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# Implementing quality and safety regulations in residential disability services: a qualitative interview study

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## ABSTRACT

**Background** Regulation plays a central role in health and social care systems, particularly in ensuring quality, safety and accountability. However, there is limited understanding of how organisations effectively implement and adhere to these regulatory requirements. In particular, little is known about how providers of residential care facilities for people with disabilities (RCF-D) navigate and apply statutory care regulations.

**Methods** We conducted semistructured interviews with managers of RCF-D. Participant recruitment followed a purposive maximum variation sampling approach. 19 participants were interviewed, representing 22 RCF-D and 16 provider organisations. Interview data were analysed using a mixed deductive–inductive approach.

**Results** Most managers were supportive of regulatory goals, creating a more favourable environment for successful implementation. By making sense of regulatory requirements and sharing insights across their organisations, managers facilitated smoother implementation. Crucially, building strong internal and external networks played a pivotal role in driving success. Collaborative relationships with inspectors, centred on a shared commitment to improving residents' lives, further strengthened the implementation process.

**Conclusion** Managers of RCF-D devised a range of strategies to manage compliance, balancing regulatory demands with problem-solving and relationship-building. These efforts were supported by a collaborative approach to working with inspectors, which fostered a shared commitment to improving residents' lives. Our findings offer practical guidance for organisations seeking to improve regulatory compliance through effective relationship management and resource alignment. Future research could investigate how framing regulation as an adaptive intervention could further enhance implementation and sustain compliance.

## BACKGROUND

Regulation has been defined as: 'sustained and focused control exercised by a public agency over activities which are valued by a community'.<sup>1</sup> Regulation is typically the responsibility of an independent authority, overseen by government.

In health and social care, regulation of individual professionals such as doctors

## WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Regulation plays a central role in ensuring the quality, safety and accountability of health and social care systems worldwide, but little is known of how organisations implement regulatory requirements.

## WHAT THIS STUDY ADDS

⇒ This study reports the perspectives of managers of residential disability services and describes the strategies they use to comply with quality and safety regulations.

## HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ This study conceptualises regulation as an intervention, and the authors argue that regulation should be subject to research from an implementation science perspective to better understand how regulatory practices are implemented, adapted and sustained.  
⇒ Our findings describe a range of themes that can inform the practice of service providers in managing regulatory engagements and achieving compliance.  
⇒ The findings may also be of interest to regulators in terms of how best to manage relationships with regulatees.

and nurses has been intensively studied,<sup>2–5</sup> but there is less insight into how organisations such as hospitals and residential care facilities respond to regulation.

The implementation of regulations has been studied across diverse disciplines such as economics, political science, public administration and health organisation studies. How individuals respond

to regulation and the processes through which regulations are integrated into everyday practice have been examined. Studies have identified key strategies used to support implementation, including instituting internal compliance systems,<sup>6</sup> appointing compliance officers<sup>7</sup> and fostering a ‘culture of compliance’.<sup>8</sup> However, implementation does not always follow a linear path. Those responsible for regulatory adherence may engage with it in different ways, such as aligning with requirements, adapting them to local contexts or resisting them altogether. Some studies have categorised these responses as amoral calculators,<sup>9</sup> conformists<sup>10</sup> or game players,<sup>11</sup> illustrating the varying degrees of engagement with regulation in practice.

Our study focused on residential care for people with disabilities. Residents in such services are vulnerable because of communication problems, cognitive difficulties and physical restrictions. People with disabilities have been subject to abuse,<sup>12</sup> experienced poorer support for privacy and independent living,<sup>13</sup> and high rates of restrictive practices<sup>14</sup> while living in residential care. The high stakes and highly regulated nature of this context make it a rich source for insight into successful practices in achieving regulatory compliance.

The focus of this study—the intervention—is regulation (figure 1). This differs from accreditation, another common form of external evaluation. There are several key differences. Accreditation can be voluntary or mandatory, depending on the country; regulation is always mandatory.<sup>15</sup> Accreditation assessments usually occur at a specified frequency (eg, every 3 years), whereas regulatory inspections can occur at any time, be contingent on the perceived level of risk and can occur without prior warning.<sup>16</sup> Accreditation agencies do not usually possess legal powers of enforcement or sanction, whereas regulators have both assessment/evaluation and enforcement powers.<sup>17</sup> These differences, and the significance of the consequences associated with regulatory non-compliance mean that implementation strategies are likely to be different in regulated bodies compared with accredited bodies.

The study aim was to describe how residential disability service managers in Ireland engage with the implementation of statutory regulations. We examine managers’ perspectives on regulation, the strategies, structures and processes they use to implement it, and key factors shaping these approaches, such as resource availability and attitudes toward the regulatory regime. Additionally, the study considers how managers perceive the impact of regulation on service quality.

## METHODS

We conducted semistructured interviews with senior managers of residential care facilities for people with disabilities (RCF-D) in Ireland.

## Setting

Approximately 95% of RCF-D in Ireland provide care for people with an intellectual/learning disability.<sup>18</sup> In August 2024, there were 88 providers of RCF-D in Ireland, operating 1622 RCF-D centres; total beds nationally was 9177.<sup>19</sup> Voluntary (not-for-profit) providers accounted for 1150 (70.9%) of RCF-D. 301 (18.6%) were operated by private (for-profit) providers and 171 facilities (10.5%) were state-run.

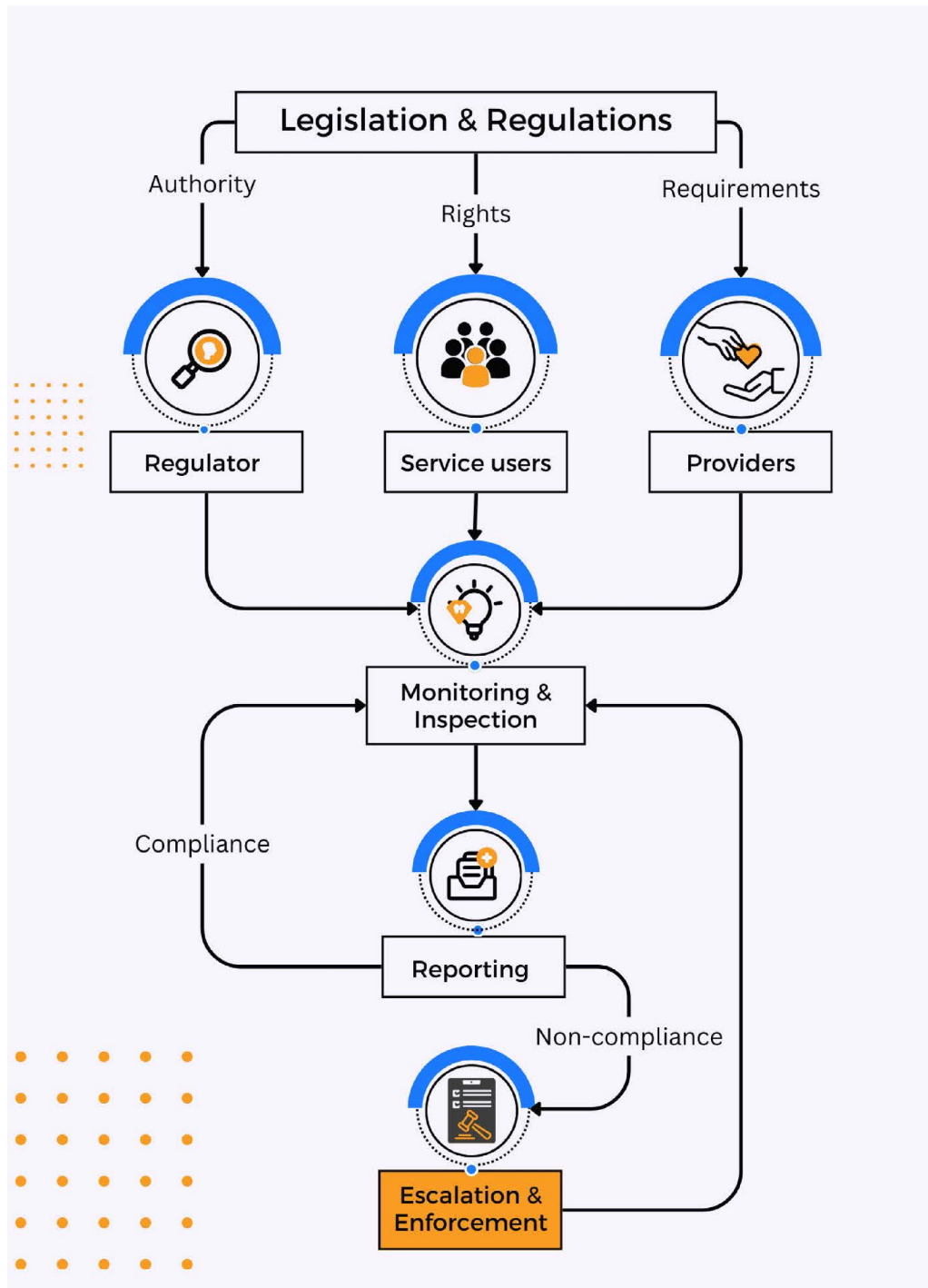
Regulation for RCF-D in Ireland was introduced in 2013, providing residents of RCF-D with certain rights (eg, individualised personal plan, respect for privacy and dignity). The regulator mandates at least two inspections of RCF-D in each 3-year registration period. Data from 2023 showed 61% of inspections were unannounced while 30% were announced and 9% short-notice announced.<sup>20</sup>

Inspectors choose what regulations to assess based on a RCF-D’s compliance history and profile. The inspector can choose to focus on regulations that were not in compliance previously, or those not recently assessed. A centre’s profile (ie, number of beds, type of care provided, premises age) may influence an inspector’s choice of regulations. Inspectors judge each regulation as compliant, substantially compliant or not compliant.<sup>21</sup>

## Participants and recruitment

Two categories of manager were sought: persons in charge (PICs) and persons participating in management (PPIMs). PICs are responsible for the day-to-day running of services. PPIMs are more senior than PICs and hold ‘senior operational management decision-making responsibilities’ for a service.<sup>22</sup> This study aimed to explore both organisation-level approaches to implementation and views and experiences of individual managers. PICs were recruited to provide individual-level material and PPIMs to provide organisation-level insight.

Service providers (n=88) were contacted requesting permission to approach people for interview; 32 (36.4%) agreed to participate. PICs and PPIMs in participating organisations (n=524) were emailed an information sheet and invited to interview. Respondents (n=40) were selected using a purposive maximum variation sampling approach<sup>23</sup> to produce diversity. Our primary characteristic for maximum variation was provider size: small/medium/large/statutory (statutory was included post hoc because the single statutory provider was also large, which would result in their proportional over-representation). We sought to recruit two participants from each of the four groups to capture potentially divergent views, that is, eight PICs and eight PPIMs. Our secondary characteristic was participants that represented urban/rural centres and different provider compliance levels to ensure participants varied from each other as much as possible. This sampling approach was applied to



**Figure 1** Regulatory system for social care in Ireland.

PICs and PPIMs separately. Participants were invited until we had satisfied maximum variation as described above. All participants signed consent forms and reviewed transcripts for comment.

#### Public–patient involvement and engagement

Public–patient involvement and engagement (PPIE) contributors were recruited through a national disability advocacy organisation and a local disability service provider. The contributors were two

residents of an RCF-D and two relatives of people living in RCF-D. PD met the residents in person on two occasions during 2023. Telephone discussions were conducted with the relatives. PPIE contributions informed the development of the interview topic guide.

#### Data collection

The topic guide (online supplemental file 1) was informed by normalisation process theory (NPT).<sup>24</sup>

We chose NPT over other frameworks because the implementation of regulations is a constant process that requires fundamental change to a wide range of practices. The fundamental requirement for implementation is therefore ‘normalisation’, which implies that everyday work practices become aligned with regulations. We considered using the Consolidated Framework for Implementation Research,<sup>25</sup> but felt this framework was too broad for our study aims and would have diluted the focus on implementation practices.

All interviews were conducted by PD (see online supplemental file 2 for interviewer personal characteristics) using Microsoft Teams, transcripts and video were collected.<sup>26</sup> Automated transcripts produced by Microsoft Teams were edited and verified by PD. Two pilot interviews were conducted and minor changes were made to the prompts before being finalised. The first phase of interviews covered PICs with PPIMs in the second phase. The topic guide for the second phase was amended by editing prompts for three questions.

### Analysis

Eight PICs were required for phase one to align with the purposive maximum variation sampling approach; we ultimately recruited 11. We used a mixed deductive–inductive approach to analysis using NVivo software.<sup>27</sup> Deductive analysis started with an NPT coding manual<sup>28</sup> to explore the data and identify text relevant to implementation. Two researchers (PD and LK) reviewed three transcripts independently and coded data to the most appropriate NPT construct. PD and LK then met to review coding and resolve inconsistencies. PD coded the remaining data.

Inductive analysis used the deductive thematic structure as a starting point and was also informed by NPT.<sup>29</sup> Two researchers independently coded the data. PD and LK met to refine the coding framework. Codes were grouped into new higher-order subthemes and parent themes. PD then coded the remaining data independently. All three authors then discussed the codes, subthemes and parent themes. This was an iterative process involving the clear delineation of themes, reallocating certain codes to alternative subthemes and agreement on theme names.

Once phase one interviews were completed, all authors were satisfied that the sample size was adequate and represented sufficient ‘information power’.<sup>30</sup> The concept of information power is contingent on the unique characteristics of a study and entails a stepwise approach as opposed to determining a sample size from the outset.<sup>30</sup> The criteria used for determining information power are: study aim (narrow or broad); sample specificity (dense or sparse); use of established theory (yes or no); quality of dialogue (strong or weak); and analysis strategy (case or cross-case). For example, a study with a narrow aim using an established theory requires fewer participants to reach

information power than the inverse. All authors were involved in the determination of information power, and each had access to the interview transcripts to assess the quality of dialogue. On the recruitment of eight PPIMs for phase two, we analysed the data as above. We again assessed these data and were satisfied that information power had been achieved.

Findings are reported in accordance with the COREQ (Consolidated Criteria for Reporting Qualitative Research) qualitative research reporting guidelines (online supplemental file 3).<sup>31</sup>

Results are reported under parent and subtheme headings, with quotes used to support observations as well as a table containing strategies to improve regulatory compliance.

## RESULTS

Interviewee characteristics are available in table 1. Interview length was 32–74 min, with a mean of 53 min. Findings are presented under five parent themes: managing organisational culture; putting the right structures and resources in place; putting the right processes in place; dealing with the outside world; and managing the relationship with the regulator (table 2).

### Managing organisational culture

Interviewees influenced, and were influenced by, the prevailing culture within their organisation regarding regulation. Managers often had to interpret or challenge the fit of regulations within their organisational culture, echoing the NPT subconstruct of differentiation, as they assessed whether regulatory changes aligned with existing practices. The subconstruct of internalisation also had relevance for this theme as managers identified the positive contribution regulation had made to services. Efforts by managers to foster a positive attitude towards regulation among staff are consistent with the NPT subconstruct, enrolment.

#### Views about the regulatory process and the regulator

Interviewees expressed positive and negative opinions on regulation. These opinions had evolved as engagement with regulation increased over time. Many interviewees spoke about regulation in positive terms, arguing that it established a baseline that became normalised.

Most interviewees acknowledged other benefits like increased staffing, improved physical premises and support for a person-centred ethos. Management positivity towards regulation meant they were well disposed to embedding regulatory requirements throughout their services. This might indicate positive interactions with the regulator, impressions of benefits for residents, or it may reflect that regulation is mandatory and positive engagement makes sense.

**Table 1** Characteristics of interviewees

Participant ID	Job title	No of centres managed (max occupancy)*	Service-user population†	Geographical location of centre‡	Provider organisation classification§	Provider organisation compliance measure¶
PIC1	Person in charge	2 (5–9)	(1) Adults (male and female) with mild, moderate, severe or profound learning disability. (2) Adults (male and female) with mild, moderate, severe or profound learning disability.	Independent urban town Independent urban town	Medium–voluntary	75.8
PIC2	Person in charge	1 (10–20)	Short-term respite for people with a neurological condition.	City	Small–voluntary	100
PIC3	Person in charge	1 (5–9)	Respite service for children aged 4–18 with significant physical disability, associated complex medical needs and those with life-limiting conditions.	Rural area with high urban influence	Small–voluntary	90
PIC4	Person in charge	1 (5–9)	Adults (male and female) with acquired brain injury.	City	Large–voluntary	94.8
PIC5	Person in charge	2 (10–20)	(1) Adults (male and female) with intellectual disability, autism spectrum disorder or acquired brain injury. (2) Adults (male and female) with intellectual disability, physical disability, autism spectrum disorder or acquired brain injury.	Rural area with high urban influence Satellite urban town	Medium–for profit	97.9
PIC6	Person in charge	1 (5–9)	Adults (male and female) with mild or moderate intellectual disability.	City	Medium–voluntary	92.6
PIC7	Person in charge	1 (10–20)	Adults (male and female) with intellectual disability.	Satellite urban town	Small–voluntary	83.3
PIC8	Person in charge	1 (21–50)	Adults (male and female) with physical disability or neurological condition, in addition to secondary disabilities such as learning disability, mental health difficulties or medical complications like diabetes.	Rural area with moderate urban influence	Large–voluntary	92.2
PIC9	Person in charge	1 (1–4)	Adults (male and female) with intellectual disability.	City	Large–voluntary	89.9
PIC10	Person in charge	1 (5–10)	Adults (male and female) with intellectual disability or autism spectrum disorder.	Highly rural/remote areas	Large–public	91.7
PIC11	Person in charge	2 (10–20)	(1) Adults (male and female) with intellectual disability. (2) Adults (male and female) with intellectual disability.	Satellite urban town Satellite urban town	Large–public	91.7
PPIM1	Area director	n/a	Provides services to people with intellectual disability and/or autism spectrum disorder.	n/a	Large–voluntary	94.6
PPIM2	Service manager	n/a	Provides services to young people with a visual impairment who may also have an additional disability, for example, learning, hearing or physical and have complex needs as a result of social, cultural, economic or emotional factors.	n/a	Small–voluntary	64.9
PPIM3	Regional manager	n/a	Provides services to people who need support across the areas of mental health, disability, aftercare, elderly, transitional and mainstream social care.	n/a	Medium–for profit	87.8
PPIM4	Service manager	n/a	Provides services to people with intellectual disabilities.	n/a	Large–voluntary	88.9
PPIM5	Social care manager	n/a	Provides care to people with a wide range of disabilities.	n/a	Large–public	91.7
PPIM6	Director of nursing	n/a	Provides care to people with a wide range of disabilities.	n/a	Large–public	91.7
PPIM7	Service manager	n/a	Provides services to adults with intellectual disability.	n/a	Medium–voluntary	87.0
PPIM8	Service manager	n/a	Provides services to adults and children with intellectual disability and other disabilities.	n/a	Medium–for profit	89.2

\*Bed numbers are placed in a range to ensure the anonymity of the centre and service provider.  
 †Describes the characteristics of individual centres in the case of persons in charge; and characteristics of the service provider organisation in the case of persons participating in management.  
 ‡Urban/rural designation obtained through search of central statistics office interactive map of urban and rural life in Ireland 2019.<sup>45</sup>  
 §The provider organisation classification variable is comprised of the size of the provider organisation and its designation as voluntary, for-profit or public. Provider size categories are as follows: small (one service); medium (2–10 services); large (>10 services). There is only one public provider and it is classified as large.  
 ¶The mean level of compliance for each provider was calculated as follows: a compliance score for each inspection from 1 January 2018 to 29 February 2024 was calculated by dividing the number of regulations found compliant by the total number of regulations assessed. The results were grouped by provider and the mean was calculated, thereby giving the mean level of compliance. National provider mean compliance from 1 January 2018 to 29 February 2024 was 87.3%.  
 PIC, person in charge; PPIM, persons participating in management.

Some interviewees had negative views about regulation, specifically the burdens of implementation, the apparent incongruence of some requirements and increased costs. Interviewees sometimes struggled to make sense of the regulations in the early years of regulation. Moreover, the ‘human’

character of RCF-D led some to question whether the application of specific prescriptions was appropriate. Notwithstanding, there was an acknowledgement that regulations had to have a certain rigidity:

**Table 2** Themes identified from qualitative analysis, and related strategies for improving regulatory compliance

Parent theme	Subtheme	Strategies for improving regulatory compliance	Examples
Managing organisational culture	Views about the regulatory process and regulator	Emphasise that the organisation and regulator have a shared goal of ensuring high quality care to foster a positive culture towards regulation	'I think a lot of services now have risen to the standard that's been created [by regulation]...and it just becomes a normal part of practice'.
	Overall strategic approach adopted by regulatee	Embed regulatory compliance in the organisation's overall ethos and strategy	'nobody's house, I know my house certainly isn't in pristine, 100% condition all the time, you know? You'll say 'we need to do this', but there's a period of time and it's acceptable to wait that period of time'.
Putting the right structures and resources in place	Implementing governance structures	Institute formal, internal oversight structures to monitor implementation of regulations	'we now have a rights commission, restrictive practice team with two independents on it. I drove that for the last year or so and it's working really well'.
	Managing human resources	Hire competent staff and train them to provide person-centred care in line with regulatory requirements	'Their [quality and compliance managers] role is more, they have an in-depth knowledge of the regulations and HIQA and the inspectors, etc...they have an in-depth knowledge of the process'.
	Resourcing services to enable compliance	Secure adequate financial resources to provide the required level of service and ensure that funders are aware of any shortcomings	'(the nature of the non-compliant findings) was speech and language, it was psychology and so on... we might have to find money in the interim and just go ahead and get something so that we're compliant'.
Putting the right processes in place	Clear assignment of responsibility for making compliance happen	Establish clear lines of accountability for implementing regulatory requirements and involve staff in tasks to deliver and maintain compliance	'you're trying to reach compliance across so many different regulations... It's a huge amount for one person...we all work together, but it's a huge amount to be responsible for it as a PIC'.
	Communication processes that support compliance	Disseminate learning from previous local inspection reports, and reports from other facilities, throughout your organisation	'you're trying to learn from colleague's inspections and... raise the standard before you get inspected'.
	Monitoring processes that support compliance	Continuously monitor and record implementation practices that are supported by internal auditing and self-assessment	'[inspectors] have to be able to make a judgment on how the service is within probably 6 or 7 hours...the better the files are...the more relaxed they are about how things are running here'.
Dealing with the outside world	Accessing external resources	Ensure that external services are available to support service user needs and build relationships with the providers of such services	'sometimes the barrier to my centre being compliant is actually an external problem: how do you get MDT input if it's not being provided by the [national health service]?'.
	Structural or environmental factors that influence the implementation process	Identify and adequately prepare for any relevant changes to policy or legislation that may impact on your organisation's capacity for compliance	'We have significant level of resources going in and responding to need. But it is becoming somewhat untenable. And the ADMA (Assisted Decision-Making (Capacity) Act) piece is adding to that. And the new safeguarding policy is going to add to it as well'.
Managing the relationship with the regulator	Effectively responding to findings of non-compliance	Devise responses to non-compliance that are prompt, effective and centred on improving the lives of service users	'I often have my own ideas around how something should be implemented. And I've no problem, respectfully, with an inspector going back and forth'.
	Relationship between service management and inspector/regulator	Build and maintain positive relationships with inspectors—and with the regulator generally—that is underpinned by openness and transparency	'[the inspector] spoke about how HIQA are...looking to be allies in the process of improving health outcomes for people's lives rather than be something that's feared'.

the unique needs of each individual doesn't always fit into the boxes I suppose...how do you create regulation without it being black and white?

This negativity meant implementation was sometimes deprioritised due to perceived negative effects. Ultimately, these perspectives (both positive and negative) had a bearing on managers' strategic approach to implementation.

Overall strategic approach adopted by regulatee

The organisational culture regarding regulation informed the strategic approach to implementation. Some interviewees felt their organisation's

culture aligned with regulatory requirements and implementation of regulations did not require significant changes to common work practices.

However, some interviewees felt regulations were sometimes unnecessary or conflicted with the interests of residents. For these regulations, managers tolerated low-level non-compliance, in the expectation that it would not trigger sanctions. This suggests managers had developed a sense of where the boundaries lay and tailored implementation to ensure they did not venture into serious non-compliance.

There were multiple instances where managers surmised that full implementation of regulations was

neither achievable nor in the service's best interests. This was due to a perverse incentive where findings of non-compliance acted as leverage for resources. In this scenario, managers felt they were not empowered or resourced to facilitate full implementation and wished for inspectors to know this:

I'd always be delighted to get that in a HIQA report because I know that that would be what I needed if I couldn't get anything else done in that regard.

This indicates managers acted as advocates for their services, regularly requesting additional resources. Requests were strengthened when supported by inspection findings, thus incentivising managers to game the system by pursuing non-compliances.

### Putting the right structures and resources in place

This theme reflects the work managers did to plan and operationalise regulatory requirements. In line with the coherence construct in NPT, this involved activities that helped staff understand and enact the intervention.

#### Implementing governance structures

Governance structures in organisations evolved to take account of regulatory requirements. These structures provided a means for managers to work together to understand what regulations required of them. Once established, the structures provided a means to monitor implementation and oversee audits that had a bearing on compliance. So, while a positive culture towards regulation was important, there remained a requirement to formulate governance structures to ensure compliance.

#### Managing human resources

The recruitment of staff was not merely an exercise in increasing resident:staff ratios or diversifying the skill mix; interviewees also spoke about how their organisations hired managers with experience of regulated environments.

Some interviewees voiced frustration with recruitment and retention of staff challenges, impacting on implementation capacity. Some felt staff did not act with management to implement regulations. This created a culture where managers felt they were solely accountable for implementation. However, managers were clear that participation by all staff in implementation was necessary, and if they were left isolated, the service would struggle to be compliant.

#### Resourcing services to enable compliance

The implementation effort was contingent on securing adequate resources (eg, premises maintenance, access to healthcare) to achieve compliance. This was a consideration for those managing ongoing compliance and those addressing non-compliance. While there was evidence of efforts to provide adequate resources

within organisations, this was typically in response to specific findings of non-compliance.

For managers who regularly advocated for additional resources, inspectors were often seen as allies, lending weight to their case. This suggests the regulator's power made them active participants in the implementation process. Furthermore, it indicates some managers saw the regulator as an advocate for increased resources, and not merely a detached evaluator of quality.

### Putting the right processes in place

Regulatory prescriptions become embedded and normalised through processes founded on the structures described above. These processes facilitate the implementation effort through unambiguous understanding of responsibilities, effective communication, training and continuous monitoring. The subthemes outlined below map onto the NPT constructs of coherence and collective action, where managers have understood what is required and worked to devise processes to support implementation.

#### Clear assignment of responsibility for compliance

Managers played a central role in implementation. They delegated tasks to support compliance and escalated matters where appropriate. They also keenly felt the responsibility for achieving compliance despite the collaborative effort.

Interviewees also described strategies used to ensure staff were aware of their responsibilities for compliance. Sometimes, this meant requiring something was done because the regulator required it, rather than for the benefit of residents. This suggests some managers thought that regulation was something foisted on them. Equally, it demonstrates the regulator had a sufficient level of authority to command the buy-in of all in support of the implementation process.

#### Communication processes that support compliance

Internal communication processes were important, such as focusing on the requirements of a specific regulation at staff meetings. Managers viewed such processes as important for ensuring staff had a consistent conception of what successful implementation looked like. Published inspection reports were useful for managers who wanted to learn how other RCF-D operated, and this learning was shared across organisations.

There were regular communications (eg, information sessions and webinars) from the regulator to aid implementation. Guidance documents were a key resource for understanding what was required for compliance. This indicates the regulator felt a sense of duty to educate regulatees and be transparent about what successful implementation looked like. This is evidence of a cooperative relationship, geared towards supporting implementation. Regulatory guidance

was not always viewed positively as some noted the large volume of documentation required an excessive amount of time to consume.

#### Monitoring processes that support compliance

Monitoring processes were required to measure and evidence compliance. Audits were a feature of monitoring processes, where managers assessed aspects of services to identify potential non-compliances. Actions arising from audits required tracking to ensure they were addressed. Implementation of regulations, therefore, required constant vigilance and attention. Successful embedding of regulatory requirements could not be taken for granted; it was a burdensome and resource-intensive undertaking requiring a sustained effort.

Continuously monitoring documentation quality was also important for implementation. Interviewees recognised inspectors were on-site for a short period of time and documentation was a key source of evidence. Thus, it was not enough that tasks were done; they needed to be documented.

Thus, good quality documentation made assessing compliance easier for inspectors and served to build cooperative and trusting relationships with them. Nevertheless, some felt regulation required an excessive focus on documentation, detracting from care opportunities and reducing appetite for implementation.

Some interviewees felt the competencies of frontline staff required continuous monitoring to ensure they understood and supported the regulations. Encouraging a collective effort and fostering legitimacy for the regulations was seen as a key driver of successful implementation. Managers were often champions for regulations, convincing staff of the positive aspects of compliance and securing ongoing support for implementation.

#### Dealing with the outside world

The successful implementation of regulations was not simply a matter of monitoring a service's processes and practices. It also meant building networks and relationships that supported implementation or aided in navigating a complex milieu of overlapping legislation, policy and guidelines. This theme is relevant for NPT's collective action construct where people work together to enact interventions and the degree to which they are supported by their organisations to do so.

#### Accessing external resources

There were regulatory requirements that some argued were entirely outside their organisation's sphere of influence. A recurring theme was the difficulty with access to community-based healthcare services. Long waiting lists meant that many were non-compliant with the 'healthcare' regulation.

Some managers felt unsupported by other state agencies in the implementation effort. Some pooled

resources to collectively source services. This demonstrates managers' willingness to establish networks outside their own organisations to support implementation.

#### Structural or environmental factors that influence the implementation process

Managers in large organisations that engaged with multiple regulators felt this was an advantage. It was reasoned that the requirements in a wide range of regulations served to raise standards throughout the organisation. New policy and legislative developments also changed the context within which services operated. These required time and effort to understand and complicated the implementation environment for managers.

#### Managing the relationship with the regulator

Interviewees spoke about the importance of good relationships with inspectors and the regulator. Some found it beneficial to work collaboratively with inspectors, mapping to NPT's collective action construct. Others challenged findings of non-compliance—echoing the NPT subconstruct of legitimacy—but not always in an adversarial manner.

#### Relationship between service management and inspector/regulator

Many interviewees spoke about how the nature of the relationship with the inspector affected their ability to implement regulations. Most inspectors were said to have a collaborative approach and were willing to work alongside services to deliver benefits for residents. In contrast, some interviewees spoke about less supportive relationships with inspectors.

Having knowledge of an inspector's professional background enabled some to target improvements to impress the inspector. Therefore, compliance was sometimes 'gamed' by overcompensating in an inspector's area of interest. This suggests that, for some managers, demonstrating a high level of competence in key areas was more important than full implementation as it improved their standing with inspectors. It also demonstrates the importance of experience and having well-developed relationships so the manager can anticipate the preferences of inspectors.

#### Effectively responding to findings of non-compliance

There were different approaches for addressing findings of non-compliance. Some managers unquestioningly accepted inspection findings. For others, their relationship with the inspector allowed space for issues to be discussed and negotiated.

Compliance could be contested, particularly where there was a good inspector–manager relationship. Some interviewees said their organisations were fully supportive of them challenging inspectors' findings, particularly where it benefitted residents.

The relationship with the inspector was also strengthened if managers could devise a clear plan to address identified issues. Some interviewees felt this disposition demonstrated their commitment to implementation and respect for the inspector's professionalism.

### Differences in individual and organisational-level responses

We observed some differences with respect to interviewees' individual views and views that reflected their organisation's perspective. This was evident when comparing responses of PICs and PPIMs. PICs focused mostly on their individual perspective, explaining how they approached implementation as managers, their strategies and their challenges. Some PICs felt caught in the middle: required by the inspector to take action but sometimes not empowered by their organisation to do so:

the PICs are the ones rolled out for the inspection and we are responsible for so much.

PPIMs tended to speak more from an organisational perspective. This is understandable due to their position, that is, overseeing quality in multiple RCF-D. This often meant their engagement with implementation was only required when non-compliance arose. Equally, their engagement was often not with individual inspectors but with more senior managers in the regulator. As such, their role was to represent (and defend) their organisation.

## DISCUSSION

Managers of RCF-D implement care regulations by establishing a range of structures and processes informed by overall organisational culture. Their implementation effort is also influenced by how they deal with the world outside their organisations and how they manage the relationship with the regulator.

While there are a small number of studies in other sectors, most of these do not focus specifically on the implementation of regulations, which is a critical aspect of improving regulatory compliance and service delivery. Our findings contribute new insights into how managers navigate regulatory requirements in this context and offer alignment with constructs in NPT, thereby advancing both theoretical and practical understanding in a previously underexplored area.

Our findings can be situated within a broader literature concerned with implementation processes for interventions closely related to regulation, such as accreditation. A large narrative review of healthcare accreditation literature in 2012 presented results that concur to some extent with our findings.<sup>32</sup> For example, financial support and macroeconomic factors were seen as key system-level levers, akin to our finding with respect to resourcing.<sup>33 34</sup> Similarly, good quality documentation was an important enabler for the implementation of accreditation, a finding

reflected in our study. In contrast to our findings, while the authors identified organisational change mechanisms arising out of the accreditation process, these mechanisms did not include a legal imperative for change in the same manner as regulation.

Overall, interviewees welcomed regulation. While many acknowledged troublesome aspects—burdensome record-keeping, increased costs—most saw it as a net benefit. Interviewees saw alignment between regulations and their commitment to providing good quality care. Interviewees often regarded inspectors as allies rather than adversaries. Inspection findings were used by PICs to make the case to their organisations for additional resources. The generally positive disposition of interviewees toward regulation may also be attributable to the approach of inspectors, often characterised in terms such as helpful, educational and collaborative. While positive working relationships may be beneficial for both parties, this could heighten the risk of regulatory capture where the regulator begins to act in the interests of the regulatee rather than the service user.<sup>35</sup>

The interviewees in our study provided some critiques of regulation. For example, inspectors were seen as often differing in their interpretation of what represented compliance. There is an inherent difficulty in asking inspectors—who have different professional backgrounds and biases—to consistently judge compliance across a wide range of care practices. Such inconsistency has been reported in other settings.<sup>36 37</sup>

Interviewees were critical of regulation, for example, arguing some regulations were an administrative burden and did not link to a resident's well-being. Some interviewees felt inspectors resorted to identifying non-compliances with menial regulations when they found no faults elsewhere, leading to resentment.

Our findings are situated in the wider context of societies that demand higher quality health and social care services and the full realisation of human rights for people with disabilities.<sup>38</sup> This is a substantial challenge to service providers operating with constrained funding and competing for staff in labour markets. Consequently, regulators walk a tightrope: overly-punitive regulation could reduce capacity in services, while a laissez-faire approach might mean poorer quality; both outcomes are suboptimal for people with disabilities. The collaborative approach identified in our findings may be a fruitful means by which to improve quality.

The lack of previous literature on the implementation of regulations in health and social care services is surprising. There is no shortage of literature on the implementation of other interventions such as clinical practice guidelines<sup>39–41</sup> or evidence-based practice.<sup>42–44</sup> We argue that regulatory requirements should receive as much attention as other interventions given their potential to leverage improvements in quality and safety. The sparse literature may be a consequence of not considering regulation to be an 'intervention' in the traditional sense. This appears

to be a missed opportunity as regulation bears many of the hallmarks of an intervention in the implementation science understanding: a quality improvement initiative; a set of prescriptions for how things should be done (regulations); and an evaluation of the success of the implementation (inspections).

### Limitations

One limitation of our study is that it is based only on interviews. Nevertheless, interviews facilitated deep exploration of the subject matter. A second limitation is that we only gathered views of managers of RCF-D. While our population is appropriate for our main phenomena of interest, this meant we could not explore related phenomena such as the impact of implementation strategies on non-management staff and residents/carers. Another limitation is our partial insight into organisation-level approaches to implementation; this would require further research to address. Another potential limitation is that the interviewer's role as a current employee of the regulator may have influenced interviewees' responses. To guard against this, the interviewer was fully transparent about this with interviewees.

### CONCLUSION

Our work draws attention to an often-overlooked aspect of health and social care management: compliance with regulatory requirements. Managers offered useful insights on how they interpret and understand regulations, how they structure and resource services to achieve compliance, and how they manage relationships with funders and inspectors. Framing regulation as an intervention provides a useful means by which to better understand how organisations succeed (and fail) in implementing regulatory prescriptions. Our findings may be of benefit to organisations that struggle to achieve compliance and for regulators that wish to better understand the various tactics and approaches adopted by regulatees.

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