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Organisational aspects of elder mistreatment in long term care

Abstract

Purpose

This paper proposes five organisational factors associated with abuse, neglect and/or loss of dignity of older people resident in care homes. It derives from one set of findings from the ResPECT Study of Organisational Dynamics of Elder Care commissioned by Comic Relief and Department of Health through the Prevention of Abuse and Neglect In the Care of Older Adults (PANICOA) programme.

Approach

A knowledge synthesis method was selected to identify organisational aspects of elder mistreatment in residential care settings. The method was selected for its suitability in examining ill-defined and contested concepts such as; elder mistreatment - where the available evidence is dispersed and produced in varied forms. A rapid review comprising a search of three health journal databases and a detailed examination of selected investigation reports into institutional mistreatment was followed by panel meetings with subject matter experts to complete the knowledge synthesis.

Findings

This paper identifies and elaborates five organisational factors associated with elder mistreatment; infrastructure, management and procedures, staffing, resident population characteristics and culture. It also indicates macro-structural factors affecting care quality.

Research implications

Further research is needed to elaborate the influence of these organisational factors on mistreatment and to understand any interactions.

Practical implications

As an adjunct to personal factors, the knowledge synthesis indicates common organisational factors contributing to institutional abuse. This suggests that care quality is produced systemically and that it can collapse as a result of seemingly minor and unrelated organisational changes.

Social implications

Care home safety and quality is an ongoing concern, with popular analysis frequently stopping at the point of describing individual errant behaviour. However, as 'problem' organisations are closed down, 'problem' organisational factors continue to recur elsewhere.

Keywords: elder abuse, neglect, mistreatment, organisation, residential care, institutional abuse, older people

Introduction

This article identifies five organisational factors associated with abuse, neglect and/or loss of dignity of older people resident in care homes. These factors arise from a knowledge synthesis which comprised a rapid review – a search of literature on mistreatment in residential care settings and investigation reports into abuse in long-term care settings - and panel meetings to examine the review findings with subject matter experts (care staff, care home managers, relatives and residents).

Although research suggested that those in residential care report better wellbeing than those at home (Böckerman, Johansson and Saarni 2011) there is a public perception that mistreatment is commonplace (Hussein, Manthorpe and Penhale 2007) and reports of institutional mistreatment occur at regular intervals in the media (British Broadcasting Corporation 2014, Action on Elder Abuse 2006). Moreover, while care quality for older people is an enduring theme in public policy there has been limited research generally into elder abuse (see systematic review by Daly, Merchant and Jogerst 2011) and even less in residential care settings. Nevertheless, recent policy developments following, for example, a review of regulatory procedures (Care Quality Commission 2013) and public consultation on adult safeguarding (Department of Health 2011) have included changes to funding, regulation, quality assessment and safeguarding.

Abuse, neglect and loss of dignity have proven difficult concepts to define. Nevertheless, categories of mistreatment have been described and include; physical abuse, psychological abuse, active and passive neglect (Dixon et al. 2010). Studies have also indicated a dearth of information about the prevalence of mistreatment of older people in institutional settings linked to a lack of consistency in reporting (Manthorpe et al. 2011). Whilst little is known about the prevalence of mistreatment of older residents, a study of residential care staff in the U.S. indicated that 36% of staff had witnessed abuse in the previous 12 months; the most common form being shouting (Pillemer and Moore 1989). A further U.S. study indicated that 44 per cent of residents reported abuse and 48 per cent reported having been handled roughly (Atlanta Long Term Care Ombudsman Program 2000).

Furnham and Taylor (2011) proposed three underlying causes of negative behaviours in organisational settings; ‘intra-personal’ (bad people), ‘inter-personal’ (bad groups and bad

management) and ‘organisational’ (counter-productive organisational structures). The third category indicates that organisational arrangements affect the way that people do their jobs. Rather than excusing bad behaviour this categorisation enables a more detailed understanding of contributory factors. This paper focuses on organisational factors as an adjunct to intra- and inter-personal categories. We use the term ‘organisational factor’ to delineate aspects of organising care provision.

Knowledge synthesis

Methods for reviewing ill-defined and diffuse concepts such as elder mistreatment are relatively underdeveloped. However, knowledge synthesis is emerging as effective means of analysis in these circumstances (Anderson et al. 2008, Petticrew and Roberts 2005, Pope, Mays and Popay 2007, Thorne et al. 2004, Walsh and Downe 2005). For our purposes, this concerned the organisational factors associated with the abuse, neglect and/or loss of dignity of older people in residential settings. The knowledge synthesis involved two types of work: firstly, searching for theoretical and empirical advances through a rapid review of recent research and grey literature and inquiry reports and, secondly, analysis of emerging findings with subject matter experts (Ferlie and McGiven 2003; Pope, Mays and Popay 2007).

There was a limited range of literature available for review and the challenge was to ensure that the review had sufficient depth and breadth of coverage. Three social science and management databases (Heath Management Information Consortium -HMIC, Psychinfo and Web of Science) were searched using the following terms; ‘abuse’, ‘neglect’, ‘mistreatment’, ‘institutional care’ ‘care facility’ ‘care home’ ‘nursing home’ ‘older people’. The results of these searches are summarised under ‘Organisational aspects of mistreatment’ below. However, it should be noted that the most fruitful means of accessing empirical studies was

achieved by tracking citations arising from the small number of empirical studies available (Pope, Mays and Popay 2007). Additional search materials were identified, such as, policy documents, inquiries, investigations and grey literature (for full details see Killett et al 2012). References from two edited collections of research into elder abuse were also retrieved (Bonnie and Wallace 2003; Bennett, Kingston and Penhale 1997). The results of these multiple searches were merged and duplicate records removed. Titles and abstracts were reviewed and obviously irrelevant reports and papers were excluded (Petticrew and Roberts 2005). Full text copies of remaining papers and reports were retrieved and examined for relevance to the study.

Inquiry reports into institutional abuse in hospital settings were included alongside those from residential and nursing homes for two reasons. First because of the limited evidence available about institutional abuse and second because the organisational provision of 24 hour a day, long term care of older people has recently shifted from health to the social care in the UK. There was a 60% reduction in the number of overnight NHS beds for older people 1987-2010 and a 360% increase in the number of places in nursing homes 1985-2005 (Ferlie et al 2013).

Firstly, the review identified the major schools of thought about elder mistreatment to ensure a broad range of disciplinary perspectives were included (Booth cited in Petticrew and Roberts, 2005:72). Secondly a data extraction template was used to identify potential organisational aspects and resultant records were organised into logical categories. The findings were grouped using narrative synthesis (Petticrew and Roberts 2005). The within-study analysis, using content analysis, initially identified ten categories which reduced to five through the cross-study analysis which developed descriptors for five organisational factors associated with institutional abuse – infrastructure, management and procedures, staffing,

resident population characteristics and organisational culture (see Tables 1-5 below). A supplementary category for macro-structural factors was also created (see Table 6 below).

The key factors of organisational mistreatment identified through the narrative synthesis were presented to service user and service provider panel groups (subject matter experts) and their responses were used to validate and refine the analysis of findings. There were 9 members of the service user panel, of whom 5 were older people living in care homes and 4 were family carers of older people living in care homes. There were 11 members of the provider panel including 3 care assistants, 2 care coordinators, 1 care home manager, 1 owner and manager of a nursing home, 1 owner and manager of a residential home, 1 owner of a residential home, 1 recently retired care home manager, 1 pharmacist providing medication management training to care home staff. Materials were sent out to panel members in advance of meetings to allow preparation.

The study identified five organisational aspects associated with institutional mistreatment (including abuse, neglect and/or loss of dignity) of older people resident in care homes. The findings are presented below beginning with a brief summary of theoretical perspectives on elder mistreatment before the findings from recent investigation reports are outlined. Each of the organisational factors related to mistreatment in residential care are elaborated.

Theoretical perspectives on elder mistreatment

Whilst mistreatment of older people in institutional settings has been relatively under-theorized, certain social science disciplines indicate means of theorizing organisational aspects of the phenomenon. Social science perspectives draw attention to both macro- and micro-sociological factors which would contribute in a systemic way to poor quality care.

Research in the organisation studies tradition highlights how care quality is affected by organisational arrangements and has focused attention on structural arrangements for providing care, illustrating how organisational arrangements can enhance or inhibit an individual's capacity to care. Alternatively, psychological perspectives have been important in explaining how workers may come to mistreat those who depend upon them (Campbell Reay and Browne 2002). One approach is concerned with individual characteristics of abusers and the abused while the other focuses on the interaction between the abuser and their environment. Sociological approaches focus on arrangements for institutional care provision. They identify a paradox between institutions offering care whilst also appearing to punish age-related dependency. By contrast, social policy perspectives omit societal, structural and organisational factors and suggest that institutional care systems will be inherently benign with abuse occurring as an aberration correctable through regulation and individual reviews (Wardaugh and Wilding 1993). Schiamberg et al. (2011) presented an ecological perspective of elder abuse in nursing homes. This approach argued that abuse occurs in a micro-systemic context. Instead of focusing on individual risk factors, they argue for a study of the dynamic interactions between individual and contextual factors.

In summary, there is little convergence of theoretical work in relation to mistreatment in residential elder care. However, the following section demonstrates common and repeated sets of circumstances which suggest that work in this area would be valuable.

Contemporary investigations into institutional mistreatment

In the UK, public inquiries investigate the circumstances surrounding organisational failures such as mistreatment of residents. As such, they provide detailed analyses and offer publically available accounts of the circumstances surrounding these events. A review of UK

investigation reports over a 40 year period found that they highlighted similar, repeated sets of circumstances leading to failures in care (Walshe and Higgins 2002). Moreover, public investigation reports have consistently reported similar sets of circumstances and have made similar recommendations (CHI 2004a, CHAI 2009) [See Note 1] despite fundamental changes to the management, regulation and structure of care services, including the closure of long stay hospitals and the creation of regulatory bodies such as the Care Quality Commission. This repetition of findings is highlighted by the similarity between two reports published 20 years apart. Martin (1984) compared the findings of inquiries into allegations of abuse within hospitals from 1969 to 1980 and identified ten broad themes encapsulating hundreds of findings and recommendations. A subsequent report (CHI 2004a), examining the eleven investigations published between 2000 and 2003, identified eight recurrent themes, namely; severe staff shortages, ineffective risk management, lack of agreed policies, supervision of staff and audit, poor team relationships, inadequate leadership, financial problems and a tendency for the service to be geographically or clinically isolated. In addition to these organisational factors the review of investigations identified risk factors at strategic and national/policy levels, such as, recent restructuring, failure to deal with earlier complaints and low priority services. These reports described repeated sets of social circumstances which relate to organisational arrangements for care provision, without exploring how these factors interacted in long-standing failures of care.

Historically, institutional abuses have tended to be conceived of as ‘isolated events’ and the individuals concerned as ‘rotten apples’ who wilfully or negligently failed in their duty of care. This approach is argued to have drawn attention away from examining organisational and system-wide structures within which such abuses took place (Manthorpe and Penhale, 1999).

The publication of the first public inquiry by the Commission for Health Improvement (CHI) in 2000, marked the beginning of a number of contemporary public inquiries in the UK. We searched CHI and CSCI reports from 2000 onwards as these follow the closure of long stay hospitals, the introduction of the NHS and Community Care Act (1990) and the establishment of new national regulatory bodies. Nine reports were selected because they involved allegations of institutional abuse toward vulnerable adults and older people within in-patient and residential care facilities:

1. Investigation into mistreatment of elderly patients at North Lakeland NHS Trust (CHI 2000:1).
2. Investigation following a police investigation into suspicious deaths of five older people at Portsmouth Healthcare NHS Trust (CHI 2002:vii)
3. Investigation into residential services for people with learning disabilities at Bedfordshire and Luton Community NHS Trust (CHI 2003a).
4. Investigation into the care of older people on Rowan Ward at Manchester Mental Health and Social Care NHS Trust (CHI 2003b:2).
5. Investigation into acute, community and mental health services at Pembrokeshire and Derwen NHS Trust (CHI 2004b).
6. Investigation into care of people with learning disabilities at Cornwall Partnership NHS Trust (CHAI 2006).
7. Investigation at Sutton and Merton NHS Trust in one hospital and three community homes (CHAI 2007).
8. Inspection of Acorn Lodge Residential Home providing care for older people (CSCI 2008).
9. Investigation of Leas Cross Nursing Home, Dublin (2009).

The findings and recommendations from these investigations indicated repeated institutional failures to properly care for vulnerable adults and older people. They found several commonly-identified problems including an increase in the number of high dependency residents, lack of capability of staff, poor staffing levels, the use of immigrant workers with little command of English and a lack of policy and guidelines and/or their proper implementation and monitoring. What is notable is that seemingly minor or relatively common changes were leading, at times, to spectacular failures of care. Hence, these investigations identified problems and concerns for the way health and social care services were organised and delivered. In addition there were incidents of repeated failure, where one or more people were found to be regularly physically abusing residents, triggering or resulting in the suspension and/or disciplining of particular staff members. The reports recommended the referral of these individual staff members to the national council of nursing for possible competence review of their practice. At Rowan Ward in England and the Leas Cross Nursing Home in Ireland, the facilities were subsequently closed down.

Organisational aspects of mistreatment

Several commonly occurring organisational factors were associated with sustained reduction in care quality: infrastructure, management and procedures, staffing, resident population characteristics and culture. Macro-structural aspects also featured. These factors are elaborated alongside reference to the source material.

1. Infrastructure

Organisational infrastructure refers to the physical environment, building design and architecture, the general upkeep of the building, provisions for catering, cleaning and

maintenance. Table 1 details relevant research and inquiries that identified infrastructure as an important contributor to the circumstances of mistreatment.

[Insert Table 1 here]

Mistreatment of older people took place in residential settings where there were run-down facilities, cramped conditions (Hawes 2003), overcrowding of residents, lack of equipment and generally poor physical environments (Wiener and Kayser-Jones 1990, CHI 2004b). One study concluded that large-sized units promoted regimentation and negatively affected individualised care (Wardhaugh and Wilding 1993). Provisions for catering, cleaning and maintenance that were found to be problematic included poor catering provision and food hygiene (CHAI 2009), unchanged bed linen, strong odours of urine/faeces (Lindbloom et al. 2005), and a lack of privacy with open bathing, toileting and washing (Bennett, Kingston and Penhale 1997). Investigations found that poor conditions in these particular residential settings were recurring problems that had been well documented in the past.

2. Management and procedures

Management, for the purpose of this study, refers to: management arrangements, systems and practices, leadership, supervision, organisation and support of staff. Procedures refer to the systems in place to guide action, including written policies and procedures. Table 2 details relevant research and inquiry reports.

[Insert Table 2 here]

Poor management and/or leadership is thought to play a key role in institutional mistreatment (Bennett, Kingston and Penhale 1997, CHAI 2009, CHI 2004a). Investigations suggested that problems arose over a substantial period of time with little effective response to concerns being raised (CHI 2004a). Problems associated with changes to management included; not having a manager in place, little continuity of management, lack of leadership, poor quality management and lack of a permanent manager in post (CHAI 2006, CHI 2003b). Overly bureaucratic and instructive management styles were associated with mistreatment alongside a lack of investigation into complaints or failure to take actions following the outcome of previous investigations (Wardhaugh and Wilding 1993). A range of inadequate policies were found in five of the investigations, including; policies on complaints, protection, the use of restraint, the management of incontinence, the management of medicines and the provision of palliative care (Bennett, Kingston and Penhale 1997, CHI 2004a, CHAI 2009).

The provider panel highlighted the need for a 'no blame culture' for mistakes as mistakes and sub-standard care were more likely to be acknowledged if staff could be sure they would not be blamed individually for the problems. Counterintuitively, members of the service user panel argued that residents would be reluctant to disclose abuse or neglect for fear that their home would close and any alternative could be worse.

Specific additional management problems included unclear lines of accountability (CHAI 2006), the absence of monitoring and supervision of services and staff; absence of staff appraisal and support and poor judgement when recruiting new employees (Buzgová and Ivanová 2009). Furthermore, poor, inconsistent or falsified record keeping was noted as was poor collection and use of information on outcomes of care (CHAI 2009).

The service provider panel group underlined the importance of relationships and argued that the leadership style of managers shaped relationships within the home. They associated respect and dignity with an absence of overly-rigid routine; the provision of on-going training; and access to sources of support for all staff including home managers and owners.

3. Staffing

Factors related to staffing were a commonly-identified theme within research studies, reports and investigations and included; inadequate staffing levels and staff shortages (CHI 2004a), extensive use of temporary or short-term staff (CHI 2003a, CHI 2003b) and high staff turnover (Lee-Treweek 1997). Table 3 shows aspects of staffing associated with mistreatment.

[Insert Table 3 here]

Problems arose where staff worked long hours and were subject to mandatory overtime leading to tired staff (Hawes, Blevins and Shandley 2001), high workloads (Global Action on Aging 2009) and low morale (CHAI 2007). Further problems related to inadequate staff skill mix (Bennett, Kingston and Penhale 1997), limited ability in English language (Wiener and Kayser-Jones 1990) and lack of competency (Teeri, Leino-Kilpi and Välimäki 2006). Some staff were unable to recognise abuse and had negative attitudes towards patients (CHAI 2007). Much of the work in this area identified lack of staff training as an issue (Bennet, Kingston and Penhale 1997, CHAI 2009). Individual characteristics of staff included alcohol dependency (Bennett, Kingston and Penhale 1997), childhood experiences of abuse and high anxiety (Campbell Reay and Browne 2001) and high anger scores (Gates, Fitzwater and

Meyer 1999). One study found too much staff autonomy contributing to mistreatment (Bennett, Kingston and Penhale 1997).

The quality of relationships between staff and residents was highly valued by both panel groups. They argued that working arrangements such as; the lengths of shifts, the number of people on duty and low staff turnover were all important in sustaining positive relationships. Resident panel members valued being treated as individuals, and also, in return, knowing staff as people with broader lives. For them, the concept of respectful care included sharing some of the responsibility for the day-to-day running of the home.

4. Resident population characteristics

Resident population characteristics associated with mistreatment include the type and level of dependency, complexity of care needs and residents' own behaviour. Table 4 details resident population characteristics associated with mistreatment.

[Insert Table 4 here]

Residents were at risk where they or their relatives had limited awareness of how to assert their rights and limited access to personal, individual choices (CHAI 2009). Moreover, investigations found that an increase in the proportion of high dependency patients could lead to mistreatment (Buzgová and Ivanová 2009, Commission of Investigation 2009). Specific characteristics associated with mistreatment included residents with high levels of dependency, cognitive impairment or dementia (Burgess, Dowdel and Prentky 2000), physically aggressive or uncooperative behaviour (Buzgová and Ivanová 2009) and passivity, introversion or frailty (Wardaugh and Wilding 1993). Indicators of mistreatment of residents

included; unexplained deaths and injuries, dramatic weight loss (Commission of Investigation 2009), untreated or poorly treated pressure ulcers (Pillemer and Bachman-Prehn 1991), over-sedation and missing property (Commission of Investigation 2009).

Both service user and provider panels were concerned about happens when the needs of residents change. Residents prefer to stay in the same place whereas staff worry about their ability to provide adequate care. There needs to be a fit between the needs of the group of residents and the adaptability of the home. The review showed that quickly changing levels of need, along with a concentration of people with high levels of need could destabilise the care provision in a home.

5. Culture

Culture refers to practices shaped by shared beliefs and expectations among staff and other groups, which, in turn, produces norms that influence the behaviour of both staff and residents. Table 5 shows the cultural factors associated with mistreatment.

[Insert Table 5 here]

Aspects of culture associated with mistreatment included social or geographical isolation with limited official or social visitors (CHI 2003b). Organisations had closed, inward-looking cultures. Managers and/or staff were institutionalised and closed to possibilities for change (CHI 2004a). There was a focus on external targets, bureaucracy or standardised rather than individual care (Bennett, Kingston and Penhale 1997). This gave rise to overly-bureaucratic or autocratic culture that left staff with little control over their work situation and no say about how work was organised (Buzgová and Ivanová 2009). Poor communication (Wiener

and Kayser Jones 1990) and factions among the staff (CHI 2004a) were also features of the local culture. Entrenched routines were seen to objectify residents (CHAI 2009) and there was a lack of renewal of expectations and new ideas (Wardaugh and Wilding 1993).

Service users emphasised contact with the outside community as vital to their wellbeing. Residential care that involves and supports a good level of integration with the local community and where there is on-site involvement of allied service providers such as social workers and doctors were also identified, by panel groups, as factors contributing to respect and dignity.

6. Macro-structural factors

Macro-structural factors were things that affected the organisation and related to wider social arrangements for residential care for older people. They are included here as they have a direct impact on care provision. Table 6 shows macro-structural factors associated with mistreatment.

[Insert Table 6 here]

Significant organisational changes such as, major structural changes, restructuring, and changes in ownership were associated with mistreatment (CHI 2004a). Reduced support from the wider organisation was indicated in one investigation report (CHI 2003b). Financial pressures were also mentioned frequently, particularly efficiency savings, reduced financial provisions and lack of resources to provide adequate care (Bennett, Kingston and Penhale 1997). A focus on high profile targets re-directed resources towards meeting targets rather than the immediate needs of staff and residents (Joint Committee on Human Rights 2007). Alongside ambiguous accountability arrangements in the wider care community (CHI 2004a), ineffective monitoring by external agencies and failure to challenge punitive care

systems was also cited (CHAI 2006). In addition, there were cases where the nature of the relationship with overseeing bodies such as an NHS Trust or social services were said to contribute to the escalation of mistreatment. This included reduction in support and ineffective monitoring by external bodies (CHI 2003b, CHI 2004a).

Organisational aspects of mistreatment in residential care

Many of the organisational factors associated with mistreatment were found in combinations of two or more factors. This leads us to speculate that these factors are commonly-occurring and potentially inter-dependent. Importantly, small changes could, at certain times, lead to a spiral of declining care. At times, small changes to one factor within a system adversely affected the overall system and the capacity of a home to deliver good quality care. The quality of care was being driven by interactions between individual actors, organisational factors and macro-structural factors.

Systems theory has been used to examine organisations as it allows consideration of interactions and processes with multiple and non-linear effects (Hatch and Cunliffe 2006). The behaviour and actions of all those involved in the organisation (e.g. residents, staff, relatives, owners) and also the context of the organisation (e.g. social, financial, physical) interact dynamically in what could be considered a complex system (Cilliers 2005). Cilliers argues that the system will organise itself to be sensitive to events that are critical to its survival. In other words, relationships between cause and effect are not straightforward and may be either amplified or minimised through dynamic interactions.

There have been several calls for the development of an early warning system to highlight the risk of serious failure (CHI 2004a:2, CHAI 2009:42). This study addresses the fact that 'there is little or no data on risks to the safety of patients which are not incidents' (CHAI 2009:32) by enhancing

understanding of organisational factors associated with mistreatment (Furnham and Taylor 2011). Further research is needed to develop understanding of interplay between organisational factors.

Limitations

There was a limited range of literature available for review and, as discussed above, there is still a lack of widespread consensus on the core concept of mistreatment. We mitigate the limitations to some extent by providing a full account of the knowledge synthesis process and by consulting with subject matter experts. The findings of this review provide directional indicators for future research and practice.

Conclusions

As an adjunct to personal factors, this knowledge synthesis elaborated five interrelated organisational factors associated with mistreatment of older people in residential settings; infrastructure, management and procedures, staffing, resident population characteristics and culture as well as delineating macro-structural factors. Further research is needed to elaborate the influence of these organisational factors on mistreatment and to understand any interactions.

It was notable that relatively small organisational changes in one or more of these areas could cause care quality to decline rapidly. The practical implication is that care quality is produced systemically and can collapse as a result of seemingly minor and unrelated organisational changes.

It is not enough to close down failing organisations, not least because the inquiry reports alone give powerful accounts of how repeated sets of circumstances led to similar and dramatic failures elsewhere. Understanding the links between organisational factors and care quality is especially important as demand for residential care continue to grow and the availability of funding remains limited.

Statement of ethical approval

The study was reviewed by Cambridgeshire 3 NHS Research Ethics Committee (ref 09/110306/63).

Notes

1. The regulatory body responsible for inspecting NHS organisations has undergone several name changes. Currently known as the Care Quality Commission (CQC), previously known as the Health Care Commission (HCC), Commission for Health Improvement (CHI), Commission for Healthcare Audit and Inspection (CHAI).

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Table 1. Research reports and inquiries identifying organisational infrastructure

Infrastructure problem	**Source material**
Dilapidated physical environment, buildings in poor state of repair	Bennett, Kingston and Penhale (1997), CHI (2004b), CHI (2003b), Hawes (2003), Wiener and Kayser-Jones (1990)
Unsanitary conditions, unchanged linen, strong odours of urine/faeces, rubbish bins overflowing	CHI (2004b), Lindbloom et al. (2005)
Cramped conditions, overcrowding	Bennett, Kingston and Penhale (1997), Hawes (2003)
Large units, regimentation and lack of individualised care	Wardaugh and Wilding (1993)
Broken equipment, lack of appropriate equipment	Bennett, Kingston and Penhale (1997), CHI (2004b), CHI (2003b), Lee-Treweek (1997)
Poor catering facilities, food hygiene issues, lack of choice or involvement in feeding/choosing food	Bennett, Kingston and Penhale (1997), CHAI (2009)
Lack of privacy, open bathing, toileting and washing	Bennett, Kingston and Penhale (1997)
Locations where abuse and neglect take place and may be observed and 'learnt' by others	Pillemer and Moore (1989)

Table 2. Research reports and inquiries identifying management and procedures

Management or procedural problem	Source material
Long-standing problems, recurrent problems, a history of complaints, failure to investigate complaints, inaction after previous problems are investigated, inaction after concerns raised	CHAI (2006), CHAI (2009), CHI (2000), CHI (2003b), CHI (2004a), Commission of Investigation (2009), Lindboom et al. (2005), Wardaugh and Wilding (1993)
Changes in unit manager, little continuity of management, lack of permanent manager in post, lack of leadership, poor quality management	CHAI (2006), CHAI (2007), CHAI (2009), CHI (2002), CHI (2003b), CHI (2004a), CSCI (2008), Wardaugh and Wilding (1993)
Unclear accountabilities	CHAI 2006), CHI (2000), CHI (2003b), Commission of Investigation (2009)
Intrinsic managerial failings	Bennett, Kingston and Penhale (1997), CHAI (2009), CSCI (2008)
Poor organisation of work routines, abusive routines, overly routine care, demanding shift patterns, poor organisation of personnel	Buzgová and Ivanová (2009), Häggström et al.(2007), Teeri, Leino-Kilpi, Välimäki (2006)
Lack of supervision, appraisal and/or support for care staff	CHAI (2006), CHAI (2007), CHI (2002), CHI (2003b), Lee-Treweek (1997), Wardaugh and Wilding (1993)
Ineffective governance, inadequate or poorly applied policies e.g. complaints procedures, governance, guidelines on palliative care, protection of residents, use of restraints, managing medicines, managing incontinence. Inadequate risk arrangements	Bennett, Kingston and Penhale (1997), CHAI (2007), CHAI (2009), CHI (2002), CHI (2003a), CHI (2003b), CHI (2004a), CSCI (2008)
Poor and inconsistent record systems, falsification of records	CHAI (2007), CHAI (2009), Lindbloom et al. (2005)
Poor use or collection of information on outcomes of care	CHAI (2009)

Table 3. Research reports and inquiries identifying factors relating to staffing

Problem with staffing	Source material
Inadequate staffing levels, staff shortages	Buzgová and Ivanová (2009), CHAI (2006), CHI (2000), CHI (2003b), CHI (2004a), Commission of Investigation (2009), Gjerberg et al. (2010), Hawes, Blevins and Shanley (2001), Lee-Treweek (1997), Lindbloom et al. (2005), Wiener and Kayser-Jones (1990)
Long working hours, tired staff, mandatory overtime	CHI (2003b), Global Action on Aging (2009), Hawes, Blevin and Shanley (2001), Wardaugh and Wilding (1993)
High workload, overstretched staff, difficult workload	Global Action on Aging (2009), Hawes, Blevins and Shanley (2001), Gates, Fitzwater and Meyer (1999), Pillemer and Moore (1989)
Low morale	CHAI (2007), Wardaugh and Wilding (1993)
Extensive use of temporary and/or short-term staff	CHAI (2007), CHI (2003a), CHI (2003b), Teeri, Leino-Kilpi and Välimäki (2006)
High staff turnover	Lee-Treweek (1997), Wardaugh and Wilding (1993), Wiener and Kayser-Jones (1990)
Inadequate skill mix or competency of staff, incompetent staff	Bennett, Kingston and Penhale (1997), CHI (2000), CHI (2003b), Commission of Investigation (2009), Teeri, Leino-Kilpi and Välimäki (2006)
Staff unable to recognise abuse, negative attitudes towards residents, unaware and inattentive staff	CHAI (2007), Garner and Evans (2002), Pillemer and Moore (1989)
Inadequate training and development of staff, undertrained staff	Bennett, Kingston and Penhale (1997), CHAI (2006), CHAI (2007), CHAI (2009), CHI (2000), CHI (2003b), Commission of Investigation (2009), CSCI (2008), Global Action on Aging (2009), Hawes, Blevins and Shanley (2001), Teeri, Leino-Kilpi and Välimäki (2006), Wardaugh and Wilding (1993)
Staff with limited English language ability	Lee-Treweek (1997), Wiener and Kayser-Jones (1990)
High levels of alcohol consumption or dependency	Campbell Reay and Browne (2001), Bennett, Kingston and Penhale (1997)
Too much staff autonomy	Bennett, Kingston and Penhale (1997)
Childhood experiences of abuse	Campbell Reay and Browne (2001)
High anxiety scores	Campbell Reay and Browne (2001)
High state of anger scores	Gates, Fitzwater and Meyer (1999)

Table 4. Research reports and inquiries identifying resident population characteristics

Resident population characteristics	Source material
Limited awareness of how to assert rights, limited access to individual choices	CHAI (2006), CHAI (2009), CSCI (2008), Wardaugh and Wilding (1993)
Increase in the numbers of high dependency residents, high levels of dependency	Bennett, Kingston and Penhale (1997), Buzgová and Ivanová (2009), CHI (2003b), Commission of Investigation (2009), Hawes, Blevins and Shanley (2001), Wardaugh and Wilding (1993)
Cognitive impairment or dementia	Burgess, Dowdel and Prentky (2000), Buzgová and Ivanová (2009), Commission of Investigation (2009), Coyne, Reichman and Berbig (1993), Dyer et al. (2000), Hawes, Blevins and Shanley (2001), Pillemer and Bachman-Prehn (1991)
Physically aggressive behaviours, resisting care	Buzgová and Ivanová (2009), Coyne, Reichman and Berbig (1993), Dyer et al. (2000), Hawes, Blevins and Shanley (2001), Pillemer and Bachman-Prehn (1991), Pillemer and Moore (1989)
Passivity, introversion, frailty	Townsend (1962), Wardaugh and Wilding (1993)
Unexplained injuries, bruising in unexpected places, untreated or poorly treated pressure ulcers	Commission of Investigation (2009), Hawes, Blevins and Shanley (2001), Pillemer and Bachman-Prehn (1991)
Unexplained or unexpected deaths	Commission of Investigation (2009)
Dramatic weight loss, dehydration, malnutrition	Burgess, Dowdel and Prentky (2000), Commission of Investigation (2009), Pillemer and Bachman-Prehn (1991)
Untreated or poorly treated pressure ulcers	Pillemer and Bachman-Prehn (1991)
Over-sedation	Commission of Investigation (2009)
Missing property	Commission of Investigation (2009)

Table 5. Research reports and inquiries identifying aspects of organisational culture

Cultural factors	**Source material**
Few visitors, geographical isolation, social isolation	CHI (2003b), Jones and White (2008), Wardaugh and Wilding (1993)
Closed, inward looking culture, unresponsive staff and/or management, closed off to possibilities for change, institutionalised staff, managers, residents	CHI (2003b) CHI (2004a), Wardaugh and Wilding (1993), Wiener and Kayser-Jones (1990)
Focus on external targets, overly bureaucratic as opposed to focus on residents needs	Bennett, Kingston and Penhale (1997), Joint Committee on Human Rights (2007)
Poor communication	CHI (2003b), Wardaugh and Wilding (1993), Wiener and Kayser-Jones (1990)
Unpredictable work demands	Lee-Treweek (1997), Wiener and Kayser-Jones (1990)
Lack of teamwork, factions and cliques among staff	CHI (2003b), CHI (2004a)Lee-Treweek (1997) Wiener and Kayser-Jones (1990)
Autocratic and/or bureaucratic culture giving staff little control over work situation, low sense of impact, no say in how work is organised	Bennett, Kingston and Penhale (1997), Buzgová and Ivanová (2009), CHAI (2007), Commission of Investigation (2009), Wardaugh and Wilding (1993)
Entrenched routines leading to depersonalisation and objectification of residents	Bennett, Kingston and Penhale (1997), CHAI (2009), Jones and White (2008), Lee-Treweek (1997)
No new ideas, renewal of expectations and possibilities	Wardaugh and Wilding (1993)

Table 6. Research reports and investigations identifying macro-structural factors

Macro-structural factors	Source material
Change of ownership, organisational changes, rapid expansion, restructuring, threats of closure, recent major structural change	CHI (2000), CHI (2003a), CHI (2003b), CHI (2004a), Commission of Investigation (2009)
Financial pressures, efficiency savings, reduced financial provision, lack of resources to provide adequate care	Bennett, Kingston and Penhale (1997), Berg, Erlingsson and Saveman (2001), CHAI (2006), CHI (2003b), Wiener and Kayser-Jones (1990)
Reduced support from larger organisation	CHI (2003b)
Ineffective monitoring by external agencies, failure of agencies to challenge punitive care systems	CHAI (2006), CHI (2000), CHI (2004a), Wardaugh and Wilding (1993)
Poor working conditions, low status work, low pay	CHI (2004a), Lee-Treweek (1997), Wardaugh and Wilding (1993), Wiener and Kayser-Jones (1990)
Ambiguous accountability in the health community	CHI (2004a)