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Inadequate Care, Abuse and Neglect in Norwegian Nursing Homes

Thesis for the degree of Philosophiae Doctor

Trondheim, Desember 2013

Norwegian University of Science and Technology
Faculty of Social Sciences and Technology Management
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Preface

Being a young student in a nursing home in the late ‘70s, I did not reflect much about how residents were treated by the staff. To witness use of force during feeding, bathing and medication, as well as ridiculing of the residents did not upset me much. Residents could be held bedridden during the whole weekend, with no other reason than: “They are tired and need to rest” or “we are short staffed today.” I knew exactly which residents were the easy ones, and who were difficult - we were told by nurses how to deal with the difficult ones. After “draining days” and “bathing days” the staff were worn out, there had been a lot of struggling with the residents. I did not question the practice, as far as I understood, this was the nature of nursing home work.

I was introduced to the field of elder abuse in the beginning of the ‘90s, when I was lecturing postgraduate students at a university college. I was invited to a seminar with the heading: “Elder abuse”, the focus of which was on older persons living at home and being abused by relatives or other closely related persons. This topic was rather unknown to me, and my first question was: “Is that such a big problem?” The two-day seminar opened my eyes, and I realised that I needed more knowledge about this. When I later brought my recently acquired knowledge to my students and to the practical field, I started to get some questions to which I had no answer. The main focus was still on older persons living in their own homes, and the abuser was a closely related person. One of my students asked: “You keep telling us about the abuse committed by relatives, but what about abuse against older patients committed by nursing staff?” She then told a story about physical abuse of a resident at a nursing home, committed by a nurse. I will forever be grateful to that student, because she called my attention to an even more taboo area than elder abuse in the community. In my efforts to find an answer to her question about abuse by nursing staff, I realised that very little research had

been done on this topic, and I had found the field of research for my Master Degree thesis. I conducted a qualitative study of abuse in nursing homes (Malmedal, 1998), and interviewed nursing home staff about observed and committed abusive actions against residents. All forms of abuse were reported; physical, psychological, neglect, financial and sexual. At the conclusion of my Master's thesis, I suggested that one should carry out larger studies that take different factors into consideration, and conduct analysis on different levels. That is why I continue with the same topic in my Doctoral thesis, but now with a quantitative approach.

The ultimate goal of my research is to contribute to improved conditions for residents in nursing homes. I share the same hope as stated by Karl Pillemer (1991), one of the early researchers in this field: that we can develop *"...a society in which all of the elderly live free from fear of maltreatment"* (p. iii). Any research which can teach us something we did not know before, that leads us to ask new questions, or has implications for improving services, is good research (Stein, 2006). I like to believe that my research will make a difference; that my findings will lead to changes.

Wenche Malmedal

Trondheim, June 2013

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Norsk sammendrag

Inadekvat pleie og omsorg, overgrep og forsømmelser i norske sykehjem

Beboere på sykehjem er spesielt sårbare og i risiko for å bli utsatt for inadekvat pleie og omsorg, overgrep og forsømmelser. Dette fordi de er mer eller mindre avhengig av hjelp grunnet kroniske sykdommer, særlig gjelder dette beboere med kognitiv svikt og atferdsmessige problemer. Gjentatte rapporter om enkelthendelser indikerer at fenomenet også finnes i norske sykehjem, men det er fortsatt lite kunnskap om i hvor stor grad dette forekommer.

En overordnet målsetting med denne avhandlingen var å bidra til økt kunnskap om inadekvat pleie og omsorg, overgrep og forsømmelser i sykehjem. Fra 16 sykehjem har 616 ansatte besvart et spørreskjema. Avhandlingen undersøker utbredelse av ulike typer handlinger rapportert av ansatte, i tillegg til å undersøke mulige faktorer som bidrar til inadekvat pleie og omsorg, overgrep og forsømmelser. Dette arbeidet vil gi kunnskap som kan være nyttig for å utvikle forebyggende strategier og dermed bidra til bedre kvalitet i sykehjem.

Avhandlingen består av tre delstudier (Paper I-III), og i tillegg noen resultater som ikke er omhandlet i artiklene. Den første delstudien undersøkte utbredelsen av ulike typer inadekvat pleie, overgrep og forsømmelser som ansatte rapporterte at de hadde begått. Den andre delstudien undersøkte ulike faktorers innvirkning på inadekvat pleie, overgrep og forsømmelser. Den tredje delstudien undersøkte ansattes holdninger til å rapportere hendelser begått av kolleger. I tillegg til resultater presentert i de tre artiklene, ble det bl. a. undersøkt hvordan ansatte forklarte at slike hendelser kunne finne sted, og om de tilla ulik forklaring for de forskjellige typene inadekvat pleie, overgrep og forsømmelser.

Studiens hovedfunn er at beboere i sykehjem utsettes for inadekvat pleie og omsorg av både emosjonell og fysisk karakter, samt forsømmelser. Totalt rapporterte 91% at de hadde observert en kollega begå minst en handling, og 87% rapporterte at de selv hadde begått minst en av de handlingene opplistet i spørreskjemaet. Forsømmelser og handlinger av emosjonell

karakter var hyppigst rapportert, både som observert og selvutført. Videre ser en at ulike karakteristika ved institusjonen (f.eks. størrelse og beliggenhet), ved ansatte (f.eks. alder og utdanning), og relasjonelle faktorer (f.eks. konflikter) i ulik grad assosieres med de tre typene. Ansatte er stort sett positive til å ville rapportere handlinger begått av kolleger, selv om noen grupper er mer tilbakeholdne, f.eks. de eldste ansatte. Ulike typer inadekvat pleie, overgrep og forsømmelser tillegges ulike forklaringsfaktorer, dette understreker behovet for å undersøke hver av typene separat.

Den høye forekomsten av inadekvat pleie og omsorg, overgrep og forsømmelser som er kommet fram i denne studien påpeker behovet for å intervenere. Det er fortsatt mangel på oppmerksomhet rundt dette i mange land, også i Norge. En forutsetning for endring er å erkjenne at problemet finnes, deretter må det følges opp med handling. Et viktig element i god praksis er å være i stand til å oppdage inadekvat pleie og omsorg, overgrep og forsømmelser og også å forstå hvilke alvorlige konsekvenser slike handlinger kan ha for beboerne.

Denne avhandlingen har bidratt til økt kunnskap om inadekvat pleie, overgrep og forsømmelser i sykehjem, men det gjenstår fortsatt mye å undersøke.

English summary

Inadequate Care, Abuse and Neglect in Norwegian Nursing Homes

Residents in nursing homes are particularly vulnerable and at risk of inadequate care, abuse and neglect because they are more or less dependent on their caregivers owing to chronic illnesses, especially those with cognitive and behavioural problems. Repeatedly reported single acts of inadequate care indicate that the phenomenon also occurs in Norwegian nursing homes, but there is a lack of knowledge about the extent to which it occurs.

The overall purpose of this thesis was to contribute to increase knowledge of inadequate care, abuse and neglect in nursing homes by exploring the frequencies and types reported by staff, investigating factors seen as predictors of inadequate care, abuse and neglect, as well as how staff attributed inadequate care. Data in the thesis were obtained from a cross-sectional survey conducted in one county in the middle of Norway including nursing staff (n=616) from 16 nursing homes.

The thesis consists of three studies, as well as some additional results. The first study (Paper I) investigated the frequency and types of inadequate care committed by staff in nursing homes. The second study (Paper II) investigated 11 factors that were hypothesized to be associated with inadequate care of emotional, negligent, and physical character committed by staff in nursing homes. The third study (Paper III) aimed to describe attitudes held by nursing home staff on reporting negative/ unwanted acts committed by their colleagues. Additionally (included in the thesis, but not published), perceived reasons for inadequate care, abuse and neglect and whether there are different reasons for the specific types of inadequate care were investigated.

Main findings are that residents in Norwegian nursing homes are exposed to different types of inadequate care, abuse and neglect. All in all, 91% of the nursing staff reported they had observed a colleague commit at least one act of inadequate care and 87% reported that they themselves had committed at least one act of inadequate care. Acts of negligent and emotional

character were most frequently reported, both as observed and committed. The types of inadequate care were associated with various institutional characteristics (e.g. size and location), staff (e.g. age and education), and relational characteristics (e.g. conflicts and aggression), but not to the same extent. Further, positive attitudes towards reporting acts of inadequate care committed by their colleagues were found, but also that some groups were more reluctant to report, e.g. the eldest groups of staff. Staff attributed the different types of inadequate care for different reasons, a result that emphasizes the need for further investigation.

The high prevalence of inadequate care, abuse and neglect in this thesis underlines the need to intervene. There is still a lack of awareness of inadequate care, abuse and neglect in institutions for older persons in many countries, and recognition of the phenomena is the first step to a change, but it needs to be followed up by actions. An important element in nursing practice is to be able to recognize the occurrence of and understand the potential severe consequences of inadequate care, abuse and neglect particularly for frail, older persons.

This thesis has contributed to extend the knowledge base regarding inadequate care, abuse and neglect in nursing homes, yet there is much more to be revealed and investigated.

Acknowledgements

Having come so far in the writing, I realize that more than a decade's job is soon over. Since I started as a doctoral student years ago, time has passed. Life is full of surprises, and because living is a full time occupation, and being a doctoral student is not, the work with the thesis has taken its time. On the one hand, writing a thesis is a one-woman job, and sometimes rather lonely; on the other hand, it would not have been possible to do this all alone, I needed "a little help from my friends".

First of all, I wish to thank the nursing staff who has participated in this study for their invaluable contribution. Special thanks are given to the coordinators for collecting the questionnaires. A response rate of 79% is impressive, without you I could not have obtained this.

Thanks also to Sør-Trøndelag University College (HiST), for supporting this thesis.

My deepest gratitude goes to my main supervisor and co-author (Paper I-III) *Britt-Inger Saveman* who has supported me and encouraged me, through the whole process, in all these years. She has patiently followed me from my first steps into the world of research, through constant periods of ups and downs, always available and optimistic. Once recovering from the shock after getting back my article manuscripts which had been dissected by her, I had to admit that her critical view and rather direct suggestions, made the manuscripts far, far better. Even if she stated: "Now it is almost ready", I knew there were more rounds to go. I am deeply grateful for all she taught me, and for being there for me.

I also wish to thank my two co-supervisors *Jan Tøssebro* and *Riina Kiik*. Jan was there from the beginning, and gave valuable inspiration and help in the first years of my work. Riina, who took over the relay baton from Jan, immediately showed belief in me and my work, encouraged me and with a friendly and supportive attitude, wisely followed me to the finish.

After starting with working on this thesis, I entered into for me a rather unknown universe of statistics. Two persons need to be mentioned in particular since their assistance has been of vital importance for me in these years. *Kyrre Svarva,* who was helpful in developing and

formatting the questionnaire, and also guided me through statistical analyses in the initial phase of my work. *Randi Hammervold*, who has not only been co-author on two articles (Paper II and Paper III), but has also given valuable contribution to analyses and interpretation of other results used in the thesis. Her tremendous knowledge and skills in statistical methods is impressive, still she is able to explain the most complicated analysis in a simplified way.

I am also very thankful to *Oddbjørn Ingebrigtsen*, colleague and co-author (Paper I) who participated in the first article and was of great help during this first, important period. Always interested, willing to give constructive criticism and to share knowledge. No wonder the students love him!

Many colleagues and friends have encouraged me throughout these years and shown interest in my work. I would especially like to thank *Toril Elstad* and *Sissel Alsaker* for sharing my ups and downs, for always being there, not only for a good discussion about serious scientific matters, but often just for a coffee, a glass of wine or two, sharing life events. Good friendships are valuable treasures!

I would also like to express my gratitude to the librarians at HiST. Internet has not made the librarians unnecessary, on the contrary. And we are blessed with the most competent ones, always positive and helpful in finding and providing us with literature. Even the most difficult task they are solving with a smile.

And many, many thanks to my dear husband, friend and partner *Voja* for invaluable help in the lay out of the tables and figures, as well as the whole manuscript. Thanks also for motivating and encouraging me, supporting me during the tougher periods, giving me wonderful breaks with our travels all over the world, as well as at the dinner table in our kitchen.

Finally: To *William, Johan, Anders, Emilie, Fride, Anny & Elise*: You have enriched my life and given me many wonderful moments of joy and happiness. Hopefully now “mormor” will be more present for you. And as a typically “mormor”, I jumped over the next generation, but my daughters and sons- in- law are not forgotten. You are all an important part of my life.

List of papers

This thesis is based on the following three papers, which will be referred to in the text by their Roman numerals:

I. Malmedal, W., Ingebrigtsen, O., & Saveman, B-I. (2009). Inadequate care in Norwegian nursing homes, as reported by nursing staff. *Scandinavian Journal of Caring Sciences:* 23 (2): 231-242.

II. Malmedal, W., Hammervold, R., & Saveman, B-I. (2013).The dark side of Norwegian Nursing Homes. Factors influencing inadequate care in Norwegian nursing homes. Accepted for publication in *Journal of Adult Protection.*

III. Malmedal, W., Hammervold, R., & Saveman, B-I. (2009). To report or not report. Norwegian nursing home staffs' attitude on reporting inadequate care committed by colleagues. *Scandinavian Journal of Public Health;* 37:744-750.

1. Introduction

Care given to the older persons can be judged as adequate or inadequate in amount and type (Fulmer & O'Malley, 1987). Studies show that inadequate care, also referred to as abuse, violence, neglect or maltreatment, are not isolated acts, but rather are part of daily life in nursing homes in many countries (Pillemer & Moore, 1989; Meddaugh, 1993; Foner, 1994; Wierucka & Goodridge, 1996; Malmedal, 1998; Saveman et al., 1999; Goergen, 2001; Hawes, 2003; Gorbien & Eisenstein, 2005; Joshi & Flaherty, 2005; Hansberry et al., 2005; Post et al.,2010; Cohen et al., 2010; McDonald et al., 2012; Drennan et al., 2012).

Different approaches and methods have been used in the effort to describe and quantify the phenomenon of elder abuse by nursing home staff, and its complexity has been discussed by several authors (Fulmer & O'Malley, 1987; Pillemer, 1988; Hawes, 2003; Daly & Jogerst, 2005; Penhale, 2010). The lack of consensus in definition and theoretical approaches is still a problem in this field of research.

In this thesis the term "inadequate care" is used as the main concept, with abuse and neglect as subsets. The choice of inadequate care as the primary focus is considered most suitable, since it is not as stigmatizing as the concept of abuse and furthermore, not only does it include intentional cases, but also unintentional inadequate care arising from lack of knowledge or lack of adequate access to services (Fulmer & O'Malley, 1987).

Residents in nursing homes are particularly vulnerable and at risk of receiving inadequate care because, due to chronic illnesses, especially those with cognitive and behavioural problems,

they are more or less dependent on their caregivers (Gibbs & Mosqueda, 2004; Gorbien & Eisenstein, 2005; Hansberry et al., 2005).

Repeatedly reported single acts of inadequate care indicate that the phenomenon also occurs in Norwegian nursing homes, but unfortunately, there is a lack of knowledge about the extent to which it occurs. Observation and interview studies (Malmedal, 1998; Slettebø, 2002; Hauge, 2004; Bergland & Kirkevold, 2006) contribute to a better understanding of the daily life in institutions for older persons and also shed more light on the dark sides of nursing homes. The Norwegian Research Council has, however, pointed out the need for larger surveys to clarify the amount of abuse and neglect amongst the elderly (Daatland et al., 2000).

The overall purpose of this thesis is to contribute to increased knowledge of inadequate care, abuse and neglect in nursing homes. By exploring the frequencies and types reported by staff, as well as investigating factors seen as predictors of inadequate care, abuse and neglect, this work will provide knowledge which can be useful for developing preventing strategies and thus improve the care in nursing homes.

The thesis is organized in nine chapters. The introduction chapter clarifies the topic of the thesis and establishes the starting point and context of the study. The background part consists of four chapters, each of them presenting perspectives and frameworks that base the understanding for this thesis. Chapter 2 presents the demographic challenge that lies ahead of us, with an ageing population and an expected increased demand of health care services, including nursing home care. In Chapter 3 the concepts of inadequate care, abuse and neglect are discussed. This chapter also provides a short presentation of previous studies that have examined inadequate care, abuse and neglect in nursing homes. Chapter 4 presents the context

of interest in this thesis, the nursing home. The double function of the nursing home, being both a care facility and a home is discussed, and whether the nursing homes succeed in fulfilling these tasks or not is questioned. It is also questioned if Goffman's descriptions of total institutions are applicable on nursing homes of today. A sub-section on culture of care in nursing homes includes also a presentation of Person-Centred-Care and The Eden Alternative. Chapter 5 presents an ecological model for the understanding of the complexity of inadequate care, abuse and neglect, and addresses risk factors on the different levels.

Chapter 6 consists of the rationale for the thesis, as well as aims and research questions.

The methodological approach, including research design, developing of the questionnaire, description of the sample, data collection, and characteristics of the participants, is described in Chapter 7. This chapter also presents the statistical analyses used in the thesis. Finally, this chapter discusses methodological and ethical considerations.

In Chapter 8 the findings are presented. The three papers included in the thesis, give answers to research question 1-5, and additional results answer research questions 6-7.

Chapter 9 discusses the findings in relation to the ecological model presented in the thesis. Based on the discussion several prevention intervention strategies are proposed on the different levels, i.e. micro-, meso-, exo-, and macrolevel.

Finally, Chapter 10 provides reflection about practical implications, and also gives concrete suggestions for practice change and for further research.

2. The demographic challenges

2.1 An ageing population

The rapid move towards an ageing population is a world-wide phenomenon. A population ages when increases in the proportion of older persons (that is, those aged 60 years and over) is accompanied by a reduction in both the proportion of children (persons under age 15) and working age (15 to 59) persons. In all Organisation for Economic Co-operation and Development (OECD) countries, populations aged 65 years and over have dramatically increased over the last 30 years, both in size and as a percentage of total population. Due to higher life expectancy and low fertility rates, the elderly population accounts for 14% of OECD population in 2008 (OECD, 2011). Although they are smaller in number, the group of adults age 80+ is growing faster than the 65+ population. Norway is no exception to the global trend (see Figure 1).

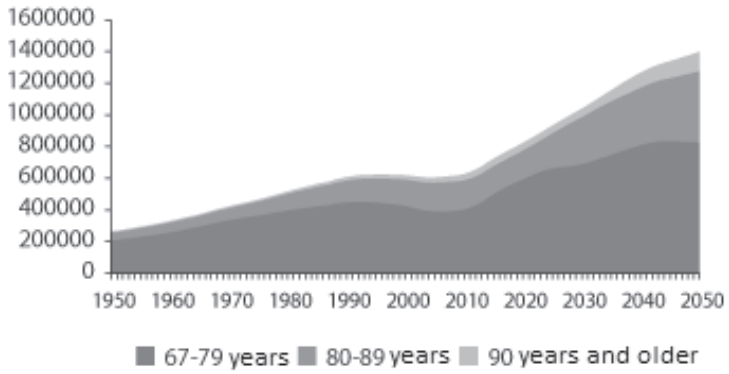

Figure 1. Persons 67 years and older from 1950–2050 (Statistisk Sentralbyrå, 2012).

The number of inhabitants in Norway is constantly increasing. In 2011, we passed the 5 million mark, and Statistic Norway estimates that there will be just under 7 million inhabitants in Norway by 2060. High birth rates after the Second World War contribute to a tremendous growth of the elderly population in the next decades. Life expectancy, which in Norway is currently 79 years for men and 83 years for women, has risen over the last few years and will continue to increase in the coming decades, therefore an ageing of the population of Norway is inevitable. Today, 13% of the population is 67 years and older, for 2060 the estimates are 22 %. In January 2013, 451,627 people were 67 years or older, and 221,585 were 80 or older in the entire country (Statistisk Sentralbyrå, 2013). This ageing population will challenge our health care and social systems. With increasing age comes the need for more help due to increased risk of sickness. And, there is a clear expectation from the population that care must be provided by public entities (Huseby & Paulsen, 2009).

2.2 Care for older persons

In Norway, the municipalities are responsible for providing care for citizens in need, including home care and institutional care for older persons. The percentage of older persons living in institutions in Norway has decreased during the last years, while the number of those receiving home care has increased. The change toward providing more home care is an explicitly expressed goal in national plans, and research shows that it is also in accordance to the wishes of the older population (Brevik & Scmidt, 2005). In 2009, about 44,400 persons lived in institutions for older persons and disabled; most of the residents were more than 80 years old (n=32,000). About 11 % of the population between 80-89 years old are residents in institutions for older persons. Amongst the eldest (more than 90 years), about 32% live in

institutions (Statistisk Sentralbyrå, 2010). The growth of the older population in the years to come will increase the need for 24-hours skilled nursing facilities (see Figure 2).

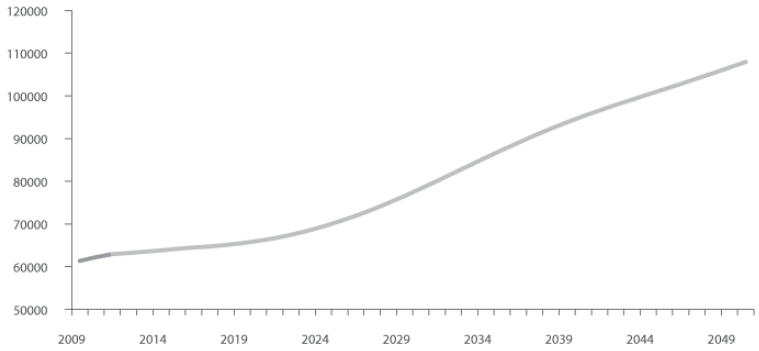

Figure 2. Need for 24-hours skilled nursing facilities 2012–2050.
Source: Holmøy et al. (2013).

Almost all Norwegian nursing homes are public, only a few are private. Radical reforms during the last decades have led to changes in the conditions in Norwegian nursing homes and more than 95% of the beds are now in single rooms. About half of the nursing homes in Norway are either in new buildings or in fully modernised and restored buildings (Helse- og omsorgsdepartementet, 2006). Norwegian nursing homes consist of long- term care units, special care units for persons with dementia diseases and specific rehabilitation wards. It is claimed that residents in institutions today are more sick and helpless than residents of earlier years (Hofseth & Norvoll, 2003; Ugreninov, 2005; Gabrielsen et al., 2012). A large Norwegian study reported that more than 80% of residents in nursing homes were assumed/judged to suffer from dementia (Selbæk et al., 2007), and that about two-thirds of the residents showed clinically significant psychiatric or behavioural symptoms. A recent report shows that four out of five nursing home residents (80 %) have an extensive need for assistance, and that this proportion has increased by 11 percentage points from 2007-

2011 (Gabrielsen et al., 2012). This indicates that, in recent years, the threshold for placement in a nursing home has risen. Although Norwegian policies support "ageing in place" there remains a need for institutional care, thus national plans also include nursing homes in the care-chain.

3. Inadequate care, abuse and neglect

3.1 How to name, categorize and define the phenomenon?

The first studies of elder abuse were conducted in the 1970s (Baker, 1975; Burston, 1975). Since then, the research field has increased, and with that, the interest of this phenomenon has raised questions concerning definitions, methods and theory. At the present, there are no agreed universal or standardised definitions of elder abuse (Penhale, 2010; Norris et al., 2013). This is an important point, as a review from 2009 (De Donder et al., 2011) demonstrates how differences in the definition and choice of measurement instrument can influence the prevalence rates found in a study. Recent studies (O'Connor et al., 2009; Se'ver, 2009; Drennan et al., 2012) use five different categories of abuse: psychological, physical, sexual, financial, and neglect. Abuse perpetrated against an older person is often not limited to only one form, for example, physical violence is often accompanied by psychological abuse, and financial abuse may be accompanied by neglect or physical abuse (Elkins & O'Neill, 2009). The World Health Organisation (WHO, 2002) report on violence and health states that *"Regardless of the type of abuse, it will certainly result in unnecessary suffering, injury or pain, the loss or violation of human rights, and a decreased quality of life for the older person"* (p.126).

The first studies of elder abuse used the term "granny battering" (Baker, 1975; Burston, 1975). From then and until today different labels have been given to this phenomena, such as "elder abuse," "elder mistreatment," "elder maltreatment," "inadequate care of the elderly," "granny abuse," "mis-care," (Biggs et al., 1995), and "ill-treatment" (Foner, 1994). It seems

that the term “elder abuse” is the most widely used expression in publications and research articles on the topic.

Biggs et al. (1995) claim that elder abuse is a social problem and that a definition is important for several reasons; to guide the enquirer towards a clearer understanding of what the issue involves, to differentiate that specific area of concern from other phenomena and to guide professionals and permit intervention.

In The Toronto Declaration, WHO (2002) defines elder abuse as follows: *“A single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person”* (p. 3). Abuse includes physical, psychological, sexual and financial abuse as well as neglect.

So what term to choose? Mis-care, mistreatment, granny battering, maltreatment, inadequate care of the elderly, ill-treatment, elder abuse as well as violence, seem to deal with the same phenomena. The research practice and the theory give several options. Is the choice of term just a linguistic matter or are there some substantial differences?

A definition of physical and psychological abuse is one by Straus et al. (1980), this is also used in Pillemer & Moore (1989): *“Physical abuse is an act carried out with the intention, or perceived intention, of causing physical pain or injury to another person”*, and *“Psychological abuse is an act carried out with the intention, or perceived intention, of causing emotional pain to another person”*(p.315).

The term “abuse” (“overgrep”) is in Norway understood more as physical abuse and does not necessarily include offending or insulting another person. In fact, when practitioners were asked what they associated with the term “abuse” most claimed that abuse was a physical act and even more severe than psychological abuse or offending a person (Malmedal, 1998; Sandmoe & Kirkevold, 2011). In some countries the term “abuse” has strong sexual overtones, and “violence” has been seen as the more appropriate term for elder abuse (Goergen, 2004). The use of the term “abuse” could act as a limit to peoples understanding of the phenomena. Different words bring about different feelings and the word abuse will probably provoke and lead to a wish to keep a certain distance. Even though you can admit the fact that you commit an act that can be labelled as negative or unwanted, you are more reluctant to admit that you commit abuse. One nurse who was interviewed in a study about this topic said: *“I do not know what term to use on this, abuse or violence or maltreatment or something else. I only know that there are things that happen in nursing home that should not happen and that is the main thing”* (Malmedal, 1998).

Fulmer & O`Malley (1987) make distinctions between abuse, neglect and inadequate care (see Figure 3) and claim that provision of care to older persons can be judged to be either adequate or inadequate. As they see it, abuse and neglect are subsets of inadequate care: *“All cases of abuse and neglect can be thought of as inadequate care, defined as the presence of unmet needs for personal care”* (p. 21)(see also Figure 3).

By formulating the problem as abuse or neglect, we are, according to Fulmer & O’Malley (1987) imposing a limitation and excluding, for example, those people who are receiving care from well-meaning, but inadequately trained caretakers. “*Since inadequate care can exist without being caused by abuse or neglect, and since it is no less important to resolve*

inadequate care due to ignorance or lack of access to services than it is to resolve inadequate care that results from abuse or neglect, this definition more closely approximates what the health care professional actually faces" (Fulmer & O'Malley, 1987, p. 23).

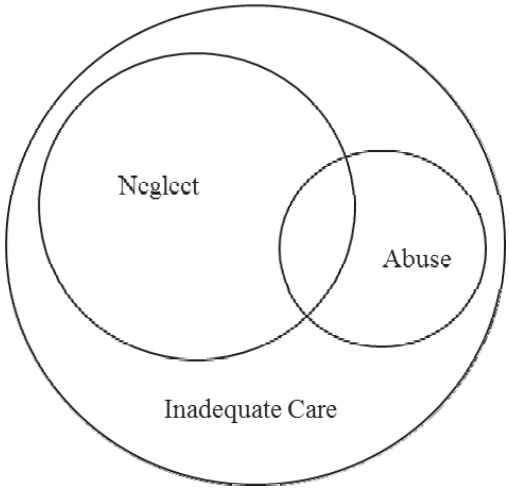

Figure 3. The universe of inadequate care (Fulmer & O'Malley, 1987, p.22)

In this thesis, the term "inadequate care" will be used as the all-inclusive term and encompass the notions of abuse and neglect. The term "inadequate" is also used by Fulmer et al. (2004) when they claim that: "inappropriate and inadequate behaviour can be manifested in a number of ways, which are labelled "physical abuse," "psychological abuse," "physical neglect" and so forth". As such, a broad definition of inadequate care has been selected: *"Inadequate care results from the presence of unmet needs for services or assistance which threaten the physical and psychological well-being of the individual"* (Fulmer & O'Malley, 1987, p.25). The definition includes unmet needs for food, shelter, clothing and supportive relationships, as well as freedom from harassment, threats and violence. Other unmet needs may arise due to lack of assistance in activities of daily living, such as going to the toilet, dressing, eating

and medication (Fulmer & O'Malley, 1987). Since neglect refers to a failure (intentional or unintentional) to provide care, the concept "missed care" is also used (Kalisch et al., 2009; Phelan, 2009). Studies have demonstrated that even though nurses were aware of appropriate standards of care, they regularly failed to meet adequate and expected standards at the point of care delivery (Kalisch et al., 2009). In order to not erroneously devalue how serious the acts of inadequate care actually can be, the concepts "abuse" and "neglect" are also used in this thesis. Fulmer & O'Malley (1987) define abuse as: *"actions of a caretaker that create unmet needs for the elderly person,"* such actions includes theft, isolation, threats, use of restraints, battering, sexual abuse, punishment and withholding food, clothing, or privileges to enforce behaviour, and neglect as: *"the failure of an individual responsible for caretaking to respond adequately to established needs for care"* (p. 21-22). Since inadequate care can be caused not only by intentional abuse or neglect, but also by lack of knowledge or proper training, this definition is more suitable for use in this study. Neglect in nursing homes may overlap with concepts of psychological abuse (e.g., social isolation) and disparities in quality of care (Lindbloom et al., 2007). In many cases it is difficult to make the distinction between acts of neglect and poor care quality, and by using the definition above, such distinction is not relevant.

Table 1 summarizes commonly used definitions in the literature relevant to nursing home setting.

Table 1. Definitions of Inadequate Care, Abuse and Neglect.

Types	Definitions
Elder abuse	A single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person (WHO, 2002). Actions of a caretaker that create unmet needs for the elderly person, including theft, isolation, threats, use of restraints, battering, sexual abuse, punishment and withholding food, clothing, or privileges to enforce behaviour (abuse including physical and emotional acts) (Fulmer & O'Malley, 1987).
Inadequate care	Inadequate care results from the presence of unmet needs for services or assistance which threaten the physical and psychological well-being of the individual (Fulmer & O'Malley, 1987).
Physical abuse	Physical abuse is an act carried out with the intention, or perceived intention, of causing physical pain or injury to another person (Pillemer & Moore, 1989).
Psychological/Emotional abuse	Psychological abuse is an act carried out with the intention, or perceived intention, of causing emotional pain to another person (Pillemer & Moore, 1989).
Financial abuse /Exploitation	Illegal exploitation and/or unauthorized use of funds or other resources of the older person (Kosberg & Nahmiash, 1996).
Neglect	The failure of an individual responsible for caretaking to respond adequately to established needs for care (Fulmer & O'Malley, 1987). Neglect is the refusal or failure to fulfil caretaking obligations and to meet the needs of the elder in order to punish or harm him/her, including behaviour such as deliberate abandonment or denial of food, medication, and health services (Lachs & Pillemer, 1995). Neglect is the failure to provide patients' basic needs (Allen et al., 2003).
Sexual abuse	Any kind of non-consensual sexual contact, including unwanted touching, sexual assault, and battery (Teaster et al., 2006).

The question of intentionality has been discussed by several authors (Fulmer & O'Malley, 1987; Daly & Jogerst, 2005; Joshi & Flaherty, 2005). In order to differentiate between intentional and unintentional acts, you have to know the reason behind the act (Joshi & Flaherty, 2005); in the case of inadequate care, the goal of intentional acts is to hurt, but this is not the case for unintentional acts. This thesis does not distinct between intentional or unintentional acts of inadequate care, and therefore, inadequate care encompasses a variety of actions that are harmful to residents in nursing homes.

The seriousness of the problem is also recognized by WHO in the World Report on Violence and Health: *"Deaths of older people, both in institutions and the community, have often been attributed to natural, accidental or undetermined causes when in fact they were the consequences of abusive or neglectful behavior"* (Krug et al., 2002, p. 130).

3.2 Studies of inadequate care, abuse and neglect in nursing homes

Inadequate care, abuse and neglect in nursing homes are mostly hidden, but now and then something is revealed. The public is shocked by reports about inadequate care in nursing homes described in newspapers and are hoping that these are only single acts. But can repeatedly reported single acts stand as evidence of a common phenomenon in nursing homes? Clough (1996) claims that some individuals will take those examples as proof of a common phenomenon, while others will deny that this type of incident is typical for nursing homes.

Systematic reviews of the literature conclude that elder abuse research is minimal and that prevalence in nursing homes is difficult to estimate (Daly et al., 2011; McDonald et al., 2012).

A study often referred to, as it was the first large study on elder abuse in institutions, was a telephone survey conducted in USA in 1987. Staff (n=577) from 57 residential and nursing homes were interviewed about abuse committed by staff (Pillemer & Moore, 1989) . 10 % of the respondents admitted at least one act of physical abuse in the preceding year and 36% had observed at least one act of physical abuse by others in the preceding year. A much higher rate of psychological abuse was reported, 81% of respondents reported that they had observed at least one act of psychological abuse in the preceding year, and 40% of the respondents admitted to committing at least one act of psychological abuse. Since this initial survey, there have been only a few larger studies worldwide. In Germany for instance, over 70% of the staff (n=361) reported that they had behaved at least once in an abusive or neglectful way towards residents over a one-year period (Goergen, 2004). Psychological abuse and neglect were the most common forms of abuse, while sexual abuse was not reported at all. However, this survey had a low response rate, only 36%, so the prevalence rates are not conclusive. In USA, data from the Ombudsman Reporting System and the nursing homes in the state relating to complaints about resident care and abuse were analysed (Allen et al., 2003). Eight per cent of the complaints received (n=4000) were about abuse and, involved 122 nursing homes. Physical abuse (n=50), gross neglect (n=23), verbal abuse (n=23), financial exploitation (n=16), and sexual abuse (n=15) were reported. Results from a study of neglect of older adults in nursing homes in USA (Zhang et al., 2010), a sample that included 414 family members, showed that about 21% of nursing home residents were neglected on one or more occasion in the last 12 months. Another survey from long-term-care, also in the USA, included 816 relatives of older adults receiving long-term-care (Post et al., 2010) and found that 4.2% had experienced physical abuse, 12.7% caretaking abuse, 11.2% verbal abuse, 13% emotional abuse, 16.2% neglect, 0.6% sexual abuse, and 9.2% material abuse. The probability that a person experienced more than one type of abuse was 51.4%. In New Zealand, an

interview study with 26 managers from 27 residential facilities (Weatherall, 2001) revealed that nearly all managers (92%) identified at least one instance of abuse toward a resident in the prior year. Psychological abuse was the most common type, and the perpetrator was usually a staff member. An Israel interview study of 71 nursing home residents who were assessed in medical centres for possible abuse by carers (Cohen et al., 2010) found that 31% reported some form of maltreatment or abuse, most being instances of disrespectful behaviour, however, psychological abuse, physical abuse and neglect were also present. A recently published report from a national survey of staff-resident interactions and conflicts in residential settings in Ireland (Drennan et al., 2012) shows that 58% of the staff had observed one or more neglectful behaviour by other members of staff in the preceding 12 months, while 27% reported that they had been involved in such act themselves. The most frequent acts were ignoring a resident when they called, and not bringing a resident to the toilet when they asked. Psychologically abusive acts were observed by 27%, and 7.5% reported that they had perpetrated one or more such act in the previous twelve months. The most frequent type was verbal (e.g., shouting at a resident in anger). Physical abuse was observed by 12% of the respondents, and 3% reported that they had committed one or more acts of physical abuse in the preceding year. Restraining a resident beyond what was needed at that time was the most frequent act of physical abuse reported. Financial and sexual abuse were rarely reported, 1.2% had observed financial abuse, while 0.2% had taken jewellery, money or something else from the resident. Sexual abuse was seen by 0.7% of the respondents and 0.2% reported that they had talked to or touched a resident in a sexually inappropriate way in the preceding 12 months. In Sweden, Saveman et al. (1999) found that 11% of the staff in nursing homes (n=499) knew of situations of elder abuse and 2% admitted that they themselves had been abusive towards an elderly resident. Of the incidents reported, 74% were physical abuse, 71% psychological abuse, and 56% neglect and maltreatment. In a Finish study of family

members´ experiences of the quality of geriatric care (Isola et al., 2003), 27% of the relatives reported actions of maltreatment. In Norway, a qualitative study of abuse in nursing homes was conducted by Malmedal (1998). Nursing home staff were interviewed about observed and performed abusive actions against residents. All forms of abuse were reported: physical, psychological, neglect, financial and sexual. A study of quality of care in Norwegian nursing homes (Kirkevold & Engedal, 2006) confirms that even though most patients receive good basic care, a practice of using pads instead of following residents to the toilet and neglect of residents need for leisure activities and to go for a walk outside the building is present. A Norwegian study of constraint in nursing homes shows that 37% of residents in regular nursing- home wards are subjected to constraints of some kind each week (Kirkevold & Engedal, 2004).

Several studies have noted that older persons experiencing one type of abuse often experience other types of abuse (Fulmer et al., 2002; Boldy et al., 2005; Fisher & Regan, 2006; Post et al., 2010).

Even though the referred studies were conducted in different settings, with different types of definitions, at different times, and with various instruments to measure inadequate care, abuse and neglect, we can conclude that inadequate care, including abuse and neglect, are not isolated acts, but rather, they are a part of daily life in institutions. Other studies (Meddaugh, 1993; Foner, 1994; Speaks, 1996; Wierucka & Goodridge, 1996; Goergen, 2001; Hunter, 2008) confirm that despite the clear mandate to ensure safety and well-being of the residents, abuse has represented, and still represents one facet of nursing home life.

4. Nursing home- a care facility or a home?

4.1 The purpose of nursing homes

In order to understand the nature of nursing homes today one has to take into consideration the history of institutionalisation of older persons in Norway. In the second half of the 1900s, institutions for older persons who could not take care of themselves were built; the main purpose of those institutions were neither as a home nor a place for treatment, it was purely meant as a place for storing the older people (Daatland, 1999). A hundred years after the first institution was built, this "storing" of older adults was criticised, mainly by physicians. Reforms were needed and a new area began where focus was put on nursing homes as an arena for active treatment; the idea of nursing homes as "homes" was not yet on the agenda. The transformation of nursing homes into arenas for active treatment did not succeed, and as the nursing homes neither had qualities of a home nor an institution for treatment, new steps were taken to try to help nursing homes succeed. The responsibility for nursing homes was moved from the municipalities into the counties in 1969. Economical incitements led to many new nursing homes, but the idea of active treatment in nursing homes was not reached. In addition, the nursing homes proved to be very expensive and beginning in1980 the focus was shifted to home care services. However, the problems in the nursing homes did not decrease. On the contrary, due to pressure from the municipalities who lacked proper housing for frail older persons, and the hospitals who claimed to be filled to capacity by older persons who needed a lot of care (but not treatment), and the problems of recruiting qualified staff, the nursing homes again were criticised for being a storing place for older adults (Alvsvåg, 1999). Thus, in 1988 the responsibility for nursing homes was given back to the municipalities

(Ot.prop 1985-1986) and it seemed that the idea of nursing homes as institutions for active treatment was lost (Hauge, 2004).

The "entrance ticket" to nursing homes is usually a disease that demands long-term treatment or comprehensive and permanent need for care (Kvaase, 1999) . Beginning in 1985 the expressed policy has been that nursing homes are to function as homes and institutions for treatment. The question regarding whether or not this has been a success continues to be discussed by numerous stakeholders.

4.2 Nursing home as a care facility

An expressed task for Norwegian nursing homes is active treatment. The Municipalities Health Services Act (Helse- og omsorgsdepartementet, 2011) outlines nurses homes' responsibility for, amongst other things: diagnosing and treatment of illnesses, rehabilitation and care to the municipalities. This may be done within the organisation of a nursing home. Provision of care in nursing homes is regulated by "Regulation of quality of care" (Helse- og omsorgsdepartementet, 2003). Amongst other issues, the regulation should ensure that the basic needs of the residents' are satisfied. These include psychological needs, preservation of dignity and self-respect, the degree of choice within the daily routine, physical needs (including nutrition), and social needs. Safe and secure services are a primary goal and quality services means that the probability for errors and adverse events to occur is reduced to a minimum. The Norwegian government has also introduced a plan that aims to increase the quality of care by 2015 (Helse- og omsorgsdepartementet, 2006). Beginning in January 2011, a new regulation was implemented "The guarantee of dignity" ("Verdighetsgarantien"). The purpose of the regulation is to ensure that care for older persons, whether it is home or

institutional care based, is organised in a way that contributes to dignified, secure and meaningful ageing. This guarantee is designed to clarify the rights of the older persons and demonstrates how care should be adjusted to the individual person (Helse- og omsorgsdepartementet, 2010).

The rights of residents in Norwegian nursing homes are constantly violated. A Norwegian nationwide survey from 2003 shows that, according to staff, 10% of the residents in nursing homes (n= 3866) did not receive sufficient help during meals, 15% did not receive sufficient help regarding personal care and personal hygiene, and 60% did not have sufficient activities and psychosocial care (Romøren, 2003). Other studies of quality of care in Norwegian nursing homes show that the care is not sufficient, especially regarding psychosocial care (Slagsvold, 1999; Hofseth & Norvoll, 2003) and the need for treatment and assistance regarding physical activities, psychiatric problems and dementia diseases are not adequately addressed (Hofseth & Norvoll, 2003). Seventy seven per cent of registered nurses in 125 Norwegian nursing homes reported that residents in their ward sometimes were treated in an irresponsible way (Hofseth &Norvoll, 2003). Another study of quality of care in Norwegian nursing homes confirms that even though most residents receive good basic care, there is a practice of using pads instead of following residents to the toilet (Kirkevold & Engedal, 2006). The same study describes neglect of residents need for leisure activities and going for walks outside the building. A Norwegian study of constraint in nursing homes shows that 37% of residents in regular nursing home wards are subjected to some kind of constraint each week (Kirkevold & Engedal, 2004).

A study of drug utilisation quality amongst more than 1,500 residents in Norwegian nursing homes revealed that the majority of the residents were at risk of side effects, insufficient use, or they were under medicated (Ruths, 2004). The findings are further supported by a study of

psychiatric symptoms and behavioural disturbances and the use of psychotropic drugs in Norwegian nursing homes showing that the prevalence of inadequate use of antipsychotic medicine amongst residents with a dementia disease and aggressive behaviour was particularly high (Selbæk et al., 2007).

Norwegian health authorities are aware of the risk that deficiencies in provision of municipal nursing and care services may occur. The Norwegian Board of Health Supervision has summarized the experience gained from supervision of municipal nursing and care services in all the counties in Norway (Helsetilsynet, 2003). Deviations from the regulations were identified in 80 per cent of the 373 supervision visits. Regulatory deficiencies were mainly related to inadequate help with basic needs, inadequate administrative procedures when allocating services, and inadequate routines for internal control. The Norwegian Board of Health Supervision also questions whether there is enough staff with the necessary competencies to meet the needs of the residents. A new supervision visit was arranged in 2010, and for institutional care the deviations from the regulations were found in different areas; there was a lack of knowledge, practice and routines to detect undernourished older persons, and thus to prevent and treat undernourishment. In addition, supervision found that residents in nursing homes were not given the correct treatment regarding rehabilitation, and that the residents freedom of movement were violated (through locked door) as a collective restriction, something that is against the regulations (Helsetilsynet, 2011). A recently published report from The Norwegian Board of Health Supervision (Helsetilsynet, 2013) about compulsory health care in nursing homes concludes that: *"The breaches of the regulations that we detected indicate that there is a great risk that service provision is inadequate"* (p.9).

4.3 Nursing home as a home

Norwegians general are particularly concerned about their homes and the environment (Gullestad, 1989), and due to the cold climate during winter, Norwegians spend a significant amount of time in their own homes. A home is associated with security, connection, continuity, relationships, a place for different types of activities, and serves as a symbol of status and materiel values (Després, 1991). Home is a place for identity building and identity preserving, a place where you can "be yourself" (Thorsen, 2008). Thorsen (2008) also emphasize the meaning of home as a storyteller; until the very end of life the home tells the unique history of the person living there. The history will help the person to recognize him/herself, as well as helping others to know the person behind the "patient." Jacobsen (2006) discusses whether there is room for home-likeness in nursing homes, and asks if our ideas of homes also should be our ideas of nursing homes. He argues that even though the nursing homes have developed more home like environments, the patients rooms remain the only area that can be seen as an exclusive room for the residents, since this room is the only room they, to a certain extent, can control and make their mark on. Studies of the meaning of home amongst older persons have shown that older persons are specially connected to their homes (Rubinstein, 1989; Rowles, 1991). A Norwegian study about older persons expectations for their own aging, showed that the majority wanted to live in their own homes, even if they became in need of care (Brevik & Schmidt, 2005), while only a few saw nursing homes as desirable alternatives.

It is reasonable to question whether the Norwegian nursing homes have succeeded in fulfilling their tasks as homes for older people. Only a few Norwegian studies have focused on nursing homes as a home (Slagsvold, 1986; Uppsata, 2000; Hauge, 2004; Hauge &

Heggen, 2008). A field study in Norwegian nursing homes (Hauge, 2004; Hauge & Heggen, 2008) showed that even though the residents' private rooms were furnished with some of their own furniture and with family portraits and decorations, the bed and the bedside table were hospital like. Indicators of non- privacy were that staff often went into the room when the resident was not present, the room had no doorbell, and the door between the room and the corridor were open quite often, and gives anyone who passes the door, insight into a private room. According to the study, the residents who were mobile spent more time in their rooms and had more opportunities for privacy than did those residents who were more dependent on the staff for moving. The diffuse boundaries between the public area and the private room, and the residents' lack of control, distinguish the nursing home from "real" home.

4.4 Nursing home – a total institution?

Half a decade ago, Goffman (Goffman, 1961) introduced the term total institutions and referred to institutional settings which were self-encompassing environments isolated from the outside world. This landmark study of total institutions had a powerful influence on the early studies of nursing homes. The phrases that Goffman used to describe the process of institutionalisation, such as "mortification on the self," "curtailment of the self" and "territories of the self" have been seen as relevant to describe life in nursing homes. Townsend (Townsend, 1964) studied institutions for old persons in England and Wales and discussed what effect institutionalisation had upon the old people living there. In his book "The Last Refuge", Townsend concluded that these institutions did not adequately meet the physical, psychological and social needs of the old people living in them and alternative services and living arrangements should quickly take their place. Some of the effects of institutionalisation as he describes it are depressingly familiar even today; lack of occupation,

isolation from family, friends and community, loneliness, loss of privacy and identity, and the collapse of power and self-determination. In each decade since this early work of Townsend, other researchers have shown the same effect of institutionalisation. In the '70s Gottesman & Bourestrom (Gottesman & Bourestrom, 1974) showed that nursing home residents were vulnerable to loneliness, boredom, and negative self-esteem. They found that residents spent more than half of their time doing little or nothing. During this same period, Norwegian nursing homes were described as storage places for old people (Eriksen & Ulstrup, 1974), and the loupe was directed towards need off improvement (Pettersen, 1972). A study of institutions for older persons in one county in Norway showed that the residents were to a very little extent free to make decisions of their daily routine, and the medical practice seemed to be insufficient (Nygård, 1974). The regulations at that time demanded that the institutions provide varied and meaningful activities for the residents; however, this seemed to be very limited, and the conclusion of the study was that the institutions, to a certain extent, could be characterized as total institutions, according to Goffman's definition (Goffman, 1961).

Studies in the '80s and '90s show improvement in the institutional care for older persons, but still Goffman's model of total institutions is applicable to nursing homes, either partially or as a whole (Shield, 1988; Clark & Bowling, 1990).

The results from a Welsh study, where nursing home residents spent approximately 70% of their time engaged in passive activities (Nolan et al., 1995), are supported by a study of 27 nursing home residents in USA which showed that the residents spent the majority of their time in passive activities, such as doing nothing, sleeping and waiting (Harper Ice, 2002). In his article titled "Flying towards Neverland," Casson (1994) uses the metaphor "being at a

departure lounge," as a reference to the fact that the residents in nursing homes are waiting for their last journey, death.

It seems that even though the facilities are making great efforts to improve quality of care, life in nursing homes is still characterised by lack of social interaction and meaningful activities, and, even today, nursing homes may, to some extent, be described as total institutions.

4.5 Culture of care in nursing homes

The written goals of the nursing homes are to provide adequate high- quality care with the residents' personal needs in mind (Helse- og omsorgsdepartementet, 2003). The clinical models of good care and high ethical standards that nursing students (and others) are taught are in many cases far from the reality in nursing homes. Many claim that achieving a high quality of care in nursing homes is an unachievable goal. As previously stated, nursing homes may, according to Goffman's understanding of the term, to some extent be seen as total institutions, and the many negative aspects of institutionalisation are well known. Grenier & Leonard (2006) claim that practices of caring are *"constructed within the organisational cultures which emphasize professional discipline and rationality,"* and further that *"the modern organisations of caring have to confront the main problems arising from the tensions between the humanitarian impulse to be caring and the effects of practices which tend to be objectifying"* (p. 101). Thus, the context of care is complicated and the work with older persons may be difficult. There is a contradictory consciousness within the individual subject, representing both an adaption to certain cultural discourses and at the same time critical questioning these discourses.

Many nursing homes have taken steps to try to prevent negative aspects of care, such as depersonalisation and deactivation of the residents, and different thinking and philosophy have been introduced to help the staff work in a more conscious and systematic way. There are different models of culture change in long-term care - two of them will be briefly presented here: The Eden-Alternative and Person-Centred Care.

4.5.1 The Eden Alternative

Barba et al. (2002) ask the following questions: *"Why aren't nursing homes places where family members of all ages would eagerly anticipate spending the day? Why aren't nursing homes places where families and community groups are anxious to visit and participate in activities? Why aren't nursing homes places where employees are happy to come to work because they feel valued and because they are pleasant places to work?"* (p.7-8). They further claim that the reality is that residents in nursing homes spend a good deal of their time alone, unable to care for themselves or their environments. They enjoy few stimulating activities, and even well cared for nursing home residents may suffer from loneliness, helplessness, and boredom.

Dr. William Thomas, who proposed the Eden Alternative as a model of culture change, says that nursing homes are primarily homes, not hospitals (Thomas, 1996). He claims that the medical model that focuses on treatment of physiological problems using medical interventions, fails to attend to psychological factors such as loneliness, helplessness, or boredom. He further claims that nursing homes damage people; because nursing homes are total institutions and total institutions damage people. According to Thomas (2003), long-term care facilities must become places where the person feel at home, family members enjoy visiting, staff are respected, listened to and appreciated, the care is good, life is worth living,

and legal action is unnecessary. Thomas (1996) conceived the Eden Alternative as an alternative to the sterile environment in which many nursing home residents live and as an answer to isolation and inactivity. He suggested creating a "human habitat," a home where the milieu is diverse, spontaneous, and natural. He wanted residents to have the opportunity to participate in caring for themselves, other residents, and their surroundings in an enhanced environment. The Eden Alternative began as a grant project in one nursing home in New Berlin, New York in 1992, and has now spread worldwide. The main elements of the Eden Alternative are: staff empowerment, resident animals, plants and gardens, children, and the community. Empowerment of staff is based on the belief that caregivers will treat the resident the way they themselves are treated. The idea behind this is that if staff feel nurtured and cared for, they will act the same way towards the residents. And if staff feel valued, they will value the residents. Bringing animals into the facility is known to have a positive effect both on residents and staff (Barba et al., 2002), as they have been shown to decrease stress, improve mood, increase communication skills, and decrease loneliness and depression. Plants and gardens change the environment from a sterile one to one that is softer and natural. Other benefits from plants are that they increase the indoor air quality, increase humidity and decrease the number of bacteria in the air (Thomas, 1996). The residents are given the opportunity to care for plants and gardens, and for many, this will bring about good memories. In the Eden Alternative model, children are integrated into the activities in the nursing home, providing the opportunity to creating ongoing relationships. The community is welcomed into the nursing home, by having meetings at the facility, arranging different cultural activities, and so on. In the Eden Alternative model, people of all ages become an integral part of the nursing home, and the nursing home becomes an integral part of the surrounding community (Barba et al., 2002).

Bauer & Nay (2003) argue that working with the family in aged care is consistent with modern nursing philosophy. But this work is not without problems and challenges for both the family and the staff. The families may have problems finding their role in the nursing home setting, and may be reluctant to complain because they do not want to be labelled as "whiners." The families' involvement in the nursing home is dependent on how staff perceive the family and on the degree of cooperation from the nursing home staff, which again are related to the care policies in the nursing home (Bauer & Nay, 2003). A review of what promotes constructive staff-family relationships in the care of older people in healthcare settings (Haesler et al., 2006) found that staff and family education on relationship development, power and control issues, communication skills, and negotiating techniques are essential factors. The review also revealed that even if staff express a theoretical support for the collaborative process, this belief often did not translate to clinical practice. It seemed more important for the staff to maintain control, rather than to collaborate with the families. The review showed that to gain sustained benefit from interventions designed to promote constructive family-staff relationship, it is essential that the management address issues like workload and staffing, and introduce care models focused on collaboration with families.

4.5.2 Person-Centred Care

The term person-centred approach was introduced into the dementia care field by Kitwood (1988) as an alternative to the approaches that emphasized the medical and behavioural management of dementia care. Kitwood wanted to bring together ideas and ways of working that emphasized communication and relationships (Brooker, 2004). The concept of person-centred care may be understood as individualized care, a value base, a set of techniques to work with people with dementia, a phenomenological perspective, or a means of

communication (Brooker, 2004). Kitwood (1997) defines person-centredness as: *"...a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being. It implies recognition, respect, and trust"* (p.8). A review of the literature on person-centredness in gerontological nursing (McCormack, 2004) extracted four core concepts from this definition and argued that these four concepts underpin person-centred nursing: (1) being in relation; (2) being in a social world; (3) being in place and (4) being with self. Brooker (2004) present four major elements in person-centred care: (1) valuing people with dementia and those who care for them (V), (2) treating people as individuals (I), (3) looking at the world from the perspective of the person with dementia (P), (4) a positive social environment in which the person living with dementia can experience well-being (S). These four elements are expressed in the form of an equation: PCC (person-centred care) = V+I+P+S. Person-centred care is about seeing all people as valued, and positively discriminate on behalf of those who are vulnerable. Person-centred care takes an individual approach and meets the unique needs of the individuals. In person-centred care the subjective experience of the individual is of great importance. For the approach to be person-centred one needs insight into the person's subjective well-being. Methods for involving people with dementia in quality of life measures is still in the early stages, however, recently, an important work by Wogn Henriksen (2012) was published. She interviewed persons with dementia and concluded that an inside perspective or life-world perspective on dementia may give "thick" descriptions of the phenomenology of dementia. A perspective that recognises the unique life world of persons with dementia may strengthen commitment and presence of caregivers and contribute to humanising dementia care. This shows that with the proper approach, the person with dementia can give valuable insight in her/his life.

Both McCormack's (2004) and Brooker's (2004) articulations of person-centred care emphasize the importance of knowing the person, the importance of valuing and relationships, and seeing the person beyond the immediate needs and appearance.

Person-centred care has become not only accepted but also, in many ways, seen as a preferred method of care. The UK National Service Framework and the UK Altzheimer's Society have chosen person-centred care for older adults as a standard in service provision (Brooker, 2004).

5. An ecological model for understanding inadequate care in nursing homes

The aetiology of abuse is a complex and varied interaction between personal, social and organisational factors (Garner & Evans, 2002). Still, there is a lack of empirical work in this area, and much of the conducted research is done by practitioners, rather than developed from an established theoretical framework. A number of different theories and perspectives have been used and presented by professionals from other areas of family violence, but these theories has not been fully tested in the context of elder abuse (Penhale, 2010). Within the area of elder abuse, rather than presenting a theory, several authors have sketched out a model with three key factors: environmental conditions, staff characteristics and resident characteristics (Pillemer, 1988; Phillipson & Biggs, 1992; Biggs et al., 1995; Clough, 1996; Wierucka & Goodridge, 1996). Pillemer (1988) adds external factors in his model to explain what he calls "deliberate maltreatment." Goergen's studies (2001; 2004) revealed that nurses attributed the causes of elder abuse to many factors including lack of staff, work overload, staff characteristics, and resident aggression. Ageism, lack of funding for elder care, and the prioritising of economics were also factors linked to elder abuse. As previously shown, there has been little theorising about abuse and neglect in institutions, and McDonald et al. (2012) state that: *"If nothing else, there is widespread acknowledgement in the literature that it is a complex phenomenon"* (p.147).

Penhale (2010) notes that it is not only necessary to differentiate between the different types of abuse, neglect and exploitation, but it is also important to differentiate between different

levels at which mistreatment may arise; at individual, community and societal levels, as well as the number of different locations and settings in which abuse may happen.

According to Kosberg et al. (2003) using systems models for the analysis of intra-family or interpersonal adversity is not new. They refer to Garbarino et al. (1977) who used a systematic orientation, based on Bronfenbrenner's human ecological perspective, to explain child abuse. Since no situation is entirely context-free, different factors, such as political, economic, and demographic must be considered as important in shaping the quality of life for family members. Kosberg et al. (2003) suggest that a systemic perspective can be helpful in understanding and explaining elder abuse. Although their study was of domestic elder abuse within diverse cultures, their conclusions are transferable to other settings. They claim that each case of elder abuse is different and occurs for many reasons, influenced by, for example, individual personality, family, social class, age, and gender. It takes place in different contexts that influence attitudes and values, as well as the definition of the different acts as right or wrong. Recently, ecological models for examining the phenomenon of elder abuse in families and home care service (Schiamberg & Gans, 2000; Carp, 2000; Sandmoe, 2011), nursing homes (Bonnie & Wallace, 2003; Schiamberg et al., 2011), as well as a study of elder abuse cases reported to the Adult protective Services (APS) (Wangmo et al., 2013) has been presented. The ecological system theory postulates that the individual is affected throughout his or her life by many systems (Wangmo et al., 2013), and seeks to understand a phenomenon as a complex and multifaceted problem, which indeed is the case for inadequate care, abuse and neglect in nursing homes (Schiamberg et al., 2011). The USA National Research Council emphasizes the need for comprehensive, ecological perspectives that will inform the understanding of elder abuse in both community and institutional settings (National Research Council, 2003). Bronfenbrenner (1979) argued that human behaviour can

only be fully understood by looking at the nested levels of influence, these levels are multiple interrelated systems. He described a structure of circles moving from the inner to the outer circle (level), and transactions between the levels flow both directions. These four levels in Bronfenbrenner's ecological model include the microsystem, mesosystem, exosystem, and macrosystem (See Figure 4).

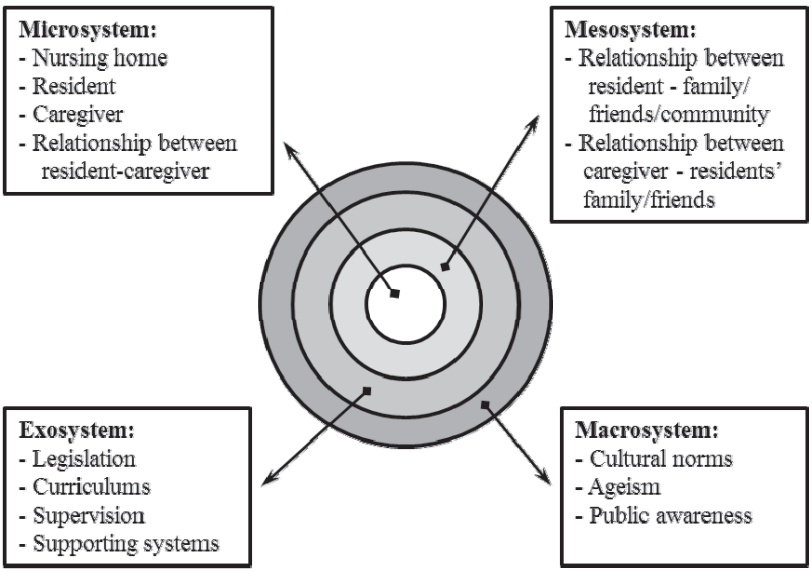

Figure 4. Modified illustration of an ecological model for understanding the complexity of inadequate care, abuse and neglect in nursing homes.

Schiamberg et al. (2011) propose an ecological framework for better understanding the distinctive risk factors associated with elder abuse in nursing homes, and the complex interaction of individual/person characteristics and contextual factors in institutional elder abuse. The dynamic relationship between the nursing home resident and the caregiver in context is the unit of interest in their model. That context has multiple levels, which may have impact on the occurrence of abuse.

Since the interaction between caregivers and residents takes place in a nursing home, and is influenced not only by the immediate nursing home setting, with key characteristics such as location, size, or physical design of the nursing home, but also more distal context, all four systems are of interest. The different levels in the model correspond with the understanding of the complexity of the phenomenon shown in this thesis.

According to Schiamberg et al. (2011) an ecological framework that addresses risk factors for elder abuse in nursing homes will focus on the interaction between the resident and the caregiver as the unit of interest; the first level of analysis is therefore the characteristics of the resident (e.g. health status, Activities of Daily Living-function) and the caregiver (e.g. level of stress, level of training). Previous research has shown that different staff and resident characteristics are related to abuse. Several studies have documented that cognitive impairment and dependency on carer due to physical functional decline are important risk factors for inadequate care, abuse and neglect (Anetzberger et al., 2000; Beach et al., 2005; Cohen et al., 2010). In addition, aggression from residents has been shown to be a predictor of abuse (Pillemer & Moore, 1989; Goodridge et al., 1996), and Goergen (2001) found that many nurses believed that abuse was a result of certain resident behaviour, such as being difficult, aggressive or having mental problems.

Studies have revealed that staff attributes causes of elder abuse and neglect to many factors, such as personality characteristics and personal problems of staff (Goergen, 2001), low job satisfaction and burnout have also been associated with abusive behaviour from staff (Pillemer & Moore, 1989). Caregivers stress is one explanation for why abuse occurs in nursing homes. The work in nursing homes is hard; it is low paid and also undervalued in society. Residents in nursing homes can have challenging behaviour and sometimes even be

abusive toward staff (Åstrøm et al., 2002). Daily life situations can end up in conflicts between caregivers and residents and one reaction to stress can be abusive behaviour. Pillemer & Moore (1989) found that a number of stress-related factors were predictors of abuse of residents by staff, such as residents aggression and conflicts.

According to Bronfenbrenner (1989) the microsystem is a pattern of activities, roles, and interpersonal relationships. It is in the microsystem context, within the nursing homes, in the relationship between staff and resident that acts of inadequate care occurs. The caregiver and the resident meet in a situation and bring to it their specific characteristics and experiences, these alone may be risk factors for abuse. The resident's dependency on the caregiver for help is associated with greater risk of abuse (Burgess et al., 2000). How staff interprets resident behaviour is also of importance. If the staff view residents attempts to resist care, or aggressiveness from residents as intentional efforts to injure staff, the likelihood of abuse increases (Hawes et al., 2001). Nursing home characteristics affect caregiver stress and job satisfaction, and the relationship between abuse and a stressful condition have been confirmed in several studies (Goodridge et al., 1996; Pillemer & Moore, 1989). Payne & Gray (2002) studied ombudsmen's perspective on abuse in nursing homes and found that stressed-out workers were one predominant explanation for the occurrence of abuse.

Meso is the relationship between two or more microsystems. One meso-factor regarding abuse in nursing homes is the relationship between the resident and the resident's family. Lack of contact with family and friends is related to the likelihood of elder abuse (Lachs & Pillemer, 1995; Donohoe et al., 2008); in addition, social isolation has been shown to be a risk factor for elder abuse in nursing homes (Nerenberg, 2006). Conflicts between staff and relatives may also affect the relationship between staff and residents.

According to Bronfenbrenner (1989), the exosystem consists of linkages and processes taking place between two or more settings, involving at least one setting not containing the people in the microsystem. In the exosystem, events occur that have an indirect influence on inadequate care; such things may include legislation and health care and service delivery policies, systems and organisations. Family-nursing home staff communication, educational programmes, guidelines, training, and internal control system are other factors that may influence to what extent abusive situations occur. Payne & Gray (2002) found that ombudsmens' explanations for abuse included amongst others: lack of training, lack of knowledge, poor screening & system failure. Legislations, for example, a mandatory reporting system for use when staff suspect abuse, will be helpful to detect actual cases of abuse and to create a more complete understanding of the phenomenon. Unlike in Sweden where staff members are obliged to report abuse or failure in care, or care that violates a person's integrity, security and dignity, in Norway, there are no specific laws or regulations to address elder abuse (Bergstrand, 2011).

On the macrosystem level, cultural values, social policy, and effective interventions are factors that may affect staff behaviour toward residents. Goergen (2001) found that nurses also attributed causes of elder abuse to broader structural issues, such as lack of funding for elder care and ageism. A cultural attitude that devalues older people will be brought into nursing homes by the staff and affect the nursing home environment. Moreover, negative stereotypes held by nurses have been found to relate to abusive behaviour (Pillemer & Moore, 1990).

Penhale (2010) discusses that it is unlikely that one theoretical perspective will be developed that can account for every type of mistreatment that happens to older people, and that a

variety of conceptual frameworks and explanations will be necessary to develop a theoretical model that accounts for specific, but different phenomena that constitute the continuum as a whole. Many studies note that their limitation lies in a tendency to aggregate all forms of abuse together, and thus they are not able to produce distinct risk factors for different forms of abuse (Lachs et al., 1997). Measuring such "average" effects may not fully cover the fact that different forms of abuse may be caused by different factors. Schiamberg et al. (2011) claim that an ecological perspective takes into account that elder abuse in nursing home settings is not a consequence of a single event and cannot be explained by a single cause, but rather that risk factors appear to exist at all levels of the ecological context .

6. Rationale for the thesis, aims and research questions

Although the majority of older people are in good health and not receivers of care from the health service, we know that need for health care increases along with age. The care for older persons is repeatedly debated in Norway. Questions about how much care is needed and where to offer the care (in institutions or at home) are followed by discussions about how to assure good quality. National standards for quality of care are given as guidance to planners, decision makers and practitioners. Governmental and municipality inspections are carried out in order to exposure irregularities.

In spite of increased research about various topics in Norwegian nursing homes, there remains little knowledge about inadequate care, including abuse and neglect. Studies are often either focused on quality in general (Slagsvold, 1986; Kirkevold & Engedal, 2006) or on specific topics such as restraint of people with dementia (Kirkevold & Engedal, 2004). There are also some qualitative studies that provide a valuable contribution in understanding life in nursing homes (Malmedal, 1998; Hauge, 2004; Slettebø, 2004). The first step resolving a problem is to recognize that the problem exists, and one way to bring attention to a problem is by conducting small, localized, descriptive studies (Stein, 2006). As such, studies directly focused on inadequate care in nursing homes are required in order to understand the phenomena and to take preventive efforts. Therefore a study of how nursing staff perceive inadequate care, abuse and neglect of residents in nursing homes is needed.

The overall purpose of this thesis is to contribute to an understanding of inadequate care, abuse and neglect in nursing homes. By exploring the frequencies and types reported by staff,

as well as investigating factors seen as predictors of inadequate care, abuse and neglect, this work will provide knowledge which can be useful for developing preventative strategies and thus improve the care in nursing homes. The following research questions were formulated:

1. What is the frequency and types of inadequate care committed by staff in nursing homes? (Paper I).
2. Is there a difference in reporting depending on age, education level and years of experience working at nursing homes? (Paper I).
3. Which factors predict the probability of inadequate care committed by staff in nursing homes? (Paper II)
4. What attitudes are held by nursing home staff on reporting negative/ unwanted acts committed by their colleagues? (Paper III).
5. Do nursing staff have different attitudes depending on age, education, and years of working experience? (Paper III).
6. What are the perceived reasons for inadequate care in nursing homes, as seen by the staff? (Additional results).
7. Do the staff perceive different reasons for the different types of inadequate care? (Additional results).

7. Material and Methods

This explorative study applies a quantitative approach, using a cross-sectional survey. In this section the different steps in development of the instrument are described, as well as a presentation of the study population, data collection and the analysis process. Methodological and ethical considerations are also included in this section. As previously stated, research in this field is still in its infancy, and thus, all contributions to gain more knowledge about this topic are valuable. Researchers have used different methods, like qualitative interviews (Malmedal, 1998; Weatherall, 2001), observational studies (Meddaugh, 1993), as well as quantitative approaches like surveys of staff (Goergen, 2003; Drennan et al.,1012) or surveys of relatives (Post et al., 2010). The quantitative approach in this thesis is grounded in the fact that there is a need for quantifying the phenomenon of inadequate care, abuse and neglect in Norwegian nursing homes. However, my overall thinking is that phenomena that occur in human/relational settings, like acts of inadequate care, abuse and neglect, happen in an interaction and a social context influenced and affected by conditions and settings beyond the immediate setting with a resident and caregiver.

7.1 Research design

This explorative study's design is cross-sectional with several retrospective sequences; data is based on a self-reported questionnaire. In the past decade, there was considerable experimentation with methods for improving the accuracy of reports of socially undesirable behaviours, and the most consistent findings in the literature are that more private (e.g., self-administered) modes of administration produce both higher reports of socially undesirable

behaviours and lower reports of socially desirable ones (Bowling, 2005). Sensitive questions are therefore best asked using self-administered questionnaires rather than face-to face interviews, as it provides higher levels of reporting. Cross-sectional studies are snap-shots that examine associations between variables at one point in time. They are useful for descriptions or investigations of relationships, but have limitations concerning inferring changes over time (Polit & Beck, 2012). The strength is that cross-sectional studies can generate hypothesis for future research, but since one obvious weakness with cross-sectional studies is that one cannot establish cause-effect, any causal conclusions should be avoided.

7.2 The questionnaire

The challenges of measuring inadequate care, abuse and neglect are well documented. First, there is a lack of validated research tools for detecting such incidents (Buri et al., 2006). No previously used questionnaire was found to fully fit the purpose of this study; therefore a new questionnaire was developed. Earlier studies in the area formed the basis for questions of interest in this study. The early works by Pillemer and colleagues (Pillemer, 1988; Pillemer & Moore, 1989; Pillemer & Bachman-Prehn, 1991) have been an inspiration for many researchers, as in this study. A German questionnaire from a study by Goergen (Goergen, 2001) was translated into Norwegian, but it was found , as a whole, too comprehensive. However, some of the questions were adapted and integrated into this study. The questionnaire from a Swedish study (Saveman et al., 1999) was also assessed in order to gather additional questions. A study of abuse and neglect in Norwegian nursing homes based on in-depth interviews with nurses and nursing assistants was helpful in understanding the phenomenon and choose items for the questionnaire (Malmedal, 1998). The development and

the validation of the questionnaire were carried out through different methods; focus group and two pilot studies.

The first draft was discussed in a focus group. The group consisted of five practitioners (registered nurses and licenced practical nurses) from one nursing home. During a session of 1 ½ hour, the issues, terms and formulation of the questions were discussed, with the purpose of obtaining validity. That is, to what extent is the instrument measuring what it purports to measure? The group contributed to changes in the questionnaire and even a second round of face validity was carried out with the same group after the first revision.

The questionnaire and procedures for handling and collecting data were first piloted amongst staff (n=44) in one large nursing home in an urban location. This pilot study was crucial in the sense of getting necessary response on the questionnaire. On the one hand, negative reactions from the staff were reported. Some of the questions seemed to provoke the staff so much that they refused to participate at all. On the other hand, several of the staff openly expressed their support for the study. All in all, this first pilot study provided useful contributions for revising the questionnaire. Acts that were not reported at all were taken out of the questionnaire; mostly including acts of severe physical character, as well as sexual abuse. Other studies have shown that sexual abuse of residents by staff in nursing homes are seldom reported (Goergen, 2004; Natan et al., 2010; Drennan et al., 2012) even if it is documented to exist (Payne & Cikovic, 1995; Teaster et al., 2007). A new pilot study was then carried out in a nursing home in the countryside, involving 37 nursing staff. The attitude towards the questionnaire was much more positive this time. Only a few had openly negative reactions toward the study and few had negative comments about the questionnaire. The questionnaire then underwent the final revisions.

The revised questionnaire consisted of seven parts; (1) background, (2) job satisfaction, (3) residents behaviour, (4) conflicts, (5) staff behaviour, (6) perceived reasons for inadequate care, and (7) whistle blowing (see Appendix III). Eleven questions regarding the respondents' background were included and consisted of items such as age, gender, education, and years of experience. Job satisfaction was measured by using a Norwegian translation (Nytrø, 1995) of the Warr-Cook-Wall job satisfaction scale (W-C-W scale) (Warr et al., 1979). Nine items on the questionnaire were related to residents' behaviour towards staff, five of the items were about aggressive behaviour. The questions about conflicts between staff and residents in direct care-giving situations, and not directly related to care-giving activities included nine items. There were two questions, each consisting of 20 items, regarding staff behaviour (inadequate care, abuse and neglect); the respondents were asked to report how often they had observed a colleague commit acts listed in the questionnaire, as well as how often they themselves had committed the same acts. One question in the questionnaire consisted of 28 items regarding perceived reasons for inadequate care, abuse and neglect. The whistle blowing section included seven statements regarding different reactions one might have when witnessing a colleague commit acts of inadequate care. The questions in this section were partly adopted from another questionnaire (Hetle, 2005) and adjusted for this use. Detailed description on how data were prepared for analyses are found in each of the papers included in the thesis.

In addition to this questionnaire, there was a form to fill in information about the nursing homes and the departments. Those questions focused on the buildings, the staff and the residents. Instead of putting all those "administrative" questions in the main questionnaire, it

was considered better that the nursing home manager and the head nurse of each department completed this part of the questionnaire.

7.3 The sample

The study was carried out in one county in the middle of Norway (Sør-Trøndelag). The total number of inhabitants in the county at the time of study was 250 000, more than half (160 000) lived in the city of Trondheim. There were 55 nursing homes in the county (total number of residents were 2422), 26 were located in the city. Two of the nursing homes (one in the city and one in the countryside) had already participated in the pilot studies. The 53 remaining nursing homes were clustered into four groups:

1) Small (less than 50 residents) urban (n=19)
2) Large (more than 50 residents) urban (n= 6)
3) Small (less than 50 residents) rural (n=17)
4) Large (more than 50 residents) rural (n=11)

From each of these groups, around 1/3 were drawn for the final sample, resulting in:

1) Six small, urban nursing homes
2) Two large, urban nursing homes in the city
3) Five small, rural nursing homes
4) Three large, rural nursing homes

In addition, a reserve list was drawn for all four groups. All nursing homes in this study were public.

7.4 Data collection

In order to update the lists of nursing homes in the county considering, for example, their number of residents, correct address and name of the manager all 53 nursing homes were phoned before drawing the sample. This round of phone calls was also used as an opportunity to preannounce the study and the possibility that this particular nursing home could be amongst the selected ones. The benefit of these telephone calls was that the managers were already aware of the study when the letter asking for their participation arrived. After having randomly selected the sample, a letter of invitation was sent to the nursing homes. A meeting with one of the staff (here called: coordinator) from each department was carried out in order to set the date and procedure for collecting data. All staff that worked during a period of ten days were given the questionnaire and asked to participate. The coordinators collected the questionnaires, which were handed to them in sealed envelopes. The data were collected during October-November 2005. In total, 780 nursing staff was asked to participate. The coordinators made two rounds of follow-ups to those who had not returned the questionnaire (n=164). I total, 616 returned the questionnaire. There were 45 coordinators in total and all of them succeeded in following the procedure.

7.5 Characteristics of the participants

There were on average 37 beds at the nursing homes in the study, varying between 13 and 76. Altogether the 16 nursing homes had 623 residents, whereof 70% were women, 4% were confined to their beds and 37% had to use a wheelchair. The registered nurses in charge reported that 59% of the residents were confused and 60% had issues with urinary-

incontinent. Of the 780 staff members who received the questionnaire, 616 participated, which gave a response rate of 79%. The response rate for each nursing home varied between 61% and 98%; five nursing homes had a response rate higher than 90%. The staff ranged in age from 16 to 74, with a mean age of 40 (SD=13). Almost all of the staff were female (97%) and only 20% worked full-time. The mean length of experience in health care was 14 years (varying from 0 to 45 years) and they had been working at the present nursing home for, on average 8 years (varying from 0 to 43 years). Regarding staff education, 25% were educated at the university college level; either registered nurses (20%), social educators (3%), occupational therapists (1%) or physiotherapists (0.5%). More than half of the participants were licensed practical nurses (educated at upper secondary school), and the rest were nursing aides who had either upper secondary school education in subjects other than nursing (9%) or only lower secondary school (3%); for 5% of the staff, education was unknown. Seventy-two per cent of the staff worked in ordinary long-term wards, 17% worked in special units for residents with dementia diseases, and the rest (11%) were working in respite units, day care units, rehabilitation units or others.

7.6 Statistical analyses

In accordance with the research questions posed in the studies and the type of data collected, several statistical techniques were used for data analyses, including descriptive statistics, factor analysis, and logistic regression analysis.

7.6.1 Paper I

Descriptive statistics were calculated for observed and committed acts of inadequate care. In the analysis of group differences, values are expressed as mean scores calculated from the

following scale: 1= Never, 2= Once a month or less, 3= Once a week or less, 4= More than once a week. Eta squared was used to investigate the relative magnitude of the differences between the means. Eta squared is a universal measure of relationship which applies regardless of the form of the relationship, and can be used whether the independent variable is measured on a ratio, interval, ordinal or nominal scale. To interpret the strength of eta squared values the following guidelines was used: .01=small effect; .06=moderate effect; and .14=large effect (Nunnally & Bernstein, 1994). The data were analysed with SPSS 14.0 software.

7.6.2 Paper II

In addition to descriptive statistics, a logistic regression analysis that investigated the differences between those who report committed inadequate care and those who not report committed inadequate care, was conducted. A logistic regression model estimates regression coefficients that can be read as the rate of change in the "log odds" as X changes. The calculated Exp(B) is the expected effect of the independent variable on the odds ratio, which is the probability of the event divided by the probability of the non-event. Initially one item, *entering the resident's room without knocking*, was removed from the item list. A frequency analysis showed that half of those who reported having committed acts of inadequate care of an emotional character had only committed this type of act. Since this is a common behaviour in a nursing home setting, and generally not viewed as a severe act of inadequate care, the item was left out of further analyses. No one admitted to having stolen money or valuables from a resident, so the only item concerning financial acts was also removed. There were some missing observations for the variables, and casewise deletion was used when estimating the logistic regression model (n=510). An ordinary least square (OLS) estimation of the model, showed no indication of multicollinearity. All variance inflation factors (VIF) indices

were below 5. A p-value below 0.05 was considered statistically significant. SPSS version 17 was used for data analysis.

7.6.3 Paper III

Descriptive statistics were calculated for the seven statements regarding attitudes towards reporting, and the scores were inverted in order to give the highest score to those who 'strongly agreed'. In the analysis of group differences, values were expressed as mean scores calculated from the following scale: Strongly disagree =1, Moderately disagree=2, Both agree and disagree =3, Moderately agree=4, Strongly agree=5. Eta squared was used to investigate the relative magnitude of the differences between the means. A p-value below 0.05 was considered statistically significant. The data were analysed with SPSS 15.0 software.

7.6.4 Analyses of perceived reasons for inadequate care

One question in the questionnaire used in the survey (Appendix III, question 18) consisted of 28 items regarding staff related, resident related, and work load related reasons for inadequate care. The question was labelled in the following way: "What do you think is the reason why residents are subjected to negative/ unwanted acts from staff? Below you will find a list of different reasons. How much do you agree or disagree in each of the statements? "The scores were reversed before the analyses were conducted, so a higher score indicates more agreement in the statement: Strongly disagree =1, Moderately disagree=2, Both agree and disagree =3, Moderately agree=4, Strongly agree=5. Parametric statistics (Student's T-test) were used to measure differences between the group of staff that had committed inadequate care and the group of staff that had not committed inadequate care with respect of how they report perceived reasons for such acts to occur. The 28 items were subjected to an exploratory factor analysis. The exploratory factor analysis revealed the presence of four components with

eigenvalues exceeding 1, explaining 37.8%, 9.3%, 6.1% and 5.3% of the variance respectively. Total explained variance is 58%. An inspection of the scree plot revealed a break after the fourth component. It was decided to use four components for further investigation to compute sum scores for four factors. An independent-samples-t-test was conducted to compare the scores for perceived reasons for inadequate care with the scores for those who reported acts of inadequate care of different types and those who did not report acts of inadequate care. A logistic regression analyses that investigated the differences between those who report inadequate care and those who not report committed inadequate care, was conducted. An OLS estimation of the model showed no indication of multicollinearity. All VIF indices were below 2.5. A p-value below 0.05 was considered statistically significant, and SPSS version 20 was used for data analysis.

7.7 Methodological considerations

The response rate was high (79%) and the respondents' willingness to answer the questionnaire indicates that the questions were relevant to nursing home care. Different methods and definitions make full comparison between the results in this thesis and other studies difficult, as do cultural and contextual differences and similarities between various nursing homes in Scandinavia and, for instance in the USA. There are some similarities, but also some major differences regarding, for example, staffing standards and staffing levels (Van Nostrand al., 1993). The broad definition of inadequate care chosen in this thesis was found to be suitable, but one may raise the question whether its broadness makes it difficult to more precisely label the reported acts as inadequate care, abuse or neglect. A major concern during the development of the questionnaire was that the acts listed as inadequate care, abuse and neglect should be recognizable to the nursing staff. The thorough process with a reference

group and two pilot studies seem to have increased the face-validity but there still are some limitations in the method that have to be mentioned. Since there was no time limit in the questionnaire for the occurrence of the acts reported, e.g. during last month or last year, some of the acts reported may have occurred as long as a couple of years ago. One assumption might be that it is the more severe acts that happened a long time ago that might be remembered and reported. Even if one assumes, however, that respondents have reported recent acts, this is a limitation and has to be considered when results are interpreted. The thesis has a nursing staff perspective, as they were invited to report acts they had observed being committed by their colleagues and also acts they themselves had committed. This may be a limitation, since inadequate care, abuse and neglect in nursing homes might be reported differently by residents themselves or by their relatives. Other researchers share the same concern about this possible bias (Payne & Fletcher, 2005; Schiamberg et al., 2011) leading to speculation regarding whether or not inadequate care, abuse and neglect are even more extensive than these types of surveys reveal.

However, the high response rate (79%) and the high frequency of reported acts of inadequate care, abuse and neglect, show that nursing staff are not reluctant to report such behaviour, a phenomenon observed also amongst family caregivers (Grafstrom et al., 1993; Cooney et al., 2006). Even though there was a high rate of reported acts, there remains the potential for possible under-reporting, owing to the knowledge of what is a desirable behaviour. As there were no registered data on the non-respondent group, no drop-out analysis was possible. The question regarding whether or not there are any differences between the non-respondents and the respondents must therefore remain unanswered.

Despite the weaknesses of a cross-sectional self-report methodology, this design can be quite useful in providing a picture of inadequate care, abuse and neglect in nursing homes. It can provide important insights and be useful for developing hypotheses about what causes inadequate care. Additional methodologies will be needed to fully test these hypotheses, but cross-sectional questionnaires can provide a relatively easy first step in studying phenomena of interest.

The perception of inadequate care, abuse and neglect is connected to the contexts in which the acts occur. Even if an act by definition should be labelled as inadequate care, abuse or neglect the staff may have various reasons for behaving the way they do. How they judge their actions can influence what they report as inadequate behaviour.

Even though it was made clear to the staff that participating in the study was voluntary, one cannot ignore the possibility, indicated by the high response rate, that some may have felt obliged to participate. On the other hand, the participants had the opportunity to return unanswered questionnaires, but only two did. Limited by the data collection method and probably an element of under-reporting, it is not possible to say anything about the exact prevalence of inadequate care.

Due to the fact that data was collected some years ago (2005), and might be considered old, one may question whether the results still are valid? Has the situation in nursing homes changed in the way that makes this data no longer relevant? Unfortunately, one might say, reports from media and from recently supervisions of municipal health and social service for elderly people conducted by the Norwegian Board of Health Supervision (Helsetilsynet, 2011) indicate that the question of inadequate care, abuse and neglect in nursing homes is not

solved. The countrywide supervision from 2010 concluded that the municipalities have a long way to go in order to ensure that: *"frail elderly people with comprehensive needs for medical treatment and care receive the care they have the right to receive"* (Helsetilsynet, 2011, p. 60). Amongst others, the supervision revealed that there is not enough staff with necessary training and skills to carry out the tasks, and there are not adequate systems for reporting adverse events and preventing them from being repeated. The extent of use of locked doors in nursing homes and limitation of the residents' rights without legal permission was found in the majority of the nursing homes. In two-thirds of the municipalities, service provision did not meet the statutory requirements. A report from The Norwegian Association of Local and Regional Authorities (KS, 2012) confirms that there is a risk for serious failure in care in all municipalities, and that failures might be caused by the system level factors, e.g lack of routines, training, control, and also because *"it is human to fail"* (p.17). A newly published report from The Norwegian Board of Health Supervision (Helsetilsynet, 2013) about compulsory health care in nursing homes concludes that there is a great risk that service provision is inadequate. Based on the resent reports and due to the fact that Norway has not presented any new research on this topic, the results presented in this thesis are considered valid and generalizable.

7.8 Ethical considerations

The thesis is based on voluntary participation by informed persons. The Privacy Issue Unit of the Norwegian Social Science Data Services has approved the study (Appendix I). The Regional Ethical Committee for Medical Research stated that this project did not need to be considered by the Committee because patients were not directly involved. Since the respondents in this survey were asked to report acts committed by themselves or others that

might be considered illegal, it was of crucial importance to assure them that the procedure provided them with anonymity.

The researcher must be aware of the broad range of ethical issues that arise during research preparation, data collection, interpreting, publication, and dissemination of research results, and take efforts to prevent misconduct.

Previous experience has shown that the present topic is of great interest to the public, and thus is highly popular amongst the media outlets. One obvious danger when media publish the results of a study such as this is that they highlight only the most severe and negative aspects and present this many-facetted phenomenon in a skewed way. The informants may feel conned by the researcher and this may lead to reluctance to participate in future studies. Individuals who supply the information that forms the basis of this research may have a concern with the use of this information and should expect confidentiality. Breaches can cause serious limitations in the ability of other future researchers to collect reliable and useful data; they can limit access to the respondents who provide the information required for research as well as access to statistical data collected by others. The respondents were invited to contact the researcher for questions or comments, but no one did so.

8. Results

In this section the main results of the three papers are presented, as well as some additional results. Readers should refer to the previous section for information about methods and material used in each paper.

8.1 Summary of the papers

8.1.1 Paper I

Malmedal, W., Ingebrigtsen, O., & Saveman, B.I. (2009). Inadequate care in Norwegian nursing homes, as reported by nursing staff. *Scandinavian Journal of Caring Sciences:* 23 (2): 231-42.

Aims: The aim of this study was to describe the frequency and types of inadequate care committed by staff in nursing homes. Another aim was to investigate if nursing staff reported in different ways depending on age, education level and years of experience working at nursing homes.

Results: All in all, 91% of the nursing staff reported they had observed a colleague commit at least one act of inadequate care and 87% reported that they themselves had committed at least one act of inadequate care. Acts of negligent and emotional character were most frequently reported, both as observed and committed. The most frequently observed act of emotional character was *entered a resident's room without knocking* (84%), *talked disrespectfully to a resident* (50%), *scold a resident* (40%), and *prohibit a resident from using the alarm* (40%). The most frequently observed acts of negligent character were *neglected oral care* (68%),

ignored a resident (67%), and *delayed care longer than necessary* (67%). Regarding acts of physical character, two frequently observed acts were *restrained/held back a resident* (44%) and *held a resident hard* (36%). Regarding acts of financial character, five persons (1%) had observed that a colleague had *taken money or valuables from a resident*. Regarding self-committed acts of emotional character, the most common reported acts were *entered a resident's room without knocking* (69%), *used diapers to prevent toilet visits* (20%), *prohibited a resident from using the alarm* (20%), and *talked disrespectfully to a resident* (14%). The most frequently committed acts of negligent character were *neglected oral care* (64%), *delayed required care longer than necessary* (55%), *ignored a resident* (44%), and *did not change diapers when needed* (21%). Regarding physical acts, 33% of the nursing staff reported that they themselves had *restrained/held back a resident,* and 22% had *held a resident hard.* No one reported that they had committed acts of financial character, such as taking money or valuables from a resident. There were significant differences between the age groups regarding observed acts of inadequate care in respect of three items: *did not wash a resident who needed washing* (p=.042), *ignored a resident* (p=.000), and *entered a resident's room without knocking* (p=.000). With the exception of physical acts, the youngest group of nursing staff tended to report more observed acts than the oldest. Regarding committed acts, three items had significant differences between the age groups: *scolded a resident* (p=.050)*, ignored a resident* (p=.040) and *gave medication when they should not* (p=.018). The oldest age group tended to report fewer committed acts than the youngest, except for physical acts. There were significant differences between staff of differing educational levels regarding observed acts of inadequate care in respect of 13 out of 20 items. The tendency was that the higher education level, the higher mean on observed acts of all types. Concerning committed acts, the differences between the educational groups were significant for 11 items. Staff with more than 25 years of experience at their present nursing

home reported more observed acts of physical character. Concerning acts committed by themselves, the nursing staff with 3-10 years of experience tended to report more acts of emotional and negligent character, and the nursing staff with more than 25 years of experience at their present nursing home reported more committed acts of physical character than did the others.

Conclusions: The results show that residents in Norwegian nursing homes are exposed to different types of inadequate care. Even though the most commonly reported acts are of emotional and negligent character and not seen as so severe, there is enough proof that residents in nursing homes are exposed to unnecessary suffering owing to inadequate care. The results that staff report differently depending on age, education and length of experience is interesting and needs to be further examined.

8.1.2 Paper II

Malmedal, W., Hammervold, R., & Saveman, B.I. (2013). The dark side of nursing homes. Factors influencing inadequate care in Norwegian nursing homes. Accepted for publication in *Journal of Adult Protection.*

Aim: The aim of this study was to investigate factors that predict the probability of inadequate care of emotional, negligent, and physical character committed by staff in nursing homes.

Results: Inadequate care of emotional character was reported committed by 30% of the staff, while 77% reported inadequate care of negligent character, and 40% reported having committed acts of physical character. Eleven hypotheses were tested with a logistic regression model. There is a significant relationship between inadequate care of an emotional character and the independent variables *urban location* (p = .000), *education at university level* (p = .044), *educated at high school level* (p=006), *job satisfaction* (p = .013), *resident*

aggression (p = .000), and *non- care related conflicts* (p = .008). There is a significant relationship between inadequate care of a negligent character and the independent variables: *job satisfaction* (p = .048), *resident aggression* (p = .015), *care-related conflicts* (p = .012), and *non- care-related conflicts* (p = .000). There is a significant relationship between inadequate care of a physical character and the independent variables *location* (p = .006), *nursing home size* (p = .006), *staff age of 50 or older* (p = .037), *education at university level* (p = .041), *resident aggression* (p = .000), and *care-related conflicts* (p = .034). The most consistent findings in the study are that resident aggression increases the probability of all three types of inadequate care, and that conflicts predict the types of inadequate care depending on whether the conflicts are directly related to care-giving activities or not. When non-care-related conflicts are present, the probability of neglect and emotionally inadequate care increases, while the probability of acts of a physical character is not affected by non-care-related conflicts. Care-related conflicts increase the probability of acts of a physical and negligent character but not acts of an emotional character. Size, location, job satisfaction, education level, and age of staff members are also significant contributing factors but not for all types of inadequate care.

Conclusions: This study investigated the relationships between 11 specific factors and inadequate care. Further studies examining other contributing factors, individual as well as structural, are needed in order to increase our knowledge. The residents' safety and dignity must be of vital interest for all and practice should aim to fulfil the objectives of the regulations.

8.1.3 Paper III

Malmedal, W., Hammervold, R., & Saveman, B.I. (2009). To report or not report. Norwegian nursing home staffs' attitude on reporting inadequate care committed by colleagues. *Scandinavian Journal of Public Health;* 37:744-750.

Aims: The aim of this study was to describe attitudes held by nursing home staff on reporting negative/ unwanted acts committed by their colleagues. Another aim was to investigate whether nursing staff have different attitudes on reporting depending on age, education, and years of working experience from health care services.

Results: The majority of the staff (66%) moderately or strongly agreed with the statement that whether or not they would report the act would depend on its severity. Twenty-eight per cent moderately or strongly agreed that they would not wish to report on colleagues, and 21% moderately or strongly agreed with the statement that they did not feel brave enough to speak out. More than half of the staff (53%) moderately or strongly agreed that they could expect to be supported by their colleagues if they reported the act, and a majority of the staff (59%) disagreed that it was no use to report anything. Fifty-eight per cent moderately or strongly disagreed that they were afraid of what would happen to them if they reported the act and the majority (68%) moderately or strongly agreed that it was best to deal with such matters internally. The eldest groups of staff seem more likely to be more reluctant to report on colleagues, to feel less brave than younger staff, to be more afraid of what will happen to them if they report, and to agree that it is best to deal with such matters internal. Regarding education, it seems that the higher educational level, the more positive attitude towards the willingness to report and less afraid about negative sanctions. Amongst the staff with more than 25 years of experience, the mean values for agreement were higher than amongst those with less experience with respect to six statements.

Conclusions: A positive attitude towards reporting acts of inadequate care committed by their colleagues was held by the staff in this study. Holding a positive attitude is one important prerequisite for certain behaviour and healthcare workers have an ethical requirement and professional duty to speak out on behalf of patients. An organisation which allows the staff to ask questions about bad practice and violations of ethical standards is an organisation that is in a position to develop the best possible practice and to provide the best possible care.

8.2 Conflicts, aggression, and reasons for inadequate care

This section includes results from analyses that are not presented in any of the papers included in this thesis, but which answer questions of interest. First, results related to the distribution of conflicts between staff and residents (question 14 in the questionnaire), and resident aggression (question 15 in the questionnaire) which are useful information for further discussion, and second, results related to questions about perceived reasons for inadequate care, abuse and neglect, as seen by the staff (question 18 in the questionnaire) are presented.

8.2.1 Conflicts and resident aggression

Almost all respondents (92 %, n=560) reported that conflicts occurred between staff and residents during care related activities. The most frequently reported situation (83%, n=490), was when residents refused to take medication, and 21% (n=122) reported that this situation lead to conflicts more than once a week. Conflicts because residents refused to wash or dress was reported by 80% (n=484), and 19% (n=117) reported that this happened more than once a week. In situations not directly related to caregiving activities, 97% (n=586) of the staff reported conflicts, for example, when residents wanted much attention (87%, n=524), and 46% (n=274) reported that this situation lead to conflicts more than once a week (Table 2).

Aggressive actions from residents directed towards staff were reported to happen quite often. The most frequent acts of aggression were being pinched, hit, scratched or pulled by the hair; one or more of these acts were experienced by 75% (n=462) of the staff, 10% (n=61) experienced this more than once a week. Almost 60% (n=354) were threatened or scolded by a resident, and 7% (n=42) experienced this more than once a week. The least frequent act of aggression was sexual harassment; 17% (n=98) reported that they had been exposed to such behaviour from residents, and 1% (n=6) reported that this happened more than once a week (Table 2).

Table 2: Distribution of conflicts and aggression

	Never % (n)	Once a month or less % (n)	Once a week or less % (n)	More than once a week % (n)
Care related conflicts occur because:				
Residents refuse to eat	33 (196)	39 (231)	18 (107)	10 (60)
Residents refuse to wash or dress	20 (119)	35 (208)	26 (159)	19 (117)
Residents refuse to go to the toilet	31 (184)	38 (229)	19 (113)	12 (74)
Residents refuse to take medication	17 (101)	38 (227)	25 (141)	21 (122)
Non care related conflicts occur because:				
Residents claim that they are robbed	43 (256)	43 (256)	10 (57)	5 (30)
Residents want much attention	13 (75)	21 (123)	21 (127)	46 (274)
Residents are bothering other residents	14 (86)	34 (205)	27 (159)	25 (148)
Residents are trying to run away	24 (143)	39 (235)	19 (115)	18 (106)
Residents have an aggressive behaviour	13 (79)	39 (235)	26 (153)	22 (133)
How often have you experienced that:				
Residents have thrown objects at you?	68 (411)	25 (151)	6 (33)	2 (10)
Residents have spat at you?	58 (357)	33 (204)	6 (39)	2 (11)
Residents have pinched, beat or scratched you or pulled you by the hair?	25 (150)	50 (305)	16 (96)	10 (61)
Residents have threatened or scolded you?	42 (256)	37 (227)	14 (85)	7 (42)
Residents have sexually harassed you?	84 (510)	14 (82)	2 (10)	1 (6)

8.2.2 Perceived reasons for inadequate care, abuse, and neglect

The nursing home staff were asked to give their opinion on why negative/unwanted acts towards residents occurred (question 18 in the questionnaire). The results are important information for answering research question 6 and 7, and for further discussion in the next section. The mean scores ranged from 1.71 to 3.79. The staff most agreed that a reason for the occurrence of inadequate care is an understaffed unit. Of the top six reasons, four were related to resident behaviour, such as *the resident refuses to accept assistance*, *the resident is particularly difficult*, and *the resident behaves in a provocative manner*. Also carer related factors, such as *the carer is impatient*, *the carer is not suited for this type of work*, or *the carer is not able to view things from the perspective of the residents*, are high on the list, with eight of the 15 top reasons for why inadequate care occurs (Table 3).

Table 3: Perceived reasons for the occurrence of inadequate care.

Statements		*N*	*Mean*	*S.D.*
1	The unit is understaffed	603	3.79	1.18
2	The resident refuses to accept assistance	597	3.46	1.10
3	The resident is particularly difficult	594	3.42	1.10
4	There are too many tasks to fulfil at the same time	593	3.28	1.23
5	The resident behaves in a provocative manner	597	3.21	1.12
6	The resident behaves violently	593	3.14	1.28
7	The carer is impatient	587	3.12	1.16
8	The carer is not suited for this type of work	598	3.09	1.30
9	The carer is not able to view things from the perspective of the residents	592	3.05	1.23
10	The carer does not get along well with the resident	592	3.05	1.12
11	The carer is burned out	590	3.03	1.14
12	The management does not show sufficient will to encourage the staff in their work	592	2.79	1.27
13	The carer has not learned how to handle conflicts	588	2.73	1.19
14	The carer has a bad day	594	2.72	1.08
15	The carer has insufficient knowledge	597	2.70	1.17
16	The routines are more important than the individual resident	595	2.60	1.28
17	The carer is angry	593	2.39	1.18
18	Bad professional behaviour does not have any consequences	590	2.38	1.23
19	The management fails to supervise the staff properly	590	2.28	1.18
20	The carer does not expect to be punished	592	2.21	1.22
21	The resident is particularly helpless	584	2.18	1.24
22	The carer does not know any other way to perform his/her duty	591	2.17	1.11
23	The colleagues behave in the same manner	586	2.11	1.15
24	The carer has negative attitudes towards elderly	592	2.07	1.20
25	The work environment at the unit is bad	587	2.04	1.14
26	The chance of the negative action being exposed is small	591	2.02	1.07
27	The colleagues do not mind it happening	593	1.98	1.06
28	The management tacitly accepts bad behaviour from staff	591	1.71	1.06

A factor analysis revealed four components, the first component scored high on eight items (from .38- .90) (Table 4). All items were related to staff's attitude, knowledge or mood, and were labelled "Staff related reasons". The second component scored on 12 items, the lowest score was .27 and the highest score was .84. This component can be related to the absence of consequences/reactions to bad professional behaviour, where this behaviour are not revealed,

punished or given any attention. Component 3 scored high on four items (from .76 - .83) and all four were related to resident behaviour. The last component scored on three items (from .51- .84). The items were related to work stress and work load, and thus the component was labelled "Work related reasons" (Table 4).

Table 4: Factor analysis for perceived reasons for inadequate care, abuse & neglect. Rotated Component Matrix.

Variables	Staff related reasons	Related to no consequences	Resident related reasons	Work related
The carer is angry	.385			
The carer has insufficient knowledge	.651			
The carer has not learned how to handle conflicts	.631			
The carer is burnt out	.763			
The carer is not able to view things from the residents perspective	.853			
The carer does not get along well with the resident	.817			
The carer is impatient	.896			
The carer is not suited for this type of work	.900			
The colleagues do not mind it happening		.820		
The resident is particularly helpless		.819		
The carer does not know any other way to perform his/her duty		.663		
The carer has negative attitudes towards elderly		.557		
The management tacitly accepts bad behaviour from staff		.843		
The chance of the negative action being exposed is small		.695		
The work environment at the unit is bad		.432		
The carer does not expect to be punished		.575		
The colleagues behave in the same manner		.534		
The management fail to supervise the staff		.507		
Bad professional behaviour does not have any consequences for the carer		.522		
The routines are more important than the individual resident		.279		
The resident behave in a provocative manner			.761	
The resident refuses to accept assistance			.818	
The resident is particularly difficult			.831	
The resident behaves violently			.764	
The unit is understaffed				.840
There are too many tasks to fulfil at the same time				.814
The management does not show sufficient will to encourage the staff in their work				.519

Parametric statistics (Student's T-test) were used to measure differences between the group of staff that had committed inadequate care and the group of staff that had not committed inadequate care with respect of how they report perceived reasons for such acts to occur (Table 5). Regarding acts of emotional character, there were significant differences in scores for staff related reasons (p=.005), residents related reasons (p=.013), and work related reasons (p=.003). Regarding acts of negligent character, there were significant differences in scores for staff related reasons (p=.000) and residents related reasons (p=.000). Regarding acts of physical character, there were significant differences in scores for staff related reasons (p=.001), residents related reasons (p=.016), and work related reasons (p=.045) (Table 5).

Table 5: Mean values of perceived reasons for inadequate care, abuse and neglect, for types of committed or never committed acts of inadequate care.

		Emotional character			Negligent character			Physical character		
		Never com. acts	Com. acts	*p-value*[1]	Never com. acts	Com. acts	*p-value*[1]	Never com. acts	Com. acts	*p-value*[1]
Staff related reasons	*M*	2.78	3.11	.005	2.45	2.99	.000	2.81	2.96	.001
	SD	(.92)	(.78)		(1.00)	(.82)		(.94)	(.80)	
Related to no consequenses	*M*	2.04	2.36	.116	1.88	2.19	.119	2.10	2.18	.440
	SD	(.80)	(.75)		(.81)	(.77)		(.81)	(.77)	
Resident related reasons	*M*	3.19	3.58	.013	2.92	3.43	.000	3.11	3.60	.016
	SD	(.98)	(.80)		(1.11)	(.86)		(.98)	(.81)	
Work related reasons	*M*	3.18	3.54	.003	2.88	3.40	.210	3.25	3.34	.045
	SD	(.99)	(.82)		(.99)	(.92)		(1.01)	(.89)	

[1] T-test.

The logistic regression model shows that the four factors of perceived reasons are related to different types of inadequate care, abuse and neglect. There is a significant relationship between inadequate care of an emotional character and *resident related reasons* (p = .002), and *work related reasons* (p = .016). There is a significant relationship between inadequate care of negligent character and *staff related reasons* (.001), *resident related reasons* (p = .007), and *work related reasons* (p = .011). Acts of physical character showed significant relationship only with *resident related reasons* (p=.000). The factor labelled *related to no consequences* did not show significant relationship with any of the types of inadequate care (Table 6).

Table 6: Logistic regression models for inadequate care of emotional, neglect and physical character.

Model 1: Emotional[1]	*Non-standardized coefficient B*	*P-value Wald test*	*Odds Ratio (Exp (B))*
Staff related	.117	.506	1.125
Related to no consequences	.180	.336	1.197
Resident related	.336	.002*	1.442
Work load related	.296	.016*	1.345
Model 2: Neglect[2]			
Staff related	.682	.001*	1.978
Related to no consequences	-.401	.083	.670
Resident related	.344	.007*	1.411
Work load related	.338	.011*	1.402
Model 3: Physical[3]			
Staff related	-.030	.858	.971
Related to no consequences	.031	.864	1.031
Resident related	.664	.000*	1.942
Work load related	-.073	.522	.930

Note 1. Model 1 summary: -2 log likelihood= 582.074; Nagelkerke $R^2 = 0.100$
Note 2. Model 2 summary: -2 log likelihood= 481.185; Nagelkerke $R^2 = 0.155$
Note 3. Model 3 summary: -2 log likelihood= 642.431; Nagelkerke $R^2 = 0.104$
*: Wald test. Significant. p-value<0.05.

9. Discussion

The findings show that inadequate care, abuse and neglect are part of daily life in the nursing homes. The ultimate goal of this thesis was to contribute to the reduction of inadequate care in nursing homes, and thus make life better for residents. This discussion section will therefore focus on prevention intervention strategies, as well as a general discussion of the main results. Where we intervene in a problem is informed by how we define and understand the issue. Data collected for the purpose of this thesis is mainly describing the microsystem level, that is the individuals (resident and staff) and the immediate context (the nursing home) of inadequate care, abuse and neglect. Since the ecological model presented in this thesis postulates that the microsystem is influenced by the other levels, and thus the problem of inadequate care, abuse and neglect has to be recognized and dealt with on all levels, not only internal in nursing homes, prevention intervention strategies will be discussed at the micro, meso, exo- and macrosystem levels.

9.1 General discussions

The results from Paper I demonstrate that inadequate care of negligent and emotional character were most frequently reported, and are in accordance with earlier studies (Goergen, 2001; Hawes, 2003; Isola et al., 2003). It is important to realize that inadequate care of emotional and negligent character can be just as devastating as acts of physical character (Payne, 2005), especially if they are occurring frequently. Even acts that can be perceived as minor might have a great impact on the older victim (Dyer et al., 2003). There are studies demonstrating that abuse and neglect significantly shorten older victims' lives, and that even a

single act can trigger a downward spiral leading to loss of independence, serious illness and even death (Lachs et al., 1998).

9.1.1 Location

On the microsystem level, the immediate setting or context where inadequate care occurs is the nursing home, with key characteristics such as location and size. In this thesis, location is defined as rural or urban. The probability of inadequate care of an emotional and physical character increases significantly for nursing homes in rural areas (Paper II). Support for this result is found in a few studies (Coburn et al., 1996; Castle & Fogel, 1998), whereas others show opposite results (Kane et al., 2004; Phillips et al., 2004). Location may influence the delivery of care in nursing homes. The older population in rural areas may have easier access to nursing homes, and residents in nursing homes in rural areas may have less functional impairment than in urban areas. It is also reasonable to believe that location is of relevance regarding staff competence; skilled staff may easily be available in urban areas. Though, one should be reluctant to draw any firm conclusion as further research is needed to fully explain this finding.

9.1.2 Size

Another key characteristic of the microsystem, the nursing home, is the size. This thesis shows that the size of the nursing home seems to be important regarding reporting inadequate care of a physical character (Paper II). Staff members working in nursing homes that have 30 residents or less are more likely to report committed acts of a physical character than staff working in nursing homes with more than 30 residents. One tends to believe that less is better regarding size of the nursing home, but the results here are in line with some other studies. A study conducted in Canada revealed that inadequate care was especially prevalent amongst

residences housing less than 40 residents (Bravo et al., 1999), with 20 per cent of the older persons receiving inadequate care. Lowenstein (1999) reported that most maltreatment incidents perpetrated in Israel are at facilities with a smaller number of patients. In contrast, other studies claimed that higher incidents of maltreatment are associated with larger number of patients at the facility (Allen et al., 2003; Jogerst et al., 2006; Natan et al., 2010). A study of everyday life in old and new nursing homes in Norway (Madsen, 2002) concluded that the new and smaller nursing homes have a greater potential regarding social relations and self-determination than the larger nursing homes, but these differences are difficult to measure.

9.1.3 Education

When exploring individual characteristics of the caregiver in the microsystem, it seems that the higher the educational level of nursing staff, the more acts of all types of inadequate care were observed and committed (Paper I). In addition, the higher the education level, the more positive the attitude toward the willingness to report/- blow the whistle, and the less fear there was regarding negative sanctions (Paper III). Therefore, the level of education of staff seems to be important, however, the findings in the present study are not consistent. On the one hand, for registered nurses or other members of staff educated to the university or college level, the risk of committing acts of a physical character nearly doubles, while for those educated at high school level, the risk of committing acts of an emotional character more than doubles (Paper II). The results are not easily explained, though these results have some support from a study (Sullivan-Marx et al., 1999) that found being a registered nurse, compared to licensed practical nurse and nursing assistant was a risk factor for the use of physical restraint. It makes sense to assume that the higher the educational level of the staff, the more acts of inadequate care they observe. Observing and judging actions of inadequate care might be dependent on the ability to reflect critically upon nursing practice, which is

closely connected to professional knowledge, length of experience and development of clinical expertise (Benner, 1984). Registered nurses may, through their education, have more knowledge about ethics and moral practice, and are more trained to reflect on care practices than other nursing staff with less education. This view is in line with results from a study about reflection in practice (Olsen, 1998), where licensed practical nurses and nurse aides said that they were not trained to ask questions about their own practice, neither through education nor through working experience. When you reflect upon your own practice and how your behaviour affects the residents, it is more likely that you realize that some of your own actions may be of a negative character. Even though nurses do have knowledge about appropriate standard of care, they regularly fail to meet adequate and expected standards when they deliver care (Kalisch, 2006; Kalisch et al., 2009). Findings from other studies support this complexity; for example, a study from Israel found that nursing aides and practical nurses demonstrated more manifestations of mental abuse than other staff (Natan et al., 2010). Different types of inadequate care might reflect different attitudes. Acts of physically inadequate care, such as holding on too tightly to a resident or tying down a resident, might be more closely connected to different tasks and actions, and thus may be motivated and justified by a wish to protect or help the resident e.g. prevent that a resident hurts himself/herself or others. On the other hand, shouting at a resident, threatening a resident with punishment, ridiculing a resident in front of others or talking to a resident with disrespect can hardly be justified by a wish to protect and help the resident. These acts seem to reflect a more negative attitude towards the residents. Other studies have found that the educational level of staff matters when it comes to attitudes towards residents, and that registered nurses hold a more positive attitude than staff who have lower levels of education (Mellor et al., 2007; Kada et al., 2009). A study on nurse staffing patterns and quality of care in nursing homes (Weech-Maldonado et al., 2004) suggests that higher levels of registered nursing staffing are

important for achieving high quality of care. Registered nurses are key employees that provide a unique and valuable contribution to the quality of care outcomes. Registered nurses possess the clinical expertise and professional skills to ensure high quality of care outcomes through their role as a resource, supervisor, and mentor for other staff.

9.1.4 Age

Caregivers' age was another individual characteristic of interest in this thesis. The results show that the oldest group of nursing staff and those with more than 25 years of experience reported more often than the other groups that they had observed or committed acts of physical character (Paper I). Moreover, those in the older age groups significantly contributed to an increase in the probability of the occurrence of acts of a physical character (Paper II). For staff members aged 50 or older the odds that acts of a physical character would occur were almost doubled when compared to their younger counterparts. This is not easily explained, and I can only suggest reasons for the surprising finding. As there was no time limit on how long ago a reported act had been observed or committed, acts of physical character, also perhaps experienced as more severe, might be easier to remember. One study conducted in Norway, focusing on nurses' attitudes toward institutionalised residents suffering from dementia (Kada et al., 2009) found that staff over 50 years old had significantly less hope and less person-centred attitudes. Previous research has shown that the amount of staff-patient conflicts and the level of burn-out are the variables most strongly related to inadequate care of physical character (Pillemer & Moore, 1990). It needs to be further examined if the oldest nursing staff and those with more experience are more involved in staff-resident conflicts, and if they are more burned out than the younger staff. It might also be that more recently educated staff are better trained to deal with difficult situations and are more confident in using methods other than physical restraint and forced care. It may also be

that senior staff members were educated at a time when the view of healthcare and well-being was more focused on hygiene and routines, and therefore more prone to encourage force in order to fulfil care duties.

There were also significant differences between the age groups in terms of their attitudes towards reporting acts of inadequate care committed by colleagues (Paper III). The tendency was for the eldest groups of nursing staff to agree that they would not report on their colleagues, that they did not feel brave enough to speak out, that they were afraid of what would happen to them if they did, and that it was best to deal with such matters internally. Our findings about the differences between age groups are interesting. Is this because the older staff have fewer opportunities to change jobs and therefore are more afraid of negative sanctions if they speak out? Do they have more fear of authority? A more positive way to interpret this finding is that the older staff are more loyal towards employers and also feel more loyalty to colleagues. The question is whether this loyalty would be at the expense of loyalty to the residents. These questions need further investigation.

9.1.5 Job satisfaction

A significant relationship was found between job satisfaction and two types of inadequate care: emotional and neglect (Paper II). The negative relationship between job satisfaction and inadequate care is confirmed by other studies (Robertson et al., 1995; Redfern et al., 2002; Castle et al., 2007); however, contradictory results have also been reported (Goodell & Ess Coding, 1994; Leveck & Jones, 1996). We did not find that job satisfaction contributes significantly to the risk of inadequate care of physical character. The results do not clarify the direction of the relationship, thus there are several options for interpretation. It would seem reasonable to suggest that low job satisfaction may lead to inadequate care but, on the other

hand, working in an environment that allows inadequate care, abuse and neglect can have a negative effect on job satisfaction. There may also be a downward spiral; low job satisfaction leads to inadequate care, which again leads to lower job satisfaction, and so on. The relationship between job satisfaction and inadequate care is not necessarily causal, in either direction. Other factors not investigated here, such as leadership and variation in cultures could possibly influence both job satisfaction and inadequate care. The finding regarding the relationship between job satisfaction and inadequate care of emotional and negligent character (but not to acts of physical character), is interesting and ought to be further examined.

9.1.6 Staffing

The highest mean score for all statements on perceived reasons for inadequate care (Table 2, p.60) was that the unit was understaffed. But the regression analysis on different factors relating to different types of inadequate care showed no significance on staff density (Paper II). This does not mean that staff density does not matter. In this thesis, concerning staff density, there is information from 616 respondents; the range of staff density is from 1.2 to 2.2, with a mean of 1.9 and standard deviation of .247. This means that it there is not much difference in staff density in the sample of nursing homes, and probably therefore, in this thesis, staff density shows no effect on inadequate care. A systematic review of studies of staffing and quality of care in nursing homes (Bostick et al., 2006) shows that there is a proven association between higher total staffing levels (especially licensed staff) and improved quality of care, and also, that there is a significant relationship between high turnover and poor resident outcomes. Functional ability, pressure ulcers, and weight loss are the most sensitive quality indicators linked to staffing. Another review (Castle, 2008) found that approximately 40% of quality indicators examined in research studies have shown an association with nursing home staffing levels. A more recent review conducted by Spilsbury

et al. (2011) however, did not identify a strong association between staffing levels and quality, despite the large number of papers included (n=50) in the review. In a comment on this review, Castle (2012) argues that there are a number of methodological challenges to undertake research in this area, and that there is a need to consider other factors, such as staff turnover and the use of agency staff when examining the quality of care in nursing homes. He refers to a study by Castle & Anderson (2011) where an examination of more recent studies and the most methodologically advanced studies could provide evidence of a stronger association between nursing home staffing levels and quality. Studies have shown that nurses deem their relationships with residents to be the central determinant of quality of care as well as an important outcome in itself (Bowers et al., 2000). Adequate staffing is essential to allowing nurses to nurture these relationships and increase the quality of care in a systematic way.

9.1.7 Conflicts and aggression

The interaction between the resident and caregiver which plays out in the context of the nursing home setting is of great importance (Schiamberg, 2011). Paper II shows that risks of inadequate care, abuse and neglect are strongly connected to resident aggression and conflicts. When analysing staff' perceived reasons for the occurrence of inadequate care, abuse & neglect (Table 3, p.62) it is clear that they attribute the occurrence to various resident factors, such as resident being provocative, violent, and/or difficult, and staff factors, such as lack of knowledge and skills, being impatient, being burned out, not being fit for this job, and having negative attitudes towards residents. Negative attitudes will inevitably have an impact on quality of care (McLafferty & Morrison, 2004), and research has shown that negative attitude towards older people from nursing staff may affect appropriateness of treatment (Ingham & Fielding, 1985; Huber et al., 1992). A study from the USA (Gething et al., 1994) showed that

the administrators in nursing homes had more positive attitudes towards residents than the nurses who provided care. Working with older people in a nursing home is expressed as one of the least preferred options for nurses (Stevens & Crouch, 1992; Rognstad al., 2004); moreover, nursing students were even more negative towards older patients after their clinical experiences (Happell, 2002). Grenier & Leonard (2006) claim that: *"...to be a caregiver of an older person involves the development of practices and attitudes which may recall, painfully or pleasurably, matching experiences from the past and anticipatory anxieties for the future"* (p.102). Distance/ dehumanisation may be a way to manage fears and anxiety about ageing and death. The amount of reported conflicts between staff and residents, and resident aggression towards staff, is fairly high in this thesis (Table 2, p.60). These results are in line with several other studies. A study amongst caregivers in a residential home in the UK (Pulsford et al., 2011) identified the most common causes of aggressive incidents to be when staff gave personal care, when residents interacted with other residents, when the person was denied something, and during general interaction with the staff. The relationship between resident aggression, conflicts and inadequate care in this thesis is clear (Paper II). Other studies have also shown that aggressive patient behaviour is related to physical and verbal abuse by the caregiving staff (Gibbs & Mosqueda, 2004; Sandvide et al., 2004; Morgan et al., 2005). How staff interpret resident behaviour is shown to be important. If the staff view residents' attempts to resist care, or aggressiveness from residents, as intentional efforts to injure staff, the likelihood of abuse increases (Hawes et al., 2001). It is not difficult to understand how painful it can be for a person who previously had a strong and self-confident identity to now be dependent on a caregiver. The older person is not in a position to negotiate with the carer, and resistance, non-compliance and aggression may be a way of striving to regain control and power. This resistance threatens the carers/ organisations need for control, surveillance, and practices claimed to be in the best interest of the client (Grenier & Leonard,

2006). Even though the study design in this thesis does not allow us to decide the causal direction of the relationship, and since aggression and conflicts also may be a respond to staff behaviour, one obvious strategy to deal with this problem is to create as much of an aggression- and conflict free zone as possible. This is not solely done within the nursing home, but is closely connected to factors outside the microsystem context, such as decisions about staffing, education- and supervision systems.

9.1.8 Blame the person

The tendency to "blame" the person (resident or carer) rather than structural factors found in this thesis was a bit surprising. Of the top six perceived reasons for inadequate care, four are related to resident behaviour (Table 3, p.62), and resident behaviour is significantly associated with inadequate care of all types (Table 6, p.65). Also, staff related factors are high on the list, composing eight of the fifteen top reasons for inadequate care (Table 3, p.62), but they are only significantly associated with neglect, not the other types of inadequate care (Table 6, p.65). The staff meant that inadequate care occurs because the residents refuse to accept assistance, is particularly difficult, behaves violently, or behave in a provocative manner. The relation between resident aggression, conflicts and inadequate care are discussed in the previous section.

In their study of 26 nursing homes in the USA, Hughes & Lapane (2006) concluded that a culture of blame and shame predominates the nursing home setting, and therefore staff may feel reluctant to report events that will draw negative attention to individuals and to the nursing home. Cooke (2012) looks at a different explanations that has been used to explain poor care, and argues that the health policy discourse in the last 20 years has *"turned away from a consideration of problems of institutional corruption and abuse and has instead*

emphasised the individual accountability of front line health workers, stressing instead that poor care and abuse are due to bad apples within the professions" (p 63). She claims that there is a growing culture of blame and that this only creates staff that does not feel empowered to speak up about threats to professional standards. One obvious danger in a culture where the blame is put on the individual carer is underreporting due to a wish of protecting ones colleagues. Also, on the other hand, protecting oneself, since the culture of blame also seems to be a culture of silence, and is likely to drive errors underground, leading to underreporting or covering up of errors (Lambert, 2004). In a culture of blame, errors will not be reported because staff can feel this is a "personal attack" (Hughes & Lapane, 2006).

In 2011, the Norwegian Ministry of Health launched a three-year campaign, "In Safe Hands," aiming to reduce patient harm, and involves both specialist health care and primary health care services (Nasjonalt Kunnskapssenter, 2013). The "In Safe Hands" campaign is currently measuring patient safety culture amongst professionals in hospitals, but not yet in nursing homes. The patient safety culture describes to what extent the professional working environment is characterised by routines and priorities that prevent adverse events and patient harm. The target areas of special relevance for nursing homes are: drug review in nursing homes, pressure ulcer prevention, urinary tract infection prevention, and fall prevention. It is a good start, and hopefully the campaign will be extended to other areas where deficiencies occur which are related to inadequate care, such as nutrition, mouth care, psychosocial care, physical activity, autonomy and respect. Scott-Cawiezell et al. (2006) claim that the challenge of moving from a culture of blame to a culture of safety is probably more complicated in nursing homes, than, for example, in hospitals, due to limited resources, overwhelmed leadership, and an educationally diverse workforce.

9.2 Prevention intervention strategies

9.2.1 Within nursing homes

Prevention intervention strategies on the nursing home level (microsystem) must aim to reduce the risk factors. Important keywords are: communication skills, person centred care, education, and training. The high level of conflicts and resident aggression reported in this thesis, and the relationship between conflicts, aggression and inadequate care indicate the importance of focusing on developing a conflict-free environment. A cluster randomised controlled trial showed that person-centred care reduces agitation in people with dementia (Chenoweth et al., 2009). Data in this thesis do not allow suggestions about whether the carers approach are person-centred or influenced by standard paradigm (Kitwood, 1997). The discussion is therefore more general.

A range of strategies are available to staff in nursing homes. Some include interpersonal approaches such as de-escalation or distraction. Others include more controlling means such as medication, isolation, and physical restraint. Different approaches to aggressive behaviour, either "controlling" or "interpersonal" can be seen as a reflection of different philosophies of care (Duxbury, 2002). One way of understanding aggressive behaviour, and thus conflicts that occur, is what Kitwood (1997) calls the "standard paradigm". The focus is on the neurological and neuro-psychiatric aspects of specific diseases, e.g. dementia, and the assumption is that the predominate response to the aggressive behaviour is to use medication or restraint. As a contrast to this view, the "person-centred" paradigm has a broader understanding about what influences the manifestation of specific diseases, e.g. dementia. One must bear in mind the person´s biography, personality, physical and mental health, and also interactions with others, as all factors are equally important. A person-centred approach means that you try to see meaning in the person's behaviour, regardless of how it is

expressed, (e.g., by aggression). A review of studies on alternative approaches to the management of dementia related aggression as a substitute to physical and chemical restraints (Enmarker et al., 2011), concluded that the optimal management of aggressive and violent actions from residents with dementia living in nursing homes was a person-centred approach. A person-centred approach may make it easier to communicate with people with dementia and thus prevent or reduce aggressive behaviour. The Swedish national guidelines for dementia care (Socialstyrelsen, 2010) highly recommend person-centred care as this may *"increase integrity, independence, and ability to take initiative, as well as decrease agitation"* (p.21). It will also most likely decrease the use of antipsychotic drugs.

The Eden Alternative is presented as a care philosophy in this thesis. It is assumed that a balance between maintaining a home-like environment and appropriate medical care is the approach most likely to optimize quality of life for nursing home residents (Morley & Flaherty, 2002).

When inadequate care, abuse and neglect are known to have happened, or suspected to have happened, something that is assumed to be the case for most nursing homes in all countries, considering the broad definition of inadequate care used in this thesis, the focus must be on intervention. Implementing strategies that increase person-centred care and reduce conflict and resident aggression will most likely influence the occurrence of inadequate care, abuse and neglect.

9.2.2 Relation with the residents' families

Important mesosystems in the ecological model is the relationship between the resident and his/her family, and also between the staff and the resident's family. It is argued in this thesis

that nursing homes, even today, to some extent may be described as total institutions according to Goffman's (1961) definition, and known risk factors of abuse in nursing homes are isolation and lack of contact with the outside world, (e.g. with family and friends) (Lachs & Pillemer, 1995; Nerenberg, 2006). Regarding inadequate care, abuse and neglect, nursing home staff have to be open to families' concerns. It is of crucial importance that staff in nursing home establish a good relation with the residents' families. Often the families are those who detect and report events that have occurred and they have great concerns about how their older family members are treated in the nursing home. Data collected from nursing home staff in Australia (Bauer, 2006) shows that even though rhetoric of family partnerships is prevalent in some nursing homes, the activities of staff in these homes are still primarily geared towards provision of physical care, and families' needs become secondary to getting the work done. Bauer (2006) suggests a new model of practice that sees working collaboratively with families as a legitimate and necessary part of the staff role. The Norwegian Ministry of Health and Care Services (Helse- og omsorgsdepartementet, 2013) has launched the concept "the open nursing home" and argued that an open nursing home can ensure continuity in the contact with the families, and make the family members feel more welcome. This will hopefully lead to increased visits and activity. Prevention intervention strategies on this level should therefore include actions that open up the institution to the world outside, this can be achieved, for example, by implementing the Eden Alternative which also includes a "family-friendly-philosophy."

9.2.3 To report or not report? About legislation and regulations

At the exosystem level, prevention intervention strategies are influenced by outside factors, such as legislation and regulations. Staff are mandated by laws and regulations to provide safe and high-quality care. In Norway, a system for reporting adverse events in specialist health

care has been established, and the purpose of this system is to support quality improvement work in health institutions. National authorities aim to also include municipal health and care services in this reporting system, and, a system like in Denmark, where the patient and relatives are entitled to report adverse events, is seen as an important tool to strengthen the work against unwanted actions (Helse- og omsorgsdepartementet, 2012). Regulations and legislation should be designed to prevent or respond to inadequate care. In Norway, there are no specific laws or regulations to address elder abuse, as it is in Sweden, where staff members are obliged to report abuse or failure in care, or care that violates a person's integrity, security and dignity (Bergstrand, 2011). In Sweden, Social Service Act Chapter 14 (Section 2) is commonly known as Lex Sarah, after the Swedish nurse Sarah Wägnert, who disclosed terrible conditions in a nursing home for the elderly in 1997. People who work with or provide care for older or disabled persons are obliged to safeguard the quality of care and to report serious wrongdoings. Individuals are also obligated to report if any older adult are or have been subjected to serious violence, such as abuse or neglect. All providers have procedures regarding how to complete a Lex Sarah-report and whom to turn to.

Paper III shows that even though the majority of the staff held a positive attitude towards reporting acts of inadequate care committed by their colleagues, 28% did not want to report on colleagues, and 21% did not feel brave enough to speak out. A smaller, exploratory study (Hamel-Lauzon & Lauzon, 2012) confirms these results. Unless nurses judge the actions of their colleagues to be very severe, they will not report violent or negligent behaviours. As Hamel-Lauzon & Lauzon (2012) report, the nurses had lost faith in the reporting system, and feared retaliation; they felt alone and helpless in the face of abuse, and did not take corrective actions. When staff fail to report such behaviour, they violate their professional responsibility and code of ethics. A study from USA found that only two out of five nursing staff reported

that they were told what happens as a result of incidence report (Hughes & Lapane, 2006). Other research confirms that nurses are not always making decisions according to the highest moral standards (Varcoe et al., 2004) and that nurses are ill-prepared to deal efficiently with ethical dilemmas (Firtho & Jackson, 2005). Emotional distress is overwhelmingly present amongst nurses who choose to remain silent (Hamel-Lauzon & Lauzon, 2012); this may lead to depression, guilt, burnout, feelings of helplessness, resignation and, in some cases, to desensitization. This distress amongst staff can negatively influence the quality of care residents receive. Failure to report abusive behaviours is not only the responsibility of the individual carer, but becomes more complex, and also involves environmental factors. Ethical considerations should therefore be integrated into the nursing home culture, and the need for reporting the events that occur must be emphasized and routines for reporting and follow-up must be established. Healthcare workers have an ethical demand and a professional obligation to speak out on behalf of patients. Ethical codes are intended to guide the carer in difficult situations, and the obligation to report on matters that may endanger patients' safety is clear. The municipality health care system needs to develop and implement mechanisms for understanding and evaluating acts of inadequate care, abuse and neglect, and staff must be encouraged by their leaders to speak out on behalf of residents rather than being punished for doing so. The ability to critically reflect upon nursing practice is closely connected to professional knowledge. Further education, discussions, and groups for reflection led by a supervisor might increase the staff's awareness of bad practices. An organisation which allows the staff to reflect upon ones own practice and ask questions about bad practices and violations of ethical standards is an organisation that is in a position to develop the best possible practice and to provide the best possible care.

9.2.4 The communities' concern

Even though most of the care provided in nursing homes, are of good quality, and that the older residents are mostly safe in nursing homes, one cannot close the eyes to the negative aspects of a life in institutions. There is still need for an ongoing discussion regarding what is good care, and where care should be provided. Inadequate care, abuse and neglect in nursing homes should be on the agenda for policy makers, and the seriousness of such acts must be highlighted in public awareness. Because many of the most effective strategies will require resources provided from the macrosystem level, I agree with Fulmer & O'Malley (1987) who state that: *"ultimately the prevention of inadequate care of the elderly is a political issue"* (p. 153). In order to succeed in quality improvement work in the municipality health and care services, the local authorities have to formulate goals for the service, and monitor them (Helse- og omsorgsdepartementet, 2012). The Office of the Auditor General's investigation of municipalities' management and oversight of services with national objectives (Riksrevisjonen, 2013), revealed that only one out of three municipality councils had expressed goals for home care for persons with dementia, and even fewer had expressed goals for nutrition and administration of medication. Many of the councils did not even receive reports on quality of care in relation to national goals. The Office of the Auditor General concludes that many municipalities have weak management and oversight of services that are important to users, and refers to the National Board for Health Supervision (Helsetilsynet, 2011) when they claim that the municipalities need to be better in developing plans and goals for their services. Inadequate management information can cause the municipal council not to have a sufficient basis to make necessary changes and priorities. This increases the risk of the provision of poor services and the chances that services do not have the quality the Norwegian Health Authorities have adopted in key areas.

Other strategies at the macrosystem level must aim to fight ageism in society and change the negative stereotyping of older persons, and also upgrade the value of the work done by caregivers in nursing homes. The Eden Alternative is grounded on a philosophy that takes into account the value of including the society in the nursing home, and including the nursing home in the society. The Norwegian Ministry of Health and Care Services (Helse- og omsorgsdepartementet, 2013) argue that an open nursing home hinders that life in institution is isolated from the world outside. By opening the nursing home to the community, the residents may take part in the outside world in a more active way, and gain access to meaningful activities. It is extremely positive that the national authorities emphasise this aspect of nursing home life; one must strive to make the nursing home environment more transparent and open to public. In the light of the demographic challenges ahead of us, this discussion must continue.

10. Conclusions and implications

As a whole, the findings presented in this thesis are interesting and indicate the need for directions for practice in relation to inadequate care, abuse and neglect. The findings also highlight the importance of competence and skills, and point out areas where there are need for extra attention. Finally, the findings support the need for more research to extend our knowledge on the "dark sides of nursing homes" in order to take step and implement strategies to prevent and decrease the occurrence of inadequate care, abuse and neglect.

10.1 Implications for clinical practice

The high prevalence of inadequate care, abuse and neglect in this thesis underlines the need to intervene. In order to gain good quality and safe services in nursing homes, which is a goal according to the Norwegian National Health Authorities (Helse- og omsorgsdepartementet, 2012), there is a need for more knowledge about the multiple dimensions of what constitutes inadequate care, abuse and neglect. Many of the methods for systematic quality improvement programs that have been in use in health and care services, is based on the microsystem level thinking (Helse- og omsorgsdepartementet, 2012). The approach in this matter however, should reflect the complexity of the phenomenon and be targeted at all levels. Staff need to be educated on the issues, and nurse- resident interactions in various settings must be explored in order to understand where and when inadequate care may take place. It is also important that all staff feel confident in reporting inadequate care incidents, and that leaders support them in doing so. It is the leaders' responsibility to ensure that the service is safe and good, and it is a national goal to strengthen the competence of the leaders in quality and patient security work

(Helse- og omsorgsdepartementet, 2012). The residents' safety and dignity must be of vital interest for all and care practices should aim to fulfil the objectives of the regulations (e.g. Regulation of Dignity). An important element in nursing practice is to be able to recognize the occurrence of and understand the potential severe consequences of inadequate care, abuse and neglect particularly for frail, older persons. Staff can implement care which they believe is for the good of the residents' because it protects them from harm, such as force -feeding or forced medication, but which can be judged as inadequate care because it is not following good practice guidance. In order to determine whether the care is inadequate or not, one has to take into consideration alternative options for handling the situations. Heath & Phair (2009) suggest that one should amongst other things, include information in respect to how the nurses tried to ensure that correct care was given, staffing level, resources, equipment and training opportunities for staff, as well as the context of care. Moreover, the consequences of a person's right to refuse care may be defined as neglect from the carer. These are difficult situations for the career and the need for support from colleagues and leaders is obvious. Allowing and encouraging the staff to critically reflect upon their own and their colleagues practice is an important task for the leaders of the facilities. Reflection on daily interactions can result in major improvements and prevent catastrophic consequences (Phelan, 2009).

The lack of an interdisciplinary approach in care of older persons has been pointed out in supervisions, especially regarding rehabilitation in nursing homes (Helsetilsynet, 2011). The Norwegian health authorities emphasise the need for an interdisciplinary approach in order to meet the residents' needs in all aspects of care: physical, psychological, spiritual, and social (Helse- og omsorgsdepartementet, 2013). The Swedish national guidelines for dementia care (Socialstyrelsen, 2010) recommend multi-professional teamwork since this may prevent and decrease behavioural problems. The need for an interdisciplinary approach when it comes to

inadequate care, abuse and neglect is also obvious. As system theory integrates personal and social elements, an ecological model requires an understanding on many levels. Even though this is part of nurses' education, the system perspectives are highlighted more in other professionals' education than amongst nurses. Nurses should therefore work along with other professionals, such as social workers, who by education are more trained to be *"concerned with people's social connections and relationships, as well as social objectives such as social justice or social change"* (Payne, 2005 p.142). In Norway, there is no tradition for including social workers into nursing home work, as there is in some other countries, for example, in the US. Federal nursing home regulations (Centers for Medicare and Medicaid Services, 1989) require all nursing facilities to provide social services, and larger facilities must employ a full- time social worker. It seems that including social work as one of the key elements of nursing home work is one way to go to ensure that the residents' social connections and relationships are not forgotten.

One advantage of using a system approach like ecological model in combating inadequate care, abuse and neglect in nursing homes is that it includes work with individuals, groups and communities, and it is not necessary to be concerned with either individual change or social reforms, one can do both.

Concrete suggestions for practice:

- Implement person-centred care and a family-friendly environment (e.g. The Eden Alternative), and thereby decrease isolation, resident aggression, and inadequate care.
- Breed a culture where staff feel nurtured, appreciated and valued.
- Give time for reflection upon own and others' practice.
- Implement training and education programmes that aim to increase the caregivers' skill to identify, document, and report inadequate care, abuse and neglect.

- Implement training and education programmes that aim specifically to increase the caregivers' skills in reducing residents' aggression and behaviour problems.
- Develop national laws, guidelines and procedures for detecting and handling inadequate care, abuse and neglect in nursing homes.
- Raise public awareness on the problem.

10.2 Implications for further research

This thesis extended the knowledge base regarding inadequate care, abuse and neglect in nursing homes, yet there is much more to be revealed and investigated. As a recommendation for further research at the level of individual characteristics, Schiamberg et al. (2011) suggest that one should investigate how risk factors for elder abuse, including characteristics of the resident and characteristics of the staff manifest themselves for each of the types of elder abuse. This is in line with a study of nursing home deficiencies where the authors concluded that since different factors were related to different types of abuse, a distinction between types of deficiencies was useful (Mullan & Harrington, 2001). Since we can clearly see that different factors relate to different types of inadequate care, abuse and neglect, the results presented in Paper II underpin the need for further investigation of each of the types separately. The ecological perspective indicates that inadequate care, abuse and neglect should be studied as a dynamic interaction between individual and contextual factors that lead to such situations.

Nationally representative studies are needed to examine inadequate care, abuse and neglect, and to point out risks and protective factors. There is also a need to do research on adverse health outcomes due to incidents of inadequate care. The problem of inadequate care in

nursing homes may increase due to the increased number of older adults in need of long-term care; therefore in order to provide more detailed, accurate data about inadequate care, abuse and neglect in nursing homes, there is a need for further research on this topic.

Relevant topics for further research:

- Through national survey studies, investigate risk factors for each of the types of inadequate care, abuse and neglect in nursing homes, on all levels (not only the microsystem level).
- Culture of care and care philosophy should be incorporated as potential risk factors.
- Explore how nursing home residents themselves experience being exposed to inadequate care, abuse and neglect by staff.
- Develop and carry out intervention studies testing the effect of different support and training programmes for staff.
- Explore whether already existing tools for assessing inadequate care, abuse and neglect are appropriate to use in nursing homes.
- Investigate the effectiveness of regulations and institutional policy that protect staff who blow the whistle on inadequate care, abuse and neglect, and whether these regulations lead to increased report rates.

10.3 Final remarks

In many countries, there is still a lack of awareness regarding inadequate care, abuse and neglect in institutions for older persons. Recognition of the phenomena is the first step toward change, but it needs to be followed up by actions. Even in countries where this has been an

ongoing debate for many years, there is still a gap between existing knowledge and legislation made to protect older adults from being exposed to inadequate care, abuse and neglect while they should be safe in nursing homes. Lack of a common definition, appropriate measurement methods, and theoretical framework for understanding the phenomena, is no doubt a challenge to researchers and practitioners. However, even without a consensus there is enough evidence that inadequate care, abuse and neglect occur in institutional settings, and thus, actions should immediately be taken to stop this unworthy behaviour when caring for nursing home residents.

If my thesis can contribute to increased attention to and knowledge about inadequate care, abuse and neglect in nursing homes, which can lead to a change in practice and improve life condition of even a small number of residents, the efforts have been worthwhile.

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Paper I

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Paper II

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Paper III

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Appendix

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Hans Holmboes gate 22
N-5007 Bergen
Norway
Tel. +47/ 55 58 21 17
Fax: +47/ 55 58 96 50
nsd@nsd.uib.no
www.nsd.uib.no
Org.nr. 985 321 884

Wenche Malmedal
Institutt for sosialt arbeid og helsevitenskap
NTNU
Dragvoll
7491 TRONDHEIM

Vår dato: 25.08.2005 Vår ref: 200501260 SS /RH Deres dato: Deres ref:

KVITTERING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 13.07.2005. Meldingen gjelder prosjekt:

13115	*Overgrep og krenkelser i sykehjem - II*
Behandlingsansvarlig	*Norges teknisk-naturvitenskapelige universitet, ved institusjonens øverste leder*
Daglig ansvarlig	*Wenche Malmedal*

Personvernombudet har vurdert prosjektet og finner at behandlingen av personopplysninger er meldepliktig i henhold til personopplysningsloven § 31. Behandlingen tilfredsstiller kravene i personopplysningsloven.

Personvernombudets vurdering forutsetter at prosjektet gjennomføres slik det er beskrevet i vedlagte prosjektvurdering. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://www.nsd.uib.no/personvern/register/

Personvernombudet vil ved prosjektets avslutning, 31.12.2008, rette en henvendelse angående status for behandling av personopplysninger.

Vennlig hilsen

for Bjørn Henrichsen

Synnøve Serigstad

Synnøve Serigstad

Kontaktperson: Synnøve Serigstad tlf: 55 58 29 42

HØGSKOLEN I SØR-TRØNDELAG

HØGSKOLEN I SØR-TRØNDELAG

Saksbehandl

Vår dato:
Deres dato:

Vår ref.:
Deres

N.N. Sykehjem

SPØRREUNDERSØKELSE "SYKEHJEMMETS SKYGGESIDER"

Omsorgen har flere sider; mest positive, men dessverre noen ganger negative. Dette gjelder innenfor sykehjemmene så vel som i andre omsorgstjenester. Jeg har tidligere kalt disse negative sidene for "skyggesider", og da jeg i forbindelse med mitt hovedfagsarbeid intervjuet ansatte i sykehjem, fikk jeg bekreftet at det noen ganger skjer ting i møte mellom beboere og ansatte som ikke burde skje. Ingen ønsker det, og vi vet lite om hvor ofte det skjer eller i hvilke sammenhenger.

I forbindelse med min doktorgrad ved NTNU, helsevitenskap, skal jeg gjennomføre en spørreundersøkelse blant ansatte i sykehjem i Sør-Trøndelag. Hensikten med prosjektet er nettopp å undersøke slike faktorer som kan ha betydning for disse "skyggesidene". Jeg ønsker med prosjektet å bidra til en økt forståelse av de ansattes arbeidshverdag og hvordan denne kan innvirke på samhandlingen med beboerne.

Undersøkelsen består i å fylle ut et spørreskjema og ditt sykehjem er trukket ut til å delta. Undersøkelsen vil foregå ved at alle ansatte som er på jobb i løpet av 10 dager vil bli invitert til svare på et spørreskjema. Dette er selvsagt helt frivillig. Selve utfyllingen tar ca 20 min. og det er viktig at det blir gitt anledning til å gjøre dette i arbeidstiden (NB! Hver enkelt skal bare svare èn gang). Det skal ikke oppgis noe navn på skjemaet og alle opplysninger vil bli slettet når prosjektet avsluttes.

For å lettest kunne administrere undersøkelsen, trenger jeg en kontaktperson på hver avdeling. Disse personene vil være av stor betydning og det er viktig for meg å få mulighet til å gi disse grundig informasjon om prosjektet og prosedyrene for utdeling og innsamling av spørreskjemaene. Jeg vil selv komme til sykehjemmet og gi denne informasjonen til deg som leder og til kontaktpersonene, samt at jeg selvsagt vil være tilgjengelig underveis ved behov.

Selve innsamlingsperioden vil være i 10 dager (2 helger + uka mellom) i løpet av oktober og november. Jeg vil komme til å ta telefonisk kontakt med deg i uke 38 eller uke 39 for å avtale tidspunkt for besøk og tidspunkt for undersøkelsen.

Postadresse
Høgskolen i Sør-Trøndelag

7004 Trondheim

Kontoradresse
Ranheimsveien 10
Trondheim

E-postadresse
postmottak@hist.no

Telefon
+47 73 55 91 50

Telefaks
+47 73 55 91 51

Melding om studien er sendt til Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste AS og de har godkjent prosjektet.

Norsk Sykepleierforbund og Fagforbundet støtter undersøkelsen og oppfordrer sine medlemmer til å delta ved å svare på skjemaet (se vedlagte kopi av brev).

Har du spørsmål i forbindelse med spørreundersøkelsen kan du gjerne ta kontakt med meg. (Jeg er bortreist mellom 15-22 september).

Wenche Malmedal
HiST, AHS, Ranheimsveien 10
7004 Trondheim
tlf. 73 55 92 45 eller 976 42 156
E-post: wenche.malmedal@hist.no

Trondheim 08.09.2005

Vennlig hilsen

Vedlegg: Brev fra Norsk Sykepleierforbund

Brev fra Fagforbundet

SYKEHJEMMETS SKYGGESIDER

SPØRREUNDERSØKELSE

Omsorgen har flere sider; mest positive, men dessverre noen ganger negative. Dette gjelder innenfor sykehjemmene så vel som i andre omsorgstjenester. Jeg har tidligere kalt disse negative sidene for "skyggesider", og da jeg i forbindelse med mitt hovedfagsarbeid intervjuet ansatte i sykehjem, fikk jeg bekreftet at det noen ganger skjer ting i møte mellom beboere og ansatte som ikke burde skje. Ingen ønsker det, og vi vet lite om hvor ofte det skjer eller i hvilke sammenhenger.

I forbindelse med min doktorgrad ved NTNU, helsevitenskap, skal jeg gjennomføre en spørreundersøkelse blant ansatte i sykehjem i Sør-Trøndelag. Hensikten med prosjektet er nettopp å undersøke slike faktorer som kan ha betydning for disse "skyggesidene". Jeg ønsker med prosjektet å bidra til en økt forståelse av de ansattes arbeidshverdag og hvordan denne kan innvirke på samhandlingen med beboerne. Hovedfokus er satt på de uønskede situasjonene, derfor er skjemaet ubalansert i forhold til helhetsbildet. Spørreskjemaet gir deg anledning til både å fortelle om ulike typer hendelser som du har opplevd, og å angi hva du tror er årsakene til at slike situasjoner kan forekomme.

Undersøkelsen består i å fylle ut et spørreskjema og ditt sykehjem har sagt seg villig til å delta. Det tar ca 20 minutter å fylle ut skjemaet, som handler om deg og din arbeidssituasjon, om egen og andres samhandling med beboerne, og hvilke tanker du gjør deg om at noen ganger skjer det ting som ikke burde ha skjedd i møte med beboerne. Nettopp fordi vi har så lite kunnskaper om dette området, er dine synspunkter og erfaringer viktige. Det er også viktig at du svarer på alle spørsmålene og krysser av for det svaret som ligger nærmest det du mener.

Det er helt frivillig å delta, og det vil ikke få noen konsekvenser for deg om du sier nei. Spørreskjemaet leveres i en lukket konvolutt, uten navn eller personlig identifikasjonsnummer. Dataene vil ikke bli presentert slik at det er mulig å gjenkjenne noen ut fra bakgrunnsopplysninger (kjønn, alder etc). Prosjektet skal være avsluttet ved utgangen av 2007, og ved utgangen av 2008 vil navn på kommune, sykehjem og avdeling bli slettet. Melding om prosjektet er sendt til Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste AS.

Norsk Sykepleierforbund og Fagforbundet støtter undersøkelsen og oppfordrer sine medlemmer til å delta ved å svare på skjemaet.

Har du spørsmål i forbindelse med spørreundersøkelsen kan du gjerne ta kontakt med:

Wenche Malmedal
HiST, AHS, Ranheimsveien 10
7004 Trondheim
tlf. 73 55 92 45 eller 976 42 156
E-post: wenche.malmedal@hist.no

HØGSKOLEN I SØR-TRØNDELAG

NTNU
Det skapende universitet

LES DETTE FØR DU STARTER!	Skjemaet skal leses av en maskin. Følg derfor disse reglene: • *Bruk svart eller blå kule- eller fiberpenn. Tusj, svak blyant eller grønn farge må ikke brukes.* • *Skriv så tydelig du kan. Ikke skriv utenfor feltene. Bare feltene blir lest.* • *Kryss av slik: ☒ Krysser du feil, fyller du hele feltet med farge, slik: ■ Sett så kryss i rett felt.* • *Ikke kopier dette skjemaet – bruk bare originalen. Kopier blir ikke lest.* • *Sett bare ett kryss på hvert spørsmål om ikke annet er oppgitt.*

BAKGRUNNSOPPLYSNINGER

1. Hvor arbeider du? *Oppgi kommune, sykehjem og avdeling.*
Bruk STORE, TYDELIGE BLOKKBOKSTAVER. *Bare ett tegn i hvert felt.* *Ikke skriv her!*

Kommune: ☐

Sykehjem: ☐

Avdeling: ☐

2. Kjønn:
Kvinne .. ☐1
Mann .... ☐2

3: Alder: ☐ år

4. Hvor stor stillingsandel har du nå?
100 % ... ☐1 50 % ..... ☐3
75 % ..... ☐2 Annet.... ☐4 ⇨*Avrund til nærmeste hele %:* ☐ %

5. Hvilken utdanning har du? *Ett eller flere kryss. Bruk bare* STORE BLOKKBOKSTAVER *og ett tegn i hvert felt.*

Sykepleier..... ☐1 Fysioterapeut..... ☐4
Vernepleier ... ☐2 Annen høgskole-
Ergoterapeut. ☐3 utdanning .... ☐5 ⇨ ☐
Hjelpepleier/omsorgsarbeider .... ☐6
Videregående skole, allmennfaglig .... ☐7
Annen utd. fra videregående skole .... ☐8 ⇨ ☐
Ingen utdanning utover grunnskolen..... ☐9
Annen utdanning .... ☐10 ⇨ ☐

6. Har du noen videreutdanning? *Ett eller flere kryss.*

Aldring og eldreomsorg (geriatri) .... ☐1
Psykisk helsearbeid .... ☐2
Administrasjon og ledelse .... ☐3
Annen videreutdanning .... ☐4 ⇨ ☐
Ingen videreutdanning .... ☐5

7. Hvor mange år har du alt i alt arbeidet i helsesektoren?
Avrund til nærmeste antall hele år. Bruk ikke desimaler. Mindre enn ett år = 1. .... ☐ år

8. Hvor mange år har du alt i alt arbeidet på din nåværende arbeidsplass?
Avrund til nærmeste antall hele år. Bruk ikke desimaler. Mindre enn ett år = 1. .... ☐ år

9. Hvilke skift arbeider du til vanlig?
Ett eller flere kryss.
Dag .... ☐1 Kveld .... ☐2 Natt.......... ☐3

10. Arbeider du vanligvis på ukedagene og/eller i helgene? *Ett eller to kryss.*
Arbeider ukedager . ☐1 Arbeider i helgene.... ☐2

Kopiering av hele eller deler av skjemaet er ikke tillatt.
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Før du fortsetter: Kontroller at du har svart på alle spørsmålene på denne sida!

11. Hvilken type avdeling jobber du på?
Bare ett kryss. Jobber du flere steder, krysser du av for stedet der du jobber mest.

Pleieavdeling ☐ 1	Dagavdeling ☐ 4	Dagsenter ☐ 7
Skjermet enhet for demente ☐ 2	Rehabiliteringsavd. (døgn) ☐ 5	Annet (*forklar* ⇩) ☐ 8
Korttids/avlastningsavdeling ☐ 3	Rehabiliteringsavd. (dag) ☐ 6	

Annen avdelingstype: *Bruk* STORE, TYDELIGE BLOKKBOKSTAVER, *og bare ett tegn i hvert felt.*

12. Har du deltatt i refleksjonsgrupper etter opplegget "Sykehjemmets skyggesider"?

Ja ☐ 1
Nei ☐ 2

13. Hvor tilfreds eller utilfreds er du med følgende forhold på jobben?
Sett kryss ved det svaralternativet som passer best for deg.

	Svært utilfreds 1	*Meget utilfreds* 2	*Noe utilfreds* 3	*Usikker* 4	*Noe tilfreds* 5	*Meget tilfreds* 6	*Svært tilfreds* 7
1. De fysiske arbeidsforholdene	☐	☐	☐	☐	☐	☐	☐
2. Muligheter til å gjøre jobben på din måte	☐	☐	☐	☐	☐	☐	☐
3. Dine arbeidskolleger	☐	☐	☐	☐	☐	☐	☐
4. Anerkjennelse du får for godt utført arbeid	☐	☐	☐	☐	☐	☐	☐
5. Nærmeste overordnede	☐	☐	☐	☐	☐	☐	☐
6. Grad av ansvar som gjelder arbeidet ditt	☐	☐	☐	☐	☐	☐	☐
7. Dine lønnsbetingelser	☐	☐	☐	☐	☐	☐	☐
8. Muligheter til utvikling	☐	☐	☐	☐	☐	☐	☐
9. Forholdet mellom ansatte og ledelse	☐	☐	☐	☐	☐	☐	☐
10. Muligheter til å gå over til en annen stilling i sykehjemmet	☐	☐	☐	☐	☐	☐	☐
11. Den måten sykehjemmet styres på i sin helhet	☐	☐	☐	☐	☐	☐	☐
12. Ledelsens lydhørhet til forslag du måtte komme med	☐	☐	☐	☐	☐	☐	☐
13. De gjeldende arbeidsordninger	☐	☐	☐	☐	☐	☐	☐
14. Muligheter til variert arbeid	☐	☐	☐	☐	☐	☐	☐
15. Følelsen av å ha en trygg og sikker jobb i tiden framover	☐	☐	☐	☐	☐	☐	☐
16. Følelsen av å spille på samme lag	☐	☐	☐	☐	☐	☐	☐
17. Grad av åpen kommunikasjon	☐	☐	☐	☐	☐	☐	☐
18. Muligheter til å være uenige med hverandre	☐	☐	☐	☐	☐	☐	☐

14. De neste spørsmålene handler om beboernes atferd mot personalet. Oppgi for hver type atferd hvor ofte du opplever dette fra beboernes side.
Ett kryss på hver linje.

Har det hendt at beboere har …	*Mer enn en gang i uken* 1	*En gang i uken eller sjeldnere* 2	*En gang i måneden eller sjeldnere* 3	*Aldri* 4
1. … uttrykt takknemlighet overfor deg?	☐	☐	☐	☐
2. … kastet noe etter deg?	☐	☐	☐	☐
3. … gitt deg ros?	☐	☐	☐	☐
4. … spyttet på deg?	☐	☐	☐	☐

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Før du fortsetter: Kontroller at du har svart på alle spørsmålene på denne side!

Har det hendt at beboere har …	Mer enn en gang i uken (1)	En gang i uken eller sjeldnere (2)	En gang i måneden eller sjeldnere (3)	Aldri (4)
5. … kløpet, slått, lugget eller klort deg?	☐	☐	☐	☐
6. … snakket pent om deg til dine kolleger/ledelsen?	☐	☐	☐	☐
7. … truet deg eller skjelt deg ut?	☐	☐	☐	☐
8. … gitt deg en klem?	☐	☐	☐	☐
9. … trakassert deg seksuelt?	☐	☐	☐	☐
10. … vist annen atferd? (*Forklar nedenfor.* ⇩)	☐	☐	☐	☐

Annen atferd: *Bruk* STORE, TYDELIGE BLOKKBOKSTAVER, *og bare ett tegn i hvert felt.*

15. Hva dreier uenigheter eller sammenstøt som personalet evt. har med beboerne seg om?
Sett ett kryss pr. linje.

Ved uenigheter eller sammenstøt kan det bl. a. dreie seg om seg om at beboerne…	Mer enn en gang i uken (1)	En gang i uken eller sjeldnere (2)	En gang i måneden eller sjeldnere (3)	Aldri (4)
1. …ikke vil spise	☐	☐	☐	☐
2. …ikke vil vaske seg eller kle på seg	☐	☐	☐	☐
3. …ikke vil gå på toalettet	☐	☐	☐	☐
4. …påstår at de er blitt bestjålet	☐	☐	☐	☐
5. …vil ha mye oppmerksomhet	☐	☐	☐	☐
6. …plager andre beboere	☐	☐	☐	☐
7. …ikke vil ta medisiner	☐	☐	☐	☐
8. …vil stikke av	☐	☐	☐	☐
9. …er aggressive/utagerende	☐	☐	☐	☐
10. …har vist annen atferd? (*Forklar nedenfor.* ⇩)	☐	☐	☐	☐

Annen atferd: *Bruk* STORE, TYDELIGE BLOKKBOKSTAVER, *og bare ett tegn i hvert felt.*

Personalets atferd overfor beboerne

16. Nå skal det dreie seg om personalets atferd overfor beboerne, uavhengig av hvilken begrunnelse de måtte ha for handlingen. Hva har du observert av kollegers atferd overfor beboerne? Her er det viktig at du krysser av for det du har observert, uavhengig av hva du tror årsaken til handlingen var, enten du mener den var forståelig/akseptabel eller ikke. *Sett ett kryss pr. linje.*

Hvor ofte har du observert at en kollega har...	Mer enn en gang i uken (1)	En gang i uken eller sjeldnere (2)	En gang i måneden eller sjeldnere (3)	Aldri (4)
1. … skjelt ut en beboer?	☐	☐	☐	☐
2. … ikke vasket en beboer som skulle vært vasket?	☐	☐	☐	☐
3. … tatt hardt tak i en beboer?	☐	☐	☐	☐
4. … gått inn på rommet til beboeren uten å banke på?	☐	☐	☐	☐
5. … truet en beboer med straff?	☐	☐	☐	☐

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Hvor ofte har du observert at en kollega har...	Mer enn en gang i uken (1)	En gang i uken eller sjeldnere (2)	En gang i måneden eller sjeldnere (3)	Aldri (4)
6. ... tatt penger eller verdisaker fra en beboer?	☐	☐	☐	☐
7. ... unnlatt å gi en beboer nok å spise?	☐	☐	☐	☐
8. ... latt en beboer vente på hjelp lenger enn nødvendig?	☐	☐	☐	☐
9. ... gitt en beboer medikamenter uten at han/hun burde gjort det?	☐	☐	☐	☐
10. ... oversett/ignorert en beboer?	☐	☐	☐	☐
11. ... holdt fast en beboer mot hans vilje?	☐	☐	☐	☐
12. ... klemt igjen nesen til en beboer for at han skulle åpne munnen?	☐	☐	☐	☐
13. ... bundet fast en beboer?	☐	☐	☐	☐
14. ... latterliggjort en beboer foran andre?	☐	☐	☐	☐
15. ... ikke nøye nok behandlet sår/skader som en beboer hadde?	☐	☐	☐	☐
16. ... forsømt munnpleien til en beboer?	☐	☐	☐	☐
17. ... snakket respektløst til en beboer?	☐	☐	☐	☐
18. ... ikke skiftet bleier på en inkontinent beboer?	☐	☐	☐	☐
19. ... hindret en beboer i å bruke ringeklokka?	☐	☐	☐	☐
20. ... tatt på bleier på en beboer for å få ned antall toalettbesøk?	☐	☐	☐	☐
21. ... vist annen atferd? (*Forklar nedenfor* ⇩)	☐	☐	☐	☐

Annen atferd: *Bruk* STORE, TYDELIGE BLOKKBOKSTAVER, *og bare ett tegn i hvert felt.*

17. Nå skal det dreie seg om din egen atferd overfor beboerne, uavhengig av hvilken begrunnelse du måtte ha for handlingen. *Sett ett kryss pr. linje.*

Hvor ofte har du...	Mer enn en gang i uken (1)	En gang i uken eller sjeldnere (2)	En gang i måneden eller sjeldnere (3)	Aldri (4)
1. ... skjelt ut en beboer?	☐	☐	☐	☐
2. ... ikke vasket en beboer som skulle vært vasket?	☐	☐	☐	☐
3. ... tatt hardt tak i en beboer?	☐	☐	☐	☐
4. ... gått inn på rommet til beboeren uten å banke på?	☐	☐	☐	☐
5. ... truet en beboer med straff?	☐	☐	☐	☐
6. ... tatt penger eller verdisaker fra en beboer?	☐	☐	☐	☐
7. ... ikke gitt en beboer nok å spise?	☐	☐	☐	☐
8. ... latt en beboer vente på hjelp lenger enn nødvendig?	☐	☐	☐	☐
9. ... gitt en beboer medikamenter uten at du burde gjort det?	☐	☐	☐	☐
10. ... oversett/ignorert en beboer?	☐	☐	☐	☐
11. ... holdt fast en beboer mot hans vilje?	☐	☐	☐	☐
12. ... klemt igjen nesen til en beboer for at han skulle åpne munnen?	☐	☐	☐	☐
13. ... bundet fast en beboer?	☐	☐	☐	☐
14. ... latterliggjort en beboer foran andre?	☐	☐	☐	☐
15. ... ikke nøye nok behandlet sår/skader som en beboer hadde?	☐	☐	☐	☐

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Hvor ofte har du…	*Mer enn en gang i uken* 1	*En gang i uken eller sjeldnere* 2	*En gang i måneden eller sjeldnere* 3	*Aldri* 4
16. … forsømt munnpleien til en beboer?	☐	☐	☐	☐
17. … snakket respektløst til en beboer?	☐	☐	☐	☐
18. … ikke skiftet bleier på en inkontinent beboer?	☐	☐	☐	☐
19. … hindret en beboer i å bruke ringeklokka?	☐	☐	☐	☐
20. … tatt på bleier på en beboer for å få ned antall toalettbesøk?	☐	☐	☐	☐
21. … vist annen atferd? (*Forklar nedenfor* ⇩)	☐	☐	☐	☐

Annen atferd: *Bruk* STORE, TYDELIGE BLOKKBOKSTAVER, *og bare ett tegn i hvert felt.*

18. Hva tror du det kommer av at beboere kan bli utsatt for handlinger fra ansatte som kan defineres som negative eller uønsket? Nedenfor finner du en liste med ulike årsaker. Hvor enig eller uenig er du i hver av påstandene? *Sett ett kryss pr. linje.*

Negative/uønskede handlinger mot en beboer fra en ansatt forekommer fordi …	*Helt enig* 1	*Nokså enig* 2	*Både enig og uenig* 3	*Nokså uenig* 4	*Helt uenig* 5
1. … det er for lite personale i boenheten	☐	☐	☐	☐	☐
2. … beboeren opptrer provoserende	☐	☐	☐	☐	☐
3. … beboeren motsetter seg hjelp	☐	☐	☐	☐	☐
4. … beboeren er spesielt vanskelig	☐	☐	☐	☐	☐
5. … den ansatte er sint	☐	☐	☐	☐	☐
6. … kollegene ikke bryr seg om at det skjer	☐	☐	☐	☐	☐
7. … beboeren opptrer voldelig	☐	☐	☐	☐	☐
8. … beboeren er spesielt hjelpeløs	☐	☐	☐	☐	☐
9. … den ansatte ikke vet hvordan hun/han ellers kan få viljen sin	☐	☐	☐	☐	☐
10. … den ansatte har en negativ holdning til gamle mennesker	☐	☐	☐	☐	☐
11. … ledelsen stilltiende godtar dårlig oppførsel fra de ansatte	☐	☐	☐	☐	☐
12. … den ansatte har for mange oppgaver å løse på en gang	☐	☐	☐	☐	☐
13. … ledelsen i for liten grad oppmuntrer medarbeiderne i deres arbeid	☐	☐	☐	☐	☐
14. … den ansatte har for lite kunnskaper	☐	☐	☐	☐	☐
15. … faren for å bli oppdaget er liten	☐	☐	☐	☐	☐
16. … arbeidsmiljøet i institusjonen er dårlig	☐	☐	☐	☐	☐
17. … den ansatte har en dårlig dag	☐	☐	☐	☐	☐
18. … den ansatte ikke regner med å bli straffet for det	☐	☐	☐	☐	☐
19. … den ansatte ikke har lært å takle konflikter	☐	☐	☐	☐	☐
20. … kollegene opptrer på samme måte	☐	☐	☐	☐	☐
21. … ledelsen ikke godt nok kontrollerer medarbeiderne	☐	☐	☐	☐	☐
22. … den ansatte er utbrent	☐	☐	☐	☐	☐
23. … den ansatte ikke setter seg inn i beboerens situasjon	☐	☐	☐	☐	☐
24. … den ansatte ikke kommer overens med denne beboeren	☐	☐	☐	☐	☐
25. … den ansatte er for utålmodig	☐	☐	☐	☐	☐
26. … dårlig pleieratferd ikke får noen konsekvenser for den ansatte	☐	☐	☐	☐	☐
27. … den ansatte ikke er egnet for dette yrket	☐	☐	☐	☐	☐

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Negative/uønskede handlinger mot en beboer fra en ansatt forekommer fordi ...

	Helt enig 1	Nokså enig 2	Både enig og uenig 3	Nokså uenig 4	Helt uenig 5
28. ... rutinene er viktigere enn den enkelte beboer	☐	☐	☐	☐	☐
29. Annet (Forklar i feltet nedenfor ⇩)	☐	☐	☐	☐	☐

Annet: *Bruk* STORE, TYDELIGE BLOKKBOKSTAVER, *og bare ett tegn i hvert felt.*

19. I det følgende handler det om ulike måter å reagere på hvis du opplever at en kollega begår negative/uønskede handlinger mot en beboer. *Sett ett kryss pr. linje.*

Hvor enig eller uenig er du i følgende påstander?

	Helt enig 1	Nokså enig 2	Både enig og uenig 3	Nokså uenig 4	Helt uenig 5
1. Om jeg ville varslet fra, kommer an på hvor alvorlig hendelsen var	☐	☐	☐	☐	☐
2. Jeg vil ikke sladre på kolleger. Det finnes andre måter å gå fram på	☐	☐	☐	☐	☐
3. Jeg opplever meg ikke tøff nok til å si fra	☐	☐	☐	☐	☐
4. Hvis jeg varsler fra kan jeg regne med støtte fra andre kolleger	☐	☐	☐	☐	☐
5. Det er ingen vits i å varsle fra, det skjer ingen ting likevel	☐	☐	☐	☐	☐
6. Jeg er redd for hva som kan skje hvis jeg varsler fra	☐	☐	☐	☐	☐
7. Det beste er å ordne opp med slike forhold internt på avdelingen	☐	☐	☐	☐	☐

Dersom du har kommentarer eller ekstraopplysninger, er det fint om du skriver i dette feltet:

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Takk for at du ville svare på spørsmålene!