, or dementia, which can lead to challenging behaviours. Additionally, integrating families and informal support networks presents difficulties and potential challenges such as lack of training and mismatches in understanding the service user's needs, compromising care quality and safety.

Chapter Summary

This chapter has highlighted various challenges that act as barriers to high-quality care and pose significant risk factors leading to safety issues and potential harm to homecare service users. These challenges are examined across multiple contexts, including institutional, organisational and management, work environment, team dynamics, individual staff factors, service users, and family and informal support networks. A summary of these challenges is provided in Table 7.1 at the end of the Chapter.

Within the institutional context, the increasing demand for homecare services in England has strained resources, infrastructure, and staffing, making it difficult for providers to support service users adequately. Insufficient government funding exacerbates these issues, resulting in an unstable homecare market characterised by low wages, high turnover rates, and inadequate staffing capacity. These factors contribute to safety concerns such as inaccessibility to care, reduced care, and disruptions in continuity. Additionally, limited provider choices, fragmented support systems, and complex bureaucratic processes hinder efficient service delivery and overall care quality.

Within organisational and management context, key challenges include financial constraints, leadership roles, and human resource management problems. Insufficient funding has made it difficult for homecare providers to sustain their businesses. Inconsistent leadership and organizational culture impact service quality, leading to inadequate workforce support and limited resource availability. Human resource management issues, particularly related to staffing, training, compensation, and support, are identified as the most significant challenges, directly affecting the quality and safety of care services.

Challenges within the homecare work environment include issues related to the physical space of service users' homes, working conditions, and task-related difficulties. Many homes are inadequately designed to meet changing care needs. Caregivers face excessive workloads, lack of breaks, and job insecurity, leading to stress, burnout, and low morale. Task-related challenges, such as insufficient time for homecare visits and the solitary nature of the work, make

managing difficult behaviours without immediate support or medical resources unsafe for caregivers.

Homecare team-level challenges include inconsistent team members, communication issues, and lack of support from team managers. Inconsistent team members can cause anxiety among service users. Communication issues, such as difficulties in receiving timely responses and poor communication, along with a lack of attention and support from care managers, create gaps in service provision and hinder caregivers from delivering timely and appropriate services. Additionally, several individual staff factors, including a lack of skills, knowledge, and poor attitudes toward safety—such as non-compliance with procedures and individual neglect—contribute to unsafe care environments.

Finally, providing safe care is fundamentally challenged by the attributes and characteristics of service users, such as age, mental illness, mental capacity, disability, or dementia, which can lead to challenging behaviors. Integrating families and informal support networks presents difficulties, including emotional abuse, lack of training, and mismatches in understanding the service user's needs, compromising care quality and safety.

These findings provide a comprehensive understanding of the fundamental challenges in homecare in England. By presenting these challenges, the chapter aims to create a framework for identifying, mitigating, and addressing safety issues and associated risks to ensure the provision of safe and high-quality care.

Table 7.1 Comparison of frameworks of contributory factors influencing safety incidents or adverse events

Challenge types	**Contributory factors influencing clinical practice** (Taylor-Adams and Vincent, 2004)	**Contributory factors influencing medication management in homecare** (McGraw, Drennan and Humphrey, 2008)	**Contributory factors influencing high-quality care and homecare service user safety** (this research)	**Correlation**
Institutional context factors	- Economic and regulatory context - National health service executive - Links with external organisations	- Purchasing arrangements - Provision of travel and contingency payments - Salaries and wages - Terms and conditions (shift patterns) - Role confusion - Proliferation of homecare providers - Use of more than one homecare provider per patient	- Increasing demand for homecare services: Strain on resources, infrastructure, and staffing. - Insufficient government funding, leading to an unstable homecare market, low wages and high turnover rates, and inadequate staffing capacity. - Systemic issues: Limited provider choices, fragmented support systems, complex bureaucratic processes.	– The findings reveal the strain on resources, inadequate staffing capacity, and fragmented support systems, which are similar to the economic and regulatory contexts, NHS executive constraints, and links with external organisations. – The analysis also notes issues like limited provider choices and systemic issues, which extend the challenges related to purchasing arrangements, salaries, role confusion, and having multiple care providers per patient.
Organisational and management factors	- Financial resources and constraints - Organisational structure - Policy, standards and goals - Safety culture and priorities	- Rationing services - Human resources - Risk management - Quality improvement - Supervision	- Financial Constraints: Difficulty sustaining businesses due to insufficient funding. - Inconsistent leadership. - Human Resource Management (Staffing issues; Training inadequacies; Compensation challenges; Lack of workforce support)	- The findings highlight financial constraints, inconsistent leadership, and staffing issues, aligning with the resource constraints, organisational structure, policy standards, and issues on quality improvement and supervision.
Work environment factors	- Staffing levels and skills mix - Workload and shift patterns - Design, availability and maintenance of equipment - Administrative and managerial support - Environment - Physical	- Building and design (e.g., ease of access) - Environment (home and local) - Equipment/supplies - Staffing continuity - Training - Workload/hours of work	- Physical Space: Inadequately designed homes for changing care needs. - Working Conditions (Excessive workloads; Lack of breaks; Job insecurity; Stress, burnout, and low morale)	- The physical space and working conditions, such as inadequate home design and excessive workloads, relate to the building design, staffing, workload, shift patterns, managerial support, and equipment maintenance.
Team factors	- Verbal communication - Written communication - Supervision and seeking help - Team structure (congruence, - consistency, leadership etc.)	- Verbal and written communication (e.g., communication between nurses and home carers, home carers and patients; legibility of records; adequate management plan) - Responsiveness of senior staff	- Inconsistent team members. - Communication Issues: - Difficulties receiving timely responses. - Poor communication. - Lack of attention and support from care managers.	- Communication issues, inconsistent team members, and lack of support map onto the verbal and written communication challenges, team structure, and supervision needs. In addition, poor communication and attention from care managers reflects the communication challenges between nurses, patients, and carers noted in the existing literature.
Individual (staff) factors	- Knowledge and skills - Competence - Physical and mental health	- Verification of skills and knowledge - Verification of competences - Physical stressors	- Lack of skills and knowledge. - Poor attitudes towards safety. - Non-compliance with procedures. - Individual neglect.	- Issues like lack of skills and non-compliance with procedures extend the challenges of knowledge, and competence. Meanwhile. stress, burnout, and low morale are found to be consistent with staff physical stressors and mental health.
Task factors	- Task design and clarity of structure - Availability and use of protocols - Availability and accuracy of test results - Decision-making aids	- Absence of protocols - Quality of information in protocols - Availability of decision-making aids - Inconsistent task definition	- Insufficient time for homecare visits. - Solitary nature of the work. - Managing difficult behaviours without immediate support.	- Task-related issues like insufficient homecare visits map onto the task design and clarity, and decision-making aids. The solitary nature of homecare work and managing difficult behaviours without immediate support extend to current understanding of issues related to task factors in homecare.
Patient factors	- Condition (complexity and seriousness) - Language and communication - Personality and social factors	- Depression, dementia - Personality, social and family circumstances, adult protection issues - Patient familiarity with treatment regimen - Treatment effectiveness - Staff–patient relationship; Patient choice	- Service user conditions: Age, mental illness, mental capacity, disability, or dementia leading to challenging behaviours.	- Service user conditions like dementia, and mental health concerns align with the complexity and communication issues of patients.
Family and informal support network factors	- Not included	- Not included	- Integration difficulties. - Lack of training for family members. - Mismatches in understanding service user's needs.	- The research identifies integration difficulties and lack of training for family members, which extends the current understanding by incorporating these additional challenges in homecare.

Chapter 8.

Enhancing Safety in Homecare: Initiatives and Practices

8. Enhancing Safety in Homecare: Initiatives and Practices

Chapter Overview

As of now, the thesis has provided rich insights into the homecare sector in England, covering a range of topics from what is considered safe or ideal homecare services to the safety issues and challenges that can act as barriers and risk factors for safety incidents.

Numerous efforts by organisations and individuals within the adult social care sector, particularly in homecare, have been made to improve care quality and ensure a safety culture in the sector. This chapter aims to illustrate various initiatives and practices implemented to enhance safety in homecare, addressing the challenges identified in the previous sections. The insights presented in this chapter draw mainly on documentary sources, which serve as valuable tools for understanding the broader context of homecare practices and safety initiatives. Documentation, such as organisational reports, policy briefs, and regulatory guidelines, offers a rich and reliable source of evidence to analyse current efforts and trends in the sector. Using these sources helps to identify established care processes, innovative practices, and lessons learned from past incidents, while also highlighting the evolving strategies for addressing challenges in the homecare sector.

Although the findings of this chapter will reveal various care processes and practices that contribute to a successful safety culture in homecare, the central focus of these efforts is the commitment to establishing a robust system for safe care delivery, as well as a culture of innovation and adaptability to changing needs. These are divided into five themes: (1) collaborations and partnerships, (2) inclusive and personalised care service, (3) strong leadership and staff support, (4) digital technology integration, and (5) strengthening homecare HRM practices.

8.1. Collaborations and Partnerships

Collaboration and partnerships within the health and social care sector have shown the benefits of working together, ultimately leading to positive care outcomes. Findings suggest that such collaborations are important for improving outcomes for service users, breaking down barriers within the

healthcare system, building trust, and ensuring the efficient use of resources. One report evidenced that some areas of focus for local systems and tangible collaborations are already making a difference in people's lives, as local partnerships are starting to have a positive impact (D.02, p.10). For example, collaboration and rotating employees among care organisations helped address capacity issues, upskill staff, and foster a shared understanding of health and social care journeys, emphasising the importance of working closely together and building trust to avoid duplication within the sector:

> *In the first year of the pandemic, we saw organisations working together and often rotating some employees' workplaces. This helped with capacity issues, but it also upskilled some staff. Continuing and developing this model would also help to break down barriers and gain a shared understanding of people's journeys through the health and social care system (D.02, p.110).*

> *I think it's really important that people within the health and social care sector work really closely together and avoid duplication. I think part of that is really about trust with people working in the homecare sector as well (I.12, Social worker).*

A notable example of collaboration and partnership within health and social care is the implementation of an integrated care system. This is a collaborative approach to care service delivery that aims to coordinate and integrate services across different organisations and sectors. For instance, health, social care, housing, homelessness, and community support services are integrated to deliver a seamless, person-centred care experience:

> *Health, social care and other services, such as housing, homelessness and community support are joined-up to provide a seamless care experience of person-led support (D.01, p.18).*

One document added that achieving integrated care is essential for health and social care organisations, which have historically operated autonomously, leading to inconsistent care quality and poor user experiences, particularly for those requiring multiple services:

> *Achieving integrated care is a new responsibility for all organisations charged with delivering health and social care services. Until now, services have operated in autonomous ways – for example, GP practices with their own financial arrangements, NHS trusts with their own workforces, or social*

> *care services operating across their own defined localities. This has meant people do not always get high-quality care or a good experience when they use services – especially if they need multiple services (D.02, p.104).*

These measures of integrated care systems can address fundamental challenges related to fragmented support systems and complex bureaucratic processes, which help facilitate more efficient service delivery and overall care quality. By breaking down barriers within the healthcare system, these collaborative efforts also contribute to addressing safety concerns, such as inaccessibility to care and disruptions in continuity.

In homecare, there is a need for a more integrated, collaborative, and information-sharing approach, with a focus on enhancing homecare service quality, safeguarding service users, and promoting learning and improvement within the sector. For example, there is a recognition of the potential for better integration of homecare with other health services, as evidenced by initiatives like integrated commissioning teams in NHS vanguard areas (D.03, p.24). The ambition is to create a well-qualified, valued workforce that collaborates effectively with care recipients and other organisations, including the NHS, along with increased cross-government and multi-agency cooperation to provide outstanding, personalised care:

> *Our ambition is that we create a qualified and valued workforce that works together, with people who draw on care and support and with other organisations, including the NHS, to deliver outstanding quality care that is sensitive to individual needs (D.01, P18).*

> *Stakeholders want to see increased cross-government and multi-agency working, among organisations with safeguarding responsibilities for protecting people with care and support needs in England (D.04, p.33).*

In summary, collaboration and partnerships within the health and social care sector are beneficial to high-quality, safe care. This includes improving service user outcomes, breaking down system barriers, building trust, and ensuring efficient resource use. The findings highlight the need for a more integrated, collaborative, information-sharing approach, particularly in homecare, to enhance service quality and safeguard users. Integrated care systems can address fragmented support systems and bureaucratic complexities, facilitating

efficient service delivery, improving overall care quality, and mitigating safety concerns like inaccessibility and continuity disruptions. The overarching ambition is to create a well-qualified, valued workforce that collaborates effectively with care recipients and other organisations, including the NHS, while increasing cross-government and multi-agency cooperation to provide safe and personalised care.

8.2. Inclusive and Personalised Care Service

One important effort to ensure safe care among care organisations is the provision of an inclusive and personalised care service. This commitment involves offering access and information about care services, enabling individuals of all circumstances to receive personalised care tailored to their unique needs and preferences. The research findings indicated that homecare providers are encouraged to ensure inclusivity, where everyone, including service users, their families, and carers, can access the necessary information and advice to make informed choices about homecare options:

> *It is vital that everyone, inclusively, has good quality care, and equal access, experience and outcomes from health and social care services (D.02, p.8).*

> *Care and support should be accessible. Everyone – whether that be people who already, or may need to, draw on care and support, their families, or unpaid carers – should be able to access the right information and advice at the right time to understand the different options available to them that best meet their preferences and circumstances, including options for where care and support would best be delivered, and costs they may need to meet (D.01, p.19).*

Ensuring equitable access to information on care allows service users to plan for the future, make informed decisions regarding their care, and receive the necessary support without delay. This effort addresses the challenges related to limited provider choices and fragmented support systems, as it helps make care more accessible and reduces delays in support. It also ensures caregivers are adequately prepared for their roles. For example, one document stated that providing accurate information helps people stay in their homes and communities longer and achieve their goals, while from the carers' perspective, having all necessary information makes them feel prepared and ready for each

shift, which is crucial for both their performance and the well-being of service users:

> *By investing in preventative services, increasing the care and support options available, and providing the right information and advice to allow people to plan for the future, we can enable people to remain in their own homes and communities for longer and achieve the outcomes that matter to them (D.01, p.14).*

> *The agency provides all the necessary information, which makes me feel prepared and ready for each shift. They ensure I'm aware of what to expect, which is crucial for both my performance and the well-being of the clients (I.17, Carer).*

The findings above highlight the importance of supporting caregivers by ensuring that they have the necessary information to perform their roles effectively. This can tackle human resource management issues such as inadequate training and support, which are essential for maintaining the quality and safety of care. Prepared and well-informed caregivers are more likely to deliver high-quality care, reduce the risk of errors, and improve the safety of service users.

In addition, tailoring care services to meet service users' needs and preferences is important to the diverse and unique requirements of service users. This measure can ensure that everyone, regardless of their background or circumstances, receives care that is respectful, responsive, and effective. The focus on personalised care aligns with the challenge of managing diverse and complex care needs, particularly for those with old age, mental illness, mental capacity issues, disabilities, or dementia. Personalised care aims to empower service users and enhance their quality of life. For example, one document emphasised that embedding personalised care could recognise individuals' specific needs, improve outcomes, and enhance their quality of life:

> *The starting point for our vision is embedding personalised care, which is vital to providing the user-led social care we envisage. It has been proven to improve outcomes and enhance quality of life, enabling people to take the level of control and responsibility that they feel comfortable with. Fundamentally, it recognises a person as an individual with specific needs, wishes and aims. It is our ambition to make personalisation the expected standard and for*

> *high-quality personalised care to be the norm across health and care (D.01, p.14).*

Similarly, one service user said that regular, personalised check-ins from the provider, beyond just questionnaires or surveys, are crucial to ensure that they are happy with their care and caregivers, and these check-ins should be tailored to the client's preference:

> *I think it should be, you know, more personalised checking in, so someone from the care provider or local authority, depending on the client preference by coming into the home or remote meeting, to have a chat with them about how they are finding the care, what the problems are (I.31, Service User).*

These findings also resonate with those in chapter six, which highlighted the importance of person-centred care in homecare services. This emphasised respect for individual preferences, autonomy, and tailored support. Additionally, effective communication is reiterated as crucial for ensuring an effective person-centred care approach.

In brief, one important effort to ensure safe care among care organisations is the provision of inclusive and personalised care services. This involves offering access to information, and tailoring care to individual needs. Equitable access to information helps service users make informed decisions and receive timely support, while caregivers are better prepared for their roles. Tailoring care services to meet users' needs and preferences is crucial for the diverse and unique requirements of service users, ensuring that everyone, regardless of background or circumstances, receives respectful, responsive, and effective care. This focus on personalised care aligns with managing diverse and complex care needs, with the aim of empowering service users and enhancing their quality of life. These findings align with chapter six's emphasis on person-centred care, highlighting the importance of respecting individual preferences, autonomy, and tailored support, with effective communication being crucial.

8.3. Strong Leadership and Care Staff Support

The research discovered that strong leadership and effective support initiatives for staff are important for a robust support system for care delivery. These measures address key challenges in the homecare sector, particularly within the organisational and management context, and homecare team-level

challenges. For example, good leadership can help navigate difficulties, ensuring that the systems remain resilient and capable of meeting demands. Meanwhile, initiatives such as in-reach services and well-being appraisals, which provide direct support to staff and promote staff's mental and physical health, can enhance caregiver preparedness and well-being:

> *Good leadership will be vital for local systems as they become established during challenging times for all services (D.02, p.102).*

> *[…] sharing of staff support initiatives that have been proven to be helpful for staff needs to be encouraged, such as 'in-reach services' and wellbeing appraisals (D.11, p.77).*

In addition, effective leadership, both at the system level and within individual organisations, is essential for ensuring the availability of adequately skilled homecare staff to support service users and deliver high-quality care. This can help address human resource management challenges within organisational and management contexts, particularly staffing issues and training inadequacies:

> *Strong, visible system leaders are important in ensuring that a local area has a sufficient staff with the right skills in the right places to support patients (D.02, p.99).*

> *We need to recognise the vital role registered managers have in ensuring the delivery of high-quality care and developing a skilled workforce in their organisation (D.01, p.71).*

Meanwhile, providing support networks for care staff can help address the fundamental challenges related to the work environment and team-level challenges. For example, having access to colleagues for advice and assistance provides a reliable support network, while ensuring that staff are adequately supported is crucial for the well-being and effectiveness of care staff:

> *Having access to colleagues and their experience is invaluable. It ensures that even if a manager isn't immediately available, there's still a support system in place. It's comforting to know there's always someone to turn to for advice or assistance (I.17, Carer).*

> *Managers still need to ensure, where possible, that staff are supported, enabled and encouraged to take leave and breaks, and*

> *where possible, arrange for their work and responsibilities to be covered (D.11, p.78).*

Furthermore, the findings have also highlighted the importance of recognition, appreciation, and support for those working in the homecare sector. This can tackle issues related to human resource management within the organisational and management context by improving job satisfaction and employee retention:

> *[…] we need to ensure that those working in social care feel recognised, rewarded and are equipped with the right skills and knowledge (D.01, P.67).*

> *The people who make up the health and social care workforce need to feel valued, rewarded and supported. Ensuring staff feel valued is important to retaining a diverse workforce with the right skill mix across health and care organisations (D.02, p.97).*

In the research, many caregivers expressed the need to feel valued and acknowledged for their work, highlighting the positive impact of incentives, acknowledgements, and recognition programmes on morale and job satisfaction. For example, one carer said, "It's always beneficial to feel valued and recognised for the work we do," expressing how recognition and appreciation can positively impact morale and job satisfaction among care workers, who face significant challenges in their roles (I.17, Carer). Similarly, other carers stressed the importance of recognising achievements that go beyond the basic job role, such as taking on extra responsibilities to support other staff, navigating challenging situations with service users, or working overtime, as these acknowledgements can significantly boost staff morale:

> *I find that any type of achievement that deserves recognition is when someone takes on responsibilities that are not within their job role. It's not in the contract, but they've taken on that extra responsibility to help support other staff members or colleagues. I feel like that should be recognised. Or when going through a very challenging situation with an individual, that also deserves recognition (I.26, Carer).*

> *We have this thing in the house called "Thank You Friday," where every Friday an email is sent, and someone within the company is recognised for their work. There was one time in the company where I was working beyond 9 to 5 and doing a lot of overtime,*

> *but I enjoyed it as well. That's why I do it. I was mentioned in that, and it did give me a kind of boost because people are recognising that you are going above and beyond what's needed. It's quite nice to be acknowledged there. So, I do like that, and that's from the HR Department (I.05, Carer).*

In summary, this section has demonstrated that strong leadership and effective support initiatives are regarded as crucial for a safe care system in homecare. These measures address key challenges within the organisational and management context and at the team level. Effective leadership ensures the availability of skilled homecare staff, addressing human resource challenges like staffing issues and training inadequacies. Support networks for care staff are vital, providing reliable assistance and advice, which is crucial for their well-being and effectiveness. The importance of recognition and appreciation was also highlighted, as these can improve job satisfaction and employee retention.

8.4. Digital Technology Integration

One significant emerging practice for a safe care culture is the integration of digital technology into homecare service delivery. For example, during the time of the COVID-19 pandemic, technology emerged as a critical tool for homecare providers to manage and maintain communication with their staff. Organisations had to alter their management of staff by adopting technologies to organise meetings online, enabling remote work for admin staff, and allowing flexible work arrangements:

> *All meetings with my staff are now on Teams. Often, we had to video call after midnight after the individual went to bed (I.07, Carer).*

> *Before COVID, staff members had to attend in person for handovers, but now I can only email or text my colleagues because we are not allowed to meet in person (I.11, Carer).*

Furthermore, in response to skills and training gaps, a few homecare organisations have tried and adopted digital tools to provide training for their care workers during COVID-19. For example, one care support worker mentioned that they had to watch online videos about COVID-19, while a homecare manager reported using Zoom for training. However, some carers found digital tools difficult to use and the online training methods unengaging, indicating ongoing challenges in addressing skills and training gaps.

Findings from documents and reports have also shown the transformative impact of digital technology on care services. One document suggested that digital tools can help identify risks, prevent incidents, and ensure quick and appropriate responses to avoidable safety incidents:

> *When technology is embedded seamlessly into care and support services, it can be transformative, helping people to live happy, fulfilled lives in their homes and communities. Digital tools can also be used to identify risk, prevent incidents from occurring and ensure quick and appropriate responses to avoidable events such as falls, urinary tract infections, medication errors and bedsores (D.01, p.40).*

Similarly, one respondent shared an example of digital technology improving care by providing timely and efficient responses to emergencies. In this case, it was the sensor that detected a service user's fall during the night, automatically alerting a paramedic and leading to the individual's prompt hospital admission:

> *We also had the Carelink, which is the sensor, so if he got up at night and if he'd fallen, the Carelink would have rang for a paramedic. The Carelink never let us down. When he did fall and on one occasion it was through the night, so I wasn't involved at all, the next thing I knew was a call from the Carelink saying that he'd been admitted to hospital after a fall, so again the sensor worked in the bungalow and the Carelink is very efficient as well (I.13, Family member).*

Digital technology is also desired to address fundamental challenges to safe care. For example, in a survey report on homecare worker retention, the majority of respondents expressed interest in using technology to enhance the work environment, addressing human resource management issues, particularly regarding retention, working conditions, and task-related difficulties:

> *The desire for innovation to improve retention was confirmed by 57% of respondents, while 59% were planning to increase the use of technology to make life easier for staff (D.12, p.2).*

Other instances of how digital technology can enhance the quality of care refer to the provision of digital tools, digitalisation of care records, and enhancement

of social interactions. These initiatives can help improve the efficiency of care delivery, thereby alleviating some of the resource constraints, creating stronger communication, and improving care coordination among care providers:

> *The use of technologies in social care should enhance the quality of care, free up time for meaningful human interactions, and create stronger connections between people and their friends, family and care networks. […]. Technologies can complement and enhance the quality of care delivered by the workforce, while digitisation of care records will ensure care staff and multidisciplinary teams have the information they need to provide holistic, person-centred care in any setting (D.01, p.42).*

Overall, the integration of digital technology in homecare services is an emerging practice for a safe care culture, with findings showing its transformative impact on care services. During the COVID-19 pandemic, technology became crucial for homecare providers to manage and maintain communication with their staff, enable remote work and flexibility, and offer training support. These technologies facilitated online meetings, remote handovers, and quick responses to emergencies, significantly improving care coordination and efficiency. However, some homecare organisations adopted digital tools for training, though challenges remain in making these tools user-friendly and engaging. The findings have highlighted the transformative impact of digital tools in identifying risks, preventing incidents, and ensuring timely responses to safety issues. Additionally, digital technology addresses challenges in human resource management by enhancing the work environment, improving retention, and alleviating task-related difficulties. The digitisation of care records and enhancement of social interactions further improve care delivery efficiency, communication, and coordination among care providers.

8.5. Strengthening Homecare HRM Practices

This section shows potential good practices and initiatives related to care workforces, which can help address a number of fundamental challenges of human resource management which impede safe care. This research found that a number of people management processes, practices, and strategies can contribute to a successful safety culture in the homecare setting. Firstly, strengthening workforce planning is critical to tackling staff shortages. This process includes reviewing workforce demands, maintaining an understanding

of care needs, and implementing effective communication strategies to manage workforce capacity and ensure quality care delivery:

> *To maintain and develop the workforce, and plan for the future, providers and systems need to review workforce demands for the longer term, including skill sets. A full understanding of the needs of the local community must be maintained to ensure services meet demand. This should include preventative health measures, as well as maintaining and improving health outcomes (D.02, p.99).*

> *From what we experienced, there was a need to ensure proper timing and understanding of the team's capacity, considering the people we had and those we needed to hire. Effective communication was crucial in managing this situation (I.03, Carer).*

Secondly, flexible working arrangements are effective strategies for improving working conditions and staff well-being, thereby addressing workforce shortages. For example, one report revealed that care staff value flexible working hours and regular feedback from line managers more than increased pay (D.12, p.2). This finding highlights the importance of addressing work–life balance to retain and motivate care staff. Similarly, a document emphasised that the development of flexible workforce models can help address workforce shortages by allowing local systems to better meet the diverse needs of all individuals:

> *Workforce shortages across all sectors need to be addressed through innovative initiatives that look to the future and can be delivered at a local level. The focus should be on shaping more flexible workforce models that help local systems meet the needs of people – all people – who are in turn empowered to take a more active role in their own wellbeing (D.02, p.5).*

During the COVID-19 crisis, homecare providers had to implement flexible recruitment arrangements and adopt an ad hoc, opportunistic, and 'all hands-on deck' approach in their recruitment and selection processes. For instance, recruitment interviews were conducted online, work experience criteria were reduced, and there were fewer reference checks and fewer shadowing shifts for new employees to lessen in-person interaction. Care providers also had to recruit more temporary carers and agency staff to deal with staff shortages during the times of crisis:

> *One challenge I had was to interview and select 22 applicants for the support worker positions (I.11, Carer).*

> *Like during COVID, there was this time I needed more people, and the only choice was to get some temp workers (I.01, Transition practitioner).*

During the pandemic, flexibility in working conditions, such as adjustments to working hours and locations to accommodate childcare and other responsibilities, was also highly valued by staff. As the pandemic subsides, care providers are advised to establish long-term policies for flexible working conditions while preparing future workforces through education and training to adapt to these new methods:

> *During the pandemic most employers provided, as far as possible, increased flexibility around working hours, location of working, while recognising additional childcare or other caring responsibilities of individual members of staff. Flexibility continues to be highly valued by staff with a recognition that homeworking is not available to staff in all roles. As the level of the pandemic subsides, staff will need to feel that their needs, wellbeing and circumstances are being considered. Firming up policy and procedures with staff and their representatives about long term flexibility in working hours and location must with start to happen with those involved in student or trainee education preparing the workforce of the future for these different ways of working within agencies and organisations (D.11, p.78).*

Thirdly, fair compensation, incentives, and job security are crucial to ensure a sustainable future supply of care staff. This research found that adequate funding should be provided to local authorities to ensure fair pay and improved working conditions for homecare workers (D.05, p.3). One carer emphasised the need for better financial support, acknowledging that the current salary does not reflect the importance of the job (I.04, Carer). Meanwhile, commissioners, providers, and other stakeholders should collaborate to ensure care workers are paid for all hours worked and to improve their terms and conditions, addressing issues such as insufficient care staff capacity, thereby ensuring a sustainable future supply of care staff:

> *We also want to work with commissioners and providers to make sure care workers are paid for all the hours they work and to improve the terms and conditions of the workforce, to help ensure*

> *a sustainable future supply of care staff. This includes acknowledging the prevalence of zero-hour contracts in the sector, which can result in uncertainty around employment status and rights (D.01, p.67).*

Fourthly, the research findings have revealed several innovative approaches to recruitment and retention that effectively tackle turnover challenges within the homecare sector. For example, enhancing the perception of homecare as a career and fostering closer integration with other healthcare providers are the top sector-wide initiatives advocated to improve staff retention (D.12, p.2). One social worker noted that highlighting benefits and career progression opportunities through the success stories of individuals advancing in homecare can encourage more people to see it as a rewarding and viable career path:

> *People are working awfully hard to press those and to think carefully about, you know, what are the benefits of working and in homecare and linking it through to career progression and getting those good news stories. We have kind of shared some stories where perhaps one of our assistant directors has talked about how they started off as a homecare and it kind of, you know, support personnel, see it as something that's valued, but also that this could be a stepping stone to a future here in health or care (I.12, Social worker).*

Other innovative approaches to recruitment and retention include creating partnerships with universities on apprenticeship programmes to support staff in becoming qualified registered nurses, thereby attracting and retaining more skilled workers in the homecare sector (D.02, p.96). Furthermore, values-based recruitment reduces turnover and recruits the right people by focusing on candidates who demonstrate key values like compassion, ensuring a better fit for caring roles, and increasing retention:

> *Attempts to reduce turnover of care workers have led some home care providers to adopt innovative approaches to recruitment, aiming to maximise retention by more careful approaches to recruiting the right people. Values-based recruitment considers the extent to which candidates demonstrate values linked to caring roles (such as compassion), alongside the candidates' skills-based experience (D.03, p.10).*

Fifth, workforce development, training, and skills enhancement within the adult social care sector are crucial to address challenges related to human resource

management, individual staff factors, and the overall quality of care in the adult social care sector. The aim is to ensure that professionals have a comprehensive understanding of care system plans, new models of care, and preventative measures, which can ultimately lead to better health outcomes for individuals and strengthen safety culture:

> *While redeployment of staff is now infrequent, all training and development will need to equip staff with the ability to, where possible, perform multiple or new roles and strategies to accomplish this are needed (D.11, P76).*

> *There is a need to expand training and education for new health and social care staff, so that the future workforce has a good awareness and understanding about system plans and new models of care. This will help to change mindsets and ensure professionals focus on people's care pathways, considering preventative health measures to achieve better health outcomes (D.02, p.110).*

There are a number of initiatives and strategies that can equip care workers with the necessary skills, knowledge, and opportunities to deliver high-quality care. For example, creating better career pathways beyond the support worker role is essential for homecare staff to envision a future within social care. One example of this is implementing a nursing associate role, which aims to bridge the gap between carers and nurses:

> *[…] building better career pathways beyond the support worker role, so that staff see a future for themselves in social care. For example, implementing a nursing associate role that aims to bridge the gap between carers and nurses (D.02, p.96).*

> *I think it would be quite a great opportunity, and I think offering incentives for people to stay, so, for example, stay with the company for three years, and we will support you in progressing onto a nursing career, or social care career, or something like that. Because I think the longer somebody stays in the company, the more they know about the company and the more invested they are in the company and the model, willing to support the progression of that company (I.05, Carer).*

Other initiatives include developing and implementing tools and frameworks that are essential for workforce development, training, and skills enhancement.

Examples include the introduction of a skills passport to ensure portability and verification of staff skills, and the creation of a universal Knowledge and Skills Framework and career structure in collaboration with the adult social care sector:

> *Skills passport: a new skills passport will help to address issues of portability of staff training and development. We will embed this as a function in a new digital care hub for the workforce. It will provide a permanent and verifiable record of skills, behaviours and achievements that can be shared with new or potential employers (D.01, p.71).*
>
> *Over the next 12 months, we will work with the adult social care sector, including providers and the workforce to co-develop a universal Knowledge and Skills Framework (KSF) and career structure for the social care workforce (D.01, pp.68-69).*

In summary, this section presented several people management processes, practices, and strategies that contribute to a successful safety culture in homecare settings. Strengthening workforce planning is important for addressing staff shortages by reviewing demands, understanding care needs, and implementing effective communication strategies. Flexible working arrangements and flexible working models can improve conditions and wellbeing, which helps address staff shortages. In addition, fair compensation, incentives, and job security can ensure a sustainable supply of care staff. Moreover, innovative recruitment and retention approaches, such as values-based recruitment and partnerships with universities, effectively tackle turnover challenges. Meanwhile, workforce development, training, and skills enhancement are vital to ensure high-quality care, with initiatives like career pathways and skills passports supporting long-term staff development.

Chapter Summary

This chapter demonstrated a number of efforts made by organisations and individuals within homecare to improve care quality and ensure a safety culture in the sector. Various initiatives and practices were implemented to enhance safety in homecare, addressing the challenges identified in the previous chapter.

First, collaboration and partnerships within the health and social care sector can improve service user outcomes, break down system barriers, build trust, and ensure efficient resource use. Integrated care systems can address fragmented support systems, facilitating efficient service delivery and improving overall care quality. The goal is to create a well-qualified, valued workforce that collaborates effectively with care recipients and other organisations, including the NHS, and increases cross-government and multi-agency cooperation for safe, personalised care.

Second, inclusive and personalised care services are crucial for ensuring safe care, providing access to information, and tailoring care to individual needs. This ensures that all service users, regardless of background or circumstances, receive respectful, responsive, and effective care, empowering them and enhancing their quality of life. This approach aligns with the emphasis on person-centred care, respecting individual preferences, autonomy, and tailored support, with effective communication being crucial.

Third, strong leadership and effective support initiatives are essential for a safe care system in homecare. Effective leadership ensures the availability of skilled staff, addressing challenges like staffing issues and training inadequacies. Support networks provide reliable assistance and advice that are crucial for staff well-being and effectiveness. Additionally, recognition and appreciation improve job satisfaction and retention.

Fourth, the integration of digital technology in homecare services has the potential to be both transformative and beneficial in addressing safety challenges. Digital tools can help identify risks, prevent incidents, and enable quick responses to safety issues. Additionally, they enhance the work environment, improve staff retention, and alleviate task-related difficulties. The digitisation of care records and improved social interactions can increase the efficiency of care delivery, as well as improve communication and coordination among care providers.

Fifth, effective people management processes, practices, and strategies are essential for fostering a successful safety culture in homecare settings. Strengthened workforce planning can address staff shortages, while flexible working arrangements have the potential to improve working conditions and staff well-being. Offering fair compensation, incentives, and job security can

help ensure a sustainable supply of care staff. Furthermore, innovative recruitment and retention approaches may alleviate turnover challenges, while workforce development, training, and skills enhancement can address human resource management issues and contribute to better care quality.

In conclusion, while this chapter highlights various care processes and practices that contribute to a successful safety culture in homecare, the central focus of these efforts is the commitment to establishing a robust system for safe care delivery. This includes fostering a culture of innovation and adaptability to changing needs. The ultimate goal is to ensure that homecare services are not only effective and efficient but also responsive to the evolving demands of care recipients and providers, thereby maintaining high standards of safety and quality.

Chapter 9.

Discussion: High-Quality and Safe Homecare

9. Discussion: High-Quality and Safe Homecare

Chapter Overview

The key objective of this study is to explore the safety culture within the homecare sector in England. This includes the identification of the elements that constitute high-quality and safe homecare, the safety incidents, and the fundamental challenges that pose significant barriers to safety as well as risk factors leading to safety incidents. Previous chapters have provided a great insight into these topics. This chapter aims to discuss these critical findings with reference to the literature review.

The first section of this chapter discusses the essence of homecare services in England and the components of high-quality and safe homecare. It then presents a conceptual framework for high-quality and safe homecare, which aims to offer insights into the crucial dimensions of delivering these services. These dimensions should be incorporated into improvement activities and daily practice in the provision of homecare services.

However, practical delivery of homecare services often encounters fundamental challenges that hinder the delivery of such care, leading to various safety incidents (also referred to as safety issues or concerns). The second section of this chapter discusses these safety issues in reference to previous studies on homecare safety issues. This discussion will provide context and highlight the urgency of these concerns, ensuring a clear understanding before addressing the fundamental challenges that prevent safe care and contribute to these incidents.

9.1. High-quality Care and Safety Culture in Homecare

In homecare, high quality of care and safety culture are key indicators of organisational performance (Mayo, Myers and Sutcliffe, 2021). From the literature, both high-quality care and safety culture share common objectives such as patient-centredness, family involvement, staff development and collaboration. Nevertheless, they differ in their specific focuses, with high-quality care concentrating on service delivery aspects and service user experience, and safety culture emphasising organisational practices, leadership, and collective efforts to ensure patient safety. This research has

argued that a strong safety culture is essential for achieving high-quality care (Idsøe-Jakobsen et al., 2024). In other words, without a safety culture, high-quality care cannot be accomplished. Therefore, discussions and analysis with references to safety culture in this thesis will inherently include considerations of high-quality care.

9.1.1. The Essence of High-Quality Homecare Services

The study's findings have revealed that homecare services often comprise a variety of activities aimed at assisting individuals with their daily routines and overall well-being. This includes practical tasks like household chores, meal preparation, and medication assistance, ensuring a comfortable living environment. Additionally, home caregivers play a critical role in providing companionship and emotional support. Promoting independence among service users is another important aspect, with caregivers emphasising the significance of allowing individuals to make meaningful decisions. Examples include consulting with the service users on daily decisions and encouraging their autonomy, promoting pride in their own abilities and home. These findings align with the definition of homecare in England, which describes a variety of care and support programmes designed to assist individuals in living within their own homes while maintaining their independence (CQC, 2013). In the UK, the core service provided by the majority of local authorities revolves around providing personal care to individuals, including a wide range of personal care and support activities, such as assisting with getting into and out of bed, washing, dressing, cooking, providing medical care, and helping with household tasks such as cleaning and shopping (CQC, 2019; The King's Fund, 2018).

Providing care service at home, therefore, must require well-developed and skilled staff to ensure that caregivers are well-equipped to handle the diverse and complex needs of service users (CQC, 2022; Bennet, Honeyman and Bottery, 2018). High-quality care in homecare is dependent on the care staff's knowledge and understanding of safety risks, and their proactive approach to deal with safety concerns, as well as the ability to communicate and collaborate within interdisciplinary teams (Ekstedt et al., 2022; Silverglow et al., 2022). Hence, the engagement of care staff is indeed important in preventing adverse events and maintaining a safe care environment. Research findings corroborate this point, revealing various scenarios where caregivers need specialised knowledge, skills, adaptability, as well as a genuine passion for care-giving to

manage various situations effectively. These empirical findings from the research extend existing literature by providing nuanced insights into the critical role of HRM practices in equipping homecare staff with the specialised knowledge and proactive competencies necessary to address safety risks effectively. These findings can deepen the understanding of how structured HRM interventions, (e.g., targeted training, interdisciplinary collaboration, and mechanisms to foster staff engagement) contribute to the prevention of adverse events and the promotion of a safe and high-quality care environment.

In addition, other important parts of high-quality care provision include the continuity of care and adequate information about care services and choice. Research findings highlighted the need for careful management of the homecare sector to balance service user's choice, promote continuous improvement, and ensure the stability required for continuity of care. These themes are consistently identified as essential components of high-quality care in England (CQC, 2022; The King's Fund, 2018, Bennet, Honeyman and Bottery, 2018). Therefore, the research findings extend existing knowledge by highlighting the critical role of strategic management in balancing service user choice with operational stability to ensure continuity of care in the homecare sector. By emphasising mechanisms for continuous improvement and effective communication, these findings provide insights into how to sustain high-quality care provision amidst the dynamic challenges of the sector.

9.1.2. Stakeholders Perspectives towards Safe Care

By definition, safety culture can be described as "the product of individual and group values, attitudes, perceptions, competencies, and patterns of behaviour that determine the commitment to, and the style and proficiency of, an organization's health and safety management" (U.K. Health and Safety Commission, 1993, p.10). This thesis has explored perceptions, attitudes, and understanding of safe homecare from perspectives of caregivers and service users.

It is interesting to see there is a mutual recognition of promoting individuals' health and well-being, being attentive to their specific needs, and ensuring a safe home environment that protects both carers and service users. However, there are differences in their views, particularly in the way participants emphasise the importance of care. From the homecare providers' and carers'

perspectives, homecare generally means the prevention of harm, the promotion of service users' health, well-being, and independence. This finding, to some extent, reflects the common definition of patient safety culture in acute care contexts, which refers to the reduction of risks of preventable harm related to healthcare to an acceptable minimum (Runciman et al., 2009). Furthermore, the safety characteristics that stand out, particularly in the context of homecare, include ensuring emotional support, companionship, and independence. This is interesting and reflects the humanistic approach to care, which involves honesty, empathy, compassion, sacrifice, and the provision of care while respecting the dignity and beliefs of service users (McCaffrey, 2019). The research findings have uncovered the unique safety characteristics in homecare (such as the provision of emotional support, companionship, and independence) that extend beyond the traditional definitions of patient safety culture in acute care settings. These findings underscore the importance of a humanistic approach to care, which emphasises the role of empathetic staff behaviour in fostering a dignified, compassionate, and supportive environment for service users, thereby addressing both their emotional and physical well-being.

From the viewpoint of homecare service users, another additional pertinent aspect of safety refers to respecting their privacy and maintaining the confidential nature of the care they receive. Providing care at home differs from other care settings, as the caregivers deliver care in the service user's personal home. For service users, their home symbolises personal privacy and integrity, and they spoke about how it is important to respect their privacy and confidentiality in their own homes. There were situations in which caregivers were in dilemmas of whether they should exercise the authority that is associated with their professional responsibility towards the service user's health or to respect their privacy. These findings, to some extent, describe a unique dynamic of providing care at home and highlight a moral conflict concerning intrusion into the service user's privacy (Magnusson and Lützén, 1999). It has provided a deeper understanding of the nuanced dynamic of homecare and emphasised the critical need for ethical frameworks and training to navigate the delicate balance between safeguarding service users' well-being and upholding their dignity and confidentiality.

Overall, while carers and service users share a common goal of promoting health and well-being in homecare settings, their perspectives may differ

slightly based on their roles and experiences. For example, carers tend to focus more on the practical aspects of safety. This can include attention to safety management and prevention of adverse events to minimise health risks. Their focus is primarily driven by a duty to maintain and improve the health outcomes of their clients. Meanwhile, service users prioritise the respect for their privacy and the confidential nature of the care they receive. For service users, the impact on their own selfhood is crucial, as the quality of care is closely tied to the degree to which their autonomy and personal boundaries are respected, which can enhance their comfort and sense of security within their homes. The research findings, therefore, confirm existing literature on patient safety culture by emphasising harm prevention and well-being promotion while extending it by highlighting unique safety characteristics in homecare, such as emotional support, companionship, and the critical balance between safeguarding well-being and respecting privacy and dignity.

9.1.3. Person-centred Care

Person-centred care is a significant aspect of homecare safety culture in this study. This entails involving service users in the care plan, listening to their needs, offering personalised support, and engaging them in decision-making processes. Insights from both homecare workers and service users demonstrate the necessity of bespoke communication and collaborative decision-making processes to ensure that individual needs and preferences remain at the forefront throughout the delivery of care. Examples range from accommodating dietary preferences to involving service users in decisions about living arrangements and treatment plans. This finding is in line with existing literature on patient safety culture within the healthcare sector (Sammer et al., 2010; Macrae, 2022), particularly in homecare research and professional practice (e.g., Anker-Hansen et al., 2018; Lang et al., 2009; Leverton et al., 2021a; Talabani et al., 2020). It also extends and contributes to the literature by providing specific insights from homecare workers and service users, demonstrating how personalised support and engagement in decision-making directly enhance care quality and safety in homecare settings.

The person-centred care approach allows homecare providers to gain a deeper understanding of service users' perspectives, needs, and available resources (Turjamaa et al., 2014). Additionally, preventive safety measures in a service user's home require true patient involvement, taking their values and integrity

into consideration (Schildmeijer et al., 2018). This thesis also adds an important argument for the need to engage the homecare service user, given unique nature of delivering care within their personal homes, which sets it apart from other care settings. Therefore, involving them in the safety culture is important, considering the intimate and personal nature of care delivery in their homes.

9.1.4. The Role of Family Members and Informal Support Networks

In homecare, safety culture includes not only individuals and groups within the care organisation but also extends to include service users, their family members, and informal support networks such as neighbours and friends. This finding from the research is important as it establishes an understanding of safety culture in terms of key stakeholder involvement, particularly in the context of homecare. In contrast to acute care settings, in which safety culture mostly involves healthcare professionals (e.g., Halligan and Zecevic, 2011; Macrae, 2008), homecare safety culture highlights the importance of engaging not only care staff, but also service users, their families, neighbours, and friends.

From the findings, the study revealed the significant roles of family members and wider informal support networks in collaboration in care plan development, communication, and providing additional layers of support and reassurance. Documents and reports consistently highlight the crucial contribution of families, friends, and other members of the individual's circle of support in delivering care, with various models such as 'Shared Lives' and circles of support aiming to leverage these resources effectively. Insights from research participants further underscore the necessity of regularly consulting with families to keep care plans up-to-date and maintain open lines of communication. They also stress the significance of involving neighbours and community members to provide additional layers of support and reassurance, beyond formal caregiving services. Previous literature highlighted similar findings where families are fully engaged in the patient care journey (Haltbakk et al., 2019; Schaepe and Ewers, 2018; Vincent et al., 2017) as family carers can bring invaluable knowledge about the service users' values, resources, and needs (Lang et al., 2009). Nevertheless, it is often the case that friends and neighbours are not incorporated into safety culture in other care settings (Levine, 2011; Park and Giap, 2020). This study highlights the crucial role of a

broader support network in delivering care at home, involving neighbours and friends in the overall framework of patient safety culture in homecare.

That being said, the level of family engagement can vary depending on the service user's needs and circumstances. Some caregivers highlight instances where extensive involvement from family members, such as parents of disabled individuals, is essential for coordinating care effectively. Conversely, others note challenges in engaging with families due to strained relationships or unstable dynamics, particularly in cases involving mental health issues. Furthermore, caregivers point out challenges associated with integrating informal support networks into homecare. Examples include instances of emotional abuse from family members, difficulties in managing disorganised schedules, and perceptions of informal carers as lacking professional training. These issues have been extensively discussed in the literature, revealing that family members, often untrained, may not consistently adhere to care staff instructions for nursing and medical tasks, or may become fatigued from continuous caregiving, increasing the risk of errors (Lang et al., 2009; Schaepe and Ewers, 2018). In such cases, it is crucial for homecare providers to invest in specialised training and education for their care staff and include an open communication among caregivers, families, friends, and other dedicated individuals involved in providing care (Anker-Hansen et al., 2018). Building relationships with service users' families, and providing training and support for them, are important to ensure consistent communication between care professionals and families (Glomsås et al., 2022; Schaepe and Ewers, 2018; Tudor Car et al., 2017).

Therefore, this research confirms and extends the literature by highlighting the pivotal role of families and wider informal support networks in homecare safety culture, consistent with prior findings that emphasise the importance of family engagement in social care (Haltbakk et al., 2019; Schaepe and Ewers, 2018; Vincent et al., 2017). It contributes uniquely by addressing the often-overlooked roles of neighbours and community members, and by exploring challenges such as strained family dynamics and the integration of informal carers, highlighting the need for open communication, specialised training, and support to enhance collaboration and reduce risks in homecare delivery.

9.1.5. A Framework of High-Quality and Safe Homecare

In summary, this section has revealed and discussed several crucial components of safe and high-quality homecare provision, representing an ideal standard for homecare services. The table below illustrates these important aspects of safe and high-quality care in the homecare sector. These findings align with previous studies that identified common themes regarding what constitutes high quality and safe care in homecare settings.

Table 9.1 A framework of high-quality and safe homecare

The essence of homecare	**Key components for delivering high-quality and safe homecare**
- Provide support services (variety of activities, practical tasks) - Offer companionship and emotional support - Promote independence - Respect privacy and confidentiality - Ensure overall well-being - Safeguard from harm/ safety incidents	Well-developed and skilled staff
	Genuine passion for care from care staff
	Continuity of care
	Adequate information about service and choices
	Patient-centred approach
	Engagement of family and informal support networks

The framework summarises findings derived from the previous discussions on the core essence of homecare and its key components for delivering high-quality and safe homecare. Specifically, the essence of homecare reflects its foundational goals, such as providing practical support, companionship, and emotional well-being, promoting independence, respecting privacy, and safeguarding against harm. The key components are drawn from the prerequisites of effective service delivery identified throughout the analysis, including the need for skilled and passionate staff, continuity of care, and the provision of adequate information to ensure stability and user choice. Furthermore, person-centred care, which prioritises user involvement and bespoke communication, is essential to maintaining safety and dignity within homecare. Additionally, the engagement of families and informal support networks underscores the collaborative nature of high-quality care and the importance of incorporating wider support systems to promote safety and well-being.

In this framework, the essence of homecare should include providing support services that encompass a variety of activities and practical tasks, offering

companionship and emotional support, promoting independence, respecting privacy and confidentiality, ensuring overall well-being, and safeguarding from harm and safety incidents. These aspects are fundamental in creating a supportive and secure environment for individuals receiving homecare.

In addition, the framework suggests that to achieve and maintain high-quality and safe homecare, care providers must focus on several key components. These include developing high-quality and safe homecare include having well-developed and skilled staff, ensuring genuine passion for care from the care staff, maintaining continuity of care, providing adequate information about services and choices, adopting a patient-centred approach, and engaging family and informal support networks.

The framework contributes to, confirms, and extends existing literature on high-quality care and safety culture in homecare by integrating key themes such as skilled and passionate staff, patient-centredness, and stakeholder involvement. It confirms findings on the importance of staff competencies and engagement in addressing safety risks (Ekstedt et al., 2022; Silverglow et al., 2022), aligns with research emphasising the collaborative role of families in care delivery (Lang et al., 2009; Vincent et al., 2017), and reinforces the value of service user involvement in personalised care (Schildmeijer et al., 2018). Additionally, it extends the literature by addressing nuanced dynamics unique to homecare, such as balancing respect for service users' privacy with professional responsibility (Magnusson and Lützén, 1999), highlighting the critical role of informal networks in safety culture, and linking HRM practices to proactive risk management. The framework also advances discussions on continuity of care, strategic management, and ethical challenges, offering actionable insights for achieving high-quality, safe, and humanistic care provision.

The framework demonstrates an ideal standard for homecare services. However, practical implementation often encounters fundamental challenges that hinder the delivery of such care, leading to various safety incidents. The next section will discuss these safety issues in reference to previous studies on homecare safety issues. This discussion will provide context and highlight the urgency of these concerns, ensuring a clear understanding before addressing the fundamental challenges that prevent safe care and contribute to these incidents.

9.2. Safety Issues in Homecare

The findings have shown a number of safety issues in homecare, which were categorised into four main areas: medication safety, emotional and social safety, functional safety, and physical and health safety.

First, medication errors, particularly among the elderly or those with health issues, pose significant safety concerns due to improper administration or self-medication. The issues with medication management have been highlighted as a significant challenge in the homecare research (Berland and Bentsen, 2017; Masotti, McColl and Green, 2010; Schildmeijer et al., 2018). This study found instances such as a service user taking painkillers throughout the night, unsupervised, which was a cause for alarm due to the risk of overdose, medications being overprescribed or underprescribed, and errors like giving a 250mg tablet instead of a 500mg dose. Recording inaccuracies was also a concern, as medications were sometimes not logged correctly, leading to potential double dosing or missed doses. These findings align with previous research in homecare, which has identified a range of problems, such as administering incorrect medication or dosages, and missed doses, among others (Lang, Macdonald, et al., 2015).

Second, the research revealed various physical and health safety incidents in homecare, showing the challenges which caregivers face while ensuring safety for service users. The findings from the interviews align closely with the literature on physical safety concerns which encompass a broad spectrum of risks (Tong, Sims-Gould and Martin-Matthews, 2016; Schildmeijer et al., 2018). Self-harm and unexpected violence from service users are some of the few examples. One carer spoke about an incident where a service user was physically harming themselves by banging their head. Another described the difficulty of managing aggressive behaviour in dementia patients who might hit, scratch, spit, or scream during personal care. In addition, health and safety concerns related to COVID-19 were particularly significant. Research participants reported that they struggled to balance homecare support with infection risk. For instance, a carer noted that a diabetic client was reluctant to receive help in their home due to fear of contracting the virus. Another reported that family members refused agency caregivers due to concerns about bringing COVID-19 into the household. Additional safety challenges included preventing clients from handling knives, navigating stairs, or going outside in unsafe

conditions, and ensuring fire safety for a heavy smoker by maintaining functional fire alarms and empty ashtrays. These findings provide important insight into physical health safety concerns in homecare.

Furthermore, research participants reported frequent slips and falls among elderly or mobility-impaired individuals. A family member recounted a service user who repeatedly fell, each incident resulting in hospitalisation. A carer described a situation where a client insisted on bathing alone and slipped in the bathroom. This is a common finding in homecare sector, where falls are a significant concern, being the most frequent and serious physical incidents in homecare in England. Approximately one in three people over the age of 65 experience a fall that results in serious injury or even death annually (McGlade and Dening, 2020).

Third, emotional and social safety is another prominent safety issue in the research findings. Caregivers in homecare emphasised the importance of companionship and emotional support in ensuring the emotional and social safety of service users. This aligns with the homecare literature review that identifies emotional and social safety issues as a prominent safety category which comprises a broad range of concerns such as isolation, loneliness, and anxiety (Lang, Toon, et al., 2015). In the study, challenges related to emotional and social safety were reported, such as distress, anxiety, and mood changes, stemming from different factors. Moreover, instances of abuse and neglect, particularly among vulnerable groups such as older adults and people with disabilities, were also highlighted in the "Safe Care at Home Review" document (Home Office and Department of Health and Social Care, 2023).

Finally, functional safety, which is defined as the impact of service users' health conditions or care provision on their ability to carry out daily tasks, employment, or leisure activities (Lang, Toon, et al., 2015). Research participants revealed the challenges faced when dementia patients refuse to eat or drink, leading to concerns about proper nutrition and hydration. Despite efforts at prompting and encouragement, the refusal persists, reflecting the advanced stage of dementia and the difficulty in ensuring their safety. Additionally, the decline in cooking skills, transitioning from elaborate meals to simpler ones like heating up a quiche, illustrates an example of dementia progression and its impact on routine tasks. These findings corroborate previous studies which identify how a general deterioration in health status can

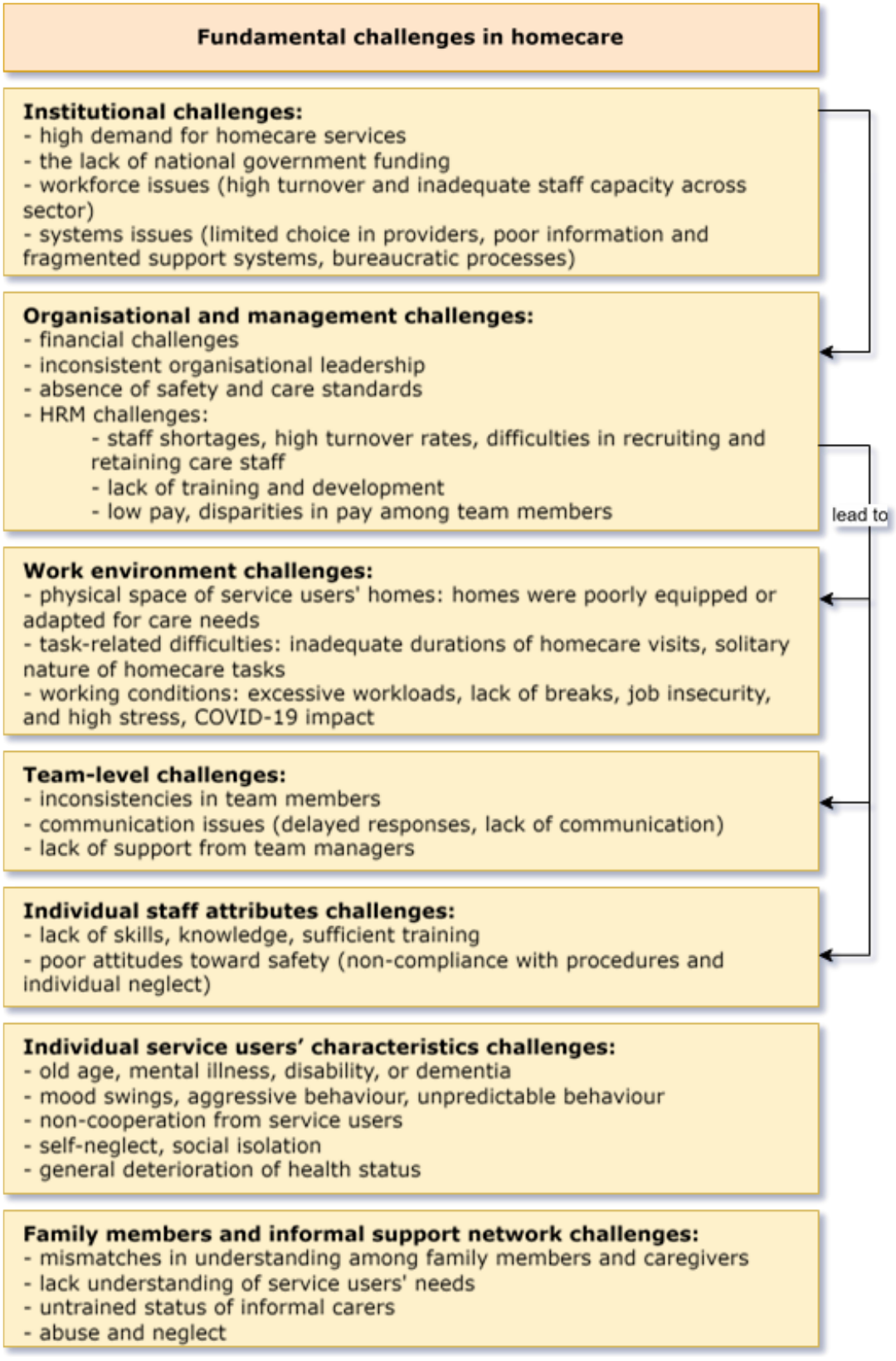
significantly impair service users' ability to manage routine tasks independently within their homes (Lang, Toon, et al., 2015; Strømme, Aase and Tjoflåt, 2020). This was discovered in research findings, as shown in cases of dementia. Furthermore, this research also found that external factors such as the COVID-19 pandemic exacerbated functional safety challenges, as restrictions limited individuals' engagement in health-promoting activities like exercise groups and social clubs. This type of safety issue could also impact their emotional and mental well-being.

The research findings align with the existing literature by highlighting key safety concerns in homecare, including medication errors, physical safety risks, emotional and social challenges, and functional safety impairments (e.g., Lang et al., 2015; Schildmeijer et al., 2018). Findings such as improper medication administration, risks of self-harm or aggression, frequent slips and falls, and the emotional toll of loneliness and anxiety mirror previously identified challenges in the homecare sector. The study extends the literature by providing detailed, context-specific insights from research participants, such as the impact of dementia on routine tasks, the role of caregivers during the COVID-19 pandemic, and the nuances of maintaining functional safety in unpredictable homecare environments. Additionally, this research contributes by shedding light on underexplored areas, such as the compounded effects of external factors like public health crises on both physical and emotional safety, and the interconnectedness of different safety dimensions. By incorporating the lived experiences of caregivers and service users, the study offers a deeper understanding of the challenges in creating a holistic safety culture, emphasising the need for tailored interventions, continuous training, and enhanced communication among all stakeholders.

9.3. Fundamental Challenges to Safe Homecare

In Chapter 7, the research presented various challenges that not only serve as barriers to high-quality care but also as risk factors leading to safety issues and potential harm to service users. This section discusses these difficulties in order to understand how they might hinder safe care at home. It also discusses their connection to safety incidents, aiming to provide an understanding of how such incidents might occur. The diagram below shows these challenges, followed by subsections that provide detailed discussions.

Figure 9.1 Fundamental Challenges in Homecare



9.3.1. Institutional Challenges

The homecare sector in England faces several institutional challenges and risk factors impacting the safety and well-being of service users. First of all, research findings corroborate the point that there has been a significant rise in demand for homecare services in England (CQC, 2019; Wittenberg, Hu and Hancock, 2018), driven by preferences to avoid residential care and hospitals' push to discharge patients quickly (CQC, 2022). The findings show that this demand strains resources, complicates homecare providers' ability to offer support, and makes accessing care difficult for those in need.

Secondly, the lack of national government funding is a prominent institutional challenge. This has led to reduced homecare services, inaccessibility to care, and disruptions in service continuity, thereby posing significant barriers to safe homecare. For example, the research findings highlight functional safety issues, such as when service users cannot access necessary care. In one instance, a council's cost-cutting measures led to a reduction in care for a service user with distorted spatial awareness who typically needs assistance with cooking and shopping. This institutional risk can significantly disrupt care provision and create challenges for homecare recipients in carrying out their daily tasks. These findings have echoed previous literature, which indicated that a lack of resources and funding is one of the main barriers to providing homecare services (Brant et al., 2019; Ganann et al., 2019; Y. Song et al., 2023). In England, inadequate funding has also been found to result in unstable market conditions, where a number of workforce issues such as low wages, high turnover rates, and inadequate staffing capacity are prevalent. Prior studies have also shown similar findings which demonstrated that underfunded homecare often leads to difficulties in staff retention and individuals' access to services, potentially resulting in adverse effects on the continuity and quality of care (Glendinning, 2012; Yeh et al., 2019). These difficulties also highlight another institutional challenge related to workforce issues across the sector.

Thirdly, major workforce issues in the homecare sector include high turnover and inadequate staff capacity. Findings have revealed that these workforce challenges in the homecare sector have adversely impacted continuity of care. High turnover within the homecare sector can disrupt care continuity and raise quality concerns, particularly with unreliable caregivers, potentially impacting

the emotional safety of service users. These findings align with the literature on challenges associated with personnel shortages, staff retention, and high turnover rates, which can impede continuity of care, reduce time spent with service users, and lower the overall quality of care (Brant et al., 2019; Ganann et al., 2019; Johannessen et al., 2020; Leverton et al., 2021b).

Fourthly, there are institutional challenges related to the homecare structure and systems, such as limited choice amongst providers, alongside the provision of inadequate information and fragmented support systems. These have created problems for individuals looking for homecare information and advice, thereby becoming a barrier to safe homecare. These findings are similar to previous research on the overall state of the homecare sector, which was found to be fragmented and varied in quality, posing challenges to the establishment of safety culture (Ganann et al., 2019; Glendinning, 2012). In particular, these types of institutional challenges can lead to individuals receiving inappropriate or insufficient support and conflicting advice, potentially affecting their overall well-being. Furthermore, complex bureaucratic processes and delays in care also hinder the efficiency of service delivery. This research found that prolonged wait times and administrative burden make it difficult for individuals to access care. These concerns present fundamental institutional challenges to the overall safety culture, as highlighted in the literature (Berland et al., 2012; Lang, Edwards and Fleiszer, 2007; McKenna, Hasson and Keeney, 2004).

9.3.2. Organisational and Management Challenges

Within the organisational and management context, the research identified several challenges. For example, lack of funding has created significant obstacles for homecare providers in sustaining their businesses due to financial constraints. These financial challenges and difficulties in accessing funded support indicate care accessibility issues, as they can disrupt the continuity of care (Macdonald et al., 2013). Moreover, the inconsistent organisational leadership and culture have been found to impact the quality and availability of homecare services. This might lead to additional organisational issues, including a lack of workforce support, lack of resources, and limited information sharing and learning. Previous research has demonstrated the importance of effective leadership and management in shaping the culture of safety within organisations (Backhouse and Ruston, 2022; Ree and Wiig, 2020). It is therefore crucial for homecare providers to establish strong leadership and

shape a cohesive safety culture to ensure high-quality and consistent care for service users.

In addition, challenges related to essential safety and care standards, such as conducting risk assessments, managing medication properly, and maintaining hygiene standards, also emerged within the organisational context. These results are consistent with the findings of other studies indicating that the absence of established safety routines and procedures within the homecare sector presents a significant challenge for homecare staff in effectively addressing various care scenarios, thereby impacting the overall safety culture (Berland et al., 2012; McKenna, Hasson and Keeney, 2004).

Perhaps, the most important finding within the organisational and management context of homecare is the fundamental challenges in HRM. HRM plays a pivotal role as it comprises a number of management aspects that help evaluate the safety culture through an organisational lens, which often revolves around enhancing the skills and knowledge of caregivers (Leverton et al., 2021b; Sutcliffe et al., 2021; Tudor Car et al., 2017), cultivating effective leadership and work engagement (Ree and Wiig, 2020), optimising teamwork and communication (Lang, Edwards and Fleiszer, 2007), recognising the challenges faced by care staff, and providing support. Challenges in HR practices were discovered in research findings related to staffing, training and development, and compensation. They are barriers to safe care and can result in different safety issues as they directly impact the quality, continuity, and reliability of care services (Berland and Bentsen, 2017; CQC, 2019; Lang, Edwards and Fleiszer, 2007; The King's Fund, 2018). The following paragraphs will discuss these difficulties.

First of all, research findings reveal that staffing issues, such as shortages and high turnover rates, pose significant challenges to delivering consistent and high-quality homecare services. These issues are linked to broader systemic problems, including insufficient funding and inadequate staffing capacity across the social care sector. Additionally, competition with other sectors offering better wages and conditions, especially in rural or high-employment areas, further hindered recruitment and retention efforts. This ongoing cycle of turnover and recruitment challenges impacts the overall stability and effectiveness of homecare services. During the pandemic, many care providers also experienced challenges in recruiting, retaining, and maintaining staff

morale (Moynihan et al., 2021; Nyashanu, Pfende and Ekpenyong, 2020; Peng et al., 2023). Data from this study showed similar findings of homecare providers struggling to retain and recruit care employees. A number of reasons for this issue include staff burn-out, fear of the virus, lack of support from care providers, and staff isolating with confirmed COVID-19 or with a suspected infection. Without a sufficient number of care workers, service users receive less care than normal because providers face challenges in maintaining continuity of care. Some service users also feel stressed and anxious when they keep receiving care from different people due to high staff turnover. These findings reflect the importance of HR practices in recruitment and retention to ensure safety and well-being of service users (Cooke and Bartram, 2015; Stuart et al., 2021; Yang and Lin, 2009).

Secondly, issues related to the lack of training and development were found to be significant challenges to safe care within the homecare sector. For example, care workers reported insufficient formal training and development opportunities, leaving them without the essential tools and resources to protect and support clients effectively. This gap increases the risk of harm, as frontline care workers may lack the necessary skills to handle challenging situations, such as managing escalating behaviour or providing proper care during crises like the COVID-19 pandemic. Instances were noted where inadequate training led to errors, such as unnecessary restraint or inappropriate handling of service users. In line with these findings, prior studies provided evidence of how lack of training and unskilled care staff can negatively impact the safety of service users (Gospel, 2015; McCann et al., 2015). Additionally, this lack of training might also indicate an organisational risk factor, if care staff are not adequately trained and supported by the homecare organisations (Johannessen et al., 2020; Leverton et al., 2021b).

During a time of crisis, such as the pandemic, training and knowledge related to COVID-19 and contagion control methods were essentials for the safety of staff and patients (Liu et al., 2020). Nevertheless, most participants reported there was a lack of training or knowledge related to COVID-19. The explanation that was given drew attention to the unprecedented nature of COVID-19 and the inconsistency of official national guidance in preventing transmission and protecting workers from the virus. Although previous studies have reported challenges in training delivery and skills gaps during COVID-19 (Kuijper et al., 2022; Leverton et al., 2023; Q. Song et al., 2023), training arrangements have

been highly focused and prioritised in hospital settings (Liu et al., 2020). Scholars even consider the COVID-19 pandemic as an opportunity for organisations to eventually upgrade their skills and competencies (Akkermans, Richardson, and Kraimer, 2020). However, in the homecare sector, lack of training is still a major HR challenge. Without proper training, homecare support staff might not know how to handle PPE requirements, or they might struggle in dealing with challenging circumstances, all of which could potentially cause harm to service users physically and mentally. COVID-19 has further exacerbated this HR challenge, adversely impacting the quality of care (Kuijper et al., 2022; Leverton et al., 2023; Peng et al., 2023). Consequently, it is imperative for homecare providers to develop relevant training strategies, ensuring their staff receive adequate knowledge and skills to perform their roles effectively and deliver high-quality care. It is also important to note that although some providers offered comprehensive initial training, opportunities for further career development were limited, highlighting the need for continuous professional growth to maintain high standards of care. Homecare providers should focus on long-term workforce planning, investing in skill development, and creating a stable, competent workforce that is not only aligned with evolving care needs but also equipped and resilient in responding to future crises (Kim, Vaiman and Sanders, 2022).

Finally, the research identified a number of challenges related to compensation, with low pay emerging as a significant issue. Caregivers expressed frustration over insufficient salaries, which they feel do not reflect the level of responsibility and effort required. Moreover, disparities in pay among team members can lead to feelings of unfairness, frustration, and financial insecurity. These compensation issues are closely linked to the broader institutional challenge of inadequate funding, resulting in lower wages for homecare workers. This, in turn, hinders the recruitment and retention of skilled caregivers, exacerbating staffing shortages and compromising the quality of care provided. These results are consistent with previous research on homecare work in England (Rubery et al., 2015).

9.3.3. Work Environment, Team, and Individual Challenges

Firstly, challenges within the homecare work environment include issues related to the physical space of service users' homes, task-related difficulties, and working conditions. For example, research participants reported instances

where many homes were inadequately equipped or adapted to accommodate care and support needs. These could lead to physical and health safety issues such as poor air quality and hazards like food being on the floor or drinks being spilled, increasing the risk of trips and falls. These findings are in line with previous studies that highlighted risk factors related to the conditions and designs of service users' homes (Tong, Sims-Gould and Martin-Matthews, 2016; Tudor Car et al., 2017).

Regarding task-related challenges, the study found that inadequate durations of homecare visits, often limited to 15-minute blocks, result in rushed and substandard care. This task-related challenge is prevalent in homecare services in England (Rubery et al., 2015) and might pose a risk factor to many safety incidents, especially medication errors, due to the inadequate time available for thorough and careful administration of medications. In the literature, task-specific challenges are evident in the absence of guidelines, protocols, and standard routines, such as those for incident reporting or the preparation and administration of medications (Berland and Bentsen, 2017). This research adds an important finding regarding the solitary nature of homecare tasks, where caregivers often work alone with service users. This situation can present significant difficulties, such as dealing with physical aggression and self-harm without the support of colleagues, thereby impacting the quality and safety of homecare services. Furthermore, the lack of oversight or supervision in solitary homecare work may lead to inadequate risk assessment and precautionary measures, increasing the likelihood of safety incidents during caregiving tasks. These findings are significant as they provide further insights into task-specific challenges in homecare, an area that has not been widely discussed and highlighted in previous literature.

Working conditions also pose significant challenges, with caregivers facing excessive workloads, lack of breaks, job insecurity, and high stress, particularly during the COVID-19 pandemic. This has led to burnout, low staff morale, and reduced levels of concentration among healthcare providers, impairing their ability to focus and perform tasks accurately (Tong, Sims-Gould and Martin-Matthews, 2016; Tudor Car et al., 2017). The pandemic also further complicated the already difficult working conditions in homecare. For example, it exacerbated functional safety issues by imposing restrictions that limit service users' participation in activities crucial to their well-being, such as exercise groups and social clubs. This reduction in engagement was found to

have profound effects on emotional and mental health, as revealed by caregivers.

Secondly, in a homecare setting, team-level challenges that can impact homecare quality and safety primarily stem from a lack of consistency in team members, communication issues, and lack of support from team managers. For example, constantly changing team members can cause distress and anxiety among service users who prefer familiar caregivers. Communication problems, such as delayed responses from supervisors and insufficient support from management, can hinder carers' ability to do their job effectively, which might impact the safety of the service user. During the time of the pandemic, many carers experienced a lack of responses from their managers. These challenges can compromise the emotional and social well-being of service users (Masotti, McColl and Green, 2010; Schildmeijer et al., 2018). Leadership communication has a strong influence on staff work performance (Aughterson et al., 2021; Mayo, Myers and Sutcliffe, 2021; Shipton et al., 2016) and lack of communication can be a major cause of stress and contribute to employee burnout (Bolino, Henry and Whitney, 2024), exacerbating working condition challenges. Indeed, COVID-19 has had a serious impact on healthcare professionals' health and well-being, as they are at high risk of stress, burnout, fear, and anxiety (Chaudhry et al., 2021; Rapp, Hughey and Kreiner, 2021; Nyashanu, Pfende and Ekpenyong, 2020). In this research, findings from the official reports have also shown that a feeling of burnout or stress can adversely impact the performance and commitment of staff to their jobs, which leads to service users receiving less care or poor-quality care. These findings are consistent with previous research of how communication issues and occupational stress during COVID-19 can negatively affect the performance of carers, potentially leading to poor quality care services (Kuijper et al., 2022; Peng et al., 2023).

Thirdly, in terms of individual challenges, several issues arise related to individual staff attributes, service users' characteristics, and the informal support networks of family members, friends, and neighbours. Regarding individual staff factors, safety culture in homecare is dependent on the care staff's knowledge and understanding of safety risks, and their proactive approach to deal with safety concerns, as well as the ability to communicate effectively and collaborate within interdisciplinary teams (Ekstedt et al., 2022; Silverglow et al., 2022). However, this study discovered that lack of skills,

knowledge and poor attitudes toward safety, such as non-compliance with procedures and individual neglect, can contribute to unsafe care environments. For example, research participants indicated that medication errors often stem from insufficient training, staff neglect, inattention, or poor safety attitudes. One staff member administered the wrong dose due to similar packaging, and carers sometimes skipped critical steps like the immediate recording of administered medications. These findings signify the risk factors associated with individual care staff attributes, particularly concerning inadequate experience, lack of knowledge, and insufficient skills among care staff (Masotti, McColl and Green, 2010; Schildmeijer et al., 2018). Previous studies highlighted that unskilled care workers, and inadequate education, and training of carers are all seen as barriers to patient safety (Berland et al., 2012; Masotti, McColl and Green, 2010). Homecare workers who lack sufficient training are often not able to carry out health-related tasks and provide safe and effective care (Leverton et al., 2021b). Hence, it is crucial for homecare providers to address training and development needs, as this not only helps tackle current challenges related to individual staff factors but also prepares healthcare workers for future crises, ensuring they are equipped with the necessary skills and knowledge to respond effectively to similar situations (Q. Song et al., 2023).

Concerning individual service users' characteristics, the research findings revealed numerous challenges related to age, mental illness, mental capacity, disability, or dementia that could lead to physical and safety issues. Examples included incidents where service users' mood swings or aggressive behaviour posed physical and emotional risks for both users and caregivers, particularly in cases of dementia. Therefore, challenges in providing safe care were evident, with instances of non-cooperation from clients and difficulties in addressing nutrition concerns due to dementia progression. The literature also highlights that providing person-centred care at home for individuals with dementia or intellectual and learning disabilities can be significantly challenging, as identifying specific needs and interpreting challenging behaviours is often difficult (Hedman, Sandman and Edvardsson, 2022; Ericson Lidman and Antonsson, 2022). The research findings are consistent with these previous studies. Communication barriers and unpredictable behaviour, such as a service user leaving without informing caregivers, further highlighted the complexities of ensuring safety and well-being for both service users and care workers in homecare settings. Furthermore, the study found that a service user's

characteristic behaviour might be one of the risk factors leading to medication safety incidents. For example, a service user, before his medication administration was managed by a care worker, repeatedly took his painkillers throughout the night, causing his family significant fear for his safety. These findings demonstrate service user-related risks, including self-neglect, social isolation, and general deterioration of health status, all of which can lead to physical and health concerns for homecare service users (McGraw, Drennan and Humphrey, 2008; Tudor Car et al., 2017).

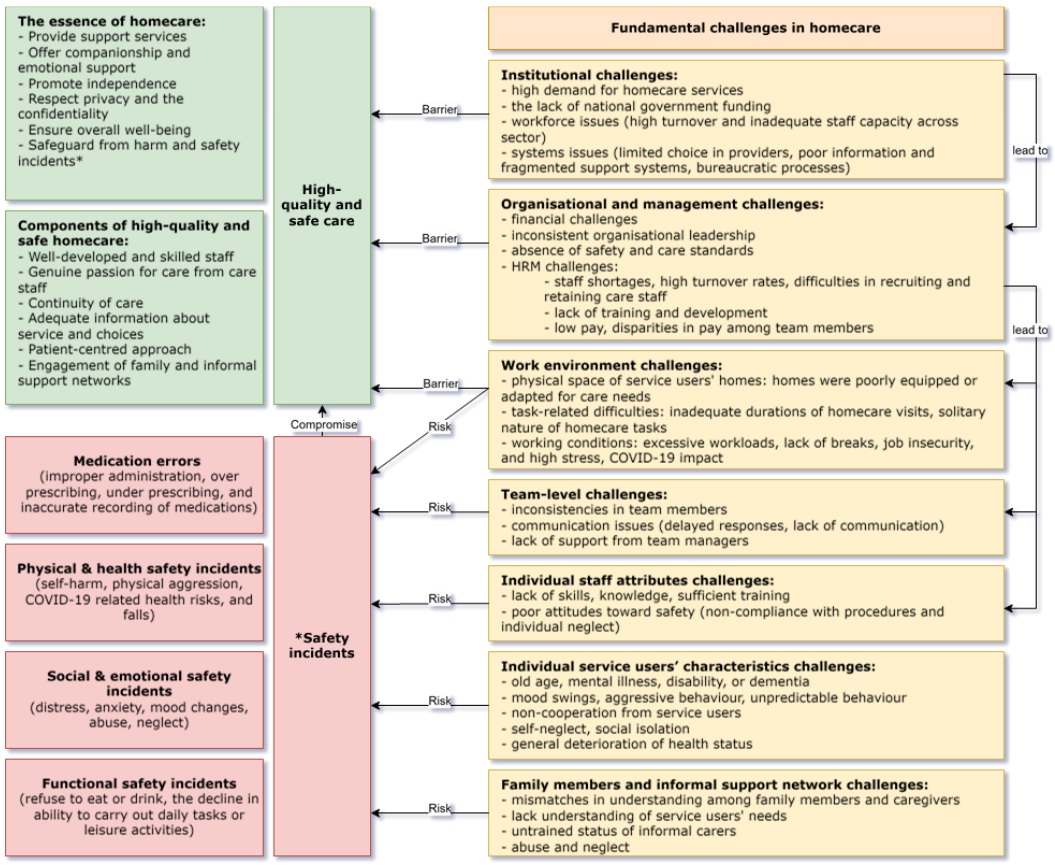
With respect to challenges in involving individual family members, friends and neighbours, a number of issues were identified including mismatches in understanding among family members and caregivers, lack of understanding of service users' needs, and the untrained status of informal carers, which can lead to unmet care standards. For example, the findings reveal that carers often face difficulties with service users' families, including issues such as lack of respect and scheduling disorganisation. Non-immediate family members may lack an understanding of service users' needs, leading to a relaxed approach and unintended errors. These findings align with previous research that highlights challenges when untrained family members do not consistently follow care staff instructions for nursing and medical tasks, and when continuous caregiving leads to fatigue, increasing the risk of errors (Lang et al., 2009; Schaepe and Ewers, 2018). Additionally, untrained family members may make mistakes due to their unfamiliarity with caregiving practices. Additionally, official documents and reports show serious concerns about abuse and neglect, such as exploitation or grooming, particularly among vulnerable groups like the elderly and disabled. These findings reflect the safety issue in terms of emotional and social challenges that arise from interactions between service users and their family members or homecare workers (Lang, Toon, et al., 2015; Tong, Sims-Gould and Martin-Matthews, 2016). Therefore, a consistent and compassionate level of care in homecare settings is much needed, advocating for a humanistic approach where emotional and social aspects are given as much attention as physical care (McCaffrey, 2019).

9.4. Fundamental Challenges: Barriers to High-Quality Care and Risk Factors for Safety Incidents in Homecare

There are various fundamental challenges that not only hinder the provision of high-quality care but also act as risk factors, potentially causing safety issues

and harm to service users. Previous sections discuss these difficulties and make links to high-quality care and safety incidents. Figure 9.2 below depicts that multiple fundamental challenges are interconnected and act as barriers to high-quality care and risk factors for safety incidents in homecare. It highlights how these challenges, classified into institutional, organisational and management, work environment, team-level, individual staff attributes, individual service users' characteristics, and family members' and informal support network challenges, can pose as barriers to high-quality care and lead to safety incidents. These safety issues are categorised as medication errors, physical and health safety incidents, social and emotional safety incidents, and functional safety incidents.

Figure 9.2 Interconnected Fundamental Challenges: Barriers to High-Quality Care and Risk Factors for Safety Incidents in Homecare



The framework is built from the discussions on high-quality and safe care, safety incidents, and the fundamental challenges in homecare in the previous sections. This framework helps identify the components of high-quality and safe care, recognises the challenges that impede high-quality care, and highlights the safety incidents and risk factors associated with homecare. All of

these aspects are important for identifying safety issues, understanding their origins, and proposing measures to minimise errors and risks, which is in line with the Safety-1 approach (Smith and Plunkett, 2019). The figure also provides a comprehensive overview of areas where interventions are needed. Addressing the fundamental challenges can help to ensure high-quality and safe care at home, as well as minimising the risk of preventable safety incidents.

From the literature review, mitigation strategies in homecare often fall into the following key categories: organisational system change (e.g., making adjustments, changes, and adaptations to provide safe care), education and knowledge sharing (e.g., providing adequate training for care staff, using assistive technology), stakeholder engagement (e.g., family involvement, patient-centred care), effective management and leadership (e.g., support for staff, communication, reviewing and screening hazardous behaviours and environments), and in some cases, harsh interventions (e.g., restraint use, psychotropic medication) (Backhouse et al., 2022; Harrison et al., 2013; Lang et al., 2009; Tudor Car et al., 2017).

These mitigation measures, however, are often developed within organisational and management contexts, work environment, team dynamics, and individual staff attributes, while overlooking other fundamental challenges within institutional contexts and broader issues arising from family members and informal support networks. Therefore, the above framework of fundamental challenges in homecare offers a comprehensive approach to address these broader issues, aiming to create a more resilient and effective homecare system that ensures high-quality and safe care for service users. It contributes to, confirms, and extends existing literature by identifying interconnected challenges and risk factors for safety incidents in homecare, thereby providing a comprehensive model for improving care quality and safety. It confirms findings from existing literature on common safety issues such as medication errors (Berland and Bentsen, 2017; Masotti, McColl and Green, 2010), physical and health safety incidents (Tong, Sims-Gould and Martin-Matthews, 2016), and emotional and social safety concerns (Lang, Toon, et al., 2015).

The framework also aligns with the emphasis on institutional and workforce challenges, including high turnover rates, low pay, inadequate funding, and training deficits, which are consistently highlighted as barriers to safe care

(Ganann et al., 2019; Leverton et al., 2021b). Additionally, it extends the literature by integrating insights into team-level challenges, individual attributes, and family or informal support networks, which have been underexplored. By highlighting these interconnected factors, the framework advances the discourse on safety culture, stressing the importance of addressing systemic, organisational, environmental, and relational dynamics to prevent safety incidents and ensure high-quality homecare.

Chapter summary

This chapter has provided a discussion on the elements that constitute high-quality and safe homecare, safety incidents, and the fundamental challenges that pose significant barriers to safety as well as risk factors leading to safety incidents. The discussion has answered the thesis' first three research questions.

There are a number of crucial components of safe and high-quality homecare provision, representing the ideal standard for homecare services. The expected nature of homecare includes providing support services, offering companionship, promoting service users' independence, respecting their privacy, and ensuring their overall well-being and safeguarding them from harm. To deliver high-quality, safe care, several components are necessary. These include well-developed and skilled staff, a genuine passion for care among staff, continuity of care, adequate information about services and choices, a patient-centred approach, and engagement of family and informal support networks. All of these dimensions should be incorporated into improvement activities and daily practice in the provision of homecare services.

Nevertheless, practical delivery of homecare services often encounters fundamental challenges that hinder the delivery of high-quality care, leading to various safety concerns. These issues are often categorised into medication errors, physical and health safety incidents, social and emotional safety incidents, and functional safety incidents. Meanwhile, multiple fundamental challenges are classified into institutional, organisational and management, work environment, team-level, individual staff attributes, individual service users' characteristics, and family members' and informal support network challenges.

The chapter has developed a framework which depicts how these fundamental challenges are interconnected and act as barriers to high-quality care and risk factors for safety incidents in homecare. This is helpful for identifying safety issues, understanding their origins, and proposing measures to minimise errors and risks, which is in line with the Safety-1 approach. Addressing these fundamental challenges can help to ensure high-quality and safe care at home, as well as minimising the risk of preventable safety incidents.

From the literature review, mitigation strategies in homecare are often developed within organisational and management contexts, work environment, team dynamics, and individual staff attributes, while overlooking other fundamental challenges within institutional contexts and broader issues arising from family members and informal support networks. Therefore, the framework of fundamental challenges in homecare offers a comprehensive approach to address these broader issues, aiming to create a more resilient and effective homecare system that ensures high-quality and safe care for service users.

The underpinning approach of the framework is Safety-1, which is useful for identifying safety issues, understanding the fundamental challenges, and proposing measures to minimise errors and risks. However, the health and social care sector is experiencing a shift from this traditional perspective to Safety-2, which emphasises understanding the routine processes and practices that lead to successful outcomes. Safety-2 encourages care organisations to examine, reinforce, and replicate the conditions that lead to successful patient care, thereby enhancing organisational resilience and adaptability in changing scenarios, ensuring consistent safety culture (Hollnagel, 2014). This research has argued that homecare safety culture should be attained by combining both Safety-1 and Safety-2 perspectives, examining both successes and failures and drawing lessons from effective practices as much as from shortcomings. The next chapter of this study will discuss the findings of initiatives and practices that can lead to successful outcomes in homecare, specifically in terms of high-quality and safe care.

Chapter 10.

Discussion: Initiatives and Practices for Enhancing Safety

10. Discussion: Initiatives and Practices for Enhancing Safety

Chapter Overview

In homecare, several efforts by organisations and individuals have been made to improve care quality and ensure a safety culture in the sector. This chapter discusses various initiatives and practices implemented to enhance safety in homecare, potentially addressing the challenges identified in the previous chapter. These discussions will answer the remaining objectives of the thesis, which are to examine the practices that support improvement in quality and safety of homecare in England, and to explore the potential for HRM practices to enhance these aspects of homecare in England.

The first section of this chapter discusses several innovative practices in homecare, including collaboration, person-centred care, leadership, and digital technology adoption. The second section examines the role of HRM practices in providing high-quality, safe care, focusing on various HRM strategies such as workforce planning, innovative recruitment and retention, flexible working arrangements, fair compensation, and comprehensive training and development. These strategies can improve organisational performance in terms of high-quality and safe care, supporting the conceptual framework of HRM practices and organisational outcomes. In the third section, the role of HRM practices in the unique context of the COVID-19 pandemic is discussed. Finally, the fourth section examines these findings with reference to two key safety approaches that can be incorporated to develop a comprehensive safety framework tailored specifically to the homecare sector.

10.1. Innovative Practices in Homecare: Collaboration, Person-centred care, Leadership, and Digital Technology Adoption

First of all, the research findings reveal that collaboration and partnerships among care providers within the health and social care sector show great benefits. These include improving service user outcomes, breaking down system barriers, building trust, and ensuring efficient resource use. These results are consistent with those of other studies and suggest that increased collaboration and partnerships improve service quality and safeguard users (Sammer et al., 2010, Macrae, 2022). Therefore, this research has highlighted the need for a more integrated, collaborative, and information-sharing

approach, particularly in homecare. The aims of this approach are also to create a valued workforce that collaborates effectively with care recipients and other organisations while increasing cross-government and multi-agency cooperation to provide safe and personalised care. In the past decade, several emerging organisations have introduced innovative models of homecare services that encompass an integrated care approach (Bennet, Honeyman and Bottery, 2018; Zimpel-Leal, 2021). This can help tackle issues such as unregulated and uncontrolled settings, and lack of collaboration and communication among care providers, which have contributed to the fragmentation of the homecare market (Lang, Edwards and Fleiszer, 2007). Research findings corroborate this point, as it found that integrated care systems can address fragmented support systems and bureaucratic complexities, facilitating efficient service delivery, improving overall care quality, and mitigating safety concerns like inaccessibility and continuity disruptions. Collaboration and partnership are also crucial for reviewing and assessing care quality in homecare. For example, in England, the local authorities are collaborating with the CQC to address substandard care, evaluate homecare services, and assess the financial performance of homecare providers. This collaboration also offers guidance and assistance when substantial concerns arise, aiming proactively to prevent large failures of care, both financially and in terms of care service quality (CQC, 2023).

Second, the provision of inclusive and personalised care services is a critical effort to ensure safe and high-quality care. This involves offering equitable access to information, which helps service users make informed decisions and receive timely support, while caregivers are better prepared for their roles. Additionally, the provision of personalised care services requires tailoring care services to meet users' needs and preferences and is crucial for the diverse and unique requirements of service users, ensuring that everyone, regardless of background or circumstances, receives respectful, responsive, and effective care. This focus on personalised care aligns with the emphasis on person-centred care, highlighting the importance of respecting individual preferences, autonomy, and tailored support, with effective communication being crucial. This approach is supported by the (Department of Health & Social Care, 2021), which positions person-centred healthcare as a strategic focus in health and social care policy. Previous research has also shown that person-centred care is essential for ensuring safety in homecare as it allows homecare providers and carers to gain a deeper understanding of service users' perspectives,

needs, and available resources, facilitating the delivery of individually designed care (Anker-Hansen et al., 2018; Lang et al., 2009; Leverton et al., 2021a; Talabani et al., 2020; Turjamaa et al., 2014).

Third, strong leadership and effective support initiatives are important for a safety culture in homecare. Previous research on leadership and healthcare quality in the UK has emphasised the role of care managers and leaders to facilitate knowledge management, and social connections cultivation, ensuring high-quality patient care (Burgess et al., 2015). This study found that strong leadership can help navigate difficulties, ensuring that the systems remain resilient and capable of meeting demands, meanwhile, initiatives such as in-reach services and well-being appraisals, which provide direct support to staff and promote staff mental and physical health, can enhance caregiver preparedness and well-being. These measures address fundamental challenges within the organisational and management context, as well as at the team level. Effective leadership and management, therefore, can help shape the culture of safety within homecare organisations (Backhouse and Ruston, 2022; Harrison et al., 2013; Lang et al., 2009; Tudor Car et al., 2017). The findings of this study show similar results, revealing that effective leadership ensures the availability of skilled homecare staff, addressing human resource challenges like staffing issues and training inadequacies. Moreover, support networks for care staff are vital, providing reliable assistance and advice, which is crucial for their well-being and effectiveness. The importance of recognition and appreciation was also highlighted in the research findings, as these can improve job satisfaction and employee retention. Hence, leaders and managers play a crucial role in providing support and maintaining strong communication for care staff, which can significantly improve their work performance (Aughterson et al., 2021; Mayo, Myers and Sutcliffe, 2021; Shipton et al., 2016). It is therefore crucial for homecare providers to establish strong leadership and shape a cohesive safety culture to ensure high-quality and consistent care for service users (Macrae, 2022; Sammer et al., 2010; Ree and Wiig, 2020).

Fourth, the integration of digital technology in homecare services is an emerging practice for a safe care culture, with findings showing its transformative impact on care services. In recent years, emerging models of homecare have incorporated technology to enhance care delivery (Bennet, Honeyman and Bottery, 2018; Zimpel-Leal, 2021). In this study, findings have highlighted the transformative impact of digital tools in identifying risks,

preventing incidents, and ensuring timely responses to safety issues. The digitalisation of care records and the provision of digital tools also contribute to more efficient and person-centred care delivery. Moreover, digital technology addresses fundamental challenges in safe care by enhancing work environments, improving staff retention, and fostering stronger communication and coordination among care providers. These findings support the integration of technology applications in homecare from previous studies, which highlight its potential for enhancing care quality and ensuring patient safety (Ganann et al., 2019; Hamblin, Burns and Goodlad, 2023; Lindberg et al., 2013). During the COVID-19 pandemic, digital technology became crucial for homecare providers to manage their staff. Nevertheless, certain challenges in implementing the technology were found to be related to communication and additional workload (Hamblin, Burns and Goodlad, 2023). These findings are discussed in detail within the context of the COVID-19 pandemic.

10.2. The Role of HRM in Providing High-quality, Safe Homecare

Extensive HRM research has consistently shown a strong link between effective HR practices and beneficial outcomes for both employees and the organisation's performance (McDermott et al., 2013; Sanders, Guest and Rodrigues, 2021). In healthcare settings, substantial evidence supports using HRM practices in hospitals to improve performance outcomes, prevent adverse events, enhance care quality, and improve patient safety (Aiken et al., 2012; Armstrong, Laschinger and Wong, 2009; Burgess et al., 2015; Cooke and Bartram, 2015; Kelly, McHugh and Aiken, 2012; Khatri, Gupta and Varma, 2017; King et al., 2011; Shantz, Alfes and Arevshatian, 2016; Townsend, Lawrence and Wilkinson, 2013; West et al., 2002; Yang and Lin, 2009). While a significant amount of research has demonstrated common findings that HRM is one of the crucial determinants to achieve successful healthcare quality programs, they have tended to focus on acute hospitals, whereas other care settings such as domiciliary care or homecare have been overlooked (Berland and Bentsen, 2017). Therefore, this thesis aims to explore HRM practices and their roles in improving safe care and high-quality care in homecare in England, addressing the gaps in the literature.

In homecare, the study found that several HRM processes, practices, and strategies can contribute to a safe and high-quality care service. Homecare providers and professionals have adopted different practices and initiatives

related to HRM to address fundamental challenges, including strengthening workforce planning, staffing, flexible working practices, training and development, and compensation. These results are significant and consistent with findings from previous research on HRM practices and its important role in ensuring high-quality care and improving patient safety in homecare in England (Berland and Bentsen, 2017; Berland et al., 2012; Ree and Wiig, 2020; Tudor Car et al., 2017).

For example, the research found that strengthening workforce planning is important for addressing staff shortages. This involves reviewing workforce demands, understanding care needs, and implementing effective communication strategies to ensure continuity and accessibility of care. Moreover, innovative recruitment and retention approaches can help tackle turnover challenges. Prior research on HRM and organisational performance in hospitals show similar implications, which indicate that strategic HR planning, recruitment, and retention are positively linked with the continuity of quality patient care (Townsend, Lawrence and Wilkinson, 2013). The research findings regarding workforce planning, recruitment and retention have provided additional insights into the literature, specifically within the homecare sector.

The study also discovered that flexible working arrangements, such as adjustments to working hours, are key issues being addressed to improve the working conditions and well-being of care staff. These approaches can help address work-life balance and motivate carers, thereby tackling challenges in working conditions and retaining staff. In addition, research findings reveal that fair compensation, incentives, and job security can address the challenges of staff shortages and retention, ensuring a sustainable supply of care staff. Previous research on Magnet hospitals has revealed similar findings which demonstrate that improving work environment and staff recognition through HRM practices can result in better outcomes for patients, nurses, and organisations (Armstrong, Laschinger and Wong, 2009; Kelly, McHugh and Aiken, 2012; Kutney-Lee et al., 2015; Lacey et al., 2007). Indeed, working conditions have been a key focus in the safety culture in acute care organisations, as highlighted in numerous evaluation tools assessing patient safety culture (Famolaro et al., 2016; Relihan et al., 2009). Other prior studies within hospital settings also indicate that effective HR practices in work environments, appraisal, and compensation can attract and retain skilled employees, thereby improving organisational performance (Aiken et al., 2012;

West et al., 2002; Yang and Lin, 2009). Similarly, in homecare, recommendations on improving working conditions of professional caregivers have been noted (Tudor Car et al., 2017). This research's findings on flexible working arrangements, compensation, incentives, and job security have further contributed to the literature on HRM practices and homecare safety.

Furthermore, workforce development, training, and skills enhancement are essential to safe and high-quality care. Prior studies within hospital settings have revealed similar results, indicating a positive link between training, development, as well as work engagement practices and quality of care (Lacey et al., 2007; Shantz, Alfes and Arevshatian, 2016; Townsend, Lawrence and Wilkinson, 2013; West et al., 2002; Yang and Lin, 2009). In homecare, research findings revealed several initiatives and strategies which can equip care workers with the skills, knowledge, and opportunities needed to deliver high-quality care. These include creating better career pathways beyond the support worker role, such as implementing a nursing associate role to bridge the gap between carers and nurses. Other initiatives involve developing tools and frameworks essential for workforce development, such as a skills passport for verifying staff skills, a universal knowledge and skills framework, and career structure in collaboration with the adult social care sector. These findings are significant and have the potential to address various challenges related to human resources management, individual staff factors, and the overall quality of homecare. It is therefore critical for homecare providers to invest in training and education for their care staff (Anker-Hansen et al., 2018; Backhouse et al., 2022).

This section has highlighted the importance of strategic HRM practices (workforce planning, innovative recruitment and retention, flexible working arrangements, fair compensation, job security, and robust training programmes) in addressing some of the challenges in homecare and improving care quality and safety. This discussion is critical for care providers to invest in these HRM areas to overcome challenges and enhance overall care. These findings also contribute to the literature discussion on the link between effective HRM practices and beneficial outcomes for both employees and an organisation's performance (McDermott et al., 2013; Sanders, Guest and Rodrigues, 2021), particularly in the context of homecare in England. Certain combinations of HRM practices, when tailored and adapted to homecare organisational contexts, can lead to improvements in high-quality and safe

care, which is an important indicator of organisational performance in healthcare settings (Katz-Navon, Naveh and Stern, 2005; Mayo, Myers and Sutcliffe, 2021).

This discussion also supports the important conceptual framework of HRM practices and outcomes. For instance, the findings reveal that involving the development of HRM practices in areas like recruitment, selection, and training can help organisations hire top employees and equip them with the necessary skills for improved organisational outcomes (Kinnie and Swart, 2017). Furthermore, the findings align with the best practice approach, as they show that incorporating different bundles of HRM practices that are aimed at improving employees' abilities, motivations, and opportunities to make positive contributions to organisational performance (Appelbaum et al., 2000; Armstrong, 2021), as evidenced by improvements in high-quality and safe care services.

In terms of abilities, the findings of this research have shown that ensuring care staff receive training and professional development opportunities can enhance their abilities and enable them to deliver high-quality care safely. For example, collaboration and partnerships within health and social care can contribute to developing employees' abilities by fostering knowledge sharing, skill enhancement, and mutual learning. Initiatives such as rotating employees among care organisations not only address capacity issues but also provide opportunities for staff to upskill and gain a broader understanding of the health and social care system. Integrated care systems also create structured pathways for workforce development, ensuring that staff can navigate complex care environments while receiving targeted training to meet the unique demands of personalised and inclusive care services. These findings align with the AMO framework's emphasis on ability-enhancing HRM practices, such as training and development, by equipping employees with the skills and knowledge necessary for effective performance (Bos-Nehles et al., 2023; Kellner, Cafferkey, and Townsend, 2019). They also extend the literature by highlighting the critical role of collaborative and integrated care approaches in operationalising ability-enhancing HRM practices, offering practical pathways to address workforce development in complex and dynamic care environments.

Regarding motivation, workplace practices that motivate staff, such as fair compensation and recognition, can contribute to reducing job stress and

improving job satisfaction, both of which are critical for maintaining safety in care settings (Pariona-Cabrera et al., 2024; Kellner, Cafferkey, and Townsend, 2019). For examples, motivation-enhancing HRM practices such as flexible working arrangements, fair compensation, and job security can address critical challenges such as work-life balance and staff retention, ultimately influencing care quality and patient safety. This study has also revealed that providing access to comprehensive information can enable service users and caregivers to make informed decisions, improving satisfaction and commitment to their roles. For caregivers, recognition, incentives, and appreciation for their contributions (such as highlighting achievements and fostering career progression) act as motivators, increasing morale and job satisfaction. These motivational factors also align with the AMO framework's focus on intrinsic and extrinsic drivers that energise and sustain employees' commitment to delivering high-quality, person-centred care (Bos-Nehles et al., 2023; Kellner, Cafferkey, and Townsend, 2019). This research also adds to the literature by showing how ability-enhancing HRM practices within integrated care systems address workforce capacity and advance personalised inclusive care.

In respect of opportunities, the findings highlight the importance of creating opportunities for employees through organisational practices that enhance collaboration and integration. Integrated care systems, for instance, provide a seamless and supportive environment that enables healthcare workers to engage effectively with other organisations, reducing bureaucratic complexities and fostering innovation. Digital technology integration further exemplifies opportunity-enhancing HRM practices by streamlining communication, improving coordination, and providing tools that allow staff to perform their roles more effectively. Such systems empower employees to access resources, contribute meaningfully to decision-making, and adapt to evolving care delivery models, thereby strengthening their capacity to deliver outstanding care (Bos-Nehles et al., 2023; Kellner, Cafferkey, and Townsend, 2019). These findings extend the literature by demonstrating how opportunity-enhancing HRM practices, particularly through integrated care systems and digital technology, can address organisational barriers, promote cross-organisational collaboration, and drive innovation in complex and dynamic environments like healthcare.

Aligning HRM practices with the AMO framework can help organisations address workforce challenges and ensure high-quality, safe care delivery. To fully

leverage the AMO framework, it is essential to balance best practices with context-specific strategies that cater to the unique needs of diverse organisational settings. The best-practice approach attempts to recognise a distinctive set of effective HRM practices that can be applied to all organisations, regardless of their context. However, it potentially overlooks the unique contexts and specific needs of different organisations or sectors, which might require tailored HRM strategies rather than standardised best practices (Beardwell, 2017). Recognising these specific nuances is also crucial for effectively implementing HRM practices to improve care quality. Therefore, the next section discusses the role of HRM practices in providing high-quality, safe care in the unique context of the COVID-19 pandemic. It aims to examine how homecare providers had to changed and adapt their HRM practices to respond to challenges brought about by the crisis.

10.3. The Role of HRM Practices in Providing High-Quality, Safe Homecare: The Case of COVID-19

This research was undertaken during the time of the COVID-19 pandemic, therefore, the findings provided rich and insightful qualitative data regarding quality of care, safe care, and different HRM challenges during this time of crisis. The previous chapter has incorporated these findings to discuss and demonstrate a number of safety issues during COVID-19 and how HRM challenges which emerged from the pandemic impacted homecare patient safety in England. Homecare providers were under pressure to respond to these critical challenges and had to employ different emerging HRM practices and strategies to mitigate the issues. This section examined how homecare organisations modified their HRM strategies to ensure the safety of patients amidst the challenges posed by the pandemic.

First of all, care staff shortages and high turnover were found as the main staffing challenges during the crisis. These issues negatively impacted the quality and safety of homecare patients, leading to difficulties in maintaining continuity of care and increased staff turnover in the care workforce. Responding to staff shortages and high turnover, homecare providers adopted ad hoc opportunistic recruitment and selection (e.g., online interviews, fewer reference checks, fewer shadowing shifts for new employees), mass recruitment, hiring temporary agency carers, and redirecting staff from other areas. Previous studies have shown that other organisations, including

healthcare providers, had similar approaches (Akkermans, Richardson, and Kraimer, 2020; Bolino, Henry, and Whitney, 2024; Mazurenko et al., 2022; Q. Song et al., 2023; Schuurmans et al., 2023). However, these measures have also created new challenges to HR managers in terms of dealing with inexperienced non-standard care staff (Tekeli-Yesil and Kiran, 2020) and ensuring there are no potential risks and ethical concerns to those who are relocated to work during COVID-19 (Dunn et al., 2020). In this research, two transition practitioners described their frustration at the way their managers required them to deliver care in people's homes, which was not part of their duties before the pandemic. Although task allocation can be a quick solution to capacity problems, it can raise conflicts and cause distress for care workers (Schuurmans et al., 2023). Previous research has also discovered the negative feelings of health professionals who were reallocated to COVID-19 units at hospitals (Danielis et al., 2021).

Second, given the extreme pressures of the pandemic, homecare organisations adopted a highly ad hoc approach to HRM to address rapidly growing problems. Communication was notably disrupted, with many carers effectively struggling to reach their managers. Issues included slow email replies, unreturned phone calls, and a reduction in one-to-one meetings. The findings have shown homecare providers had to find new ways to improve communication and manage their performance. However, there was a lack of well-being support from homecare team leaders for their staff, whereas in hospital settings, there has been evidence of how effective leadership and communication can improve performance of health professionals during the time of COVID-19 (Liu et al., 2020). These findings also call for a well-being-oriented HRM that prioritises the overall well-being of employees, going beyond traditional HRM practices that primarily focus on enhancing employee performance and organisational outcomes (Guest, 2017). To maintain communication and managing staff performance during the pandemic, homecare organisations' approaches have included using digital technologies to organise meetings online, enabling remote working for admin staff, and allowing flexible working arrangements such as online handovers or late-night video calls for night shift care workers. These adaptation measures corroborate findings from previous research on organisations adopting digital tools and remote working to maintain communication with their staff (Akkermans, Richardson and Kraimer, 2020; Mazurenko et al., 2022; Q. Song et al., 2023). These findings also support the contemporary approach to HRM, which highlights the use of digital online

platforms and management systems (Snell et al., 2023). Nevertheless, even with digital tools, some respondents in this study still expressed their struggles in communicating with their managers. This finding is in accordance with Aughterson et al.'s (2021) research showing difficulties in communication among healthcare workers during the pandemic despite the implementation of digital technology. Interestingly, this study also found an opposite result of some other participants describing their feeling of pressure while being constantly expected to answer calls or emails. This emerging issue was similarly discussed in prior research on technostress and digital exhaustion (Adisa et al., 2022; Aleksić, Černe and Batistič, 2024).

Third, lack of training provided by care providers during the COVID-19 pandemic was found to be significant. Previous discussion in chapter 9 has suggested that inadequate training can hinder staff in handling challenging situations, which could potentially lead to errors and harm. The only adaptation approach which all homecare providers in this study took was to use online training tools such as videos, newsletters, and virtual training courses. Nonetheless, some care workers expressed the opinion that such methods of passive online training were not very engaging. This research also found very little evidence of homecare managers providing training on the use of digital tools. Prior research has suggested that the effective use of technology requires staff training and education to increase competency, mitigate technological errors, and maximise the benefits (Ganann et al., 2019). Therefore, homecare providers should not overlook this training need on the utilisation of technology for staff to facilitate their work and communication (Q. Song et al., 2023). In addition, although using digital technology is a popular measure among organisations during the time of the pandemic (Akkermans, Richardson and Kraimer, 2020; Mazurenko et al., 2022), this study has shown that homecare organisations still faced major HRM challenges related to identifying the needs for technological training, the development of a training program, and the utilisation of proper training methods. Therefore, homecare managers need to explore innovative training methods and programmes, ensuring that staff members are equipped with all the essential knowledge to prepare effectively for future crises.

To sum up, this section has discussed the findings of how homecare organisations have responded to the difficulties during the pandemic through huge individual and collective efforts, from increasing care staff capacity by

adopting ad hoc opportunistic recruitment and selection, and redirecting staff from other areas, to embracing digital technologies and allowing flexible working arrangements. Nevertheless, some of the HRM issues including staff shortages and training gaps persist without definite solutions, and COVID-19 even brought further challenges in how to deal with non-standard employment, redirect and reallocate staff appropriately, and maintain effective communication while making sure there is no technostress or digital exhaustion among staff. Therefore, homecare organisations in England are still facing many major HRM challenges, and at the same time have to ensure to protect the well-being of both carers and service users.

10.4. Homecare Safety Framework

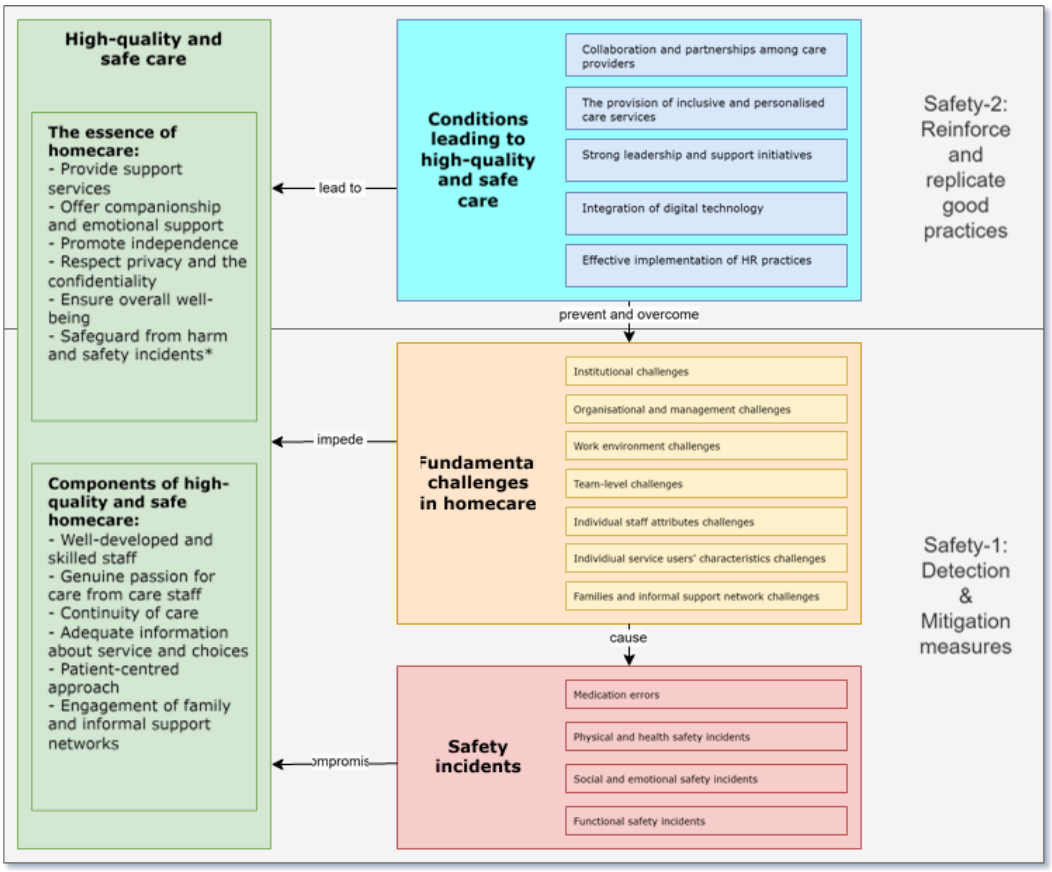
This chapter has discussed interesting findings regarding initiatives and practices that could help contribute to high-quality and safe homecare. These include collaboration and partnerships among care providers, provision of an inclusive and personalised care service, strong leadership and staff support, integration of digital technology, and the effective implementation of HRM practices. These conditions were found to have significant benefits that can help address fundamental challenges in homecare and strengthen the safe care system. This is in line with the Safety-2 approach, which underscores the importance of understanding the processes and practices that lead to successful care outcomes (Smith and Plunkett, 2019). In this approach, care providers are encouraged to examine, reinforce, and replicate the conditions that lead to positive care, thereby enhancing organisational resilience and adaptability in changing scenarios, and thus ensuring consistent safety culture (Hollnagel, 2014). The management of HRM practices in responding to the COVID-19 pandemic challenges serves as a prominent example. The discussion on the role of HRM practices in ensuring safe homecare during the pandemic has shown that homecare providers had to adapt their strategies to address the extreme pressures and unforeseen circumstances brought about by COVID-19. These adaptive measures demonstrated the critical role of HRM in maintaining high-quality care, ensuring safety, and fostering organisational resilience in the face of unprecedented challenges.

Table 10.1 Conditions leading to high-quality and safe care

Collaboration and partnerships among care providers	The provision of inclusive and personalised care services	Strong leadership and support initiatives	Integration of digital technology	Effective implementation of HR practices
- Integrated care systems - Integrated, collaborative, and information-sharing model	- Equitable access to information - Tailoring care services - Person-centred care	- Strong leadership and effective support - Wellbeing appraisals - Staff recognition and appreciation	- Digitalisation of care records - Digital tools for communication - Integration of technology applications in homecare	- Strengthening workforce planning - Adaptive recruitment strategies - Flexible working arrangements - Workforce development, training, and skills enhancement

The previous chapter proposed a framework that depicts multiple fundamental challenges acting as barriers to high-quality care and risk factors for safety incidents in homecare. This framework helps to identify the components of high-quality and safe care, to recognise the challenges that impede high-quality care, and helps us to understand safety incidents and risk factors. These are critical for developing mitigation measures to minimise errors and risks, which is in line with the Safety-1 approach (Smith and Plunkett, 2019). However, this research has argued that homecare safety culture should be attained by combining both Safety-1 and Safety-2 perspectives, examining both successes and failures. Therefore, this chapter has added to the discussion by highlighting the importance of integrating the Safety-2 perspective to create a comprehensive approach to homecare safety, ensuring that all aspects of high-quality and safe care are effectively managed. Figure 10.1 illustrates the framework of safety culture in homecare, incorporating both Safety-1 and Safety-2 approaches.

Figure 10.1 Homecare Safety Framework: Integrating Safety-1 and Safety-2 Approaches



This framework is built from the previous discussions of the high-quality and safe care, fundamental challenges in homecare, safety incidents, and the conditions leading to high-quality and safe care. Starting from the bottom, the framework illustrates a number of safety incidents that can compromise high-quality and safe care at home. These issues can arise from various fundamental challenges that pose significant barriers to safety culture in homecare. Homecare providers, therefore, are encouraged to be aware of these safety issues and understand their origins to detect risks and develop mitigation measures, keeping safety risks to a minimum (Safety-1). These are in line with the first four stages of the cultural maturity model suggesting that safety culture evolves from the pathological stage (where safety is largely ignored) to the reactive stage (where safety measures are implemented only after incidents occur), then to the calculative stage (where systematic safety procedures are established), and to the proactive stage (where continuous improvement and anticipation of safety issues are prioritised) (Ashcroft et al., 2005; Fleming and Wentzell, 2008). This progression reflects the increasing integration of safety practices focusing on detection and mitigation of safety issues. Similarly, the Safety-1 perspective aligns with three key principles of

the high reliability organisation (HRO) model: preoccupation with failure (identifying and addressing minor errors as indicators of larger issues), reluctance to oversimplify (integrating diverse perspectives and considering innovative approaches to avoid minimising problems), and sensitivity to operations (monitoring real-time changes and understanding how issues in one area impact others) (Rotteau et al., 2022).

Meanwhile, the top of the framework depicts various conditions that can lead to high-quality and safe care and overcome fundamental challenges. Homecare providers, therefore, should reinforce and replicate these good practices to enhance resilience and ensure a consistent safety culture (Safety-2). This reflects the more advanced stages of the cultural maturity model (proactive, generative) that emphasise on promoting and reinforcing best practices, where safety is deeply ingrained and becomes a fundamental aspect of organisational operations (Ashcroft et al., 2005; Fleming and Wentzell, 2008). Compared to the HRO framework, Safety-2 is supported by a commitment to resilience (building an organisation's capacity to address unforeseen challenges and prevent escalation), and deference to expertise (valuing expertise based on situational demands rather than strict hierarchies) (Rotteau et al., 2022).

Both the cultural maturity model and the high reliability organisation (HRO) theory underpin Safety-1 and Safety-2 approaches in shaping safety culture and have been applied across various industries and contexts. However, the homecare safety framework developed in this thesis offers a more detailed, sector-specific approach by simultaneously incorporating both Safety-1 and Safety-2 perspectives, rather than solely progressing through the stages of the cultural maturity model (Goncalves Filho and Waterson, 2018). It also addresses the limitations of HRO theory, such as inconsistent and conflicting interpretations of its principles and the lack of detailed guidance or a step-by-step process for becoming an HRO (Dwyer, Karanikas and Sav, 2023; Myers and Sutcliffe, 2022). The framework is particularly useful for homecare organisations as it provides insights tailored to their sector-specific needs and situations, facilitating the development of a strong safety culture.

Chapter Summary

This chapter has discussed various initiatives and practices implemented to enhance care quality and safety in homecare in England. These discussions

addressed another main objective of the thesis, which is to examine the conditions, practices, and strategies that can lead to high-quality and safe care.

First, collaboration and partnerships among care providers can result in significant benefits, such as improving service user outcomes, breaking down barriers, building trust, and ensuring efficient resource use. This highlights the need for a more integrated, collaborative, and information-sharing approach in homecare. Integrated care systems can mitigate the institutional challenges related to unregulated settings, fragmented support systems, or bureaucratic complexities. Collaboration and partnership are also crucial for reviewing and assessing care quality in homecare, which can address the issues of substandard care and proactively prevent significant failures of care.

Second, providing inclusive and personalised care is critical for ensuring high-quality and safe care. This approach involves providing equitable access to information that helps service users make informed decisions and receive timely support. It also includes tailoring care to individual needs and preferences to ensure respectful, responsive, and effective care for all. Person-centred care in homecare allows providers to better understand service users' perspectives and needs, which can facilitate the delivery of customised care.

Third, strong leadership and effective support initiatives are essential for fostering a safety culture in homecare. Effective leadership helps navigate difficulties and maintains system resilience, while support initiatives improve the preparedness and well-being of care staff. These measures can address fundamental organisational and team-level challenge as they facilitate skilled staff availability, tackle HR difficulties, promote staff well-being, and ensure job satisfaction through recognition and support networks.

Fourth, the integration of digital technology in homecare is an emerging practice that significantly enhances care services. This measure has a transformative impact on care services by identifying risks, preventing incidents, and enhancing communication and coordination. Digital tools and digitalised care records contribute to more efficient and person-centred care, which can address fundamental challenges by improving work environments, enhancing staff retention, and promoting communication and coordination among care providers. During the COVID-19 pandemic, digital technology became crucial for homecare providers to manage their staff. Nevertheless,

certain challenges in implementing the technology were found to be related to team communication and additional workload.

Fifth, HRM practices and strategies can address homecare difficulties and improve organisational performance in terms of high-quality and safe care. These practices include workforce planning, innovative recruitment and retention, flexible working arrangements, fair compensation, and comprehensive training and development. These findings contribute to the literature on the link between effective HRM practices and positive outcomes for both employees and organisational performance, especially in homecare in England. In the context of the COVID-19 pandemic, homecare organisations had to adapt the HRM practices by adopting ad hoc recruitment, redirecting staff, embracing digital technologies, and allowing flexible working arrangements to respond to the difficulties brought about by the crisis. Nevertheless, some of the HRM issues, including staff shortages and training gaps, persist; meanwhile, new challenges have emerged, such as managing non-standard employment, reallocating staff, and maintaining effective communication without causing technostress or digital exhaustion.

The five themes of initiatives or conditions discussed above were found to have significant benefits that can help address fundamental challenges in homecare and strengthen the safe care system. This aligns with the Safety-2 approach, which emphasises understanding and replicating successful practices to ensure a consistent safety culture and organisational resilience. This chapter highlights the importance of integrating the Safety-2 perspective to create a comprehensive framework on safety culture in homecare, incorporating both Safety-1 and Safety-2 approaches to ensure that all aspects of high-quality and safe care are effectively managed. The framework illustrates best practices, fundamental challenges, and safety incidents, offering a detailed, sector-specific approach to high-quality and safe care. It also provides tailored insights for developing a robust safety culture in homecare organisations.

Chapter 11.

Conclusion

11. Conclusion

Chapter Overview

The research aims to explore the topic of patient safety culture in homecare in England. It has discovered and discussed critical findings that are relevant to the foundational factors of high-quality, safe care, safety issues, fundamental challenges, safety practices and approaches, as well as the role of HRM in shaping and sustaining homecare safety culture.

This chapter outlines the contributions to research and the implications of practice. It details how the research addresses gaps in the existing literature by providing sector-specific insights into homecare safety culture. Then, it discusses the practical implications for government agencies, policymakers, homecare commissioners, providers, caregivers, service users, and their families by offering guidelines to enhance care quality and safety.

The chapter also highlights possible limitations regarding generalisability, the capture of the full complexities and nuances of homecare settings, and the applicability of the developed frameworks. Consequently, it suggests directions for future research to address these limitations and further explore the emerging critical findings of the thesis.

Finally, the chapter summarises key takeaways of each chapter. It provides a final, cohesive narrative that ties together the entire thesis with the aim to reinforce the original research aims and highlight the study's overall contribution to knowledge.

11.1. Research Contributions

This PhD thesis makes contributions to the research by addressing multiple gaps in the literature on patient safety culture, specifically within homecare settings in England. It extends the existing body of knowledge in several ways.

For over two decades, the focus of patient safety culture research has predominantly been on hospital settings, with limited attention given to social care environments, including homecare. This thesis contributes to the shift of focus to homecare to address the lack of evidence in this area and aims to

provide a comprehensive examination of patient safety culture within this context. By focusing on homecare, this research contributes to the broader fields of organisational science and healthcare. It offers new insights into the role of safety culture in non-acute care settings and expands the scope of patient safety research beyond hospitals and acute care facilities. These insights are detailed as follows:

First, the study identified the key foundational factors that constitute high-quality and safe homecare. It has shown that safety in homecare includes not only ensuring the service users' overall well-being and safeguarding them from harm, which is a common definition of patient safety culture in acute care contexts (Runciman et al., 2009), but also emphasises offering companionship, promoting service users' independence, and respecting their privacy. This is interesting and reflects the humanistic approach to care, which involves honesty, empathy, compassion, sacrifice, and the provision of care while respecting the dignity and beliefs of service users (McCaffrey, 2019). Additionally, to deliver high-quality, safe care in homecare services, the study contributes to the homecare literature by highlighting the importance of skilled staff, genuine passion for care, continuity of care, comprehensive information about services and choices, a patient-centred approach, and the engagement of family and informal support networks.

Second, the research also examined safety issues and the fundamental challenges in delivering high-quality, and safe care services in homecare. These insights are critical for developing strategic measures to address these challenges, which can ultimately enhance safety and care quality in homecare settings. In terms of safety issues, the research contributes to the literature by revealing a number of specific safety incidents in homecare in England. These have been categorised into medication errors, physical and health safety incidents, social and emotional safety incidents, and functional safety incidents. Regarding fundamental challenges, the research has discovered various challenges across multiple contexts, including institutional, organisational, and management, work environment, team dynamics, individual staff factors, service users, family members, and informal support networks. These findings not only map onto existing literature's frameworks of contributory factors resulting in safety incidents but also extend to the current knowledge (e.g., challenges related to the solitary nature of homecare work, integration difficulties for family members, and informal support networks).

Third, the study investigated and discussed various initiatives and practices that have been implemented to improve care quality and ensure a safety culture in homecare. These include collaboration, person-centred care, effective leadership, digital technology adoption, and effective HRM practices. These findings contribute to the existing knowledge on patient safety approaches in the sector, with a central focus on establishing a robust system for safe care delivery. This system involves fostering a culture of innovation and adaptability to changing needs. The ultimate goal is to ensure that homecare services are effective, efficient, and responsive to the evolving demands of care recipients and providers, thereby maintaining high standards of safety and quality.

Furthermore, this thesis has explored how HRM practices can shape and strengthen the safety culture in homecare, which emphasises the critical link between HRM and patient safety. These practices include workforce planning, innovative recruitment and retention, flexible working arrangements, fair compensation, and comprehensive training and development. These findings contribute to the literature on the link between effective HRM practices and positive outcomes for both employees and organisational performance, especially in homecare in England. Additionally, in the context of the COVID-19 pandemic, homecare organisations had to adapt HRM practices by adopting ad hoc recruitment, redirecting staff, embracing digital technologies, and allowing flexible work arrangements to respond to the difficulties brought about by the crisis. These adaptive measures demonstrate the critical role of HRM in maintaining high-quality care, ensuring safety, and fostering organisational resilience in the face of unprecedented challenges. These significant findings enrich the existing body of knowledge on the effective management of HR, which demonstrates its key role in helping care organisations operate efficiently and supporting their workforce to adapt to disruptive changes and crises.

Fourth, the research has analysed the safety approaches through the lens of Safety-1 and Safety-2 perspectives. This study argues that a homecare safety culture should be attained by combining both Safety-1 and Safety-2 perspectives, examining both successes and failures. Therefore, the study contributes to the literature by developing a homecare safety framework, which incorporates both safety perspectives to create a comprehensive approach to homecare safety to ensure that all aspects of high-quality and safe care are

effectively managed. The homecare safety framework offers a detailed, sector-specific approach that moves beyond the stages of the cultural maturity model. It also addresses the limitations of HRO theory, such as inconsistent and conflicting interpretations of its principles and the lack of detailed guidance for becoming an HRO. By providing a more comprehensive approach to safety, this framework makes a theoretical contribution to the field, which improves understanding of how to effectively implement safety practices in homecare settings.

Finally, in terms of methodological contributions, this research employs a data collection approach through interviews, which helps gain rich insights into the safety culture in homecare. A key strategy is data source triangulation that involves interviews with diverse participant groups, including homecare workers, service users, and family members. This strategy helps enhance the depth and reliability of the findings. Additionally, combining document analysis with interviews further corroborates findings across data sets and minimises potential biases. This triangulation of qualitative methods, including in-depth one-to-one interviews and comprehensive document analysis, provides a deep understanding of the research topics, thereby strengthening the study's overall validity.

11.2. Implications for Practice

By exploring patient safety culture in homecare, this research provides implications for policymakers, homecare commissioners, providers, caregivers, service users, and their families. This can support informed decision-making and policy development, aligning with the UK government's efforts to reform adult social care and improve service quality. Additionally, by providing evidence-based recommendations for improving safety culture, the research aligns with current efforts to adapt and expand homecare services to meet the growing demand and evolving needs of an aging population, particularly in the wake of the COVID-19 pandemic.

First of all, the thesis has identified and examined the foundational components for delivering high-quality and safe homecare, presenting a framework that illustrates the ideal standards for homecare services (Table 9.1). This framework emphasises the importance of care providers and support workers understanding the core principles of homecare services. These include

providing support services that comprise a variety of activities and practical tasks, offering companionship and emotional support, promoting independence, respecting privacy and confidentiality, ensuring overall well-being, and safeguarding from harm and safety incidents.

Care providers and leaders also need to be aware of the essential components of delivering high-quality and safe homecare. The implications for homecare providers include the necessity of investing in the continuous development and training of skilled staff, fostering a genuine passion for care among the workforce and implementing strategies to ensure continuity of care. Providers should also prioritise clear communication and offer adequate information about services and choices to service users and their families. Furthermore, adopting a patient-centred approach and actively engaging family and informal support networks are critical for delivering holistic and effective homecare services.

Second, the thesis has also developed a comprehensive framework depicting that multiple fundamental challenges are interconnected and act as barriers to high-quality care and risk factors for safety incidents in homecare (Figure 9.2). It highlights how these challenges, categorised into institutional, organisational and management, work environment, team-level, individual staff attributes, individual service users' characteristics, and family members' and informal support network challenges, can pose as barriers to high-quality care and lead to safety incidents. These safety issues include medication errors, physical and health safety incidents, social and emotional safety incidents, and functional safety incidents.

This framework's implications for practice involve using it to recognise challenges impeding high-quality and safe care and highlight associated safety incidents and risk factors. These insights are critical for identifying safety issues, understanding their origins, and proposing measures to minimise errors and risks. Recognising fundamental challenges allows government agencies, policymakers, care commissioners, and care providers to address these issues systematically. This can be achieved through targeted interventions, such as improving funding mechanisms, enhancing leadership and management practices, optimising work environments, fostering team cohesion, and providing comprehensive training for both staff and informal carers. By providing a comprehensive overview of where interventions are needed, the

framework guides practitioners in addressing fundamental challenges, ensuring high-quality and safe care at home, and reducing the risk of preventable safety incidents.

Third, this study explored various conditions contributing to high-quality and safe homecare (Table 10.1). These include fostering collaboration and partnerships among care providers through integrated care systems and information-sharing models, ensuring the provision of inclusive and personalised care services by providing equitable access to information, and tailoring care to individual needs. Additionally, strong leadership and support initiatives, such as regular well-being appraisals and staff recognition, are crucial for enhancing job satisfaction and care quality. Also, integrating digital technology, such as digitalising care records and utilising digital communication tools, can streamline processes and improve service efficiency. These findings imply the importance for government agencies, policymakers, commissioners, and care providers to prioritise collaborative, technology-driven, and well-supported care environments to enhance the overall quality and safety of homecare services.

Fourth, the research discovered the role of HRM in shaping and sustaining the safety culture in homecare. Effective HR practices, including strengthened workforce planning, adaptive recruitment strategies, flexible working arrangements, fair compensation, and prioritising workforce development and training, are essential for addressing workforce challenges and ensuring the delivery of high-quality care. For care providers, these results call attention to the need to invest in robust HR practices to build a resilient, skilled, and satisfied workforce. This investment is critical for shaping and sustaining a safety culture in homecare, as it ensures that staff are well equipped, motivated, and committed to maintaining high safety standards.

This research also discussed findings regarding the role of HRM in providing high-quality, safe care during the COVID-19 pandemic. The discussion showed significant challenges faced by homecare providers and how they had to adapt their strategies to address the extreme pressures and unforeseen circumstances brought about by COVID-19. A number of implications are proposed for responding to future crises, with the overarching aim of ensuring effective management of HRM practices in responding to address key areas: staffing, performance management, and training. For example, homecare

providers could utilise short-term adaptive recruitment strategies if needed, while also focusing on long-term workforce development and resilience to effectively respond to current care needs and future crises. They should prioritise staff well-being for retention and care quality, alongside implementing flexible work arrangements and digital communication methods, with a focus on providing comprehensive support and avoiding technostress and exhaustion from digital tools. Homecare providers also need to address training gaps by identifying needs, creating relevant programmes, and using effective delivery methods - a strategy crucial for equipping healthcare workers with skills for current and future crises, thereby enhancing resilience and adaptability in homecare.

Fifth, this research has investigated the Safety-1 and Safety-2 approaches and integrated both perspectives to create a comprehensive framework for homecare safety culture (Figure 10.1). The framework illustrates best practices, fundamental challenges, and safety incidents, offering a detailed, sector-specific approach to high-quality and safe care, which facilitates the development of a robust safety culture in homecare organisations. The homecare safety culture framework not only addresses existing safety incidents but also reinforces and replicates best practices, ultimately enhancing the overall quality and safety of homecare services. This integrated approach ensures that care providers can proactively identify and mitigate risks while continuously improving care standards through the adoption of best practices.

For government agencies and policymakers, this framework provides helpful guidelines for creating supportive legislation and funding initiatives that prioritise both preventive and proactive safety measures. Care commissioners can utilise this framework to establish standards and benchmarks that ensure consistency and quality across different care providers. Meanwhile, for care providers, the framework offers a structured approach to identifying and mitigating risks while promoting a culture of continuous improvement and excellence in care delivery, which helps ensure that the system remains resilient and responsive to disruptive changes.

For care workers, the framework serves as a guide to best practices and a tool for enhancing professional development, ensuring that they are well equipped to deliver safe and high-quality care. Service users can benefit from a more reliable and responsive care system that prioritises their safety, well-being, and

individual needs. Meanwhile, family members gain confidence and peace of mind knowing that their loved ones are receiving care that adheres to safety standards and best practices while also being encouraged to actively participate in the care process. By adopting and integrating the comprehensive framework of homecare safety culture, stakeholders at all levels can work collaboratively to elevate the standards of care, which can ensure a safer and more effective care environment for all service users.

11.3. Limitations and Future Research

This PhD thesis has discussed and provided rich insights into the elements that constitute high-quality and safe homecare, the safety incidents, and the fundamental challenges that act as barriers to safety and pose risks leading to safety incidents. It has also examined different initiatives and practices that have been implemented to enhance safety, especially the role of HRM in shaping and strengthening the safety culture. Based on the findings and discussions, this research has developed several theoretical frameworks that offer a detailed, sector-specific approach to high-quality and safe care.

However, one limitation of this study is its geographical focus on homecare in England, which may hinder the generalisability of its findings to other regions with different healthcare systems and socio-economic contexts. Another limitation is that the findings might not fully portray the complexities and nuances of the all homecare settings in England due to the small sample size and challenges in recruiting and engaging research participants due to the COVID-19 pandemic. Although the study adopted the triangulation of sources to include secondary data from documents, this methodology may still fall short in providing a comprehensive view of the diverse homecare environments. Therefore, this research does not aim to generalise its findings to all homecare settings but rather to provide a detailed, context-specific understanding of safety culture within the sector. Future research could employ further qualitative methodology, such as grounded theory, ethnography, and phenomenology, and case studies, with larger and more diverse sample sizes to gain richer and more context-specific insights (Creswell and Poth, 2016).

This research has developed several theoretical frameworks that offer a detailed, sector-specific approach to high-quality, safe care. However, these frameworks may not fully capture the complexities and variations across

different homecare settings. For example, there might be other wider and deeper contextual factors that can influence and shape safety cultures, such as socio-economic, cultural, and environmental factors. Differences in organisational structures, service delivery models, and individual needs of service users can impact the applicability and effectiveness of these frameworks. Therefore, future safety culture research could be tailored to specific types of homecare, such as for-profit versus not-for-profit organisations, and different service models like hourly visits versus live-in. Future studies could also consider the unique needs of different homecare service users, including the elderly with dementia, individuals with mobility issues, or those recovering from injuries. In addition, future research should aim to empirically validate the proposed frameworks through comprehensive fieldwork or cross-sectional or longitudinal studies (Saunders, Lewis, and Thornhill, 2019) to assess their effectiveness. Comparative studies across different regions and healthcare systems can also refine the frameworks and enhance their wider applicability (Mrayyan, 2022). These efforts would add deeper insights and create evidence to better conceptualise the complexity of the homecare safety culture while also providing a practical tool to support the implementation.

Finally, this PhD research discovered a number of emerging findings that future research could aim to explore and expand upon. For example, Section 9.1 discussed these findings, which refer to the humanistic approach to care, the balance between professional responsibility and respecting privacy in homecare settings, the unique nature of delivering care within personal homes, and the role of informal support networks in homecare. Section 9.3 examined fundamental challenges across multiple contexts and found external factors related to COVID-19, which future studies could expand upon using the PESTLE (Political, Environmental, Social, Technological, Legal, and Economic) model (De Val et al., 2021).

Other critical emerging challenges in homecare that should be further investigated include the solitary nature of homecare work and the difficulties in integrating family members and informal support networks. Furthermore, Chapter 10 discussed various conditions and HRM practices that can significantly impact homecare safety culture. Future studies can further examine these topics, such as integrated homecare, the integration of digital technologies in homecare, or well-being-oriented HRM.

11.4. Final Conclusion

The research starts with a background that highlights the importance of safety culture in healthcare organisations and identifies a number of significant gaps in the literature on patient safety culture in homecare. These gaps indicate the need for research, especially given the sector's growing importance in England's health and social care landscape and in light of the COVID-19 pandemic.

Given these contexts, the primary objective of this PhD thesis is to explore the patient safety culture in homecare in England. This research aim defines the specific questions and objectives. The research seeks to discover critical foundational factors that constitute high-quality and safe care, examine prominent safety issues in homecare, and investigate the fundamental challenges in delivering such care services. It also seeks to understand the safety approaches and practices that can improve care quality and safety, and the role of HRM practices in shaping and strengthening homecare safety culture.

To achieve these objectives, the research begun with a review of the literature on a number of relevant topics, which has helped establish a foundational understanding and contextual framework for the study. Chapter 2 reviewed various topics related to organisational culture, safety culture, patient safety culture in healthcare, and an overview of homecare in England. Meanwhile, Chapter 3 looked into the literature on patient safety culture in homecare, which include the involvement of various stakeholders, understanding safety enablers and barriers, recognising safety issues and associated risk factors, and understanding the approaches to safety culture in homecare. The research also reviewed the literature on HRM and safety culture in homecare in Chapter 4. As the study was conducted during the COVID-19 pandemic, the chapter also outlined HRM challenges during the crisis, which thereby highlights the crucial role of HRM practices in helping organisations adapt to disruptive changes and to ensure high-quality and safe care.

The research aims and literature review inform this research methodology by ensuring alignment with the objectives of the study and identifying existing gaps and best practices. Chapter 5 presents the research methodology of the

study. Starting with the constructivist ontological assumption that social phenomena are complex and shaped by social actors, this study adopts an interpretivist epistemology that is aligned with the interpretive paradigm to explore the rich meanings of safety culture in homecare. Using an inductive approach, the study collects qualitative data to build theoretical concepts based on detailed interpretations from social actors. The research strategy employs narrative inquiry and triangulation, which incorporates semi-structured interviews and documents for data collection. Thematic analysis is used for interview data, while qualitative content analysis is applied to written documents. Chapter 5 also addresses ethical considerations and discusses the impact of the COVID-19 pandemic on the methodology.

The study reveals a number of significant findings regarding the foundations of safe care and safety issues in homecare (Chapter 6), fundamental challenges in the sector (Chapter 7), and initiatives and practices that have been made to improve care quality and safety culture (Chapter 8). These insightful findings are significant and important for answering the research questions. They provide a deep understanding of the complexities and nuances of safety culture in homecare by offering perspectives from various stakeholders and different sources of documentation.

In particular, Chapter 6 identifies several components of safe homecare which include the essence of high-quality and safe homecare, person-centred care, and the role of family members and informal support networks (e.g., friends, neighbours). It also demonstrates various safety incidents and categorises them into four types: medication safety issues, physical and health safety issues, emotional and social safety issues, and functional safety issues. Chapter 7 provides rich insights into the fundamental challenges serve as barriers to high-quality care and pose as risk factors leading to safety issues. These challenges relate to the institutional context, organisational and management, work environment, teams, individual staff, tasks, service users, and family members and informal support networks. Meanwhile, Chapter 8 provides findings about initiatives and practices that have been made to improve care quality and safety culture in homecare. The chapter illustrates five significant themes that include collaborations and partnerships, inclusive and personalised care service, strong leadership and staff support, digital technology integration, and strengthening HRM practices.

This PhD research discusses the insightful findings with reference to the literature review in order to answer the research questions and achieve the primary research aim. Chapter 9 discusses the foundational factors of high-quality and safe homecare, the safety issues, and the fundamental challenges in the sector. These discussions allow the development of the first theoretical framework of this study, which depicts how homecare fundamental challenges are interconnected and act as barriers to high-quality care and risk factors for safety incidents. This is useful for identifying safety issues, understanding their origins, and proposing measures to minimise errors and risks, which is in line with the Safety-1 approach. Meanwhile, Chapter 10 discusses the initiatives and practices implemented to improve homecare quality and safety. It also highlights the important role of HRM practices in shaping and maintaining safety culture in homecare, particularly in the context of COVID-19 pandemic. These discussions enable the development of homecare safety framework, which incorporates both Safety-1 and Safety-2 approaches. The framework illustrates the interlink among best practices, fundamental challenges, and safety incidents, offering a detailed, sector-specific approach to high-quality and safe care. It also presents tailored insights for developing a robust safety culture in homecare organisations.

Finally, the research outlines several contributions, implications, limitations, and directions for future research. The study has made a number of contributions to academic research and practical implications by addressing the gaps in the literature and offering safety improvement guidelines for government agencies, policymakers, homecare commissioners, providers, caregivers, service users, and their families. The study also acknowledges possible limitations concerning generalisability, the capture of the complexities and nuances of homecare settings, and the applicability of the developed frameworks. As a result, it proposes directions for future studies to address these limitations and further examine the emerging findings from the thesis.

Chapter Summary

For over two decades, patient safety culture research has predominantly focused on hospital settings, with limited attention to the social care sector, including homecare. This PhD thesis makes relevant contributions to the study of patient safety culture by addressing multiple gaps in the literature specific to homecare settings in England.

The research contributes to the literature by providing sector-specific details on the key foundational factors that constitute high-quality and safe homecare, safety issues, fundamental challenges across multiple contexts, and various initiatives and practices implemented to improve care quality and safety. These findings not only align with the existing literature but also extend the current knowledge in patient safety culture within health and social care.

The study has also explored how HRM practices can shape and strengthen the safety culture in homecare, and how these practices can help organisations to adapt to disruptive changes. These findings contribute to the literature on the link between effective HRM practices and positive outcomes for both employees and organisational performance, especially in the context of homecare providers in England. The results also enrich the existing body of knowledge on HRM's key role in helping care organisations operate efficiently and supporting their workforce to adapt to disruptive changes and crises.

Furthermore, this PhD study has contributed to the literature by developing the homecare safety framework, which incorporates both Safety-1 and Safety-2 perspectives to create a detailed, sector-specific approach to homecare safety. This framework makes a theoretical contribution to the field of safety approaches and management in healthcare and improves the understanding of how to effectively implement safety practices in homecare settings.

In terms of methodological contributions, this research employs a data collection approach through interviews, which helps gain rich insights into homecare safety culture. A key strategy is data source triangulation, involving diverse participant groups, such as homecare workers, service users, and family members, enhancing the depth and reliability of the findings. In addition, the research combines document analysis with interviews to further corroborate findings across data sets and minimise potential biases, thereby strengthening the overall validity of the research.

The findings of this research have practical implications for policymakers, homecare commissioners, providers, caregivers, service users, and their families. By presenting a conceptual framework for high-quality and safe homecare, the study supports informed decision-making and policy development, which aligns with efforts to reform adult social care and improve

service quality in the UK. The framework emphasises the need for continuous staff development, genuine care, clear communication, patient-centred approaches, and engagement of family members and informal support networks.

Additionally, the study highlights the importance of collaboration among care providers, inclusive and personalised care, strong leadership, digital technology integration, and effective HRM practices. These insights can guide the development of targeted interventions to enhance safety culture, improve care quality, and ensure that homecare services are resilient, efficient, and responsive to the evolving needs of an aging population, particularly in the wake of the COVID-19 pandemic.

This research integrates Safety-1 and Safety-2 approaches to develop a conceptual framework of homecare safety culture that illustrates best practices, fundamental challenges, and safety incidents. This framework provides detailed sector-specific guidelines that help care providers proactively identify and mitigate risks while continuously improving care standards through the adoption of best practices. It serves as a valuable tool for government agencies, policymakers, care commissioners, providers, workers, and families to collaboratively enhance care quality and ensure a safe, effective homecare environment for all service users.

Despite the valuable insights provided, this study has several limitations. Its geographical focus on homecare in England may limit the generalisability of the findings to other regions with different healthcare systems and socio-economic contexts. Additionally, the findings might not fully capture the complexities and nuances of all homecare settings in England due to the small sample size. Future research should aim to overcome these limitations by employing further qualitative methodologies, such as grounded theory, ethnography, phenomenology, and case studies with larger and more diverse sample sizes.

In addition, empirical validation through comprehensive fieldwork or cross-sectional or longitudinal studies is essential to assess the effectiveness of the proposed frameworks. Comparative studies across different regions and healthcare systems will also further refine these frameworks and enhance their broader applicability. These efforts will deepen the understanding of homecare

safety culture and provide practical tools to support the implementation of high-quality and safe care practices.

Finally, this PhD research discovered several emerging findings that future research could explore further. These include the humanistic approach to care, balancing professional responsibility with respecting privacy in homecare, the unique dynamics of providing care in personal homes, and the role of informal support networks. Additionally, the research highlighted the fundamental challenges that emerged during the COVID-19 pandemic, which could be examined using the PESTLE model. Other critical areas for future investigation include the solitary nature of homecare work, integrating family members and informal support networks, and various conditions and HRM practices impacting homecare safety culture (e.g., integrated homecare, digital technology integration, and well-being-oriented HRM).

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Appendices

Appendix A. Ethical Approval

University of Nottingham
UK | CHINA | MALAYSIA

Faculty of Social Sciences
Nottingham University Business School
University of Nottingham
Jubilee Campus
Nottingham
NG8 1BB

05/02/2021

To whom it may concern,

Ethics Review Application: 201929107 – Thoai Le: Patient Safety in Home Care: Exploring the Impact of Human Resource Management Practices on Care Quality and Patient Safety in Home Care in England

I am writing as chair of the Nottingham University Business School Research Ethics Committee (NUBS REC) to confirm a favourable ethical opinion for the above research on the basis of the documentation submitted below. This opinion was given on the above stated date.

The School REC operates according to the University of Nottingham's *Code of Research Conduct and Research Ethics, and the Economic and Social Research Council (ESRC) Framework for Research Ethics.*

The documents reviewed and approved are:

- NUBS REC Ethics Review Checklist
- Research Participant Information Sheet
- Research Participant Privacy Notice
- Research Participant Consent Form
- Research Participant Instructions

The following condition applies to this favourable opinion:

1. The research must follow the protocol agreed and any changes will require prior NUBS REC approval.

For further information about the School's Research Ethics Committee or approval process, please contact the Research Ethics Officer, Davide Pero at davide.pero@nottingham.ac.uk or +44 (0)115 84 67766.

Yours faithfully,

Dr Amanda Crompton
Chair of Nottingham University Business School Research Ethics Committee

Appendix B. Information for Research Participants

University of Nottingham
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Information for Research Participants

Thank you for agreeing to participate in the research project. Your participation in this research is voluntary, and you may change your mind about being involved in the research at any time, and without giving a reason.

This information sheet is designed to give you full details of the research project, its goals, the research team, the research funder, and what you will be asked to do as part of the research. If you have any questions that are not answered by this information sheet, please ask.

This research has been reviewed and given favourable opinion by the Nottingham University Business School Research Ethics Committee.

What is the research project called?

Patient Safety in Home Care: Exploring the Impact of HRM Practices on Care Quality and Patient Safety in Home Care in England.

Who is carrying out the research?

Thoai Le (Lee), PhD Student in Business and Management, Nottingham University Business School

What is the research about?

The aim of my research is to investigate the patient safety culture in home care in England and explore the people management issues in home care which affect the quality of care and the safety of patients. The research will also explore how home care's quality can be improved through the appropriate development and implementation of HRM practices.

What groups of people have been asked to take part, and why?

The participants are the social actors including the caregivers, family members, service users, and service providers at both senior and team staff levels. The participants are identified and selected using the researcher's network and other research participant's connections. The research is expected to show how social actors interact, work, learn and make decisions, all of which might impact the care quality in the settings of home care.

What will research participants be asked to do?

The participants will be invited for the interviews that are semi-constructed by Thoai Le. During the interviews, the participants will be asked questions about the topics of patient safety, and the service users, family members and staff experience in home care settings. Each interview is expected to take about 45 minutes to 1 hour and will be audio-recorded for transcription and analysis purpose only and will be strictly confidential. As it might be uneasy for participants to think and disclose information about their experience, they are free to withdraw from the interview at any time without giving reasons. They can also decide not to answer any individual questions during the interview. If a participant chooses to withdraw, the data that he/she has provided will be destroyed and will not be used for any analysis. There will be a thank-you payment for participant's time offered to every participant who complete the interview at the end. The thank-you payment will be a £5 gift card for each participant who agrees to participate and complete the interview.

University of Nottingham
UK | CHINA | MALAYSIA

What will happen to the information I provide?

Participants' anonymity in this research will be protected and the information that participants provide will be kept strictly confidential. The individual participants will be assigned pseudonyms which will be discussed and presented in the research outputs. In written documentation, all names and identifying characteristics will be changed or omitted entirely to ensure anonymity. The data will be safely stored in OneDrive using University of Nottingham credentials and will also be synced with local data storage of internal computer hard drive. Regular backups will protect against accidental or malicious data loss. Data will be securely destroyed once it is no longer needed. Original recordings will be deleted from all devices once the interview has been transcribed and made anonymous, as well as checked for accuracy. Respondents will be assigned a code to identify each transcript, recorded on a password protected spreadsheet kept on secure servers in a password protected folder. Transcripts will be password protected and stored on University servers.

What will be the outputs of the research?

The outcomes will be used to complete the researcher's PhD thesis in Business and Management at Nottingham University Business School.

Contact details:

Researcher:

Thoai Le (Lee), +44 (0)7802607538, thoai.le@nottingham.ac.uk
Centre for Health Innovation, Leadership and Learning (CHILL)
Nottingham University Business School
Room C30, Business School South Building
University of Nottingham
Jubilee Campus
Nottingham, NG8 1BB
nottingham.ac.uk/business/about/research/researchstudents/Thoai.Le.html

Supervisor:
Dr Simon Bishop, +44(0)1158466060,
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Nottingham University Business School
University of Nottingham
B2 Business School North
Jubilee Campus
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Supervisor:
Professor Carl Macrae,
carl.macrae@nottingham.ac.uk
Nottingham University Business School
University of Nottingham
C16 Business School North
Jubilee Campus
Nottingham, NG8 1B

Complaint procedure

If you wish to complain about the way in which the research is being conducted or have any concerns about the research, then in the first instance please contact the Researcher or Supervisor(s). Or contact the School's Research Ethics Officer:

Davide Pero
Nottingham University Business School, Jubilee Campus
Nottingham NG8 1BB
Phone: 0115 84 67763
Email: davide.pero@nottingham.ac.uk

Appendix C. Participant Consent Form

University of Nottingham
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Nottingham University Business School
Participant Consent Form

Name of Study: Patient Safety in Home Care: Exploring the Impact of Human Resource Management Practices on Care Quality and Patient Safety in Home Care in England

Name of Researcher(s): Thoai Le (Lee)

Name of Participant:

By signing this form, I confirm that (please initial the appropriate boxes)**:**	**Initials**
I have read and understood the Participant Information Sheet, or it has been read to me. I have been able to ask questions about the study and my questions have been answered to my satisfaction.	
I consent voluntarily to be a participant in this study and understand that I can refuse to answer questions and I can withdraw from the study at any time, without having to give a reason.	
Taking part in this study involves an interview that will be audio recorded then transcribed in full. The recording will be destroyed after being transcribed.	
Personal information collected about me that can identify me, such as my name or where I live, will not be shared beyond the study team.	
My words can be quoted in publications, reports, web pages and other research outputs.	
I give permission for the de-identified (anonymised) data that I provide to be used for future research and learning.	

I agree to take part in the study

_____	_____	_____
Name of Participant	Signature	Date
_____	_____	_____
Researcher's name	Signature	Date

2 copies: 1 for the participant, 1 for the project file

Appendix D. Online Recruitment of Research Participants (1)

University of Nottingham
UK | CHINA | MALAYSIA

Business School
University of Nottingham
Jubilee Campus
Nottingham
NG8 1BB

Calling for Research Participants

Patient Safety in Home Care: Exploring the Human Resources Management Challenges in Home Care in England.

The aim of the research is to explore safety culture and people management challenges in home care in England, and to develop ways of improving care quality through the appropriate implementation of human resources management practices.

If you are a **care manager**/ **support worker**/ **volunteer**/ **service user**/ or a **family member**, we would be very grateful if you would consider taking part in an open-ended interview about your experience in **homecare**. This could take place by video call or phone call, at your convenience and take about 30-45 minutes to complete.

To take part, please email: Thoai.Le@nottingham.ac.uk

Where is this study conducted?	Online/Telephone
Compensation:	Online Shopping voucher (£5)
Study type:	Interview

The ethical approval for this study has been obtained from Nottingham University Business School Research Ethics Committee on 05/02/2021. If you require any further information, please do not hesitate to contact Thoai.Le@nottingham.ac.uk.

To take part, please email: Thoai.Le@nottingham.ac.uk

Thank you!

nottingham.ac.uk/business

Appendix E. Online Recruitment of Research Participants (2)

HOME > FIND RESEARCH > STUDY OVERVIEW

Safety care for homecare service users (England)

28 June 2024

The aim of this research is to investigate the patient safety culture in home care in England and explore the people management issues in home care which affect the quality of care and the safety of patients. Home care is a term describing a variety of care and support programmes that aim to help people live in their own homes. The research will also explore how home care quality can be improved through the appropriate development and implementation of human resource management practices.

Requirements

- Participants include home care service users* and family members
- *The service user participants to be included in the study must be receiving home care service at home; Mentally sound and capable of giving informed consent and making decisions.

☐ YES, I MEET THESE REQUIREMENTS

TAKE PART IN THIS STUDY

Keywords

University of Nottingham | homecare | home care | domiciliary care | patient safety | safe care | Interview | interview study

Ethical approval

This study has been approved by the Nottingham University Business School Research Ethics Committee on 05/02/2021

Contact researcher

ACADEMIC STUDY

STUDY ESSENTIALS

University of Nottingham, GB
60 min(s) to complete
Prize draw (online shopping voucher)
Interview

ONLINE

Online research

SHARE THIS STUDY

Facebook
Twitter
LinkedIn
Reddit
Pinterest
Email this study
Print a poster version (PDF)

Appendix F. Interview Topic Guide

<table>
<tr><td></td><td>Caregivers</td><td>Service Users</td><td>Family Members</td></tr>
<tr><td>Introduction questions</td><td>- Role/Type of Care Provided
- Duration of Employment in Homecare
- Primary Responsibilities</td><td>- Type of Care Received
- Duration of Receiving Homecare Services</td><td>- Relationship to Service User
- Duties/Types of Care Provided
- Duration of Involvement in Homecare</td></tr>
<tr><td>Overall Experience</td><td>- Motivation
- Challenges and Rewards
- Support and Resources
- Training and Development
- Communication and Relationships with Colleagues, Service Users, Family Members
- Suggestion/Feedback for Improvement
- Other Experiences</td><td>- Quality of Care
- Support and Resources
- Communication and Relationships with Caregivers, Family Members
- Impact on Life
- Suggestion/Feedback for Improvement
- Other Experiences</td><td>- Quality of Care
- Support and Resources
- Communication and Relationships with Caregivers, Service Users
- Suggestion/Feedback for Improvement
- Other Experiences</td></tr>
<tr><td rowspan="3">Safety in homecare</td><td colspan="3">- Meaning of high-quality care? Meaning of safe care?
- The most important parts of high-quality and safe care?</td></tr>
<tr><td>- Safety Challenges and Risks (prompts: Staffing, Training and Development, Work Environment, Resources, Support and Communication, Workload, etc.)</td><td>- Safety Challenges and Risks (prompts: Consistency and Reliability, Support and Communication, Relationships with Carers and Family Members, etc.)</td><td>- Safety Challenges and Risks (prompts: Consistency and Reliability, Support and Communication, Relationships with Carers and Service Users, etc.)</td></tr>
<tr><td colspan="3">- Examples of Safety Incidents? Instances of Feeling Unsafe?
- Mitigation Measures/ Changes/ Suggestions and Feedback for Improvement?</td></tr>
<tr><td>Topics for Further Discussion</td><td colspan="3">- COVID-19 experience
- Personalised Care
- Friends and Family Engagement
- Digital Technology
- Service Users’ Characteristics (Caregivers)
- HRM Practices (Caregivers)</td></tr>
</table>