Elder mistreatment in Portuguese care homes: intersections with organisational and professional factors – a mixed methods study

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Thematic Panel no.21 - Inequalities and care needs in old age

(Paper in progress. This is an early draft version. Please do not circulate or quote)

Abstract

Recent literature highlighted that the lack of recognition of care work, poor wages and difficult working conditions have a direct impact on quality of care, which may be a reflection of low public investment in the care system. However, further research is needed to explore the real impact of organisational and professional factors that appear to play together to the decrease of care quality and determines the occurrence of elder mistreatment practices. The paper is based on a self-administered questionnaire to be filled out by care workers (n=280; response rate of 70% achieved), in 16 Portuguese care homes, in one council in the metropolitan area of Lisbon. Logistic regression was employed to determine the relationship between violence and covariates, and chi-square tests were used to examine the association between types of violence and organisational, professional and individual variables.

Results indicate that overall, 54.7% of care workers have observed institutional violence, in daily practices: 48.7% psychological violence; 36.0% neglect care practices; 14.0% physical and 3.3% financial violence. The study suggests that organisational and individual factors are significantly associated with institutional violence. Findings revealed that omissions or lack of monitoring of care practices, the difficulty of managing conflicts inside teams and the lack of human resources, in relation to the workload, are the main factors for mistreatment, in care practices observed. Elder mistreats is bound to structural issues that long-term care policies and research has to confront.

Introduction

Elder mistreatment has for two decades been conceived of as a public health problem, with serious health, social and economic consequences for the victims but also a central issue, in terms of human rights concerns, of the right of older persons to live in institutions with dignity. Studies on elder mistreatment [i] have considered mainly the prevalence, causes and risk factors within a family context, and focus less on collective structures (nursing homes and residential care). According to WHO, 4-6% of older persons are estimated to be the victims of violence in a family context, and these percentages are expected to be higher in institutions.

Based on a systematic review and meta-analysis, Yon et al. (2018) concluded that the prevalence of mistreatment in institutions is under-estimated (80%) and global action to improve the monitoring of institutional violence is required. There are signs that preventing elder mistreatment in institutions should be an urgent social policy issue and actions are required to protect older people's rights to freedom from injury, violence and abuse (WHO 2012; WHO 2016). One of the actions of the WHO strategy and actions plan (2012-2020) is to "improve the quality of services in the community and in institutions, to adapt them better to the special needs of older people with functional limitations, and to ensure that quality guidelines are in

place for preventing elder maltreatment" (WHO 2012, 21). Recently, ENNHRI (2017) recognised that European countries should facilitate the ongoing monitoring of the human rights situation of older people in long-term care.

The need to focus on quality care practices is crucial due to several factors. Firstly, Europe's population is ageing rapidly. The global population of older people (>65), in 2016, in the EU28 was 19.2% (Eurostat 2019) and will rise to 30% by 2050. Secondly, the population aged 80 or above is projected to almost triple to 10% by 2050 and the group of the oldest-old is likely to require more institutional care, who tend to have cognitive impairments or require help with their physical needs (Gil 2017), depend on others and, therefore, are more vulnerable to situations of abuse and neglect (McDonald et al. 2012; Hawes 2003). However, elder mistreatment in institutions involves much more than reducing an interpersonal relationship problem (Harbinson 1999; Dixon et al. 2009).

Both the Kamavarapu et al. (2017) systematic review and the Yon et al. systematic review (2018) consider that clients, staff, institutional and environmental factors appear to play a role together in increasing the risk of violence, and that further research into the associations between the three actors (organisation, staff and residents) is needed (Castle et al. 2015; Kamavarapu et al, 2017). Although research into risk factors suffers from several weaknesses (e.g. lack of unified operational definitions of mistreatment, measurement problems and inconsistent research methodologies), some risk factors have nevertheless been consistently identified, including the characteristics of victims and staff, of the facilities and the working environment" (Yon et al. 2018, 62).

One of the main sets of risk factors for victims is being female, aged 80 or above, who tend to have cognitive impairments or require help with their physical needs (Gil 2017), a profile that is consistent with the statistical profile of long term-care in Europe (Eurostat 2016).

A second consistent set of risk factors are staff stressors (Yon et al. 2018; Malmedal et al. 2014, Drennan et al. 2012; Goergen 2004; McDonald et al. 2012) where, in particular, the staff attributed their experience of stress as being down to staff shortages and time pressure, high levels of staff turnover and a high ratio of staff/residents. This conclusion seems to be very significant. Quality of care lies in the balance between staffing ratios and training, while it is also recognised that excessive workloads and long working hours, as well as poor working conditions coupled with a high rotation of staff, who are poorly trained and remunerated, constitute risk factors for acts of passive neglect due to the physical and mental exhaustion of care workers (Gil 2018; 2019).

Inadequate staffing and lack of direct care staff supervision were noted as institutional-level factors associated with physical neglect, poor care (Lindbloom et al. 2007; Simmons et al. 2012) and neglectful care: the failure to provide care when needed or providing inadequate assistance (Dixon et al. 2009; 2013). Neglect has also been termed inadequate care (Malmedal et al. 2009, 25), which is associated with "the presence of unmet needs for services or assistance, which threaten the physical and psychological well-being of the individual".

Kroger & Puthenparambil (2017) propose the concept of care poverty to stand for unmet care needs (practical and personal) and to emphasize the social policy dimension of inadequate care. The frontiers between poor and inadequate care lead to mistreatment and become tenuous in an institutional context. This distinction is all the more difficult when the system is characterised by a lack of recognition of care work, omissions or limited monitoring of care practices in a conflictual organisational climate with poor communication, which can lead to the

institutionalisation of an omission of care culture (Gil 2018), and thus, one way to increase the risk of elder mistreatment.

In this care process continuum, there are different levels of relational and organisational conflict, which can impact on care practices, but due to their invisibility these remain under-studied and further research is required.

The area of psychosociology of organisations has a vast number of studies on organisational conflict and the paradoxical effects which this has on team decisions and performance. "Conflicts are always multidimensional, centred on tasks or relations, which combine cognitive, affective, emotional and motivational elements, sometimes provoking constructive, and at other times, destructive effects" (Pissarra 2014, 419). Conflict may be *intrapersonal* or *interpersonal*. The former may manifest itself when the tasks performed by any individual are inadequate, and intrapersonal conflict occurs when there are differences between two or more individuals which may occur due to individual differences, limited resources and role differentiation. Differences in personality, values, beliefs and attitudes, age and experience are some of the factors that contribute to the occurrence of situations involving interpersonal conflict. The intensity and the frequency of organisational conflict depends on various factors, such as the structural conditions of the organisation, the type of leadership, groups with different powers, lack of definition of roles, lack of interpersonal contact, poor communication, and Hall considers such conflict as impact on power (Hall 2004).

The aim of this paper is to explore different levels of conflicts inside organisations and analyse the impact of organisational and professional factors that appear to work together to decrease care quality practices which determine the occurrence of elder mistreatment practices.

Methods

Following the recommendations proposed by Yon et al. (2018), concerning what future research about elder mistreatment in institutional settings should concentrate on, the aim is to focus on four aspects: clearly define populations; types of violence (staff-to-resident, resident-to-resident or visitor-to-resident violence); characteristics of institutions, such as staff to patient ratios, ratio of trained staff, training for staff, and care guidance; methodological aspects (sampling procedure, use of standardised measurement tools, and method of data collection such as face-to-face interview for older adults and self-administrated questionnaires for the staff) (Yon et al. 2018, 64).

In addition to these aspects, consistent indicators to measure mistreatment, as proposed by Drennan et al. (2012), can be a useful typology of behaviours to measure elder mistreatment in institutional settings.

Sampling and procedures

This study was carried out in one council in the metropolitan area of Lisbon and thirty-two nursing homes (both for-profit and not-for-profit) were invited to participate and sixteen agreed to participate (12 not-for-profit and 4 for-profit nursing homes), with all participants giving their informed consent. On average, there were 36 residents in the nursing homes surveyed, varying between 9 and 84 residents, providing care to physically and mentally dependent people (80% of residents have dementia).

Although the study included resident interviews and observation of daily life, the focus of this article is on the perspectives of care workers, which can be assumed as a limitation since the rates of elder mistreatment perpetrated by the staff only provide a partial picture of the extent of the problem and do not indicate the overall estimate of violence in the institution (Yon et al. 2018).

Participants and instruments

In the first phase, were conducted 40 in-depth interviews with care workers to obtain data on organisational features of the settings, focused on: personal and professional trajectories, the organisational definition of care; impacts and problems associated with care work and factors influencing good and bad care.

In addition, it was carried out a self-completed questionnaire to be filled out by care workers, in those 16 Portuguese care homes (n=280; response rate of 70% achieved).

Altogether 280 questionnaires were delivered and 186 were received. There were 36 incomplete questionnaires which were cancelled, as they did not answer more than half the questions contained in the questionnaire. Altogether, 150 were considered, equivalent to a response rate of 57%.

The majority of respondents were female, aged between 21 and 68 years of age, with the average age being 47. The majority of the respondents (84.7%) were of Portuguese nationality and 15.3% were born abroad (African countries, Brazil, Ukraine). Of the total number of respondents, 43.8% were married and 30.8% were single, most had had an average of 6-9 years of schooling (58.5%) and completed secondary school studies (23.8%). Only non-Portuguese nationality respondents had experienced higher educational studies. The average time working in the profession was 10 years and the average time working in their institution decreased to 7 years. The majority (77.3%) worked as an employee and were on a permanent contract. Most of the care workers who were on a fixed-term contract had been working in the home for less than 5 years.

The aim of the self-completed questionnaire was to characterise the interpersonal features of the settings, identifying a social portrait of the staff (age, sex, level of education, professional experience), the working environment (team profile, organisational climate, working hours, absence from work and intention to leave), professional performance (work satisfaction, burnout levels, physical and mental health) and organisational factors that influence care work (contextual, interpersonal, material and motivational factors). We used the following instruments: job satisfaction/commitment and intention to leave (Filipova 2011); Shirom-Melamed Burnout Measure (SMBM) - the SMBM contains 14 items divided into three subscales: physical fatigue (P); emotional exhaustion (E) and cognitive weariness (C); General Health Questionnaire (GHQ-12) and analysis of cultural organisation (leadership, cohesion within the organisation and values) (Cameron & Quinn 1999; Gonçalves 2014).

In order to explore how the different levels of conflict coexist and determine care practices, we sought to explore the concept of conflict within the social relations which are established in the institutional space between the various social actors: residents-care workers; between residents; between families; between families-care workers; between families-residents; between care workers; between professional staff; between managers and care workers. Three groups of indicators were defined: the quality of relationships, the existence of conflicts and the

frequency of their occurrence. For the first group, a single question with five items was utilised, from 0 (not satisfactory) to 5 (completely satisfactory), which was recoded into 3 items (Hardly/not satisfactory, reasonably satisfactory and very satisfactory).
Frequency of occurrence involved the use of seven items for each type of relation, from 0 (never or almost never) to 7 (always or almost always) in order to measure the severity of the conflict. In order to facilitate analysis, the 7 items were recoded into 4 items: very frequent, frequent, occasional and never. These two indicators were complemented with an open question about the justifications given by care workers for the occurrence of the different conflicts that occur in the institutional space.

The measurement of conflicts between staff and resident interactions and risk factors was based on Goergen's operational definitions (2001; 2004; Rabold & Goergen 2013; Drennan et al. 2012). The complexity and the multidimensionality of the problem requires a distinction between conduct committed by the professionals or as observers of actions committed by others (work-colleagues, staff, residents, family members or residents) (Lachs et al. 2007; Rosen et al. 2008; Pillemer et al. 2011).
Starting from the five types of violence analysed (physical, psychological, negligence, financial and sexual), 31 types of behaviour were categorised (committed and observed) in the previous 12 months prior to the interview.

Table 1 - **Operational definitions of elder mistreatment in institutional settings**

(observed and committed)

Neglect	Not change a resident each time they were wet or soiled after an episode of incontinence
	Ignored a resident when they called
	Not bring a resident to the toilet when they asked
	Give a resident too much medication to keep them sedated/quiet
	Refuse to help a resident with their hygiene needs
	Refuse to help a resident with their feeding needs
	Neglect to turn or move a resident to prevent pressure sores
Physical abuse	Restrain a resident beyond what was needed at the time
	Push, grab, shove or pinch a resident
	Throw something at a resident
	Slap or hit a resident
	Kick a resident or hit them with a fist
	Hit or try to hit a resident with an object
Physical abuse	Isolate a resident beyond what was needed to control them
	Insult or swear at a resident
	Shout at a resident in anger
	Deny a resident food or privileges as part of a punishment
	Threaten to hit or throw something at a resident
Financial abuse	Take jewellery, money, clothing or something else from a resident or resident´s room
Sexual abuse	Talk to or touch a resident in a sexually inappropriate way

Drennan, J., Lafferty, A., Treacy, M., Fealy, G., Phelan, A., Lyons, I., Hall, P., (2012) *Older People in Residential Care Settings: Results of a National Survey of Staff Resident Interactions and Conflicts*, UCD and HSE.

Reciprocity of conflict in the interactions between care worker and care receivers requires that the conduct of the residents, whether directed at the care workers or at other residents, also be

considered (Lachs et al. 2007; Rosen et al. 2008; Pillemer et al. 2011; Drennan et al. 2012). Other behaviours considered as psychological violence were insulting, spreading rumours and threatening; for physical violence, physical aggression, kicking, pushing or throwing or striking with an object; and sexual violence, obscene gestures and sexual harassment.

Data analysis

Descriptive analysis of the questionnaire was carried out using the Statistical Package for the Social Sciences (SPSS) (version 25) and NVivo 11 for Windows (qualitative data analysis computer software package) – used in the content analysis of some of the open questions.
Logistic Regression was utilised to determine the relationship between violence and covariates and a Chi-square with and without Mont-Carlo Correction, Spearman Correlation, Mann-Whitney, and Kruskall-Wallis tests were used to examine the association between types of violence and individual, organisational variables. In these tests, statistical significance was defined as $p<0.05$.

Findings

The semi-structured interviews highlighted that excessive workloads and poor working conditions, coupled with high staff turnover and poor training and pay, have consequences not only on the quality of the care that these care workers can offer, but also their physical and mental health, job satisfaction and work environment.
These results address the main justifications that respondents identified as the factors that most influenced the quality of care work. Lack of personnel, low wages, little training, pressure on working hours given the volume of work, few social benefits and alternating shifts were considered the contractual factors that most influence the quality of work (figure 1). At the interpersonal level, a bad environment, lack of feedback, criticism of work and lack of technical supervision were also, in descending order, factors that the respondents indicated as having the most impact on the quality of service provision. As motivational factors, ranked according to order of greatest importance, the lack of valorisation of work, the hard-physical work involved in the tasks, dealing with illness/death and the few experiences of success stand out. Contextual factors, the physical conditions of the home, and available equipment were the factors that, according to the respondents, affect care work least.

Figure 1 - **Factors that most influence care work**

Contractual and material factors (K(2)=90.688, p<0.001)	**Interpersonal factors** (K(3)=75.194, p<0.001)	**Motivational Factors** (K(3)=20.522, p<0.001)
Lack of staff	Bad environment	Lack of valorisation of the work
Low salaries	Lack of feedback	Hard physical work involved in the tasks
Little training	Criticism of work	Dealing with illness/death
Pressure on working hours given the volume of work	Lack of technical supervision	Few experiences of success
Few social benefits		
Alternating shifts		

One of the factors that emerged as a determining factor in the quality of service provisioned is the issue of organisational conflict. Conflicts occur mostly between co-workers, between

residents and staff, or between managers and staff (table 2). More than half also identified conflicts between residents. When the frequency of conflicts was analysed, conflicts with a higher frequency which occurred between co-workers, between residents and staff, and between residents stood out more strongly.

Table 2 - **Sources of conflicts and their frequency**

	N	%
Existence of conflicts (n=150)		
Between co-workers	117	**78.0**
Residents and employees	100	**66.7**
Between managers and staff	85	**56.7**
Between residents	79	**52.7**
Between staff and family members	66	44.0
Between technical staff	66	44.0
Between family members/residents	62	41.3
Between family members	45	30.0
Frequency of conflicts between co-workers (n = 117)		
Occasional	50	42.7
Frequent	48	41.0
Very frequent	19	16.2
Frequency of conflicts between employees and residents (n = 100)		
Occasional	56	56.0
Frequent	41	41.0
Very frequent	3	3.0
Frequency of conflicts between managers and staff (n = 85)		
Occasional	51	60.0
Frequent	27	31.8
Very frequent	7	8.2
Frequency of conflicts between residents (n = 79)		
Occasional	49	62.0
Frequent	28	35.4
Very frequent	2	2.5

In the case of *conflict within work teams,* associated factors are a lack of communication and group cohesion, personality traits, lack of work organisation and disputes about the distribution of work and defined rosters (schedules, substitutions, days off and holidays) and the tiredness/stress of care workers.

Conflict with managers is seen mainly through the lack of leadership or the leadership profile (authoritarian, bureaucratic, dominated by a commercial/unprofessional perspective) and a lack of communication within the organisation. Conflicts arise around the organisation of work, the distribution of tasks, and the devaluation of work.

Conflicts with residents are attributable to the individual characteristics of the older persons, personality traits (stubbornness, authoritarianism, distrust, aggression), or motivated by illness and dementia. Lack of knowledge of how to deal with dementia, care workers who are unfit to care for, lack of training and time, are some of the reasons invoked by the respondents to justify the occurrence of conflicts in the interactions between care workers and residents. Conflict is also generated by the non-acceptance of institutional rules (including lack of cooperation in activities such as hygiene, dressing) or due to the complaints made by older people regarding

the disappearance of clothing and goods, occupation of places, quality or food or wanting to be served first.

Similar reasons lie at the basis of *conflicts with families:* dissatisfaction and complaints about the lack of care and omissions. Conflicts are due to general dissatisfaction with care (not in accordance with established rules, discontent, demands, ingratitude), complaints about the disappearance of objects, clothing, the way care is provided and the lack of communication in the institution. Lack of communication emerges as a central factor involving the various actors who take their places on the stage of care.

The following table shows the respondents' categories justifying the factors involved in the occurrence of the various conflicts.

Table 3 **- Nature of organisational conflict**

Three reasons for the conflict	N	%
With residents (n = 74)		
Personality trait	24	**32.4**
Disease/dementia	21	**28.4**
Complaints and omissions	17	23.0
Non-acceptance of the rules and their compliance	12	16.2
Between co-workers (n = 79)		
Lack of communication	26	**32.9**
Care worker profile and personality traits	17	**21.5**
Lack of group cohesion	14	17.7
Organisation of work and leadership	11	13.9
Job-related queries and rosters (schedules, holidays)	7	8.9
Tiredness/stress	4	5.1
With the managers (n = 54)		
Lack of leadership	24	**44.4**
Lack of communication	17	**31.5**
Organisation of work and rosters (schedules and rosters)	9	16.7
Little recognition of the work done	4	7.4
With the family (n = 34)		
Dissatisfaction and demands	11	**32.4**
Lack of communication	9	26.5
Complaints about care and omissions and disappearance of property	8	23.5
Family problems	6	17.6

Analysis of the data enables us to show that underlying institutional care, different levels of conflict may coexist, whether organisational or relational, with inevitable impacts on care practices.

In this *continuum* between care and conflict, and based on the premise that residential structures are created with the purpose of providing adequate and quality services, these can also be transformed into places of great organisational conflict generating omission of care and sometimes even mistreatment.

Next, we will carry out a three-dimensional analysis, where data will be presented regarding institutional violence, dimensioned in terms of being observed, committed and suffered.

Conflicts observed by care workers against residents - From conflicts observed to those committed

Results indicate that, overall, 54.7% of care workers have observed institutional violence, in daily practices, in the preceding 12 months: 48.7% psychological violence; 36.0% neglectful care practices; 14.0% physical and 3.3% financial violence (table 4).
Psychological violence and negligence recorded the highest values: in the 12 months prior to the interview there were, on average, 2.5 instances of psychological violence and 2.6 instances of negligence, while the average for physical violence was 1.6 instances. Analysis of the behaviours indicates that ignoring (34.0%), shouting (33.3%), rejecting (16.0%) and not respecting privacy (12.0%) were the most commonly observed behaviours.

Neglectful care, representing 36.0% of the acts observed between co-workers, translates into omissions in basic daily life activities, such as personal hygiene (shaving, combing, brushing teeth), bathing, changing underwear and accompanying to the bathroom (making somebody wait on purpose, or putting on a diaper without the need for it), are some of the behaviours that characterise bad practices observed in the institutional space.

Regarding *physical violence*, at least 1 of the 6 physical violence behaviours were observed by the respondents, corresponding to a total of 14.0%. Amongst these of note were physical restraint (tying, constraining) and the use of strategies to restrain the old person.

Knowledge of cases of *financial violence* was reported by only 3.3% of the respondents.

The figures decrease significantly as regards *violence committed themselves*, with 16.7% of those interviewed admitting to having committed at least one of these behaviours. The highest figures were also recorded for psychological violence (13.3%) and negligence (6.7%).

Analysis of the specific behaviours committed themselves, albeit to a lesser extent, reveals a similarity in the behaviours observed by third parties: shouting reported by 10.7%, ignoring (5.3%) and not respecting privacy (2.0%) were some of the behaviours stated in terms of psychological violence. The use of physical and chemical restraints (2.7%), as a form of physical violence, and omission of daily life activities such as hygiene, bathing, brushing teeth, combing, among others, is stated by a total 4.7% of respondents. In both situations (observed and committed) no cases of sexual violence were reported.

Table 4 - **Behaviours reported by assistant staff (observed and committed), in the last 12 months**

	Observed		**Average/ Behaviours**	**Committed**		**Average/ behaviours**
	N	%		N	%	
Types of violence (n = 150)						
V. Psychological[1]	73	48.7	2.5	20	**13.3**	1.9
V. Physical[2]	21	14.0	1.6	3	2.0	1.3
Negligent care[3]	54	36.0	2.6	10	**6.7**	2.0
V. Financial	5	3.3	1	1	0.7	1.0
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Overall violence[4]	82	54.7	4.5	25	**16.7**	1.5
Behaviours involving psychological violence (n = 150)						
Shouting at a resident	**50**	**33.3**		16	**10.7**	
Intentionally ignoring a resident when they call	51	**34.0**		8	**5.3**	
Rejecting an older person	24	**16.0**		2	1.3	
Giving nicknames in a pejorative way (in order to hurt)	9	6.0		2	1.3	
Humiliating to make them feel ashamed	7	4.7		1	0.7	
Punishing (not taking to the living room, or to the garden)	**-**	**-**		-	-	
Not respecting privacy	**18**	**12.0**		3	**2.0**	
Provoking the older person in a deliberate manner until causing anger	7	4.7		1	0.7	
Verbally threatening the older person	**8**	**5.3**		2	1.3	
Verbally insulting (calling names)	7	4.7		2	1.3	
Punishing by refusing access to a meal (food, drink)	4	2.7		-	-	
Spreading rumours about residents	4	2.7		1	0.7	
Physical violence						
Closing in a room as punishment	2	1.3		-	-	
Tightening very strongly	3	2.0		-	-	
Physical aggression (spanking, pushing, throwing an object)	3	2.0		-	-	
Tying the older person to a chair to not have so much work (wrists, belly)	10	6.7		1	0.7	
Using other restraining strategies to not give so much work	11	7.3		2	**1.3**	
Using medication to keep the person calmer and to have less work	5	3.3		1	0.7	

[1] At least 1 of the 12 observed behaviours of psychological violence.
[2] At least 1 of the 6 observed behaviours of physical violence.
[3] At least 1 of the 10 observed behaviours for negligence
[4] At least 1 of the 24 behaviours observed for the 4 types of violence (psychological, physical, financial and neglect).

Negligent care				
Not changing the position of a bedridden older person	22	14.7	1	0.7
Not caring about hygiene (shaving, combing, brushing teeth)	24	16.0	3	**2.0**
Not caring about hygiene (not showering)	14	9.3	4	**2.7**
Not changing underwear	9	6.0	1	0.7
Making an older person wait on purpose	28	18.7	3	2.0
Placing diapers without this being necessary to avoid helping going to the toilet.	13	8.7	2	1.3
Intentionally making someone wait to go to the toilet	15	10.0	2	1.3
Leaving the older person in bed all day	8	5.3	3	2.0
Giving poor information about medication	3	2.0	1	0.7
Disrespecting special diets	5	3.3	-	-
Financial violence				
Misappropriation of property (money, jewellery, clothing, or other personal property)	5	3.3	1	0.7
Sexual violence				
Subject the person to contact of a sexual nature without consent	---		---	-

The occurrence of some of the observed behaviours, mainly of a psychological type, stems from an organisational context with major labour conflict. This result was obtained through a statistically significant association between the observed occurrences of violence within the institutional context and the greater level of conflict within the work teams (frequency of occurrence – very frequent):

- shouting ($X^2(2)=7.485$; $p=0.024$); provoking the older person in a deliberate manner until causing anger ($X^2(2)=16.294$; $p=0.001$); verbally threatening the older person ($X^2(2)=7.470$; $p=0.028$); punishing (not taking to the living room, or to the garden) ($X^2(2)=10.565$; $p=0.015$); punishing by refusing access to a meal (food, drink) ($X^2(2)=10.857$; $p=0.024$) and tying the older person to a chair to not have so much work (wrists, belly) ($X^2(2)=16.117$; $p=0.001$)[5];
- A statistically significant association of the behaviour shouting with the occurrence of conflicts in work teams was identified (frequent: OR=3.97 [$CI_{95\%:}$ 1.13-13.99]; very common: OR=5.60 [$CI_{95\%:}$ 1.27-24.64], which means that it increases the probability of the shouting behaviour being observed when conflicts occur frequently and very

[5] Despite the statistically significant association between behaviours and the level of conflict, except for shouting, as regards the other behaviours [provoking the older person in a deliberate manner until causing anger; verbally threatening the older person; punishing (not taking to the living room, or to the garden); punishing by refusing access to a meal and tying the older person to a chair to not have so much work (wrists, belly)] none of these behaviours had a predictive value.

frequently in the work teams[6]. In other words, the risk of observing shouting behaviour occurs five times more often when there are very frequent conflicts in the work teams, while the risk of observing shouting behaviour occurs four times more often if the occurrence of conflict is frequent;

- The dimension of the home is also a factor that enhances the occurrence of some of the observed behaviours, especially psychological ones[7], such as rejection of the older person, verbal threats, and physical violence. A high level of conflict and larger-sized organisational contexts also inevitably impacts on the mental health of care workers;
- The data show that individuals with worse mental health (GHQ12) showed more psychological behaviour: humiliation ($X^2(1)=5.881$, p=0.015); use of punishments ($X^2(1)=6.842$, p=0.009), provoking anger ($X^2(1)=5.401$, p=0.020); spreading rumours ($X^2(1)=14{,}651$, p=0.002) and tying ($X^2(1)=5{,}312$, p=0.021), the latter a physical behaviour;
- A higher number of daily working hours[8] and a greater vulnerability for care workers suffering from physical and emotional burnout[9] shows a statistically significant relationship with observed neglectful behaviours (negligence in terms of assistance with hygiene, putting on diapers, without this being necessary, avoiding helping in the bathroom, making the resident wait on purpose, leaving the resident in bed all day and the use of physical restraints).

Conflicts comitted by residentes against care worker

Overall, 52.0% of respondents reported having been the target of at least one violence behaviour by residents of the institution in the past 12 months, which is indicative of the climate of tension that arises associated with interactions between residents and care workers. Insulting, spreading rumours and swearing are the main behaviours regarding psychological violence for almost half of the respondents (47.3%) while physical aggression (kicking, pushing) are also some of the behaviours suffered. Sexual harassment and obscene gestures were reported less frequently.

Table 5 - **Violence committed by residents against care staff in the last 12 months**

	n	%
Types of violence (n = 150)		
V. Psychological	71	47.3
V. Physical	38	25.3
V. Sexual	21	14.0
Overall violence committed[10]	78	52.0

[6] An analysis model was studied using binary logistic regression according to the Forward de Wald method, with the reference category ("rc": *observation of shouting at an older person) (dependent variable)* was studied. The former was carried out with the independent variable, the frequency of occurrence of conflicts among co-workers ("rc": frequent). This showed a good data fit (Hosmer and Lemeshow Test: $X^2(2)=7.485$; *p*=0.024), sensitivity=84.4%; specificity=45.2%; differential of overall percentage of correctness in relation to the null model =0.14%).

[10] At least 1 of the 10 behaviours committed against the care worker for the 3 types of violence (psychological, physical and sexual).

V. Psychological (n = 150)		
Insulting	45	30.0
Spreading rumours	21	14.0
Swear words	20	13.0
Threatening	6	4.0
V. Physical		
Physical aggression	**27**	**18.0**
Kicking	**23**	**15.3**
Pushing	22	14.7
Striking or hitting with an object	**12**	**8.0**
V. Sexual		
Obscene gestures	17	11.3
Sexual harassment	11	7.3

From the data obtained it can be concluded that there is a statistically significant relationship between the behaviours committed by the care workers and the violence suffered by the residents, which means that there is ***bidirectional violence.*** The reciprocity of violence leads to the care workers themselves being victims of violence, which is therefore bilateral and results from social interaction (a basic assumption of the dyadic discord theory) (Burnight & Mosqueda, 2011).

Regarding care workers who reported that they are the target of insults from the residents, they themselves report that they shout($X^2(2)=15.289$, $p<0.001$) and that they make them wait on purpose ($X^2(2)=6.942$, $p=0.031$). In the case of the conduct suffered from "spreading rumours", this arises with a statistically significant association especially in the case of negligence behaviours such as not caring about hygiene ($X^2(2)=6.586$, $p=0.038$), making someone wait in the bathroom ($X^2(2)=8.102$, $p=0.034$) and leaving in bed ($X^2(2)=11.448$, $p=0.006$) (figure 2).
This statistical relationship is exacerbated by the greater number of behaviours committed when we are faced with acts of physical violence, such as pushing and physically assaulting. In the case of pushing, behaviours committed which increase are: shouting ($X^2(2)=8.566$, $p=0.011$); ignoring ($X^2(2)=6.676$, $p=0.035$); rejecting ($X^2(2)=8.620$, $p=0.028$); making someone wait ($X^2(2)=11.785$, $p=0.005$); making someone wait in the bathroom ($X^2(2)=8.541$, $p=0.029$). In the case of physical

[8] Negligent care is observed in organisations where the assistants work more hours daily (do not bathe (mean rank "yes" (97.75)>"no" (70.93)), making wait on purpose (mean rank "yes" (8.11)>"no" (7.74).

[9]The individuals with a higher emotional burnout rate report more behaviours observed relating to negligence (making wait on purpose (t (142)=2.379, $p=0.019$) and putting diapers, without being necessary (t(140)=2.235, $p=0.027$). Care workers who present a higher physical burnout score observe more behaviours not only involving neglect, such as not changing underwear (t(140)=-2.395, $p=0.018$), as well as physical ones, such as the use of strategies such as restraining to not give so much work (t(141)=-2.381, $p=0.026$), tightening strongly (t(142)=-2.856, $p=0.005$), physical aggression (t(141)=-2.838, $p=0.005$) and provoking the older person in a deliberate manner until causing anger (t(143)=3.1167, $p=0.002$). The care workers with the highest levels of cognitive burnout reported behaviours observed such as no bathing (t(142)=2.458, $p=0.015$), provoking anger (t(143)=-2.423, $p=0.017$) and physical aggression (t(141)=-2.096, $p=0.038$). Care workers with a higher burnout score reported behaviours such as provoking the older person on purpose (t(143)=-2.065, $p=0.041$) and not changing underwear (t(140)=2.282, p=0.24).

[10] At least 1 of the 10 behaviours committed against the care worker for the 3 types of violence (psychological, physical and sexual).

aggression, such as hitting or kicking, the behaviour with a statistical relation is shouting ($X^2(2)=13.543$, $p=0.001$) and in the case of kicking, behaviours such as waiting in the bathroom ($X^2(2)= 9.405$, $p=0.038$) are some of the behaviours committed in which there is a statistically significant relationship.

Figure 2 **- Bidirectional violence**

Type of violence	Suffered	Type of violence	Committed
Psychological	Insults	Psychological	Shouting
		Negligence	Making wait on purpose
	Spreading rumours	Negligence	Not caring about hygiene Making somebody wait in the bathroom Leaving in bed
Physical	Kick	Negligence	Making somebody wait in the bathroom
	Pushing	Psychological	Shouting Rejecting Ignoring
		Negligence	Making wait on purpose Making somebody wait in the bathroom
	Physical aggression (hitting/smacking)	Psychological	Shouting

Conclusion

Both the results of the interviews and the survey are consensual in relation to the lack of investment there has been in Portugal in relation to the profession of care worker, in terms of training, qualifications and social recognition of the profession. This lack of recognition is part of a social system that places little value on the care given to the old people (Hussein 2017).

The social disqualification that exists around care has repercussions on the organisational culture, which is markedly closed and with little focus on "the ethics of caring" (Brugère 2017), in which the fragmentation of professional practices (in the health and social field) prevails and there is a lack of internal communication. This organisational model is reflected in the way in which the cohesion of work teams is managed, sometimes accompanied by the absence of a strategic vision from those who manage these organisations, which are some of the problems identified that contribute to an organisational climate characterised by conflict. An organisational climate allied to difficult working conditions (low wages, rotating shifts, little social recognition of the profession being carried out) and fragility of monitoring care practices. In this system of caring, sometimes with uncertainty regarding the technical supervision of care, the delegation of responsibilities to figures who are on the front line, but play a dual role, of care workers and, at the same time, of "shift coordinators", without being given the institutionally and financially due social recognition, is often a reason for discord and major organisational conflict, with inevitable impacts on the quality of care. A care which is characterised by its collectivisation, through the routine planning of tasks, which it is necessary to fulfil, and sometimes in times for care records, within a system where the staff/resident ratios are out of

step with a population already advanced in age and in need of long-term care. A population in a situation of great physical and mental dependence, in which dementia has taken on considerable import, as the main pathology, and with demographic projections estimating the exacerbation of this. According to the OCDE (2018), it is estimated that there are more than 20 people with dementia in Portugal per 1000 individuals in 2017, and it is estimated that this figure will increase to 31.2% in 2037.

The collectivisation of care which is provided within an institutional context is incompatible with so-called *good care,* defined by the fact that this is person-centred based on individualisation. Personalisation, humanity, attention, respect for individuality and dignity of care, are some of the terms that have been created nowadays to satisfy basic needs (food, personal hygiene and comfort, health care) but also rehabilitation and maintenance of the individual's capacities (physical exercise, movement, occupation and social interaction). The satisfaction of this set of needs suggests two key phrases: the human factor (improvement and professionalisation) and the time factor, of providing in the sense of implying the long time that is necessary for care to be exercised in an individualised and timely manner.

The results of the survey show that the occurrence of some of the observed behaviours, especially of a psychological kind, results from an organisational context of major labour conflict. When conflicts occur more regularly in work teams, the risk of situations being observed on a daily basis which involve screaming directed at residents increases 5 times more within institutional dynamics.

A significant level of labour conflict also causes impacts on the mental health of care workers, thus constituting a factor that inevitably contributes to the quality of the care being provided. We can conclude that individuals who demonstrate worse mental health, observe more behaviours of a psychological type (humiliation, the use of punishments and threats) and the use of strategies such as the use of third-party physical restraint, a result that is in line with other international studies (Pillemer & Moore 1989; Goergen 2004, Malmedal et al. 2009; Buzgova & Ivanová 2009).

On the other hand, care workers who work more hours per day, who show higher rates of physical and emotional burnout, show omissions in their practical behaviours in relation to the care provided for personal hygiene, as well as the excessive use of physical restraint, justified by the overload of work as a way to prevent possible falls.

This data confirms the most prevalent forms of neglect which are related to care activities such as omission of care (Malmedal et al. 2009; Drennan et al. 2012; Cooper et al. 2018), which included observing a member of staff ignore a resident when they have called, or not bringing the resident to the toilet when they asked or refusing to help a resident with their hygiene needs, not turning a resident to prevent pressure sores, and the excessive use of restraints. Burnout was also significantly associated with self-reports of neglect of older people (Drennan et al. 2012; Cooper et al. 2018).

Some of these results corroborate that the borders that separate *poor care and mistreatment,* sometimes institutionally accepted as inadequate, but hardly contested in practice, through a policy and an interventive organisational culture. This indicates that we are dealing with the *institutionalisation of a culture of omission*, where aspects such as mistreatment and neglect appear as problems not associated with the care that is provided in the institutional space and

which are further characterised by their invisibility or are underreported, such as behaviours involving the misappropriation of assets, jewellery or other personal objects.

The level of institutional conflict increases, when it is recognised that mistreatment is both committed and mistreatment is suffered, thus making institutional violence a bidirectional process, not understanding exactly where the conflict begins and where it ends.

In this context of severe conflict, sometimes older people also react and insults, rumours, physical aggression (pushing, kicking and throwing an object) and obscene gestures are also committed by the residents themselves against the care workers. Conflicts between care workers and residents include dress and hygiene-related conflicts, resident complaints (disappearance of objects, type of nourishment, occupancy of places or wanting to be served first), as well as non-acceptance of institutional rules. Conflict committed by older persons (mostly related to the resident wanting to go outside the facility or personal hygiene) tends to occur due to misunderstandings, especially when staff attempt to carry out care tasks for residents with cognitive impairments (Goodridge et al, 1996). In general, care workers and professional staff are not prepared to deal with and care for persons with dementia and behaviour problems. This problem can reinforce the possibility of mistreatment, mainly physical aggression, which can become interactive (Steinnetz 1988; Paveza et al. 1992). These authors showed that families with Alzheimer's patients were more vulnerable to violent behavioural episodes linked to the disease itself, which also highlighted the difficulty in dealing with dementia itself. Mistreatment results from misunderstanding, thoughtlessness, heavy workloads, a lack of skills and knowledge (DeHart et al. 2009).

This interdependence between what is committed and what is suffered has also been reported (Pillemer & Moore 1989; Buzgova & Ivanová 2009; Drennan et al. 2012): staff burnout and high levels of conflicts between staff and residents were also identified as predictors of mistreatment and there is evidence that those care workers who experience violence from a resident are more likely to respond by being abusive towards the older person. Drennan et al. (2012)'s study showed that the strongest predictors of the neglect and violence were identified as high levels of burnout, the frequency with which resident-related stressors occurred, staff experiences of mistreatment by residents and respondents experiencing psychological distress.

The complexity of this process thus requires a distinction of levels of conflict where the organisational system, as a global system, is itself a generator of major inequality and, sometimes, a facilitator of institutional violence, distant from a true organisational culture of care. Elder mistreatment is not perceived as the commission or omission of a direct carer, but as occurring in a system - it requires a systemic approach (Cooper et al. 2018) and a structural reform is needed where older persons in need of care have to claim rights to equal conditions, similar to those of other citizens (Jonson & Hamett 2016).

A care culture based on competencies (DeHart et al. 2009), including those dealing with definitions and policies, risks of mistreatment, communication and respect in relationships with residents, and development of a cooperative work environment is needed to prevent elder mistreatment.

Bibliography

Brugère, F. (2017*) L´Éthique du "care* [The ethics of "care"], Que sais-je?, Presses Universaires de France: Paris.

Buzgova, R., & Ivanova, K. (2009) Elder abuse and mistreatment in residential settings, *Nursing Ethics,* 16 (1), 110-126.

Cameron, K., & Quinn, E.R., (1999) *Diagnosing and changing organizational culture - The Competing Values Framework.* University of Michigan: Prentice Hall Series in Organizational Development.

Castle, N., Ferguson-Rome, J. and Teresi, J. (2015) Elder abuse in residential long-term care: an update to the 2003 National Research Council Report, *Journal of Applied Gerontology*, 34(4), 407–43.

Cooper C, Marston L, Barber J, Livingston D, Rapaport P, Higgs P, et al. (2018) Do care homes deliver person-centred care? A cross-sectional survey of staff-reported abusive and positive behaviours towards residents from the MARQUE (Managing Agitation and Raising Quality of Life) English national care home survey. *PLoS ONE* 13(3): e0193399.

DeHart, D. Webb, J., Cornman, C. (2009) Prevention of Elder Mistreatment in Nursing Homes: Competencies for Direct-Care Staff, *Journal of Elder Abuse and Neglect*, Volume 21, Issue 4, 360-378.

Dixon, J., Biggs, S., Stevens, M., Manthorpe, J. and Tinker, A. (2013) Defining the 'perpetrator': abuse, neglect and dignity in care, *Journal of Adult Protection*, Vol. 15 No. 1, 5-14.

Dixon, J., Biggs, S., Tinker, A., Stevens, M. and Lee, L. (2009) *Abuse, Neglect and Loss of Dignity in the Institutional Care of Older People*, National Centre for Social Research, London.

Drennan, J., Lafferty, A., Treacy, M., Fealy, G., Phelan, A., Lyons, I. and Hall, P. (2012) *Older people in residential care settings: Results of a national survey of staff–resident interactions and conflicts*, Dublin: University College Dublin and National Centre for the Protection of Older People.

ENNHRI (2017) *Respect My Rights*, An ENHRI Toolkit on Applying a Human Rights- Based Approach to Long-term Care for Older Persons, Co-funded by the European Union, Brussels.

Eurostat (2015) *People in the EU: who are we and how do we live?* – Statistics on an ageing society, Luxembourg: Publications Office of the European Union.

Filipova, A.A. (2011) Ethical climates in for-profit, non-profit, and government skilled nursing facilities: managerial implications for partnerships, *JONA'S Healthcare Law, Ethics, and Regulation* / Volume 13, 3(4),125-31.

Gil, AP, (2017) A conceptual model to approach Elder Abuse and Neglect in residential care settings, paper discussed at a paper-based session in the "*Transforming Care Conference*", Milan, 26th to 28th 2017.

Gil, A.P., (2018) Care and mistreatment - two sides of the same coin? An exploratory study of three Portuguese care homes, *International Journal of Care and Caring,* vol 2, no 4, 551–73.

Gil,A.P. (2019) Quality procedures and complaints: nursing homes in Portugal, *The Journal of Adult Protection,* Vol. 21 Issue: 2, pp.126-143.

Goergen, T. (2004) A multi-method study on elder abuse and neglect in nursing home, *Journal of Adult Protection*, Vol. 6 No. 3, 15-25.

Gonçalves, S. (2014) Cultura organizacional [organisational culture], *Psicosociologia do trabalho e das organizações – princípios e práticas [Psychosociology of work and organizations - principles and practices],* Pactor: Lisboa, 465-499.

Goodridge, D.M., Johnston, P. and Thomson, M. (1996) Conflict and aggression as stressors in the work environment of nursing assistants: Implications for institutional elder abuse. *Journal of Elder Abuse and Neglect,* 8 (1), 49–67.

Hall, R. H. (2004) *Organizações* [Organisations]. Pearson, São Paulo: Brasil.

Harbison, J. (1999) The changing career of Elder abuse and neglect as a social problem in Canada: Learning from feminist frameworks, *Journal of Elder abuse & neglect,* vol. 11 (4), 59 - 80.

Kamavarapu, Y.S., Ferriter, M., Morton, S. and Völlm, B. (2017) Institutional abuse: characteristics of victims, perpetrators and organisations. A systematic review, *European Psychiatry,* 40: 45–54.

Hawes, C. (2003) Elder abuse in residential long-term care settings: what is known and what information is needed?", in Bonnie, R. & Wallace, R. (Eds), *Elder Mistreatment: Abuse, Neglect, and Exploitation in an Ageing America,* The National Academies Press, Washington, DC, 446-91.

Hussein, S. (2017) "We don't do it for the money' … the scale and reasons of poverty pay among frontline long-term care workers in England, *Health and Social Care in the Community*, 25(6), 1817–26.

Jonson, H., Hamett, T. (2016) Introducing an equal rights framework for older persons in residential care. *The Gerontologist,* vol. 56, nº 5, 800-806.

Kröger, T., Puthenparambil, J..Care Poverty among Older People: A New Approach to Comparative Care Policy Research, paper presented in 3rd Transforming Care, Conference Politecnico Milano, 26–28June, 2017.

Lachs, M; Bachman, R.; Williams, C.S.; O´Leary, J. R. (2007) Resident-to-resident elder mistreatment and police contact in nursing homes: findings from a population-based-cohort, Jo*urnal of The American Geriatrics Society*, 55, 840-845.

Lindbloom, E., Brandt, J., Hough, L. and Meadows, S. (2007) Elder mistreatment in the nursing home: a systematic review, *Journal of the American Medical Directors' Association*, Vol. 8 No. 9, 610-16.

Malmedal, W., Hammervold, R.,Saveman, I. (2014) The dark side of Norwegian nursing homes: factors influencing inadequate care, *The Journal of Adult Protection*, 16(3), 133–51.

McDonald, L., Beaulieu, M., Harbinson, J., Hirst, S., Lowenstein, A., Podnieks, E. and Wahl, J. (2012), Institutional abuse of older adults: what we know, what we need to know, *Journal of Elder Abuse & Neglect*, vol. 24 No. 2, 138-60.

Natan, MB, Matthews P, Lowenstein A. (2010) Study of factors that affect abuse of older people in nursing homes. *Nursing Management* (Harrow),17, 20–4.

OECD (2018). *Health at a glance 2018*: OECD indicators, Paris: OECD Publishing.

Paveza, Gregory; Cohen, Donna; Eisdirfer, Carl; Freels, Sally; Semla, Todd; Asford, J.; Gorelick, Philip; Hirschman, Robert; Luchins, Daniel; Levy, Paaul (1992) Severe family violence and Alzheimer´s disease: prevalence and risk factors, *The Gerontologist,* vol. 32, nº 4, 493-497.

Pillemer, K., & Moore, D. W. (1989) Abuse of patients in nursing homes: Findings from a survey of staff. *The Gerontologist*, 29, 314–320.

Pillemer,K; Chen, E; Van Haitsma, K.; Teresi, J.; Ramirez, M.; Silver, S.; Sukha, G; Lachs; M. (2011) Resident-to-Resident Aggression in Nursing Homes: Results from a Qualitative Event Reconstruction Study. *The Gerontologist*, 1-10.

Pissarra, J. (2014) Equipas virtuais ou virtualização do trabalho em equipa. Gonçalves, S. (org.) Psicossociologia do trabalho e das organizações – princípios e práticas. [Virtual teams or virtualization of teamwork]. Gonçalves, S. (org.) *Psychosociology of work and organizations - principles and practices* Pactor: Lisboa, 391-430.

Rabold, S., & Goergen,T. (2013) Abuse and neglect of older care recipients in domestic settings – results of a survey among nursing staff of home care services in Hanover (Germany), *The Journal of Adult Protection,* 15(3),127 – 140.

Rosen, T.; Lachs, M.; Bharucha, A; Stevens, S; Teresi, J.; Nebres,F.; Pillemer, K. (2008) Resident-to-Resident Aggression in Long-Term Care Facilities: Insights from Focus Groups of Nursing Home Residents and Staff. *Journal of The American Geriatrics Society*, 56 (8), 1398–1408.

Saveman, B. I.; Astrom, S.; Bucht, G. Norberg, A. (1999) Elder abuse in residential settings in Sweden, *Journal of Elder abuse and Neglect,* 10 (1/2), 43-60.

Spencer, D., Funk, L., Herron, R., Gerbrandt, E., Dansereau, L. (2018) Fear, Defensive strategies and caring for cognitively impaired family members, *Journal of Gerontological social work,* 62(4), 1-19.

Simmons, S., Durkin, D., Rahman, A., Choi, L., Beuscher, L. and Schnelle, J. (2012) Resident characteristics related to the lack of morning care provision in long-term care, *The Gerontologist*, vol. 53 No. 1, 151-61.

World Health Organization (2002) *World report on violence and health*, E. G. Krug, L. L. Dahlberg, J. A. Mercy, A. B. Zwi, and R. Lozano (Eds.), WHO, Geneva, Switzerland.

World Health Organization (2016) *Multisectoral Action for a Life Course Approach to Healthy Ageing*: Draft Global Strategy and Plan of Action on Ageing and Health, WHO, Geneva, Switzerland.

World Health Organization Regional Office for Europe (2012) Strategy and Action Plan for Healthy Ageing in Europe, 2012–2020, WHO, Copenhagen, Denmark.

World Health Organization (2014) *Global status report on violence prevention* 2014, WHO, Geneva, Switzerland.

Yon, Y., Ramiro-Gonzalez, M., Mikton, C., Huber, M., Seth, D. (2018) The prevalence of elder abuse in institutional settings: a systematic review and meta-analysis, *The European Journal of Public Health,* vol. 29, No. 1, 58–67.

[i] I used a broader definition of institutional violence to cover mistreatment, abuse and neglect of older people.