Title: **A conceptual model to approach Elder Abuse and Neglect in residential care settings**

Ana Paula Gil

CICS.NOVA - Interdisciplinary Centre of Social Sciences – CICS.NOVA Faculty of Social Sciences and Humanities FCSH/NOVA, Lisbon, Portugal

Thematic Panel 26 – Quality of care

Abstract: The purpose of this paper is to discuss a conceptual framework that analyses the relationships between organisational aspects of residential care settings and the interpersonal features of care providers and their relation with the residents´ quality of life. Based on this purpose we would like to discuss how to link long-term care and elder abuse and neglect, through a conceptual model to approach this issue, focusing on a person-centred perspective. The preliminary data were based on self-reported 41 responses of care workers and through observations of daily life practices in three nursing homes in Sintra Council (council of the Metropolitan Area of Lisbon). Therefore, these exploratory approaches were important to improve the conceptual model, due to the lack of conceptual clarification, it allowed to test the instruments and to explore some emerging issues, reveals some preliminary data about elder abuse and neglect, and risk factors. One which we highlighted was the conflicts within work teams and the work conditions of care workers because it is one of the principal factors related mainly with an inadequate care and neglect issues.

1. Introduction

A longer life expectancy is one of the most significant issues raised by the demographic ageing in Europe. The increase in the number of people aged 80 and older and the projected increase in life expectancy (Eurostat, 2015) suggest that a greater number of older people will require long-term care.

Considering 1 in every 3 elderly living in institutions are women over 80, tend to have cognitive impairments or require help with their physical needs (Dufour-Kippelen & Mesrine, 2003; Gil, 2010; Renaut, 2012) increased needs for long-term care, depending on others and, therefore, are more vulnerable to situations of abuse and negligence. Surveys on abuse and negligence against older people have studied mainly the prevalence, causes and risk factors in family context, and focus less on collective structures (nursing homes and residential care) ignoring, therefore, its extension and dimension. According to WHO, 4 to 6% of the elders are estimated to be the victims of violence in family context, and these percentages are expected to be higher in institutions. In Portugal, 12% of people 60 and over, have been victims of some kind of violence, be it physical, psychological, financial, sexual as well as negligence in family context (Gil. et.al, 2014).The aim of the study *Ageing and Violence* was to estimate prevalence of violence (financial, physical, psychological, neglect and sexual) in Portuguese Population 60 and over, within the family context and it also allowed to identify risk factors. Our data reveals that 12.3% of older people were victims of some type of violence by someone with whom they had a trusted relationship with. Out of 100, 12 people over 60 have already suffered some kind of violence; it means that nearly 314.291 people have been victims of violence. Financial and psychological violence were the most prevalent types of violence, each affecting 6.3%. 2.3% were the victims of some form of physical violence, neglect and sexual violence were the forms of violence presenting the least prevalence. This study revealed that people over 80 (22.1%), with basic education (26.6%) and who live alone (18.2%) were more likely to saying that they had experienced violence. Thus, the old age was a risk factor.

To date, there were no incidence or prevalence studies of abuse and neglect in Portuguese institutions. *How can situations of negligence and abuse be avoided in residential care settings?* These are problems that an ageing society has to face and deal with, and to prevent this problem we have to study its dimension.

By definition abusive acts in institutions include physically restraining patients, depriving them of dignity (by, for instance, leaving them in soiled clothes) and choice over daily affairs, intentionally providing insufficient care (such as allowing them to develop pressure sores), over-and under-medicating and withholding medication; and emotional

neglect and abuse (WHO, 2014). Some of the risk factors identified with elder abuse and neglect in institutions, are related with low standards for welfare services and care facilities for elder persons; where staff are poorly trained, remunerated, and overworked; where the physical environment is inadequate; and where policies operate in the interests of the institution rather than in that of the residents´. However, the existent studies about elder abuse in residential care settings don´t reflect how to overlap the omission of the resident population as the main social actor in the elder abuse process, and they are imprecise about the associations among the individual client, staff, and institutional characteristics and abuse, and the focus is based on, exclusively, a professional point of view.

The focus on a person-centred perspective and the residents´quality of life, based on daily practices, interactions and continuity of residents´selves (Pirhonen,.& Pietilä (2015) can also be a way to include the residents in the centre of analyses and promote the residents´ empowerment. Therefore, the purpose of this paper is to discuss a conceptual framework that analyses the relationships between organisational aspects of residential care settings and the interpersonal features of care providers and their relation with the residents´ quality of life. Based on this purpose we would like to discuss how to link long-term care and elder abuse and neglect, through a conceptual model to approach this issue, focusing on a person-centred perspective. Some preliminary results will be presented from the study "Ageing in an Institution: An Interactionist Perspective of Care". The study is being carried out in Sintra Council (council of the Metropolitan Area of Lisbon) and 30 nursing homes (profit and non-profit) were invited to participate. The study is being carried out during 2017. The exploratory phase allowed testing the instruments and exploring emerging issues, reveals some preliminary data about elder abuse and neglect, and risk factors. One of them is the conflicts in care workers team and the work conditions, which we would like to highlight because it is one of the principal factors related mainly with an inadequate care and neglect issues.

2. Literature review

The main studies carried out in Europe and the USA, in the last two decades, about elder abuse in institutional settings do not focus on national samples, or the focus is based on, exclusively, a professional point of view. The core for this methodological option is the difficulty not only in having access to the residents, but also for the residents to confirm that they are victims of abuse and negligence being, therefore, prone to avoid complaining and denouncing the social isolation in which they sometimes live.

Studies on elder abuse and neglect in institutional settings have varied depending on the approach (observed, committed and self-reported by professionals), the measurement period (last month or year), the definition and measurement. Thus, results obtained are different, making the comparison between studies difficult. Most of these studies started with the WHO (2002) definition of abuse and the four types (physical, psychological, financial and sexual) and negligence, although neglect and psychological abuse, committed by professionals, are the most common forms of abuse. However, most of these studies have no theoretical models and operational concepts, and the theoretical explanations have no empirical correspondence, not distinguishing such explanatory causes and risk factors. As mentioned by Mcdonald, et.al, (2012) there are no prevalence studies about elder abuse in institutional settings, based on population samples, and without prevalence estimates of the problem, it is impossible to identify risk factors (Stahl, 2000), this is only possible through longitudinal studies or population-based samples (Pillemer &,Finkelhor (1992). Due to this, the figures obtained can be underestimated (Lindbloom, et.al. 2007). A critical approach of the systematic review was carried out and we highlighted four aspects. **(1)** Though in these studies, the frontier between variables of context regarding structural aspects of organisations and those of human resources, are sometimes not so clear, the characteristics of the staff or associated factors (working hours, job satisfaction, burnout levels, social and cultural attitudes towards older people) are also variables that concur to the explanation of the committed abuses (Pillemer et.al. 1989; Buzgova et.al., 2009; Saveman et.al.,1999; Malmedal, et.al, 2014). Malmedal et.al., (2014), based on the Fulmer definition (1989), propose an intermediate concept, *inadequate care* which links care quality and elder abuse. Inadequate care may lead to the loss of dignity making the individual more vulnerable to the risk of abuse and negligence. The term inadequate care is an all-inclusive term; it is defined as a set of actions or omissions which may affect residents´ physical and psychological well-being, and their quality of life. One problem in this analytical approach is the sensitive line which separates poor care, inadequate care and elder abuse and neglect.

(2) A second common aspect of the international studies on this problem is the difference between estimates according to observation and the committed or the self-reported acts of abuse by professionals (Saveman et.al., 1999; Goergen, 2004; Drennanet, et.al. 2012). The complexity and the multidimensionality of the problem, require a distinction between abuses committed by the professionals themselves or as observers of actions committed by others, be it work-colleagues, family members or residents among themselves (Lachs, et.al. 2007, Rosen et.al. 2008; Pillemer, et.al.,2011). The difficulty of obtaining estimates that can be compared between countries can be explained because it is consensual that

definitions of elder abuse also vary across countries to reflect and include "cultural, ethnic, and religious variability in norms and traditions" (Lowenstein, Eisikovits, Band-Winterstein, & Enosh, 2009 cit, Castle et.al, 2015:282). This normative variability can complicate literature reviews, research, and efforts to identify rates of abuse, and qualitative research is needed to understand the meaning and interpretation of terms that are used to measure and define abuse and neglect in institutional settings.

(3) Despite recent recognition that further research into the associations between the three actors (organisation, staff and residents) is needed (Kamavarapu et.al, 2017), there is still an uncertainty how these associations are related and are processed. Sometimes indicators are confusing if they belong to the organisational or professional level. Based on a sistematic review, Kamavarapu et.al. (2017) considered that clients, staff, institutional and environmental factors appear to play a role in increasing the risk of abuse. Therefore, victims' characteristics are reduced always to gender, age, dementia and cognitive decline, intellectual and physical disability. Excluding the resident population, justified by reasons of methodology, i.e. by the difficulty to reach the residents, as well as "their mental inability to evaluate the quality care, denying or accepting the inadequate care as part of institutional life, the fear to report the suspicion or the acknowledged" (McDonald et.al, 2012:149).

 (4) A fourth aspect highlighted in reviewed studies, are the variables concerning residents´ individual characteristics, related to socio-demographic characteristics (age, sex) or health status (mental or physical). In most of the studies, the information is collected by proxy, never based on the residents´ perspective (except Goergen, 2004). The residents are excluded from the process due to a main argument: the physical and mental illness (always justified by dementia) or aggressive behaviours. As pointed out by Buzgova & Ivanová (2009), abuse can also be generated by physical disability, dementia and mental illness, as well as residents´ aggressiveness, motivated by their situation of dependency and social disaffiliation (Saveman et.al., 1999). Underlying these results, there seems to exist a social construction by researchers and professionals.

Harbinson (1999) believes that the way the elder abuse and neglect has been approached by the professionals and researchers, has not allowed involving older persons as key players in a scenario in which the family is conceived as a place of care and protection and violence which arises is thus, silenced. This idea can be also extrapolated to the residential care settings, where there is an internalisation of values based on a social designation process in which the resident is identified as someone who needs protection by dependency, vulnerability and social disaffiliation. This social conception makes the resident unable to make decisions, leaving him at the mercy of others´ decisions,

contributing to the elderly resignation from their responsibility either in combating the problem, or in suffering silently. Elder abuse and neglect is much more than reducing an interpersonal relationship problem.Not to focus on older people and older care recipients, regarding elder abuse in nursing homes, is a matter of ageism and a failure to make the rights of older care recipients real (Jònson,2016).

To exclude the residents from the analysis, as the central social actor, the direct consequence is a negative image of ageing, based on the physical and mental frailties."The medicalisation of old age"(Ennuyer, 2002:173) makes advanced age (over 80) based exclusively on a single component, the biomedical, in detriment of all the social and collective determinations of the individual, that is, the individual is deprived of all his life course and history. The excessive formalisation of procedures generates routine work that makes it difficult to personalise care and enshrines the belief that "all old people are the same": without a significant past, history and a personality of its own "(López, 2003: 113).

A change of paradigm: *from "institution-centred" to a "resident-centred perspective*

The use of mixed methods and different actors is a way to explore social interactions among residents, staff and managers and a way to change the focus from an "institution-centred perspective" to a "resident-centred perspective". The change to a centred-perspective also depends on the focus of the analysis. Investigating this complex object is only possible through a methodology based on observations of daily life in the institutions, interactions between residents and staff, and the analysis of the organisational system providing care. Residents must be the focus of the social and organisational interactions. The focus changes entail several issues: *What is the difference between quality of care, poor care, inadequate care and elder abuse and neglect? How can this be measured? How can we enter nursing homes and have access to the residents? How to link quality care and abuse and neglect?* These questions are critical issues which imply a deep reflection of which is the best conceptual and methodological approach to adopt.

Long-term care studies of quality have been guided by Donabedian´s conceptual approach (Donabedian, 1980) encompassing structural features of the settings, services delivery process and outcomes, although empirical attention has not been given to all components simultaneously and the residents´ quality of life. This has led to criticism that measurement of long-term care had focussed too much on clinical quality (bed sores, weight loss, containment measures), devoting little attention to the quality of life for people in need of care (OECD: 2013).

To focus on quality of life implies a change of the paradigm from "institution-centred" to a "resident-centred perspective, based on the distinction between *quality of care* approaches, focuses on the staff skill levels, the appropriateness of medical and social care, adherence to guidelines for providing care. In contrast, the *quality of caring* refers to the nature of staff and resident interactions that is as important to quality of life as the quality of care received (Noelker, & Harel, 2001), that enable them to maintain the *self* (Goffman, 1993).Concepts of *self* and identity, sense of control and well-being, are ignored in the measurement of quality of life of older people in nursing homes (Murphy et.al, 2006).

While considerable conceptual efforts have been made to model quality of life in long-term care, ASCOT[The adult social care outcomes toolkit]approach were designed to capture information about residents outcomes(cleanliness and comfort, good nutrition, safety, control over daily life, social interaction, occupation, accommodation, dignity).The ASCOT(CH3) (Towers et.al, 2016) includes mixed methods(interviews and observation) and is an innovative method to include people, living and receiving support in residential settings, who have severe needs(memory, communication impairments) and social care outcomes are expressed as a scale of an individual´s long term care related quality of life (SCRQoL).The National Adult Social Care Survey has used ASCOT to survey all users has been developed across different care settings in England, and other OCDE countries have been implementing. SCRQoL scores are generated by combining the answers from eight dimensions with a score of zero indicating high level needs (i.e. low quality of life) and a maximum possible score is 24 being the highest quality of life. For 2011-12, in England, the average score for the SCRQOL was 18.7 similar to the score in 2010-11.There tends to be correspondence between being in good health and having a good quality of life:65% of respondents in good health rated their quality of life as good, very good or could not be better. Conversely, only 10% of respondents in poor health say their quality of life is very good (OECD: 2013). Although the ASCOT measure is recognised as an excellent practice by OECD (2013), as a quality monitoring system of resident´s quality of life and a method to be adapted for use as a care home quality indicator, (Towers et.al, 2016) considered that feasibility testing suggested the measure had potential for use in quality monitoring but highlighted the importance of training in observational techniques and interviewing skills.

The aim of the residents' methodologies is to focus on social outcomes, the everyday life experience of residents and their quality of life; through a system of scoring and interpreting outcomes measures, from 8 domains, ASCOT (CH3) is possible to obtain for each resident/case a score of SCRQol (current, expected and gained).The final score will

allow to distinguish three levels:(1) optimum or ideal SCRQoL;(2) some needs in every domain and (3) high-level needs can include situations of poor care, abuse and neglect.

Based on Kamavarapu et.al, (2017) factors, identified as risk factors for institutional abuse, as sketched out in figure 1. In this conceptual model we add other social determinants of elder abuse and neglect which are differentiate in blue.

This conceptual framework reflects the organisational, the staff and victims' factors. Regarding the characteristics institutions, the organisation and management, the organisational policy, the environment, staff management and training are the main identified situational risk factors. In addition, the organisational features of the settings include the analysis of cultural organisation (leadership, style cohesion in the organisation and values)(Quinn & Rorbaugh (1983); the organisation of the care provision (the appropriateness of health and social care, safe and timely, and adherence to standard guidelines and procedures for providing care); organisation and staff support, including staff to resident ratios, training and credentialing of staff policy, the skill level of staff and the quality service management and report; and social representations of care and recipients´ care are factors which have consequences throughout the organisation to individual work care. As staff characteristics, gender, age, role/function – frontline direct care staff, qualification and training – lower qualification, untrained, personality, working conditions, personal and psychological stressors, are some of the main risk factors.

 As victims' characteristics, they emphasise the gender, age, dementia and cognitive decline, intellectual and physical disability and other factors, no family or other regular visitors and history of abuse, and data is collected always by proxy.

To this model we add the social actor; the resident must be the focus of the social and organisational interactions. The residents' perspectives focus on social outcomes (SCRQoL) based on the everyday life experience of residents (admission process, daily routine, family and social interactions, social and health care evaluation) and social perceptions of quality of life (Nolker & Harel, 2001; Kane et.al., 2002, 2003; Malley et.al, 2012; Towers et.al. 2016).

 Charpentier (2007) proposes a concept of "daily life empowerment", inspired by the interactionist and constructivist perspectives, which is defined as the opportunity that people have to verbalise their wishes (interests, motivations, habits) and organise their daily life according to their own priorities. This concept is particularly relevant, both from a theoretical and practical point of view, in a situation where individuals are, for several reasons, deprived of their freedom to fully exercise their power to act, as is the case of collective accommodation (Charpentier, 2007:39).

According to previous research (Kitwood, 1997; Nolan, et.al. 2004), person-centred care emphasises the individual's autonomy. Person-centredness calls the individual into play, making person-centred care suitable for people who are capable of self-determination and taking responsibility for themselves. Pirhonen & Pietila (2015), based on the recognition theory (Axel Honneth, 2005; 2012; Laitinen (2009), which proposes, in the case of people with cognitive disorders, the term "person-sensitive care", which shifts the responsibility from an incapable person to other people around, while at same time acknowledging the person´s own needs and opinions" (p. 101). This includes family members, friends or staff member. The main argument of the recognition concept is defined as "our existence as individuals depend on whether other people recognise us as persons and treat us accordingly" (p.96). Recognising older people as persons would support the continuity of their self when self is understood both as cognition and action, and it sustains the preservation of older people´s life-long identity. Focus on person-centred perspective, based on daily practices and interactions, is a way to explore continuity and rupture identity which endangers the *preserved* and *threatened autonomy* of the individual (Caradec, 2012). *Preserved autonomy* is defined as the capacity of older people to maintain a certain decision-making power over their daily lives, when confronted with the loss of functional and interpersonal capacities, and they try to keep activities and routines that are meaningful, in order to preserve a feeling of their own value as a person, to be recognised by others and, thus, to maintain spaces of familiarity with the world. The *autonomy is threatened* when support is compromised by omission, is inadequate or undignified, or when the individual abdicates of his or her own autonomy, in a deliberate way, in order to depend from others (*renounced autonomy*) and become more vulnerable to situations of abuse and negligence.

Organisation:

- Type, legal nature, dimension
- **Organisations and management**
  - closed models of organisation (cultural organisation)
  - punishung regime
  - low standards for welfare services and care facilities
  - reduced financial resources
- **Organisational policy :**
  - absence of quality control system
  - lack of clear policies around abuse
- **Environnement**
- **Staff management**
  - ineffective staff supervision
  - intimidation by senior staff
  - lack of personal and intimate care monitoring the provision and during night
- **Training and guidance**
  - lack of guidance to staff

Professional

- Gender
- Age
- Role/function – frontline direct care staff
- Qualification and training – lower qualification, untrained
- Personality
- Working conditions
- Psychological stressors
- Physical and mental health
- Education and professional profile
- Work environment (team profile, organisation climate)
- work conditions: working hours, absences, salary, social benefits, social protection
- Work satisfaction
- Quality of care: care activities adequacy
- Concepts of care and residents: recognition
- Quality of caring: interactions and conflicts

Residents

- **Gender**
- **Age**
- **Dementia and cognitive decline**
- **Intellectual disability**
- **Problem behaviours**
- **Other (no family or other regular visitors)**
- **History of abuse**
- Past history and reasons to admission
- The residents' perspectives focus on social outcomes(SCRQoL) based on the everyday life experience of residents (admissions process, daily routine, family and social interactions, social and health care evaluation) and social perceptions of quality of life (Individual´s long term care related quality of life (SCRQoL)
- Meanings of everyday life and ageing in an institution: preserved and threatened autonomy
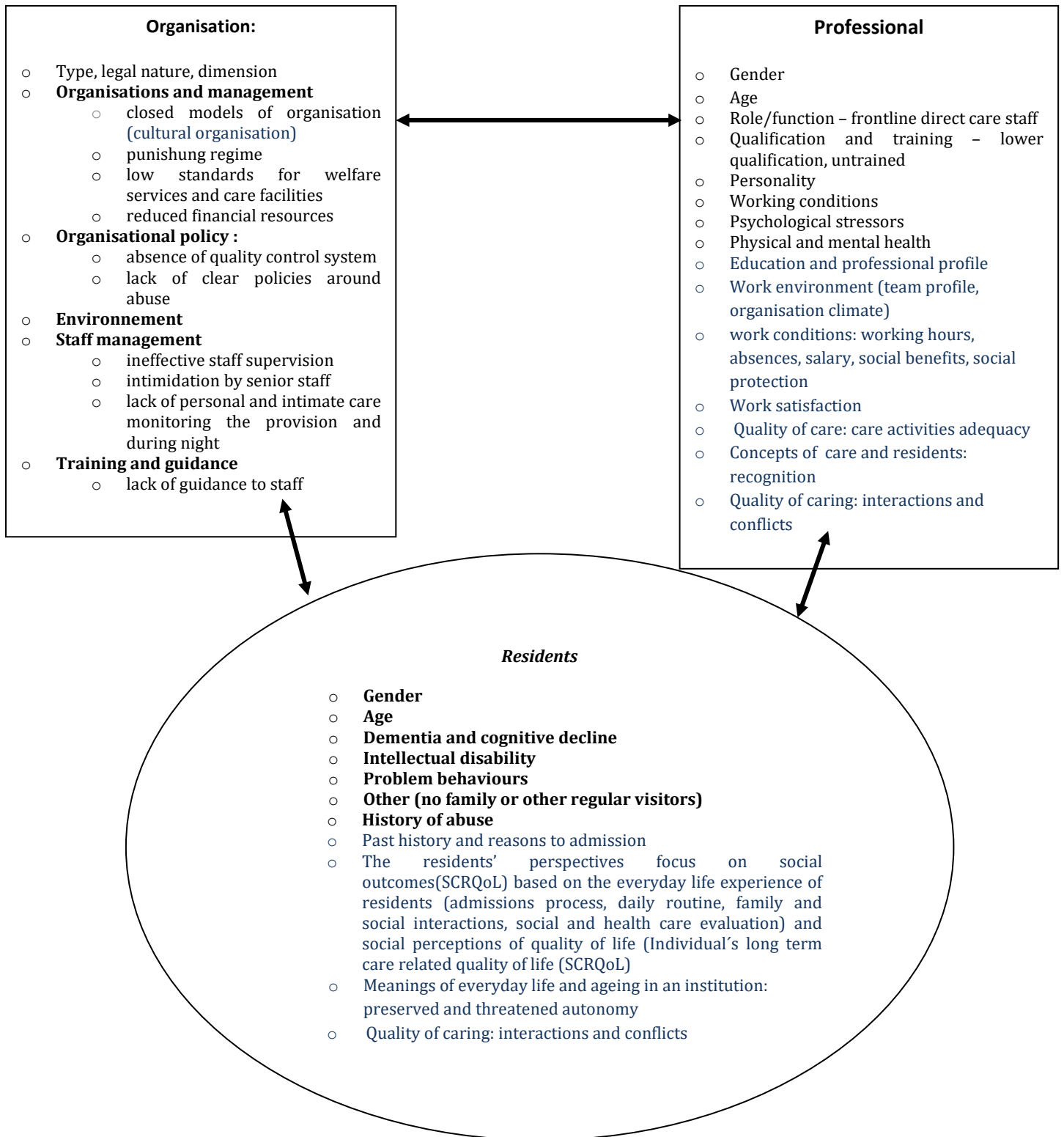- Quality of caring: interactions and conflicts

Figure 1 – Factors identified as risk factors for institutional abuse (adapted Kamavarapu, et.al. 2017)

3. Methodology

A systematic review in scientific databases was conducted to explore the peer-reviewed evidence, in total, 30 articles were included and analysed. A systematic review in scientific databases was conducted to explore the peer reviewed evidence. We searched the Scopus MEDLINE from 1989 to 2016. These searches were conducted with a combination of the key words: "abuse, mistreatment, maltreatment, neglect, elderly, seniors," and was limited to nursing homes. Our intention was to identify conceptualisation, dimensions and measures used, and risk factors. A critical approach of the systematic review was carried out. As mentioned by Pillemer (2016) elder abuse prevalence in institutional settings is "not covered because of the lack of research in this area; no reliable prevalence studies have been conducted of such mistreatment in nursing homes or other long-term care facilities" (Pillemer et.al.2016:195). One reason for this lack of research is related to the frailties of the conceptual and theoretical framework to approach elder abuse and neglect, and the design studies and methodological strategies to reach resident population. This contribution is one of the aims of "Ageing in an Institution" study. The main objective of the study is to analyse the relationships between the organisation of nursing homes and the interpersonal features of care providers and their relation with the residents´ quality of life. The study is being carried out in Sintra Council (council of the Metropolitan Area of Lisbon) and 30 nursing homes (profit and non-profit) were invited to participate.. Currently, 70 in-depth interviews were conducted (30 residents and 40 care workers), in three residential settings in Sintra Council, focusing on: daily-life experiences (admission process, daily routine, family and social interactions, social and health care evaluation) and social perceptions of quality of life, capturing information about long- term care outcomes, which focuses on items such as cleanliness and comfort, good nutrition, safety, control over daily life, social interaction, occupation, accommodation and dignity.

The adult social care outcomes toolkit (ASCOT)-Care homes version (CH3) includes different methodologies: observation, interview with service users and interviews with staff. We used a non-official adult social care outcomes toolkit (ASCOT)-Care homes version (CH3), integrated in-depth interviews (after the informed consent). The aim was to test all the instruments and adapt them to the Portuguese reality. All the 30 in-depth interviews were recorded and are currently being transcribed. The fieldwork took between one and two weeks in each nursing home.

In addition, we conducted an interview with the managers of the nursing homes to obtain data on the organisational features of the settings: cultural organisation, provision of care organisation; organisation and support of staff, including staff to resident ratios, training and credentialing of staff policy, the skills levels of staff and the identification of the

number of care staff and the quality service management and report. Besides the face- to-face interviews we used one of the instruments to collect the contextual aspects, by observation, the therapeutic Environment screening survey for nursing homes and residential care (TESS-NH/RC)(Sloane, et.al.,2002).Is a method of recording observations of the physical environment of long-term care settings, based on a set of indicators: maintenance; cleanliness; odours; safety; lighting; appearance/homelikeness/personalisation; orientation/cueing; privacy; noises; plants; outdoor areas; residents´appearance and impressions.

In addition, we conducted a self-completed questionnaire to be filled out by 41 care workers. The aim was to characterise the interpersonal features of the settings, identifying the social portrait of the staff (age, sex, level of education, professional experience), the work environment (team profile, organisation climate, working hours, absence from work and intention to leave), professional performance (work satisfaction, burnout levels, physical and mental health), social attitudes towards ageing and care. We used the following instruments:job Satisfaction/commitment and intention to leave (Filipova, 2011);Shirom-Melamed Burnout Measure(SMBM): the SMBM contains 14 items in three subscales:physical fatigue (P); emotional exhaustion (E) and cognitive weariness(C);General Health Questionnaire(GHQ-12); attitudes towards ageing (Pillemer & Finkelhor, 1992).The distinction between quality care and quality of caring (Nolker &Harel, 2001)implies describing the contents of the tasks´ and care activities and the nature of staff and resident interactions (individualised and dignified relations or conflicts).To measure conflicts between staff and resident interactions(observed, engaged, experienced and mistreated) and risk factors will based on Goergen (2004) and Rabold, & Goergen (2013).

We will present some of the preliminary results based on 41 care workers responses [92% were women and the mean age was 43 (between 22 and 67), with low qualification], in the following issues:

(1) *In your daily work with older people which factors influence the quality of your work?*

(2) *Let us now refer to other types of problems, namely situations of conflict that may influence working with older people. Sometimes situations of conflict arise (residents, colleagues, managers, technical staff, family and others).From your experience with which regularity do these conflicts occur?*

(3) *Types of conflicts in the last 12 months (acts of abuse and neglect committed by the care workers themselves or as observers of actions committed by others, work-colleagues and by residents)?*

(4) *In your opinion, which of the 3 reasons account for these conflicts (residents, colleagues, managers, technical staff, family and others)*

(5) *In your opinion, what led to these situations of conflict?*

The statistics analysis was made through SPSS and some questions a content analysis was performed based on the description about facts using N Vivo.

4. **Analysis:** *quality care a forgotten taboo*

Based on observations and interviews to managers and staff some of the risk factors mentioned by (Kamavarapu et.al, 2017) were identified. Based on the three cases, we are facing a care system with closed models of organisation: imposition of behavioural rules and stiffness in the use of time and space, some punishing regime (power abuse), low standards of welfare services, but medium and good physical care facilities for elder persons and policies operate in the interests of the institution rather than in that of the residents´. In terms of organisational policy, in none of the observed nursing homes was there an effective and systematic system of quality control and a lack of clear policies around abuse and neglect was inexistent. Staff management was characterised by a failure to comply with the ratio of staff, according the Portuguese legislation [1 care worker for every 5 dependent residents] in two settings, and a lack of management and omissions in monitoring of personal and intimate care. In terms of training and guidance, a lack of effective staff guidance was evident and the training in the workplace was not accredited, and not always adapted to the needs of the care workers, and mainly the residents´ needs, dementia and behaviour problems. It was the major conclusion in the three nursing homes, care workers and technical staffs, in general, are not prepared to deal and care for people with dementia and behaviour problems. The isolation of people with dementia in special rooms, in two nursing homes, were observed and were justified by reasons of security and a way of not disturbing the other residents. People are not physical and mental stimulated, sometimes they are mechanically restrained all day, and daily life is circumscribed to tiny rooms leading to narrow and difficult accesses for someone with no time-space orientation.

All these institutions´ characteristics have an impact on the organisation of staff´s individual work and working conditions. The conditions of work from care workers´ affect not only the quality of the care that caregivers are able offer residents, but also have an impact on their physical and mental health. Thus, working conditions are an important

focus for health and social research (Schwendimann, et.al. 2013), with impact on their work environment (team profile, organisation climate, working hours, absence from work and intention to leave) and professional performance (work satisfaction, burnout levels, health, physical and psychological well-being).All these relevant factors related with care process, will shape the underlying model, centred on tasks (basic tasks´ contents of care activities) or centred on person, based on individualised and dignified relations, which in all three cases were inexistent.

The non-recognition of the care workers´ profession, poorly trained, remunerated, and overworked, with omissions of technical supervision and closed culture of care, working in a conflict climate organisation, such factors may decrease quality of care and increase the risk of poor and inadequate care. These factors lead to the loss of dignity in a culture of omissions (rationing of care) and making the individual more vulnerable to the risk of abuse and negligence, with impacts on residents´ physical and psychological well-being, and their quality of life.

When the 41 care workers were questioned on the following: *In your daily work with older people which factors influence the quality of your work?* It is consensual that the major problems were: lack of staff and overworked (36), conflicts within work teams (34), insufficient training and poorly trained (33), working conditions with lack of equipment to support caring (31), low salaries (31), a lack of feedback regarding their work (28) and technical supervision, and a lack of social recognition of their profession (30).

Figure 1- **Factors influencing the quality of care work**

Although, 67% of the conflicts reported by the care workers are conflicts inside the care workers teams, this can be hypotheticaly related with the disparities between observed and committed acts of abuse and neglect observed and committed by care workers, hidden power relations in organisations and conflicts inside the care-workers´ teams, and the

absence of an effective care quality control system. "Poor supervision" and "closed culture of care" are recognised as situation risk factors (Mcdonald, et.al, 2012; Phelan, 2015:217).The care model related with professionals´ practices are inseparable from the culture organisation of the institutional settings. We can see these disparities in estimates between acts of abuse and neglect committed by the care workers themselves or as observers of actions committed by others, work-colleagues and by residents.

The most commonly observed acts were of psychological nature (screaming at a resident (89,3%), intentionally ignoring (75%), rejection(39%) and neglectful care. They are often related with care activities: omission of care, such as not changing the position of a bedridden person, omitting to turn the resident to prevent pressure sores, making them wait to go to the toilet intentionally, neglect of hygiene needs, including toileting, bathing, oral care or neglecting to change a resident following an episode of incontinence or placing diapers without it being necessary to avoid supporting the WC; refusing to answer a resident when they call and making the resident wait on purpose, and not respecting their privacy. Almost a third, reported submitting residents to institutionalised practices: restraining a resident beyond what was needed, during several hours and daily, inappropriate physical restraint and bed rail use or pharmacologic restraints. To a lesser proportion, financial and physical abuse emerged. In a total of 41 interviews, 28 recognised some form of abuse or neglect, corresponding to 68% of the sample.

Table nº 1 **- In the last 12 months, you observed any colleague ever to…**

Psychological abuse		%
Screaming at a resident	25	**89,3**
Intentionally ignoring a resident when they call	21	**75,0**
Rejecting a resident	11	39,3
Giving nicknames in a pejorative way (in order to hurt)	3	10,7
Making a resident angry on purpose	6	21,4
Verbally threatening the resident	3	10,7
insulting a resident intentionally	3	10,7
Punishing (do not taking them to the living room, or the garden)	2	7,1
Punishing by refusing to feeding them a meal (food, drink) Spreading rumours	2	7,1
Humiliating to make them feel ashamed	2	7,1
Neglectful care		
Placing diapers without it being necessary to avoid supporting the WC	6	21,4

Neglect in their hygiene (shaving, combing, brushing teeth)	7	**25,0**
Not changing position a bedridden person, omitting to turn the resident to prevent pressure sores	8	**28,6**
Making them intentionally wait to go to the toilet	7	**25,0**
Leaving the resident in bed all day	3	10,7
Neglecting their bathing hygiene	4	14,3
Not changing their underwear	3	10,7
Making the elderly wait on purpose	10	**35,7**
Not respecting their privacy	6	**21,4**
Disrespecting special diets	1	3,6
Inappropriate use of restraint (physical and chemical)		
Mechanically restraining a resident to minimise the workload	7	**25,0**
Using other restraining strategies not to have so much work (belts)	4	14,3
Sedating a resident to minimise workload	1	3,6
Physical abuse		
Grabbing too hard	1	3,6
Physical aggression (slapping, pushing, throwing an object at them)	2	7,1
Financial abuse		
Stealing resident money or other valuables	4	14,3

Therefore, there are differences between estimates related with as observers and committed actions. The most commonly committed acts were of psychological character (screaming at a resident, intentionally ignoring) and neglectful care related with omission of care, such as hygiene needs including toileting, bathing, adequate clothing and respect privacy.

Table nº 2 **- In the last 12 months, you committed any of these acts**

Psychological abuse		%
Screaming at a resident	9	**32,1**
Intentionally ignoring a resident when they call	5	**17,9**
Verbally threatening the resident	1	3,6
Making a resident angry on purpose	1	3,6
insulting a resident intentionally	1	3,6
Punishing (do not taking them to the living room, or the garden)	1	3,6

Punishing by refusing to feeding them a meal (food, drink)	1	3,6
...spreading rumours	1	3,6
Humiliating to make them feel ashamed	1	3,6
Neglectful care		
Placing diapers without it being necessary to avoid supporting the WC	1	3,6
Neglect in their hygiene (shaving, combing, brushing teeth)	1	3,6
Leaving the resident in bed all day	1	3,6
Neglecting their bathing hygiene	1	3,6
not respecting their privacy	3	**10,7**
Inappropriate use of restraint (physical and chemical)		
...mechanically restraining a resident to minimise the workload	1	3,6
Financial abuse		
...stealing money or other valuables	1	3,6

The data reveals that sometimes we are in a context of severe conflicts where insult, rumours, physical aggression and sexual abuse are committed by the residents themselves against the care workers.

Table nº 3 - **In the past 12 months, have any residents ever:**

Psychological abuse		%
...insulting intentionally	9	**32,1**
...spreading rumours	7	**25,0**
Physical abuse		
...physical aggression (hitting, slapping, hands to neck)	8	**28,6**
...kicking	3	10,7
...Pushing	4	14,3
... throwing an object at and hit	2	7,1
Sexual abuse		
Making obscene gestures	3	**10,7**
...sexually harassed	2	7,1

How do care workers interpret these conflicts?

We asked interviewees to select three reasons to explain conflicts. For residents: *"dementia", "dependency", "decompensated" "behaviour problems", "poor training and supervision", "think that they are at their own homes", "lack of understanding"* and *"superiority behaviour".*

The reasons pointed out by care workers were *"lack of organisation", "workload", " not knowing to work as a team", "care workers without an adequate profile", "stress", "tiredness", "burnout", "communication problems"* and *"struggles between lighter* work and heavier work".

Families pointed out reasons related with essentially with "*mistrust, disappearance of personal goods and products and robberies".* Managers' conflicts are related with *"communication problems", "a commercial perspective"* and *"managers being volunteers without a professionalisation".*

We can conclude that the reasons mentioned are in same direction of the risk factors identified to explain the occurrence of inadequate care and elder abuse in institutions, related to essentially with organisational features of long-term care policies, with low standards of care facilities: lack of staff (non-compliance with staff ratios), poor working conditions (poorly trained, remunerated, and overworked), difficulty in managing conflicts, staff without an adequate profile to be a care worker, ineffective staff supervision and residents´ characteristics: people with severe impairments, mental and physical, with behaviours problems and the difficulty to lead and care for. These difficulties generate stereotypes and beliefs regarding the process of getting older in a nursing home, not as their home, and residents are seen, and treated, as "users", sometimes as a "*child*", *"who needs rules"*, " *must be treated with discipline / firmness*", or "*someone who needs love and care*", without an identity and a history, where there is an absence of a culture of social rights and the institutionalisation of the care omission is something normalised in institutional practices. This "care omission culture institutionalisation" is due to main two reasons: (1) the older person is conceived as someone with multiple needs (social, physical, psychological), in a situation of isolation and breakdown of family ties, which make the dependent person part of a problematic group, not only because of their age, but also because of multiple losses (Gil, 2010); (2) Services are not organised around the person herself, but in reference to the institutions' criteria (admission processes, available services, rhythms of care) and the greater or lesser sensitivity and availability of care workers. Thus, the "autonomy is annihilated and the system systematically constructs the

older person as dependent of a care network in which the person has no freedom of choice"(Guillemard, 1995:201). One example of autonomy loss has to do with personal care related with hygiene needs: "*Placing diapers without it being necessary to avoid supporting the WC*" or "*making them wait to go to the toilet intentionally*" or "*making the elderly wait on purpose*" are examples of neglectful care and ways of (un)care that promote dependency. Synthesising, structures that more than preventing the loss of autonomy, paradoxically, contribute to reinforce the social construction of old age, as a time of dependence and retreat to self-determination, and the older person is a simple piece of an institutional dynamic with instituted and informal powers.

These factors may influence how the individual sees and feels the nursing home as the continuity of her or his home or as an anonymous and strange collective space where there are norms to be respect and to be obey, in a hierarchical system, as *total institution* (Goffmann, 1968).The social perceptions of the nursing home, as a death place is surrounded by negative feelings of loss of autonomy, independence and quality of life, and these social perceptions can influence the likelihood of the adverse organisational outcomes and the social recognition of the role of these organisities in long-term care policies.

Figure nº 2 - In **your opinion, what are the reasons of these conflicts situations?**

5. Discussion

Lopes (2017) referred that, although Portugal has been seeing some convergence towards the EU average in coverage rates for formal care provision [In 2017 there were 2.348 nursing homes in Portugal), it should be noted that coverage rates alone do not necessarily correspond to appropriate coverage (Lopes,2017:70). Some factors are pointed out:

"excessive workloads and long working hours", "poor working conditions are coupled with high rotation of staff" (*idem,* 70), poorly trained and remunerated.

Some of the risk factors identified to explain the occurrence of inadequate care and abuse and neglect, are related with the working conditions in care work they themselves shaped by the national workplace policies and practices and the social recognition of the profession. As highlight by Lopes (2017) **"**quality of care is a topic that has remained absent from the public debate on long-term care in Portugal, and once this can be a side effect of the chosen model of provision based on the quasi-monopoly of provision by the non-profit sector" (p.70)[1]. This author considered that "the non-profit sector itself, either because it operates as a monopoly or because of ideological orientations towards care, is still very embedded in the Christian doctrine of charity and assistance and not in a culture of social rights" (Lopes, 2017:71).

We consider that in Portugal quality care issue seems to be a forgotten taboo which has been absent from the public debate on long-term care and would be important to be visible due to also the demographic scenarios. In 2013, 5% of the Portuguese population was 80+ and demographic projections suggest a significant growth in the number of people over 80 by 2060, to reach 16% (EU, 12%) (INE14), due to the increasing life expectancy. The increased needs for long-term care, whether health and social care, is one of the most societal challenge that an ageing society has to face and quality of care will be one of them.

Our preliminary data confirm some of Drennanet´s et.al. (2012) results which have shown that the most commonly observed acts were of a negligent and psychological nature. They are often related to care activities; such as omission of care, failure to provide food or water or adequate clothing; omitting to turn the resident to prevent pressure sores; neglect of hygiene needs, including toileting, bathing, oral care or neglecting to change a resident following an episode of incontinence; refusing to answer a resident when they call; improper or non-administration of prescribed medicines; submitting residents to institutionalised practices; restraining a resident beyond what was needed (Hantikainen & Kappeli, 2000), inappropriate physical restraint and bed rail use or pharmacologic

---

[1] The services and facilities for the elderly are mainly provided by *non-profit institutions* (partly funded by the state), which assume the role of a solidarity network. The Private institutions of social solidarity (IPSS) have emerged from the initiatives of private individuals or associations. They are non-profit, oriented towards social solidarity and recognised by the state, to which they may apply for funding. Very recently, long-term care did not feature public sector involvement and was mainly provided by *Misericórdias* (holy churches).The *Misericórdias* are independent, non-profit institutions with a religious background. To an extent degree, these services are also provided by private for-profit institutions (Joel et.al., 2010).

restraints (Glendenning, 1999). In many cases, particularly those involving pressure sores, malnutrion, and dehydration, dysphagia, researchers may have difficulty making a distinction between acts of neglect and examples of poor care quality and severe or fatal mistreatment, only overcome with the identification of markers by the forensic medicine (Lindbloom, et.al. 2007), which is a limitation in a research design based on observation and interviews.

In this linkage between quality of caring and quality of care (Nolker and Harel, 2001) there are interactions that need *mutual recognition* by residents and staff. The lack of social and institutional recognition of the care work (cleaning, washing, dressing, etc.) and low qualifications and, therefore, poorly paid, gives rise to a tension between normative expectations - to take care well – and care practices. This tension may be conceptualised in terms of theory of institutional power (Stahl, 2011). The core idea is the distinction between institutional and non-institutional social power. The author distinguishes intra-institutional power, or power within an institution, which consists of the power relations created and sustained by institutional rules. In an organisation the "institutional power is defined as the "power persons acquire through their position in a stable and integrated system of social rules" (Stahl, 2011:350)

In any institutional settings there are formal rules which command organisational routines and practices, and different times "visiting times, sleeping times, recreation times, or medication times" (Phelan, 2015:217), or procedures related on how to care (social and health practices) and these rules require a collective acceptance of recognition, from whom is responsible for the management, the professionals and residents.
The struggle between a closed culture of care, based on collective and uniform norms, and an individualised model care based on person-centred, depends on, several times, of an informal power detained by staff members (being at the care forefront) within institutions themselves. Stahl (2011) defines as a constitutive power the kind of power which sustains, creates, destroys or changes the institutional rules themselves. In contrast with the interpersonal recognition, based on people´s personhood, "institutional recognition concerns institutional deontic powers explicitly" (Ikaheimo and Laitinen, 2011:9). The hidden informal power relations in organisations, conflicts inside the care-workers´ teams and the absence of an effective care quality control system, can explain the differences of estimates of abuses committed by the professionals themselves or as observers of actions committed by work-colleagues. The institutionalisation of the care acts omission is something normalised in institutional practices, where the older person is a simple piece of an institutional dynamic with instituted and informal powers. In this context of

conflicts, sometimes older persons also react and the insults, rumours, physical aggression and obscene gestures are also committed by the residents themselves against the care workers.

One of the major conclusions evidenced in the three nursing homes, was that care workers and technical staff, in general, are not prepared to deal and care for people with dementia and behaviour problems. This problem can reinforce that elder abuse, mainly physical aggression, can be interactive, as pointed out by Steinnetz (1988) and (Paveza et. al. 1992). These authors revealed that caregivers were also victims of physical abuse, concluding that families with Alzheimer's patients were more vulnerable to violent behavioural episodes linked to the disease itself. All these studies mentioned, as the main cause, the frustration of functional and cognitive incapacity (Steinnetz, 1988); (Paveza et al., 1992), which also highlighted the difficulty in dealing with the dementia itself.

The institutional and non-institutional social power depends from the culture organisation and the provision of care organisation system. It is related with the leadership, style cohesion in the organisation and values (Quinn & Rorbaugh (1999). The organisation-level effects, the impact of organisational culture on individuals--e.g., employee morale, commitment, productivity, physical health, and emotional well-being-is also well-documented (Quinn & Rorbaugh, 1999).The type of organisation (hierarchy culture; market culture; clan culture and an adhocracy culture) is a crucial factor in the long-term effectiveness of organisations and in their care model, which needs further research into the associations. Depending on the organisation culture the care institutions recognise older people as "customers", "residents", "patients", "persons" or "users", and these social perceptions manifested in institutional dynamics and daily practices. As we have seen in daily practices of care, we can identify, simultaneously, conducts of quality of care, poor and inadequate care and abuse and neglect, which have a tenuous frontline of concepts.

Although providing an exploratory approach to the phenomenon, most of these studies do not allow the determination the extension of the problem at a national scale, neither theorising about the causal explanations. In residential long-term care settings, theories and conceptual models of abuse are needed which expand to include characteristics of the staff, institution and the elder himself having an effect on outcomes such as the resident's ´quality of life (Castle et.al., 2015).

This conceptual approach needs a continuous testing, through mixed methods (interviews, questionnaires and observational data), based on observations of daily life in the institutions, interactions between residents and staff, and the analysis of the provision of care organisation system, in a larger and national sample of institutions. This paper has

some limitations. Firstly, the preliminary data were based on self-reported responses of care workers and through observations of daily life practices. Secondly, although the study is being carried out during 2017 and the sample was composed by currently by three nursing homes, the data obtained are exploratory and preliminary.

Therefore, these exploratory approaches were important to improve the conceptual model, due to the lack of conceptual clarification, it allowed to test the instruments and to explore some emerging issues, and one which we highlighted was the conflicts within work teams and the work conditions of care workers, which determine the *quality of care and caring.*

The resulting information of this conceptual framework approach intends to support future preventive measures and contribute to a safer and dignified ageing in the residential sector, and to the development and a better evidence-based approach to improve quality in long-term care and elder abuse prevention.

Bibliography

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.
Caradec V. (2012). *Sociologie de la vieillesse et du vieillissement [Sociology of old age and ageing].* Paris : Éditions Armand Colin.

Castle, N. G. (2012). Resident-to-resident abuse in nursing homes as reported by nurse aides. *Journal of Elder Abuse & Neglect*, 24, 340–356.

Castle,N., Ferguson-Rome, J., Jeanne, 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- 443.

Charpentier, Michele (2007). *Vieillir en milieu d'hébergement [Ageing in an institution]*. Québec: Presses de l'Université du Québec.

Donabedian, A., 1980. *Explorations in Quality Assessment and Monitoring*. Ann Arbor, MI: Health Administration Press.

Drennanet, J; Lafferty, A.; Treacy, M.; Fealy, G.; PhelAn, A.; Lyons, I.; Hall, P., (2012). *Older people inresidential care settings results of a national survey of staff resident interactions and conflicts*, UCD and HSE.

Dufour-Kippelen & Mesrine, S. (2003). Les personnes âgées en institution [Old people in institutions]. *Revue Française des Affaires Sociales – Handicaps, incapacités, dépendance*, 1-2, 123-148.

Ennuyer, B. (2002). *Les malentendus de la dépendance* – De l´incapacité au lien social, Paris: Dunod.

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, nonprofit, and government skilled nursing facilities: managerial implications for partnerships. *Health c Law Ethics Regul*, 2011 Oct-Dec;13(4):125-31; quiz 132-3.

Fulmer TT. (1989). Mistreatment of elders: Assessment, diagnosis, and intervention. *Nursing Clinics of North America.* 24:707–716.

Gil, A. P. (2010). *Heróis do quotidiano: Dinâmicas familiares na dependência* [Every day heroes: Family dynamics in dependency]. Lisbon,: Fundação Calouste Gulbenkian, Fundação para a Ciência e a Tecnologia.

Gil, Ana Paula; Irina Kislaya; Ana João Santos; Baltazar Nunes; Rita Nicolau, Ana Fernandes (2014), Elder Abuse in Portugal: Findings from the First National Prevalence Study, *Journal of Elder Abuse & Neglect*, 27(3):174-195.

Glendenning, F (1999), Elder abuse and neglect in residential settings: the need for inclusiveness inelder abuse research. *Journal of Elder Abuse and Neglect*, 10 (1), 1-11.

Goffman, E. (1993 [1959]).The Presentation of the Self in Everyday Life, Lisbon: Water Clock.

Goffman, E. (1968). *Asylums: Essays on the social situation of mental patients and other inmates*. Harmondsworth: Penguin.

Goergen, T. (2004). A multi-method study on elder abuse and neglect in nursing home, *Journal ofAdult Protection*, 6 (3), 15-25.

Greve, B.(edit.).(2017).*Long-term care for the elderly in Europe – Development and prospects*, Routledge

Guillemard, Anne Marie (1995), "Vieillissement et Exclusion" in Paugam, Serge (Dir), L´*Éxclusion – Le État des savoirs,* Paris, Éditions La Découverte, p.193-206.

Hantikainen, V.& Kappeli, S. (2000). "Using restraint with nursing home residents: a qualitative study of nursing staff perceptions and decision-making", *Journal of Advanced Nursing*, 32 (5), 1196-1205.

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

Honneth, A. (2005). *The struggle for recognition. The moral grammar of social conflicts*. Cambridge: Polity Press.

Honneth, A. (2012). The I in We. Studies in the theory of recognition. Cambridge: Polity Press.

Ikaheimo, H.& Laitinen, A. (2011). *Recognition and social ontology.* Boston:Brill.

Joel, Marie-Eve; Dufour-Kippelen, S., Samitca, S. (2010), *The long-term care system for the elderly in Portugal,* European Network of Economic Policy Research Institutes,

Jonson, H. (2016). Framing scandalous nursing home care: What is the problem? *Ageing and Society*, 36(2), 400-419.

Kane, R.A., (2001). Long-term care and a good quality of life: bringing them closer together'. *The Gerontologist,* 41(3): 293-304.

Kane, R.A., (2003a). Definition, measurement, and correlates of quality of life in nursing homes: toward a reasonable practise, research, and policy agenda. *The Gerontologist,* 45 (2), 28-36.
Kane, R.A., Kling, K.C., Bershadsky, B., Kane, R.L., Giles, K., Degenholtz, H.B., Liu, J. and Cutler, L.J., 2003b.Quality of life measures for nursing home residents'. *Journal of Gerontology*, 58A (3), 240-248.

Kane, R.L., Bershadsky, B., Kane, R.A., Degenholtz, H.B., Liu, J., Giles, K. and Kling, K.C., (2004). Using resident reports of quality of life to distinguish among nursing homes. *The Gerontologist*, 44(5): 624-632.

Kamavarapu, Y.S., Ferriter, M., Morton, S., Vo̎llm, B. (2017). Institutional abuse – Characteristics of victims, perpetrators and organsations: A systematic review. *European Psychiatry* 40, 45–54.
Kitwood, T. (1997).*Dementia reconsidered: The person comes first*. Buckingham:Open University Press.

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. *Journal of The American Geriatrics Society*, 55, 840-845.

Laitinen, A. (2009). The scope of "recognition": The role of adequate regard and mutuality. In H. C. Schmidt am Busch, & C. F. Zurn, (Ed.), *The philosophy of recognition: Historical and contemporary perspectives* (319–334). Lanham: Rowman & Littlefield.

Lindbloom, E., Brandt,J., Hough, L. Meadows, S. (2007). Elder Mistreatment in the Nursing Home: A Systematic Review- JAM Med Dir Assoc.8: 610–616.

Lopes, Alexandra, Long-Term care in Portugal – quasi-privatization of a dual system of care (p. 59-74) in Greve, Bent (edit.).(2017).*Long-term care for the elderly in Europe – Development and prospects*, Routledge

Lopez, P. (2003). Maltrato en el âmbito institucional [Maltreatment in the institutional scope]. *Revista Multidisciplinar de Gerontologia*. 13 (2), 102-113.

Malmedal, W., Hammervold, R., Saveman, I. (2014).The dark side of Norwegian nursing homes: factors influencing inadequate care. *The Journal of Adult Protection*, Vol. 16 (3), 133 – 151.

Malley J, Towers A, Netten A, Brazier J, Forder J, Flynn T. (2012). An assessment of the construct validity of the ASCOT measure of social care-related quality of life with older people. *Health Qual Life Outcomes.*10 (1):21.

McDonald, L., Beaulieu, M., Harbinson, J. Hirst, S., Lowenstein, A. Podnieks, E. Wahl, J. (2012). Institutional abuse of older adults: what we know, what we need to know. *Journal of Elder abuse and Neglect,* 24 (2):138-160.

Murphy, K., O'Shea, E., Cooney, A., Shiel, A., Hodgins. M. (2006), *Improving Quality of Life for Older People in Long-Stay Care Settings in Ireland*. Dublin: National Council on Ageing and Older People.

National Institute of Statistics (INE) (2014). *Projections of resident population 2012-2060* [Projeções de população residente 2012-2060]. INE, Portugal

Noelker, L.S. & Harel, Z., 2001. Humanizing long-term care: forging a link between quality of care and quality of life' in Noelker, L.S. and Harel, Z., (eds), i*nking Quality of Long-Term Care and Quality of Life*. Canada: Springer Publishing Company.

Nolan, M.R., Davies, S., Brown, J., Keady, J., & Nolan, J. (2004). Beyond 'person-centred' care: A new vision for gerontological nursing. *Journal of Clinical Nursing,* 13(1), 45–53.

OECD/European Commission (2013). *A Good Life in Old Age? Monitoring and Improving Qualityin Long-term Care,* OECD Health Policy Studies, 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", in *The Gerontologist,* vol. 32, nº 4, p. 493-497.

Phelan, A. (2015). Protecting care home residents from mistreatment and abuse: on the need for policy. *Risk Management and Healthcare Policy*, 8: 215-223.

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.& Finkelhor, D. (1992). The prevalence of elder abuse: a random sample survey. *The Gerontologist,* 28:51–57.

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.

Pillemer, K., Burnes, D., Riffin, C. Lachs, M. (2016). Elder Abuse: Global Situation, Risk Factors, and Prevention Strategies. *The Gerontologist,* vol. 56 (2), 94-205.

Pirhonen, J.& Pietilä, I. (2015). Patient, resident, or person: Recognition and the continuity of self in long-term care for older people. *Journal of Aging Studies,* 35, 95–103.

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,* Vol. 15 (3), 127 – 140.

Renaut, S. (2012). Les apports de l'enquête handicap santé [The contributions of the disability-health survey]. *Gérontologie et Société,* 5 (1), 55-74.

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.

Schwendimann,R.; Zuniga, F.; Ausserhofer, D.; Scubert, M.; Engberg, S. Geest, S. (2013). Swiss Nursing Homes Human Resources Project (Shurp): protocol of an observational study. *Journal of advanced Nursing* (JAN): 915-926.

Stahl, T. (2011). Institutional Power, Collective Acceptance, and Recognition, in Ikaheimo, H.& Laitinen, A. (Ed.). *Recognition and social ontology*. Boston: Brill, 349-372.

Sloane, Mitchell, Weisman G, Zimmerman S, Foley KM, Lynn M, Calkins M, Lawton MP, Teresi J, Grant L, Lindeman D, Montgomery R. (2002). The Therapeutic Environment Screening Survey for Nursing Homes (TESS-NH): an observational instrument for assessing the physical environment of institutional settings for persons with dementia*. J Gerontol B Psychol Sci Soc Sci.* Mar;57(2):S69-78.

Steinnetz, S. K. (1988), Duty bound: elder abuse and family care, Newbury Par, Sage.

Towers, A-M., Smith, N., Palmer, S. Welch, E., Netten A. (2016).The acceptability and feasibility of using the Adult Social Care Outcomes Toolkit (ASCOT) to inform practice in care homes. *BMC Health Services Research BMC*.16:523.

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.). Geneva, Switzerland: WHO.

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