

## **Nursing home leaders' perception of factors influencing the reporting of elder abuse and neglect: a qualitative study**

Janne Myhre<sup>1</sup>, Wenche Malmedal<sup>1</sup>, Susan Saga<sup>1</sup>, Joan Ostaszkievicz<sup>2,3</sup>, and Sigrid Nakrem<sup>1</sup>

<sup>1</sup>Department of Public Health and Nursing, Faculty of Medicine and Health Sciences NTNU, Norwegian University of Science and Technology, Trondheim, Norway

<sup>2</sup>Centre for Quality and Patient Safety Research- Barwon Health Partnership, Deakin University, School of Nursing and Midwifery, Geelong Australia.

<sup>3</sup>National Ageing Research Institute, LTD, Melbourne, Victoria, Australia.

*Janne Myhre*: RN, MSc, PhD candidate, at Department of Public Health and Nursing, Faculty of Medicine and Health Sciences, Norwegian University of Science and Technology NTNU, Trondheim, Norway

*Wenche Malmedal*: RN, MSc, PhD, Associate professor at Department of Public Health and Nursing, Faculty of Medicine and Health Sciences, Norwegian University of Science and Technology NTNU, Trondheim, Norway

*Susan Saga*: RN, MSc, PhD, Associate professor at Department of Public Health and Nursing, Faculty of Medicine and Health Sciences, Norwegian University of Science and Technology NTNU, Trondheim, Norway

*Joan Ostaszkievicz*: RN, MSc, PhD, Associate professor at Centre for Quality and Patient Safety Research- Barwon Health Partnership, Deakin University, School of Nursing and Midwifery, Geelong Australia.

*Sigrid Nakrem*: RN, MSc, PhD, Professor at Department of Public Health and Nursing, Faculty of Medicine and Health Sciences, Norwegian University of Science and Technology NTNU, Trondheim, Norway

\*Correspondence to [Janne.myhre@ntnu.no](mailto:Janne.myhre@ntnu.no)

Department of Public Health and Nursing, Faculty of Medicine and Health Sciences NTNU, Norwegian University of Science and Technology, Trondheim, Norway

Full list of author information is available at the end of the article

Janne Myhre	<a href="mailto:janne.myhre@ntnu.no">janne.myhre@ntnu.no</a>
Wenche Malmedal	<a href="mailto:wenche.k.malmedal@ntnu.no">wenche.k.malmedal@ntnu.no</a>
Susan Saga	<a href="mailto:susan.saga@ntnu.no">susan.saga@ntnu.no</a>
Joan Ostaszkievicz	<a href="mailto:joan.ostaszkievicz@deakin.edu.au">joan.ostaszkievicz@deakin.edu.au</a>
Sigrid Nakrem	<a href="mailto:sigrid.nakrem@ntnu.no">sigrid.nakrem@ntnu.no</a>

### **Authors' contributions**

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

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## **Abstract**

**Purpose:** The purpose of this study was to explore factors that influence reporting of adverse events related to elder abuse and neglect in nursing homes from nursing home leaders' perspectives. Good leadership requires in-depth knowledge of the care and service provided and the ability to identify and address problems that can arise in clinical practice.

**Design/methodology/approach:** A qualitative explorative design with data triangulation was used. The sample consisted of 43 participants from two levels of nursing home leadership, representing six municipalities and 21 nursing homes in Norway. Focus group interviews were undertaken with 28 ward leaders and individual interviews with 15 nursing home directors. The constant comparative method was used for the analyses.

**Findings:** Both ward leaders and nursing home directors described formal and informal ways of obtaining information related to elder abuse and neglect. There were differences between their perceptions of the feasibility of obtaining formal reports about abuse in the nursing home. Three main categories of influencing factors emerged: 1) *organisation structural factors*; 2) *cultural factors*; 3) *abuse severity factors*. A main finding is that in its present form, the Norwegian adverse event reporting system is not designed to detect abuse and neglect.

**Originality/value:** This paper provides an in-depth understanding of patient safety and factors related to reporting elder abuse in nursing homes in Norway.

**Key words:** Nursing home, leaders, patient safety, adverse event reports, elder abuse, neglect, focus group interviews, individual interviews

**Paper type:** Research paper



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17 **4 Abstract**  
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## 1 Background

2 Nursing homes are intended to serve as a home for the resident (Nakrem et al., 2013) and, at  
3 the same time, provide them with health care and social services on a 24-hour basis.

4 Residents in these institutions often have complex care needs, dementia or other forms of  
5 cognitive impairment (Helvik et al., 2018), display challenging behaviour (Selbaek et al.,  
6 2008), and require care and assistance in activities of daily living. These factors are  
7 associated with a high risk of abuse and neglect (Drennan et al., 2012; Malmedal et al., 2014;  
8 Ostaszkiwicz, 2017). The complexity of residents' needs, in addition to the interactions of  
9 different staff members and participants around each resident, makes the delivery of care in  
10 nursing homes complex (Cilliers, 2002; Anderson et al., 2003). Due to this complexity, the  
11 quality of care and patient safety in nursing homes are influenced by associations between  
12 organisational factors, technical performance of care and the interpersonal relationships  
13 between all participants in the organisation's culture (Donabedian, 2002; Nakrem 2015). In  
14 addition to institutional practices and culture, quality of care and patient safety in nursing  
15 homes are also determined through values, attitudes and certain implicit knowledge in society  
16 and its policies (Foucault, 2002). One of the most fundamental responsibilities for nursing  
17 home providers is to ensure that residents are free from abuse and that there are systems in  
18 place to protect them from harm (Phelan, 2015). However, studies have shown high rates of  
19 abuse and neglect in nursing homes in many countries, including Norway (Yon et al., 2018;  
20 Botngård et al., 2020)

21  
22 The World Health Organisation (WHO) defines elder abuse as: 'a single, or repeated act, or  
23 lack of appropriate action, occurring within any relationship where there is an expectation of  
24 trust which cause harm or distress to an older person' (WHO, 2002, p, 3). Elder abuse can be  
25 divided into forms of abuse: physical, psychological, financial and sexual abuse, and neglect  
26 (Working Group on Elder Abuse, 2002). The type of abuse is also categorised according to the  
27 relationship between the key stakeholders (Yon et al., 2018): staff-to-resident abuse (Yon et  
28 al., 2018; Botngård et al., 2020), family-to-resident abuse (Bužgová and Ivanová, 2009) and  
29 resident-to-resident abuse, also called resident-to-resident aggression (Rosen et al., 2008; Lachs  
30 et al., 2016). Abuse has serious consequences for residents' health and wellbeing, including  
31 reduced quality of life, psychological and physical harm, loss of assets and increased  
32 morbidity and mortality (Yunus et al., 2017).

1 To prevent abuse and promote safety and quality, nursing home leaders need comprehensive  
2 information about the care and service provided and any problems that may arise in clinical  
3 practice. One way of obtaining that information is from formal reporting systems. The  
4 development and utilisation of reporting systems in health care services are fundamental  
5 strategies to reduce preventable harm to patients and improve quality and safety (Nakrem et  
6 al., 2009; National Patient Safety Foundation, 2015; Archer et al., 2017). The goal of using a  
7 reporting system is to identify patient risk situations and learn from events and, thereby,  
8 improve patient safety (Howell et al., 2016). However, an important barrier to improving  
9 patient safety and increasing the quality of care is underreporting (National Patient Safety  
10 Foundation, 2015; Archer et al., 2017). Underreporting of abuse and neglect is well  
11 documented, and there is a need to understand factors that influence whether the staff report  
12 or not (Cooper et al., 2009; Malmedal et al., 2009; Touza Garma, 2017). A survey of staff in  
13 16 nursing homes in the central part of Norway found that a failure to report inadequate care  
14 could be due to a lack of staff knowledge, a lack of reflection on their practice or a fear of  
15 punishment (Malmedal et al., 2009). Other studies have also highlighted attitudes, fear of  
16 consequences and a lack of responses and feedback from the leaders as factors affecting the  
17 reporting of abuse (Cooper et al., 2009; Moore, 2017). A survey of nurses in Norway found  
18 that 76% had reported adverse events 1- 5 times in the previous years, but few nurses had  
19 experienced a positive outcome from such reporting (Hofstad, 2015).

20  
21 Most studies that have investigated factors affecting the reporting of abuse have focused on  
22 the perspective of staff members who provide direct care (Cooper et al., 2009; Malmedal et  
23 al., 2009; Moore, 2017; Touza Garma, 2017). However, knowledge about nursing home  
24 leaders' perceptions of factors that influence reporting elder abuse and neglect is also  
25 essential because their perceptions will affect what they signal to staff as important to  
26 report. Nursing home leaders also play a key role in developing strategies for higher quality  
27 and patient safety in nursing homes. To the best of our knowledge, this is the first study to  
28 investigate factors that influence the reporting of safety issues related to elder abuse and  
29 neglect from the perspectives of nursing home leaders.

### 30 31 *The reporting system in Norway*

32 In Norway, the provision of care in nursing homes is delivered under the "National  
33 Regulation of Quality of Care" (Norwegian Ministry of Health and Care Services, 2003),  
34 which, among other issues, aims to ensure that residents' basic needs are met (Norwegian

1 Ministry of Health and Care Services, 2003). This includes meeting the nursing home  
2 residents' social, psychological and physical needs; preserving their dignity, autonomy and  
3 self-respect; and promoting their choices in everyday life. Health personnel have a moral and  
4 legal responsibility to advocate for the residents' safety (International Council of Nurses,  
5 2006). In addition, the responsibility of health personnel to report adverse events is formally  
6 regulated in the National Health Personnel Act § 17. This act states: 'Health personnel shall  
7 of their own account provide information to the supervision authorities on condition that may  
8 endanger patients' safety' (Norwegian ministry of health and care services, 1999). There are  
9 no instructions on how health personnel should notify the supervision authorities, but since  
10 nursing homes in Norway have no external reporting system that is directly connected to the  
11 supervision authorities, notifying must be done by phone, mail or email. In addition, each  
12 municipality and nursing home is required to have an internal quality and safety system, and  
13 health personnel are encouraged to first notify internally before notifying the supervising  
14 authorities (Norwegian Ministry of Health and Care Services, 2017). The national regulation  
15 of management and quality improvement in health care services aims to ensure that there is a  
16 system in place in each nursing home to monitor the overall quality and safety of care, and  
17 that leaders use information from reports for learning and improving quality (Norwegian  
18 Ministry of Health and Care Services, 2017).

19  
20 In 2017, an amendment was passed in 'The Health Care Service Act' in Norway to point out  
21 the responsibilities of municipalities in detecting and preventing violence and abuse (§3-3a)  
22 (Norwegian Ministry of Health and Care Services, 2011). However, there is currently no  
23 taxonomy or list of events related to abuse and neglect in the reporting system. Abuse and  
24 neglect could be classified within the category 'patient safety adverse events'. In the present  
25 study, we use the term adverse event to refer to situations where the outcome for the resident  
26 is harmful or potentially harmful caused by intentional or unintentional abuse. This term also  
27 includes failure to deliver needed care, defined as the omission or neglect of delivering any  
28 aspect of required resident care.

### 29 30 *Aim of the study*

31 The aim of the study was to explore factors that influence reporting of adverse events related  
32 to elder abuse and neglect in nursing homes from nursing home leaders' perspectives.

33  
34



## 1 **Methods**

### 2 *Design*

3 The study is part of a larger study funded by the Research Council of Norway (NFR) (Project  
4 number 262697). As there is little research and knowledge related to this topic, we chose to  
5 use a explorative qualitative design with data triangulation, with data from focus groups and  
6 individual interviews at different management levels (Patton, 2015). In Norway, all nursing  
7 homes have two levels of leaders: ward leaders (WL) and nursing home directors (NHD).  
8 Since both roles can influence each other through a hierarchical relationship and collectively  
9 affect the quality of care and patient safety (Castle and Decker, 2011), we gathered  
10 information from both groups.

### 11 *Participants*

12 Participants were recruited over a period of six months: August 2018 through January 2019.  
13 A recruitment email was sent to all NHDs in six municipalities, both urban and rural areas of  
14 Norway. The recruitment email included two invitation letters: one letter to NHDs and the  
15 other for NHDs to forward to the WLs at their nursing homes. Inclusion criteria were a  
16 person who was: (a) employed in a leadership position in a nursing home and (b) employed  
17 full time in that role. The WLs were invited to participate in focus group interviews;  
18 however, because there are few NHDs in each municipality, and it was difficult to get them  
19 together for focus group interviews, NHDs were invited to participate in individual  
20 interviews. Forty-three participants were recruited: 15 individual interviews were conducted  
21 with NHDs, and six focus group interviews were conducted with a total of 28 participants,  
22 comprising 23 WLs, two quality leaders and three service leaders. However, in this study, all  
23 28 participants in the six focus group interviews are named 'ward leaders' (WL), since they  
24 all were members of the leadership team. Characteristics of the participants are presented in  
25 Table 1.

### 26 **Table 1: Demographics of the participants (n= 43)**

### 27 *Data collection*

28 The focus group interviews and the individual interviews took place in a meeting room in a  
29 nursing home in the participating municipalities. Each focus group interview lasted  
30 approximately 90 minutes, and each individual interview lasted approximately 60 minutes.  
31 Six focus group interviews were conducted, with three to six participants in each group. The

1 focus groups were composed as follows: one focus group with three participants; two focus  
2 groups with four participants; one focus group with five participants; two focus groups with  
3 six participants. Two researchers carried out the focus group interviews. JM moderated all six  
4 interviews, SN was co-moderator for two group interviews, and SS was co-moderator in one  
5 group interview. In the other three interviews, two researchers from the larger research team  
6 were co-moderators. The role of the co-moderator during the focus group interviews was to  
7 help the moderator to keep an overview of the group, ask questions, take notes and minimize  
8 bias. All 15 individual interviews were carried out by JM. Participants were asked about how  
9 they obtained information about elder abuse involving health care staff, co-residents or  
10 relatives and what they perceived were the barriers and enablers to reporting these adverse  
11 events. We used the same interview guide for both the focus group interviews with the WLs  
12 and the individual interviews with the NHDs (Table 2), and participants were encouraged to  
13 speak freely. All interviews were recorded and transcribed verbatim, retaining pauses and  
14 emotional expressions.

## 16 **Table 2: Interview guide**

### 18 *Data analysis*

19 A constant comparative method was used for the data analysis (Boeije, 2002; Charmaz,  
20 2006). This allowed us to generate a thematic understanding through an open exploration of  
21 nursing home leaders' perceptions. The constant comparative method facilitated the possible  
22 identification of themes and differences between individuals and cases within the data  
23 (Boeije, 2002). As this study involved two levels of leaders, we wanted to gain a sense of the  
24 distinction between the different roles of leadership. The analysis started immediately after  
25 each interview, where the first author listened to the recorded interview. Memo writing was  
26 then used through the whole process of data collection and analysis and served as a record of  
27 emerging ideas, questions and categories (Charmaz, 2006). Next, in line with the constant  
28 comparative method, open line-by-line coding of the transcribed interviews was performed  
29 (Boeije, 2002; Charmaz, 2006). The codes were compared for frequencies and commonalities  
30 and then clustered to organise data and develop sub-categories. The sub-categories were  
31 examined to construct the final categories and main theme. We conducted the comparison  
32 between groups in three main steps: 1) comparison within a single interview; 2) comparison  
33 between interviews within the same group; 3) comparison of interviews from different groups  
34 (Boeije, 2002; Charmaz, 2006). To add credibility and diminish researcher bias, two

1 researchers (JM and SN) coded all transcribed interviews independently. During the analysis  
2 process, the authors held several meetings where codes and their connections were discussed  
3 until consensus was reached. To ensure that the emerging categories and themes fitted the  
4 situations explored, we went back and forth between contextualisation, data analysis and  
5 memo writing (Boeije, 2002). All interviews took place in Norway. Interviewing,  
6 transcription and the first analyses of the data were performed in Norwegian. Then the results  
7 of analyses were translated into English. One of the authors of this paper is English speaking,  
8 which was a strength for the discussion related to translation of meaningful units, categories  
9 and themes from the analyses. We went back and forth during the translation discussion until  
10 we reach consensus. An example of the analysis process is shown in Table 3.

### 11 12 **Table 3: Example of data analyses: Cultural factors**

#### 13 14 *Ethical consideration*

15 Ethical approval for this study was given by the Norwegian Centre for Research Data (NSD)  
16 Nr: 60322. All participants gave written consent to participate in the interviews and for the  
17 use of the data from the interviews.

#### 18 19 **Results**

20 Both NHDs and WLs perceived that elder abuse and neglect in their nursing homes were  
21 underreported, due to difficulties in obtaining information from the staff through the formal  
22 adverse event reporting system. At the same time, participants also described a variety of  
23 ways of obtaining information. They referred to formal reports such as written complaints  
24 and the computerised adverse event reporting system. They said that they also obtained  
25 information about adverse events by reading the nursing notes in the electronic patient record  
26 system. In addition, participants described informal ways of obtaining information and  
27 reports of abuse in the nursing home with WLs receiving verbal information from staff and  
28 NHDs receiving verbal information from the WLs when present in the ward. An overview of  
29 the ways of reporting abuse is presented in Figure 1. Three main categories of factors that  
30 influence reporting adverse events related to elder abuse and neglect in nursing homes  
31 emerged from our analysis: 1) *organisation structural factors*; 2) *cultural factors*; 3) *abuse*  
32 *severity factors*. Sub-categories and examples are presented within each category below. An  
33 additional finding was that NHDs and the WLs differed in their perceptions of the feasibility  
34 of the formal adverse event reporting system to provide them with comprehensive

1 information about the magnitude and nature of adverse events in the nursing home. These  
 2 differences are presented within the sub-categories when relevant.

### 3 4 **Figure 1: Formal and informal ways of reporting**

### 5 6 **Table 4: Theme and sub-categories**

#### 7 8 **Organisation structural factors**

9 Organisation structural factors influence what information is communicated about abuse and  
 10 neglect in the nursing home setting, as well as how the information is communicated.  
 11 “Closeness to staff and residents”, “technology tools”, “competing priorities” and “formal  
 12 education and communication skills” were factors at the organisational and structural levels  
 13 that the leaders perceived as affecting reports of abuse and neglect.

#### 14 15 *Closeness to staff and residents*

16 As shown in Figure 1, participants described a variety of ways they obtained information  
 17 about abuse or potential abuse. NHDs stated that due to their physical remoteness from staff  
 18 and residents, the formal adverse event reporting system was an important information source  
 19 related to risk situation in the nursing homes. One NHD remarked:

20 *“My role in this is to try to let them know that I am hindered by the opportunity to act*  
 21 *in relation to unwanted events unless they are systematically reported as an adverse*  
 22 *event” (NHD 7).*

23 By contrast, WLs indicated that they perceived their physical proximity to staff and residents  
 24 was an important factor in obtaining informal information about patient safety risk situations  
 25 related to abuse. One WL remarked:

26 *“We know our ward. I can feel the climate among the staff, and how they are doing.*  
 27 *So, if something is happening, I catch it very quickly” (WL, group 2).*

28  
 29 WLs pointed out that being present at the ward and having ‘an open-door policy’ were factors  
 30 that facilitated informal reporting.

#### 31 32 *Technology tools*

33 All nursing homes had computerised adverse event reporting systems and electronic patient  
 34 record systems (EPR). The NHDs described the adverse event reporting system as a good

1 system for adverse events to be reported. As one NHD remarked: *“I think the adverse event*  
2 *reporting system is a very good system”* (NHD 2). However, on the other hand, the WLs  
3 described the adverse event reporting system as rigorous and time-consuming. One WL said:  
4 *“It is a system that is hard to navigate. You must push a lot of buttons to finish the report. It*  
5 *takes a lot of time, it does. So, I think that it’s not a good system”* (WL, group 3). Both NHDs  
6 and WLs said that it is the WLs that are responsible for managing adverse event reports  
7 within the nursing homes.

8  
9 All participants also pointed out that the EPR was an important source of information about  
10 patient safety risks, as staff were required to document information about all events that  
11 affected residents’ health in the EPR. However, most of the participants also described a lack  
12 of routines related to which situations should be reported in the adverse event reporting  
13 system in addition to the EPR. The WLs emphasised the problem with duplicate information  
14 when using both systems and were concerned about the time staff had to spend on reporting:

15 *“Where should it be documented? Is it necessary to document it as an adverse event if*  
16 *you already have documented it in the patient record and done something about the*  
17 *problem? What is then the purpose of the extra documentation in the adverse event*  
18 *system?”* (WL, group 3).

19  
20 According to the participants, staff documented most incidents of resident-to-resident  
21 aggression in the EPR. The WLs indicated that resident-to-resident events happen so often  
22 that it would be too time-consuming for the staff to report all these events in the adverse  
23 event reporting system.

#### 24 *Competing priorities*

25 Both NHDs and WLs indicated that WLs identified many adverse events when they were  
26 present in the ward, and that it was important that the WLs were present as a good role model  
27 for staff. At the same time, all WLs indicated that there were many competing priorities in the  
28 nursing home, including administrative tasks such as making sure that there was enough staff  
29 and participating in meetings. The WLs pointed out that the many competing priorities made  
30 it difficult for them to be as present as they wanted and keep an overview of the occurrence of  
31 adverse events in the ward. Some WLs also said that this also could result in a failure to  
32 prioritise following up on adverse events reports that they were responsible to manage:  
33

1  
2  
3 1 “You have to make sure that there are enough staff at work, and you have to make the  
4 ward work day to day. So, the adverse event report handling is probably something  
5 2 that we can push aside.... but that doesn’t mean we don’t do anything about the  
6 3 problems. Because many of those events reach us anyway” (WL, group 5).  
7 4  
8 5  
9 6

### 6 *Formal education and communication skills*

7 According to all participants, another factor that affected reporting of patient safety issues  
8 related to abuse was the staff’s lack of formal education qualification. Participants said that  
9 unskilled staff, in particular, lacked knowledge to detect patient safety events and changes in  
10 residents’ health status. One WL noted: “Unskilled staff do not have the clinical gaze and  
11 cannot catch if the resident is developing something or at risk. They don’t catch it and, hence,  
12 they will not report it” (WL, group 3). Participants also indicated that this lack of knowledge  
13 could expose residents to abuse without staff being aware, and that this was also a barrier for  
14 reporting. One WL stated that: “Lack of knowledge is also what I see as important. Because,  
15 many times, the staff don’t understand that what they do can be abusive” (WL, group 2).

16 Some participants pointed out that registered nurses reported more than other staff members  
17 and indicated that this could be due to their higher educational level. One NHD noted: “But  
18 that is probably because it is the nurse that mostly discovers patient safety issues” (NHD 3).  
19

20 Many participants mentioned that due to recruiting problems, the nursing homes had to  
21 employ unskilled staff members as well as staff from different countries. Foreign staff  
22 members may lack the ability to communicate in Norwegian.

23 “There are probably a lot of situations that are not documented or reported. Because  
24 we have staff from a lot of different countries working here and, for them, there is  
25 difficulty in reporting” (WL, group 4).  
26

27 This was perceived as a barrier to documenting significant aspects of health care and  
28 reporting adverse events.  
29

### 30 **Cultural factors**

31 Cultural factors were another theme that emerged from our analysis. We found that  
32 “Perception of what constitutes abuse”, “loyalty among staff” and “openness, quality and  
33 safety” were factors within the organisational culture that the leaders perceived as affecting  
34 reports of abuse.

## 1 2 3 4 1 5 2 *Perception of what constitutes abuse*

6  
7 3 All participants discussed the definition of elder abuse and neglect and said that the cultural  
8  
9 4 perception of what constitutes abuse and neglect influences what is reported. They indicated  
10  
11 5 that the culture itself was an important factor that would affect reports of abuse and neglect.  
12  
13 6 As one NHD remarked: *“Precisely, the culture itself can be an obstacle to receive reports of*  
14  
15 7 *such incidents and to uncover incidents in its entirety. So, culture is important”* (NHD 13).  
16  
17 8 Some participants also indicated that the nursing home culture could be standardised and  
18  
19 9 task-oriented. In such a culture, the staff may inadvertently handle the residents roughly, use  
20  
21 10 force or not pay attention to residents’ wishes.

22  
23 11 *“I see that there are some ‘autopilots’ in our nursing home. They have worked for*  
24  
25 12 *many years, and the work is just done by itself. I don’t know if they understand it. So,*  
26  
27 13 *maybe we need to focus more on good care, so that not...well, [for example,] when*  
28  
29 14 *the resident is holding onto the bed linen, the staff do not force [his/her] hands open*  
30  
31 15 *and go on just to finish their task”* (WL, group 6).  
32  
33 16

34  
35 17 Participants also pointed out that, over time, inappropriate practices and cultures could  
36  
37 18 become normal in the nursing home, with the consequence that staff would not raise concerns  
38  
39 19 about poor quality care. As one WL said: *“I don’t get adverse event reports on inappropriate*  
40  
41 20 *culture and norms”* (WL, group 5).  
42  
43 21

## 44 45 46 47 22 *Loyalty among staff*

48  
49 23 All participants indicated that staff were unlikely to report incidents in which they themselves  
50  
51 24 harmed a resident. This was particularly the case if the staff member understood that this  
52  
53 25 behaviour was harmful. In addition, they also pointed out that staff members’ loyalty to each  
54  
55 26 other was a barrier to reporting abuse and neglect. As one WL said:

56  
57 27 *“I think it is difficult for the staff to deal with such situations. For example, if two staff*  
58  
59 28 *members are going into a room together, and one discovers that the other is handling*  
60  
61 29 *the resident a little rough or is verbally abusive... Well, I think they would hesitate to*  
62  
63 30 *report it to me due to their loyalty to each other”* (WL, group 3).  
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65 31

66  
67 32 The WLs stated that if a staff member reported an event of staff-to-resident abuse or neglect,  
68  
69 33 it was usually reported verbally and not as an adverse event report.  
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### 1 *Openness, quality and safety*

2 All participants pointed out that they tried to encourage a culture of openness, quality and  
3 safety in the nursing home and perceived this to be an enabler for securing information about  
4 events of abuse and neglect. They thought that reflection on practice increased the staff's  
5 awareness of what constituted abuse to residents. To promote a culture of openness related to  
6 quality and safety concerns, all participants felt they had a responsibility to give feedback to  
7 staff. One WL remarked:

8 *“But in any case, no adverse event is written if the staff don't feel that there is a point*  
9 *in writing it. ‘Nothing happens anyway,’ is what they say then. So, it is important that*  
10 *we give them feedback” (WL, group 1).*

11  
12 In addition, some WLs also pointed out that they were unable to give staff feedback on all  
13 reports, especially related to staff-to-resident abuse due to confidentiality and the handling of  
14 these events as a personnel issue.

### 15 16 *Abuse severity factors*

17 Abuse severity factors were the third theme that emerged from our analysis. We found that  
18 “forms of abuse” and “internal vs. external reporting” were factors affecting reports of abuse.

### 19 20 *Forms of abuse*

21 Forms and type of abuse was a factor that all participants believed influenced reporting of  
22 abuse or neglect in the nursing home. For example, physical, sexual and financial abuse were  
23 considered to be the most serious forms of abuse. At the same time, all participants said that  
24 these forms of abuse were never reported on mere suspicion, only if there was clear evidence  
25 of the situation. Harm from psychological abuse was thought to be difficult to identify and  
26 probably never reported. All participants indicated that staff reported incidents of neglect  
27 particularly if the neglect was related to organisational factors that were out of their control,  
28 such as a lack of staffing:

29 *“It is easiest to write an adverse event report on, ‘There was so much to do that the*  
30 *residents were left alone most of the day’, or ‘The leader should have made sure that*  
31 *there was enough staff at work’” (WL, group 4).*

32  
33 At the same time, many participants also commented on the sensitive nature of reporting  
34 abuse, especially forms and types of abuse including staff-to-resident abuse. Some



1 participants also said that some events of staff-to-resident abuse should be handled as a  
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1 participants also said that some events of staff-to-resident abuse should be handled as a  
2 personnel issue and not be reported in the adverse event system. One NHD remarked: “*I think  
3 that abuse from staff is a sensitive personnel issue, and that should not be reported in the  
4 adverse event system*” (NHD 2). The leaders also commented that if a resident or a relative  
5 acted negatively towards a staff member, then these situations were always reported in the  
6 adverse event system.

#### 7 8 *Internal vs. external reporting*

9 Only a few leaders had forwarded internal adverse events reports externally to the health care  
10 authorities. Participants cited the nature of the external reporting system as a barrier to  
11 external reporting. *Since there was no connection between the internal reporting system in the  
12 nursing homes, and external reporting to the health care authorities, notifying or reporting to  
13 the health care authorities had to be done by phone, mail or email, which was perceived a  
14 barrier.* Participants also indicated they made judgments about reporting based on their  
15 assessment of the severity of events. All participants stated events that had been externally  
16 reported included sexual abuse from a staff member, financial abuse from relatives with the  
17 need for financial guardianship and resident-to-resident aggression leading to severe harm or  
18 death.

19 *“We have had a case here that was absolutely terrible, where one resident died after  
20 an event with another resident. Clearly, then we contacted the police and reported it  
21 to the health care authorities”* (NHD, 4).

22 In addition, some leaders said they had reported relatives who were physically abusive to  
23 residents to the police but not to the health care authorities. They had contacted the police to  
24 secure restraining orders.

25 *“We have a resident with a relative who is physical abusive, and, in relation to that,  
26 we reported the relative to the police. The police came, and we got a restraining order  
27 for the relative”* (NHD 1).

28  
29 Some leaders also described contacting security guards or the police for help to handle  
30 resident-to-resident aggression. However, these events were not always reported to the health  
31 authorities.

## 1 Discussion

2 The aim of the study was to explore factors that influence reporting adverse events related to  
3 abuse and neglect in nursing homes from the perspectives of nursing home leaders. Three  
4 main categories emerged: *organisation structural factors*, *cultural factors* and *abuse severity*  
5 *factors*. In addition, we also discovered differences between the NHDs and the WLs relating  
6 to their perceptions of the feasibility of the formal adverse event reporting system to provide  
7 them with comprehensive information about the magnitude and nature of adverse events in  
8 the nursing home.

9  
10 The findings revealed that, at an organisation structural level, the NHDs' physical distance  
11 from staff and residents is a factor that affects their perception of the value of the formal  
12 reporting system as a mechanism for obtaining patient safety information. In contrast, the  
13 physical proximity that WLs have to staff, and residents meant that the informal reporting  
14 system was an important source of information about patient safety. At the same time, their  
15 perception of the usefulness of the adverse event reporting system also affected the feasibility  
16 of obtaining information about the magnitude and nature of elder abuse and neglect through  
17 formal reports. Findings suggest NHDs have a more 'positive' view of the adverse event  
18 reporting system than the WLs. This finding is in line with other studies that have found that  
19 top leaders have a more positive view of patient safety than other members of the  
20 organisation (Castle et al., 2011; Castle et al., 2012; Wagner et.al., 2009). On the other hand,  
21 the WLs are responsible for handling and managing the adverse events reports in addition to  
22 other tasks and demands related to the day-to-day operations in the ward. Managing adverse  
23 events reports was an additional to-do task for the WLs, which could lead to their perception  
24 of the informal reporting system as preferable to formal reports. As the WLs are the closest  
25 leader-level to the staff and residents, an important question for future research is the extent  
26 to which the WLs influence whether the staff report or not.

27  
28 Another finding in this study was that both WLs and NHDs described a lack of clarity in  
29 determining which situations should be reported in the adverse event report system in  
30 addition to being documented in the EPR. According to the National Health Personnel Act in  
31 Norway, health personnel are responsible for reporting conditions that may endanger patient  
32 safety (Norwegian ministry of health and care service, 1999). However, 'conditions that may  
33 endanger patient safety' can be viewed as a broad definition of events that health personnel  
34 are responsible to report. A broad definition of adverse events has in previous research also

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3 1 been criticised for limiting the opportunities to shape the priorities in safety and quality  
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5 2 improvement (Macrae, 2015; Stavropoulou et al., 2015). Without a clear taxonomy of events  
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7 3 defined as abuse and neglect, perceptions and understanding of what may endanger patient  
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9 4 safety might instead differ from one nursing home to the next depending on the  
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11 5 organisational culture, or 'the way we do things here' (Nakrem, 2015; Braithwaite et al.,  
12  
13 6 2017). Lack of a taxonomy and cultural understanding of factors that threaten patient safety  
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15 7 in relation to abuse and neglect places great pressure on the individual staff members'  
16  
17 8 knowledge and skills. Previous research of staff perception of factors that affect reports of  
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19 9 abuse and neglect has also demonstrated that individual staff members' knowledge and skills  
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21 10 are important (Cooper et al., 2009; Malmedal et al., 2009; Touza Garma, 2017). Formal  
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23 11 education as a factor affecting reports of abuse was also a finding in the present study. At the  
24  
25 12 same time, individuals in an organisation such as nursing homes are part of a culture where  
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27 13 certain practices, rules and norms are learned and legitimated as true within this institutional  
28  
29 14 context (Goffman, 1968; Foucault 2002)

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31 15  
32 16 More particularly, the nursing home culture as a factor affecting the detection and reporting  
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34 17 of abuse and neglect was an important finding in this study. A recently published systematic  
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36 18 review of the association between organisational and workplace cultures and patient  
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38 19 outcomes (Braithwaite et al., 2017) also points out that understanding patient safety culture is  
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40 20 the most important first step related to increasing patient safety. Members of an organisation  
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42 21 build social knowledge related to routines, norms and rules of handling daily life in the  
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44 22 institution (Goffman, 1968; Foucault, 2002). The social knowledge forms culturally accepted  
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46 23 behaviour and affects the interpersonal power process between staff and residents and the  
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48 24 care that is delivered (Donabedian, 2002; Foucault, 2002; Nakrem, 2015). Some nursing  
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50 25 home leaders in this study described the interpersonal process of care as being standardised  
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52 26 and task-focused. A task-focused culture focuses on getting the job done in a way that  
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54 27 supports the institution and the staff but does not prioritise residents' individual needs. Such a  
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56 28 culture indicates that the staff are under pressure and influenced by healthcare policies that  
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58 29 mandate efficiency and cost savings (Foucault, 2002; Foucault, 2012). Therefore, structural  
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60 30 factors, such as a low level of staffing, have an important impact on the culture and the  
31  
32 31 processes of care (Donabedian, 2002).

33 Related to the importance of understanding patient safety culture, findings in the present  
34  
35 32 study revealed some important cultural factors as barriers to obtain information related to

1 abuse and neglect in the nursing home. The staff's perception of what constitutes abuse was  
2 one factor. The loyalty amongst staff related to not reporting each other was another cultural  
3 factor found in this study leading to the underreporting of abuse and neglect. Loyalty  
4 amongst staff as a barrier aligns with findings from other studies of staff perception and  
5 factors related to underreporting abuse (Malmedal et al., 2009; Moore, 2017). To counteract  
6 these cultural barriers to reporting abuse, our findings suggest it is important to create a  
7 culture of openness about quality of care and safety, so that staff feel safe to report adverse  
8 events. In a Norwegian study of staff perceptions of patient safety culture in nursing homes,  
9 communication and openness in addition to adequate staffing were found to be important  
10 factors for patient safety culture, yet, staff scored low on this dimension (Ree and Wiig,  
11 2019). The WLs' description of being present at the ward and having an open door policy are  
12 important leadership behaviours in relation to creating a culture of openness (Castle and  
13 Decker, 2011). On the other hand, the WLs' lack of time to be present at the ward due to  
14 competing priorities can affect the culture and, in the end, influence whether the staff report  
15 or not.

16  
17 An important finding was the impact of the abuse severity factor for reporting elder abuse  
18 and neglect as a safety issue. The results of the study revealed the possibility that even if  
19 leaders are aware of abuse and neglect involving co-residents, relatives and staff members,  
20 only a few of such events are reported to the health authorities. This may indicate that the  
21 severity of abuse and neglect in the nursing home context is minimised and overlooked by the  
22 nursing home leaders (Myhre et al., 2020), and that some nursing homes operate as closed  
23 systems, i.e. what happens in the nursing home stays in the nursing home (Goffman, 1968;  
24 Foucault, 2012). Healthcare leaders are under pressure to follow a healthcare policy that  
25 values efficacy and cost savings (Foucault, 2002; Foucault, 2012). Within this policy context,  
26 nursing home leaders are valued as good leaders if their budget is in balance, and they are  
27 loyal to this goal. Nursing home leaders may construct meaning of conditions that may  
28 endanger patient safety related to abuse and neglect by identifying themselves and their roles  
29 with this efficacy and cost saving discourse. (Foucault, 2002). Hence, a disincentive exists for  
30 nursing home leaders to report adverse events caused by organisational factors, such as low  
31 staffing or cultural factors.

32  
33 Nursing home leaders participating in this study described elder abuse as a sensitive topic,  
34 and that not all abuse events should be reported in the adverse event system. This can indicate

1 that it is easier to blame individual staff members or residents themselves than the healthcare  
2 policy the leaders are pressured to follow (Goffman, 1968; Foucault, 2012). Even though  
3 nursing home staff have high professional standards and want to do a good job, abusive  
4 behaviour on the part of individual staff members does occur, although the frequency is low  
5 (Stewart et al., 2011; Botngård et al., 2020). To promote patient safety and prevent abuse and  
6 neglect in nursing homes, nursing home leaders need to address both abusive behaviour by  
7 individual staff as well as organisational and cultural factors over which individual staff  
8 members have no control. A study from US, using mail survey to the Departments of Health  
9 in all 50 states, found that abuse is the only adverse event that almost always is required to be  
10 reported to the supervision authorities, hence it also has the highest incidence of follow-up  
11 with a surveyor visit (Wagner et al., 2011). This shows a need for Norwegian policymakers to  
12 establishing clear laws that protect and serve vulnerable adults exposed to mistreatment.

#### 14 *Strengths and limitations of the study*

15 This study involved participants from two leader levels from different nursing homes and  
16 municipalities in Norway, which is a strength and increases the transferability of the findings.  
17 Due to the difficulty of conducting focus group interviews with the NHDs, the data collection  
18 methods used in this study consisted of both focus group interviews and individual  
19 interviews. Using these methods together has advantages and limitations. Both methods are  
20 suited to explore people's experiences with a specific phenomenon. Since NHDs and WLs  
21 can influence each other and collectively affect the quality of care and patient safety, we  
22 viewed the advantages of including both WLs and NHDs in the study to be greater than any  
23 disadvantage arising from using different data collection methods.

25 The research group is composed of researchers with broad research experience from two  
26 different countries. This, in turn, strengthens the trustworthiness of our findings and the  
27 credibility of the research. Three of the authors have worked several years in nursing homes  
28 as WLs, which can be viewed as both a strength and a limitation and requires a particular  
29 focus on reflexivity throughout the research process. Due to this background knowledge, it  
30 was possible to pose in-depth questions to explore a broad range of issues. However, the  
31 background knowledge can also affect the type of follow-up questions that were asked during  
32 the interviews. To counterbalance this possible bias, two researchers were always present  
33 during the interviews, and the analyses were also coded by two researchers (JM and SN)  
34 independently.

## Conclusion

To prevent abuse and neglect of residents in nursing homes, it is important to understand factors that affect detection and reporting of the phenomena. Our study revealed in-depth information about key factors related to underreporting from the perspective of nursing home leaders. In its present form, the Norwegian adverse event reporting system is not designed to detect abuse and neglect. There is also a need for a clear taxonomy that defines what to report regarding abuse and neglect. It is important that nursing homes operate as open, blame-free cultures that acknowledge that safety risk situations in patient care arise not merely from the actions of individuals but also from the conflicting, incomplete or suboptimal organisation and culture of which they are a part and within which they interact.

## Abbreviations

NFR: Research Council of Norway

RN: Registered Nurse

WHO: World Health Organisation

NHD: Nursing home director

WL: Ward leader

EPR: Electronic patient record system

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**Table 1. Demographics of the study participants**

Background characteristics	WLs (n= 28) Number (%)	NHDs (n= 15) Number (%)
<b>Age (years)</b>		
30 -39	6 (22)	1 (7)
40 -49	11 (39)	2 (13)
≥ 50	11 (39)	12 (80)
<b>Gender</b>		
Female	25 (89)	13 (87)
Male	3 (11)	2 (13)
<b>Number of beds managing:</b>		
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)
<b>Number of staff managing:</b>		
0	2 (7)	
10 -29	9 (33)	
30 - 49	11 (39)	
50 - 99	6 (21)	5 (33)
100 - 199		6 (40)
≥ 200		4 (27)
<b>Working experience in this position</b>		
0 -4	20 (71)	8 (53)
5- 9	7 (25)	3 (20)
≥ 10	1 (4)	4 (27)
<b>Total working experience as a leader in years</b>		
0 -4	11 (39)	1 (7)
5- 9	6 (22)	1 (7)
≥ 10	11 (39)	13 (86)
<b>Formal leader education</b>		
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)

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; <i>physical abuse, psychological abuse, financial abuse, sexual abuse and neglect</i> , 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 and 3 in the interview guide: 'Experience of abuse' and 'How to follow up on abuse', will be reported elsewhere

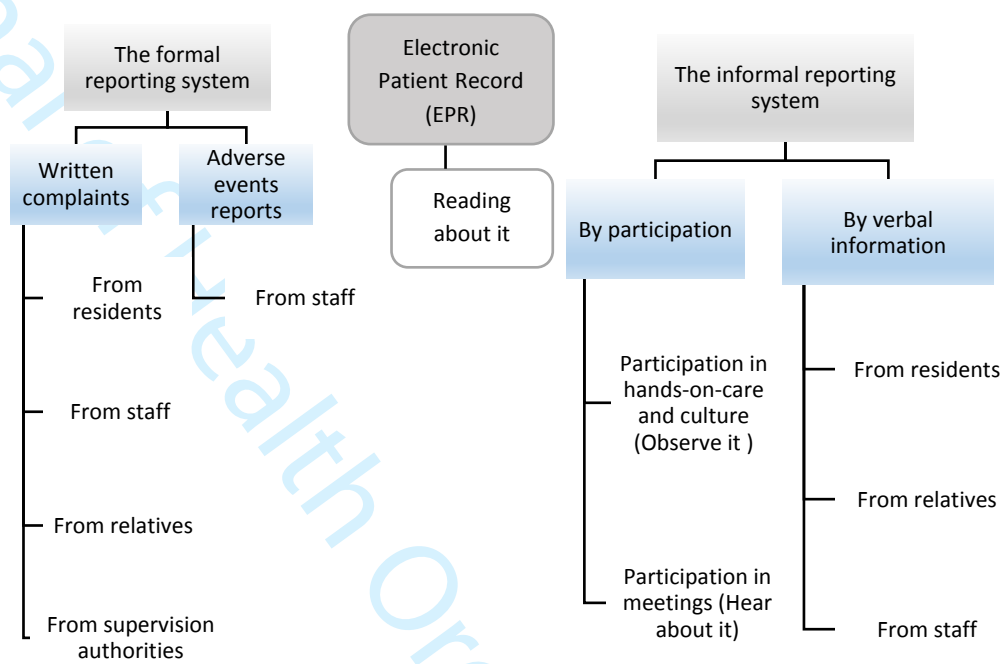
**Table 3 Example of data analyses: Cultural factors**

Sub category	Codes	Illustrative quotes
Perception of what constitutes abuse	Complexity	<i>In this culture, the staff may think that what they do actually is right.</i> (NHD 13)
	Task oriented culture	<i>'Then it is something about, do staff even know when they expos a resident to abuse. Because they may think that their approach is correct and that there is nothing, wrong with being a little clear, or handling the residents a little rough to get the task done'. (WL group 5)</i>
	Rules, norms and regulation	<i>'There is a barrier to report this. First, it is about the loyalty staff has to each other's. Then there is something about, that you want to be absolutely sure before reporting such events. (NHD 15)</i>
Loyalty among staff	The culture its selves is an important factor	<i>'I think that one reason why not all events reach us, may be that there is a loyalty within the staff group, and no one wants to tell on a college'. (WL group 2)</i>
	No one reports themselves	<i>'With the use of reflection, we see that staff become more aware of the residents, the environment around the residents and how they mutually influence each other. (NHD 14)</i>
	Loyalty	<i>'Then there is something about; how much does the staff member that has filed the reports need to know without me breaking the confidentiality to the staff member that is reported'. (WL group 3)</i>
Openness, quality and safety	Protect each other	
	Verbal communication	
	Have to be sure	
Openness, quality and safety	Reflection increase staff's awareness	
	Openness	
	Feedback	
Openness, quality and safety	Not possible to give feedback on everything	

**Table 4 Themes and sub-categories**

<b>Theme</b>	<b>Sub- categories</b>
Organisation structural factors	Closeness to staff and residents Technology tools Competing priorities Formal education and communication skills
Cultural factors	Perception of what constitutes abuse Loyalty among staff Openness, quality and safety
Abuse severity factors	Forms of abuse Internal vs. external reporting

Figure 1 Formal and informal reporting systems



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