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# Navigating Involuntary Care Home Closures: Professional Perspectives and Thematic Analysis of Failures in Norfolk

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## Introduction

Norfolk (UK) is a largely rural county with a rapidly ageing population and thus has a large plethora of care home, assisted living, and nursing home options available for older people. There is also a proportion of care homes within Norfolk that focus on providing residential care for under 65s who are unable to live independently due to learning disabilities and/or autism. Cawston Park Hospital was one such facility that dedicated itself to providing these services. That was until May 2021, when the Care Quality Commission closed the service due to inadequate standards of care (2021a). Suspicions had been raised surrounding the quality of care available at the care home after three residents (Joanna, Jon and Ben), all in their 30s, had died within a 27-month period between 2018-2020 (Norfolk Safeguarding Adults Board, n.d). After a Safeguarding Adults Review, it was found that inadequate care management and abuse had been directly responsible for their deaths (Norfolk Safeguarding Adults Board, 2021).

There has been renewed fervour by Norfolk County Council to improve standards of care, spurred on by the untimely deaths of Joanna, Jon and Ben. There has been the implementation of the Transforming Care Agenda, which has led to the introduction of 'Transforming Care Navigators', which moves to support people with complex needs in the community focusing on improving the quality of care in Norfolk (NCC, n.d). There has also been across organisational involvement from Norfolk County Council, Norfolk and Waveney System and other local authorities to help highlight areas for development in how care providers can be supported in Norfolk (Bunting, 2024). However, Norfolk still has the highest percentage of homes rated as "inadequate" at time of writing for those with learning disabilities and autism at 30%; compared to the rest of the East of England, such as Cambridgeshire which only has 5% of homes rated "inadequate" by CQC (2023a). Learning Disability Service employees such as social workers, assistant practitioners and other healthcare professionals have been involved in over 25 home closures of inadequate facilities from 2020-2023. They come from a range of organisations such as Norfolk County Council, Norfolk and Waveney Integrated Care Board and Norfolk Community Health and Care.

Although there have been studies that have addressed the impact of home closures on residents across the UK (Hallewell et al., 1994; Holder & Jolley, 2012; Netten et al., 2005), there have been limited studies conducted around the professional viewpoints of those involved in involuntary care home closures, such as local authority staff, care quality commission workers, police and safeguarding specialists. The two main studies found as part of the initial

planning for this research were studies specifically on care manager experiences in a closure (Williams et al., 2007) and a more recent study conducted on residents, residents' families and external care staff (Glasby et al., 2018). Additionally, although we found a study that addressed evidence of neglect leading up to closures (Bach-Mortensen et al., 2024) it was difficult to find academic studies that reviewed whether specific failings worked in combination when it came to care home closure.

As well as furthering the literature on perspectives of different job roles being involved in home closure and reasons for closure, we have also used this study as an opportunity to evaluate the use of debriefing practices in home closures. Evans et al. (2023) conducted a systematic literature review of 184 research papers on debriefing. They noted that debriefings could give healthcare staff a voice to discuss their emotions and experiences at work, but that there was a gap in research as to what the effects of this would be. As there is an inconsistent practice of using debriefing with Norfolk County Council employees, it was considered prudent to collect data surrounding the wellbeing/emotional outcomes of those who had been debriefed vs those who had not been debriefed to add to this body of work and potentially create long-term protocols within Norfolk County Council related to debriefing practices.

## Methods

This study has taken a two-pronged approach when looking at home closures in Norfolk. Firstly, we conducted a thematic analysis to investigate whether there were any commonalities in what caused care homes to become unsuccessful in adhering to Care Quality Commission regulatory standards to understand the context of the participants involved in our study were working in within Norfolk. To conduct the thematic analysis, this research followed the 'six phases' of thematic data analysis suggested by Braun and Clarke (2006).

We chose to analyse reasons for closure from care homes that had been closed between 2020-2023. From those 25 initial care homes available, 15 of these homes were given a "Notice of Proposal" to close; 10 of these had to be forcibly closed by regulatory action and were chosen for this study, the other 5 were closed voluntarily by the service providers. We excluded the 5 homes which closed voluntarily to focus only on those that had been forcibly closed. This is because involuntarily closed homes provided a clear and unambiguous data set regarding non-compliance and critical issues, and by focusing on the most problematic cases, we felt we can contribute to providing a learning opportunity for the entire sector. Additionally, Norfolk County Council (who were a partner in this research) wanted insights from involuntarily closed homes

to help inform policymakers about resource allocation and support mechanisms needed to ensure higher standards of care. As well as this, thematic analysis of local government documents is considered reliable because these documents are typically produced through systematic processes, following regulatory standards and legal requirements. They provide structured, detailed, and official records of events, decisions, and policies, making them trustworthy sources for identifying consistent themes and trends (Leary et al., 2021).

In the second half of our study, we conducted focus groups. Focus groups are individuals selected by researchers to discuss a particular topic, speaking from their own experiences (Merton, 1987). The interactive nature of the focus groups meant that the participants could ask each other questions and be open to re-considering their viewpoints of the experiences being discussed (in the case of this research, involuntary care home closures). We used Eliot and Associates (2005) guidelines for conducting the focus groups and analysing the data.

For the focus groups, the sample consisted of 13 participants: six social care professionals (some of whom were social workers) and healthcare workers who had undergone a debrief (the debriefed participants) and seven who had not (the non-debriefed participants). These participants were chosen as they had been involved in at least 1 out of 10 of the involuntary closures. Participants were sourced from those working at Norfolk County Council via an internal service-wide email asking for participants. We conducted one focus group with each group. The first focus group was conducted with debriefed participants and lasted 1hr and 44 minutes. The second focus group was with non-debriefed participants and lasted 2hrs and 24 minutes.

We decided to undertake the two methods together because we felt it would give a more comprehensive understanding of the current situation in Norfolk; thematic analysis of Care Quality Commission reports allows for a detailed and systematic examination of documented issues, providing a foundation of factual data. Following this with focus groups enabled us to capture experiential insights and practical perspectives from practitioners, creating a more holistic understanding such as was found in a study using a focus group of GP's (Vleminck et al., 2014). We also felt that practitioners can provide context and nuances that reports alone might not reveal. They can share first-hand experiences, challenges, and insights into the operational realities of care homes, adding layers of understanding to the issues identified in the reports. Finally, involving practitioners in focus groups engages key stakeholders in the research process. This participatory approach can lead to more relevant and

actionable findings, as those directly involved in the care homes contribute their perspectives.

## Findings

Care Quality Commission Reports

Four themes of care risks were drawn out from the thematic analysis of the reports. They were: ‘Poor overall culture within the home’, ‘Lack of support for staff and managers’, ‘Unfit environment to provide good quality care’ and ‘Ineffective systems in place to provide good quality care’.

Theme 1 – ‘Poor overall culture within the home’

| Code | Sub-codes |
|---|---|
| Culture | Lack of person-centred care |
| | The service had poor communication with relatives |
| | Poor relationships between staff and people |
| | Restrictive practices in place causing people’s dignity to become compromised |
| | Abuse and poor staff behaviour |
| | Poor overall social environment |

Having an open culture in a learning-disabled facility is characterised by a commitment to person-centred care, effective communication with relatives, exemplary staff behaviour, and a positive social environment, and is crucial for fostering a supportive and nurturing atmosphere for residents (Mascha, 2006). Having a poor overall culture can therefore be particularly problematic. In many reports looked at in this study, the Care Quality Commission noted that organisational culture was often closed off and care home providers were unwilling to collaborate with external organisations, their own staff members and/or families:

> A closed culture had developed under the current management structure. For example, staff told us of 'cliques' that had formed between staff groups, and there was a culture of bullying among them. One staff member told us, "I feel that certain company policies and practices have developed an abusive culture within what once was a lovely, happy and caring home." On speaking with one person, they told us, "[Staff member] shouts at me. (CQC, 2021b, p. 10).

Across the reports, there were multiple instances of relatives not being notified of incidents occurring to family members within the home and only being updated about the resident when they prompted the homes for updates:

> One relative told us several personal items of value belonging to their family member had gone missing. These missing items had not been reported to the police, or to the local authority and CQC as a safeguarding incident. The provider had failed to fully investigate these missing items or put actions in place to reduce future risk. (CQC, 2023b, p. 8).

> Relatives told us communication with them was not open and inclusive. One relative told us, "Not good recently. The home had a Covid outbreak. I was not informed by the home that [family member] had Covid and found out from the Social Services Team when I was trying to arrange a visit. (CQC, 2022a, p. 16).

These homes often had a culture of believing that they should be the "deciders" of what care the resident should be receiving with little movement for personalisation. In one home, there was incidents of ignoring residents and their families' medical wants and end of life care wishes. This incident was attributed directly to the home's poor culture of staff wilfully misreading or misrepresenting to residents and their families what decisions the service was allowed to make, leading to the incidents described above which went beyond the home's legal purview (CQC, 2020a).

Theme 2 – 'Lack of support for staff and managers'

| Code | Sub-codes |
|---|---|
| Staff Issues | Staff training issues |
| | Poor working conditions for staff causing low staff morale |
| | Reliance on temporary staff |
| | Staff poorly managing and monitoring people |
| | Staff shortage issues |
| Poor Management and Support for Staff | Poor management negatively impacting staff |
| | Staff feeling like they are not supported enough by managers |
| | Managers not getting enough support |

Good management, high-quality staff training, and appropriate staffing levels are essential in a learning disability home to ensure the provision of safe,

effective, and compassionate care. A study conducted in Croydon (UK) noted that improving the standards of management in care homes in general often correlated to an improvement in outcomes for residents with potentially preventing abuse as well as increasing staff morale (Lawrence and Banerjee, 2009).

In most of the homes in this study, the general lack of training suggests the residents were not cared for by skilled, knowledgeable staff. The managers of some homes did not give the staff the support they needed, as they were "spread too thin", managing multiple different homes:

> The manager, who had been in post since January 2022, was responsible for three services, one of which was a 20-minute drive away. All staff and all relatives stated they thought the manager was spread too thinly. One staff member commented, "The current manager is very good [and] fast acting but most of the time involved in the other units [which is] the provider's decision. (CQC, 2023c, p. 10).

> Staff were not deployed in a manner which took in to account their skills and experience. The deputy manager told us they were not provided with information about agency staff from the provider. They said this meant agency staffs skills and experience weren't known to them and they couldn't take this into account when organising the rotas. (CQC, 2021c, p. 9).

In all the homes included in the analysis, there were staff overdue for at least one element of mandatory training (whether legally required or as part of good practice):

> One staff member told us they were supporting people without having had the correct training for situations where people may have to be put into a safe-hold for their own protection. They told us, "I was very scared, I didn't know what to do and had to shout for help." (CQC, 2023d, p. 12).

The home above also had only half of the staff employed with up-to-date training in safeguarding despite this being a legal requirement under the Care Act 2014 (Ibid).

Theme 3 – 'Unfit environment to provide good quality care'

| Code | Sub-codes |
|---|---|
| Unfit environment to provide good quality care | Poor cleanliness in the service |
| | Dangerous service for residents |
| | Socialisation issues |
| | Capacity issues |

A clean and safe environment in a learning disability home is vital to protect residents from health risks, infections, and accidents, ensuring their physical well-being. Additionally, providing spaces where residents can socialise without the risk of injury fosters a sense of community, encourages social interaction, and supports their emotional and mental health. These factors are essential for creating a nurturing and secure environment where individuals with learning disabilities can thrive. A scoping review from 2022 found that in seven published studies on environments in learning disabled homes, facilities that were able to emulate a safe, clean, "home-like" environment seemed to have a more positive effect on health and behaviour in residents (Roos et al., 2022).

Many of the homes in this study had serious failings in the physical environment. In multiple homes it was noted that bedrooms had malodour or that employees did not clean up after completing personal care tasks such as supporting residents with personal care:

> We identified serious concerns in relation to the cleanliness of the environment. Faeces was found around the communal toilet on the first floor on two of our visits. This included on the inside of the door handle and the flushing button. We observed people using this toilet with faeces present on both visits…. Bedding and towels in people's rooms were soiled. (CQC, 2022b, p. 8).

There was also an incident in one home of a resident being able to ingest harmful chemicals on multiple occasions demonstrating contraventions of Control of Substance Hazardous to Health Regulations (CQC, 2023d). Several homes also had issues with making sure that residents could communicate with people, leading to lack of socialisation for residents:

> one person had a care plan in place detailing the use of sensory items. However, the registered manager told us these items were not in use. There was no review or evidence in the care plan to show why this was the case. (CQC, 2022b, p. 14).

> The service was not supporting all people to maintain contact with their families during the Covid 19. Some people were supported with video calls to family, but relatives told us some calls were missed. Where this type of communication was not possible there were no additional measures in place, such as newsletters or photographs to help people stay in touch. (CQC, 2020b, p. 12).

Theme 4 – 'Ineffective systems in place to provide good quality care'

| Code | Sub-codes |
|---|---|
| Inadequate Care Plans and Guidance | No subcodes |
| Ineffective Systems in Place | Health management (medication and diet) |
| | Inadequate accident and incident recording |
| | Poor governance and insight |
| | Safeguarding issues |
| | Ineffective risk management |
| | Inadequate complaints and feedback processes |
| | Limited progress tracking for staff or residents |

Having clear care plans, effective oversight, and robust processes for feedback and complaints in a learning disability home is essential for ensuring personalised and consistent care that meets each resident's needs. Clear care plans guide staff in delivering appropriate support, while oversight ensures adherence to best practices and regulatory standards. Good processes for feedback and complaints empower residents and their families and staff to voice concerns as whistleblowing tends to have negative effects on the whistle-blower when there is no option to be able to address concerns through organisational procedure (Kelly & Jones, 2013).

Across all the homes in this study, it was evidenced that there were inefficient systems/processes in place to prevent abuse or to effectively investigate abuse allegations such as a lack of reporting to external agencies (as required by legislation, Care Act 2014) in multiple homes.

> Safeguarding concerns had not been shared in an appropriate and timely manner. This had impacted on the ability of the local authority to carry out their duties. (CQC, 2022b, p. 2).

> We found managers did not always report safeguarding concerns externally as required by law. (CQC, 2020b, p. 8).

There were also inefficient systems to provide good care in terms of medication and diet. Several homes did not have correct support plans or had support plans such as healthy eating guides which did not go into enough detail and so could not be followed correctly (CQC, 2021c). Where staff identified risks, most homes did not have staff proactively seeking support on these because they had no protocols/guidance on what to do in reporting:

> The incident reporting and monitoring system was ineffective as incidents were not always identified or reported using this system. This meant oversight of risk and identification of areas for improvement was not robust. Where incidents were recorded on this system, they did not help improve the quality and safety of the service provided or stimulate lessons learnt. The deputy manager told us that no analysis or review of incidents took place within the service. Staff told us incidents were not discussed and used as opportunities to learn lessons and improve the support provided. (CQC, 2021c, pp. 8-9).

The most serious issues were that in multiple homes there was a lack of understanding of medication recording charts leading to risks of medication being given to the wrong residents/being given incorrect dosages or improper training around medication storage:

> People's medicines were stored in individual boxes with their names on it. However, we found one box had different names written on either end. This raised the risk that medicines might be administrated incorrectly. (CQC, 2022b, p. 8).

> When we looked at people's medicines and their records we identified some discrepancies which indicated that incorrect doses of some medicines may have recently been given to people. Whilst staff carried out daily medicine checks we found that some of these were inaccurately recorded… We found that some information about people's medicines available to staff to assist them give people their medicines was inconsistently recorded and potentially misleading. (CQC, 2023d, p. 10).

> The temperature of the medicine refrigerator in which medicines requiring refrigeration (including injectable medicines) were stored was not being monitored and recorded on a daily basis to ensure the medicines remained safe for use. Some medicines that had limited shelf-lives on opening were not handled in a way that would ensure they were only used for the duration of their shelf-life. (CQC, 2023e, p. 9).

## Focus Groups

### Topic 1 – Emotional Challenges

A main theme across both the debriefed and non-debriefed participants was the emotional challenges of the involvement in involuntary home closures. Both groups mentioned feeling guilty when a resident is moved into a new home and it does not work out as planned:

> It’s a big emotional toll every time you have to move somebody because of quality issues.

Both groups discussed feelings of worry for service users, upset for the user's families, and frustration at the complexity and difficulty of the home closure process. Both groups also agreed they feel a constant cycle of burnout and stress due to constant closures. They felt embroiled in closures and provider failures and feel angry and frustrated because of this:

> I'm angry at staff intentionally exploiting residents vulnerability, I worry about the people. I worry about the families. But the owner, I am angry at.

However, one topic the non-debriefed group discussed, which the debriefed group did not, was the professional pressure they felt to juggle multiple responsibilities. When participants were asked how they manage these emotional impacts, both groups agreed that there is no time to process everything emotionally and that home closures were relentless, giving no respite. However, the non-debriefed group stated that this led to feelings of inadequacy and trauma, which were not present among the debriefed participants:

> Feelings of guilty when you move a client to a different home and it doesn't work out. Feel like you've failed. Feel guilty that you moved them and it went wrong.

> Hard to have the reputation of being the bad people, because the practitioners are the face, so people often blame them instead of others.

Despite lengthy conversations from both groups regarding negative emotions on home closures, both groups touched on the positive feelings when it works out well when a resident is moved. The debriefed focus group added that the little wins keep them going. This group also spoke about how some staff can find it empowering if they can get through a very challenging event, which can develop their professional resilience:

> Some people find it empowering to be able to get through a very, very difficult event.

> Going through difficult events made me more motivated to help the residents.

This was not something that was highlighted as much within the non-debriefed group.

Participants also discussed the impacts of the COVID-19 pandemic on their work. They revealed that as they were physically isolated when working, this may have caused emotional isolation:

> Virtual working is very challenging. Can't check in on people, they can't check in on you. Can't emotionally support people as easily as in person.
>
> Can overhear [in the office] if someone is struggling, so are aware, and you can help them. At home, you don't know how people are feeling.

One participant revealed that COVID completely segmented social care and health care and they felt 'it never returned to normal', even after the pandemic. They stated that this would be a reason to have active debriefs together. When the participants were asked if being involved in the closures felt isolating, one participant said they sometimes did not know how other staff members felt due to everyone working from home.

Topic 2 – Logistical Challenges

When discussing the logistical challenges of closures, both focus groups mentioned moving residents at short notice as one of the main challenges. They agreed that residents generally have little time for transition and support since home closures often happen very suddenly:

> Had two days to move people and had no control on where they were moving to. This is the hardest thing about a home closure.

Another challenge both groups agreed on was that they find it hard to communicate with providers and proprietors, as poor providers tend to lack care. Both groups said the system can hinder a smooth move, balancing what is best for the service user in an ideal situation vs balancing risks in the current placement:

> Client wants to visit home first but that's not possible. So, its stressful and traumatic for them.
>
> Stressful when there are no in-county options so you have to look at out of county options. Difficult to move someone out of county, very far away from their previous home, where they may not know anyone.
>
> Some providers are very good salesmen – they say they'll do things but then don't do any of it.

Furthermore, the non-debriefed group mentioned the challenge of being stretched on resources, due to the impacts of the cost-of-living crisis and COVID. They mentioned that dealing with a closure is tougher now compared to before the cost-of-living crisis. The debriefed group also noted that COVID made closures more difficult but not to the same extent as the non-debriefed group.

Topic 3 – Workload Challenges (non-debriefed group)

The topic of problematic workload only arose in the non-debriefed focus group. The non-debriefed participants stated that the closure put stress on their workloads, leading to challenges in keeping on top of all their tasks. For instance, one participant stated that their initial reaction to the home closing was a large amount of stress on workload:

> I have so much work to do that I don't even have weekends off, otherwise I wouldn't be able to keep on top of it.
>
> So many things to juggle work-wise, when dealing with a big home closure. Feel like you're not on top of your work.

Other participants agreed that there are several things to juggle workwise when dealing with a large home closure, and it is often to the detriment of other service user cases:

> You've still got all the other cases bubbling. But these [home closure] cases have to be prioritised because you've got no other option because they are at the highest priority. But that, you know, that really does have an effect on you. And you do end up doing more hours than you should be because otherwise all of us would probably be off sick because your mental health would be that bad, that you would get so behind.

One participant mentioned that although they were benefitting from engaging in the focus group, they were still thinking about other work they had to do – they were distracted by their work. Problematic workload was not mentioned at all by the debriefed participants who although mentioning large workloads, did not use emotive tones or words to describe them as an issue.

Topic 4 – Utility of Debriefs

When discussing the utility of debriefs, both groups agreed that debriefs were helpful and should be made compulsory. However, their reasonings behind this were different. The non-debriefed group stated that making them compulsory would benefit Norfolk County Council in that they felt it would help with staff retention. They also said they would only have time to attend them if they were compulsory:

> The debriefs would have to be made compulsory. Yeah, when you put things into your diary as compulsory, no one questions it but make it's not compulsory. When you're off doing something not compulsory you've got your workload to worry about.  something's always going to

> give, and it won't be your workload, will it? it's going to be something like training which is optional. Because like even today I'm loving this discussion. But even now in the back of my head I'm thinking, oh my God, I wonder what emails I've got. But then like I said, I'm getting so much out of this discussion that although in the back of your head you're thinking, oh, I've got other things I need to be doing. But I think as practitioners and like that's why I said about my CPD as well, adding this for my registration. I think it's so important to reflect on these sorts of situations because we're coming across it so much more often.

In contrast, this issue was not raised in the other focus group. The debriefed group seemed generally more positive when discussing implementing regular debriefs as a 'realistic' option and did not feel they should be compulsory as otherwise they would not happen. Instead, the debriefed group said they should be compulsory because they felt debriefs have emotional benefits that could help their co-workers:

> Debrief helped close a chapter, emotionally. We had this really intense period of time. We worked quite a lot and, you know, and over time, it affected us. You know, we thought about people in residential homes. So obviously when you finish with a day, they don't suddenly become safe for the evening. So, yeah, when you sign off, it doesn't mean the issues are gone. So it did affect us a lot at the time. I think definitely for me.

> Debriefs help – it was useful to sort of get that out in the open and for people to express their frustration and anger about the home closures.

> Debriefs can be a good opportunity to acknowledge the impact of secondary trauma stress.

Both groups also proposed a multidisciplinary debrief. The debriefed group said that it could have been interesting to have a debrief with quality assurance colleagues in their debriefs. The non-debriefed group mentioned including senior managers in debriefs to hear their perspectives. They added that it would be very powerful to hear the senior managers talking about their feelings:

> Debriefs with senior managers. Would be really powerful for them to talk about how they feel. Had that survey that normally comes around annually: Do you feel valued? That's a tick box exercise. But that's not the same as hearing someone's voice, how they feel.

## Discussion

In 2017, the Care Quality Commission published their policy document 'Registering the Right Support', which aimed to show that they were "taking a

firmer approach to the registration and variations of registration for providers who support people with a learning disability and/or autism" (2017, p. 4); going forward "providers should be able to demonstrate that they can provide appropriate, person-centred care" (Ibid: 5). This policy was created on the back of the Winterbourne View Hospital scandal in 2011, where the abuse of learning-disabled residents was exposed on BBC Panorama (Ibid: 3). This was later updated to 'Right Support, Right Care, Right Culture' to "clarify to providers how we implement this policy" (2022c, p. 2) in the wake of Cawston Park Hospital scandal in Norfolk. This policy expects providers to follow a 'People's Expectations' service model when designing or running their service, which aims to give residents a reasonable expectation that their experiences will be as follows:

- "I have a good and meaningful everyday life"
- "My care and support is person-centred, planned, proactive and coordinated"
- "I have choice and control over how my health and care needs are met"
- "My family, and paid support and care staff get the help they need to support me to live in the community"
- "I have a choice about where I live and who I live with"
- "I get good care and support from mainstream health services"
- "I can access specialist health and social care support in the community"
- "If I need it, I get support to stay out of trouble"
- "If I am admitted for assessment and treatment in a hospital setting because my heath needs can't be met in the community, it is high-quality and I don't stay there longer than I need to" (Ibid, pp. 6-7).

There is a small contingent of research focusing on care home closures which often focuses on marketisation or competitiveness issues in maintaining a steady business environment to keep the homes safe from closure (Bowblis, 2011; Li et al., 2010). In more recent years, more attention has been paid to closures relating to deficiencies in regulation/process following by care home directors/owners and staff (Allan & Forder, 2015; Allan, 2023). Our thematic analysis of 10 care homes suggests that there are four main themes of failure, which when happening simultaneously, will make it more likely to be involuntarily closed by the Care Quality Commission: Poor overall culture within the home; Lack of support for staff and managers; Unfit environment to

provide good quality care; and, Ineffective systems in place to provide good quality care.

Waggett (2012) found that learning disabled care homes with a poor organisational culture where staff had grievances with management and a large amount of sick leave/dependence on temporary staff had worse outcomes for residents. Waggett posited that this was because residents suffered in terms of not being able to form more meaningful relationships with staff members due to their negativity towards the organisation transferring in how caring they wanted to be towards residents (Ibid: 445). This can be problematic in that developing positive relationships between staff and residents is a common core measurement in quality-of-life assessments for those with learning disabilities (Schalock et al., 2002). In a study by Jingree and Antaki (2005), they found that staff who were trying to follow what they believed were conflicting organisational rules, would end up having this frustration evident in their speech patterns and this would discourage residents from speaking up or having more of a say in the management of their care. It is therefore unsurprising that poor culture featured so heavily in the closed homes in this study. Recently, Spall (2024) interviewed service users in learning disabled care homes in Norfolk and found that although most were happy with the relationships they had with staff, inconsistent staffing or large amounts of temporary staff use was detrimental to relationship building.

De-centring those with learning disabilities and their families from decisions about their care is problematic in terms of autonomy and legal rights. It has also been noted that empowering service users to advocate for themselves has positive outcomes when it comes to safeguarding as it means service users feel more confident to speak up if they feel they are being abused or at risk of abuse (Jenkins et al., 2011). Service users often want to be part of conversations about their safeguarding or medical issues, however poor leadership and organisational cultures that are unwilling to devote time and human resources to implementing this as standard care mean that these residents become ignored and have their autonomy taken away (Mahon et al., 2024). We found evidence of this in terms of poor support for staff and management. In a systematic review of care relationships in learning disability residential settings across the UK, Mamolis et al. found adequate training of staff could mitigate issues with staff and service user relationships in 13 different studies with a focus on empowering service users (2024).

Alongside the new quality standards for over-65s homes introduced in 2014, Mortensen et al. have asserted that there has been “a noteworthy increase in enforcements in for-profit care homes” regarding closures in recent years

(2024, p. 301). Allan views this in a positive light in that: "closure of a home care provider is likely to mean a change in circumstance for those that were supported by the firm and this could have welfare implications. Given a poor-quality provider has closed, moving to a new provider should be welfare improving overall" (2023, p. 149). In the longer-term this may be the case, however our study has highlighted the need to address the emotional challenges for healthcare professionals during the closure itself. As well as the fact that there has been limited attention on homes providing care to learning disability and/or autism residents compared to the plethora of studies on older peoples' care. This study found that both debriefed and non-debriefed participants had indicators of worsening issues with stress, however it was slightly more pronounced in the non-debriefed participants. This suggests a lack of psychological safety, which the Care Quality Commission argues is important for a comfortable working climate (CQC, 2024).

Poor care homes are problematic for external professionals involved in their closure because they can worsen issues such as secondary traumatic stress (Hanson, 2015), a condition which was mentioned by participants in the focus groups. Bride (2007) conducted a study whose results indicated that social workers in particular are susceptible to experiencing some of the symptoms of secondary traumatic stress during their careers. Secondary traumatic stress is different from post-traumatic stress disorder (despite having similar symptoms/presentations) as it is resultant from vicarious exposure rather than direct traumatic exposure (Canfield, 2005). Bride found that social workers may develop secondary traumatic stress from their indirect exposure to trauma in service users that they manage and found that 15.2% may meet the diagnostic criteria for post-traumatic stress disorder at least (2007). These disorders are damaging because it can impair social workers' ability to support those who seek their services effectively and, thus, impact the quality of care being given. Debriefing has been effective in achieving positive outcomes for healthcare workers who experience patient death (Harder et al., 2019) and it is suggested from our findings that a debrief can be an excellent opportunity to acknowledge the potential impact of secondary traumatic stress during a home closure. For debriefed participants, they stated that debriefs helped close emotional chapters after intense work periods, providing an opportunity to process emotions and thoughts related to the closure. The debriefs helped participants feel reassured that they were all working together towards the same goal.

Bride suggests that experiencing secondary traumatic stress is believed to be one of the reasons why many social workers leave the field prematurely (Ibid, p. 68) and this is often linked to the professionals not feeling connected

to their peers when trying to process emotional challenges. This demonstrates the negative impacts of stress on social workers, emphasising the importance of investigating how to support staff. This is important as Craig and Sprang discovered in their study that the higher the number of people experiencing abuse or trauma that the practitioner is supporting will impact the likelihood of the practitioner experiencing secondary traumatic stress (2010). Goossen (2020) discovered that secondary traumatic stress can impact staff by decreasing their morale and worsening their job performance. This is relevant when considering the number of residents in care home closures who were subject to abuse and how this relates to the secondary traumatic stress experienced by the health and social care professionals dealing with the closures. Safeguarding issues negatively impacts practitioners and home closures often have many safeguarding concerns, such as those found in the thematic analysis (NHS, 2020). The British Medical Association (2020) claims that to reduce the risk of trauma, professionals must seek social support from colleagues, use peer support and utilise any opportunities for debriefing.

Stamm states that healthcare professionals who deal with trauma can experience compassion fatigue, where practitioners begin to feel indifferent towards any suffering of their service users, usually caused by a combination of secondary traumatic stress and burnout (2010). There is also previous evidence from one study that lone-working can exacerbate compassion fatigue and burnout from a study conducted on frontline caregivers during COVID-19, which was present among our focus group participants (Marshall, 2020). A study by Yi et al. (2016) also suggested that regular debriefing may be beneficial for those suffering with compassion fatigue (with an onus on further study into this idea).

A recent study suggested that although a debriefing does not result in a "decrease of cognitive effort to perform [a] task" it may give the participant time to think about the task in a way that makes it feel more manageable (Meguerdichian, 2022, pp. 8-9). This is reflective of a study by Mullan et al. (2021) where debriefing was presented as "value-added time" to think about workloads constructively, producing more positive results. Another recent study noted that the authors believed debriefing could be used to help understand peoples' "cognitive load" relating to their workload by using debriefs (although it was not in the scope of their study) (Fraser et al., 2018, p. 7).

## Conclusion

This research has found that four main themes were present across involuntarily closed residential learning disabled and autism care homes, which point to significant shortcomings in staff training, working conditions, managing individuals under care, and raising concerns about the safety and quality of the services provided. This research suggests four themes in particular have been prevalent in Norfolk care homes and indicates an imminent and severe risk of involuntary closure when happening together.

From our focus groups with Norfolk County Council staff, both groups agreed with the idea of implementing debriefs as standard procedure within the council in the future. However, ultimately, we did not find a large difference in attitudes between the debriefed and non-debriefed health and social care professionals. The difference we found in terms of the more pronounced negative outlook concerning workload in the non-debriefed group was interesting as it could indicate a higher risk of stress-related issues when not being regularly debriefed, which could be investigated in further research. We did find that healthcare professionals did see some benefit in being debriefed. One participant argued that offering debriefs would benefit Norfolk County Council in particular as it would mean they could identify what went wrong in a closure, what could have been done differently and how to improve home closure processes in the future.

## Limitations

A limitation of this study is that it only explored the relationship between learning disability care home closures and health and social care professionals within Norfolk due to the geographical restriction of what the funding procured for this study could be used for. This may affect its generalisability to other regions in the UK. This study also had a small sample size; analysing 10 CQC reports and conducting focus groups with 13 professionals may not provide a comprehensive view of all the issues present in forcibly closed care homes. The small sample size may limit the robustness and breadth of the thematic analysis. Additionally, as health and social care best practices change regularly, this study might not account for changes over time in regulatory practices, care home operations, or health and social care policies. Findings from a specific period therefore may not be applicable to future situations.

## Future Research

A risk matrix tool has been created from these themes to help health and social care staff consider which homes may be at risk (UEAhscp, n.d). We anticipate that this risk matrix will help identify poor care homes earlier and support their improvement and will allow for quick recognition of how risky a service is for the people supported there. We expect that it will allow the service to map out where the difficulties are quicker than before and see what areas are indicative of issues (e.g. culture, environment, support for staff and managers, the systems in place, etc.). This will be rolled out for internal use within Norfolk County Council for health and social care commissioners, practitioners who visit care homes and the integrated quality service, as well as key stakeholders in external services in 2024. Measuring the success of the new risk matrix tool is an intention of the team for future research.

Debriefs can only be instigated and staff can only be supported if staff attend a debrief initially. This is so that they can see their benefits and then want to attend more in the future. Although debriefs are desirable, they are not essential. Realistically, it might be difficult to make debriefs compulsory as staff should be recognised as completely autonomous, so that they can make their own decisions regarding their personal well-being. However, Norfolk County Council will be looking into what can be done to make more measurable outcomes regarding debriefs that do occur as well as creation of a debrief fact sheet for professionals running these sessions to use.

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Ethics Approval

This study was performed by those employed by Norfolk County Council. The organisation follows a Research Governance Framework and studies are required to provide an ethical approval form for any studies they conduct to the Insights and Analytics department. This department then approve projects on a case by case basis, with this project approved via email in 2023.

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