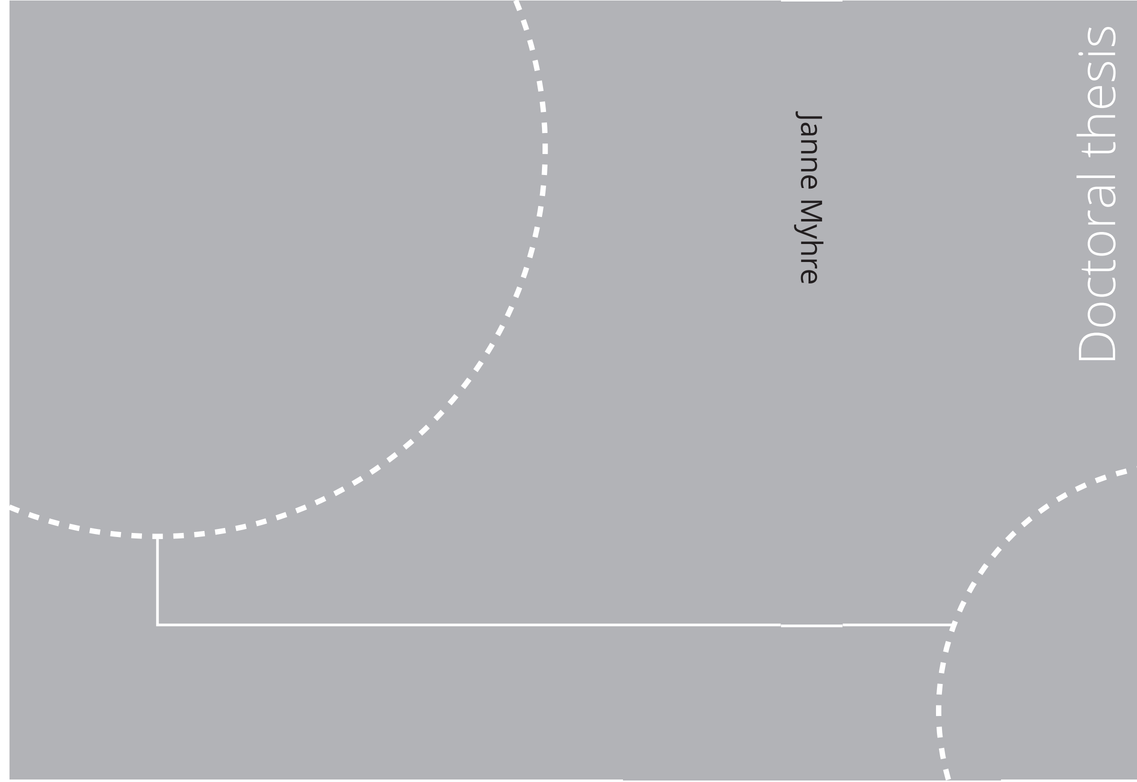

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Janne Myhre

The role of leadership in promoting safety for nursing home residents and preventing elder abuse and neglect

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Thesis for the degree of Philosophiae Doctor

22 April 2021

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Norsk sammendrag

Lederskapets betydning for å fremme pasientsikkerhet og forebygge vold, overgrep og forsømmelser i sykehjem

Ifølge Verdens Helseorganisasjon (WHO), forekommer vold, overgrep og forsømmelse i alle land hvor sykehjem finnes. En av utfordringene med å avverge, rapportere og forebygge vold, overgrep og forsømmelse i institusjoner, er de ulike oppfatningene om hva dette er. Ulike forståelser eksisterer mellom forskere, helsepersonell, pårørende og beboere selv. I sykehjemmene har ledere et spesielt ansvar for å sikre trygge tjenester av god kvalitet. Det er derfor av stor betydning å utvikle kunnskap om ledere i sykehjem sin forståelse av dette fenomenet. Ledernes forståelse påvirker hva de signaliserer til ansatte som viktig å rapportere, og hva de følger opp for å sikre et trygt miljø for både ansatte og beboere.

Hovedmålsettingen med denne studien var å utforske lederskapets betydning for pasientsikkerhetsspørsmål knyttet til vold, overgrep og forsømmelser. Avhandlingen beskriver ulike forståelser av fenomenet vold, overgrep og forsømmelser i en institusjonell kontekst og beskriver hvordan dette kan sees på som komplekse fenomener. Videre beskriver avhandlingen kvalitet og pasientsikkerhet og hvordan uønskede hendelser kan følges opp med mål om læring i organisasjoner. Avhandlingen er basert på fokusgruppeintervju med 28 avdelingsledere og dybdeintervju med 15 enhetsledere fra seks kommuner og 21 sykehjem.

Funnene viser at ledere ikke er kjent med begrepene vold overgrep og forsømmelser og beskriver dette som sterke ord. De kommer likevel opp med eksempler på hendelser som de tolker som fysisk eller psykisk skadelig for beboerne. Samtidig viser funnene en dobbelthet i ledernes eksempler. Hendelser blir beskrevet som skadelig, men samtidig også forsøkt rasjonalisert og unnskyldt. Lederen får kjennskap til hendelsene gjennom både uformell og formell rapportering. Det er en ulikhet mellom ledernivåene i opplevelsen av nytteverdien til det formelle avvikssystemet, hvor enhetslederne er mer positive enn avdelingslederne. Oppfølging av hendelser ble gjort på tre nivåer, individ, gruppe og organisasjon. Det er ulik forståelse mellom ledernivåene når det gjelder årsaken til hendelsene, hvor enhetslederne viser til ansatte med dårlige holdninger, mens avdelingslederne også viser til mangler på systemnivå. Interne og eksterne krav kombinert med en opplevd maktesløshet i forbindelse med å sette inn tiltak på alle nivåer, samt manglende evalueringsverktøy for de tiltak som settes inn påvirker den oppfølgingen som blir gjort. Dette vises gjennom ledernes forsøk på å tilpasse seg interne og eksterne krav, gjennom rasjonalisering av vold overgrep og forsømmelser og dermed en lineær personfokusert tilnærming i stedet for en helhetlig tilnærming som hensyntar kompleksiteten i fenomenene vold, overgrep og forsømmelser.

Kandidat: Janne Myhre
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Veiledere: Sigrid Nakrem, Susan Saga, Wenche Malmedal og Joan Ostaszkiewicz
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Overnevnte avhandling er funnet verdig til å forsvares offentlig for graden philosophiae doctor i Medisin og helsevitenskap
Disputas finner sted Torsdag 22 April 2021.

“I believe in the complexity of the human story, and that there’s no way you can tell that story in one way and say, ‘this is it.’ Always there will be someone who can tell it differently depending on where they are standing……this is the way I think the world’s stories should be told; from many different perspectives.”

Chinua Achebe (Things fall apart, 1959)

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Scientific environment

This project was conducted between October 2017 and November 2020 and is one of three project in the main-research study; *Elder abuse in residential care settings – A multi-method study on abuse and neglect of older patient in Norwegian nursing homes,* funded by the Research Council of Norway. During my work with the thesis I held a PhD Research Fellow position at Department of Public Health and Nursing, Faculty of Medicine and Health Sciences NTNU, Norwegian University of Science and Technology, Trondheim, Norway. A three- month period in 2019 was spent collaborating with researchers at the National Centre on Elder Abuse (NCEA) at Keck School of Medicine USC, in Los Angeles US. An additional three months period from October 2019 through January 2020 were spent collaborating with my co-supervisor Joan Ostaszkiewicz and her research team at Centre for Quality and Patient Safety Research – Barwon Health Partnership, Institute for Healthcare Transformation, Deakin University School of Nursing and Midwifery in Geelong, Australia.

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Hamar November 2020

Janne Myhre

Summary

This thesis describes the phenomenon of elder abuse and neglect in the institutional context from the perspective of nursing home leaders. Elder abuse and neglect in nursing homes is a complex multifactorial problem and entails various associations across personal, social, and organizational factors. One -way leaders can prevent abuse and neglect and promote quality and safety for residents is to follow up on any problems that may arise in clinical practice in a way that facilitates staff learning. How nursing home leaders follow up and what they follow up on might reflect their perceptions of abuse, its causal factors, and the prevention strategies used in the nursing home. At the same time, descriptions, perceptions, and understandings around the concept of elder abuse and neglect in nursing homes vary in different jurisdictions as well as among healthcare staff, researchers, family members, and residents themselves. Different understandings of what constitutes abuse and neglect and its severity complicate identification, reporting, and managing the problem.

To address the knowledge gap outlined above, the aim of this thesis is to explore the role of leadership in patient safety concern related to elder abuse and neglect. Knowledge about nursing home leaders' perceptions of elder abuse, their experiences of barriers and enablers to reporting elder abuse and neglect, and how the leaders follow up on reports and information are essential because their understanding of the phenomenon will influence what they signal to staff as important to report and what they investigate to create a safe and healthy environment for both residents and staff. The specific objectives were to explore:

- How nursing home leaders perceive elder abuse and neglect;
- What nursing home leaders experience as barriers and enablers to reporting elder abuse and neglect; and
- How nursing home leaders follow up on information and reports of elder abuse and neglect.

The research method and design were qualitative and explorative, including both focus group interviews with care managers and individual interviews with nursing home directors. A total of 43 participants from six different municipalities and 21 nursing homes were included.

A core finding was a lack of awareness about the concept of elder abuse and neglect. Keywords from the categorization of abuse helped the participants to reflect upon the topic and revealed examples of events they interpreted as being harmful or distressful to residents. At the same time, our findings revealed an ambiguity in the nursing home leaders' examples. While, on one hand, they described the situations as harmful, on the other hand, they rationalized and attempted to provide excuses for why it was happening. The ambiguity in the nursing home leaders' examples can be viewed as an attempt to adapt to internal and external demands by rationalizing abuse and diminishing personal and professional accountability.

The nursing home leaders in our study experienced difficulties obtaining information related to abuse and neglect within the nursing homes because of structural factors related to the organization, cultural factors, and abuse severity factors. Because of difficulties obtaining information from the formal reporting system, nursing home leaders have to adjust and find other ways to obtain information such as reading the nursing notes in the electronic patient record system and using an informal reporting system, including information provided verbally by staff and through observation. Nursing home directors expressed a more positive view of the usefulness of the formal reporting system than care managers did. Generally, the follow-up on reports and various information leaders receive is linked to the belief that patient safety can be improved by learning from incidents and "near misses.".

Our findings revealed that nursing home directors and care managers differ in their beliefs about the root causes of elder abuse. A felt powerless within the leaders in terms of being able to follow up on all levels, and a lack of evaluation tools was seen as a barrier to facilitating patient safety and systematic organizational learning. The leaders' attempts to adapt to both internal and external demands could be seen in their reliance on a linear personal approach rather than a system approach when they followed up on abuse and neglect within the nursing home context.

Acronyms and abbreviations

ADL	Activity of Daily Living
AHRQ	The Agency for Healthcare Research and Quality
CAS	Complex Adaptive System
CDC	Center for Disease Control and prevention
IOM	Institute of Medicine
NPS	Neuropsychiatric symptoms
NPSF	National Patient Safety Foundation
NSD	Norwegian Centre for Research Data
RN	Registered nurse
TIME	Targeted Interdisciplinary Model for Evaluation and treatment of neuropsychiatric symptoms
WHO	World health organization
PCC	Person centered care

List of papers

This thesis is based on the following publications:

1. Myhre, Janne; Saga, Susan; Malmedal, Wenche Karin; Ostaszkiewicz, Joan; Nakrem, Sigrid. (2020) Elder abuse and neglect: an overlooked patient safety issue. A focus group study of nursing home leaders' perceptions of elder abuse and neglect. *BMC Health Services Research* 20 (199). DOI: 10.1186/s12913-020-5047-4

2. Myhre, Janne; Malmedal, Wenche Karin; Saga, Susan; Ostaszkiewicz, Joan; Nakrem, Sigrid. (2020) Nursing home leaders' perceptions of factors influencing the reporting of elder abuse and neglect: a qualitative study. *Journal of Health Organisation and Management.* 34 (6); 655-671. DOI: 10.1108/JHOM-02-2020-0031

3. Myhre, Janne; Saga, Susan; Malmedal, Wenche Karin; Ostaszkiewicz, Joan; Nakrem, Sigrid. (2020) React and act; A qualitative study of how nursing home leaders follow up on staff-to-resident abuse. *BMC Health Services Research* 20 (1111).
DOI: 10.1186/s12913-020-05969-x

“Explanations exist; they have existed for all time; there is always a well-known solution to every human problem—neat, plausible, and wrong.”

H.L. Mencken. (Prejudices, the second series, published in 1921)

1.0 Introduction

Abuse and neglect imply violations of human rights, dignity, and well-being of the elderly and have consequences such as reduced quality of life, psychological and physical harm, loss of assets, and increased morbidity and mortality (1). Elder abuse occurs in both domestic settings and in institutions such as nursing homes (2, 3). Although there is no consensus on the definition of elder abuse, the most commonly used description comes from the World Health Organization (WHO), which describes elder abuse as: “a single or repeated act, or lack of appropriate action, occurring in any relationship where there is an expectation of trust which causes harm or distress to an older person” [(4) p.3]. Five subtypes of abuse are generally recognized: physical, psychological, financial, sexual, and neglect (5). The type of abuse is further categorized according to the relationship between the key stakeholders, and in nursing homes, it is often divided into staff-to-resident abuse (3, 6), family-to-resident abuse (7), and resident-to-resident aggression (8, 9). However, operational definitions and understandings of what elder abuse is vary in different cultures, jurisdictions, and among healthcare staff, researchers, family members, and residents themselves (3, 10-14). Different understandings of what constitutes abuse and its levels of severity complicate detecting, reporting, and managing the problem. Moreover, previous research on elder abuse in nursing homes has not examined the phenomenon from the perspective of nursing home leaders

Globally it is estimated that one in ten older people experience abuse every month (15, 16), and the rates may be higher for those living in institutional settings. Research and anecdotal evidence has suggested that elder abuse occurs in every country where nursing home exist (3). In Norway, a survey of nursing home staff found that 60.3% of the staff had exposed a resident to one or more incidents of abuse in the past year (6). The majority of staff reported that they had never committed financial or sexual abuse against a resident. Physical abuse was reported by 9.6%, and psychological abuse and neglect had the highest prevalence, with 40.5% and 46.9% respectively (6). Living in a nursing home may also mean sharing room and space with co-residents, and recent literature has identified resident-to-resident aggression as a common form of abuse in nursing homes (8, 9, 17). Lachs and colleagues revealed that 407 of 2,011 residents from ten facilities had experienced at least one resident-to-resident

incident of aggression over a one-month observation period, with a prevalence of 20.2% and the most common form being verbal aggression (8)

The majority of research on elder abuse has been conducted in domestic settings, while research on elder abuse in institutions is still in its infancy (16, 18). The institutional context differs from the domestic setting because nursing homes are complex social systems comprised of different stakeholders including staff, leaders, residents, and relatives in constantly shifting interactions (19, 20). One of the major difficulties related to detecting, reporting, and managing abuse within nursing homes is the range of opinions about what constitutes abuse and its severity (10, 21-23). Within nursing homes, elder abuse has been conceptualized as a specific form of institutional abuse (24), and nursing homes may be seen as settings in which abuse and neglect occur (7) since rules and regulations in institutions can themselves be considered abusive, e.g., deciding when residents will sleep, eat, and bathe; the potential use of restraints; and requirements around sharing living space with other residents. In addition, the relationship between staff and residents is characterized by differences in power, and the resident is often dependent on staff to fulfil most of his/her basic needs (25, 26). Determinants related to abuse within institutions are also complex and multifactorial, entailing various associations between personal, social, and organizational factors in addition to factors within the wider society (11, 27). This means that the risks of staff-to-resident abuse and resident-to-resident aggression extend beyond the traits and circumstances of the older adults and the staff who abuse or neglect them as well as the aggressive resident who harms them (27).

To prevent abuse and promote safety and quality, nursing home leaders need comprehensive information about the care and service provided and any problems that may arise in clinical practice. One way of obtaining this information is through formal reporting systems. The development and utilization of reporting systems in healthcare services are fundamental strategies to reduce preventable harm to patients and improve quality and safety (28-30). The goal of using a reporting system is to identify patient risk situations and learn from incidents, thereby improving patient safety (31). However, a significant barrier to improving patient safety and increasing the quality of care is underreporting (28, 29). The underreporting of

elder abuse is estimated to be as high as 80% (32), and there is a need to understand factors that influence whether or not the staff communicate incidents (33-35). Underreporting of abuse has been found to be related to lack of staff knowledge, a lack of reflection on their practices, or fear of punishment (33, 35, 36). Other studies have also highlighted attitudes, fear of consequences, and a lack of responses and feedback from leaders as factors affecting the reporting of abuse (34, 37). However, none of these studies has sought to understand the phenomenon from the perspective of nursing home leaders.

Prevention of harm is a core principle in all healthcare services and a responsibility of leadership (38-40). Nursing home leaders are legally and morally responsible for ensuring that required quality and safety standards are met (29, 30, 38). Effective leadership plays a key role in developing the staff's understanding of residents' needs (41, 42) and creating a strong safety culture of respect, dignity, and quality (30, 38, 39, 43). However, despite the vast body of knowledge that exists about the importance of leadership, nursing home research has, to date, paid scant attention to the role that leaders play regarding identifying, reporting, managing, and preventing elder abuse. Consequently, there is a gap in the knowledge when it comes to the role of leadership in patient safety matters related to elder abuse and neglect. Knowledge about nursing home leaders' perceptions of elder abuse, their experiences related to barriers and enablers to reporting, and how they follow up on reports and information is essential. Leaders' understandings of this phenomenon will influence what they signal to staff as important to report and what they investigate in order to create a safe and healthy environment for both residents and staff. In order to develop future intervention strategies for improving quality of care and patient safety and to prevent elder abuse, we need knowledge related to the phenomenon from the perspectives of nursing home leaders. This thesis aims to explore these perspectives.

2.0 Background

2.1 Norwegian nursing homes

Approximately 40,000 residents live in nursing homes in Norway, representing 12.9% of the population over 80 years of age; residents' mean age is 85 years (44). Most of these residents have several chronic diseases that require continuous care and often many, if not most, are dependent on staff for assistance in activities of daily living (45, 46). Approximately 84% of nursing home residents have dementia (47), and 75% of these residents have clinically significant neuropsychiatric symptoms including agitation, aggression, anxiety, depression, psychosis, and apathy (45).

Most of the nursing homes in Norway are run by the municipalities and financed by taxes and service user fees. Residents pay an annual fee equal to 75% of the resident's national age pension. In addition, residents may pay an additional fee if they have income from their assets but with an upper limit determined by the government. However, the payment cannot exceed the actual expenses of the institutional stay (48). These charges cover all medical services, nursing, accommodation, and food. Clothing, hairdressers' services, podiatry, personal consumption, and expenses for social activities are not covered by the payment. Nursing homes are organized into different wards depending on the types of services they are expected to offer residents. The main types of wards are a special care ward for people with dementia and a regular ward for those with severe physical disorders, although most of the residents in these wards also have dementia. There are also wards for short-term rehabilitation, respite care, and palliative care. In addition, wards for short-term stays for assessment and evaluation of both physical and mental disorders to determine the level of future care requirements are available (49).

Norwegian nursing homes must follow national specific regulations from the Ministry of Health and Care Services regarding staff, leadership, and residents' rights (49, 50). Among other concerns, the national regulations state that each nursing home is required to have an administrative manager, known as the nursing home director. Some nursing home directors lead more than one facility. Each nursing home has ward leaders and quality leaders, and in some municipalities, a service leader. Together, individuals in these roles form the leadership

team in each nursing home (49) and are the leadership level in closest proximity to staff and resident. Nursing homes are also required to have a physician and adequate staffing; most nursing home physicians are general practitioners in part-time positions. Related to staffing, statistics have indicated that approximately 30% of staff in community elderly care in Norway are assistants with no formal healthcare training, and 60% are assistant nurses with a degree from upper secondary school (51). Moreover, a survey of nurses in Norwegian nursing homes found significant variations among nursing homes in regard to the numbers of registered nurses (RNs), nurse assistants (NAs), and staff with no formal education in relation to number of residents (52). Deviations from planned staffing are mainly related to staff on sick leave (52).

The provision of care in Norwegian nursing homes is delivered under the National Regulation of Quality of Care (50), which, among other matters, aims to ensure that residents' basic needs are met (50). This includes meeting the nursing home residents' social, psychological, and physical needs; preserving their dignity, autonomy, and self-respect; and promoting their choices in everyday life. Management of care in Norwegian nursing homes is directed by 'the regulation of management and quality improvement in health care services' (53). The regulation focuses on the leader's responsibility to ensure that there is a system in place to monitor residents' overall quality of life and safety and to create a safety culture that detects situations and factors that may cause harm to residents and staff (53).

The quality of care in Norwegian nursing homes has been assessed by studies integrating the professionals', residents', and family's perspectives of quality of care and its domains (30, 54-57). Findings from these studies reveal that quality of care in nursing homes encompasses different areas, such as the living conditions, the nursing staff, the direct nursing care, and the social environment, in addition to external factors like national policy, laws and regulations, management of the organization, and the physical building (54). This demonstrates that measuring and defining quality of care is multifactorial and complex. A cross-sectional study in Norway measuring quality of care from the perspective of staff found that, overall, the care that was delivered to residents was considered to be "good basic care" (58). This study revealed, however, that residents' opportunities to take part in

leisure activities, such as going outside or for a walk, were often neglected. A high staff-to-resident ratio was strongly associated with better quality of care (58). In addition, person-centered care (PCC) is pointed out as the main framework for good quality of care in nursing homes both nationally and internationally (59, 60). In Norway, a cross-sectional study measured the association between PCC and organizational and ward characteristics in nursing homes (61). The study showed that a high level of PCC was associated with greater job satisfaction among staff and empowering leadership behavior.

The Ministry of Health and Care Services in Norway has indicated that municipal health leadership today does not meet the expected standards (62). The Norwegian Board of Health has repeatedly found that quality control in healthcare services is poor and that quality and safety are low priorities for management (62). Furthermore, it has found that the density of leaders is low and that management skills are lacking (63). Recently, governmental strategies to improve safety have been launched, such as the Patient Safety Program and a system for monitoring health services using quality indicators (64). At the same time, a report from the Office of the Auditor General in 2019 pointed out that the quality of care and patient safety in community elder care is low and that many municipalities fail to use the measures from the Patient Safety Program to ensure patient safety (65).

2.1.2 Reporting system in Norway

Health personnel have a moral and legal responsibility to advocate for residents' safety, including the prevention of elder abuse (66). The responsibility of health personnel to report adverse events is formally regulated in the National Health Personnel Act § 17, which states: "Health personnel shall of their own account provide information to the supervision authorities on condition that may endanger patients' safety"(67). There are no instructions for how health personnel should notify the supervisory authorities, but since nursing homes in Norway have no external reporting system that is directly connected to such authorities, notification must be made by phone, mail, or email. In addition, each municipality and nursing home is required to have an internal quality and safety system, and health personnel are encouraged to first notify internally to the nursing home leaders before notifying the supervisory authorities (53). The national regulation of management and quality

improvement in healthcare services aims to ensure that there is a system in place in each nursing home to monitor the overall quality and safety of care, and that leaders follow up and use information from reports for learning and improving quality (53). This regulation highlights leaders' responsibilities to establish a culture of openness where events are reported, openly discussed, and analyzed. The follow-up for incidents involves analyzing the causes and implementing preventive measures designed to ensure that incidents do not recur. Any follow-up should also include an evaluation of the measures taken in response to an incident (53). However, a survey of nurses in Norway found that 76% had reported adverse events from one to five times in the previous years, but few nurses had experienced a positive outcome from such reporting (68).

In 2017, an amendment was passed in the Municipal Health Care Service Act' in Norway identifying the responsibilities of municipalities to detect and prevent violence and abuse (§3-3a) (69). However, there is currently no taxonomy or list of incidents related to abuse and neglect in the reporting system. Abuse and neglect could be classified within the category "patient safety adverse events." In this thesis, I will use the term "adverse event" to refer to situations where the outcome for the resident is harmful or potentially harmful and caused by intentional or unintentional abuse. This term also includes failure to deliver needed care, defined as the omission or neglect of delivering any aspect of required resident care.

2.2 Elder abuse and neglect

This thesis focuses on the role of leadership in patient safety issues related to elder abuse and neglect. This section will provide an overview of descriptions and perceptions of elder abuse, including forms and type of abuse, its prevalence, and its consequences. Determinants of elder abuse in nursing homes will then be presented in this section and more broadly in subsequent sections.

2.2.1 Description, perceptions and categorization of elder abuse and neglect

Elder abuse has profound and pervasive consequences. At an individual level, the person who are exposed to abuse or neglect may experience quality of life concerns, such as physical trauma, reduced self-worth, and both psychological and physical harm (1).

The term elder abuse emerged as a social problem in 1975 when the first studies of this phenomenon were published by Baker and Burston using the term “granny battering” (70, 71). At that time, abuse was viewed as a social welfare and family matter and defined mostly as the physical assault of older women (72). In the 1980s, greater interest was directed to the problem, and today it is viewed as a public health concern (72, 73). As interest in elder abuse increased, discussions related to definitions, methods, and theories were raised, and several definitions of elder abuse have been developed over time. However, there is still no agreement on how to describe the phenomenon (73). Mysyuk et al. (72) reviewed elder abuse definitions throughout history and found that definitions have changed and evolved considerably since 1970 from the terms granny battering or granny bashing to the terms elder mistreatment, inadequate care, and elder abuse. Goergen and Beaulieu (23) conducted a critical analysis of the contemporary literature in the field of elder abuse. They pointed out that the difficulty of defining elder abuse has resulted from a lack of conceptual development in the area. They further noted that there is a lack of clarity in the terms and concepts related to elder abuse, such as trust, vulnerability, harm, context, and the relation between abuse and neglect (23). Part of the difficulties in describing this phenomenon is related to the fact that abuse is perceived differently within different settings and cultures, and among researchers, healthcare workers, relatives, and the older persons themselves (23, 74, 75)

The most frequently cited and used definition of elder abuse within the literature was coined by the British organization Action on Elder Abuse in 1995 and later modified by the World Health Organization in 2002 in the Toronto declaration. Here, elder abuse is defined as “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” [(4)p3]. Another definition comes from the Centers for Disease Control and Prevention (CDC), which defines elder abuse as “an intentional act, or failure to act, by a caregiver or another person in a relationship involving an expectation of trust that causes or creates a risk of harm to an older adult” [(76) p 23]. The US National Research Council Panel uses the term elder mistreatment and defines it as “intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended) to a vulnerable elder by a caregiver or other person who stands in a trusted relationship to the elder, or failure by a caregiver to satisfy the elder’s

basic needs or to protect the elder from harm" (77). The UK Department of Health includes human rights in their definition of elder abuse as "a violation of an individual's human rights by another person(s), which may or may not be intentional"(78). Fulmer and O`Malley (79) made distinctions between abuse, neglect, and inadequate care and claimed that provision of care to residents can be judged to be either adequate or inadequate. The common element of all these definitions is that an older person is harmed or put in harm's way by acts or omissions involving complex interpersonal relationships. The differences are related to whether the act is intentional or not.

Various types of abuse are noted within all descriptions, such as physical abuse, emotional or psychological abuse, financial or material abuse, sexual abuse, and neglect (5). Within some cultures and jurisdictions, self-neglect has also been included as a factor in elder abuse but not in most jurisdictions, such as Norway (80). Furthermore, the type of abuse is categorized according to the relationship between the key stakeholders, and in nursing homes, it is divided into staff-to-resident abuse (3, 6), family-to-resident abuse (7) and resident-to-resident aggression (8, 9). Table 1 shows operational descriptions of abuse and neglect as used in self-reported prevalence surveys to staff in nursing homes (5, 6, 81).

Table 1 Operational description of abuse and neglect based on acts of abuse used in staff survey (5, 6, 81)

Five areas of abuse and neglect	Abusive actions
Physical Abuse	Hitting, slapping, pushing, kicking, misuse of medication or restraint.
Psychological abuse	Emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks.
Sexual Abuse	Rape and sexual assault or sexual acts to which the older adult has not consented, or could not consent, or into which he or she was compelled to consent.
Financial Abuse	Theft or the misuse or misappropriation of property or possessions.
Neglect	Ignoring medical or physical care needs, failure to provide access to appropriate health care, neglect of social care, withholding of necessities of life, such as medication, adequate nutrition and heating. Neglect of oral care, delaying care of a resident, ignoring a resident, Not treating a resident's wounds carefully enough, Not changing diapers on a resident, prohibiting a resident from using the alarm

Most of the research related to elder abuse has been conducted in domestic settings. This is however a different context than nursing homes. Within the nursing home context, there is an expectation of trust in relationship to paid staff, the organization as a whole, and close friends and family members who visit the resident (10). Living in a nursing home may also mean sharing a room and space with other residents, and resident-to-resident aggression is included in the term elder abuse in the nursing home context (9). In addition, all nursing homes have organizational routines related to times for sleeping, eating, and administering medications; these affect residents' choices in everyday life and the interpersonal relationship between staff and resident. In 1997, Bennett et al. described institutional abuse as involving repeated acts and omissions caused by either the regime in the institution or abuse perpetrated by individuals and directed at other individuals in the setting (82). Moreover, the UK Department of Health policy describes institutional abuse as a lack of positive response to the complex needs of residents, the rigid routines, inadequate staffing, and an insufficient knowledge base within service [(83)p 12]

Resident-to-resident aggression is included in the term elder abuse in nursing homes. In the literature, resident-to-resident aggression has been defined as "negative and aggressive physical, sexual, or verbal interactions between long-term care residents that, in a community setting, would otherwise be unwelcome and potentially cause physical or psychological distress to the recipient" [(9) p 2]. A focus group study including 7 residents and 96 staff members identified 35 different types of physical, verbal, and sexual resident-to-resident aggression, with shouting or yelling at them being the most common (9). Rose et al. (84) explored staff-reported strategies to manage resident-to-resident aggression and found that staff have different informal strategies to manage resident-to-resident aggression. Most of their strategies were reactive, and staff seldom documented residents' behaviors or reported these to supervisors or colleagues (84). A study from Ellis et al. (85) found that resident-to-resident aggression was generally ignored by staff as a type of abuse. Abuse perpetrated by relatives and close friends and family members toward an older person is documented from research in domestic settings (2), but whether or not such abuse continues inside the nursing home has gained less attention.

A study from the Czech Republic by Buzgova and Ivanova (7) explored the staff's lived experience with abuse and found that staff had observed financial exploitation of residents by relatives.

When it comes to staff-to-resident abuse, a systematic review exploring staff's conceptualization of elder abuse in nursing homes found that staff were often uncertain about how to identify abuse, especially psychological abuse and caregiver abuse such as neglect (22). Cooper et.al (21), conducted a qualitative study of care workers' abusive behaviors toward residents in nursing homes and found that situations with potentially abusive consequences were common, but that deliberate or intentional abuse rarely occurred. This study also found that care workers acted in potentially abusive ways because they lacked knowledge and strategies related to caring for residents with dementia and other complex care needs (21).

A complicating factor in the description and understanding of elder abuse is that the voices of the older people themselves have generally been excluded (14). In describing elder abuse, it is important to include older people's subjective interpretations, which can challenge prevailing discourses mediated by disciplines such as law, medicine, and social science research. A study of eight countries conducted by the WHO in 2002 and titled "Missing voices" (14), highlighted that elder abuse could be interpreted in various ways. A qualitative study from Erlingsson et al. conducted in Sweden (86), found that elder abuse was related to older persons' perceptions of their changing roles at the individual level, in the family, and in society. This was related to age discrimination, social isolation, and their own role in the abuse, suggesting that this was something they brought on themselves. Other studies that have integrated perceptions of abuse from older people themselves highlight ageism, the loss of self-determination, and perceptions about how ageism affects the healthcare services that are delivered (13, 14).

Since many nursing home residents suffer from dementia and, thus, have potential difficulties expressing their experiences and perceptions of abuse within this context, it can be useful to include relatives' perceptions in order to describe abuse. A Swedish study from Harnett and

Jonson explored relatives' perceptions of elder abuse in nursing homes (87), and found that abuse was viewed as a violation of an older person's identity. This was related to staff's failure to take into consideration what relatives know about the resident's appearance, daily routines, and preferred activities in the daily life within the institution. Another voice that is missing in the literature is that of the nursing home leader and her or his perceptions of this phenomenon. Leaders have the opportunity to influence the culture and care practice in nursing homes and set policy for staff. Hence, knowledge about their empirical understanding of the phenomenon of elder abuse and neglect is important for developing more-effective prevention strategies and increasing safety for both staff and residents.

2.2.2 Prevalence

Existing research demonstrates a wide range of prevalence regarding numbers of incidents of elder abuse, which can be due to the data-collection methods used. There are variations in reference periods used to measure the extent of abuse and in the operational definition, and the number of items included in each subcategory is selected differently by researchers (10, 88). The most frequently used method for measuring staff-to-resident abuse in nursing homes is a self-reported survey administered to staff. Few studies of the prevalence of abuse in nursing homes are based on self-reported surveys by older adults themselves or their proxy. A recent study from Yon et al. (3) synthesized previous studies on self-reported data by older adults or their proxies. However, they only found two studies and since a minimum of three is required to conduct a meta-analysis, there were not enough studies to be pooled for information about overall abuse as reported by older residents themselves or their proxies (3).

Although there is a lack of prevalence studies related to elder abuse committed by family members and/or close friends inside the nursing home, it is estimated that, in domestic settings, one in ten older people experiences abuse every month A meta-analysis of 52 included studies from Yon and colleagues (2), estimated a pooled prevalence rate for overall elder abuse perpetrated by close friends and family members within domestic settings to be 15.7%.

A study by Botngård et al. conducted among nursing home staff in Norway showed that 60.3% had exposed a resident to one or more incidents of abuse in the past year (6). Psychological abuse and neglect had the highest prevalence, with 40.5% and 46.9% respectively. Physical abuse was reported by 9.6%, while financial or sexual abuse against a resident was not reported. The majority of staff in this study reported that they had never committed financial or sexual abuse. Comparably, in a study from Ireland, Drennan et al. (81) found that a total of 27.4% of staff reported that they had been involved in at least one neglectful act within the preceding 12 months. The most frequently reported neglectful acts were ignoring a resident when he or she called (22.6%) and failing to take a resident to the restroom when he or she asked (13.3%). Related to physical abuse, 3.2% of staff in this study reported that they had committed one or more acts in the previous year, where the most frequent act was restraining a resident beyond necessary at the time. Psychologically abusive acts against residents during the previous 12 months were reported by 7.5% of staff, and the most frequently reported type was shouting at a resident in anger (81). Yon et al. (3) conducted a meta-analysis and synthesized nine previous studies on self-reported data by the staff in nursing homes, estimating a pooled prevalence of 64.2% of staff who admitted to elder abuse.

Regarding resident-to-resident aggression, Shinoda-Tagawa and colleagues (89) conducted a case-control study in 2004 with the use of a minimum of data and incident reports to assess risk factors for resident injuries inflicted by co-residents. One of their findings was that residents with dementia in special care units were almost three times more likely to be injured by co-residents than those living in other units. Lachs and colleagues (8) determined that 20.2% of residents had been involved in at least one incident of resident-to-resident aggression during a one-month observation period. The most common form was verbal aggression. In Norway, a survey of staff observing resident-to-resident aggression found that 88.8% had observed one or more incidents of aggression toward a co-resident during the past year (90). A bias within this study is that nursing home staff working in the same unit may have observed and reported the same incident of resident-to-resident aggression, resulting in a higher number.

2.2.3 Determinants of elder abuse

Several theories have been developed over time to explain determinants of abuse and neglect. These mainly address the dynamics that occur between individuals such as power and control, caregiver stress, and abusive behavior that has been learned over time (91, 92). An often-used theoretical model is the ecological model, where determinants of abuse and neglect within nursing homes are divided into four levels: individual, relationship, institutional, and society (27). In this model, the first level (micro) focuses on individual characteristics such as biological and demographic determinants of being exposed to abuse or exhibiting abuse. The second level (meso) explores the relationships between residents and staff. The third level (exo) examines institutional factors where these relationships and interactions take place. The fourth level (macro) explores larger societal factors such as cultural norms, ageism/sexism, and public policy/economic concerns (27). Factors at each of the four levels can either increase the risk of abuse and, hence, vulnerability to abuse or can be proactive, thus reducing the risk of vulnerability to abuse.

Related to staff characteristics, Wang el al, (93), found that staff who were younger, less educated, and lacking specific training and who perceived a greater burden displayed a tendency toward more abusive behaviors. Lack of training, low education, and stress and burnout have also been identified as determinants related to staff characteristic in other studies (81, 94, 95). Among residents, cognitive impairments or dementia have been found to be strong determinants for being a victim of abuse and/or neglect (34), particularly in relation to patients with dementia and aggressive behaviors that result in assaults on staff (81, 95-97). A literature review by Dong also identified physical impairment of the elder person as a particular factor, and elders with Alzheimer’s disease combined with a physical impairment were reported to have been 4.8 times more likely to have experienced elder abuse than those without Alzheimer’s disease accompanied by a physical impairment (98).

On a relationship level, Drennan et al. found that staff who had experienced conflicts with residents were more likely to admit to having abused a resident, where the most frequently reported conflict involved managing a resident who was unwilling to undress; this was reported by 77.0% of respondents as occurring at least once in the preceding 12 months

(81). Several authors have reported a stressful relationship between caregiver and resident to be a determinant for abuse (7, 99). In the Irish study by Drennan and colleagues (81), resident-related events that the respondents identified as most stressful involved caring for residents with aggressive behaviors.

At an institutional level, rural facilities have demonstrated better scores for some quality components than urban facilities, e.g. pressure ulcer incidents and declines in urinary continence (100); at the same time, rural facilities have been found to have a higher prevalence of the use of physical restraint (101). Low staff-to-resident ratios and high staff turnover have been found to diminish care quality and to also be determinants of elder abuse and neglect (95, 102). Staff with less education may, furthermore, be a determinant of abuse because they may not recognize life-threatening situations (102).

In regard to resident-to-resident aggression, studies have identified determinants in the person being exposed to aggression and the person exhibiting it, in addition to determinants at the institutional level. The person being exposed to aggression was found, in one study, to most often be male (89) while, in another study, female (103) and to have cognitive impairment, dementia with agitation, and aggression (89, 103, 104). Residents who exhibit aggression are more often male (105, 106), and several studies have found that residents who exhibit aggression are often younger than the resident being exposed to the aggression (105, 106). Moreover, residents who exhibit aggression frequently have cognitive impairment and aggressive behavior tendencies (89, 103). On an institutional level, resident-to-resident aggression has been found to occur in public areas such as dining rooms and hallways as well as in private areas such as a resident's own private room (104). In addition, a higher incident rate of resident-to-resident aggression has been found in special care wards for residents with dementia (89) and in larger nursing homes compared to smaller nursing homes (105).

When it comes to determinants of abuse perpetrated by relatives inside nursing homes, these have yet to be described. However, in domestic settings, mental illness and alcohol misuse have been identified as determinants of abuse on an individual level in relatives (88). In the older person being exposed to abuse, several studies have identified that dementia and

aggressive behavior were determinants in domestic settings also (88, 107). On the relationship level, it has been found that the person who commits elder abuse is often strongly dependent on the person he or she is mistreating (108). Other risk factors described in domestic settings are social isolation and caregiver stress (109) Descriptions of elder abuse and its determinants reveal that abuse and neglect in the nursing home context are complex and multifactorial (27). For this reason, sections 2.3, 2.4 and 2.5 will give a broader presentation of determinants and proactive factors connected to elder abuse on relational, institutional, and social levels.

2.3 Social constructions of nursing homes in light of power and control theories

Elder abuse in nursing homes occurs in the context of an institutional frame. Hence, it is necessary to include the context as a determinant of elder abuse. How nursing homes are constructed and conceptualized within the society and its policy affect the care culture and the interpersonal relationship between staff and residents, as well as how nursing home leaders perceive elder abuse and which incidents they follow up on. The concept of the nursing home is one that has been developed over time throughout history and is described by different theoretical approaches and political strategies. Today, nursing homes are intended to serve as full-time homes for their residents (56), and at the same time, nursing homes are medical institutions for residents with complex care needs, many of whom are dependent on staff for care and assistance on a 24-hour basis seven days a week. The importance of acknowledging the context as relevant in a study of leadership is related to the fact that the role of leadership will be performed within the social construction of the institutional frame. How a nursing home is constructed and perceived within society today affects how nursing homes and their residents are written and spoken about and forms the discourse of what is perceived as quality of care and what is constituted as abuse within nursing homes.

The seminal French philosopher and historian Michel Foucault (1926–1984) questioned the role of institutions in the modern society (110). He was preoccupied with the question how people conceptualize their everyday life and address the relationship between power and knowledge and how these concepts are used as forms of social control through social institutions (110, 111). Although Foucault did not perceive himself as a theorist of power, his

interest in power have nevertheless connected him to the concept (112). Foucault focused on how power functions and how the power-knowledge duality forms, shapes and changes over time. He linked knowledge to power and argued that power is a ubiquitous and relational phenomenon, unstable and circulating, neither good or bad, and referred to this as the capillary level of power (26, 113). In this way, power infiltrates and becomes part of daily life within institutions (26, 110, 111).

In nursing homes, power is exerted by politicians and healthcare directors, who utilize it in their interactions with nursing home directors who, in turn, exert power in their relationships with the care managers. Likewise, care managers have power over the staff in a nursing home, and the staff exert power, in the end, in their relationships with residents. In nursing theories, power in the phenomenon of caring for another person has also been discussed (114). The asymmetrical relationship between staff and residents places an ethical obligation on staff to handle the power that exists in the relationship in a way that upholds the resident's capacity for action. Norwegian nurse and philosopher Kari Martinsen has described power and the dilemma between neglect of adequate care and the resident's rights to autonomy and choice in everyday life, as well as how paternalistic attitudes of healthcare staff can fail to take into consideration the residents' choices in their everyday lives (114, 115). Martinsen was inspired by the Danish philosopher K.E. Løgstrup and his interpretation of the mutual dependence within all human existence, where trust and power are always at stake (116). The question is how this power is managed.

In his book *Discipline and Punish*' (26), Foucault described the development of the modern regime of social control. He used the prison as an example of an institution, such as schools, hospitals, the military, and nursing homes, to illustrate how discipline, including punishments and rewards, is used to rehabilitate citizens' souls with the aim of creating docile bodies based on the construction of normalization. Three processes enable the production of docile bodies: hierarchical observation, normalizing judgment, and examination (26). Hierarchical observation is linked to how all of us in the society are constantly monitoring and tracking ourselves and each other. In the context of nursing homes, it can be translated to how nursing home leaders, staff, and residents are all monitored in the nursing home context. Normalizing

judgment refers to the rules and regulations that normalize behavior and compare everyone to what are considered the "normal standards." The idea of the norm as used today began as a power relation by people in authority who imposed discipline on their subjects. The norm then became the statistical average. But now, the concept of norm has shifted to become the minimum threshold, that is, what is considered to be the minimum acceptable quality standard in nursing homes. The last process in discipline is examination, which is also referred to as the normalized gaze. The modern examination makes it possible to qualify, quantify, classify, and then punish based on a seemingly objective and scientific standard (26, 110, 113). Examples of how leaders are monitored and examined are found in their budgets, their results, working-condition surveys administered to staff, and reports of numbers of staff on sick leave. Leaders who have exceeded their budgets are publicly examined in leader meetings. In contrast, leaders who have their budgets in balance are rewarded publicly and used as an example of good leaders. Hence, all leaders within such a leader culture will strive to be what is defined as a good leader. Through this discipline process, nursing home leaders become both controlled subjects and active participants in controlling, following, and reinforcing what are viewed as the norms within a society and, hence, acceptable norms within nursing homes (26, 112). Foucault argued that the way institutions are organized reflects how power is justified within the society (26, 112).

Discipline, normalization, control, and productive exercises can be viewed from the perspective of historical settings and structures in society and how these work on people (113). Foucault referred to the continuities and discontinuities between "epistemes" as the knowledge systems that primarily informed the thinking in a society in a certain period of history. In modern society, it has been argued that age represents an important cultural dimension of social status (117, 118). Ageism can be described as the devaluation of a particular social group due to age (118), and this devaluation can lead to the justification of certain discriminatory behaviors, such as abuse and neglect (118, 119). In addition, ideas from new public management were introduced to the healthcare sector in the 1970s through the '80s and included an increased focus on standardization and performance management to improve quality and efficiency in healthcare organizations (120). Attitudes of ageism combined with an increased focus on efficacy in society are learned through socialization and

become the discourses of social knowledge, which is enacted within institutions (117, 118, 121). This social knowledge will form the social interaction, care culture, and leadership behavior within nursing homes. In the literature, elder abuse in nursing homes has also been conceptualized as a specific form of institutional abuse (24, 122), described by the Harrow Council, a local authority in London, UK, as “the mistreatment of people brought about by poor or inadequate care or support, or systematic poor practice that affects the whole care setting. It occurs when the individual’s wishes and needs are sacrificed for the smooth running of a group, service, or organization”(122). A qualitative study by McGlone and Fitzgerald’s (123) examining the perception of ageism in healthcare services from the perspectives of older persons themselves and staff found that policies and practices were negatively influenced by ageism and affected access to services and the quality of care. In Norway, a case study in five municipalities explored the allocation of health care between younger and elder populations (124). The researchers found that the needs of elder people related to social activities and personal hygiene were perceived as less important than the same needs of younger people.

2.4 Quality of care and patient safety

All healthcare organizations aim to deliver high-quality care, to prevent harm, and to meet the needs and expectations of their residents and/or patients. This section will provide an overview of quality of care and patient safety in nursing homes and the connection between elder abuse and patient safety, including monitoring and reporting abuse and learning from incidents.

2.4.1 Quality of care and patient- safety in nursing homes

Quality of care is typically described as achieving the best possible healthcare outcomes (125), while safety is described as the avoidance of harm to residents (29). Quality of care is a multidimensional concept and is influenced by the different perspectives and interests of various stakeholders as well as various healthcare facility characteristics (54, 126). In 2001, the Institute of Medicine (IOM) released a report titled “Crossing the quality chasm: A new health system for the 21st century” (125), which outlined six important domains of quality: patient safety, effectiveness, a patient-centered approach, timeliness, efficiency, and equity.

Both internationally and nationally, patient safety is highlighted as one of the most important and influential dimensions of healthcare quality. (127). In 2010, the Norwegian Knowledge Centre for the Health Services outlined a description of quality that included outcomes such as “health welfare,” which also focused on non-medical outcomes of care such as integrity, dignity, and quality of life. These can be perceived as important quality indicators from the nursing home residents’ perspectives that focus more on the psychological and emotional aspects of good care (128).

In order to assess and evaluate quality in health care, Donabedian’s model is often used as a framework (54, 126). According to this framework, quality of care can be described and divided into three main categories: structure, process, and outcome. Structure quality comprises structural factors that affect the performance of care, such as the nursing home building itself, the staff, financing, and equipment. Process quality is the direct care provided by staff and is divided into two interrelated components: technical care is the application of science and technology, and interpersonal processes involve the relationship between the staff and the residents. Outcome quality refers to the effect of health care on the residents and the population (126). Factors in each quality category can be determinants of abuse. In addition, each factor can interact with the others, which makes defining quality of care a complex undertaking and, thereby, results in what is perceived as abuse and neglect within a nursing home context becoming indistinct.

The inclusion of safety as a quality dimension in health care was realized in 1999, when the Institute Of Medicine (IOM) released the landmark report “To err is human” (129). This report estimated that between 44,000 and 98,000 Americans die as a result of medical errors in hospitals each year. No numbers were reported for nursing homes. The report triggered substantial efforts in health care to identify sources of errors, develop safety metrics, and create impactful policy initiatives to improve safety (29). In 2015, the National Patient Safety Foundation (NPSF) summarized the 15-year progress made since “To err is human” (29) and concluded that improvements in safety had been slower to materialize than expected. This report emphasized the need to promote patient safety in all healthcare settings, not only in hospitals but also in settings such as nursing homes. It also highlighted the need for increased

focus on a culture of safety, a safety system with a focus on learning, and the importance of leadership (29, 38). This emphasis is also found in Norwegian governmental policies, guidelines, and white papers (50, 130), where leadership and a culture of safety are especially pointed to as essential for establishing safe healthcare systems. In Norway, patient safety is described as the protection against events that result in unintended harm to the patient by act of commission or omission rather than by the underlying disease or condition of the patient (131). The IOM defines patient safety as the prevention of harm to patients. Emphasis is placed on a system of care delivery that (a) prevents errors; (b) learns from the errors that do occur; and (c) is built on a culture of safety that involves healthcare professionals, organizations, and patients (29).

The importance of focus on a patient-safety culture within the organization to increase patient safety has been highlighted in both national and international reports and white papers (38, 64). (38, 64). A patient-safety culture is part of the care culture within the organization, but in addition to the traditional care culture, a patient-safety culture has an increased focus on safety. Care culture will be further described in chapter 2.5.3. A commonly utilized description of a patient-safety culture is the product of individuals and group value attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to and the style and proficiency of an organization's health and safety management (29). An extensive range of safety-culture factors have been identified and organized into dimensions such as leadership, teamwork, evidence-based patient care, communication, learning, just culture, and patient-centered care, and together they form a safety-culture framework (38, 132). This framework is used when assessing patient safety culture in surveys administered to staff in nursing homes. A Norwegian study measuring staff's perceptions of patient-safety culture found that communication and openness were perceived as the most important dimensions of patient safety, yet staff scored low on these (133).

Perceptions of health and safety within organizations have been found to vary between people in the blunt end and people at the sharp end (134, 135). A study from Castle et.al (135) explored the perception of a safety culture within nursing homes from the perspectives of nursing home directors and care managers, and found that nursing home directors had a

more positive view of the safety culture with the organization than care managers did. This study pointed out the importance of further research to explore patient safety between levels of leadership. Another factor affecting patient safety is the perception of which events constitute harm to residents in nursing homes.

2.4.2 Elder abuse as patient-safety incident

Elder abuse in nursing homes involves physical and emotional harm to residents and can, therefore, be described as a patient-safety issue. However, the connection between abuse and patient safety has not been clearly elaborated in the elder abuse or the patient-safety field. This could be because current discourses and methods of describing and capturing information on safety-adverse events are strongly based on studies from hospitals (136). The Agency for Healthcare Research and Quality (AHRQ) highlights that the vulnerability and complexity of nursing home residents make them different from most hospital patients and that further research is needed to understand what constitutes safety issues in nursing homes (137). Nursing home residents are often dependent on care and assistance in activities of daily living such as assistance getting in/out of bed, dressing, toileting, eating, walking, and socialization. The AHRQ points out that adequate staffing is necessary to ensure that all aspects of care are provided 24-hours a day, seven days a week to prevent care omissions that, in turn, may contribute to adverse events (136, 137). In the elder-abuse research field, omission of care is described as neglect (11, 138)

A review of the literature on patient safety and quality of care events found that the most common adverse event reported by staff is a medication error (139). A Swedish study measuring type of adverse events in nursing homes found that medication errors, falls, and delayed or inappropriate care comprised the majority (89%) of serious adverse events (140). In 2016, the AHRQ conducted a literature review to describe safety issues in nursing homes (136, 137). Key patient-safety issues included falls, pressure ulcers, infections, and medication errors/adverse drug events including inappropriate use, catheter left in bladder, physical restraints, unintentional weight loss, decline in activities of daily living, fecal/urinary incontinence, depressive symptoms, and pain (136, 137). Some of these incidents described as patient-safety events within this research are, in the elder-abuse research field, labeled

abuse and neglect; for instance, physical restraint and inappropriate drug use are considered physical abuse, and unintentional weight loss and decline in activities of daily living are considered neglect (81).

Traditionally, safety issues have been linked mainly to physical harm, but in recent years, the problem of psychological or emotional harm has been pointed out in patient-safety research (39, 141, 142). In 2018, Cooper et al. (142), conducted a literature review to develop a classification framework of severity of harm arising from patient-safety incidents in primary care. They identified 21 approaches to the classification of harm severity, which they analyzed and used to further develop a new classification system built on the WHO's International Classification for Patient Safety. This new classification takes into consideration hospitalization and psychological harm but, in addition, incorporates near misses and uncertain outcomes (142, 143).

2.4.3 An individual approach or a total system approach to abuse in nursing homes

Adverse events can be viewed in different ways, and each approach gives rise to quite different philosophies of error management (38, 144). An individual approach focuses on the unsafe acts, errors, or violations of individuals at the sharp end of direct care, such as the nursing home staff. This approach links unsafe acts to apparent mental processes in individual staff including intention, forgetfulness, poor motivation, carelessness, and recklessness. Follow-ups on events within this approach are directed toward reducing unwanted human behavior (144, 145). A definition of elder abuse as an intentional act can lead to an individual approach in the follow-up and, hence, does not include the complex nature of determinants of abuse in nursing homes. A systems approach views humans as fallible and incidents as expected, even in the best organizations (144). In this approach, incidents are viewed as consequences rather than causes, with their origins in system factors such as "error traps" in the workplace and "safety gaps" in the organizational process, often referred to as "Swiss cheese"(144). In the latest report from the AHRQ, "Leading a culture of safety: A blueprint for success,"(38), a total system approach is pointed to as the way to improve quality and safety in health care. This approach includes constant prioritization of a safety culture by leaders, which is critical in relation to incidents of abuse in nursing homes

(38). In a total-system approach, a just culture is highlighted as an important component of a safety culture. The AHRQ and Institute of Healthcare improvement (IHI) define a just culture as one that focuses on identifying and correcting system factors without blaming individuals for human errors and, at the same time, establishes zero tolerance for reckless behavior (38). In order to do so, leaders must investigate each event to determine whether the incident was caused by human error (e.g., slips), at-risk behavior (e.g., taking shortcuts), or reckless behavior (e.g., purposely ignoring required safety steps). The result of such an investigation should determine the response and the follow-up.

Elder abuse is mainly related to determinants at a system and organizational level (11, 95), but reckless abusive behavior on the part of individual staff members does occur, although the frequency is low (6, 146). To promote patient safety and prevent abuse and neglect in nursing homes, nursing home leaders need to address abusive behavior by individual staff as well as organizational and cultural factors over which individual staff members have no control.

2.4.4 Monitoring and reporting elder abuse

The safety field in health care has taken inspiration from other high-risk industries such as aviation. This has led to an increased focus on how healthcare organizations can learn from adverse events, mitigate contributing factors, prevent future errors, and ultimately make healthcare safer (147). An adverse-events system is designed to obtain information about patient-safety incidents, which can then be translated into individual and organizational learning (148). The successful translation of adverse-event reports to learning outcomes comprises four main aspects (149). First, data input needs to be independent and non-punitive to enhance a culture of learning. Second, collecting data relies on staff having the opportunity to narrate their own versions of events so that the data reflect the true nature of the incident and identify the multitude of factors connected to the incident. The third aspect includes analysis, where the reports are turned into lessons. The fourth is feedback, where all those in the organization are included and can see that something positive comes from the reporting (149).

Prior research on incident reports in nursing homes has revealed that the reporting of adverse events varies widely (150), and that it is used on a limited basis for quality improvement (148). An important barrier to improving patient safety and increasing the quality of care is the underreporting of adverse events (28, 29). Underreporting of abuse and neglect is well-documented (33, 35, 151), and there is a need to understand factors that influence reporting. Nursing home residents' own inability to communicate the abuse or their fear of repercussions and retaliation is one important factor of underreporting (3, 11). Another factor that was explored in a literature review by Garma is health professionals' knowledge and attitudes about detecting and reporting elder abuse (33). The main findings in this study were that an understanding of the abuse phenomenon, the accuracy of health professionals' knowledge, and their expectations about the consequences of reporting or how they define their professional role have an effect on their actions and whether they report.

Moore conducted a qualitative study in 2017 to explore reasons for staff failure to report abuse in nursing homes. He found that a fear of reporting was a main barrier for staff to report abuse within NHs (37). A survey of staff in 16 nursing homes in the central part of Norway found that a failure to report inadequate care could be due to a lack of staff knowledge, a lack of reflection on their practice, or a fear of disciplinary action against them (35). Other factors found to affect underreporting from staff, is lack of feedback and responses from nursing home leaders (34, 37). A literature review of factors affecting the overall patient safety incident reporting, found barriers to be; fear of adverse consequences, process and systems of reporting and incident characteristics (28). Other common barriers reported in the literature by healthcare professionals included fear of blame, legal penalties, the perception that incident-reporting does not improve patient safety, a lack of organizational support, inadequate feedback, a lack of knowledge about incident-reporting systems, and a lack of understanding about what constitutes an incident (28, 148, 150, 152).

2.4.5 Learning from incidents of abuse

The use of a reporting system is linked to the belief that patient safety can be improved by learning from incidents and "near misses" (148). Learning can take place at the individual and at the organizational level. Individual learning focuses on increasing knowledge

and skills for individual staff members to enable them to do a better job, while organizational learning involves sharing the thoughts and actions of all the individuals in the organization, which entails a cultural change (148, 153). Fiol and Lyles described learning as the process of improving actions through better knowledge and understanding (154). Huber stated that learning takes place in an organization if, through its process of information sharing, organizational behavior is changed (155). Lave and Wegner (156) described learning as a process that takes place in practice when a group of people share their different perspectives.

Argyris and Schön's theory of group learning within organizations (153, 157) is often referred to as central in understanding organizational learning from patient-safety incidents. According to their theory, organizational learning can be divided into "single-loop learning," which refers to the correction of errors without significantly changing the overall safety culture, and "double-loop learning," which refers to a cultural change that involves questioning and alterations of the governing values within the organization. To exemplify single- and double-loop learning, Argyris used a thermostat. This thermostat uses double-loop learning if it questions why it is programmed to measure temperature and then adjusts the temperature itself (158). Learning in their model is referred to as the "mechanisms" by which people link their thoughts (cognitive schemas) to their actions (153, 159). In the theory of single- and double-loop learning, Argyris and Schön further distinguished between espoused and in-use schemas, which are, according to their model, what drives learning behavior.

The distinction between espoused and in-use schemas is connected to the behavioral rules and assumptions that people publicly proclaim they adhere to, and the rules and assumptions that observations of their actual behavior indicate they are using in reality (159). The differences between what people claim or even believe often differ from the values and principles manifested through their behavior in the organization. This contradiction can sometimes be reflected within a "blaming attitude" toward learning from safety incidents. The espoused model for learning is often referred to as "learning model II." The governing rules and assumptions in this model are that people within an organization should cooperate to search for solutions. This is done by gathering facts, generating options, and involving all

members in a discussion. Through the discussion, members of the organization together explore the root cause or causes of the incident and then identify assessment to use for preventing the incident from reoccurring. This model also requires that people be open to changing their minds. The cognitive schema within the model provide instructions for double-loop learning. Although this is the espoused model for learning in organizations, research has shown that another model is actually used to drive learning behavior within organizations (158-160). In-use model for learning is referred to as "learning model I." Its governing rules and assumptions are that people strive to win rather than lose and to suppress negative feelings; people in such organizations feel that they are under the influences of control. The schema that construct learning model I block any questioning that can contribute to a change in people's awareness, with the result that they get trapped in single-loop learning (159). The follow-up of incidents within organizations that use model I involves attempts to find simple solutions without questioning the governing assumptions or the root cause, such as resources. In his study of aviation safety, Rose (160), pointed out that, when a culture experiences risk minimization and simple solutions such as blame, the desire to learn from the incident is significant diminished.

For organizations to engage in double-loop learning, they must move from model I to model II. This means that they must destroy defensive routines and endure embarrassment, experience fear of failure, and be open to changing their minds. In order to do so, Argyris and Schön argued that organizations must facilitate group learning by building competence and self-confidence through a cognitive process (158). By thinking, asking questions, and making discoveries, people's subjective perceptions of the world around them are created. When members of an organization are given the opportunity to share their thoughts and feelings, mutual cognitive schema among people in the organization will be constructed (158, 159). When members of an organization discover and modify their learning system through double-loop learning, they learn to learn, also called deutero-learning (161), which enables organizations to continuously improve (162).

2.5 Leadership in complex organizations

Complexity theory offers another important perspective for studying elder abuse and patient safety in nursing homes. This chapter provides an overview of nursing homes, elder abuse, and patient safety with perspectives from complexity science. Stakeholders within a system interact and produce behavior within the system. Description of care culture and self-organization in complex systems will be presented, in addition to a discussion of the importance of leadership.

2.5.1 Nursing homes, elder abuse and patient safety with perspective from complexity science

Complexity science has, in recent years, been applied to healthcare science, where healthcare organizations are described as complex adaptive systems (19, 20, 163). Complexity theory can be described as a meta theory since it combines and organizes concepts of complexity and local theories into one framework. The theories aim to understand how things relate to each other and how these interactions work (20). A pioneer in the field of complexity science is philosopher Paul Cilliers, who wrote *Complexity and Postmodernism* (20). Cilliers drew a distinction between the term complex and complicated. Complicated systems can be divided into parts, isolated, described, and then reassembled; examples include cars, aircraft, and computers. Complex systems, on the other hand, consist of several parts closely connected to each other, and the more parts and connections the system has, the more complex the system will be. As a result, a complex system cannot be taken apart and has to be studied as such. Cilliers exemplified complex systems as the brain, social systems, and ecological systems (20).

Nursing homes are an archetypal example of a complex organization (19, 164). The complexity of residents' needs in addition to the social complexity of different stakeholders around each resident makes the delivery of care in nursing homes complex (19, 20). Furthermore, both staff and residents in this context constitute a complex system themselves, where the biopsychosocial model implies that biological, psychological, and social factors interact in changing and shifting ways. Each of the factors in this model belongs to its own system, such as the brain belonging to the biological system, the emotions and thoughts to the psychological system, and the nursing home to the social system (20). As described

previously, determinants of elder abuse are related to personal factors related to the staff and the resident, the interpersonal relationship between them, and factors within the organization and the wider society. All these interact with each other and not always in a predictable way.

Elder abuse and neglect in nursing homes can be characterized as difficult to define, having multiple causes, lacking good or clear solutions, being socially complex, and involving changing human behavior (165), which fits the description of "wicked problems," a term coined by Professors Horst Rittel and Melvin M. Webber (166). To turn wicked problems into wicked opportunities, leaders must learn to dance with the complexity (167); this means combining a transdisciplinary mindset with a goal to create a more-holistic creative approach to solving the problem. In his book *Dialogue Mapping: Building Shared Understanding of Wicked Problems,* Conklin noted that wicked problems must be met with shared understanding and shared commitment by the stakeholders in the organizations (168).

In the elder-abuse research field, efforts have been made to prevent abuse and neglect, but no intervention strategy has resulted in a significant reduction in abuse over time (75, 85, 169). A Cochrane review of interventions to prevent the occurrence or recurrence of elder abuse found that the quality of the available evidence is low and that there is little research to guide practice (169). Most of the intervention research that aims to prevent or reduce abuse has focused on increased knowledge and skills among staff (170, 171); this can be viewed as linear thinking, meaning that there is a solution to the problem and there is a cause and effect. Most people like to simplify things so that they fit into this model of thinking but doing so is likely to result in only one or two of the factors involved being taken into consideration. The opposite is non-linearity, where the complexity of all factors is considered (20), meaning that the whole is more than the sum of its parts. Moreover, this implies that intervention strategies to reduce abuse and neglect in nursing homes must consider this complexity in order to be effective (20). Including findings from other research fields is an important transdisciplinary approach for preventing abuse.

In patient-safety science, there has been a paradigm shift that acknowledges the complexity of healthcare organizations and draws on ideas from complexity and systems theory (163).

The aim is organizational improvement in order to generate insights into how care quality emerges from multiple interacting factors. This thinking is referred to as Safety-II, a broader system-level thinking with the aim of shifting away from reactive behaviors associated with Safety-I to more proactive solutions (42). This way of thinking acknowledges a constant need for adjustment and adaptation due to the differences between work as imagined from protocols, books, and procedures and work as it is performed in practice (172). The gap between work as imagined and work as performed in practice is described as a danger to patient safety yet remains poorly understood.

2.5.2. Care culture and self-organization in complex systems

Among policymakers, researchers, managers, and staff, culture is a much-discussed construct, and within the literature, it has been described in numerous ways (42, 173-175). At the same time, the importance of culture has been highlighted through research and literature. One frequently used description of culture is from Schein (175), who described it as the pattern of basic assumptions that a group has invented, discovered or developed in order to learn to cope with its problems of external adaption and internal integration. These solutions have worked well enough to be considered valid and, thus, have been taught to new members of the organization as the correct way to perceive, think, and feel in relation to the problems. Thomas Kitwood, a British social psychologist and a pioneer in the development of person-centered dementia care, defined culture as “a settled, patterned way of giving meaning to human existence in the world, and of giving structure to action within it” (176). He stated that interactions between staff and residents had the potential to either uphold or undermine the personhood of individuals with dementia and that interactions resulting in harm to residents were related to the care culture rather than being intentional by staff (176, 177). A qualitative study from Pickering et al. (43), included 22 staff members and found that staff who experienced bullying and a “toxic” work environment used adaptive strategies that negatively affected the care provision and were attributed to the development of several resident and worker safety outcomes, such as abuse and neglect.

Human systems such as care cultures are a typical example of systems that the science of complexity deals with and where adaptation and self-organization are central (19, 20).

According to Cillers (20), self-organization is a process whereby people within an organization interact with each other to create adaptive survival strategies not only for themselves but also for the system or parts of the system to which they belong. Nursing home leaders are part of the culture within the nursing home where they interact with staff, but they are also part of the leader culture within the municipalities where they interact and adapt to the external and internal demands of being a leader within this system. In the book *Complexity and Creativity in Organizations* by Ralph Stacey (159), the author used a flock of birds to illustrate how agents in an adaptive system follow simple rules by examining each other's behavior and adjusting their own behavior in order to fly in formation (19, 159). This self-organization occurs in all social systems, whether we recognize it or not. When self-organization leads to instability, such as conflicts with residents, the system might suddenly change course or take an unexpected direction. Since self-organization has a certain degree of unpredictability, the emergence of the system behavior will have the same degree of unpredictability (20).

Care culture can be summarized as features of institutional life that are shared across the organization and between members, and that include their cognitive beliefs, assumptions, and attitudes that are visible and not in the conscious awareness. The culture is reflected through behaviors, practices, and interactions (42, 175). Culture is described as the social and cognitive "glue" that binds people together within an organization and is reflected in "the way things are done around here," which is taught to new members of the organization. A recently published systematic review of the association between organizational and workplace cultures and patient outcomes (42) also points out that understanding patient-safety culture is the most important first step related to increasing quality of care and patient safety. This study found that positive organizational and workplace cultures were consistently associated with a wide range of patient outcomes such as reduced mortality rates, falls, and infections and increased patient satisfaction (42). A study from UK by Killett et.al (178), investigated the relationship between NH culture and residents' experiences of care and found that organizational culture is locally produced and shifting but also affected by external factors such as resources.

2.5.3 The importance of leadership in complex organizations

Leadership is a universal activity and one of the social sciences most examined phenomena (179), but at the same time, it is difficult to define precisely. A classic description of leadership is a division between two main focuses: (a) the leadership role related to coordination of an organization and (b) the leadership role in relation to work outcomes and activities and tasks that leaders undertake in order to achieve these outcomes (180). Henry Mintzberg, one of the pioneers in leadership theory, defined a leader as the person in charge of the organization or one of its sub-units (181). Northouse described leadership as a process whereby a person influences a group of individuals to reach a common goal (182). Haynes considered leadership to be about competence and skills, in addition to creative individual judgment for completing tasks connected to the leadership role. He related his description of leadership to the fact that leaders have to take the lead and coordinate in complex environments (180).

The importance of leadership related to patient outcome, such as quality of care and patient safety, has been highlighted in both national and international reports and by prior research (29, 38, 53, 64). A systematic review by Wong et al, (183), found a relationship between positive relational leadership styles and higher levels of patient satisfaction and lower patient mortality, fewer medication errors, less restraint use, and lower rates of infections. German et al. examined factors that nurses perceived as influencing their motivation and performance at work in a systematic review and found that leadership behaviors influence their motivations and perceptions of resident's needs both directly and indirectly (41). Donoghue and Castle, examining the relationship between leadership style and staff turnover in 2900 nursing homes (184), identified a correlation between leaders who solicit and act upon input from their staff and a lower level of staff turnover. In addition, the length of tenure and experience as a nursing home leader has been found to influence the quality of resident care (185).

Many staff members in nursing homes are unskilled or semi-skilled and because of that, it has traditionally been believed that a top-down, bureaucratic leadership approach is suitable (186). However, this approach imposes barriers to the freedom of interaction that is needed for effective self-organization (159). A top-down, bureaucratic leadership approach will not

control or change the self-organization process within the nursing home. Self-organization will occur anyway, but the outcome may differ from the organization's goals for high-quality outcomes (19). Hence, a combination of traditional management and innovative, bottom-up leadership is needed to achieve system change (180). Leadership practice can be viewed as a tool for altering organizational strategies in order to change and adapt to external and internal demands (19, 180). According to Stacey (159) the organizational strategies that leaders need to employ in complex organizations can be divided into three processes: (a) increasing information flow, (b) adding more connections among people in the organizations, and (c) promoting the development of more diversity in cognitive schema in people within the organization. When leaders use these strategies, they can influence self-organization in a way that facilitates better outcomes for nursing home residents because increased information flow, more connections among people, and changes in cognitive schema such as assumptions in the culture will generate new behaviors among staff within the organization (19, 159)

Summarizing the background chapter

To summarize, the conceptual part of this thesis has presented existing knowledge of descriptions and perceptions of elder abuse, its prevalence, and its determinants. Social constructions of nursing homes in light of power and control theories have been presented. Furthermore, quality of care and patient safety are described, in addition to leadership in complex organizations. A lack of knowledge is identified regarding the role of leadership in patient-safety issues related to elder abuse and neglect. This involves how nursing home leaders perceive elder abuse, their experiences of barriers and enablers to reporting incidents of abuse, and how they follow up such reports.

3.0 Research aim

The aim of this thesis was to explore the role of leadership in patient-safety concerns related to elder abuse and neglect. Nursing home leaders can influence the care culture and set policy for staff. Hence, how leaders perceive elder abuse, their experiences of barriers and enablers to reporting abuse and how they follow up reports are of critical importance. Therefore, their perceptions of the phenomenon will affect what they signal to staff as important to report and which incidents they will investigate in order to create a safe and healthy environment for both staff and residents.

The specific objectives were to explore:

- How nursing home leaders perceive elder abuse and neglect;
- What nursing home leaders experience as barriers and enablers to reporting elder abuse and neglect; and
- How nursing home leaders follow up on reports of elder abuse and neglect.

4.0 Method

In this section, I will present the study design, sampling and data collection, and the analysis process. I will also present ethical considerations related to the study.

4.1 Study design

This study sought to obtain a holistic understanding of nursing home leaders' perceptions and experiences of a complex and poorly understood topic in a specific context, with a focus on the specific and detailed rather than the average. How people experience and perceive situations and why they act as they do within a situation cannot be captured by numbers. Thus, we believed that the use of a qualitative explorative method would be the most effective way to study this phenomenon (187). Qualitative methods provide knowledge about people's experiences of their situations and how they interpret, understand, and link meaning to events (188). This is called contextual knowledge, and the aim is to obtain a deep understanding of the experience of being an individual in a specific context with a particular theme (189). The interview method was chosen to explore the topic because perception and experience related to a specific phenomenon cannot be directly observed. The use of qualitative interviewing is linked to the assumption that the perspectives of others create meaningfulness and knowledge that can be made explicit (188).

Each nursing home in Norway is required to have an administrative manager, called the nursing home director, and some nursing home directors lead more than one facility. In addition, each nursing home has ward leaders and quality leaders, and in some municipalities, a service leader. Together, individuals in these roles form the leadership team in each nursing home. In this thesis, members of the leadership team are referred to as care managers. Since both nursing home directors and care managers can influence each other through a hierarchical relationship and can, collectively, affect the quality of care and patient safety (190), we gathered information from both leadership levels. When planning the study, the intention was to use focus group interviews as a data-collection method. The difference in hierarchical levels of leadership between nursing home directors and care managers may influence the power difference within focus groups and generate a situation where some participants are reluctant to speak (187). Since we wanted to create an environment where all

participants felt free to talk about their thoughts and feelings on the topic elder abuse, it was decided to have homogeneous groups and not mix nursing home directors and care managers in the same focus group. However, since there are few nursing home directors in each municipality, gathering them together for focus group interviews proved to be difficult. Hence, the nursing home directors were invited to participate in individual interviews, while the care managers were invited to participate in focus group interviews. Since the questions and topics to be discussed during the interviews were related to negative aspects of care, the researcher was aware that this could be challenging in a group setting. However, the participants' experiences and descriptions were based on their roles as leaders, where a group discussion could be beneficial. To ensure that the topics were addressed properly, we piloted the interview setting and interview guide with teachers from the nursing education department at NTNU and members of the research team. We used their feedback to revise the interview guide and discuss the nature of the setting. Following the pilot test, we modified the interview guide by reducing the number of subjects, which resulted in three main topics.

4.2 Sampling

Qualitative studies typically focus on sampling selected for a specific purpose (188). Purposive sampling was initially used to ensure that the participants recruited could see the phenomenon from the perspective of a leader. The use of purposeful sampling is linked to the power and logic of selecting information-rich cases and participants for in-depth study. Studying information-rich cases can reveal in-depth understanding and insight into the purpose of the study rather than empirical generalizations (188). Participants for this study were recruited from both urban and rural municipalities, from the middle to the south of Norway. Inclusion criteria for participants were (a) being employed in a leadership position in a nursing home and (b) being employed full time in that role. Each municipality and its nursing home leaders were recruited using a stepwise approach, as we sought to acquire a theoretical sampling until saturation of data was achieved (191, 192).

4.3 Participants

Participants who volunteered represented managers from a total of 21 nursing homes, all public enterprises owned and run by the municipality. The nursing homes represented 6 municipalities in Norway and urban as well as rural areas. All of the nursing homes were regular nursing homes, but some also had special care wards intended for residents with cognitive deficits or dementia. A total of 43 participants were recruited: 15 individual interviews were conducted with nursing home directors, and 6 focus group interviews were conducted with a total of 28 participants comprising 23 ward leaders, 2 quality leaders and 3 service leaders. The focus groups were composed as follows:

- 1 focus group with 3 participants;
- 2 focus groups with 4 participants;
- 1 focus group with 5 participants; and
- 2 focus groups with 6 participants.

In papers 1 and 3, we chose to refer to all 28 participants in the 6 focus group interviews as care managers. In paper 2, we have used the term ward leaders for all members of the leadership team. Within this thesis, the term care managers is used. The reason for the different term usage is related to the commonly used term in the journal in which the papers were published. Table 2 displays the characteristics of the participants.

Table 2. Demographics of the study participants (*n* = 43)

Background characteristics	CM (*n*= 28) Number (%)	NHD (*n*= 15) Number (%)
Age (years)		
30 -39	6 (22)	1 (7)
40 -49	11 (39)	2 (13)
≥ 50	11 (39)	12 (80)
Gender		
Female	25 (89)	13 (87)
Male	3 (11)	2 (13)
Number of beds managing:		
0	5 (17)	
10 - 19	8 (29)	
20 - 29	8 (29)	
30 - 40	6 (21)	
40 - 59	1(4)	8 (53)
60 - 99		3 (20)
100 - 199		3 (20)
≥ 200		1 (7)
Number of staff managing:		
0	2 (7)	
10 -29	9 (33)	
30 - 49	11 (39)	
50 - 99	6 (21)	5 (33)
100 - 199		6 (40)
≥ 200		4 (27)
Working experience in this position		
0 -4	20 (71)	8 (53)
5- 9	7 (25)	3 (20)
≥ 10	1 (4)	4 (27)
Total working experience as a leader in years		
0 -4	11 (39)	1 (7)
5- 9	6 (22)	1 (7)
≥ 10	11 (39)	13 (86)
Formal leader education		
0	1 (4)	1 (7)
0,5 -1 years course	18 (64)	5 (33)
1 - 2 years course	3 (11)	2 (13)
Master's Degree	6 (21)	7 (47)

Note: CM=Care Manager; NHD=Nursing Home Director

4.4 Recruitment and data collection

Participants were recruited over a six-month period from August 2018 to the end of January 2019. The first recruitment e-mail was sent to healthcare managers in 11 municipalities, both urban and rural areas from the middle to the south of Norway. Healthcare managers from 6 municipalities accepted the invitation, while 5 healthcare managers stated that nursing home

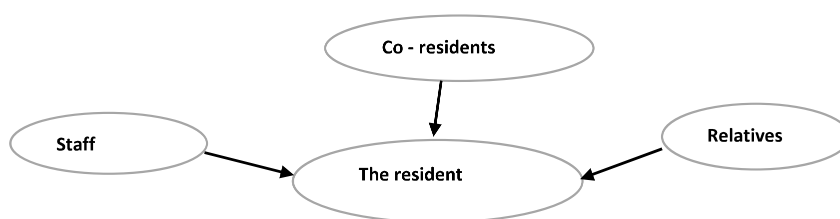
leaders in their municipalities did not have time to participate. Subsequently, a second recruitment e-mail was sent to all nursing home directors in the 6 municipalities that had accepted the invitation. The second recruitment e-mail included 2 invitation letters: one letter to nursing home directors and the other for nursing home directors to forward to care managers in their nursing homes. The care managers were invited to participate in focus group interviews, while the nursing home directors were invited to individual interviews.

The interviews took place in a meeting room in a nursing home in the participating municipalities. Each focus group interview lasted approximately 90 minutes, and each individual interview lasted approximately 60 minutes. Two researchers conducted the focus group interviews. The PhD candidate was the moderator in all six interviews; the main supervisor was co-moderator for two group interviews; and one of the co-supervisors was co-moderator in one group interview. For the other three interviews, two researchers from the larger research team were co-moderators. All 15 individual interviews were conducted by the PhD candidate. The interviews were semi-structured, based on an interview guide where informants were asked to reflect on several main themes, and followed up with open-ended and exploratory questions (187, 189). We used the same interview guide for the focus group interviews with the care managers and the individual interviews with the nursing home directors (Table 3).

During the introductory information for the interviews, we presented a figure (Figure 1) and asked participants about their experiences and thoughts on the topic of elder abuse in relation to healthcare staff, co-residents, or relatives. Participants were encouraged to speak freely. However, during the first focus group interview, we found that participants were not familiar with the topic or the term elder abuse. Hence, to explore the topic in the ensuing interviews, the moderator gave the participants keywords from the categorization of abuse (e.g., abuse can be described as physical, psychological, sexual, financial, or as neglect) (5). We found that this helped the participants to reflect, and they subsequently offered examples of abusive situations they had heard about or witnessed. During the process of data collection, we further compared our experiences in interview one with interview two, which aligns with the constant comparative method (192). This led to including keywords in the interview guide to

ensure that all topics were addressed. To ensure the credibility of an open thematic understanding of participants' experiences and diminish bias by presenting the keywords, we were conscious about letting the participants speak freely about their experiences and thoughts on this topic and participants were not given any definitions of abuse or examples related to these keywords. The participants freely decided in which order they wanted to talk about different forms and situations of elder abuse. All interviews were recorded and transcribed verbatim, retaining pauses and emotional expressions.

Figure 1 Model of interactions where abuse can occur as used in the interviews



Note: Participants chose freely in which order they wanted to talk about the different forms and situations of elder abuse.

Table 3 Interview guide

Topic	Key questions
Introduction	Can you describe what you will define as abuse and neglect in nursing homes?
Your experiences of elder abuse and neglect	Within these situations (fig 1), and these categories; *physical abuse, psychological abuse, financial abuse, sexual abuse and neglect,* can you describe your experience of elder abuse and neglect?
Communication of elder abuse and neglect	Can you describe how you get knowledge about situations of elder abuse and neglect in the nursing home? What do you think are barriers and enablers to reporting elder abuse and neglect?
How to follow up on elder abuse and neglect	When you get knowledge about situations of elder abuse and neglect, how do you follow it up? What do you do to prevent it from happening again?
Closure	Do you have anything to add that has not yet been mentioned? How did you experience participating in this focus group?

4.5 Analysis

The constant comparative method was used for the data analysis of all three papers (191, 192). This method allowed us to generate a thematic understanding through an open exploration of nursing home leaders' perceptions. The constant comparative method facilitated the possible identification of themes and differences between individuals and cases within the data (192). Paper 1 involved one leader level, and we conducted the comparison in two main steps: (a) comparison within a single interview and (b) comparison between interviews. Papers 2 and 3 involved two leader levels, and as we wanted to gain a sense of the distinction between the different roles of leadership, we conducted the comparison in three main steps: (a) comparison within a single interview, (b) comparison between interviews within the same group, and (c) comparison of interviews from different groups (191, 192).

The analysis was initiated immediately following each interview, where the first author listened to the recorded interview. Memo-writing was then used throughout the whole process of data collection and analysis and served as a record of emerging ideas, questions, and categories (191). Next, in line with the constant comparative method, open line-by-line coding of the transcribed interviews was performed (191, 192). (191, 192). The codes were compared for frequencies and commonalities and then clustered to organize data and develop sub-categories. The sub-categories were examined to construct the final categories and main themes. To add credibility and diminish researcher bias, two researchers, namely the PhD candidate and the main supervisor, coded all transcribed interviews independently. During the analysis process, the authors held several meetings where codes and their connections were discussed until consensus was reached. To ensure that the emerging categories and themes fitted the situations explored, we went back and forth between contextualization, data analysis, and memo-writing (192).

4.6 Ethical considerations

Ethical approval for this study was granted by the Norwegian Centre for Research Data (NSD) Nr: 60322. This research study concerns the negative aspects of care given to individuals who are vulnerable due to old age, functional problems, and dependence upon professional care. In addition to general ethical considerations when research involves

individuals, particular care was taken in this study to avoid any discomforting pressure to participate. After each interview, we offered participants a summary, and the researchers provided information about the opportunity to talk about their thoughts and feelings if any had experienced the interview situation as difficult. The research team comprised individuals with professional backgrounds and experience in service delivery and, thereby, were well-informed and capable of assessing difficult situations. Each participant signed a written consent form after receiving oral and written information about the study. All identifiable characteristics are excluded from the presentation of data to ensure the anonymity of all individuals.

5.0 Results and summary of the papers

In this section, the main results of the three papers are presented. Methods and material used in each paper have been presented previously in the methods section.

Paper 1

Elder abuse and neglect: An overlooked patient-safety issue – A focus group study of nursing home leaders' perceptions of elder abuse and neglect

The aim of the study was to explore nursing home leaders' perceptions of elder abuse and neglect. We included 28 nursing home leaders in the role as care managers. Their perceptions of different situations, such as resident-to-resident aggression, relative-to-resident abuse, and staff-to-resident abuse, were explored. However, during the first interview, we experienced that participants were not familiar with the topic of elder abuse. To explore the topic in the ensuing interviews, we gave the participants keywords from the categorization of abuse (e.g., abuse can be described as physical, psychological, sexual, financial, or as neglect). When given keywords, all participants came up with examples of situations they interpreted as harmful or distressful to residents. A summary of the forms of harmful situations reported by participants is presented in Table 4.

Table 4 Examples of forms of abuse as described by care managers

	Co- residents ***"A normal part of nursing home life"***	*Relatives* ***"A private affair"***	Direct Care staff ***"An unthinkable event"***
Physical abuse			
Hitting, kicking, pushing, and throwing things	X		X
Rough handling		X	X
Use of force or restrain		X	X
Psychological abuse			
Verbal abuse	X	X	X
Violation of resident's privacy	X		X
Financial abuse			
Stealing or destroying a resident's assets	X	X	X
Sexual abuse			
Sexual assault	X		X
Neglect			
Neglect of user participation		X	X
Health care neglect			X

Although care managers reported situations they interpreted as harmful to residents, our findings revealed an ambiguity in their examples. The situations, on the one hand, were described as harmful. On the other hand, they were rationalized as care managers attempted to provide excuses for why such incidents were occurring. Three main categories are described in the findings: *Abuse from co-residents – "A normal part of nursing home life"; Abuse from relatives – "A private affair";* and *Abuse from direct care staff – "An unthinkable event."*

Related to resident-to-resident aggression, findings reveal that aggression between nursing home residents was so common that the leaders participating in this study perceived it as a "normal part of nursing home life." Aggression between residents was perceived to be related to residents' dementia disease. Care managers described a lack of strategies for managing aggressive behaviors, and several added that the risk of harm caused by resident-to-resident aggression was something residents must accept when living in a nursing home, which demonstrates the normalization of resident-to-resident aggression. Moreover, this shows a lack of accountability for the complexity of aggressive behaviors and the responsibility of the organization.

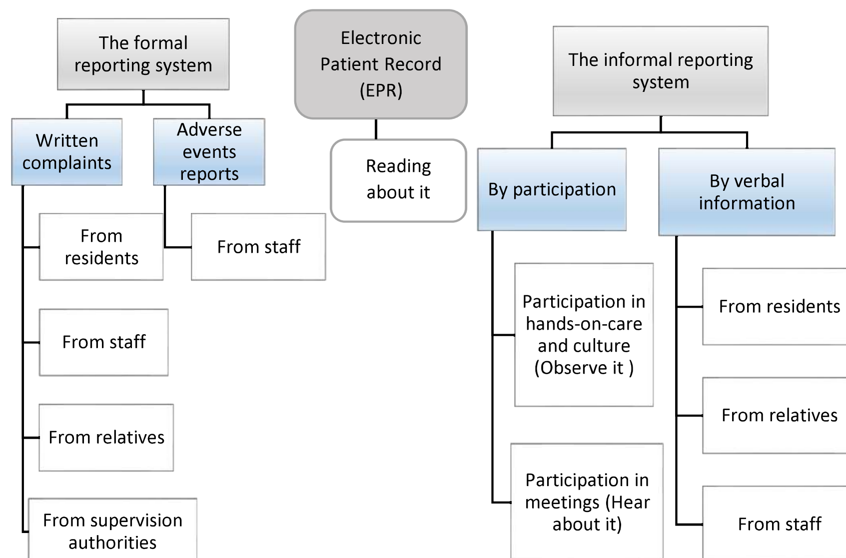
With respect to relative-to-resident abuse, findings demonstrate that care managers viewed negative incidents that resulted in harm or distress as private affair between the resident and his or her relatives, and that it was difficult to intervene. Similar to resident-to-resident abuse, this indicates that care managers place the responsibility for the observed abuse on the relationship between the resident and his or her relatives, without accounting for its complexity and their own agency in these situations. Although several care managers had experience of staff-to-resident abuse within all abuse categories, it was difficult for them to admit this, and such incidents were viewed as "unthinkable events." Instead, care managers were mostly interested in talking about resident-to-staff aggression, which they emphasized was a problem in their nursing homes. Unprovoked or intentional abuse directed toward a resident, therefore, is unthinkable with this justification and their trust in the staff.

Paper 2

Nursing home leaders' perceptions of factors influencing the reporting of elder abuse and neglect: A qualitative study

The aim of this study was to explore factors that influence reporting adverse events related to elder abuse and neglect in nursing homes from the perspective of nursing home leaders. This study included participants from two levels of leadership, namely 15 nursing home directors and 28 care managers. Both nursing home directors and care managers perceived that elder abuse and neglect in their nursing homes were underreported due to difficulties obtaining information from the staff through the formal adverse-event reporting system. At the same time, participants described a variety of ways to obtain information. They referred to formal reports such as written complaints and a computerized adverse-event reporting system. They said that they also obtained information about adverse events by reading the nursing notes in the electronic patient record system. In addition, participants described informal ways of obtaining information and reports of abuse in the nursing home, with care managers receiving verbal information from staff and nursing home directors receiving verbal information from the care managers when present in the ward. We found differences between nursing home directors and ward leaders' perceptions of the feasibility of obtaining information about the magnitude and nature of formal reports of adverse events related to abuse in the nursing home, where nursing home directors had a more positive view of the formal reporting system. An overview of the ways of reporting abuse is presented in Figure 2.

Figure 2 Formal and informal reporting systems



Three main categories of influencing factors were identified: *Organization structural* factors influence what information is communicated about abuse and neglect in the nursing home setting, as well as how the information is communicated. "Closeness to staff and residents," "technology tools," "competing priorities," and "formal education and communication skills" were factors at the organizational and structural levels that the leaders perceived as affecting reports of abuse and neglect. *Cultural factors* were another theme that emerged from our analysis. We found that "perception of what constitutes abuse," "loyalty among staff," and "openness, quality, and safety" were factors within the organizational culture that the leaders perceived as affecting reports of abuse. *Abuse severity factors* comprised the third theme that emerged from our analysis. We found that "forms of abuse" and "internal vs. external reporting" were factors affecting reports of abuse.

Paper 3

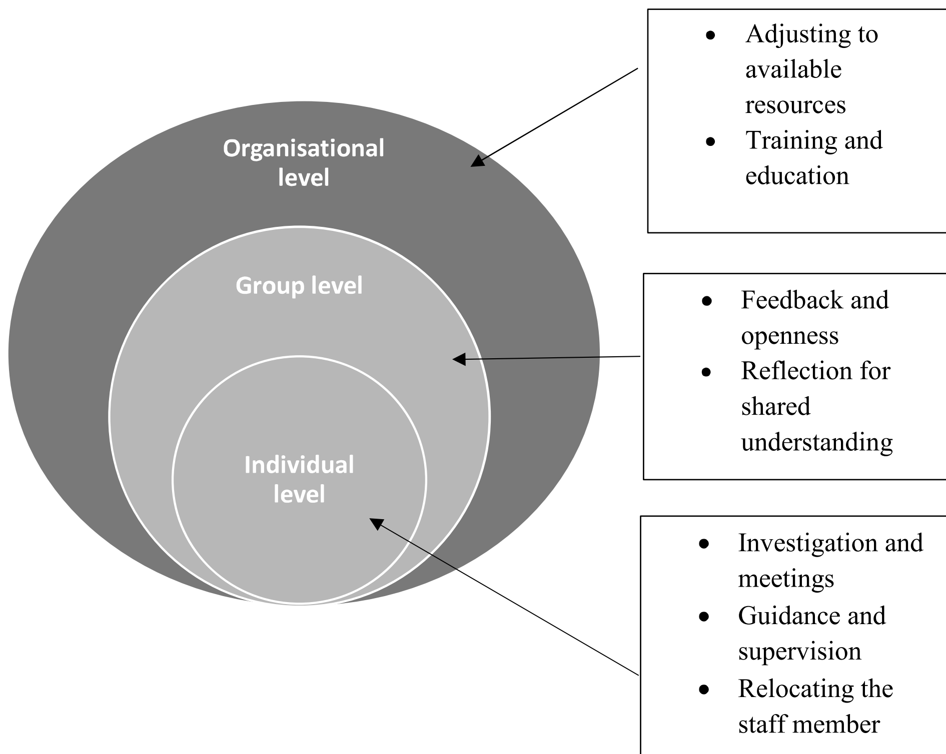
React and act: A qualitative study of how nursing home leaders follow up on staff-to-resident abuse

The aim of this study was to explore how nursing home leaders follow up on reports and information regarding staff-to-resident abuse. This study included participants from two levels of leadership, namely 15 nursing home directors and 28 care managers. Few participants had experienced severe sexual or financial abuse on the part of staff. Most participants had experience mainly in regard to following up on incidents of physical abuse, such as the use of restraint or rough handling during care, psychological abuse, and neglect. Nursing home directors and care managers described measures that were taken on an individual, group, and organizational level. An ambiguity emerged from the nursing home leaders' examples of follow-up measures. On one hand, nursing home leaders indicated their intention to follow up incidents of harm or distress to residents. On the other hand, they found it difficult to define harm stemming from abuse and expressed feeling powerless in regard to being able to follow up on all levels. An additional finding was that they lacked effective tools for evaluating the measures taken, and this influenced how and what leaders actually acted upon.

The findings reveal that nursing home leaders followed up incidents of staff-to-resident abuse on three different levels (Fig. 3). First, on an individual level, participants described staff-to-resident abuse as related primarily to individual characteristics of certain staff members. For example, they stated that some staff members had personalities and/or attitudes that were unsuitable for working with older people in a nursing home. Other factors mentioned as potential contributors to elder abuse included staff's personal problems, lack of knowledge, stress, and burnout. Both care managers and nursing home directors expressed that they did not want information or reports from staff in relation to patient abuse or neglect to be anonymous because they needed to know the name of the person to whom they should speak. "Investigations and meetings," "guidance and supervision," and "relocating the staff member" were noted as ways that the participants followed up on information and reports of

incidents or potential incidents of abuse at the individual level. Second, on a group level, participants stated that caring for residents with dementia and aggressive behaviors was a daily challenge for all staff, especially in regard to residents who resisted care. Therefore, the leaders felt they had to intervene not only for individual staff members but also at a group level. Participants discussed how to define elder abuse and said that the organizational culture influenced what was perceived as acceptable staff behavior. “Feedback and openness” and “reflection for shared understanding” were ways the leaders chose to follow up information and reports of incidents or potential incidents of abuse on a group level. Third, on an organizational level, both care managers and nursing home directors linked abuse to organizational factors such as lack of staff with formal education and knowledge about caring for residents with dementia. Here, care managers and nursing home directors had different perceptions of whether inadequate staffing was a factor related to the incidence of abuse in nursing homes. The sub-categories “adjusting to available resources” and “training and education” emerged as ways the participants follow up on information and reports of incidents or potential incidents of abuse at an organizational level.

Fig. 3 Follow-up on reports and information about abuse and neglect by nursing home leaders



6.0 Discussion

In this section, the main results of papers 1–3 will be discussed by setting the results in the context of other research projects and in relation to theories from complexity science, patient safety, and Foucault's perspectives of power. Next, methodological considerations will be discussed. Finally, a conclusion with implications for practice and suggestions for future research will be outlined.

6.1 Discussion of the findings

The discussion is divided into three sections. The first is a discussion of internal and external demands affecting safety issues such as abuse and neglect. Next, leadership strategies and adjustments aimed to meet internal and external demands in complex organizations are considered. The last section considers the ambiguity of describing and detecting elder abuse and neglect in nursing homes. A model bringing theory and result together will be presented at the end of the discussion.

A core finding in all three papers was a lack of awareness about the concept of elder abuse. Keywords from the categorization of abuse helped the participants to reflect upon the topic, and examples of events they interpreted as being harmful or distressful to residents were disclosed. At the same time, our findings revealed ambiguity in the care manager's examples. On the one hand, care managers described the situations as harmful, while on the other, they presented excuses for why they were happening. This ambiguity in the care managers' examples could be interpreted as an attempt to adapt to internal and external demands, such as residents with complex care needs and aggressive behaviors, low staffing levels in terms of number and education, lack of openness, lack of routines and procedures, and a heavy workload for the leader. In addition, the nursing home leaders are under pressure from external demands in the healthcare system to deliver high-quality services, improve outcomes, and – at the same time – deliver cost-savings and efficacy. These demands were found to affect the reporting of abuse and neglect, how such incidents were followed up, and how abuse and neglect were explained and perceived. When receiving information and reports of abuse and neglect, nursing home leaders use different strategies and adjustments.

For example, they follow up on an individual level, offer feedback and reflection on a group level, and make adjustments to priorities on the organizational level. A difference between the care managers and the nursing home directors was found in their perception of the usefulness of the formal reporting system, where nursing home directors had a more positive view. In addition, we found a difference between the two groups in their beliefs about the root cause of elder abuse. These differences can result in the felt powerlessness we found with care managers in regard to not being able to follow up on all levels. Moreover, the lack of evaluation tools was identified as a barrier for facilitating patient safety and systematic organizational learning. The leaders' adjustments and adaptations can contribute to their reliance on a linear person-approach rather than a systematic approach when they follow up on abuse and neglect within the nursing home context.

6.1.1 Internal and external demands affecting safety issues such as abuse and neglect

Internal and external demands can be understood as latent determinants affecting how abuse is detected, reported, and managed in nursing homes. To implement strategies to prevent elder abuse, knowledge about the context of the nursing homes and how demands affect leaders' daily quality and safety work within this context is critical. Numerous research studies, reports, and white papers have highlighted the importance of leadership in securing quality of care to residents in nursing homes (19, 38, 186, 193, 194). At the same time, translating and implementing such evidence-based research into practice has been pointed out as challenging (195, 196). This can be due to the fact that the literature says little about how contextual factors influence successful quality and safety implementations in nursing homes (136, 197). Even though patient-safety research has revealed numerous quality and safety challenges in nursing homes (136, 137), there is still little research related to safety challenges in this context compared to hospitals (136). Knowledge about these internal and external demands as experienced by nursing home leaders is important for understanding the contextual factors that affect abuse and neglect. Our findings describe several internal demands within the nursing home on the individual, relational, and organizational levels. The pressure in the healthcare system from external demands to provide high-quality services while, at the same time, focusing on cost-savings and efficacy, presumably influenced by attitudes of ageism, was also visible within our findings. In addition, the leaders need to

manage adaptation to these internal and external demands that inevitably occur in the care and safety culture within nursing homes (19, 163).

On a micro level, our findings showed that, it is common for residents to have complex care needs and to display aggressive behaviors, which was described as a factor affecting both staff-to-resident abuse and resident-to-resident aggression. It is worth mentioning that residents in nursing homes often have complex care needs, dementia or other forms of cognitive impairment (45), display challenging behavior (198), and most require care and assistance in the activities of daily living. Aggressive behavior in residents has also been found to be a determinant of abuse in other studies (81, 89, 98). Based on a biopsychosocial approach, aggressive behavior in residents can be understood as an event resulting from complex interactions between biological, psychological and social factors (59, 199). This means that aggressive behavior is multifactorial and complex and can be described as a "wicked problem"(164, 166), which reveals a need for a broad biopsychosocial approach to meet resident's needs. Both national and international guidelines also recommend non-pharmacological interventions based on person-centered care for addressing aggressive behaviors in nursing home residents (60, 200). A Norwegian model called the Targeted Interdisciplinary Model for Evaluation and Treatment of Neuropsychiatric Symptoms (TIME), with a holistic biopsychosocial approach and a person-centered care framework, has shown significant between-group differences in the reduction of aggression in residents in favor of the TIME interventions (194, 199). The consistent implementation of models that have been found to reduce aggressive behaviors could be an important tool for leaders aiming to prevent and reduce abuse in nursing homes.

Related to staff determinants, the leaders in our study stated that abuse by staff was unthinkable. At the same time, if abuse and neglect occurred, they related the events mainly to personality, attitude, personal problems, a lack of knowledge, a lack of ability to communicate in Norwegian, and stress or burnout in individual staff members. Stress or burnout has also been identified as a determinant of abuse and neglect in other studies (81, 95). This has been related to organizational factors such as the staff's perception of a low level of staffing (81, 201) and a lack of coping strategies for working with residents who

exhibit aggressive behaviors (81). A resident's aggressive behavior shown toward staff was stated by the leaders to affect the interpersonal relationships between staff and residents. Prevalence surveys measuring staff-to-resident abuse in nursing homes have also found that staff who had experienced conflicts with residents were more likely to commit abuse (81, 96). Conflict here is defined as aggression from residents toward staff in a given situation. The most frequent conflict reported in staff surveys is managing a resident who is unwilling to undress (81).

However, in institutions, regulations and rules influence times for activities and tasks such as undressing. A task-oriented care culture focuses on getting the job done in a way that supports the institution and the staff but does not prioritize residents' individual wishes. Such a culture can indicate that staff are under pressure and influenced by the need to adhere to healthcare policies that mandate efficiency and cost-savings (26, 121). According to complexity theory, people in complex systems will attempt to adapt to internal and external demands through self-organization (19, 20); this adaptation can have both positive and negative consequences (163). The negative consequences of adaptation are seen when an abnormal culture becomes normal, for example, by accepting the use of physical and/or chemical restraints, rough handling during care, or arguing with a resident to complete a task such as undressing (43). This abnormal culture will normalize abusive behavior and, hence, staff do not report it (43). However, by recognizing this form of negative self-organization, leaders can begin to influence the culture to facilitate better outcomes (19, 20).

An additional factor in our findings, related to the culture, was the loyalty that staff have to each other, which negatively affected the reporting of abuse and neglect. Loyalty among staff has also been identified as a barrier for reporting patient-safety incidents in other studies (28, 37). However, none of those studies have included the perspectives of nursing home leaders. Our findings show that nursing home leaders wanted to identify the individual staff member involved in a situation described in an adverse-event report in order to know who to talk to when following up. The loyalty that leaders experience among staff can be an adaptive strategy to the lack of anonymous incident reporting. According to international

recommendations, anonymous adverse-event reports are important because they prevent a "shaming and blaming culture" (31).

At the organizational level, care managers in our study stated that inadequate staffing was a contributing factor to staff-to-resident abuse and resident-to-resident aggression. On the other hand, nursing home directors pointed to insufficient prioritizing of tasks. Previous research has also found that inadequate staffing in terms of education, numbers, and high turnover were risk factors for elder abuse in nursing homes (7, 21, 81). None of these studies included the perceptions of both care managers and nursing home directors which represents a limitation. Another organizational factor identified in our study was a lack of procedure and routine related to which incidents that should be reported as abuse and where to report them – in the adverse-event reporting system, in the nursing notes, or to the head of personnel services. Without a clear taxonomy of events defined as abuse and neglect, perceptions and understandings of what may endanger patient safety might differ from one nursing home to the next depending on the organizational culture or "the way we do things here" (42, 202).

A difference was found between the care managers and the nursing home directors in their perceptions of the usefulness of the formal reporting system, including a more "positive" view of the adverse-event reporting system from the nursing home directors than from the care managers. This finding is in line with findings of other studies that have found that top leaders have a more positive view of patient safety than other members of the organization (134, 135). This is interesting in relation to the fact that nursing home directors in our study reframe low levels of staffing as being about lack of correct prioritizing from staff. Hence, if the problem is not defined as a problem, the situation will be perceived as more positive.

Among external factors, our findings indicate that leaders are under the influence of healthcare policies that mandate efficacy and cost-savings, such as a nursing home director pointing out that the budget needs to be in balance. In addition, the participants in our study stated that, when nursing home leaders investigate reports and information, they sometimes lacked confidence in the resident's story, which may indicate that nursing home leaders are influenced by attitudes of ageism. Certain behaviors such as abuse or discounting the stories

of people with dementia and failing to notice a lack of adequate staffing in elder care seem to be justified and influenced by attitudes toward ageing in society (118). Patient-safety research has recognized that these roles, such as leadership, are critical to the safety and quality of patient care (38, 163), and the strategies and adjustments leaders apply to meet internal and external demands have consequences for patient safety and quality of care outcomes (19, 38).

6.1.2 Leadership strategies and adjustments in complex organizations

Leadership practice is described as a tool to alter organizational strategies to change and to adapt to external and internal demands (19, 180). This includes the leader's ability to develop a patient-safety culture (38). It has been argued that successful leaders are those who change how people relate to one another (19) and, thereby, change the self-organization and care culture within the nursing home.

Nursing home leaders in our study had experience mainly in following up on incidents of physical abuse, psychological abuse, and neglect by staff. Prevalence studies on abuse in nursing homes have also found psychological abuse and neglect to have the highest prevalence (6, 81). To effectively investigate and follow up on these incidents, leaders need comprehensive information (203). However, our findings demonstrate the difficulty of obtaining information from the formal reporting system. Because of that, nursing home leaders adjust and find other ways to obtain information, such as by reading the nursing notes in the electronic patient-record system or being present in the ward. This can be perceived as an important strategy for increasing the information flow and upholding connections within the organization. Previous research has also found associations between how leaders communicate with and listen to their staff and a low level of staff turnover (184). A study by Anderson et al, (19) explored the relationship between leadership practice and resident outcomes. Their findings showed that a relation-oriented leadership practice, including allowing for openness, greater communication, and participation from all stakeholders in the organization, contributes to better resident outcomes, such as reduced use of restraints and immobility. However, our findings demonstrate that the many competing priorities in the nursing home, in combination with leaders' workloads, hindered care managers from being

present and facilitating openness, information flow, and connection to the staff as much as they wished.

Moreover, our findings revealed that, when incidents of abuse or neglect occurred, nursing home leaders linked these incidents mainly to the individual characteristics of the staff members involved. However, staff-to-resident abuse is a complex multifactorial problem (11, 27). Moving a staff member to another nursing home, which was the reaction of some nursing home leaders to incidents of elder abuse, can be described as a linear solution that does not alter the complexity of the situation or any other internal or external factors within the organization and the culture. This can be described as an example of single-loop learning, where the aim is to just “fix” the problem; yet single-loop learning does not capture the underlying condition leading to the incident that has occurred (159). Hence, neither the individual staff member nor the organization will learn in the long term.

For long-term learning and to prevent incidents such as abuse or neglect, an organization has to undertake what Argyris and Schön’s described as double-loop learning (161). When using double-loop learning, people in the organization start to question the underlying norms, assumptions, and organizational factors that could be determinants of the incident (153, 159, 161). Previous research has also found that, through reflection of adverse events, long-held assumptions that form socially accepted behavior within a culture can be challenged and changed by questioning existing processes and procedures (153, 204, 205). An empirical finding from the use of the TIME model is that, through systematic reflection, staff caring for residents with aggressive behaviors enhanced their coping and learning skills (164, 194). However, although nursing home leaders in our study point to reflection and feedback as important, they also describe difficulties facilitating these forms of learning.

Both nursing home directors and care managers mentioned a lack of evaluation tools to determine whether reflection is the best way to follow up and develop the organizational culture and, thereby, prevent abuse and neglect in nursing homes. It can be questioned if the leaders’ need for evaluation tools is related to the disciplinary process of power that exists in the society (26), and due to that, if reflection involves increased use of resources there is a

need to document the effect when the leaders are examined about their budget. This can be connected to the fact that another barrier to reflection identified in this study was a shortage of resources. National guidelines point to leaders' responsibilities to monitor the overall quality and safety of resident care and to establish a culture of openness where events are reported, openly discussed, and analyzed. These guidelines also point out that the follow-up should include an evaluation of the measures taken in response to an incident (53), yet our findings demonstrate a discrepancy between the strategies pointed out in the guidelines and what leaders actually do.

6.1.3 The ambiguity of describing and detecting elder abuse and neglect in nursing homes

Preventing safety issues, such as abuse and neglect, is connected to the ability to detect and describe such situations (80). Our findings revealed that even though nursing home leaders can cite examples of harmful situations, an ambiguity exists as the nursing home leaders also try to reframe these situations. Abuse from staff was described as a strong term and perceived as "unthinkable," due to the leader's trust in staff and a belief in the staff's intention to be good. At the same time, if situations did occur, nursing home leaders mainly linked them to individual factors in staff members. The nursing home leaders try to reframe staff-to-resident abuse to focus on the verbal and physical aggression they commonly witness from nursing home residents toward staff. This might raise the question of whether the nursing home leaders reframe abuse into picturing the staff as victims. In a cultural understanding of staff as victims, unprovoked or intentional abuse toward a resident can be unthinkable, justified by the trust the leaders have in the staff members. (10, 80).

Furthermore, we found that residents who exhibited aggressive behavior that affected co-residents was so common that the care managers perceived it as "a normal part of nursing home life" and linked it mainly to symptoms of dementia. At the same time, it is worth noting that, in the resident-to-resident aggression, both residents can suffer harm. Due to that, aggressive behavior among nursing home residents is a complex and multifactorial problem (194), where causes, in addition to changes in the brain due to dementia, can be related to, for example, unmet needs, an acute medical condition, pain, over- or under-stimulation, and a lack of knowledge, notice, and communication on the part of the caregiver (59). Nursing

home leaders' perceptions of resident-to-resident aggression as normal puts residents at risk and represents a failure to deliver much-needed care to both residents.

Residents in nursing homes are placed at further risk since relatives with abusive behaviors were found to be perceived as "a private affair" between the resident and his or her relatives due to difficulties of intervention. Elder abuse in nursing homes perpetrated by relatives has been explored only in a study from the Czech Republic (7). At the same time, another study explored family and staff interactions and communication difficulties related to residents who resist care (206). Some of the findings within these studies can be related to our findings, such as a perception of relatives having unrealistic expectations and distrust in the nursing home staff's care and relatives forcing a resident to eat.

The ambiguity in the nursing home leaders' examples can be understood as an attempt to rationalize abuse and reduce their personal and professional accountability. Inadequate resources combined with the complexity of residents' needs, the complex organization, and demands for improved outcomes put intense pressure on nursing home leaders (20, 207). People in complex systems will attempt to make sense of tasks and orders by adapting to internal and external demands (19, 20). Nursing home leaders are not only part of the care culture within the nursing home but also part of the leadership culture in the municipalities and will, therefore, adjust in order to cope with demands affecting both cultures. The leaders in institutions are influenced by what Foucault would call a societal discipline or discourse to provide efficacy and cost-savings (111, 208). In this discourse, nursing home leaders are controlling the staff but are themselves, at the same time, subjected to control. Nursing home leaders constitute the institution and render the system feasible while, at the same time, they also believe that this is the source of their feelings of powerlessness. The question is, then, are they really powerless? It is possible that nursing home directors respond to demands for efficiency and cost-savings by placing the responsibility for preventing abuse on staff members and attributing it to their individual prioritizing instead of using their power to correct systemic defects. In contrast, the care managers generally have less power than nursing home directors, which may result in a feeling of powerlessness when it comes to

correcting system defects. This will, in turn, lead to the normalization of insufficient resources in the nursing home sector (26).

The results of this study revealed the possibility that, even if leaders are aware of abuse and neglect involving co-residents, relatives, and staff members, few of these incidents are actually reported to the health authorities. This may indicate that the severity of abuse and neglect in the nursing home context is minimized and overlooked by nursing home leaders. At the same time, this might align with findings of previous studies that explored abuse from the staff perspective. The review identified a wide range of abusive behaviors but little common understanding of what constitutes elder abuse in nursing homes (22). The difficulty described in the literature related to defining elder abuse and its determinants may reflect the reality, namely that, at its core, elder abuse is hard to predict, difficult to define, and often a symptom of another set of problems, all of which indicate that abuse is, indeed, a wicked problem. In the literature, abuse in nursing homes has also been conceptualized as a specific form of institutional abuse (24) and a setting in which abuse and neglect take place (7). It could be that staff-to-resident abuse is a strong term, as our participants express. The term *institutional abuse* includes a more systemic view of abuse in nursing homes and less "blame" on the individual. In that case, the term *staff-to-resident abuse* should not be used, and hence, *institutional abuse* should be used when we refer to mistreatment in nursing homes. There is a tendency in healthcare organizations to treat patient-safety issues as failings on the part of individual staff members (38, 144). In contrast, a system-based approach focuses on the idea that most patient-safety problems reflect predictable human failings in the context of poorly designed systems (144, 209)

6.1.4 Bringing the results together–The leadership adjustment model to elder abuse in a complex system

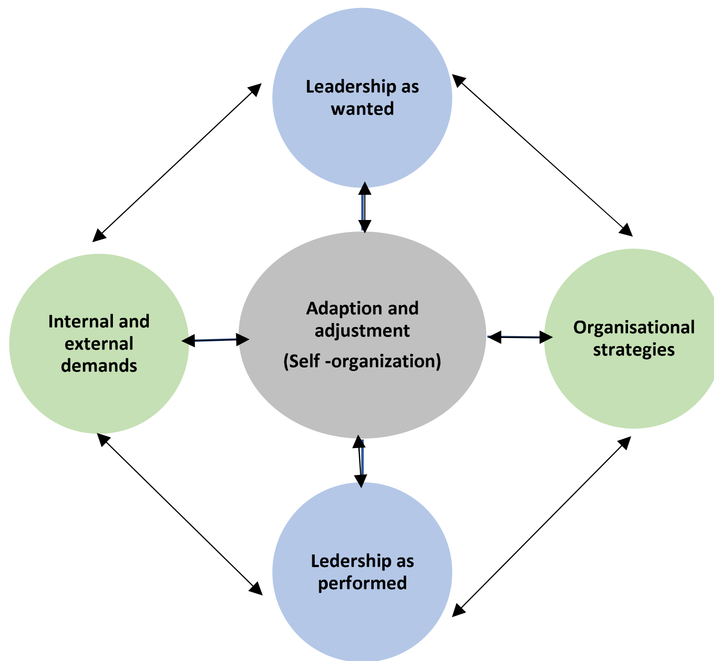
To bring the results together, a model called "the leadership adjustment model to elder abuse in a complex system" was developed. This model connects the empirical findings to theory from complexity science with elements from the theory of power and control, organizational learning, and patient-safety research. However, it should be stated that a model itself is a reduction of the complexity in reality and leads to a loss of information of the whole system

(20). Yet division and reduction into models are, nevertheless, necessary in order to gain an overview of the phenomenon being studied or described (20, 159). In real life, each of the factors within the model will interact with the others in a pattern that is not always predictable.

The ambiguity noticeable in the perspective of the nursing home leaders is conceptualized within the model as the differences between *leadership as wanted* and *leadership as performed*. Leadership as wanted can be understood as the leader's intention or the imagined outcome of the leadership role. Nursing home leaders generally have the intention of creating quality of care and patient safety within their nursing homes. But the leadership role does not exist in a vacuum; it is also shaped and affected by norms and attitudes within the society and the understanding of being a leader within the nursing home context. Leadership intentions are also influenced by ageism and concepts from new public management related to efficacy and cost-savings. Moreover, the nursing home leader's role is affected by the demands in the system, such as a majority of residents with complex care needs; demands for improved resident outcomes; a high rate of staff turnover, including staff on sick leave; and a low level of staffing in terms of number and education, in addition to discipline and demands to provide efficacy and quality.

Nursing home leaders are part of the care culture within the nursing home, but they are also part of the leadership culture in the municipalities and will adjust to cope with demands coming from both cultures. Strategies that have been pointed out as essential for changing self-organization and developing a learning culture in complex organizations are (a) increasing information flow, including both internal and external information; (b) adding more connections among people; and (c) promoting the development of greater diversity in cognitive schemes (159). However, our findings indicate that leadership work is too often characterized by misalignments between demands and the protentional strategies to be used. This can contribute to the understanding of why *leadership as performed*, that is, what leaders actually do, differs from what national and international guidelines say leadership's goals should be (38, 53).

Fig. 4 The leadership adjustment model to elder abuse in a complex system



6.2 Methodological considerations

There are several methodological considerations related to how the method we have used may have influenced the results and interpretation of the findings presented. Methodological concern will be reflected upon and connected to validity, reliability, and transferability (210). Validity and reliability are also referred to as trustworthiness, credibility, dependability, and confirmability. Transferability is used instead of generalization, which refers to judging whether the findings are relevant to similar settings (210).

According to Patton (188), the credibility of an empirical study depends on both a rigorous data-collection method and data analysis, in addition to the credibility and reflexivity of the researchers. To make certain that the results are trustworthy, we took several steps to ensure transparency and to reflect upon any assumptions and perceptions that we as researchers might have brought to the research that could affect the outcome (210). Three of the researchers have experience as care managers, but none of us have experience as nursing home directors. Our experience as care managers may have influenced what we asked about and how we perceived what we heard. This could have threatened the trustworthiness of the findings. At the same time, our experiences may have made it possible to ask follow-up questions that may not have been possible without that background knowledge of the context. In order to enhance the trustworthiness of the findings, two researchers were present at all focus group interviews, and the whole research team was involved in the analyses of data.

The criteria used for recruiting, including, and excluding participants for interviews are important to determine the studies' credibility and transparency. The selection of the municipalities can be described as a convenience sample recruited by sending e-mails to healthcare managers in 11 municipalities from the middle to the south of Norway (188). Healthcare managers from six municipalities accepted the invitation. The choice of including municipalities from the middle to the south of Norway was made because of resources and to minimize travel time and costs for the research team but, at the same time, to strive for a representative sample of nursing home leaders, including those in urban and rural areas.
The sampling of nursing home leaders in these six municipalities was done purposely to permit understanding of the phenomena of elder abuse and of leadership in depth. The aim

was to gain information-rich cases that could bring to light matters of importance (188). But, at the same time, each municipality and its nursing home leaders were recruited using a stepwise approach, as we sought to acquire a theoretical sampling until saturation of data was achieved. There is a need for methodological awareness including the search for deviating cases in qualitative research (188). Care managers for focus group interviews and nursing home directors for individual interviews were included based on a perception of saturation of the meaning of the data. We found that, after the fifth focus group interview and the thirteenth individual interview, no new information was generated.

By gathering information from the perspectives of two levels of leadership, the intention of the present work was to develop a deeper understanding of how nursing home leaders promote safety for their residents and prevent elder abuse in nursing homes. In our study, the care managers were invited to participate in focus group interviews. Focus group interviews are especially useful for studying group experiences (187). The group dynamics allow the questions asked to be discussed from several points of view, and the dynamic can create new perspectives and opinions during the discussion. People's perceptions and experiences are studied as a shared meaning in a culture, recognizing that each person brings to bear the understanding held by colleagues, friends, family, or members of the groups to which he or she belongs (211). Through discussion and responding to questions posed in focus groups, participants can generate new knowledge as a group that can affect individual learning and beliefs (188). However, focus group interviews can also be dominated by participants who attempt to decide on the agenda or who may withhold information to avoid creating friction in the group. In this manner, a weakness of focus groups is that they may develop consensus (187). But based on our observations, we believe that these situations were not occurring in our six focus group interviews. Two researchers were present in each focus group interview, which enhanced trustworthiness. Since the questions and topics, we aimed to address during the interviews were related to negative aspects of care, we were aware that these could be challenging in a group setting. However, the participants' experiences and descriptions were based on their roles as leaders, where a group discussion can be beneficial.
The nursing home directors were invited to participate in individual interviews since there are few nursing home directors in each municipality and gathering them for focus group

interviews was difficult. These interviews were all conducted by one researcher. In individual interviews, the discussion and reflection that emerge in a group setting will be missing. Which can create a difference of the data that arise between focus group interviews and individual interviews. Hence, the use of two data collection methods could be a limitation. But we viewed the advantages of including two level of leadership, using both data collection methods to be greater than the disadvantages. Both methods are suitable for exploring people's experiences with a specific phenomenon (188). Including both care managers and nursing home director' perceptions gave us deeper insight into the relationship between the leadership levels and how, together, they affect the quality of care and patient safety in nursing homes.

The dependability and confirmability of the findings are strengthened by rigor in the analyses. The transcripts of all interviews were coded by two independent researchers, which generated similar codes and themes, increasing the trustworthiness of the findings. The findings were discussed with the research team, which comprised researchers from two different countries and with broad research experience. This discussion lead to different viewpoints during the data coding and strengthened the consistency and dependability of the findings. Discussing findings with different researchers adds confidence in the consistency of the analysis. Transferability is linked to the context in which the research was conducted and the target group or readers of the research (188, 210). For readers to decide whether or not the findings are relevant and can be applied to their situations, a contextual description is necessary (188). Transferability of the present research to a general account of nursing home leaders' perceptions of elder abuse, their experiences with factors affecting reporting, and how they follow up reports of abuse is testable only by attending to further information about this receiving context (188).

6.3 Conclusion and implications for practice

National and international reports and white papers have highlighted the importance of leadership to promote high-quality care and patient safety (38, 64). This thesis reveals in-depth information about key factors of the role of leadership in promoting safety for nursing home residents and preventing elder abuse. Nursing home leaders' perceptions of elder abuse,

their experiences related to barriers and enablers to reporting abuse, and how they follow up on reports and information have been discussed in this thesis. “The leadership adjustment model to elder abuse in a complex system” connects the empirical findings to theory in order to explain the complex work of nursing home leaders. Further research and development of practice should recognize that nursing homes leaders perform their role in complex adaptive systems. It should also be acknowledged that there is a gap between leadership as wanted, according to national and international white papers, and leadership as performed due to adaptations and adjustments to internal and external demands. Strategies used by the nursing home leaders to influence the care culture and self-organization, and to put in place measures on all levels in the nursing home organization are affected by lack of evaluation tools and a felt powerlessness. Thus, there is a need to evaluate whether the strategies and measures being used are effective.

In addition, there is a necessity to clarify the term elder abuse in the context of nursing homes. We suggest using the term institutional abuse, which includes less “blame” on the individual than the term staff-to-resident abuse. In its present form, the Norwegian adverse-event reporting system is not designed to detect abuse and neglect. Also needed is a clear taxonomy that defines what to report regarding abuse and neglect. Nursing home leaders must be given clarification about how they should follow up incidents of elder abuse on different levels in the organization and about their roles in its prevention. They also need evaluation tools to facilitate systematic organizational learning. Moreover, nursing homes must operate as open, blame-free cultures that acknowledge that incidents of elder abuse in patient care arise not only from the actions of individuals but also from the complex everyday life of which they are a part and in which they operate.

6.4 Areas for future research

Elder abuse, patient safety, and leadership are complex multifactorial concepts. The scope of this thesis and the three papers has determined what is presented and, thereby, provides only parts of the total picture. Therefore, there will be aspects of these phenomena that have not been possible to present in this thesis but that should be further studied. Important topics associated with elder abuse could include leadership type and style in relation to how the

leadership is performed and the nursing home context with organizational routines and procedures, staffing and environment, internal culture, and external leadership culture. Additionally, a broader inclusion of interventions designed to prevent aggressive behaviors of nursing home residents toward staff and how this influences interpersonal relationships between staff and residents should be further studied. Knowledge of nursing home leaders' experiences related to positive aspects of care and what they perceive is needed to do more of what is working well could be an interesting safety focus. Intervention studies to explore different leadership strategies and their effects on self-organization and resident outcomes in complex organizations are also needed. Exploring these issues in relation to organizational theory, complexity science, and dementia-care research could provide a broader picture of the role of leadership in promoting safety and preventing elder abuse among nursing home residents.

Exploring and comparing the experiences of nursing home staff, residents, and relatives to nursing home leaders' perspectives of elder abuse and neglect would also add interesting and valuable findings. A relevant research design might entail a survey of nursing home leaders to verify the finding of this study in relation to the factors discussed above. Another methodological approach could be participatory action research with the aim of strengthening nursing home leaders' strategies to prevent abuse in the nursing home context. The differences between care managers and nursing home directors regarding perceptions of patient safety should also be further explored.

References

1. Yunus RM, Hairi NN, Choo WY. Consequences of Elder Abuse and Neglect: A Systematic Review of Observational Studies. Trauma, Violence, & Abuse. 2017;20(2):1-17.
2. Yon Y, Mikton CR, Gassoumis ZD, Wilber KH. Elder abuse prevalence in community settings: a systematic review and meta-analysis. The Lancet Global health. 2017;5(2):147-56.
3. Yon Y, Ramiro-Gonzalez M, Mikton CR, Huber M, Sethi D. The prevalence of elder abuse in institutional settings: a systematic review and meta-analysis. Eur J Public Health. 2018;0:1-10.
4. WHO. [World Health Organization].The Toronto Declaration on the Global Prevention of Elder Abuse Geneva: World Health Organization,; 2002 [Available from: http://apps.who.int/iris/bitstream/10665/42495/1/9241545615_eng.pdf.
5. Working Group on Elder Abuse. Protecting our future, Report: Dublin, The Stationery Office. 2002
6. Botngård A, Eide AH, Mosqueda L, Malmedal W. Elder abuse in Norwegian nursing homes: a cross-sectional exploratory study. BMC Health Services Research. 2020;20(1):1-12.
7. Bužgová R, Ivanová K. Elder abuse and mistreatment in residential settings. Nurs Ethics. 2009;16(1):110-26.
8. Lachs MS, Teresi JA, Ramirez M, van Haitsma K, Silver S, Eimicke JP, et al. The Prevalence of Resident-to-Resident Elder Mistreatment in Nursing Homes. Ann Intern Med. 2016;165(4):229-36.
9. Rosen T, Pillemer K, Lachs M. Resident-to-resident aggression in long-term care facilities: An understudied problem. Aggression and Violent Behavior. 2008;13(2):77-87.
10. Phelan A. Protecting care home residents from mistreatment and abuse: on the need for policy. Risk management and healthcare policy. 2015; 8:215-23.
11. McDonald L, Beaulieu M, Harbison J, Hirst S, Lowenstein A, Podnieks E, et al. Institutional abuse of older adults: what we know, what we need to know. Journal of elder abuse & neglect. 2012;24(2):138-60.
12. Castle N, Ferguson-Rome JC, Teresi JA. Elder abuse in residential long-term care: an update to the 2003 National Research Council report. J Appl Gerontol. 2015;34(4):407-43.
13. Lafferty A, Treacy MP, Fealy G, Drennan J, Lyons I. Older people's experiences of mistreatment and abuse: Dublin: NCPOP, University College, Dublin.; 2012 [Available from: https://www.hse.ie/eng/services/publications/olderpeople/mistreatementandabuse.pdf.
14. WHO. [World Health Organization]. Missing Voices; Views of Oler Persons on Elder Abuse Geneva, 2002 [Available from: https://www.who.int/ageing/publications/missing_voices/en/.
15. Yongjie Y, Mikton C, Wilder K, Gassoumis Z. A research protocol to guide the systematic review and meta-analysis of elder abuse prevalence studies. Canadian Journal on Aging/La Revue canadienne du vieillissement. 2017;36(2):256-65.
16. Ho CS, Wong S-Y, Chiu MM, Ho R. Global prevalence of elder abuse: A metaanalysis and meta-regression. East Asian archives of psychiatry. 2017;27(2):43.
17. Pillemer K, Chen EK, Van Haitsma KS, Teresi J, Ramirez M, Silver S, et al. Resident-to-resident aggression in nursing homes: results from a qualitative event reconstruction study. Gerontologist. 2012;52(1):24-33.
18. Pillemer K, Burnes D, Riffin C, Lachs MS. Elder Abuse: Global Situation, Risk Factors, and Prevention Strategies. Gerontologist. 2016;56 Suppl 2:194-205.
19. Anderson RA, Issel LM, McDaniel Jr RR. Nursing homes as complex adaptive systems: relationship between management practice and resident outcomes. Nurs Res. 2003;52(1):12-21.
20. Cilliers P. Complexity and Postmodernism. London: Routledge; 1998.

21. Cooper C, Dow B, Hay S, Livingston D, Livingston G. Care workers' abusive behavior to residents in care homes: a qualitative study of types of abuse, barriers, and facilitators to good care and development of an instrument for reporting of abuse anonymously. Int Psychogeriatr. 2013;25(5):733-41.
22. Radermacher H, Toh YL, Western D, Coles J, Goeman D, Lowthian J. Staff conceptualisations of elder abuse in residential aged care: A rapid review. Australian journal of ageing,. 2018;37(4):254-67.
23. Goergen T, Beaulieu M. Critical concepts in elder abuse research. Int Psychogeriatr. 2013;25(8):1217.
24. Nerenberg L. Elder abuse prevention: Emerging trends and promising strategies. New York: Springer Publishing Company.; 2007.
25. Pillemer K, Bachman-Prehn R. Helping and hurting: Predictors of maltreatment of patients in nursing homes. Res Aging. 1991;13(1):74-95.
26. Foucault M. Discipline and Punish: The Birth of the Prison. St Ives: Penguin Books.; 1977.
27. Schiamberg LB, Barboza GG, Oehmke J, Zhang Z, Griffore RJ, Weatherill RP, et al. Elder abuse in nursing homes: An ecological perspective. Journal of elder abuse & neglect. 2011;23(2):190-211.
28. Archer S, Hull L, Soukup T, Mayer E, Athanasiou T, Sevdalis N, et al. Development of a theoretical framework of factors affecting patient safety incident reporting: a theoretical review of the literature. BMJ open. 2017;7(12):1-6.
29. National Patient Safety Foundation. Free from Harm, Accelrating Patient Safety Improvment Fifteen Year after To Err is Human (NPSF) Boston: National Patient Safety Foundation (NPSF), ; 2015 [Available from: http://www.ihi.org/resources/Pages/Publications/Free-from-Harm-Accelerating-Patient-Safety-Improvement.aspx.
30. Nakrem S, Vinsnes AG, Harkless GE, Paulsen B, Seim A. Nursing sensitive quality indicators for nursing home care: international review of literature, policy and practice. Int J Nurs Stud. 2009;46(6):848-57.
31. Howell A-M, Burns EM, Hull L, Mayer E, Sevdalis N, Darzi A. International recommendations for national patient safety incident reporting systems: an expert Delphi consensus-building process. BMJ Qual Saf. 2017;26:150-63.
32. WHO. [World Health Organization]. A Global Response to Elder Abuse and Neglect: Building Primary Health Care Capacity to Deal with the Problem Worldwide. Main Report Geneva. 2008 [Available from: https://apps.who.int/iris/handle/10665/43869.
33. Touza Garma C. Influence of health personnel's attitudes and knowledge in the detection and reporting of elder abuse: An exploratory systematic review. Psychosocial Intervention. 2017;26(2):73-91.
34. Cooper C, Selwood A, Livingston G. Knowledge, detection, and reporting of abuse by health and social care professionals: a systematic review. The American Journal of Geriatric Psychiatry. 2009;17(10):826-38.
35. Malmedal W, Hammervold R, Saveman BI. To report or not report? Attitudes held by Norwegian nursing home staff on reporting inadequate care carried out by colleagues. Scandinavian journal of public health. 2009;37(7):744-50.
36. Wagner LM, Damianakis T, Pho L, Tourangeau A. Barriers and facilitators to communicating nursing errors in long-term care settings. Journal of patient safety. 2013;9(1):1-7.
37. Moore S. reasons for staff failure to report abuse of residents in nursing homes. Nurs Times. 2017;113(7):53-7.

38. American College of Healthcare Executives, The National Patient Safety Foundation, Institute for Healthcare Improvement. Leading a culture of safety. A blueprint for success, 2017 [Available from: https://www.osha.gov/shpguidelines/docs/Leading_a_Culture_of_Safety-A_Blueprint_for_Success.pdf
39. Sokol-Hessner L, Folcarelli PH, Annas CL, Brown SM, Fernandez L, Roche SD, et al. A Road Map for Advancing the Practice of Respect in Health Care: The Results of an Interdisciplinary Modified Delphi Consensus Study. The Joint Commission Journal on Quality and Patient Safety. 2018;44:463–76.
40. Pilbeam C, Doherty N, Davidson R, Denyer D. Safety leadership practices for organizational safety compliance: Developing a research agenda from a review of the literature. Safety science. 2016;86:110-21.
41. Brady G, Pamela,, Cummings GG. The influence of nursing leadership on nurse performance: a systematic literature review. J Nurs Manag. 2010;18(4):425-39.
42. Braithwaite J, Herkes J, Ludlow K, Testa L, Lamprell GJBo. Association between organisational and workplace cultures, and patient outcomes: systematic review. BMJ open. 2017;7(11):1-11.
43. Pickering CEZ, Nurenberg K, Schiamberg L. Recognizing and Responding to the "Toxic" Work Environment: Worker Safety, Patient Safety, and Abuse/Neglect in Nursing Homes. Qual Health Res. 2017;27(12):1870-81.
44. SSB [Statistics Norway]. Nøkkeltall for helse i Norge [Key number for health care in Norway]. Statistisk Sentralbyrå SSB; 2019 [Available from: https://www.ssb.no/helse/nokkeltall.
45. Helvik A-S, Selbæk G, Benth JŠ, Røen I, Bergh S. The course of neuropsychiatric symptoms in nursing home residents from admission to 30-month follow-up,. PLoS One. 2018;13(10):1-18.
46. Røen I, Selbæk G, Kirkevold Ø, Engedal K, Testad I, Bergh S. Resource Use and Disease Course in dementia-Nursing Home (REDIC-NH), a longitudinal cohort study; design and patient characteristics at admission to Norwegian nursing homes. BMC Health Serv Res. 2017;17(1):365.
47. Helvik A-S, Engedal K, Benth JŠ, Selbæk G. Prevalence and severity of dementia in nursing home residents. Dement Geriatr Cogn Disord. 2015;40(3-4):166-77.
48. Helse-og omsorgsdepartementet. [The Norwegian Ministry of Health and Care Services]. Egenbetaling for kommunale tjenester i og utenfor instiusjon [User fees for primary care in and outside institution] 2014 [Available from: https://www.regjeringen.no/no/tema/helse-og-omsorg/helse--og-omsorgstjenester-i-kommunene/innsikt/egenbetaling-i-og-utenfor-institusjon/id434597/.
49. Helse- og omsorgsdepartementet. [The Norwegian Ministry of Health and Care Services]. Forskrift for sykehjem og boform for heldøgns omsorg og pleie [National regulations for nursing homes and residential care] 1998 [updated 21.06.2013. Available from: https://lovdata.no/dokument/SF/forskrift/1988-11-14-932.
50. Helse- og omsorgsdepartementet [The Norwegian Ministry of Health and Care Services]. Forskrift om kvalitet i pleie-og omsorgstjenestene [Regulations of the Quality of the Health Care Services], 2003 [Available from: https://lovdata.no/dokument/SF/forskrift/2003-06-27-792.
51. Bing-Jonsson PC, Hofoss D, Kirkevold M, Bjørk IT, Foss C. Sufficient competence in community elderly care? Results from a competence measurement of nursing staff. BMC Nurs. 2016;15(1):5.
52. Gautun H, Bratt C. Planlagt og faktisk bemanning i sykehjem og hjemmesykepleien 2012 [Available from: http://www.fafo.no/media/com_netsukii/20232.pdf.

53. Helse-og omsorgsdepartementet [The Norwegian Ministry of Health and Care Services]. Forskrift om ledelse og kvalitetsforbedringer i helse og omsorgstjenesten [Regulation of management and qualityimprovement in health care services]; 2017. Available from: https://lovdata.no/dokument/LTI/forskrift/2016-10-28-1250.
54. Nakrem S. Measuring quality of care in nursing home-what matters? Doctoral thesis. 2011. Available from: https://ntnuopen.ntnu.no/ntnu-xmlui/handle/11250/264458
55. Nakrem S, Vinsnes AG, Seim A. Residents' experiences of interpersonal factors in nursing home care: a qualitative study. Int J Nurs Stud. 2011;48(11):1357-66.
56. Nakrem S, Vinsnes AG, Harkless GE, Paulsen B, Seim A. Ambiguities: residents' experience of 'nursing home as my home'. Int J Older People Nurs. 2013;8(3):216-25.
57. Vinsnes AG, Nakrem S, Harkless GE, Seim A. Quality of care in Norwegian nursing homes–typology of family perceptions. J Clin Nurs. 2012;21(1-2):243-54.
58. Kirkevold Ø, Engedal K. Quality of care in Norwegian nursing homes–deficiencies and their correlates. Scand J Caring Sci. 2008;22(4):560-7.
59. Kales HC, Gitlin LN, Lyketsos CG. Management of neuropsychiatric symptoms of dementia in clinical settings: recommendations from a multidisciplinary expert panel. JAGS. 2014;62(4):762-9.
60. Helsedirektoratet [The Norwegian Directorate of Health]. Nasjonal faglig retningslinje om demens [Norwegian National Guidline on Dementia], Available from; https://www.helsedirektoratet.no/retningslinjer/demens. In: Helsedirektoratet, editor. Oslo.2017.
61. Røen I, Kirkevold Ø, Testad I, Selbæk G, Engedal K, Bergh S. Person-centered care in Norwegian nursing homes and its relation to organizational factors and staff characteristics: A cross-sectional survey. 2018;30(9):1279-90.
62. Helse- og omsorgsdepartementent. [The Norwegian Ministry of Health and Care Services]. Fremtidens primærhelsetjeneste-nærhet og helhet. (St meld. 26 2014- 2015) [The primary health service of the future - proximity and wholeness], Oslo: Departementenes servicesenter; 2015 [Available from: https://www.regjeringen.no/no/dokumenter/meld.-st.-26-2014-2015/id2409890/.
63. Helsetilsynet. [The Norwegian board of health]. Tilsynsmelding 2012 [Supervision report]. Oslo: Statens Helsetilsyn; 2013 [Available from: https://www.helsetilsynet.no/publikasjoner/tilsynsmelding/2012/.
64. Helse- og omsorgsdepartementet. [The Norwegian Ministry of Health and Care Services]. Kvalitet og pasientsikkerhet 2013 [Quality and patient safety 2013] (St.meld. nr. 11 2014–2015). Oslo: Departementenes servicesenter.2013 [Available from: https://www.regjeringen.no/no/dokumenter/Meld-St-11-20142015/id2345641/.
65. Riksrevisjonen [Office of the Auditor General]. Riksrevisjonens undersøkelse av tilgjengelighet og kvalitet i eldreomsorgen [Office of the Auditor General examination of accessibility and quality of care for the elderly] 2018-2019 [Available from: https://www.riksrevisjonen.no/globalassets/rapporter/no-2018-2019/tilgjengelighetkvaliteteldreomsorgen.pdf.
66. International Council of Nurses. The ICN code of ethics for nurses. Geneva: ICN. 2006 [Available from: https://www.icn.ch/sites/default/files/inline-files/2012_ICN_Codeofethicsfornurses_%20eng.pdf.
67. Helse- og omsorgsdepartementet. [The Norwegian Ministry of Health and Care Services]. Helsepersonale loven, No. 64 relating to Health Personnel etc. [Health Personnel Act. with legislative work], 1999 [Available from: https://lovdata.no/dokument/NL/lov/1999-07-02-64
68. Hofstad E. Avvik stoppes og avvises [Adverse events are stopped and rejected]. Sykepl Fag. 2015;10(3):32-7.

69. Helse- og omsorgsdepartementet. [The Norwegian Ministry of Health and Care Services]. Lov om kommunale helse- og omsorgstjenester m.m. [The municipalities health and care service act] 2011 [Available from: https://lovdata.no/dokument/NL/lov/2011-06-24-30.
70. Baker AA. Granny- battering. Modern Geriatrics. 1975;5:20-4.
71. Burston GR. Letter: Granny battering. Br Med J. 1975;3(5983):592.
72. Mysyuk Y, Westendorp RG, Lindenberg J. Added value of elder abuse definitions: a review. Ageing Research Reviews. 2013;12(1):50-7.
73. Wallace RB, Crabb VL. Toward definitions of elder mistreatment. In: Dong X, red. Elder Abuse, Research, Practice abd Policy. Chicago: Springer; 2017. p. 3-20.
74. Roberto KA. The complexities of elder abuse. Am Psychol. 2016;71(4):302.
75. Roberto KA. Theorizing Elder abuse. In: Dong X, red. Elder Abuse, Research, Practice abd Policy. Chicago: Springer; 2017. p. 21-44.
76. Hall JE, Karch DL, Crosby A. Uniform definitions and recommended core data elements for use in elder abuse surveillance. Version 1.0. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention; 2016.
77. Bonnie RJ, Wallace RB, Council NR. Consepts, definitions and guidelines for measurement. In: Bonnie. RJ, Wallace. RB, editors. Elder mistreatment: Abuse, neglect and exploitation in an aging America. Washington, DC: The National Academies Press: National Research Council (US)Panel to Review Risk and Prevalence of Elder Abuse and Neglect.; 2003. p. 34- 59.
78. Manthorpe J, Perkins N, Penhale B, Pinkney L, Kingston P. Select questions: considering the issues raised by a Parliamentary Select Committee Inquiry into elder abuse. J Adult Prot. 2005;7(3):19.
79. Fulmer T, O'Malley T. The difficulty of defining abuse and neglect. Inadequate care of the elderly New York: Springer Publishing. 1987:13-24.
80. Phelan A. The role of the nurse in detecting elder abuse and neglect: current perspectives. Nursing: Research and Reviews. 2018;8:15-22.
81. Drennan J, Lafferty A, Treacy MP, Fealy G, Phelan A, Lyons I, et al. Older people in residential care settings: Results of a national survey of staff-resident interactions and conflicts. Dublin: NCPOP University College, 2012.
82. Bennett G, Kingston P, Penhale B. The dimensions of elder abuse: perspectives for practitioners. London: Macmillan International Higher Education Press LTD; 1997.
83. Dunn P. No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse: Department of Health; 2000. Available from: https://www.gov.uk/government/publications/no-secrets-guidance-on-protecting-vulnerable-adults-in-care
84. Rosen T, Lachs MS, Teresi J, Eimicke J, Van Haitsma K, Pillemer K. Staff-reported strategies for prevention and management of resident-to-resident elder mistreatment in long-term care facilities. Journal of elder abuse & neglect. 2016;28(1):1-13.
85. Ellis JM, Teresi JA, Ramirez M, Silver S, Boratgis G, Kong J, et al. Managing resident-to-resident elder mistreatment in nursing homes: the SEARCH approach. J Contin Educ Nurs. 2014;45(3):112-21
86. Erlingsson CL, Saveman B-I, Berg AC. Perceptions of Elder Abuse in Sweden: Voices of Older Persons. Brief Treatment & Crisis Intervention. 2005;5(2).
87. Harnett T, Jönson H. That's not my Robert! Identity maintenance and other warrants in family members' claims about mistreatment in old-age care. Ageing & Society. 2010;30(4):627-647.
88. Lachs MS, Pillemer K. Elder abuse. The Lancet. 2004;364(9441):1263-1272.

89. Shinoda-Tagawa T, Leonard R, Pontikas J, McDonough JE, Allen D, Dreyer PI. Resident-to-resident violent incidents in nursing homes. JAMA. 2004;291(5):591-8.
90. Botngard A, Eide AH, Mosqueda L, Malmedal W. Resident-to-resident aggression in Norwegian nursing homes: a cross-sectional exploratory study. BMC Geriatr. 2020;20(1).
91. Mosqueda L, Burnight K, Gironda MW, Moore AA, Robinson J, Olsen B. The Abuse Intervention Model: A Pragmatic Approach to Intervention for Elder Mistreatment. J Am Geriatr Soc. 2016;64(9):1879-83.
92. Ostaszkiewicz J. A conceptual model of the risk of elder abuse posed by incontinence and care dependence. Int J Older People Nurs. 2017;00: 1-11.
93. Wang J-J. Psychological abuse behavior exhibited by caregivers in the care of the elderly and correlated factors in long-term care facilities in Taiwan. The journal of nursing research: 2005;13(4) :271-80.
94. Corbi G, Grattagliano I, Ivshina E, Ferrara N, Solimeno Cipriano A, Campobasso CP. Elderly abuse: risk factors and nursing role. Intern Emerg Med. 2015;10(3):297-303.
95. Kamavarapu YS, Ferriter M, Morton S, Vollm B. Institutional abuse - Characteristics of victims, perpetrators and organsations: A systematic review. Eur Psychiatry. 2017;40:45-54.
96. Malmedal W, Hammervold R, Saveman B-I. The dark side of Norwegian nursing homes: factors influencing inadequate care. The Journal of Adult Protection. 2014;16(3):133-51.
97. Cohen-Mansfield J, Werner P. Longitudinal predictors of non-aggressive agitated behaviors in the elderly. Int J Geriatr Psychiatry. 1999;14(10):831-44.
98. Dong XQ. Elder abuse: systematic review and implications for practice. J Am Geriatr Soc. 2015;63(6):1214-38.
99. McCool JJ, Jogerst GJ, Daly JM, Xu Y. Multidisciplinary reports of nursing home mistreatment. J Am Med Dir Assoc. 2009;10(3):174-80.
100. Kane RL, Bershadsky B, Kane RA, Degenholtz HH, Liu J, Giles K, et al. Using resident reports of quality of life to distinguish among nursing homes. The Gerontologist. 2004;44(5):624-32.
101. Castle NG, Fogel B. Characteristics of nursing homes that are restraint free. Gerontologist. 1998;38(2):181-8.
102. Gibbs LM, Mosqueda L. Confronting elder mistreatment in long-term care. Annals of Long Term Care. 2004;12:30-40.
103. Lachs M, Bachman R, Williams CS, O'leary JR. Resident-to-resident elder mistreatment and police contact in nursing homes: Findings from a population-based cohort. J Am Geriatr Soc. 2007;55(6):840-5.
104. Rosen T, Lachs MS, Bharucha AJ, Stevens SM, Teresi JA, Nebres F, et al. Resident-to-resident aggression in long-term care facilities: Insights from focus groups of nursing home residents and staff. J Am Geriatr Soc. 2008;56(8):1398-408.
105. Murphy B, Bugeja L, Pilgrim J, Ibrahim JE. Deaths from Resident-to-Resident Aggression in Australian Nursing Homes. J Am Geriatr Soc. 2017;65(12):2603-2609.
106. Caspi E. The circumstances surrounding the death of 105 elders as a result of resident-to-resident incidents in dementia in long-term care homes. Journal of elder abuse & neglect. 2018;30(4):284-308.
107. Dyer CB, Pavlik VN, Murphy KP, Hyman DJ. The high prevalence of depression and dementia in elder abuse or neglect. J Am Geriatr Soc. 2000;48(2):205-8.
108. Pillemer K. Elder abuse is caused by the deviance and dependence of abusive caregivers. Current controversies on family violence. 2004:207-20.
109. Lachs MS, Berkman L, Fulmer T, Horwitz RI. A prospective community-based pilot study of risk factors for the investigation of elder mistreatment. J Am Geriatr Soc. 1994;42(2):169-73.

110. Dreyfus HL, Rabinow P. Michel Foucault: Beyond structuralism and hermeneutics: Chicago: University of Chicago Press; 2014.
111. Henderson A. Power and knowledge in nursing practice: the contribution of Foucault. J Adv Nurs. 1994;20(5):935-9.
112. Juritzen TI. Omsorgsmakt: Foucaultinspirerte studier av maktens hvordan i sykehjem. Doctoral thesis. 2013. Available from: https://www.duo.uio.no/handle/10852/34724
113. Hacking I. Between Michel Foucault and Erving Goffman: between discourse in the abstract and face-to-face interaction. Economy and society. 2004;33(3):277-302.
114. Alvsvåg H. Philosophy of caring. In: Alligood R, Martha, editor. Nursing theorists and their work-e-book. St. Louis Missouri: Elsevier; 2018. p. 136-55.
115. Martinsen K. Omsorg i sykepleien-en moralsk utfordring. I: Fokus på sygeplejen 90. red. Bente Persson, Jytte Pedersen, Ruth Truelsen 1989. s: 181-210. København: Munksgaard. 1989.
116. Løgstrup KE. Den etiske fordring [The ethical demand]. Copenhagen, Denmark: Gyldendalske Boghandel Nordisk Forlag. 1956.
117. Roscigno VJ, Mong S, Byron R, Tester G. Age discrimination, social closure and employment. Soc Forces. 2007;86(1):313-34.
118. Phelan A. Elder abuse, ageism, human rights and citizenship: Implications for nursing discourse. Nurs Inq. 2008;15(4):320-9.
119. Band-Winterstein T. Health care provision for older persons: the interplay between ageism and elder neglect. J Appl Gerontol. 2015;34(3):113- 127.
120. Pollitt C, Bouckaert G. Public management reform: A comparative analysis of NPM, the Neo-Weberian State, and New Public Governance. Oxford: Oxford University Press; 2011.
121. Foucault M. The Archaeology of Knowledge [1969], trans. by AM Sheridan Smith. Abingdon: Routledge. 2002.
122. Harrow Council Institutional Abuse ND. Available from: http://www.harrow.gov.uk/info/200184/adults_at_risk/749/institutionalabuse Accessed August 20 2020
123. McGlone E, Fitzgerald F. Perceptions of ageism in health and social services in Ireland. Dublin: National Council on Ageing and Older People. 2005.
124. Gautun H, Grødem AS, Hermansen Å. Hvordan fordele omsorg. Utfordringer med å prioritere mellom yngre og eldre brukere. Oslo: FAFO, 2012.
125. Institute of Medicine (US), Committee on Quality of Health Care in America. Crossing the quality chasm: A new health system for the 21st century,. Washington (DC),: National Academies Press; 2001.
126. Donabedian A. An introduction to quality assurance in health care: Oxford: University Press; 2002.
127. Donabedian A. The definition of quality and approaches to its assessment. Explorations in quality assessment and monitoring; New York; Health Administration Press; 1980
128. Rygh LH, Helgeland J, Braut GS, Bukholm G, Fredheim N, Frich JC, et al. Forslag til rammeverk for et nasjonalt kvalitetsindikatorsystem for helsetjenesten. 2010. Available from: https://www.fhi.no/publ/2010/forslag-til-rammeverk-for-et-nasjonalt-kvalitetsindikatorsystem-for-helsetj/
129. Donaldson MS, Corrigan JM, Kohn LT. To err is human: building a safer health system: Washington:National Academies Press; 2000.

130. Helse- og omsorgsdepartementet. [The Norwegian Ministry of Health and Care Services]. Melding til Stortinget nr. 10 (2012 - 2013) God kvalitet- trygge tjenester. Kvalitet og pasientsikkerhet i helse og omsorgstjenesten. [Quality and patient safety in the health and care service] Oslo: Helse- og omsorgsdepartementet 2012 [Available from: https://www.regjeringen.no/no/dokumenter/meld-st-10-20122013/id709025/.
131. Saunes IS, Svendsby PO, Mølstad K, Thesen J. Kartlegging av begrepet pasientsikkerhet [Mapping the concept of patient safety] Oslo: Nasjonalt kunnskapssenter for helsetjenester; 2010 [Available from: https://www.fhi.no/globalassets/dokumenterfiler/notater/2010/notat_2010_kartlegging-av-begrepet-pasientsikkerhet_v2.pdf.
132. Cappelen K, Aase K, Storm M, Hetland J, Harris A. Psychometric properties of the Nursing Home Survey on Patient Safety Culture in Norwegian nursing homes. BMC Health Serv Res. 2016;16:446.
133. Ree E, Wiig S. Employees' perceptions of patient safety culture in Norwegian nursing homes and home care services. BMC Health Serv Res. 2019;19(1):1-7.
134. Castle NG, Wagner LM, Sonon K, Ferguson-Rome JC. Measuring administrators' and direct care workers' perceptions of the safety culture in assisted living facilities. The Joint Commission Journal on Quality and Patient Safety. 2012;38(8).
135. Castle NG, Wagner LM, Ferguson JC, Handler SM. Safety culture of nursing homes: Opinions of top managers. Health Care Manage Rev. 2011;36(2):175.
136. Simmons SF, Schnelle JF, Sathe NA, Slagle JM, Stevenson DG, Carlo ME, et al. Defining Safety in the Nursing Home Setting: Implications for Future Research. J Am Med Dir Assoc. 2016;17(6):473-81.
137. Simmons S, Schnelle J, Slagle J, Sathe NA, Stevenson D, Carlo M, et al. AHRQ Comparative Effectiveness Technical Briefs. Resident Safety Practices in Nursing Home Settings. Rockville (MD): Agency for Healthcare Research and Quality (US); 2016.
138. Reader TW, Gillespie A. Patient neglect in healthcare institutions: a systematic review and conceptual model. BMC Health Serv Res. 2013;13:156.
139. Lee SE, Scott LD, Dahinten VS, Vincent C, Lopez KD, Park CG. Safety Culture, Patient Safety, and Quality of Care Outcomes: A Literature Review. West J Nurs Res. 2017: 00(0):1-26.
140. Andersson A, Frank C, Willman AML, Sandman PO, Hansebo G. Factors contributing to serious adverse events in nursing homes. J Clin Nurs. 2017;27(1-2):354-3622.
141. Sokol-Hessner L, Folcarelli PH, Sands KE. Emotional harm from disrespect: the neglected preventable harm. BMJ Qual Saf. 2015;24:550–3.
142. Cooper J, Williams H, Hibbert P, Edwards A, Butt A, Wood F, et al. Classification of patient-safety incidents in primary care. Bull World Health Organ. 2018;96(7):498.
143. WHO. [World Health Organisation]. Conseptual Framwork for the international classification for patient safety. 2009. Available at: http://www.who.int/patientsafety/taxonomy/icps_full_report.pdf
144. Reason J. Human error: models and management. BMJ. 2000;320(7237):768-70.
145. Vincent C. Patient safety. Chichester: John Wiley & Sons; 2010.
146. Stewart K, Wyatt R, Conway J. Unprofessional behaviour and patient safety. The International Journal of Clinical Leadership 2011;17(2):93–101.
147. Donaldson L. An Organisation with a Memory: Learning from Adverse Events in the NHS. Chaired by the chief medical officer. London UK: The Stationery Office; 2000.
148. Stavropoulou C, Doherty C, Tosey P. How Effective Are Incident-Reporting Systems for Improving Patient Safety? A Systematic Literature Review. Milbank Q. 2015;93(4):826-66.

149. Mahajan R. Critical incident reporting and learning. Br J Anaesth. 2010;105(1):69-75.
150. Wagner LM, Castle NG, Handler SM. Use of HIT for adverse event reporting in nursing homes: barriers and facilitators. Geriatr Nurs. 2013;34(2):112-5.
151. Moore S. See no evil, hear no evil, speak no evil? Underreporting of abuse in care homes. The Journal of Adult Protection. 2016;18(6).
152. Health Quality Ontario. Patient Safety Learning Systems: A Systematic Review and Qualitative Synthesis. Ont Health Technol Assess Series. 2017;17(3):1-23.
153. Argyris C, Schön DA. Organizational learning II: Theory, method and practice. Massachusetts: Addison-Wesley Publishing Company; 1996.
154. Fiol CM, Lyles MA. Organizational learning. Acad Manage Rev. 1985;10(4):803-13.
155. Huber GP. Organizational learning: The contributing processes and the literatures. Organization science. 1991;2(1):88-115.
156. Lave J, Wegner E. Situated learning: Legitimate peripheral participation. New York, 1991. Cambridge University Press.
157. Argyris C, Schön DA. A theory of action perspective. Boston: Addison-Wesley Publishing Company; 1978.
158. Argyris C. Double-loop learning, teaching, and research. Academy of management learning & education. 2002;1(2):206-18.
159. Stacey RD. Complexity and creativity in organizations: San Francisco: Berrett-Koehler Publishers; 1996.
160. Andrew R. "Free lessons" in aviation safety. Aircraft Engineering and Aerospace Technology. 2004;76(5):467-71.
161. Argyris C. Single-loop and double-loop models in research on decision making. Adm Sci Q. 1976;21:363-75.
162. Senge PM. The art and practice of the learning organization. New York: Doubleday; 1990.
163. Anderson J, Ross A, Macrae C, Wiig S. Defining adaptive capacity in healthcare: A new framework for researching resilient performance. Appl Ergon. 2020;87:103111.
164. Lichtwarck B, Myhre J, Goyal AR, Rokstad AMM, Selbaek G, Kirkevold Ø, et al. Experiences of nursing home staff using the targeted interdisciplinary model for evaluation and treatment of neuropsychiatric symptoms (TIME)–a qualitative study. Aging & mental health. 2018;23(8):966-75.
165. Burns D, Hyde P, Killett A. Wicked problems or wicked people? Reconceptualising institutional abuse. Sociol Health Illn. 2013;35(4):514-28.
166. Rittel HW, Webber MM. Dilemmas in a general theory of planning. Policy sciences. 1973;4(2):155-69.
167. Spencer F. Turning wicked problems into wicked opportunities. Accessed on. 2016;14(07).
168. Conklin J. Dialogue mapping. Building Shared Understanding of Wicked Problems West Sussex, England: John Wiley & Sons. 2006.
169. Baker PR, Francis DP, Mohd Hairi NN, Othman S, Choo WY. Interventions for preventing elder abuse: applying findings of a new Cochrane review. Age Ageing. 2017;46(3):346-8.
170. Ayalon L, Lev S, Green O, Nevo U. A systematic review and meta-analysis of interventions designed to prevent or stop elder maltreatment. Age Ageing. 2016;45(2):216-27.
171. Jacobsen FF, Mekki TE, Førland O, Folkestad B, Kirkevold Ø, Skår R, et al. A mixed method study of an education intervention to reduce use of restraint and implement person-centered dementia care in nursing homes. BMC Nurs. 2017;16(1):55.
172. Anderson J, Ross A, Back J, Duncan M, Snell P, Walsh K, et al. Implementing resilience engineering for healthcare quality improvement using the CARE model: a feasibility study protocol. Pilot and feasibility studies. 2016;2(1):61.

173. Gartshore E, Waring J, Timmons S. Patient safety culture in care homes for older people: a scoping review. BMC Health Serv Res. 2017;17(1):752.
174. Castle NG, Handler S, Engberg J, Sonon K. Nursing home administrators' opinions of the resident safety culture in nursing homes. Health Care Manage Rev. 2007;32(1):66-76.
175. Schein EH. Organizational culture and leadership (Tird edition): San Francisco:John Wiley & Sons; 2010.
176. Kitwood T. Dementia reconsidered: The person comes first. Birmingham: Open University Press.; 1997. 7-19 p.
177. Kitwood T, Bredin K. Towards a theory of dementia care: personhood and well-being. Ageing & Society. 1992;12(3):269-87.
178. Killett A, Burns D, Kelly F, Brooker D, Bowes A, La Fontaine J, et al. Digging deep: how organisational culture affects care home residents' experiences. Ageing & Society. 2016;36(1):160-88.
179. Antonakis J, Day DV. Leadership: Past, present, and future. In: Antonakis J, Day DV, editors. The nature of leadership. Los Angeles: Sage Publications Inc; 2018. p. 3-26.
180. Haynes P. Managing complexity in the public services: New York: Routledge; 2015.
181. Mintzberg H. The nature of managerial work. New York: Harper & Row; 1973..
182. Northouse PG. Leadership: Theory and practice: London: Sage publications; 2018.
183. Wong CA, Cummings GG, Ducharme L. The relationship between nursing leadership and patient outcomes: a systematic review update. J Nurs Manag. 2013;21(5):709-24.
184. Donoghue C, Castle NG. Leadership styles of nursing home administrators and their association with staff turnover. The Gerontologist. 2009;49(2):166-74.
185. Bravo G, Wals PD, Dubois M-F, Charpentier M. Correlates of care quality in long-term care facilities: A multilevel analysis. The Journals of Gerontology Series B: Psychological Sciences and Social Sciences. 1999;54(3):P180-P8.
186. Havig AK, Skogstad A, Kjekshus LE, Romoren TI. Leadership, staffing and quality of care in nursing homes. BMC Health Serv Res. 2011;11:327.
187. Krueger Richard A, Casey Mary Anne. Focus groups: A practical guide for applied research. Los Angeles: Sage publications; 2014.
188. Patton MQ. Designing qualitative studies. In M. Patton (Ed.) Qualitative research and evaluation methods. Los Angeles: Sage Publications, Inc; 2015.
189. Malterud K. Qualitative research: standards, challenges, and guidelines. The lancet. 2001;358(9280):483-8.
190. Castle NG, Decker FH. Top management leadership style and quality of care in nursing homes. The Gerontologist. 2011;51(5):630-42.
191. Charmaz K. Constructing grounded theory: A practical guide through qualitative analysis. London: Sage; 2006.
192. Boeije H. A purposeful approach to the constant comparative method in the analysis of qualitative interviews. quality and quantity,. 2002;36(4):391-409.
193. Rokstad AMM, Vatne S, Engedal K, Selbæk G. The role of leadership in the implementation of person-centred care using Dementia Care Mapping: a study in three nursing homes. J Nurs Manag. 2015;23(1):15-26.
194. Lichtwarck B, Myhre J, Selbaek G, Kirkevold Ø, Rokstad AMM, Benth JŠ, et al. TIME to reduce agitation in persons with dementia in nursing homes. A process evaluation of a complex intervention. BMC Health Serv Res. 2019;19(1):349.
195. Straus S, Tetroe J, Graham ID. Knowledge translation in health care: moving from evidence to practice: London: John Wiley & Sons; 2013.

196. Wiig S, Ree E, Johannessen T, Strømme T, Storm M, Aase I, et al. Improving quality and safety in nursing homes and home care: the study protocol of a mixed-methods research design to implement a leadership intervention. BMJ open. 2018;8(3):020933.
197. Ree E, Johannessen T, Wiig S. How do contextual factors influence quality and safety work in the Norwegian home care and nursing home settings? A qualitative study about managers' experiences. BMJ open. 2019;9(7):025197.
198. Selbaek G, Kirkevold O, Engedal K. The course of psychiatric and behavioral symptoms and the use of psychotropic medication in patients with dementia in Norwegian nursing homes--a 12-month follow-up study. Am J Geriatr Psychiatry. 2008;16(7):528-36.
199. Lichtwarck B, Selbaek G, Kirkevold O, Rokstad AMM, Benth JS, Lindstrom JC, et al. Targeted Interdisciplinary Model for Evaluation and Treatment of Neuropsychiatric Symptoms: A Cluster Randomized Controlled Trial. Am J Geriatr Psychiatry. 2018;26(1):25-38.
200. Livingston G, Huntley J, Sommerlad A, Ames D, Ballard C, Banerjee S, et al. Dementia prevention, intervention, and care: 2020 report of the Lancet Commission. The Lancet. 2020;396(10248):413-46.
201. Goergen T. Stress, conflict, elder abuse and neglect in German nursing homes: A pilot study among professional caregivers. Journal of elder abuse & neglect. 2001;13(1):1-26.
202. Nakrem S. Understanding organizational and cultural premises for quality of care in nursing homes: an ethnographic study. BMC Health Serv Res. 2015;15(1):508.
203. Wagner LM, Castle NG, Reid KC, Stone R. U.S. Department of Health adverse event reporting policies for nursing homes. J Healthc Qual. 2013;35(3):9-14.
204. Frankel AS, Leonard MW, Denham CR. Fair and just culture, team behavior, and leadership engagement: The tools to achieve high reliability. Health Serv Res. 2006;41(4):1690-709.
205. Ellström PE. Integrating learning and work: Problems and prospects. Human resource development quarterly. 2001;12(4):421-35.
206. Utley-Smith Q, Colón-Emeric CS, Lekan-Rutledge D, Ammarell N, Bailey D, Corazzini K, et al. The nature of staff-family interactions in nursing homes: staff perceptions. Journal of aging studies. 2009;23(3):168.
207. Siegel EO, Young HM, Zysberg L, Santillan V. Securing and Managing Nursing Home Resources: Director of Nursing Tactics. Gerontologist. 2015;55(5):748-59.
208. Foucault M. The Foucault effect: Studies in governmentality: University of Chicago Press; 1991.
209. Carayon P, Wetterneck TB, Rivera-Rodriguez AJ, Hundt AS, Hoonakker P, Holden R, et al. Human factors systems approach to healthcare quality and patient safety. Appl Ergon. 2014;45(1):14-25.
210. Williams V, Boylan A-M, Nunan D. Critical appraisal of qualitative research: necessity, partialities and the issue of bias. BMJ Evidence-Based Medicine. 2020;25(1):9-11.
211. Gubrium JF, Holstein JA. Handbook of interview research: Context and method: London: Sage Publications; 2001.

Paper I

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Elder abuse and neglect: an overlooked patient safety issue. A focus group study of nursing home leaders' perceptions of elder abuse and neglect

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Abstract

Background: The definition and understanding of elder abuse and neglect in nursing homes can vary in different jurisdictions as well as among health care staff, researchers, family members and residents themselves. Different understandings of what constitutes abuse and its severity make it difficult to compare findings in the literature on elder abuse in nursing homes and complicate identification, reporting, and managing the problem. Knowledge about nursing home leaders' perceptions of elder abuse and neglect is of particular interest since their understanding of the phenomenon will affect what they signal to staff as important to report and how they investigate adverse events to ensure residents' safety. The aim of the study was to explore nursing home leaders' perceptions of elder abuse and neglect.

Methods: A qualitative exploratory study with six focus group interviews with 28 nursing home leaders in the role of care managers was conducted. Nursing home leaders' perceptions of different types of abuse within different situations were explored. The constant comparative method was used to analyse the data.

Results: The results of this study indicate that elder abuse and neglect are an overlooked patient safety issue. Three analytical categories emerged from the analyses: 1) Abuse from co-residents: 'A normal part of nursing home life'; resident-to-resident aggression appeared to be so commonplace that care leaders perceived it as normal and had no strategy for handling it; 2) Abuse from relatives: 'A private affair'; relatives with abusive behaviour visiting nursing homes residents was described as difficult and something that should be kept between the resident and the relatives; 3) Abuse from direct-care staff: 'An unthinkable event'; staff-to-resident abuse was considered to be difficult to talk about and viewed as not being in accordance with the leaders' trust in their employees.

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Conclusions: Findings in the present study show that care managers lack awareness of elder abuse and neglect, and that elder abuse is an overlooked patient safety issue. The consequence is that nursing home residents are at risk of being harmed and distressed. Care managers lack knowledge and strategies to identify and adequately manage abuse and neglect in nursing homes.

Keywords: Elder abuse, Neglect, Patient safety, Long-term care, Nursing homes, Care managers, Leadership, Qualitative, Focus group

Background

Little is known about elder abuse in nursing homes, and compared to research on other forms of interpersonal abuse, research about elder abuse in nursing homes is still in its infancy [1, 2]. Although no national prevalence data are available in any country internationally, high rates of elder abuse and neglect have been reported in nursing homes, including Norway [1, 3]. According to the World Health Organisation (WHO), elder abuse has been identified in almost every country where these institutions exist [4]. In the Toronto Declaration, WHO defines elder abuse as 'a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which cause harm or distress to an older person' [5] p:3. Prevention of harm is a core principle in health care services and a leadership responsibility [6–8]. Nursing home leaders are legally and morally responsible for ensuring that required quality and safety standards are met [6, 9, 10]. The National Patient Safety Foundation (United States) defines patient safety as 'freedom from accidental or preventable injuries or harm produced by medical care' [10], p,2. This includes preventing elder abuse and examining the factors that foster an unsafe environment for both residents and staff [6, 7, 11]. Furthermore, elder abuse can be categorized according to type of abuse. The definition from 'Protecting Our Future: Report from the Working Group on Elder Abuse' (Ireland) includes physical, psychological, financial and sexual abuse, and neglect (Table 2) [12]. Abuse in nursing homes may also be categorized according to type of relation [1]; staff-to-resident abuse [3, 13], family-to-resident abuse [14, 15] and resident-to-resident abuse, also called resident-to-resident aggression [16, 17].

A recent meta-analysis of the prevalence of elder abuse in long-term care settings estimated a pooled prevalence of 64.2% of abuse perpetrated by staff in the past year, where psychological abuse and neglect had the highest prevalence [1]. A survey of 16 nursing homes in the central part of Norway found that 91% of staff had observed a colleague engaging in some form of inadequate care,

and 87% of staff reported that they themselves had perpetrated some form of inadequate care in the past [3]. Comparably, in a study from Ireland, Drennan et al. found that 57.5% of staff had observed one or more abusive behaviours from a colleague in the previous year [13]. Neglect and psychological abuse were the most commonly observed or perpetrated acts [3, 13]. Living in a nursing home may also mean sharing room and space with co-residents, and in recent literature, resident-to-resident aggression has been identified as a common form of abuse in nursing homes [16–18]. Lachs and colleagues revealed that 407 of 2011 residents from ten facilities had experienced at least one resident-to-resident event over one month observation, showing a prevalence of 20.2%, and the most common form was verbal abuse [16]. The literature about elder abuse in domestic settings shows that close family and friends can be perpetrators of abuse [15], but few studies have investigated the role of family members as perpetrators of abuse in nursing homes. A study from the Czech Republic found that nursing home staff had observed relatives participating in financial exploitation combined with psychological pressure on residents in nursing homes [14]. However, comparing findings in the literature on elder abuse in nursing homes is challenging because definitions and understandings of abuse can vary in different cultures, jurisdictions, and among health care staff, researchers, family members, and residents themselves [1, 2, 11, 19–21]. Different understandings of what constitutes abuse and its severity complicate detecting, reporting and managing the problem.

Nursing homes are complex social systems that consist of different participants, including staff, leaders, residents and relatives in constantly shifting interactions [22, 23]. The aetiology of abuse in nursing home settings is described as complex, comprising varying associations between personal, social and organisational factors [2, 24]. Nursing home residents often have complex care needs, dementia or other forms of cognitive impairment [25], display challenging behaviour [26], and depend on assistance in daily activities and care, all factors associated with a high risk of abuse and neglect [3, 13, 24, 27]. In Norway, 80% of nursing home residents have dementia, and 75% have significant neuropsychiatric symptoms such as agitation, aggression, anxiety, depression, apathy and psychosis [25]. Residents who display aggressive behaviour toward staff are at greater risk of experiencing

abuse [13, 27, 28]. Findings in Drennan et al.'s Irish study revealed that 85% of the nursing home staff had experienced a physical assault from a resident in the previous year [13]. Aggressive behaviour has also been found to trigger resident-to-resident aggression in nursing homes [16, 17]. Related to organisational factors, there is an association between inappropriate environmental conditions for residents, low levels of staffing, and abuse and neglect [13, 14, 29]. As a result of this complexity, elder abuse in nursing homes is difficult to define precisely [11]. Within the literature, elder abuse in nursing homes is conceptualised as a specific form of institutional abuse [30] and a setting in which abuse and neglect take place [14], since rules and regulations in institutions can be abusive themselves, e.g., deciding residents' sleeping and meal times, the use of restraint, and shared living spaces with other residents.

Good leadership plays a key role in developing staff's understanding of residents' needs [31, 32] and creating a strong safety culture of respect, dignity, and quality [6, 7, 9, 33]. The importance of leadership in developing a patient safety culture is highlighted in a report from the National Patient Safety Foundation [10]. In Norway, governmental strategies to improve leadership and safety culture have been launched, such as the Patient Safety Programme and a system for monitoring health services using quality indicators [34]. Leadership is defined as a process whereby a person influences a group of individuals to reach a common goal [35], such as a strong safety culture. The safety culture of an organisation is defined as 'the product of individual and group values, attitudes, perceptions, competencies, and patterns of behaviour that determine the commitment to, and the style and proficiency of, an organisation's health and safety management' [10, 36] p:23. This includes detecting situations that can be harmful to residents. However, several studies have shown that underreporting of abuse and neglect is a significant problem [1, 37, 38]. Residents' own inability to communicate about the abuse or their fear of repercussions and retaliation are important factors of underreporting [1, 2]. Therefore, staff should be able to recognise and report situations that can be perceived as harmful or distressful from the perspective of residents. However, a systematic review of staff's conceptualisation of elder abuse in residential care found that staff were often uncertain about how to identify abuse, especially psychological abuse and caregiver abuse and neglect [39]. Despite the vast knowledge that exists about the importance of leadership, nursing home research has not yet paid much attention to the role leaders play regarding identifying elder abuse. Consequently, there is a gap in knowledge about elder abuse from the perspective of nursing home leaders. Knowledge about nursing home leaders' perceptions of elder abuse and neglect are essential because their understanding of the phenomenon will affect what they signal to staff as important to report and what they investigate to create a safe and healthy environment. To our knowledge, this is the first study that seeks to understand the nature of elder abuse from the perspective of nursing home leaders.

Methods

Aim of the study

The aim of the study was to explore nursing home leaders' perceptions of elder abuse and neglect.

Design

The present study is part of a larger study funded by the Research Council of Norway (NFR), project number 262697. A qualitative exploratory design with focus group interviews was conducted to gain greater insight into this important but poorly understood topic. Qualitative methods provide knowledge about people's experience of their situation and how they interpret, understand and link meaning to events [40, 41]. In focus group interviews, group dynamics allow the questions to be discussed from several points of view, and the group's dynamics can create new perspectives and opinions during the discussion [42]. This study follows The Consolidated Criteria For Reporting Qualitative Research (COREQ) (Additional file 1).

Settings

In Norway, approximately 39,600 residents live in nursing homes (12.9% of the population > 80 years), and their mean age is 85 years [43]. These nursing homes are mainly run by the municipalities and financed by taxes and service user fees. Residents pay an annual fee equal to 75% of the resident's national age pension. In addition, residents may pay an additional fee if they have income of their assets, but with an upper limit decided by the government. However, the payment cannot exceed the actual expenses of the institutional stay [44].. Management of care in Norwegian nursing homes is regulated by 'the regulation of management and quality improvement in health care services' [45]. The regulation focusses on the leader's responsibility to ensure that residents' basic needs are satisfied. This includes the leader's responsibility to ensure there is a system in place to monitor residents' overall quality and safety and to create a safety culture that detects situations and factors that can cause harm to residents and staff [45].

Each nursing home is required to have an administrative manager, called the nursing home director, and some nursing home directors lead more than one facility. In addition, each nursing home has ward leaders and quality leaders, and in some municipalities, a service

leader. Together, individuals in these leader roles form the leadership team in each nursing home [46]. The ward leader is a registered nurse (RN) who supervises and manages staff. Ward leaders are also responsible for budgets in their own wards and the quality of care for residents. There are often several wards and ward leaders in each nursing home. The quality leader is an RN who monitors the overall quality of care in the nursing home in collaboration with the ward leaders. The service leader supervises and manage service staff members who are in contact with nursing home residents (e.g., activity coordinators, cleaning staff and kitchen staff) and is also responsible for the budget related to his or her staff. Individuals employed in one of these leader positions provide the closest level of leadership to staff and residents but are not part of the daily direct hands-on care of residents. There is no national requirement regarding formal leader education to be employed in these leader positions, but leader education is a high priority in many municipalities. These individuals often have lengthy experience as RNs or have previous leader experience.

Sample

The study sample was recruited from 12 nursing homes in six municipalities in Norway. Inclusion criteria were a person who: (a) was employed in a leader position as ward leader, quality leader, or service leader in a nursing home, and (b) was employed full time in the leader position. The inclusion criteria were chosen because these individuals directly affect quality and safety in the nursing home, as they are the closest level of leadership to the staff and residents. Purposive sampling was initially used to ensure that participants recruited could see the phenomenon from the perspective of a leader. During the data collection, each municipality and its nursing home leaders were recruited using a step-wise approach, as we were seeking to get a theoretical sampling until saturation of data was achieved [40, 41]. A total of 28 individuals participated in the study, 23 participants were ward leaders, two participants were quality leaders, and three participants were service leaders. However, in this study, all 28 participants are named 'care managers'. Characteristics of the participants are presented in Table 1.

Table 1 Demographics of the sample ($n = 28$)

Background characteristics	Number (%)
Age (years)	
30–39	6 (22)
40–49	11 (39)
≥ 50	11 (39)
Gender	
Female	25 (89)
Male	3 (11)
Number of beds managing:	
0	5 (17)
10–19	8 (29)
20–29	8 (29)
≥ 30	7 (25)
Number of staffs managing:	
0	2 (7)
10–29	9 (33)
30–49	11 (39)
≥ 50	6 (21)
Years in this position	
0–4	20 (71)
5–9	7 (25)
≥ 10	1 (4)
Total working experience as a leader in years	
0–4	11 (39)
5–9	6 (22)
≥ 10	11 (39)
Formal leader education	
0	1 (4)
0,5–1 years course	18 (64)
1–2 years course	3 (11)
Master's Degree	6 (21)

Recruitment and data collection

Participants were recruited over a period of six months, from August 2018 through the end of January 2019. A recruitment email was sent to health care managers in 11 municipalities in both urban and rural areas. Health care managers from five municipalities stated that they could not find time to participate in the study, while six health care managers accepted the invitation. Thereafter, a second recruitment email was sent to all nursing home directors in these six municipalities. The email included an invitation letter, which the nursing home director forwarded to all individuals employed in a leader position at their nursing homes. Six focus group interviews were conducted, with three to six participants in each group. The focus groups were composed as follows: one focus group with three participants; two focus groups with four participants; one focus group with five participants; two focus groups with six participants.

All six focus group interviews took place in a meeting room in a nursing home in the participating municipalities. Each focus group interview lasted approximately 90 min. All participants gave informed written consent before the interviews started. Two researchers carried out the interviews. JM was the moderator in all six interviews, SN was co-moderator for two group interviews,

and SS was co-moderator in one group interview. In the other three interviews, two researchers from the larger research team were co-moderators. During the introductory information about the focus group interview, we presented a figure (Fig. 1), and asked participants about their experience and thoughts on the topic of elder abuse from health care staff, co-residents or relatives. Participants were encouraged to speak freely. However, during the first interview, we experienced that participants were not familiar with the topic. To explore the topic in the ensuing interviews, the moderator gave the participants keywords from the categorization of abuse (e.g., abuse can be described as physical, psychological, sexual, financial, or neglect) (Table 2) [12]. We found that this helped the participants reflect, and they subsequently came up with examples of abusive situations they had heard about or witnessed. During the process of data collection, we further compared our experiences in interview one with interview two, which is in line with the constant comparative method [40]. This led to including keywords in the interview guide to ensure that all topics were covered (Additional fil 2). To ensure the credibility of an open thematic understanding of participants' experiences and diminish bias by presenting the keywords, we were conscious about letting the participants speak freely about their experiences and thoughts on this topic. Moreover, they were not given any definition of abuse or examples related to these keywords (Table 2) [12]. The participants freely decided in which order they wanted to talk about different forms and situations of elder abuse. All interviews were recorded and transcribed verbatim, retaining pauses and emotional expressions.

Data analysis

A constant comparative method with a grounded theory approach was used. This allowed us to generate a thematic understanding of elder abuse through an open exploration of the experience described by nursing home leaders [40, 41]. The constant comparative method facilitated possible identification of themes and differences between individuals and cases within the data [40]. Our analysis started right after each interview, where the first author listened to the recorded interview. Memo writing was then used through the whole process of data collection and analysis and served as a record of emerging ideas, questions and categories [41]. Next, in line with the constant comparative method, open line-by-line coding of the transcribed interviews was performed [40, 41], since we wanted to capture the meaning from the participants' perspectives as they emerged from the interviews. The codes were compared for frequencies and commonalities and then clustered to organise data and develop sub-categories. The sub-categories were examined to construct the final categories and main theme. To add credibility and diminish researcher bias, two researchers (JM and SN) coded the transcribed interviews independently. During the analysis process, the authors held several meetings where codes and their connections were discussed until consensus was reached. To ensure that the emerging categories and themes fit the situations explored, the researchers went back and forth between contextualization, data analysis and memo writing [40]. An example of the analysis process is shown in Table 3.

Ethical consideration

Ethical approval for this study was given by the Norwegian Centre for Research Data (NSD), Registration No: 60322. Each participant signed a written consent form after receiving oral and written information about the study. All identifiable characteristics are excluded from the presentation of data to ensure the anonymity of all individuals.

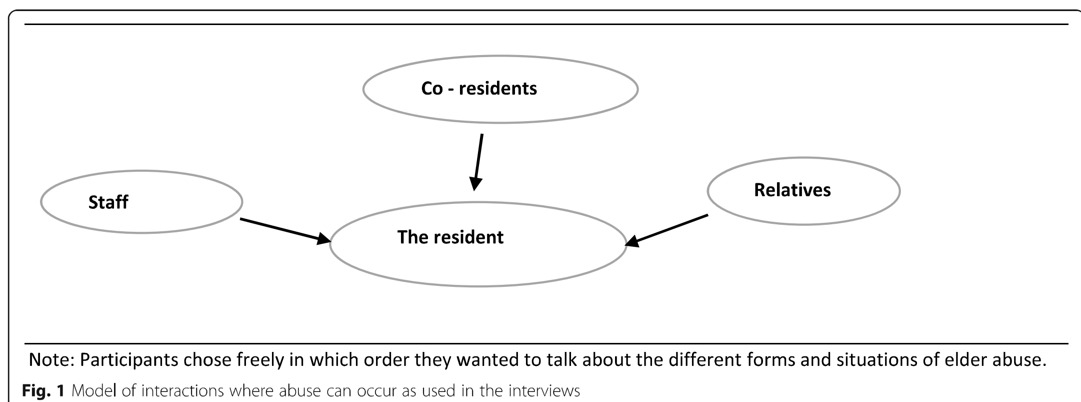

Fig. 1 Model of interactions where abuse can occur as used in the interviews

Table 2 Operational definitions of abuse and neglect in residential settings [12]

Five areas of abuse and neglect	Abusive actions
Physical Abuse	Hitting, slapping, pushing, kicking, misuse of medication or restraint.
Psychological abuse	Emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks.
Sexual Abuse	Rape and sexual assault or sexual acts to which the older adult has not consented, or could not consent, or into which he or she was compelled to consent into which he or she was compelled to consent.
Financial Abuse	Theft or the misuse or misappropriation of property or possessions.
Neglect	Ignoring medical or physical care needs, failure to provide access to appropriate health care, social care or educational services, withholding of necessities of life, such as medication, adequate nutrition and heating.

Results

The main theme, 'Elder abuse in nursing homes, an overlooked patient safety issue', found in this study indicates an overall lack of awareness of elder abuse and its harm among care managers. Three analytical categories emerged from the analyses: 1) Abuse from *co-residents – 'A normal part of nursing-home life'*, 2) Abuse from *relatives – 'A private affair'*, and 3) Abuse from *direct-care staff – 'An unthinkable event'.* Since there were no remarkable differences in care managers' experiences, we present results without differentiating the participants. Below, we describe each category, together with examples of forms of abuse and neglect. These examples are used to describe the care managers' perceptions of elder abuse and neglect (Table 4).

Abuse from co-residents – 'A normal part of nursing-home life'

Resident-to-resident aggression was described as the biggest issue related to abuse in nursing homes and a daily challenge for the participants: '*That is what I also see, that co-residents are the biggest challenge regarding this topic'* (Group 2). The main cause of resident-to-resident aggression reported by care managers was symptoms of dementia, especially in the initiator, but also in the victim. The care managers expressed that they did not know how to address this problem. As one said, '*It happens because of the cognitive failure, so yes. But, at the same time, it is also difficult to do something about it'* (Group 2). Some care managers also stated that the risk of harm caused by resident-to-resident aggression was something residents must accept when living in a

Table 3 Example of data analysis in the category "abuse from co-residents"

Sub- Categories	Code	Meaning unit
Common	Resident-to resident aggression are common	*We have very often residents that are both physically and psychological aggressive towards other residents.*
Resident - to resident aggression as normalized	Difficult to do something with resident- to resident aggression	*I think it is due to the cognitive failure, so then it is not an abuse, because it doesn't help to just talk to the resident.*
	Resident-to-resident aggression a big part of everyday life in nursing homes	*We may have a little thick skin in relation to where the limit goes for what we accept. Because it is such a big part of our everyday life that it became normal in a way.*
	Normal behaviour from people with dementia	*When we have focus on dementia, it becomes normal for us to see such behaviour.*
Hitting	Physical abuse – hitting when trespassing a resident rom	*We had a patient who was hit and beaten by the same resident several times. The resident walks into his room and simply knocked him down, and that is a despair.*
Verbal abuse	Psychological abuse – verbal abuse normal behaviour for people with dementia	*Then we have residents with frontotemporal dementia who just acts in that way, they just verbally offending others, but it is their way of behaving.*
Violation of resident's privacy	Psychological abuse – violation of resident's privacy when trespassing into another resident's room	*Trespassing into another residents' room that happens a lot, but it's a violation of their privacy, and if the resident can't speak or is cognitive impaired, they may be unable to tell if something is happening.*
Stealing things	Financial abuse – stealing things	*They steal things from each other's room, yeas that happened.*
Sexual assault	Sexual abuse – sexual assault and an ethical dilemma	*We see sexual approaches or that they forgot that they are married and find each other instead. But that is more a dilemma than an assault …. or maybe it can be an assault… well I don't know.*

Table 4 Examples of forms of abuse as described by care managers

	Co- residents ***"A normal part of nursing home life"***	*Relatives* ***"A private affair"***	Direct Care staff ***"An unthinkable event"***
Physical abuse			
Hitting, kicking, pushing, and throwing things	X		X
Rough handling		X	X
Use of force or restrain		X	X
Psychological abuse			
Verbal abuse	X	X	X
Violation of resident's privacy	X		X
Financial abuse			
Stealing or destroying a resident's assets	X	X	X
Sexual abuse			
Sexual assault	X		X
Neglect			
Neglect of user participation		X	X
Health care neglect			X

nursing home: '*There is a predictable risk, when living in nursing homes, [of] such incidents; there is a foreseeable risk that this will happen*' (Group 5). This demonstrates that resident-to-resident abuse is normalized.

Care managers considered physical abuse to be the most serious form of resident-to-resident aggression, often leading to visible harm and despair. At the same time, all care managers had examples of residents who had been beaten, knocked down, or kicked by co-residents.

'We have one resident now that is beaten a lot by the other residents. It's a little extreme, but I think that such things can happen quite often in dementia care because, as in this case, the resident being beaten is not silent for a minute. She speaks and yells all day, and the other residents become annoyed since she disturbs them' (Group 4).

Care managers described psychological abuse as acts of 'everyday bullying' and threats made among residents. They interpreted these situations as a normal consequence of the dementia disease in the individual resident. One care manager noted, '*What I think is the challenge is the everyday bullying. It is seen as normal behaviour for that group of residents*' (Group 1). When discussing psychological abuse connected to co-residents, all care managers provided examples of residents trespassing in other residents' rooms. They interpreted this behaviour as a violation of residents' privacy. At the same time, it was perceived as normal since it happened quite often. The care managers also reported that when residents trespassed and entered another resident's room, the risk of other forms of abuse such as financial abuse increased. One care manager remarked, '*We have some challenges related to residents who enter other residents' rooms and destroy or take other residents' possessions. It can be pictures and different things*' (Group 3).

Related to sexual abuse by co-residents, all care managers had examples of residents who had shown sexual interest in another resident. The care managers viewed this sexual interest as an ethical dilemma for them. On the one hand, they want residents to have a healthy sex life in the nursing home, but on the other hand, this is difficult when a resident has dementia and may not be competent to give consent. Several care managers experienced that what seemed to be voluntary sexual interest between residents could not be that, after all:

'In that situation, she was very interested in him, and he was very interested in her. And it was like, yes, they were in the room together and so on. I remember it as very, very difficult because she often had a lot of pain. I do not know if there was penetration, but it was, in any case, an attempt, yes, it may as well have been that too. I had a lot of trouble because I was unsure whether she understood what happened and who it was happening with because it was often very difficult for her after they had been in the room together. I remember it as a huge ethical dilemma. But I never thought that it was a sexual. .. that it was an assault or something. But, right now, I think it was' (Group 5).

During the focus group discussion, care managers reflected on the complexity of letting residents express themselves sexually and the risk of sexual assault. From their statements, it was clear that they had not reflected on this topic earlier. A summary of forms of harmful situations related to resident-to-resident aggression reported by participants is presented in Table 4.

Abuse from relatives – 'A private affair'

Abuse directed towards residents from their relatives was reported to be a particularly difficult problem. According to the care managers, relative-to-resident abuse was often hidden, occurring behind private closed doors when a relative was visiting the resident. Therefore, participants described it as difficult to discover and associated mainly with the private relationship between the resident and his or her relatives:

'*It is very difficult. It is a relative who is going to visit her mother in the nursing home, she closes the door to the room and wants to be there alone with her mom, and we have very large rooms, so we thought they were having a nice time inside the rom. But then we discovered that the mom had some bruises, and then we understood that things were happening*' (Group 3).

Not all care managers had knowledge of or experience with relative-to-resident abuse, which highlights the private nature of these forms of abuse. Abuse from relatives was viewed as being linked to past family conflict, which continued inside the nursing home. The care managers deliberated over the extent to which they should interfere in the private relationship when they suspected this form of abuse. They reported that the problem was knowing what to do and when and how to interfere, especially when the resident has dementia or another form of cognitive impairment. One care manager remarked, '*It is very difficult. I have a patient who may not be competent to give consent. So, I have a responsibility I must take, but I think it's challenging to know what to do*' (Group 2). Cases where the resident clearly did not want anyone in the nursing home to know about the abuse or to do anything about it and just wanted to maintain the relationship with his or her family member despite the abuse were reported to be particularly difficult. The care managers expressed that they lacked a strategy or authority in these situations, and harm to the resident being exposed was accepted.

'*But it is not always that the resident wants us to do something, either. It may have been this way for a long time, and then, maybe it's okay then. Well, I don't know*' (Group 5).

Physical and sexual abuse from relatives was regarded as the most hidden form of abuse from relatives. Some care managers provided examples of physical abuse, but none had experienced sexual abuse. However, all care managers commented that when it happened, it took place behind private closed doors. In addition to past family conflict, abuse from relatives was often related to mental problems and/or drug abuse issues. One care manager said, '*I have experienced some older people who have children with drug issues and such things. And it is in those cases, I have experienced physical abuse towards residents from relatives*' (Group 4). Related to physical abuse from relatives, care managers also reported situations where a relative forced the resident to, for example, eat, get dressed, wash and groom, or exercise. These situations were linked to unrealistic expectations in relatives, and not trusting the staff is doing a good job.

'*After her husband had been there, we saw that she was so red around the cheek. We then found out that the husband squeezed her mouth open and poured cream into her*' (Group 3).

Care managers viewed psychological abuse from relatives as disrespectful communication with the resident. A participant stated, '*We experience that relatives can be quite disrespectful to their loved ones. But, at the same time, it may have been this way their whole life*' (Group 6).

Care managers expressed that financial abuse from relatives was a common occurrence. They cited examples of stealing money from residents, threatening residents in order to get money from them, and unauthorized use of a resident's finances. One participant stated, '*What I see most from the relative's part is financial abuse. It is very common, actually*' (Group 1). Relatives' economic problems were reported to be a causal factor related to financial abuse. At the same time, care managers indicated that financial problems and financial exploitation by relatives were private issues, and as such, they were reluctant to interfere.

Related to neglect, care managers described that some relatives made decisions on behalf of the resident without considering what the resident wanted and needed or would agree upon. Care managers stated that sometimes the health care staff also disagreed with the relative's decision. One care manager noted, '*We have situations where relatives make decisions on behalf of the resident, which we do not agree upon, and which we might think the resident would not agree upon either*' (Group 3). Care managers also described experiences of relatives who refused to allow a resident to buy items the care managers considered necessary and not provided by a nursing home. These could be things such as clothes, hairdressing services, or podiatry, but it could also be related to taking part in activities that cost money. A care manager remarked:

'*I have a resident who called her son to ask if she could go to a podiatrist because she really needed it, but her son refused and said she has no money for that*' (Group 5).

Thus, because of neglect by their relatives, residents might go without necessities of daily living and may not be able to participate in activities they would like to take part in. A summary of forms of harmful situations related to relative-to-resident abuse reported by participants is presented in Table 4.

Abuse from direct-care staff – 'An unthinkable event'

When care managers were prompted to talk about staff-to-resident abuse, they reframed the discussion to focus

on the verbal and physical aggression they commonly experienced from nursing home residents. They interpreted aggression directed toward them as a risk to their health and safety. Moreover, they stated this phenomenon was a daily concern. One noted, '*We have the opposite focus in our units. We focus on staff being subjected to abuse by residents*' (Group 2). Several care managers also indicated that they understood that staff could become stressed and frustrated in their relationship with an aggressive resident:

'*We have a case that is extremely difficult, where there are many violations against staff by a resident. And then, to be in such a situation where you can quickly retaliate. .. this is difficult*' (Group 6).

Despite this, care managers expressed that elder abuse was not a topic they talked about in their daily work at the nursing home. They indicated that they wanted to trust the employees. Therefore, abuse from staff was difficult to talk about and almost unthinkable to them. One care manager said, '*I think that no one who works in the nursing home started there just to be able to hurt someone, and that is perhaps why this is such a sensitive and difficult topic*' (Group 5). The word 'abuse' was also reported to be a very strong term and mainly related to intentional physical acts. However, in the discussion, care managers also included unintentional acts in their examples of elder abuse and expressed that, to some degree, it could be difficult to know the full intention of a staff member's actions. At the same time, they emphasised that staff's intentions were mainly good, and therefore abuse was unthinkable:

'*Everyone who works in a nursing home is motivated by and has a desire to help someone. So, most of the [incidents] of abuse by staff. .. I think it may be those with a good intention at the heart of it. [For instance, thinking] "I thought he should have a shower, but I forgot to ask"*' (Group 5).

Care managers discussed examples of the use of physical and chemical forms of restraint and rough handling during care. Utilization of restraints and dilemmas related to their use was discussed in all focus groups, and care managers pointed out that the staff are sometimes compelled to use both physical and chemical restraints to help or protect the resident:

'*I think in relation to, well it is really both physical and psychological abuse. I think of cases, especially at night, where there is low staffing and many residents with aggressive behaviour, where it may be chosen to lock some residents into their rooms to prevent them from being exposed to abuse from co-residents so the staff can deal with the situation, but it is abuse to be locked inside*' (Group 2).

Rough handling was something that all care managers had experienced. This was thought to be mainly unintentional and something that could happen when caring for residents with aggression or those who resist care. Care managers expressed that, to define it as abuse, it had to be significant, or there needed to be visible signs of such handling, such as bruising. At the same time, the care managers also pointed out that residents in nursing homes often bruise easily, and it can be difficult to determine whether such marks are related to abuse:

'*Sometimes, we saw that she was so easy to bruise, and sometimes we clearly noticed hand marks on the bruises around her body. But it can be enough that you handle someone a little hard, and in the old ones, then they get bruises, although it can also indicate that there has been resistance, right. But then this happens all the time*' (Group 4).

Psychological abuse from staff members was linked to verbal abuse. Care managers cited examples of yelling at a resident in anger, speaking to a resident in a disrespectful tone, or being rude, which allegedly occurred in relation to resident-to-staff aggression. When discussing psychological abuse, some care managers also provided examples of violations of residents' privacy by staff members, such as discussing residents' health care issues and challenges in public areas in the nursing home:

'*If there has been a resident with a rejection of care responses, for example, that has been difficult to cooperate with, then that frustration can be expressed in public areas with other residents present. Without caution by staff, this is something other residents are going to hear*' (Group 5).

Financial abuse was thought to be related to stealing money or destroying a resident's property. At the same time, care managers reported that their nursing home policies do not allow residents to keep much money in their rooms in order to protect residents from financial abuse by staff, visitors, or others, and hence, financial abuse from staff rarely happened. One said, '*Financial abuse only happens if the residents have money laying around*' (Group 1).

When talking about sexual abuse, care managers offered examples of residents who stated that they were sexually assaulted by staff members. These were often female residents who expressed that male staff had sexual intentions towards them during care. At the same time, care managers reported that such statements from residents could be part of the dementia disease, and that resident could have hallucinated the abuse. Care managers indicated that sexual abuse by staff was unthinkable to them:

'*Sometimes, older people with cognitive impairment say things that we can become uncertain about. They say things, but we can't be sure there has been an assault. Often, we think that it has not happened. It's about us*

knowing them; they say a lot of these things and are very sexually oriented' (Group 4).

Even so, a few care managers mentioned examples of sexual abuse by staff a long time ago that had been reported to the police, and the staff member was convicted.

Related to neglect, care managers reported that staff often did things for residents to save time instead of letting them do it independently. They also reported being aware that, in many situations, staff members do not pay attention to residents' wishes and thereby neglect to include them in decisions concerning daily life in the nursing home. One care manager noted, '*It says on the duty list that you should shower today, so you should shower, even if you might say, "No, I don't want to." So, yes, it is your turn today'* (Group 3). Another form of neglect by staff was reported to be linked to health care neglect. Care managers referred to events such as not helping a resident with needed health care, giving a resident an incontinence product instead of helping them use the toilet, not calling for medical help when needed, and not following up on medical conditions:

'To put on a pad instead of following the patient to the toilet, for those who still manage to use the toilet themselves . . . that can happen' (Group 6).

The care managers reported that, because of low financial resources, staff must prioritize their work and tasks every day. For this reason, situations not specifically related to medical treatment and physical or health outcomes were given lower priority. This reprioritization was framed as acceptable and was not defined as neglect. One said, '*It is about our time. So, no, we don't have time for you or that need is not important. It is about what we have to prioritize'* (Group 6). A summary of forms of harmful situations related to staff-to-resident abuse reported by participants is presented in Table 4.

Discussion

The aim of the study was to explore nursing home leaders' perceptions of elder abuse and neglect. We found that most of the care managers were not explicitly aware of elder abuse in their daily work. However, when given keywords, they all came up with examples of situations they interpret as harmful or distressful to residents. This shows that care managers need time to reflect on complex aspects of care to become aware of abuse and neglect as a safety issue. At the same time, our findings revealed an ambiguity in the care managers' examples. The situations, on the one hand, were described as harmful. On the other hand, they were rationalized as care managers attempted to excuse why it was happening. Three main categories are described in the finding: *Abuse from co-residents – 'A normal part of nursing-home life', Abuse from relatives – 'A private affair', Abuse from direct care staff – 'An unthinkable event'.* These findings indicate that this cohort of nursing home care managers lack awareness of the abuse they observe or hear about. Particularly, these findings demonstrate that harm or distress to residents caused by abuse are an overlooked patient safety issue in these nursing homes.

Findings revealed that resident-to-resident aggression is a common form of abuse in nursing homes and a daily challenge. There is a high prevalence of residents with neuropsychiatric symptoms of dementia, including aggression, agitation and psychosis in nursing homes [25, 26]. These symptoms impact on co-residents and staff safety, and resident-to-resident aggression is the most common form of abuse in nursing homes [16, 17]. However, our findings revealed that harm resulting from resident-to-resident aggression was perceived as normal. This raises the question of whether care managers perceptions place the responsibility on the resident, without accounting for the complexity in the aggressive behaviour and the responsibility of the organization [22]. It is worth noting that in resident-to-resident aggression, both residents can suffer harm, since the initiator is likely to be confused and usually not responsible for the acts. For the victim, resident-to-resident aggression has both physical and psychological consequences [47]. However, previous research has also indicated that abusive behaviour can be understood as less abusive when the victim has dementia, and for that reason it is often not reported [17, 48]. Recognising that aggressive behaviour has a multifactorial aetiology, best practice recommendations [49] and research evidence [50, 51] call for a comprehensive biopsychosocial approach that investigates the resident's unmet needs, medical conditions, environmental factors, and interactions between residents and caregivers and a tailored response [49]. Care managers' perceptions of resident-to-resident aggression as normal and a foreseeable risk, places residents at risk and is also a failure to deliver much needed care to the initiator.

With respect to relative-to-resident abuse, findings demonstrate that care managers perceive negative events resulting in harm or distress as a private affair between the resident and his or her relatives, and that is difficult to intervene. Similarly, to resident-to-resident abuse, this indicates that the care managers place the responsibility of the observed abuse on the relationship between the resident and his or her relatives, without accounting for the complexity and their own responsibility in these situations. Care managers examples of relatives who force a resident to eat due to unrealistic expectations and distrust in nursing home staff's care reveals that care managers find it difficult to interact with families. This finding points to potential communication difficulties between staff and resident's relatives that could adversely affect the resident [52, 53]. A Norwegian study that

investigated quality of care from the perspective of families in long-term care found that family members saw themselves as an important link between staff and the resident, and an essential voice regarding the resident's needs and wishes [53]. However, given the nature of the nursing home and the complexity of its organization and routines [22, 23], it can be difficult for someone outside the organization to judge what is and is not adequate clinical practice. Collaboration and communication with the residents and their relatives depend on how the culture in the nursing home view these interactions; the relatives with right to an opinion, or professional as experts and in control [6, 22, 52]. This will in turn affect the quality and safety of the care that is delivered to the residents.

Although some care managers had experience of staff-to-resident abuse within all abuse categories, it was also difficult for them to admit to this form of abuse, and it was viewed as an 'unthinkable event.' Instead, care managers were mostly interested in talking about resident-to-staff aggression which they emphasised was a larger problem in their nursing homes. Resident- to-staff aggression can cause physical and psychological harm to staff, reduced job satisfaction, stress and burnout, emotional reactions including sadness, guilt and helplessness [28]. However, resident-to-staff aggression may also lead to reactive abuse and neglect, due to frustration in staff member being exposed to aggression [11, 13, 27, 28]. Findings in the present study demonstrate that care managers lack awareness of the staff's reactive responses to aggression from residents. This might raise the question if they perceive staff as victims in these situations and that abuse from staff is understandable. Unprovoked or intentional abuse towards a resident therefore is unthinkable with justification in their trust to the staff.

Difficulties in defining abuse in nursing home settings have been found in studies that include staff's perceptions [39, 54], where abusive situations are seen as normal in the nursing home culture [17, 33, 39, 55]. However, these studies did not specifically focus on care managers' or leaders' understandings. Our study reveals important information related to detection and management of abuse in nursing homes, since care managers' perception of abuse affects what they signal to staff as important to report. Care managers have the opportunity to influence the culture and care practice in the nursing home and are responsible for setting policies for the staff, it is therefore essential that they are aware of and able to face situations that constitute potential harm to the residents. But, to be able to define situations that can be experienced as harm and distress, it is essential to see situations from the perspective of the residents. Harm and distress are defined differently from the point of view of the one who causes the harm [39, 54], the one observing or hearing about it [14], or the one who experiences a situation of harm or distress [20, 21]. Our findings indicate that the care managers had difficulties in seeing potential harm caused by abuse and neglect from the perspective of the residents. Leaders' abilities to promote a safety culture for both the resident and staff are linked to their leadership skills, knowledge of the resident's needs and their capacity to implement effective safety care practices [6, 31, 32]. Care managers' lack of awareness in identifying and following up on abuse will necessarily affect the safety culture in the organisation and, in the end, clinical outcomes such as quality and safe care for the residents [6, 10, 56].

A recent Norwegian study found that communication, openness and staffing were significant predictors of staff's overall perception of patient safety in nursing homes, yet the nursing home staff scored low on these dimensions [56]. This finding aligns with our study, which revealed that care managers find it difficult to distinguish between prioritising and patient neglect. Low financial resources and low staffing can affect the perception of what constitutes harm and safety in the nursing home culture. Low finances, combined with the complexity of residents' needs, the complex organisation, and demands for improved outcomes, puts great pressure on nursing home leaders [22, 57]. The ambiguity in their examples can be understood as an attempt to rationalize abuse and diminish their personal and professional accountability. People in complex social systems will try to make sense of tasks and orders by adapting to internal and external demands [22, 23]. Health care policies that mandate efficiency, cost saving, and nursing home care managers' focus on prioritising contribute to lowering the limit for what is perceived as quality and safety, resulting in low quality and unsafe environment as the norm and accepted in nursing homes.

Strengths and limitations of the study

A strength of this study is that it involves participants who are in leader positions in different nursing homes and municipalities in Norway, which could increase the transferability of these findings. The research team consists of members from two countries, all with broad research experience, which contributed to multiple perspectives and discussions during analyses of the data. This strengthens the trustworthiness of our findings, and the credibility of the research. Three of the authors have worked several years in nursing homes as care managers, but none of those nursing homes participated in this study. The researchers' backgrounds as care managers has both advantages and disadvantages. A variety of aspects of participants' experiences was discovered by posing in-depth questions that might not have been possible without the background knowledge. However, the

background knowledge can influence the type of follow-up questions that were asked. To counterbalance this possible bias, two researchers were always present during the interview, and the analyses were also independently coded by two researchers (JM and SN). Each focus group consisted of three to six participants, which can be perceived as small groups and a limitation. However, the participants gave a rich description of the phenomenon. Therefore, we decided to include data from the smallest groups.

The examples of abuse and neglect our participants described in the present study could be second-hand information because leaders are not always part of the direct hands-on care residents receive. At the same time, this study has sought to understand the nature of elder abuse from care managers' perspective, which is of great importance due to their responsibility for creating a safe environment for both residents and staff. Even though the examples are second-hand information, the findings are representative of the care managers' perceptions of the information and what we thought was important to study.

Conclusion

Many nursing home residents have dementia, neuropsychiatric symptoms, and complex needs, which increases the risk of their being exposed to abuse and neglect. At the same time, little is known about the nature of elder abuse in nursing homes and compared to research on other forms of interpersonal abuse, the study of elder abuse in nursing homes is still in its infancy. Care managers influence the culture and care practice in nursing homes and set policies for staff. Knowledge about their empirical understanding of the phenomenon is important to form more effective intervention and prevention strategies. The present study shows an ambiguity in the nursing home leaders' examples of abuse and neglect. On the one hand, the situations were described as harmful. On the other hand, they were rationalized with an attempt to excuse their occurrence. Our study revealed that elder abuse and neglect is an overlooked patient safety issue in nursing homes. Care managers lack knowledge and strategies to identify and adequately manage abuse and neglect in nursing homes, and this warrants further research.

Supplementary information

Supplementary information accompanies this paper at https://doi.org/10.1186/s12913-020-5047-4.

Additional file 1. COREQ checklist.
Additional file 2. Interview guide.

Abbreviations

NFR: Research Council of Norway; RN: Registered Nurse; WHO: World Health Organization

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Ethical consideration

Ethical approval for this study was given by the Norwegian Center for Research Data (NSD), Registration No: 60322. All the participants were provided with written information about the study. They gave written consent to participate in the interviews and for the use of the data from the interviews.

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Authors' contributions

JM wrote the manuscript. JM, SS, WM, JO and SN developed the study design. JM transcribed the interviews, and JM and SN performed the analysis of the interviews, with discussion including all authors. SN supervised the project. All authors did critical revisions of the manuscript for important intellectual content and read and approved the final manuscript.

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Availability of data and materials

The datasets generated and/or analyzed during the current study are not publicly available due to format of the data not allowing for completely anonymizing data but are available from the corresponding author on reasonable request.

Consent for publication

The participants consented to the publication of de-identified material from the interviews.

Competing interests

The authors declare that they have no competing interests.

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References

1. Yon Y, Ramiro-Gonzalez M, Mikton CR, Huber M, Sethi D. The prevalence of elder abuse in institutional settings: a systematic review and meta-analysis. Eur J Pub Health. 2018.
2. McDonald L, Beaulieu M, Harbison J, Hirst S, Lowenstein A, Podnieks E, et al. Institutional abuse of older adults: what we know, what we need to know. J Elder Abusw Negl. 2012;24(2):138–60.

3. Malmedal W, Ingebrigtsen O, Saveman BI. Inadequate care in Norwegian nursing homes--as reported by nursing staff. Scand J Caring Sci. 2009;23(2): 231–42.
4. Krug E, Dahlburg L, Mercy J, Zwi A, Lozano RJWH. et al, Abuse of the elderly in World Report on violence and health. 2002.
5. WHO. The Toronto Declaration on the Global Prevention of Elder Abuse. Geneva: World Health Organization, Availablel at; http://apps.who.int/iris/bitstream/10665/42495/1/9241545615_eng.pdf.; 2002.
6. American College of Healthcare Executives, The National Patient Safety Foundation, Institute for Healthcare Improvement. Leading a culture of safety. A blueprint for success. 2017.
7. Sokol-Hessner L, Folcarelli PH, Annas CL, Brown SM, Fernandez L, Roche SD, et al. A road map for advancing the practice of respect in health care: the results of an interdisciplinary modified Delphi consensus study. Jt Comm J Qual Patient Saf. 2018;44:463–76.
8. Pilbeam C, Doherty N, Davidson R, Denyer D. Safety leadership practices for organizational safety compliance: developing a research agenda from a review of the literature. Saf Sci. 2016;86:110–21.
9. Nakrem S, Vinsnes AG, Harkless GE, Paulsen B, Seim A. Nursing sensitive quality indicators for nursing home care: international review of literature, policy and practice. Int J Nurs Stud. 2009;46(6):848–57.
10. National Patient Safety Foundation. Free from Harm, Accelrating Patient Safety Improvment Fifteen Year after To Err is Human (NPSF). Boston: Available at; www.npsf.org: National Patient Safety Foundation (NPSF), ; 2015.
11. Phelan A. Protecting care home residents from mistreatment and abuse: on the need for policy. Risk Manag Healthc Policy. 2015;8:215–23.
12. Working Group on Elder Abuse. Protecting our future, Report: Dublin, . The Stationery Office. 2002.
13. Drennan J, Lafferty A, Treacy MP, Fealy G, Phelan A, Lyons I, et al Older people in residential care settings: results of a national survey of staff-resident interactions and conflicts. 2012.
14. Bužgová R, Ivanová K. Elder abuse and mistreatment in residential settings. Nurs Ethics. 2009;16(1):110–26.
15. Yon Y, Mikton CR, Gassoumis ZD, Wilber KH. Elder abuse prevalence in community settings: a systematic review and meta-analysis. Lancet Glob Health. 2017;5(2):147–56.
16. Lachs MS, Teresi JA, Ramirez M, van Haitsma K, Silver S, Eimicke JP, et al. The prevalence of resident-to-resident elder mistreatment in nursing homes. Ann Intern Med. 2016;165(4):229–36.
17. Rosen T, Pillemer K, Lachs M. Resident-to-resident aggression in long-term care facilities: an understudied problem. NHI Aggression Violent Behav. 2008;13(2):77–87.
18. Pillemer K, Chen EK, Van Haitsma KS, Teresi J, Ramirez M, Silver S, et al. Resident-to-resident aggression in nursing homes: results from a qualitative event reconstruction study. Gerontologist. 2012;52(1):24–33.
19. Castle N, Ferguson-Rome JC, Teresi JA. Elder abuse in residential long-term care: an update to the 2003 National Research Council report. J Appl Gerontol. 2015;34(4):407–43.
20. Lafferty A, Treacy MP, Fealy G, Drennan J, Lyons I. Older people's experiences of mistreatment and abuse. Dublin: NCPOP, University College, Dublin; 2012.
21. World Health Organization (2002). Missing voices; views of Oler persons on elder abuse, Geneva; 2002.
22. Cilliers P (2002). Complexity and postmodernism: understanding complex systems. London Routledge.
23. Anderson RA, Issel LM, McDaniel RR Jr. Nursing homes as complex adaptive systems: relationship between management practice and resident outcomes. Nurs Res. 2003;52(1):12–21.
24. Ostaszkiewicz J. A conceptual model of the risk of elder abuse posed by incontinence and care dependence. Int J Older People Nursing. 2017:1–11.
25. Helvik A-S, Selbæk G, Benth JŠ, Røen I, Bergh S. The course of neuropsychiatric symptoms in nursing home residents from admission to 30-month follow-u. PLoS One. 2018;13(10):1–18.
26. Selbaek G, Kirkevold O, Engedal K. The course of psychiatric and behavioral symptoms and the use of psychotropic medication in patients with dementia in Norwegian nursing homes--a 12-month follow-up study. Am J Geriatr Psychiatry. 2008;16(7):528–36.
27. Malmedal W, Hammervold R, Saveman B-I. The dark side of Norwegian nursing homes: factors influencing inadequate care. J Adult Prot. 2014;16(3): 133–51.
28. Lachs MS, Rosen T, Teresi JA, Eimicke JP, Ramirez M, Silver S, et al. Verbal and physical aggression directed at nursing home staff by residents. J Gen Intern Med. 2013;28(5):660–7.
29. Goergen T. A multi-method study on elder abuse and neglect in nursing homes. J Adult Prot. 2004;6(3):15–25.
30. Nerenberg L. Elder abuse prevention: emerging trends and promising strategies. New York: Springer Publishing Company; 2007.
31. Brady GP, Cummings GG. The influence of nursing leadership on nurse performance: a systematic literature review. J Nurs Manag. 2010;18(4):425–39.
32. Braithwaite J, Herkes J, Ludlow K, Testa L, GJBO L. Association between organisational and workplace cultures, and patient outcomes: systematic review. BMJ Open. 2017;7(11):1–11.
33. Pickering CEZ, Nurenberg K, Schiamberg L. Recognizing and responding to the "toxic" work environment: worker safety, patient safety, and abuse/neglect in nursing homes. Qual Health Res. 2017;27(12):1870–81.
34. HOD. (Helse- og omsorgsdepartementet) [Ministry of Health and Care Service] (2013) Kvalitet og pasientsikkerhet 2013 [Quality and patient safety 2013] (St.meld. nr. 11 2014–2015). Oslo: Departementenes servicesenter. 2013.
35. Northouse PG. (2018). Leadership: theory and practice. Los Angeles; Sage publications.
36. Health and Safety Commission. Third report: organizing for safety. London: HMSO; 1993.
37. World Health Organization. A global response to elder abuse and Negelct: building primary health care capacity to Deal with the problem worldwide. Geneva: Main Report; 2008.
38. Cooper C, Selwood A, Livingston G. Knowledge, detection, and reporting of abuse by health and social care professionals: a systematic review. Am J Geriatr Psychiatry. 2009;17(10):826–38.
39. Radermacher H, Toh YL, Western D, Coles J, Goeman D, Lowthian J. Staff conceptualisations of elder abuse in residential aged care: a rapid review. Aust J Ageing. 2018;37(4):254–67.
40. Boeije H. A purposeful approach to the constant comparative method in the analysis of qualitative interviews. J Qual Quantity. 2002;36(4):391–409.
41. Charmaz K (2006). Constructing grounded theory: a practical guide through qualitative analysis. London; sage publications.
42. Krueger RA, Casey MA. Focus groups: a practical guide for applied research. Los Angeles: Sage publications; 2014.
43. SSB. Statistisk Sentralbyrå. [Statistics Norway](2019). Nøkkeltall for helse i Norge [Key number related to health care in Norway]. Available from: https://www.ssb.no/helse/nokkeltall https://www.ssb.no/helse/nokkeltall: Statistisk Sentralbyrå SSB.
44. HOD. Helse-og omsorgsdepartementet [Ministry of health and care services]. (2014). Egenbetaling for kommunale tjenester i og utenfor instiusjon [User fees for primary care in and outside institution]. [updated 18.12.2014]: https://www.regjeringen.no/no/tema/helse-og-omsorg/helse%2D%2Dog-omsorgstjenester-i-kommunene/innsikt/egenbetaling-i-og-utenfor-institusjon/id434597/.
45. HOD. Helse-og omsorgsdepartementet [Ministry of health and care services]. Forskrift om ledelse og kvalitetsforbedring i helse og omsorgstjenesten [Regulation of management and quality improvement in health care services] no. 1036; Amendment 01.01.2017. 2017 https://lovdata.no/dokument/LTI/forskrift/2016-10-28-1250.
46. HOD. Helse- og omsorgsdepartementet [Ministry of health and care services]. Forskrift for sykehjem og boform for heldøgns omsorg og pleie [Regulation for nursing homes and residential care] (Updated 01. july 2013) no. 708; Amendment 01.01.1989. 1989. https://lovdata.no/dokument/SF/forskrift/1988-11-14-932.
47. Trompetter H, Scholte R, Westerhof G. Resident-to-resident relational aggression and subjective well-being n assisted living facilities. Ageing Mental Health. 2011;15(1):59–67.
48. Matsuda O. An assessment of the attitudes of potential caregivers toward the abuse of elderly persons with and without dementia. Int Psychogeriatrics. 2007;19(5):892–901.
49. Kales HC, et al. Management of neuropsychiatric symptoms of dementia in clinical settings: recommendations from a multidisciplinary expert panel. JAGS. 2014;62(4):762–9.
50. Lichtwarck B, Selbaek G, Kirkevold O, Rokstad AMM, Benth JS, Lindstrom JC, et al. Targeted interdisciplinary model for evaluation and treatment of neuropsychiatric symptoms: a cluster randomized controlled trial. Am J Geriatr Psychiatry. 2018;26(1):25–38.

51. Lichtwarck B, Myhre J, Goyal AR, Rokstad AMM, Selbaek G, Kirkevold Ø, et al. Experiences of nursing home staff using the targeted interdisciplinary model for evaluation and treatment of neuropsychiatric symptoms (TIME)–a qualitative study. Aging Ment Health. 2018:1–10.
52. Utley-Smith Q, Colón-Emeric CS, Lekan-Rutledge D, Ammarell N, Bailey D, Corazzini K, et al. The nature of staff-family interactions in nursing homes: staff perceptions. J Aging Stud. 2009;23(3):168.
53. Vinsnes AG, Nakrem S, Harkless GE, Seim A. Quality of care in Norwegian nursing homes–typology of family perceptions. J Clin Nurs. 2012;21(1–2): 243–54.
54. Cooper C, Dow B, Hay S, Livingston D, Livingston G. Care workers' abusive behavior to residents in care homes: a qualitative study of types of abuse, barriers, and facilitators to good care and development of an instrument for reporting of abuse anonymously. Int Psychogeriatr. 2013;25(5):733–41.
55. Jones A, Kelly D. Whistle-blowing and workplace culture in older peoples' care: qualitative insights from the healthcare and social care workforce. Sociol Health Illn. 2014;36(7):986–1002.
56. Ree E, Wiig S. Employees' perceptions of patient safety culture in Norwegian nursing homes and home care services. BMC Health Serv Res. 2019;19(1):1–7.
57. Siegel EO, Young HM, Zysberg L, Santillan V. Securing and managing nursing home resources: director of nursing tactics. Gerontologist. 2015; 55(5):748–59.

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RESEARCH ARTICLE Open Access

React and act: a qualitative study of how nursing home leaders follow up on staff-to-resident abuse

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Abstract

Background: Elder abuse in nursing homes is a complex multifactorial problem and entails various associations across personal, social, and organisational factors. One way leaders can prevent abuse and promote quality and safety for residents is to follow up on any problems that may arise in clinical practice in a way that facilitates learning. How nursing home leaders follow up and what they follow up on might reflect their perceptions of abuse, its causal factors, and the prevention strategies used in the nursing home. The aim of this study was to explore how nursing home leaders follow up on reports and information regarding staff-to-resident abuse.

Methods: A qualitative explorative design was used. The sample comprised 43 participants from two levels of nursing home leadership representing six municipalities and 21 nursing homes in Norway. Focus group interviews were conducted with 28 care managers, and individual interviews took place with 15 nursing home directors. The constant comparative method was used for the analyses.

Results: Nursing home leaders followed up incidents of staff-to-resident abuse on three different levels as follows: 1) on an individual level, leaders performed investigations and meetings, guidance, supervision, and occasionally relocated staff members; 2) on a group level, feedback, openness, and reflection for shared understanding were strategies leaders used; and 3) on an organisational level, the main solutions were to adjust to available resources, training, and education. We found that leaders had difficulties defining harm and a perceived lack of power to follow up on all levels. In addition, they did not have adequate tools for evaluating the effect of the measures that were taken.

Conclusions: Nursing home leaders need to be clear about how they should follow up incidents of elder abuse on different levels in the organisation and about their role in preventing elder abuse. Evaluation tools that facilitate systematic organisational learning are needed. Nursing homes must operate as open, blame-free cultures that acknowledge that incidents of elder abuse in patient care arise not only from the actions of individuals but also from the complex everyday life of which they are a part and in which they operate.

Keywords: Nursing home, Leaders, Patient safety, Organisational learning, Elder abuse, Staff-to-resident abuse, Adverse events

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Background

Nursing homes are institutions, with a dual demand of serving as a home for residents [1] but also providing social services and complex health care day-and-night [2]. Residents in these institutions have chronic diseases, complex care needs, and physical impairments, and they may have dementia or other forms of cognitive impairment [3]. Many residents have significant neuropsychiatric symptoms such as agitation, aggression, anxiety, depression, apathy, and psychosis [4]. In addition to the complexity of residents' needs, complexity exists in that nursing homes consist of different stakeholders such as staff, leaders, relatives, and residents themselves in constantly shifting interactions [5, 6]. Patient safety and quality of care in nursing homes is multifactorial, comprising associations between organisational factors, the technical performance of care, and the organisation's culture [2, 7] as well as values, attitudes, and knowledge in society and its policies [8]. Leaders of these institutions have a responsibility to ensure that residents' human rights are protected, and that residents are safe and free from harm [9, 10]. However, research have found high rates of staff-to-resident abuse in nursing homes [11–13].

The World Health Organisation (WHO) defines elder abuse as 'a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which cause harm or distress to an older person ([14], p 3). Abuse can be subdivided into physical abuse (e.g., slapping, pushing, inappropriate use of restraints), emotional or psychological abuse (e.g., humiliating, threatening, or treating a resident like a child), financial or material abuse (e.g., misusing power of attorney, stealing, selling personal belongings without consent), sexual abuse (e.g., any unwanted sexual activity), and neglect (e.g., failing to provide for basic health or medical needs, abandonment) [15]. For nursing home residents, the consequences of abuse include reduced quality of life, psychological and physical harm, loss of assets, and increased morbidity and mortality [16].

A survey of nursing home staff in Norway found that 60.3% had exposed a resident to one or more incidents of abuse in the past year [13]. The majority of staff in this study reported that they had never committed financial or sexual abuse against a resident. Physical abuse was reported by 9.6%, and psychological abuse and neglect had the highest prevalence, with 40.5 and 46.9% respectively [13]. A meta-analysis of the prevalence of elder abuse in nursing homes estimated a pooled prevalence of 64.2% of staff-to-resident abuse in the past year; additionally, in this study, psychological abuse and neglect had the highest prevalence [11]. Psychological abuse and neglect are often related to care activities such as leaving a resident alone [12], omitting to change wet incontinence pads [17], ignoring or rejecting residents [12, 13], omitting to provide oral health care [13], and arguing with or shouting at residents [12, 13].

The many different interpretations on what constitutes abuse and its severity complicate its detection, reporting, and management in nursing homes [9, 18, 19]. In addition, in nursing homes, elder abuse has been conceptualised as a specific form of abuse, such as institutional abuse [20] and a context where abuse and neglect take place [21]. The relationship between staff and residents is characterized by differences in power, and the resident is dependent on staff to fulfil most of his/her needs [22, 23]. But also due to the fact that regulations and rules within the institutional context can be abusive itself, such as deny residents choices in everyday life, e.g. when to dress and undress and have meals, and sharing room and space with other residents. Risk factors for abuse within institutions are also complex multifactorial problems entailing various associations between personal, social, and organisational factors [24, 25]. This means that the risk of some forms of staff-to-resident abuse extends beyond the traits and circumstances of the older adults and the staff who abuse them [25]. At the same time, intentionally criminal abuse should be reported to the police. In order to do so, openness in the organisation is crucial so that the nursing home leaders get knowledge about the situation that has occurred or the suspicion of what is occurring.

Preventing harm is a core principle of health care and a responsibility of leaders [26]. Leadership is critical for patient safety and prevention of harm since leaders influence the culture and care practices in nursing homes and set policies for staff [27]. Good leadership is an essential factor in developing staff's understanding of residents' needs [28, 29]. According to the Institute for Healthcare Improvement (IHI) report "Leading a Culture of Safety: A Blueprint for Success" [26], healthcare organizations that are successful in improving safety and eliminating harm have leaders who understand and commit to the principles of a 'just culture'. The IHI defines a 'just culture' as one that focuses on identifying and correcting system factors without blaming individuals for human mistakes and, at the same time, establishing zero tolerance for reckless behaviour [26]. In order to do so, leaders need to investigate each event to determine whether the incident was caused by human error (e.g., slips), at-risk behaviour (e.g., taking shortcuts), or reckless behaviour (e.g., ignoring required safety steps). The result of the investigation should determine the response and the follow-up [26].

To be able to effectively investigate and follow up, leaders need comprehensive information about the care and service provided. This information can be obtained from the formal reporting systems or from informal reports, such as verbal information and observation. The

use of a reporting system and various information sources is linked to the belief that patient safety can be improved by learning from incidents and 'near misses' [30]. Learning can take place at the individual and at the organisational level. Individual learning focuses on increasing knowledge and skills for individual staff members to enable them to do a better job, while organisational learning involves sharing the thoughts and actions of all the individuals in the organisation; furthermore, organisational learning entails a cultural change [30, 31]. Organisational learning is mediated through individual learning or problem-solving processes but the opposite is not true [32]. Argyis and Schön divided organisational learning into 'single-loop learning', which refers to the correction of errors without significantly changing the overall safety culture, and 'double-loop learning', which refers to a cultural change that involves questioning and alterations of the governing values within the organisation [31].

In Norway, the responsibility of nursing home leaders to follow up on information and adverse-event reports is formally regulated in the national regulation of management and quality improvement in healthcare services [33]. This regulation points to leaders' responsibilities to monitor the overall quality and safety of resident care and to establish a culture of openness where events are reported, openly discussed, and analysed. The follow-up for incidents involves analysing the causes and implementing preventive measures designed to ensure that incidents do not happen again. Any follow-up should also include an evaluation of the measures taken in response to an incident [33]. Knowledge and understanding of how nursing home leaders follow up on information and reports regarding elder abuse are essential because one might assume that their reactions and responses reflect their perceptions of abuse, its causal factors, and the prevention strategies applied in the nursing home. To the best of our knowledge, this is the first study to investigate how nursing home leaders follow up on information and reports of staff-to-resident abuse.

Aim of the study

This study aimed to explore how nursing home leaders follow up on reports and information regarding staff-to-resident abuse.

Methods

Design

The present study is part of a larger study funded by the Research Council of Norway (NFR); project number 262697. In the present study we used a qualitative exploratory design that included both focus group and individual interviews. Results from the first analyses of the focus group interviews have been published previously [19], and selected data related to how the lower level of managers understand the consept elder abuse was analysed. However, we did not report from data about follow-up on elder abuse. This is also reflected in the interview guide. The present study reports unpublished data from the focus groups in addition to new data from individual interviews with nursing home directors. By combining individual interviews with nursing home directors and focus group interviews with care managers, the present study also compares and contrasts leadership levels.

In Norway, all nursing homes have two levels of leadership: the nursing home director and the nursing home leader team. These two leader levels can influence each other through their hierarchical relationship, and together they can influence the quality of care and patient safety [27]. By gathering information from the perspectives of both levels, the intention of the present work was to develop a deeper understanding of how nursing home leaders follow up on staff-to-resident abuse in nursing homes. This study follows the Consolidated Criteria for Reporting Qualitative Research (COREQ) [34].

Settings

The vast majority of Norwegian nursing homes are owned and run by municipalities, financed by taxes and resident payment; less than 10% are private non-profit institutions [35]. Nursing homes are led by nursing home directors, who are administrative managers for entire facilities, and some nursing home directors are administrators for more than one nursing home. The next level of managers is a leadership team comprising ward leaders, a quality leader, and, in some municipalities, a service leader [36]. The ward leader is a registered nurse (RN) who is responsible for staff and residents and the budget for his or her ward. The quality leader is an RN who monitors the overall quality of care in collaboration with ward leaders. The service leader is responsible for service staff such as activity coordinators, cleaning staff and kitchen staff and budgets related to these staff. Individuals on the leader team provide the closest leadership to staff and residents, but they do not provide direct hands-on care.

The provision of care in Norwegian nursing homes is delivered under the "National Regulation of Quality of Care" [37]. This regulation aims to ensure that residents' basic needs are met, including their psychological and physical needs, and that their dignity, autonomy and self-respect are preserved. Health personnel have a responsibility to report any adverse event that may endanger patient safety. This is formally regulated in the "National Health Personnel Act" [38]. Abuse can be classified within the category of patient safety and adverse events that health personnel are responsible for

reporting. In the present study, we used the term adverse event to refer to events and incidents of intentional or unintentional abuse where the outcome for the resident is harmful or potentially harmful. This term also includes failure to deliver needed care, defined as the omission or neglect of delivering any aspect of required resident care.

Sample

The study sample was recruited from 21 nursing homes in six municipalities in Norway.

These six municipalities can be divided into one small municipality with population size < 4999, two middle range municipalities with 5000–19,999 inhabitants and three large municipalities with population size > 20,000. Inclusion criteria were as follows: a) the person is employed in a leadership position in a nursing home and (b) is employed full-time in that role. We recruited municipalities and nursing home leaders with a stepwise approach, because we wanted to get a theoretical sampling until saturation of data was achieved [39, 40]. In all, 43 participants were recruited: 15 individual interviews were conducted with nursing home directors and 6 focus group interviews were conducted with a total of 28 participants comprising twenty-three ward leaders, two quality leaders and three service leaders. In this study, we chose to refer to all 28 participants in the six focus group interviews as 'care managers' since all were members of the leadership team. The characteristics of the participants are presented in Table 1.

Recruitment and data collection

The recruitment period was from August 2018 to the end of January 2019. The first recruitment e-mail was sent to healthcare managers in 11 municipalities, both urban and rural areas. Healthcare managers from six municipalities accepted the invitation, while five healthcare managers stated that nursing home leaders in their municipalities did not have time to participate. Subsequently, a second recruitment e-mail was sent to all nursing home directors in the six municipalities that had accepted the invitation. The second recruitment e-mail included two invitation letters: one letter to nursing home directors and the other for nursing home directors to forward to care managers in their nursing homes. The care managers were invited to participate in focus group interviews, while the nursing home directors were invited to participate in individual interviews since there are few nursing home directors in each municipality and it was difficult to gather them for focus group interviews.

All interviews took place in a meeting room in a nursing home in the included municipalities. Each focus group interview lasted approximately 90 min, and each individual interview lasted approximately 60 min. Before the interview started participants were asked about demographic information, see Table 1. JM was the moderator for all six focus group interviews. Co -moderator was SN in two group interviews, SS in one group interview and two researchers from the larger research team for the other three interviews All 15 individual interviews were conducted by JM. We used the same interview guide for the focus group interviews with the care managers and the individual interviews with the nursing home directors (Table 2). The researchers made the interview guide after studying the literature on elder abuse in nursing homes. Participants were asked about their experiences and thoughts on the topic of elder abuse and how they follow up on these situations. We encouraged participants to speak freely. All interviews were recorded and transcribed verbatim, retaining pauses and emotional expressions. Data from the focus group interviews exploring the care managers perceptions of elder abuse (the first topic in the interview guide) were published in a previous paper [19]. The present study includes a secondary analysis of data from the focus group interviews with the care managers and new analysis of the individual interviews with nursing home directors focusing on the second and last topic in the interview guide.

Data analysis

The constant comparative method allowed us to generate a thematic understanding through an open exploration of experiences described by nursing home leaders [39, 40], and permits the possible identification of themes and differences between the two different leadership levels. The analysis started immediately after each interview, when the first author listened to the recorded interview. We used memo writing throughout the process of both data collection and analysis. The memo document worked as a file of emerging ideas, thoughts, questions and categories [39]. An open line-by-line coding of the transcribed interviews was the next step in the analysis process [39, 40]. Next, we compared codes from the open coding for commonalities and frequencies. Further, codes were then clustered to develop sub-categories. To construct the final categories and main theme, the sub-categories was examined. We went back and forth between memo writing, data analysis and contextualisation to ensure that the emerging categories and themes fitted the situations explored [39]. Comparisons between groups were conducted in three main steps: 1) comparison within a single interview; 2) comparison between interviews within the same group; and 3) comparison of interviews from different groups [39, 40]. The first and last author (JM and SN) coded all transcribed interviews independently in order to diminish research bias and increase credibility. All authors

Table 1 Demographics of the study participants ($n = 43$)

Background characteristics	Care manager (n = 28) Number (%)	Nursing home director (n = 15) Number (%)
Age (years)		
30–39	6 (22)	1 (7)
40–49	11 (39)	2 (13)
≥ 50	11 (39)	12 (80)
Sex		
Female	25 (89)	13 (87)
Male	3 (11)	2 (13)
Number of beds managing:		
0	5 (17)	
10–19	8 (29)	
20–29	8 (29)	
30–40	6 (21)	
40–59	1 (4)	8 (53)
60–99		3 (20)
100–199		3 (20)
≥ 200		1 (7)
Number of staff managing:		
0	2 (7)	
10–29	9 (33)	
30–49	11 (39)	
50–99	6 (21)	5 (33)
100–199		6 (40)
≥ 200		4 (27)
Working experience in this position		
0–4	20 (71)	8 (53)
5–9	7 (25)	3 (20)
≥ 10	1 (4)	4 (27)
Total working experience as a leader in years		
0–4	11 (39)	1 (7)
5–9	6 (22)	1 (7)
≥ 10	11 (39)	13 (86)
Formal leader education		
0	1 (4)	1 (7)
0,5–1 years course	18 (64)	5 (33)
1–2 years course	3 (11)	2 (13)
Master's Degree	6 (21)	7 (47)

met several times during the analysis process to discuss codes, their connections and reach consensus.

Ethical consideration

Ethical approval for this study was granted by the Norwegian Center for Research Data (NSD), Ref. no. 60322. All participants were provided with written information about the study and gave written consent to participate in the interviews and for the use of the data collected from the interviews.

Results

In the beginning of the interviews, participants were reluctant to share their experiences of staff-to-resident abuse in their nursing home. Participants considered the term 'abuse' and the topic of staff-to-resident abuse, which was mainly related to intentional physical acts and sexual abuse, as highly sensitive. Few participants had experienced severe sexual or financial abuse on the part of staff. Most participants had experience mainly in regard to following up on incidents of physical abuse such as use of restraint or rough handling during care, psychological abuse and neglect. In the analyses, we found that nursing home leaders follow up on elder abuse in nursing homes on three different levels: *1) an individual level; 2) a group level; 3) and an organisational level.* An additional finding involved the differences between how nursing home directors and care managers were involved in the follow-up and how they perceived the root causes of the abuse. Their involvement and perceptions influenced how they reacted and acted upon and how they followed up on incidents. Analytical categories and sub-categories are presented in Fig. 1.

Follow-up on an individual level

All participants described staff-to-resident abuse as related primarily to individual characteristics of certain staff members. For example, they stated that some staff members had personalities and/or attitudes that were unsuitable for working with older people in a nursing home. Other factors that were mentioned included staff's personal problems, lack of knowledge, stress, and burnout. Both care managers and nursing home directors expressed that they did not want information or reports from staff in relation to patient abuse to be anonymous because they needed to know the name of the person to whom they should speak. "Investigation and meetings", "guidance and supervision" and "relocating the staff member" were noted as ways the participants followed up on information and reports of incidents or potential incidents of abuse at the individual level.

Investigation and meetings

All participants stated that, when they received information about an incident of abuse, they invited the staff member involved in the situation to a meeting. However, participants found these meetings were 'difficult'. In part, the difficulty was said to be related to differences in peoples' accounts of the incident. For example, one participant explained that, often, the staff member involved in

Table 2 Interview guide

Topic	Key questions
Introduction	Can you describe what you will define as abuse and neglect in nursing homes?
Your experiences of elder abuse and neglect	Within these situations (Fig. 1), and these categories; *physical abuse, psychological abuse, financial abuse, sexual abuse and neglect,* can you describe your experience of elder abuse and neglect?
Communication of elder abuse and neglect	Can you describe how you get knowledge about situations of elder abuse and neglect in the nursing home? What do you think are barriers and enablers to reporting elder abuse and neglect?
How to follow up on elder abuse and neglect	When you get knowledge about situations of elder abuse and neglect, how do you follow it up? What do you do to prevent it from happening again?
Closure	Do you have anything to add that has not yet been mentioned? How did you experience participating in this focus group?

Note: The results from the topic 1 'Experience of elder abuse 'is published with data from focus group interviews with care managers

the situation had one version of what happened; the staff member who had observed the situation saw it another way; and the resident involved had a third story. Difficulty trusting the resident's version of what happened was related to his or her cognitive status; one care manager remarked: *"What I think is difficult here is that these residents … they are almost like children. What is fiction and what is truth of what they say?"* (Care manager, group 1). All participants described being uncertain about which of the three stories they should consider to be the most accurate. The nursing home leaders said that they wanted to be sure and to have evidence before confronting or following up on information regarding abuse by a staff member. Because of this, both the care managers and the nursing home directors stated that the care managers who received the information first, were required to undertake a thorough investigation. This investigation was allegedly conducted before a meeting, but it could also take place after a meeting with the staff member involved:

> *"As a leader, you must do a lot of investigation in the beginning of a case. Because when you talk to the staff member you are going to follow up, that staff member has a completely different version than the one you have been told".* (Care manager, group 3)

Having received several written adverse-event reports related to the same staff member was perceived as evidence, as were care managers observations and accounts of the incident. However, one problem was that it could be difficult to elicit adverse-event reports related to abuse from staff. Some leaders stated that staff-to-resident abuse was too sensitive a topic to be reported in the adverse-event reporting system.

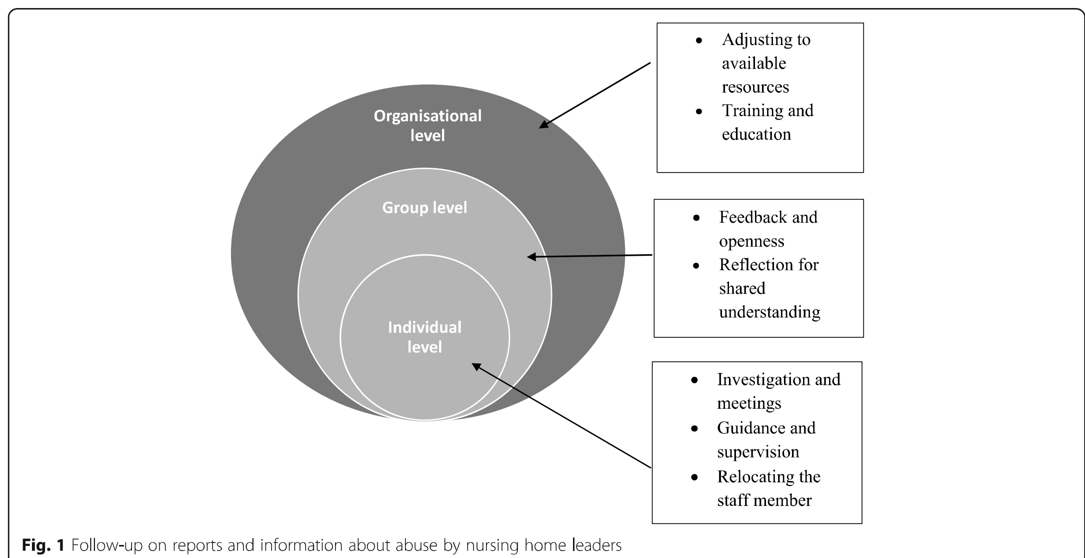

Fig. 1 Follow-up on reports and information about abuse by nursing home leaders

Participants indicated that care managers were responsible for most of the follow-up on an individual level. Nursing home directors were involved in the investigation of cases perceived as severe. Several participants also noted that they had to involve the human resource department in handling staff-to-resident abuse if the abuse was serious or the staff member disagreed with the finding. Only a few participants had experienced cases with clear evidence of severe physical, sexual or financial abuse. Those leaders who had experienced dealing with such incidents had contacted the police and the health authorities.

Guidance and supervision

In situations where abuse took the form of disrespectful behaviour toward a resident or where staff did not reflect on their own practice, participants said that they attempted to guide the staff member to reflect on and to understand the situation during a meeting. One nursing home director remarked: *"The very best is if you can talk things through during the meeting and the staff themselves reflect and realize that what they have done isn't good practice"* (Nursing home director, 6). Another way to follow up after a meeting was to give the staff member a written reprimand. At the same time, several participants felt that a written reprimand was a serious response and an action they worked to avoid. According to several participants, an additional way of following up was to provide guidance and supervision with the intention of getting the staff member to change his or her behaviour. This could be used if they suspected that the staff member lacked technical or relational knowledge and skills. In such cases, care managers and nursing home directors stated that care managers could follow up by having conversations with the staff member, while a registered nurse could supervise the staff member in his or her daily interactions with residents. Although all participants mentioned guidance and supervision in daily care as a way to follow up on an individual level, few participants had used this strategy themselves. The main barrier to doing so was stated to be the consideration of confidentiality for the staff member in need of follow-up in relation to other staff.

Relocating the staff member

Both care managers and nursing home directors indicated that it was difficult to go through the process of dismissing a staff member who was considered unsuitable for working in a nursing home setting, without having enough evidence. One care manager remarked: *"You need a lot of documentation in those cases, and I feel that staff can do quite a lot and still have strong protection"* (Care manager, group 2). Participants indicated that, in situations involving complaints from residents on a ward but insufficient evidence to dismiss the staff member, he or she was moved away from the resident. According to the nursing home directors and the care managers, relocation was done on the ward away from the resident who had complained to another ward in the nursing home or to another nursing home, where the staff member continued the same care activities.

> *"We have had one case here that involves rough handling of a resident. The entire human resources section was connected to that case, and it ended up with moving the staff member to another nursing home."* (Care manager, group 4)

Other participants stated that staff members could be relegated to another role or to other tasks that did not involve direct resident care, e.g. kitchen or cleaning work, which might result in the staff members choosing to quit his or her job at the nursing home.

Follow-up on a group level

Participants stated that caring for residents with dementia and aggressive behaviours was a daily challenge for all staff, especially residents who resisted care. Therefore, the leaders felt they had to intervene not only for individual staff members but also at a group level. Participants discussed how to define elder abuse and said that the organisational culture influenced what was perceived as acceptable staff behaviour. "Feedback and openness" and "reflection for shared understanding" were how the leaders followed up on information and reports of incidents or potential incidents of abuse on a group level.

Feedback and openness

Both care managers and nursing home directors suggested that it was important to build a culture of openness within the nursing home. One way of doing that was by giving feedback on reports of incidents of abuse or potential abuse at a group level. However, how this was done depended on internal routines in the different municipalities. Some participants said that they gave staff feedback on all reports of adverse events at staff meetings at the ward. Reports related to abuse were read and discussed anonymously by the staff-member group with the intention to learn; for example, incidents of physical and chemical restraint were handled this way: *"Then I raised it at a staff meeting; What do we do in such situations and which options do we have?"* (Care manager, group 2).

In addition, several stated that they sent information by e-mail to staff if they received reports concerning situations that they wanted all staff to be aware of. A few participants said that they had monthly meetings in the nursing home and meetings together with all the nursing

homes in the municipality twice a year where adverse-event reports were discussed. However, according to most participants, there are no routines for handling and giving feedback on reports. Participants from these municipalities expressed that they gave feedback on reports of adverse events only to staff involved in the incidents on an individual level.

In terms of providing feedback, all participants described difficulty identifying all harmful incidents and obtaining comprehensive information about every incident of potential or actual abuse in the nursing home. To counterbalance this difficulty, both care managers and nursing home directors pointed out that they attempted to build a culture of openness that would prompt staff to report such incidents. Hence, participants emphasised the importance of reporting and said they encouraged staff to offer feedback and to guide each other during their daily work. Several also suggested that the feedback staff gave to each other was more important than the feedback they gave as leaders.

An additional finding was the difficulties participants experienced when evaluating measures taken after an adverse-event report:

> *"I think it is very difficult to evaluate this. You can look at the number of adverse-event reports. But we work to get staff to write adverse-event reports, while we at the same time are putting in place measures with the intention to get fewer adverse-event reports, and then it will not be right to evaluate by just looking at the numbers. So, the evaluation is very much through behaviour changes in individual staff members, or the experience the staff and the manager have of the climate in the ward".* (Nursing home director, 4)

This indicates that, because of the difficulties described by the participants involved in evaluating at a group level, they perceived it as easier to evaluate behaviour change in an individual staff member.

Reflection for shared understanding

All participants viewed reflection as a way to follow up on information and reports of abuse on a group level. Sometimes when leaders obtained second-hand information about abuse, they felt it was difficult to approach the individual staff member and, instead, attempted to address the problem on a group level:

> *"It isn't always easy for me as leader when I get information like: 'Something happened three weeks ago, but I didn't see it myself'; it is the resident's experience of what the staff member has done. Then I make it a case and bring it to a reflection meeting with all the staff, and hopefully someone will take it into account".* (Care manager, group 3)

The participants also believed that reflection could prevent abuse from occurring in the first place. They pointed out that reflection was important because of the complex, everyday care required in the nursing home and especially related to caring for residents with aggressive behaviour. Participants identified different reflection models such as the Targeted Interdisciplinary Model for Evaluation and Treatment of Neuropsychiatric Symptoms (TIME), person-centred care in dementia (VIPS), and the systematic model for ethical reflection (SME) as helpful resources for understanding residents with aggressive behaviour. The care managers also stated that participating in reflection meetings gave them insight into the nursing home culture. But even though all participants identified reflection as important, they also indicated that lack of time and resources were barriers for them to organise and participate in reflection meetings to the extent that they wished. Several care managers further stated that they did not have time to organise reflection at all:

> *"We can have a conversation after something has happened and talk about that situation. But we do not have time to do planned ethical reflection".* (Care managers, group 4)

Due to a lack of resources and difficulties organising reflection meetings, some nursing home directors referred to ethical reflection as 'everyday reflection' and considered it something that the staff should do on their own during the shift. One nursing home director said: *"You don't have to feel that you need to spend extra time on reflection. It should be a natural part of the workday in the nursing home"* (Nursing home director, 15). At the same time, other participants stated that knowing whether or not reflection actually improved the culture in the nursing home was problematic.

Follow-up on an organisational level

Both care managers and nursing home directors also linked abuse to organisational factors such as lack of staff with formal education and knowledge about caring for residents with dementia. Here, care managers and nursing home directors had different perceptions of whether inadequate staffing was a factor related to the incidence of abuse in nursing homes. The sub-categories "Adjusting to available resources" and "Training and education" emerged as ways the participants follow up on information and reports of incidents or potential incidents of abuse at an organisational level.

Adjusting to available resources

All care managers described lack of staff resources as a factor that increased the risk of abuse in the nursing home. At the same time, they also expressed a powerlessness related to the situation. Therefore, when abuse by staff was caused by an inadequate staffing level, it tended to be tolerated:

> *"I had a case with chemical restraints that ended with an adverse-event report. Then I had a conversation with the nurse where we discussed it, and I understand her despair. At night there are so few staff; we have one health professional at each ward on 24 residents and one nurse responsible for all three wards with a total of 72 residents. It is scraped to the bone; there is no room for something to happen. Of course, it should not affect the resident, but at the same time, it is a problem that is not easy to solve in any way".* (Care managers, group 2)

In contrast to the care managers perceptions, only one nursing home director mentioned inadequate staffing as a factor related to abuse. Instead, nursing home directors referred to the need for individual staff members to better prioritise their work and that a lack of correct prioritisation was a factor that could cause an incident. They remarked that they followed up on reports from staff regarding inadequate staffing by instructing care managers to help individual staff members to more effectively prioritise their work:

> *"We have a budget that we need to have in balance. So, what I say to staff when they report low level of staffing is that, first of all, we have to ensure that we get the right things done in the right order. The staff need to know that they are allowed to prioritise. We had one case just now, where a staff member reported lack of time to follow up on the residents as an adverse event. I told the ward leader to tell the staff member that she can get help to prioritise her work, if she has a problem with that".* (Nursing home directors, 8)

Although the care managers identified inadequate staffing as a factor related to abuse, they also indicated that they adjusted the service to the available resources and to align with norms in comparable nursing homes. They expressed that, when they received adverse-event reports from staff regarding neglect of resident care due to lack of time, they instructed staff regarding the available resources. However, if a resident showed aggressive behaviour, both the nursing home directors and care managers stated that they could put on extra staff. However, they indicated that it could be difficult to evaluate whether or not the extra staff was the appropriate solution.

Training and education

Participants described difficulty recruiting skilled staff and noted that many of the staff members at their nursing homes were unskilled. Both nursing home directors and care managers expressed concern that staff who lacked the necessary knowledge could increase the risk of resident abuse without being aware of it, and that unskilled staff may not be able to detect changes in residents' health status, thereby risking neglecting a resident's medical needs. At the same time, care managers said that they were unable to recruit adequately skilled staff, and, as a result, employing unskilled staff was necessary:

> *"But, on the other hand, I don't think we are able to do anything about this. We can't manage without unskilled staff, and it is not going to happen that all unskilled personnel suddenly decide to become nurses (RNs) either, or that we can give a full position to every skilled nurse who wants it".* (Care manager, group 4)

All participants said that they organised internal staff meetings with an educational focus on strategies to promote residents' safety. Preventing the use of restraint and procedures related to its use were important topics for internal staff meetings. However, both nursing home directors and care managers stated that it was difficult to motivate and include all staff, especially night and weekend staff, in these meetings. Several participants stated that, to counterbalance these difficulties, their organisations employed a few staff members with extra training and knowledge related to restraint. These staff members had a special responsibility to guide and supervise other staff. Both nursing home directors and care managers said that they tried to encourage staff to guide each other and learn from others in the context of their everyday practice. They also pointed out the responsibility staff have for updating themselves on relevant knowledge. A nursing home director remarked: *"As professionals, the staff [members] have a duty to guide each other"* (Nursing home director, 12).

Discussion

This study explored how nursing home leaders follow up on reports and information regarding staff-to-resident abuse. Nursing home directors and care managers described measures that were taken on an individual, group, and organisational level. An ambiguity emerged from the nursing home leaders' examples of follow-up measures.

On one hand, nursing home leaders indicated an intention to follow up on incidents of harm or distress to residents. On the other hand, they found it difficult to define harm stemming from abuse and felt powerless in terms of being able to follow up on all levels. An additional finding was that they lacked effective tools for evaluating the measures taken, and this influenced how and what leaders actually acted upon.

Participants in this study stated that they had little experience with reckless behaviour from staff, intentional physical acts, sexual abuse, or financial abuse. Even so, these incidents of evident abuse were perceived as incidents that should be acted upon by contacting the police and healthcare authorities. Intentional physical, sexual, and financial abuse do occur in nursing homes, but the frequency of these types of staff-to-resident abuse is low [13]. The most common forms of abuse are neglect and psychological abuse [11–13], but how the latter type is perceived influences what is reported. Hence, the incidents that nursing home leaders act on differ [19]. One important factor in determining abuse and its severity is the ability to consider a harmful situation from the perspective of the resident [7, 41, 42]. However, our study showed that when nursing home leaders investigated reports, they encountered varying and conflicting accounts of the incident. These accounts differed not only between staff members but also between residents and staff. It is concerning that leaders demonstrated a lack of confidence in the resident's story, and this raises the question of whether their reactions are influenced by ageism. Certain behaviours such as abuse or discounting the stories of people with dementia seem to be justified and influenced by attitudes towards ageing in society [43]. This is also supported by previous research, indicating that abusive behaviour is rated as less serious when the resident has dementia [44].

Findings revealed that nursing home leaders in the present study linked incidents of abuse mainly to individual characteristics of the staff members involved, such as personality, attitude, personal problems, lack of knowledge, stress, and burnout. However, staff-to-resident abuse is a multifactorial problem [24, 25]. Understanding risks for staff-to-resident abuse in nursing homes requires a simultaneous focus on both the resident and the staff as a dyad and understanding the pattern of interaction that takes place between them within the contextual frame of the institution and the wider society [25]. There is a tendency in healthcare organisations to treat patient-safety issues as failings on the part of individual staff members [26, 45]. In contrast, a system-based approach focuses on the idea that most patient-safety issues reflect predictable human failings in the context of poorly designed systems [45, 46]. Nursing home leaders in our study wanted to identify the individual staff member involved in the situation in the adverse-event report so that they knew who to talk to when following up. According to international recommendations for national patient-safety incident-reporting systems, anonymous adverse-event reports are important because they prevent a 'shaming and blaming culture' [47]. Moreover, adverse-event reports should be collected for the purpose of learning rather than to address the failings of individual staff members [48]. Leaders play a central role in balanced accountability for both individual staff members and the organisation as a whole [26]. To determine whether the cause of an event is related to an individual's reckless behaviour or to systemic factors, a systematic analysis approach is needed [26, 45, 49]. However, a systematic review of adverse-event analysis methods found that some approaches are limited because they do not capture the complexity of an adverse event [50]. This poses the question of whether the leaders in this study attempted to simplify the complexity of incidents of abuse by determining a linear solution of cause and effect and considering mainly individual factors rather than conducting a larger systematic analysis. It is alarming that some staff members were relocated as a follow-up when a leader became aware of their behaviour. Moving staff to another location where they continue to have the same care responsibilities will not facilitate individual or organisational learning.

The complexity of caring for residents with dementia and aggressive behaviour within a complex organisation was indicated by the participants to be a risk factor for abuse. Aggressive behaviour is complex and multifactorial, and can relate to individual resident factors, environmental factors and caregiver factors [51, 52]. Both staff's and the organisation's ability to meet residents' needs and to adapt and cope with this complexity are challenged [51, 53]. According to complexity theory, people in complex systems will try to adapt to internal and external demands [5, 6]. This adaptation can have both positive and negative consequences [53]. Negative consequences of adaptation are seen when an abnormal culture becomes normal, for example, accepting the use of physical and chemical restraint, arguing with a resident, or rough handling during care [54]. One way leaders can facilitate learning within organisations is through feedback and openness [7, 29, 31]. Using adverse-event reports facilitates organisational learning and a just culture and avoids attributing blame to individuals [26]. Feedback and openness were also perceived as important by all participants, but how they implemented feedback from reports differed. Some leaders used adverse-event reports to promote organisational learning, even though most leaders gave feedback only to the specific staff member involved in an incident, which is a barrier for organisational learning. The leaders in this study stated

that they often followed up on a group level by initiating reflective practices and, thereby, attempted to facilitate a cultural understanding of what constitutes abuse in the nursing home. Previous research has also found that, through reflection, long-held assumptions that form socially accepted behaviour within a culture can be challenged and changed by questioning existing processes and procedures [31, 32, 55]. This type of learning, developed by Argyris and Schön [31], is referred to as double-loop learning. The importance of systematic reflection has also been revealed in a Norwegian study, where staff caring for residents with aggressive behaviours enhanced their coping and learning skills through reflection [51]. However, the participants in our study stated that lack of time and resources was a main barrier to organisational learning through reflection. Many leaders responded to this barrier by placing the responsibility for reflection on individual staff members. However, the literature shows that organisational learning through reflection takes place when readiness to learn and a mental model for interpreting experiences are shared by staff [32]. This includes the idea that staff members must 'learn how to learn' with the use of reflection and must have time to do so [31, 32].

On an organisational level, findings from the present study suggest that care managers view inadequate staffing in regard to education and numbers as a contributing factor to staff-to-resident abuse. In contrast, nursing home directors stated that staffing was not the problem. Rather, the problem was related to incorrect prioritisation by individual staff members. Previous research found that lack of staffing in terms of education and numbers and high staff turnover were risk factors for abuse in nursing homes [12, 18, 21]. However, these studies did not include the perceptions of nursing home leaders. Care managers generally have less power than nursing home directors, which may result in a feeling of powerlessness to correct system defects. Care managers' and nursing home directors' differing perspectives about the association between staff and staff-to-resident abuse are noteworthy, particularly as previous research has identified associations between consistent leadership style in care managers and nursing home directors and quality of care and patient safety in nursing homes [27].

In order to meet nursing home residents' needs for safe, high-quality care, a shared cultural understanding of the complexity of nursing home services and adequate staffing with the necessary competencies are required [9]. It is possible that nursing home directors respond to demands for efficiency and cost savings by putting the responsibility for preventing abuse onto staff members and attributing it to their individual prioritising instead of using their power to correct system defects. A further interesting finding is the lack of evaluation tools at a group and an organisational level. According to the national regulation of management and quality improvement in healthcare services in Norway, any follow-up of adverse events should also include an evaluation of the measures that were taken in response [33]. However, findings indicate that it is easier to identify changes in individual staff members' behaviours than in the organisation or at the group level. This may explain the existence of a culture of blame in health care.

Strengths and limitations of the study

This study involved participants from two levels of leadership from different nursing homes and municipalities in Norway, which is a strength and increases the transferability of the findings. Data collection methods consisted of both focus group interviews and individual interviews due to the difficulty of conducting focus group interviews with nursing home directors. Since nursing home directors and care managers can influence each other and jointly influence quality of care and patient safety, we viewed the advantages of including both data collection methods to be greater than the disadvantages since both methods are suitable for exploring people's experiences with a specific phenomenon.

Three of the authors have worked as care managers in nursing homes for several years; this can be considered a strength as well as a limitation and requires a particular focus on reflexivity throughout the research process. Because of this background knowledge, it was possible to pose in-depth questions to explore a broad range of issues. However, background knowledge could also affect the type of follow-up questions asked during the interviews. To counterbalance this potential bias, two researchers were always present during the focus group interviews, and the analyses were coded by two researchers (JM and SN) independently. All findings were also discussed in the research group, which comprised researchers with broad research experience from two different countries. This, in turn, strengthens the trustworthiness of our findings and the credibility of the research.

Conclusion

To prevent abuse of residents in nursing homes, it is important to understand how nursing home leaders follow up such incidents and what they follow up specifically. Our study revealed in-depth information about key factors related to how nursing home leaders react and act in response to elder abuse, which reflects their understanding of what constitutes abuse, its causal factors, and prevention strategies used in nursing homes. Nursing home leaders need to be clear about how they should follow up incidents of elder abuse on different levels in the organisation and their roles in its

prevention. Nursing home leaders also need evaluation tools to facilitate systematic organisational learning. Moreover, nursing homes must operate as open, blame-free cultures that acknowledge that incidents of elder abuse in patient care arise not only from the actions of individuals but also from the complex everyday life of which they are a part and in which they operate.

Abbreviations

NFR: Research Council of Norway; RN: Registered Nurse; WHO: World Health Organization; IHI: Institute for Healthcare Improvement

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Authors' contributions

JM wrote the manuscript. JM, SS, WM, JO and SN developed the study design. JM transcribed the interviews, and JM and SN performed the analyses of the interviews, with discussion including all authors. SN supervised the project. All authors participated in critical revisions of the manuscript for important intellectual content, and all read and approved the final manuscript.

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Availability of data and materials

The datasets generated and/or analysed during the current study are not publicly available due to the format of the data not allowing for a complete anonymisation. However, data are available from the corresponding author on reasonable request.

Ethics approval and consent to participate

Ethical approval for this study was granted by the Norwegian Center for Research Data (NSD), Registration No: 60322. All participants were provided with written information about the study, and all gave written consent to participate in the interviews and for the use of the data from the interviews.

Consent for publication

The participants consented to the publication of de-identified material collected from the interviews.

Competing interests

The authors declare that they have no competing interests.

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References

1. Nakrem S, Vinsnes AG, Harkless GE, Paulsen B, Seim A. Ambiguities: residents' experience of 'nursing home as my home'. Int J Older People Nursing. 2013;8(3):216–25.
2. Nakrem S. Understanding organizational and cultural premises for quality of care in nursing homes: an ethnographic study. BMC Health Serv Res. 2015; 15(1):508 1–13.
3. Helvik A-S, Engedal K, Benth JŠ, Selbæk G. Prevalence and severity of dementia in nursing home residents. Dement Geriatr Cogn Disord. 2015; 40(3–4):166–77.
4. Helvik A-S, Selbæk G, Benth JŠ, Røen I, Bergh S. The course of neuropsychiatric symptoms in nursing home residents from admission to 30-month follow-up. PLoS One. 2018;13(10):1–18.
5. Anderson RA, Issel LM, McDaniel RR Jr. Nursing homes as complex adaptive systems: relationship between management practice and resident outcomes. Nurs Res. 2003;52(1):12–21.
6. Cilliers P. Complexity and postmodernism: understanding complex systems. London: Routledge; 2002.
7. Donabedian A. An introduction to quality assurance in health care. New York: Oxford University Press; 2002.
8. Foucault M. The Archaeology of Knowledge [1969], Trans. By AM Sheridan smith. London: Abingdon, Routledge; 2002.
9. Phelan A. Protecting care home residents from mistreatment and abuse: on the need for policy. Risk Manag Healthcare Policy. 2015;8:215–23.
10. National Patient Safety Foundation. Free from Harm, Accelerating Patient Safety Improvement Fifteen Years after To Err is Human (NPSF). Boston: National Patient Safety Foundation (NPSF); 2015. Available at www.npsf.org.
11. Yon Y, Ramiro-Gonzalez M, Mikton CR, Huber M, Sethi D. The prevalence of elder abuse in institutional setting: asystematic review and meta-analysis. Eur J Pub Health. 2018;(0):1–10.
12. Drennan J, Lafferty A, Treacy MP, Fealy G, Phelan A, Lyons I, et al. Older people in residential care settings: results of a national survey of staff-resident interactions and conflicts. 2012.
13. Botngård A, Eide AH, Mosqueda L, Malmedal W. Elder abuse in Norwegian nursing homes: a cross-sectional exploratory study. BMC Health Serv Res. 2020;20(1):1–12.
14. WHO. The Toronto Declaration on the Global Prevention of Elder Abuse. Geneva: World Health Organization; 2002. Available at http://apps.who.int/iris/bitstream/10665/42495/1/9241545615_eng.pdf.
15. Working Group on Elder Abuse. Protecting our future, Report. Dublin: The Stationery Office; 2002.
16. Yunus RM, Hairi NN, Choo WY. Consequences of elder abuse and neglect: a systemtic review of observational studies. Trauma Violence Abuse. 2017; 20(2):1–17.
17. Ostaszkiewicz J. A conseptual model of teh risk of elder abuse posed by incontinence and care dependence. Int J Older People Nursing. 2017;00:1–17.
18. Cooper C, Dow B, Hay S, Livingston D, Livingston G. Care workers' abusive behavior to residents in care homes: a qualitative study of types of abuse, barriers, and facilitators to good care and development of an instrument for reporting of abuse anonymously. Int Psychogeriatr. 2013;25(5):733–41.
19. Myhre J, Saga S, Malmedal W, Ostaszkiewicz J, Nakrem S. Elder abuse and neglect: an overlooked patient safety issue. A focus group study of nursing home leaders' perceptions of elder abuse and neglect. BMC Health Serv Res. 2020;20(199):1–14.
20. Nerenberg L. Elder abuse prevention: emerging trends and promising strategies. New York: Springer Publishing Company; 2007.
21. Bužgová R, Ivanová K. Elder abuse and mistreatment in residential settings. Nurs Ethics. 2009;16(1):110–26.
22. Pillemer K, Bachman-Prehn R. Helping and hurting: predictors of maltreatment of patients in nursing homes. Res Aging. 1991;13(1):74–95.
23. Foucault M. Discipline and punish: The birth of the prison. St Ives: Penguin Books; 1977.
24. McDonald L, Beaulieu M, Harbison J, Hirst S, Lowenstein A, Podnieks E, et al. Institutional abuse of older adults: what we know, what we need to know. J Elder Abuse Neglect. 2012;24(2):138–60.
25. Schiamberg LB, Barboza GG, Oehmke J, Zhang Z, Griffore RJ, Weatherill RP, et al. Elder abuse in nursing homes: an ecological perspective. J Elder Abuse Neglect. 2011;23(2):190–211.
26. American College of Healthcare Executives, The National Patient Safety Foundation, Institute for Healthcare Improvement. Leading a culture of safety: A blueprint for success. 2017.
27. Castle NG, Decker FH. Top management leadership style and quality of care in nursing homes. Gerontologist. 2011;51(5):630–42.
28. Brady G, Pamela CGG. The influence of nursing leadership on nurse performance: a systematic literature review. J Nurs Manag. 2010;18(4):425–39.
29. Braithwaite J, Herkes J, Ludlow K, Testa L, Lamprell GJ. Association between organisational and workplace cultures, and patient outcomes: a systematic review. BMJ Open. 2017;7(11):1–11.
30. Stavropoulou C, Doherty C, Tosey P. How effective are incident-reporting Systems for Improving Patient Safety? A Systematic Literature Review. Milbank Q. 2015;93(4):826–66.

31. Argyris C, Schön DA. Organizational learning: a theory of action perspective. Toronto: Addison-Wesley; 1998.
32. Ellström PE. Integrating learning and work: problems and prospects. Hum Resour Dev Q. 2001;12(4):421–35.
33. HOD Helse og omsorgsdepartementet [Norwegian Ministry of Health and Care Services]. Forskrift om ledelse og kvalitetsforbedringer i helse og omsorgstjenesten [Regulation of management and quality improvement in health care services] 2017. Available at https://lovdata.no/dokument/LTI/forskrift/2016-10-28-1250 (accessed 09 May 2020).
34. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care. 2007;19(6):349–57.
35. SSB. Statistisk Sentralbyrå. [Statistics Norway]. Nøkkeltall for helse i Norge [Key number related to health care in Norway]. 2019. Available from: https://www.ssb.no/helse/nokkeltall https://www.ssb.no/helse/nokkeltall.
36. HOD Helse og omsorgsdepartementet [Norwegian Ministry of Health and Care Services] Forskrift for sykehjem og boform for heldøgns omsorg og pleie [National regulations for nursing homes and residential care] 1998 [updated 21.06.2013. Available from: https://lovdata.no/dokument/SF/forskrift/1988-11-14-932.
37. HOD Helse og omsorgsdepartementet [Norwegian Ministry of Health and Care Services]. Forskrift om kvalitet i pleie-og omsorgstjenestene [Regulations of the Quality of the Health Care Services], 2003. Available from https://lovdata.no/dokument/SF/forskrift/2003-06-27-792.
38. HOD Helse og omsorgsdepartementet [Norwegian Ministry of Health and Care Services] Helsepersonelloven [Health Personnel act of 2 July, No. 64]. 1999. Available at https://lovdata.no/dokument/NL/lov/1999-07-02-64.
39. Charmaz K. Constructing grounded theory: a practical guide through qualitative analysis. London: Sage; 2006.
40. Boeije H. A purposeful approach to the constant comparative method in the analysis of qualitative interviews. Qual Quant. 2002;36(4):391–409.
41. World Health Organization. Missing Voices; Views of Oler Persons on Elder Abuse, report. Geneva: WHO; 2002.
42. Nakrem S, Vinsnes AG, Seim A. Residents' experiences of interpersonal factors in nursing home care: a qualitative study. Int J Nurs Stud. 2011;48(11):1357–66.
43. Phelan A. Elder abuse, ageism, human rights and citizenship: implications for nursing discourse. Nurs Inq. 2008;15(4):320–9.
44. Matsuda O. An assessment of the attitudes of potential caregivers toward the abuse of elderly persons with and without dementia. Int Psychogeriatr. 2007;19(5):892–901.
45. Reason J. Human error: Models and management. BMJ. 2000;320(7237):768–70.
46. Carayon P, Wetterneck TB, Rivera-Rodriguez AJ, Hundt AS, Hoonakker P, Holden R, et al. Human factors systems approach to healthcare quality and patient safety. Appl Ergon. 2014;45(1):14–25.
47. Howell A-M, Burns EM, Hull L, Mayer E, Sevdalis N, Darzi A. International recommendations for national patient safety incident reporting systems: an expert Delphi consensus-building process. BMJ Qual Saf. 2017;26:150–63.
48. Committee on Patient S, Health Information T, Institute of M. Health IT and Patient Safety: Building Safer Systems for Better Care. Washington (DC): National Academies Press (US) Copyright 2012 by the National Academy of Sciences. All rights reserved; 2011.
49. Liang C, Zhou S, Yao B, Hood D, Gong Y. Toward systems-centered analysis of patient safety events: improving root cause analysis by optimized incident classification and information presentation. Int J Med Inform. 2020;135:1–8.
50. Lundberg J, Rollenhagen C, Hollnagel E. What-you-look-for-is-what-you-find: The consequences of underlying accident models in eight accident investigation manuals. Saf Sci. 2009;47(10):1297–311.
51. Lichtwarck B, Myhre J, Goyal AR, Rokstad AM, Selbeak G, Kirkevold Ø, et al. Experience of nursing home staff using the targeted interdisciplinary model for evaluation and treatment of neuropsychiatric symptoms (TIME) - a qualitative study. Aging Ment Health. 2018;23(8):966–75.
52. Kales HC, Gitlin LN, Lyketsos CG. Management of neuropsychiatric symptoms of dementia in clinical settings: recommendations from a multidisciplinary expert panel. JAGS. 2014;62(4):762–9.
53. Anderson J, Ross A, Macrae C, Wiig S. Defining adaptive capacity in healthcare: a new framework for researching resilient performance. Appl Ergon. 2020;87:1–9.
54. Pickering CEZ, Nurenberg K, Schiamberg L. Recognizing and responding to the "toxic" work environment: worker safety, patient safety, and abuse/neglect in nursing homes. Qual Health Res. 2017;27(12):1870–81.
55. Frankel AS, Leonard MW, Denham CR. Fair and just culture, team behavior, and leadership engagement: The tools to achieve high reliability. Health Serv Res. 2006;41(4):1690–709.

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Appendix I

NTNU

Fakultet for medisin og helsevitenskap
Institutt for samfunnsmedisin og sykepleie

Dette er en forespørsel til deg som leder av helse- og omsorgstjenesten om deltakelse fra din kommune i et forskningsprosjekt med tittelen:

Lederskapets betydning for å fremme pasientsikkerhet i sykehjem.

Bakgrunn og hensikt

Bedre kvalitet og pasientsikkerhet står sentralt i regjeringens politikk for å utvikle pasientens helsetjeneste. Pasientsikkerhet er vern mot unødig skade som følge av helsetjenestens ytelser eller mangel på ytelser. Pasientene skal være sikre på at tjenestene virker og at de er trygge. Derfor er det viktig at helsetjenesten kontinuerlig jobber for forbedring. Et viktig virkemiddel er at det gis mulighet til å lære av uheldige hendelser, noe som bare er mulig dersom det er trygt å melde fra om uønskede hendelser og feil. Det primære målet må være forbedring av helsetjenesten og derved pasientsikkerheten. Forskrift om ledelse og kvalitetsforbedring i helse- og omsorgstjenesten som trådte i kraft 1. januar 2017 slår tydelig fast at det er leder som har ansvaret for å identifisere, kartlegge og gjennomføre grundige analyser av uønskede hendelser.
Hensikten med dette prosjektet er å oppnå kunnskap om uønskede pasient hendelser som omhandler vold, overgrep og forsømmelser i norske sykehjem, og hvordan ledere erfarer å bruke disse meldingene til å fremme pasientsikkerhet.

Prosjektet inngår i en PhD avhandling, finansiert av midler fra Forskningsrådet HELSEVEL, og eies av NTNU, fakultet for medisin og helsevitenskap, institutt for samfunnsmedisin og sykepleie, Trondheim. Prosjektet er et av tre delprosjekter som er tilknyttet hovedprosjektet «Vold og overgrep i norske sykehjem», hvor vi i denne delen vil se på hvordan ledere kan fremme pasientsikkerhet og forebygge den typen pasienthendelser.

Hva innebærer prosjektet

For å oppnå kunnskap om forekomst av og innholdet i avviksmeldinger i norske sykehjem, vil vi gjennomføre en deskriptiv tverrsnitts studie. Det medfører at vi vil inkludere et representativt utvalg av sykehjem fra norske kommuner. I den forbindelse ønsker vi å inkludere 1 – 3 sykehjem fra deres kommune, både langtids og korttidsavdelinger. Vi ønsker å innhente rapporterte uønskede pasienthendelser fra hvert inkluderte sykehjems avviks- og meldesystem. Avvikene vil bli innhentet 2 år tilbake i tid (2016 og 2017) i anonymisert form. I tillegg vil vi innhente opplysninger om sykehjemmet som: type avdeling, antall pasienter, antall ansatte, samt ulike dokumenter relatert til kvalitetsprosedyrer.

Vi ønsker også å gjennomføre intervjuer med sykehjems ledere for å få kunnskap om deres erfaringer med avviks- og meldesystemet og arbeidet med å utvikle en pasientsikkerhetskulltur. Deltakelse i intervju er frivillig og ingen ledere er forpliktet til å stille til intervju selv om kommunen har sagt ja til deltakelse i prosjektet.

Postadresse	Org.nr. 974 767 880	Besøksadresse	Telefon	Saksbehandler
Postboks 8905		Håkon Jarls gate 11	+47 73597577	
7491 Trondheim	postmottak@mh.ntnu.no	Samfunnsmedisinbygget, 1. etg.		
Norway	www.ntnu.no/ism			

Adresser korrespondanse til saksbehandlende enhet. Husk å oppgi referanse.

Varighet

Innhenting av avviksmeldinger og gjennomføring av intervju med sykehjems lederer vil skje i perioden høsten 2018 – sommeren 2019.

Mulige fordeler og ulemper

Kunnskapen vi får gjennom prosjektet vil kunne bidra til utviklingen av trygge og sikre tjenester for pasienter i norske sykehjem. Dersom sykehjemmet bruker ressurser på innhenting av avviksmeldinger vil dette bli kompensert av NTNU. Vi vil også dekke reiseutgifter for sykehjems ledere ved deltakelse i intervju.

Personvern: Hva skjer med informasjonen fra din kommune?

Informasjonen som er registrert skal kun brukes slik som det er beskrevet i hensikten med studien. Informasjon vil bli presentert i anonymisert form, dvs. uten navn eller andre gjenkjennbare opplysninger til personer, sykehjem eller kommune.

Prosjektet er godkjent av Norsk Senter for forskningsdata (NSD). I tillegg har regionale komiteer for medisinsk og helsefaglig forskningsetikk (REK) godkjent innhenting av avviksmeldinger uten samtykke fra pasient også i de tilfellene der det benyttes avvikssystemer som rapporterer hendelser i pasientjournalen.

Kontaktinformasjon

PhD stipendiat, Janne Myhre. Tlf; 47370180, mail: janne.myhre@ntnu.no

Hovedveileder for prosjektet: Professor, Sigrid Nakrem, mail: sigrid.nakrem@ntnu.no

Har du spørsmål er det bare å ta kontakt.

Hilsen

Janne Myhre
PhD stipendiat
Institutt for samfunnsmedisin og sykepleie (ISM)
Fakultet for medisin og helsevitenskap (MH)
Norges tekniske naturvitenskapelige universitet (NTNU)
Tlf: 47370180
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Appendix II

NTNU

Fakultet for medisin og helsevitenskap
Institutt for samfunnsmedisin og sykepleie

Forespørsel til ledere om deltakelse i fokusgruppeintervju i forbindelse med studien:
Lederskapets betydning for å fremme pasientsikkerhet i sykehjem.

Dette er en forespørsel til deg som leder om å delta i et forskningsprosjekt hvor hensikten er å få kunnskap om ledere i norske sykehjem sine erfaringer med å fremme pasientsikkerhet ved bruk av avviks- og meldesystemet, samt gjennom utviklingen av en pasientsikkerhetskultur. Denne studien er en del av et større prosjekt som har til hensikt å undersøke temaet overgrep og forsømmelse i norske sykehjem.

Hva innebærer prosjektet

Vi ønsker å samle data ved hjelp av fokusgruppeintervju (samtalegrupper) med ledere, både enhetsledere og avdelingsledere ved norske sykehjem. Fokusgruppeintervjuer er en datainnsamlingsform hvor en samler flere deltakere til en fokusert samtale for å få utdypende informasjon om forhåndsbestemte temaer. Tidsbruken vil være ca. 90 minutter og intervjuet vil bli tatt opp på bånd.

Mulige fordeler og ulemper

Kunnskapen fra gjennomføringen av prosjektet vil kunne bidra til utviklingen av trygge tjenester for sykehjemspasienter. Du må medregne tidsbruk i form av reise til og fra intervjusted og til selve intervjuet. Prosjektet vil dekke reisekostnader i forbindelse med din deltakelse.

Frivillig deltakelse og mulighet for å trekke sitt samtykke

Det er frivillig å delta i prosjektet. Dersom du ønsker å delta undertegner du samtykkeerklæringen på siste side. Du har anledning til å trekke deg fra fokusgruppeintervjuet underveis uten å oppgi noen grunn for dette. Dersom du trekker deg fra prosjektet, kan du kreve å få slettet innsamlede data, med mindre dataene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner. Dersom du ønsker å trekke samtykke, eller du ønsker ytterlige opplysninger om studien, kan du kontakte:
PhD stipendiat Janne Myhre på tlf. 47370180, eller på e-postadresse: janne.myhre@ntnu.no.
Ved behov kan du også kontakte prosjektleder og Hovedveileder Sigrid Nakrem på e-postadresse: sigrid.nakrem@ntnu.no

Hva skjer med informasjonen om deg?

Informasjonen som er registrert om deg skal kun brukes slik som det er beskrevet i hensikten med studien, å beskrive erfaringer fra lederer i norske sykehjem. Informasjonen fra intervjuene vil bli presentert i anonymisert form, dvs. uten navn eller andre gjenkjennbare opplysninger.

Prosjektledere har ansvaret for at alle opplysninger om deg blir behandlet på en sikker måte. Informasjonen om deg vil bli anonymisert og slettet senest fem år etter prosjektslutt som er 2021.

Godkjenning

Studien er godkjent av Norsk senter for forskningsdata (NSD)

Jeg,_____________________________________ (navn med blokkbokstaver).

bekrefter at jeg har mottatt informasjon om fokusgruppeintervjuet og samtykker i å delta i intervju

Underskrift: ___________________________________

Dato:_______________

Jeg bekrefter å ha gitt informasjon om deltakelse i fokusgruppeintervju:

Navn:____________________________________(Rolle i prosjektet)

Dato:_____________________________

Appendix III

NSD

Janne Myhre
Postbok 8905
7491 TRONDHEIM

Vår dato: 28.05.2018 Vår ref: 60322 / 3 / HJP Deres dato: Deres ref:

Vurdering fra NSD Personvernombudet for forskning § 31

Personvernombudet for forskning viser til meldeskjema mottatt 13.04.2018 for prosjektet:

60322	*Lederskapets betydning for å fremme pasientsikkerhet i sykehjem*
Behandlingsansvarlig	*NTNU, ved institusjonens øverste leder*
Daglig ansvarlig	*Janne Myhre*

Vurdering

Etter gjennomgang av opplysningene i meldeskjemaet og øvrig dokumentasjon finner vi at prosjektet er meldepliktig og at personopplysningene som blir samlet inn i dette prosjektet er regulert av personopplysningsloven § 31. På den neste siden er vår vurdering av prosjektopplegget slik det er meldt til oss. Du kan nå gå i gang med å behandle personopplysninger.

Vilkår for vår anbefaling

Vår anbefaling forutsetter at du gjennomfører prosjektet i tråd med:
- opplysningene gitt i meldeskjemaet og øvrig dokumentasjon
- vår prosjektvurdering, se side 2
- eventuell korrespondanse med oss

Vi forutsetter at du ikke innhenter sensitive personopplysninger.

Meld fra hvis du gjør vesentlige endringer i prosjektet

Dersom prosjektet endrer seg, kan det være nødvendig å sende inn endringsmelding. På våre nettsider finner du svar på hvilke endringer du må melde, samt endringsskjema.

Opplysninger om prosjektet blir lagt ut på våre nettsider og i Meldingsarkivet

Vi har lagt ut opplysninger om prosjektet på nettsidene våre. Alle våre institusjoner har også tilgang til egne prosjekter i Meldingsarkivet.

Vi tar kontakt om status for behandling av personopplysninger ved prosjektslutt

Ved prosjektslutt 01.10.2021 vil vi ta kontakt for å avklare status for behandlingen av personopplysninger.

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

Se våre nettsider eller ta kontakt dersom du har spørsmål. Vi ønsker lykke til med prosjektet!

Dag Kiberg

Hanne Johansen-Pekovic

Kontaktperson: Hanne Johansen-Pekovic tlf: 55 58 31 18 / hanne.johansen-pekovic@nsd.no

Vedlegg: Prosjektvurdering

Personvernombudet for forskning

Prosjektvurdering - Kommentar

Prosjektnr: 60322

FORMÅL
Formålet med prosjektet er å undersøke hvordan avviks- og meldesystemet kan bli brukt av ledere for å forbedre pasientsikkerhet med tanke på overgrep og forsømmelse ved norske sykehjem.

UTVALG
Utvalget vil bli basert på 3 små og 3 store sykehjem fra 5 kommuner, tilsammen 30 sykehjem. Datainnsamlingen er delt opp i en kvantitativ og kvalitativ del, og utvalget i de to delprosjektene vil være ulike.

DATAINNSAMLING KVANTITATIV DEL
Den kvantitative delen av prosjektet er en tverrsnittstudie av avviksmeldinger. Du skal samle inn 400 avviksmeldinger som er innmeldt i 2016 og 2017, fra sykehjemmene som inngår i prosjektet. Avviksmeldingene skal anonymiseres før de utleveres til deg. Avviksmeldingene skal i utgangspunktet allerede være anonymiserte i institusjonens avviks- og meldesystemet. Ved noen sykehjem er avviksmeldingene knyttet opp til journalsystemet. For at helsepersonell skal kunne hente ut avviksmeldinger og anonymisere disse for utlevering til deg, har du mottatt en dispensasjon fra taushetsplikt fra REK i vedtak fra REK10.04.2018 (2018/308/REK midt). Vi gjør oppmerksom på at du må etterfølge vilkårene i vedtaket fra REK.
Du vil også samle inn opplysninger om sykehjemmene i et spørreskjema som skal utfylles av leder, samt dokumentasjon fra kommunen som omhandler prosedyrer og kvalitetsarbeid knyttet til overgrep og forsømmelse. Denne delen av datainnsamlingen vil ikke samle inn personopplysninger.

Siden du i den kvantitative delen av prosjektet ikke skal samle inn eller behandle personopplysninger, vil denne delen av prosjektet falle utenfor meldeplikten. Under følger tilbakemelding for den kvalitative delen av prosjektet som er meldepliktig.

DATAINNSAMLING KVALITATIV DEL
I den kvalitative delen av prosjektet skal du utføre fokusgruppeintervjuer med tilsammen 50 ledere fra sykehjemmene som inngår i prosjektet.

Vi minner om at informantene har taushetsplikt, og at de ikke kan gi opplysninger som kan identifisere en enkeltperson direkte eller indirekte, med mindre det blir innhentet samtykke fra den enkelte til dette. Det er svært viktig at intervjuene gjennomføres på en slik måte at taushetsplikten overholdes. Intervjuer og informantene har sammen ansvar for dette, og bør drøfte innledningsvis i intervjuet hvordan dette skal håndteres.

INFORMASJON OG SAMTYKKE - KVALITATIV DATAINNSAMLING
Du har i meldeskjema oppgitt at utvalget som deltar i den kvalitative delen av prosjektet vil bli gitt muntlig og skriftlig informasjon. Det reviderte informasjonsskrivet mottatt 23.05.18 er godt utformet.

INFORMASJONSSIKKERHET

Lagring på server er passord og brukerstyrt, datamaskin står i låsbart rom med adgangskontroll. Intervjuene vil transkriberes uten personidentifiserbare data. Utskrifter av transkriberte intervju vil bli oppbevart i låsbart skap på kontor med adgangskontroll.

Personvernombudet forutsetter at de ovenfor nevnte prosedyrene for informasjonssikkerhet og øvrig behandling av datamaterialet er i tråd med NTNU sine retningslinjer for datahåndtering og informasjonssikkerhet.

PROSJEKTSLUTT OG ANONYMISERING

Prosjektslutt er oppgitt til 01.10.2021. Det fremgår av informasjonsskrivet at du vil lagre datamaterialet med personopplysninger i opptil fem år av mulige kontrollhensyn (REK vedtak), senest til 01.10.2026.
Datamaterialet skal så anonymiseres. Dersom du anonymiserer datamaterialet før oktober 2026 ber vi om at du informerer oss om dette på epost til personvernombudet@nsd.no.
Anonymisering innebærer vanligvis å:

- slette direkte identifiserbare opplysninger som navn, fødselsnummer, koblingsnøkkel
- slette eller omskrive/gruppere indirekte identifiserbare opplysninger som bosted/arbeidssted, alder, kjønn
- slette lydopptak

For en utdypende beskrivelse av anonymisering av personopplysninger, se Datatilsynets veileder:
https://www.datatilsynet.no/globalassets/global/regelverk-skjema/veiledere/anonymisering-veileder-041115.pdf