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Neglecting the care of older people in residential care settings: A national document analysis of complaints reported to the Finnish supervisory authority

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Abstract

Neglecting to provide older people with the care they need in residential care settings leads to human suffering and increased service needs. Research is lacking on neglect in older people's residential care and one way to assess the key issues is to study complaints. The aim of this study was to analyse official complaints related to allegations of neglect in residential care settings caring for older people in Finland. The data covered 317 complaints that were recorded in the national database in 2018 and 2019. The analysis of the complaints yielded 2,922 observations of neglect in older people's care in residential care settings. Based on our results, most of the complaints were made by family members when the patients were alive and their motivation was to improve the care their relative received, as well as the care of others, in the residential care home. The complaints focused on neglecting clinical care, including restricting older people's movements, not providing daily activities and not paying sufficient attention to their hygiene and secretions. Other complaints included issues relating to nutrition, medication, communication and issues that compromised their privacy, respect and dignity. Nearly three of four complaints identified staffing issues in relation to neglect and most of the complaints concerned private, rather than public, residential care homes. Although the complaints only concerned a small proportion of the annual care provided, more attention should be paid to care practices that prevent neglect in residential care and to multi-level monitoring for dignified care.

KEYWORDS

complaints, document analysis, neglect, older people, quality of care, regulations, residential care, staffing levels

1 | BACKGROUND

The risk of older people's care needs being neglected in residential care settings is topical. Global demographic changes, combined with rising risks for multimorbidity, have increased the need for residential care for older people (Buzgova & Ivanova, 2011; Halonen et al., 2019; Mori et al., 2019). Older people are vulnerable in residential care, as they are very dependent on the staff who take care of them (Heath & Phair, 2009; Ronald et al., 2016; Tuominen et al., 2016) and they are often unable to stand up for their rights. In addition, the COVID-19 pandemic has resulted in neglected care, particularly among older people (Kuper & Shakespeare, 2021; Steptoe & Di Gessa, 2021). Neglect has also been highlighted over the last few decades increased (Friedman et al., 2019), as privatisation and service changes (Friedman et al., 2019; Puthenparambil, 2018; Puthenparambil et al., 2017; Winblad et al., 2017) have overintensified services, compromised organisational resources and challenged staffing levels (Winblad et al., 2017).

Neglect is an example of abuse in care settings (Heath & Phair, 2009; Hutchison & Kroese, 2015; Krug et al., 2002; World Health Organization (WHO), 2014). It can be defined as inaction, which results from the refusal, or failure, to fulfil the obligations that meet care needs (Dixon et al., 2013; Woollard & Howard-Snyder, 2016). The concept of neglect is both close to, and partially overlaps, the concepts of abuse and violation (Buzgova & Ivanova, 2011; Fearing et al., 2017; World Health Organization (WHO), 2014). They have also found to emerge simultaneously in care (Hutchison & Kroese, 2015; Myhre et al., 2020; Schiamberg et al., 2011). Neglect has been further defined as intentional or unintentional acts. It also includes neglecting care, which refers to patients believing that staff do not care, because of the way they behave towards them (Reader & Gillespie, 2013).

Neglect in older people's care has been described as abandoning older people and denying them basic care, such as movement, nutrition or hygiene. Other examples include neglecting clinical care, such as not monitoring symptoms, not providing the proper medication or health services older people need (Lachs & Pillemer, 1995; Schiamberg et al., 2011). In addition, neglect has focused on failing to provide older people with the help or services they need to function at an optimal level or avoid harm (Dixon et al., 2009; 2013; Lindbloom et al., 2007). Neglecting communication has also been highlighted (Fearing et al., 2010). Neglecting care has been shown to lead to inappropriate and substandard clinical practice (Malmedal et al., 2014), which has caused physical and psychological symptoms in older adults, together with premature mortality and increased healthcare needs (Yunus et al., 2019).

Complaints at a national level have been found to be one of the mechanisms for identifying quality of care and responding to allegations of neglect in older people's care in residential care settings (Bloemen et al., 2015). Previous studies have focused on complaints referred to ombudsmen and most of these have related to verbal and psychological abuse by staff (Bloemen et al., 2015; Magruder et al., 2019; Phillips & Guo, 2011), together with physical (Bloemen et al., 2015; Phillips & Guo, 2011), sexual and financial exploitation. Intentional gross neglect by staff, and physical and sexual abuse of residents by residents, have also been reported (Bloemen et al., 2015). National reviews of complaints about older people's care in residential care settings have focused on physical abuse by non-residents. One study of 11,749 residents reported that 28% of them reported abuse of this kind (Bloemen et al., 2015). Another study of 324 residents reported that 28% had been verbally or psychologically abused by non-residents (Magruder et al., 2019).

What is known about the topic?

- Older people living in residential care homes have the right to be treated with dignity.
- Neglect of older people's care needs have been reported in residential care settings.
- Official monitoring is crucial to ensure that individuals receive proper, dignified care.

What this paper adds?

- Most of the complaints about older people's care in residential settings focused on neglect in clinical care: lack of clinical care was reported in three-quarters of the complaints and inadequate monitoring was reported in more than half.
- Staffing issues were included in nearly three-quarters of the complaints.
- More than a third of the complainants in this study had previously made a legally-based complaint about the same issue.

Previous studies have often focused on the prevalence of abuse of older people in residential care settings (Yon et al., 2018), but there is still insufficient information about neglect in relation to the care provided in such settings. However, older people have the right to be treated with dignity and should be granted access to sufficient care to meet their needs, maintain their optimum well-being (Active Citizen Network, 2002; Jacobs, 2015; United Nations, 1948) and avoid neglect or abuse (ENNHRI, 2017; European Charter of Rights and Responsibilities of Older People in Need of Long-Term Care and Assistance, 2010; United Nations, 1991).

This study focused on complaints about older people's care in residential care settings in Finland. These were based on cases handled by regional authorities that supervised the care received by older people in residential care settings. The aim of the study was to produce a deeper understanding of the characteristics and content of the complaints that were received. This knowledge is needed to direct multi-level monitoring, to prevent neglect and to ensure, and maintain, older people's basic rights in residential care setting. Our research questions were:

1. What were the characteristics and content of the complaints that were made about neglect in older people's care in residential care settings?

2. How were the characteristics and content of complaints associated with the demographic factors of the residents whose care needs had allegedly been neglected?

2 | METHODS

2.1 | Study design

We carried out a retrospective document analysis (Bowen, 2009; Rasmussen et al., 2012) of complaints made to the Finnish regional supervisory authorities in 2018–2019 about neglect in older people's care in residential care settings.

2.2 | The research setting

At the end of 2019, there were 523,700 people over 75 years of age living in Finland and approximately 91,820 (18%) of them received older people's services of some kind. Approximately 46,500 (8.5%) were living in residential care, which equated to 17.9 million care days per year. (Finnish Institute for Health & Welfare, 2020.) The organisation and quality of residential care is regulated in Finland (Ministry of Social Affairs & Health, 2020) and older people can live in sheltered housing with 24-hr assistance, elderly care homes and long-term institutional care in healthcare centres (Act 1301/2014; Act 980/2012). All service providers have to register with the National Supervisory Authority for Welfare and Health to operate (Act 922/2011). Municipalities are responsible for providing services or procuring them from private service providers. In 2019, the private care sector provided 52% of care facilities (Finnish Institute for Health & Welfare, 2020). In Finland, older people have the right to have equal access to residential care and receive quality care and services from those facilities (Act 980/2012). Nationally, cases relating to older people's residential care have registered since 2010 and in 2013 the supervisory authority issued 216 decisions (Aejmelaeus et al., 2014). In January 2019, the Finnish National Supervisory Authority withdrew the license of one residential care organisation for older people, because they were negligent with regard to the care provided for their residents. That decision triggered a wide-ranging public discussion on the quality of older people's care in Finland. In addition, complaints to all authorities that supervise health and social care for older people rose to 1,056 in 2019 (Valvira, 2020).

According to Finnish legislation (Act 785/1992), anybody who is not satisfied with the care or treatment they have received, or become aware of, is entitled to make a written complaint to the regional or national authorities responsible for healthcare supervision. This includes friends or families advocating on behalf of vulnerable individuals. At the regional level, complaints are sent to one of the six Regional State Administrative Agencies, which are supervisory authority offices. More serious complaints are handled by the National Supervisory Authority for Welfare and Health, including those that result in serious disability or even death. Other authorities, such as the Parliamentary Ombudsman Chancellor of Justice, occasionally deal with complaints about the care system. The supervisory authority considers if the evidence demonstrates incorrect procedures or neglect in patient care that demand supervisory measures (Act 559/1994; Parliament of Ombudsman of Finland, 2020).

2.3 | Data collection

The data for the study consisted of complaints about neglect in older people's care in residential care settings that were sent to the six Finnish Regional State Administrative Agencies in 2018 and 2019. Since this was the first study of this type in Finland, we collected data from a 2-year period to gain a deeper understanding of the content of complaints and to create the basis for later research. During these two years, the regional agencies received almost 6,000 complaints regarding the health and social care provided for citizens of all ages and these were registered and stored in an electronic database by one of the regional offices, on behalf of all six offices. The data were selected in three phases. First, the officials at the regional office that collated the data carried out an electronic pre-search of their database, using older people and residential care as the search terms, and this resulted in 430 complaints. Second, the researchers (TM, OP) selected complaints based on the predefined inclusion criteria (Figure 1), which resulted in 321 complaints. Finally, four complaints were excluded because they were duplicates and one was excluded because the data file was damaged. This meant that 317 complaints were included in our review (Figure 1).

The data were selected in February 2020 after we received permission from the Finnish Ministry of Social Affairs and Health. Due to the classified nature of the documents, the data retrieval was conducted at the office of The Regional State Administrative Agency of South Finland, which coordinates the national database. The main complaint documents submitted to the authorities were produced electronically or provided in written form and they varied from one to 10 pages. Some of the complaints also contained photographs, videos, text messages, documents that used other digital applications and other patient-related documents. However, this study just collected data from the main complaint document.

We collected the data and placed it in an observation matrix. First, we extracted the information on the characteristics of the complaints: the focus of the complaint, details of the resident and the action that the complainant expected to be taken. Then, we extracted all the descriptions relating to neglect, as well as other kinds of misconduct, including abuse or violence in older people's care. These were based on previously published definitions (Dixon et al., 2013; Fearing et al., 2010; Reader & Gillespie, 2013; World Health Organization (WHO), 2014). Each specific description of neglect was counted as one observation, regardless of how many times it was mentioned in the complaint document. We grouped all the descriptions based on their similarities and differences and created 13 subcategories. These were then reduced to four main categories that covered different types of neglect in residential care:

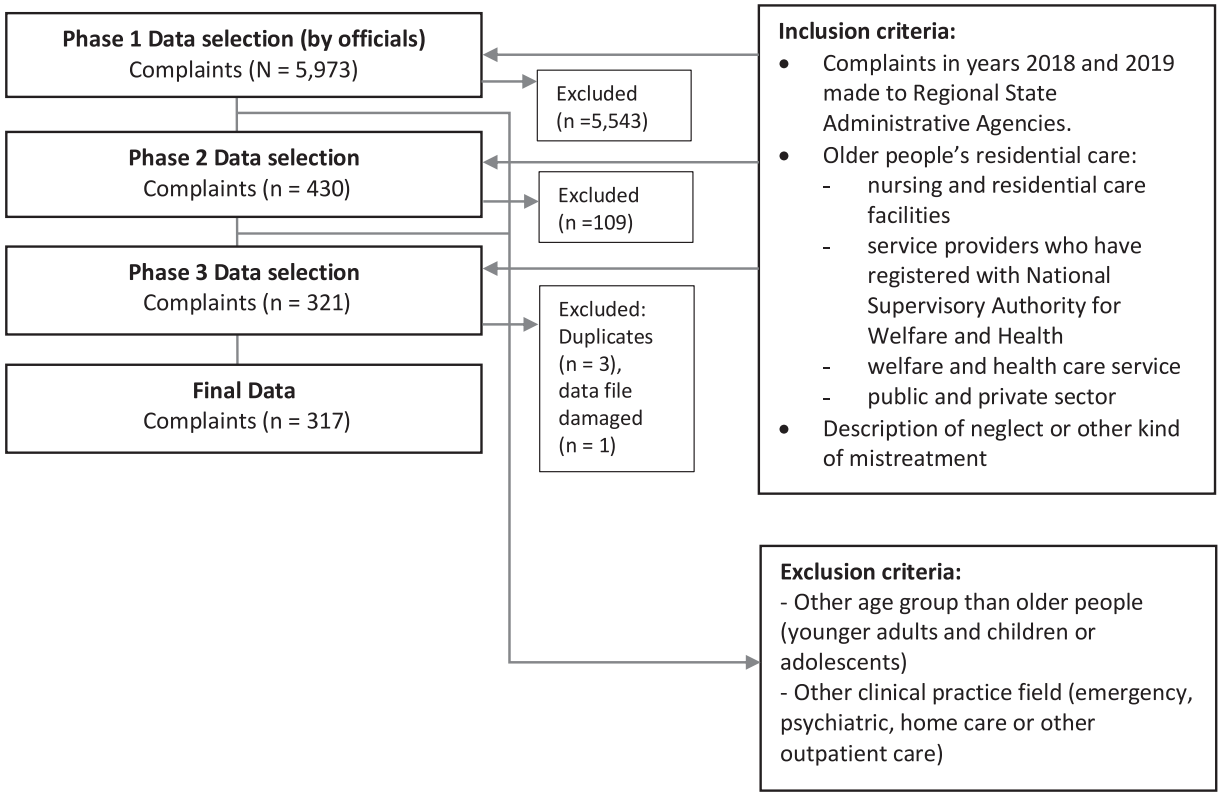

FIGURE 1 Flow chart of the data selection

basic nursing care, clinical care, which included safety, communication and staffing issues. We tested the structure and content of the observation matrix using the first 50 complaints, carried out some minor changes and then applied those to the entire data. Two researchers (TM, OP) reviewed all the complaints and extracted the data, according to the observation matrix. Then the researchers circulated the documents and double-checked that the extracted data were understandable and covered the relevant points.

After that, the first part of matrix, was divided into eight variables that included the type of organisation that provided the care, who made the complaint and the age of the resident. The second part of the observation matrix, which covered neglect in basic nursing care, clinical care, including safety, communication and staffing issues, was then divided into 13 main categories, with 22 variables.

2.4 | Statistical analysis

We used descriptive statistics. Categorical variables were expressed as numbers and percentages and continuous variables as means and ranges. The analysis was carried out with SPSS Statistics, version 25.0 (IBM Corp.). We expressed the results according to the number of complaints ($N = 317$), the total number of observations in the complaints ($N = 2,922$) and how old the resident was in the year that the complaint was made, based on the year they were born. We explored the statistical association between the neglect category, namely basic nursing care, clinical care, including safety, communication and staffing issues, and the service sector and the residents' age, gender and status. Statistically significant associations were examined with Pearson's correlation coefficients and defined as $p < .01$.

2.5 | Ethical considerations

The Finnish Ministry of Social Affairs and Health granted permission for the study in December 2019 (VN/12399/2019). Informed consent was not required from the residents or complainants because the Ministry is responsible for, and owns, the data we used. As the data were classified, the researchers had to sign personal confidentiality agreements regarding the collection, handling, saving and reporting of the data. The data were collected at the regional office that coordinated the database. The complaints were pseudonymised during the data collection and no information that identified the residents was allowed. Three of the authors (TM, OP, MK) were responsible for the data collection and two double-checked all the observation matrixes.

3 | RESULTS

3.1 | Characteristics of the complaints and residents

Just over two-thirds of the 317 complaints were made in 2019 (70%) and the rest were made in 2018. Most concerned private

healthcare (63%) and were made by family members (91%). The subject of the complaint was usually the actual resident (96%) and most were female (68%) and still alive (74%) when the complaint was made. The residents' ages were mentioned in 70% of the complaints, with a mean age of 85.2 years (range 56 to 102). We noted that 37% of the complaints stated that they had also made a previous, legally-based claim about the same issue. In addition, 36% mentioned that they had made an earlier complaint to the residential care home about the same issue and 27% reported that the case was still being officially investigated by that organisation (Table 1).

The vast majority of the complainants (98%) specified one of more expectations about what action they expected from the supervisory authority. Most of these focused on care practices at the residential care unit (45%) and the future care of the resident who was named in the complaint (39%). They also related to older people's care in general (12%) (Table 2).

3.2 | Content of neglect in residential care

The 317 complaints contained 2,922 observations of alleged neglect in older people's care in residential care settings. More than two-thirds focused on basic nursing care (37%) and clinical care, including safety (32%). The remainder covered communication (15%) and staffing related issues (15%), including allegations of inadequate staff resources and professional misbehaviour (Table 2).

3.3 | Neglect in basic nursing care

Neglect in basic nursing care was mentioned in 72% of the 317 complaints. They accounted for 37% of the 2,922 observations and included: neglect of older people's movements and activities (13%), hygiene and secretion issues (12%), nutrition and hydration (10%) and living environment (2%) (Table 2).

3.3.1 | Movement and activity

Neglecting the care that residents received, by restricting their movements or not providing them with activities, was reported in 53% of the complaints. The most frequent complaint was insufficient activity (32%), because the residents never, or seldom, had the chance to go outdoors or participate in organised activities. In addition, older people were not allowed to rest or be by themselves when they wanted to be or they were disturbed by other residents. Some residents had no opportunities to use their own phones, see family members or spend time with others. A quarter of the complaints (25%) included restricted movements, such as being placed in a bed or a chair with edges or restraints so that they could not move freely. It also included having their bedroom doors closed so that they could not request assistance or move about in the facility. Some lacked the help they needed to move or take care of themselves. As a result, they were moved against their will, including situations when they told staff it was painful, or forced to use hygiene products, rather than being taken to the toilet. Insufficient position care was documented in 21% of the complaints and this included being left in bed during the day and not being transferred to a chair or wheelchair.

3.3.2 | Hygiene and secretions

Neglect in relation to hygiene and secretions was reported in 42% of the total complaints. For example, 25% of older people did not receive the help they needed to visit the toilet and problems with constipation and urinary catheters were neglected. In addition, staff used diapers inappropriately or took too long to change them and neglected residents' hygiene by not washing them. A quarter of the complaints (25%) said that staff did not help residents to take care of their own hygiene. Just over a fifth of the complaints (21%) talked about dirty or damaged clothes or bedsheets, residents not receiving daily help to dress or being made to wear clothes that were not appropriate for the time of day. In addition, there were some complaints that residents could not wear their own clothes or that staff used their clothes for other residents.

3.3.3 | Nutrition and hydration

Neglected nutrition and hydration were reported in 41% of the total complaints. Just under a third of the complaints (30%) were about insufficient monitoring of nutrition and hydration, irregular mealtimes and mealtimes that lasted too long. Complaints also stated that staff fed residents too fast or left them without food or drinks. A fifth (20%) of the complaints related to the kind of food that residents were given. For example, residents were given the wrong type of food, including food that they were allergic to or ordinary food when they needed pureed food. Complaints also mentioned that the food was not nutritious, the portions were too small, the food was monotonous, damaged, of low quality or served cold. Indications of malnutrition, such as weight loss and dehydration, were documented in 15% of the complaints.

3.3.4 | Living environment

Almost a fifth of the basic nursing care complaints (19%) reported neglect relating to the living environment, such as bad air quality, dirty rooms, inadequate lighting and unnecessary equipment in the patients' rooms.

TABLE 1 Demographic data and characteristics of the 317 complaints and the residents and care providers that the complaints related to

Components and variables	Year of complaint 2018 (*n* = 96)	2019 (*n* = 221)	*n* 317	% 100
Focus of complaints				
Sector (*n* = 315)				
Private	56	143	199	63.2
Public	38	78	116	36.8
Complainant (*n* = 312)				
One relative	88	195	283	90.7
Close friend	2	7	9	2.9
Group of relatives	1	6	7	2.2
Professionals	1	5	6	1.9
Guardian	1	3	3	1.0
Resident	1	0	1	0.3
Other	0	3	3	1.0
Neglect related to (*n* = 317)				
One resident	94	210	304	95.9
Group of residents	1	6	7	2.2
Unit in general	1	5	6	1.9
Previous complaints about case (*n* = 129)				
Earlier legal claim	18	30	48	37.2
Earlier complaint to	15	31	46	35.7
Other official complaint	13	22	35	27.1
Characteristics of residents				
Age (*n* = 223)				
56–79 years	18	34	52	23.3
80–89 years	28	68	96	43.1
90–102 years	24	51	75	33.6
Gender (*n* = 301)				
Female	56	150	206	68.4
Male	37	58	95	31.6
Alive or dead (*n* = 303)				
Alive	73	150	223	73.6
Dead	21	59	80	26.4
Expected to see action relating to				
Unit	42	102	144	45.4
Resident	39	85	124	39.1
Older people's care	10	28	38	12.0
Other concerns	2	4	6	1.9

3.4 | Neglect of clinical care, including safety

Neglect relating to clinical care, including safety, was mentioned by 85% of the total complaints and 32% of the total observations. Of these 922 observations, 19% were about neglect in clinical care and 12% were about patient monitoring (Table 2).

3.4.1 | Clinical care

Neglect of clinical care included staff responding insufficiently to care needs or not responding at all. This was reported in 69% of the total complaints and almost half of these complaints (48%) focused on staff neglecting to observe symptoms and to respond to older

TABLE 2 Observations of neglect in older people's residential care, according to the complaints studied

Components categories and variables	Complaints N = 317		Observations N = 2,922		Observations per complaint	
	n	%	n	%	Mean	Range
Neglecting basic nursing care	**229**	**72.2**	**1,078**	**36.9**	**3.40**	**0–20**
Movement and activity	166	52.5	367	12.6	1.16	0–7
Activity	*102*	*32.2*	*180*	*6.2*	*0.57*	*0–4*
Restrictions	*79*	*24.9*	*103*	*3.5*	*0.32*	*0–3*
Position care	*66*	*20.8*	*84*	*2.9*	*0.26*	*0–3*
Hygiene and secretion	132	41.6	344	11.8	1.09	0–8
Secretions	*80*	*25.2*	*108*	*3.7*	*0.34*	*0–3*
Washing	*79*	*24.9*	*120*	*4.1*	*0.38*	*0–4*
Dressing	*67*	*21.1*	*116*	*4.0*	*0.37*	*0–4*
Nutrition and hydration	130	41.0	297	10.2	0.94	0–6
Help with nutrition	*96*	*30.3*	*151*	*5.2*	*0.48*	*0–5*
Form of nutrition	*63*	*19.9*	*94*	*3.2*	*0.30*	*0–4*
Malnutrition	*46*	*14.5*	*52*	*1.8*	*0.16*	*0–2*
Living environment	61	19.2	70	2.4	0.22	0–2
Neglecting clinical care and safety	**270**	**85.2**	**922**	**31.5**	**2.88**	**0–11**
Clinical care	219	69.1	561	19.2	1.74	0–8
Symptoms	*153*	*48.3*	*321*	*11.0*	*1.01*	*0–4*
Medication	*138*	*43.5*	*179*	*6.1*	*0.56*	*0–4*
Care products	*52*	*16.4*	*61*	*2.1*	*0.19*	*0–3*
Monitoring	185	58.4	361	12.4	1.14	0–6
Lack of monitoring	*123*	*38.8*	*123*	*4.2*	*0.39*	*0–1*
Falling	*88*	*27.8*	*97*	*3.3*	*0.31*	*0–2*
Requests for help	*53*	*16.7*	*67*	*2.3*	*0.21*	*0–3*
Locking doors	*32*	*10.1*	*32*	*1.1*	*0.10*	*0–1*
Unclear hurts	*27*	*8.5*	*27*	*0.9*	*0.09*	*0–1*
Physical privacy	*15*	*4.7*	*15*	*0.5*	*0.05*	*0–1*
Neglecting communication	**212**	**66.9**	**479**	**14.8**	**1.4**	**0–6**
Informed decision	192	60.6	360	12.3	1.14	0–5
Insufficient information	*146*	*46.1*	*199*	*6.8*	*0.63*	*0–4*
Decision-making	*117*	*36.9*	*161*	*5.5*	*0.51*	*0–3*
Service contract	73	23.0	119	4.1	0.29	0–3
Neglect of property	*23*	*7.3*	*55*	*1.9*	*0.1*	*0–3*
Neglect of contract	*57*	*18.0*	*64*	*2.2*	*0.2*	*0–3*
Staff-related issues	**225**	**71.0**	**443**	**14.8**	**1.40**	**0–6**
Lack of staff	128	40.4	128	4.4	0.4	0–1
Unprofessional behaviour	112	35.3	184	5.7	0.58	0–5
Lack of competencies	83	26.2	83	2.8	0.26	0–1
Insufficient management	39	12.3	39	1.3	0.12	0–1
Lack of language skills	9	2.8	9	0.3	0.03	0–1

people's care needs. This resulted in delayed access to treatment and insufficient patient documentation. There were complaints that older people did not receive adequate daily care and that documented orders or instructions concerning palliative care were not carried out. Neglecting residents' medication was also reported in almost half of the neglect of clinical care complaints (44%), namely medication errors in daily medicines, wrong doses and insufficient painkillers. In addition, staff did not monitor older people when they

took medication or follow the correct procedures when they disposed of medication.

We also found that 16% of the clinical care complaints related to neglecting to provide care products. For example, staff did not use rehabilitation equipment or make sure that residents had their glasses or hearing aids.

3.4.2 | Monitoring

Just over half of the patient safety complaints (58%) related to lack of surveillance. The most frequent complaint was leaving residents alone (39%), followed by complaints about insufficient safety measures (28%), which resulted in residents falling from their bed or chair or leaving the unit. These were followed by staff not responding to safety alarms (17%), not locking doors (10%), unclear or inexplicable injuries (9%) and violations of physical privacy by other residents (5%).

3.5 | Neglect related to communication issues

Neglecting communication-related issues was mentioned in 67% of the total complaints and in 15% of the total observations that were related to informed decisions and service contracts (Table 2).

3.5.1 | Informed decisions

Neglecting communication with regard to informed decisions was reported in 61% of the total complaints. Almost half of those complaints (46%) related to sharing insufficient information with family members and/or the resident. Staff had not informed family members about residents' health or they had provided incorrect information. In addition, staff failed to respect residents' privacy by talking about them in front of other residents or their families. Neglect in relation to decision-making was reported in 40% of the complaints about informed decisions and these were mostly about the fact that residents and their next of kin were not involved in decision-making or care planning. In addition, some complaints stated that decisions could have been made against residents' wishes. Staff also neglected to compile, or update, residents' individual statutory care plans.

3.5.2 | Service contracts

Neglect of service contracts was reported in 23% of the total complaints. Ambiguities regarding residents' property was mentioned in 7% of the service contract complaints and these related to missing or damaged personal belongings, incorrect or excessive billing and inappropriate use of the residents' money. In just under a fifth of cases (19%), the service contract between the care organisation and the resident was not followed. Some complaints stated that the family members were wrongly expected to be responsible for the basic care of residents, instead of staff.

3.6 | Neglecting staffing-related issues

Neglect with regard to staffing-related issues was reported in 71% of the total complaints and these accounted for 15% of the total observations (Table 2). The most frequent issues in these 443 observations were allegations of inadequate staff resources (40%) and professional misbehaviour (35%), with staff failing to behave politely and professionally towards residents or their family members. This included inappropriate conversations, swearing, yelling and patronising behaviour towards the resident or family members. Not treating residents gently was reported by some complainants and one complaint concerned an unprofessional relationship between a staff member and a resident. In addition, lack of staff competencies (26%), insufficient management (12%) and insufficient staff language skills (3%) were reported.

3.7 | Associations between demographic factors and the content of complaints

When we reviewed the associations between neglected movement and activity by care sector we found that these were more common in the private sector ($p = .007$). Neglecting symptoms ($p = .001$) and medication ($p = .005$) were more likely to be reported when the resident was still alive. Complaints after residents' deaths were more likely ($p = .001$) to be about wanting to see changes in all older people's care (Table 3).

4 | DISCUSSION

This study provides new knowledge on the content of complaints about how the care of older people was neglected by residential care homes. Although the complaints only related to a small proportion of the care provided each year, they offer valuable information that can inform the development of high-quality older people's residential care (Spasova et al., 2018). This study shows that the complaints about neglected care often related to older people's movement being restricted, lack of activities and how hygiene and secretions were managed. Lack of clinical care was reported in three-quarters of the complaints and inadequate monitoring in more than half. It is worth noting that some forms of neglect, such as restricting movement, can also be defined as physical violence. It is also important to point out that staffing issues were mentioned in three-quarters of the complaints. Most complaints were made by family members about the clinical care of residents who were still alive, but they also hoped that this would result in changes that benefitted all patients.

The finding that the complaints mainly focused on neglecting older people's basic care needs is crucial. Neglecting daily nutrition,

TABLE 3 Associations between the content of complaints about the care of older people and the background data of the care provider and the client

	Complaints	Sector			Alive		
	N = 317	Public (*n* = 116)	Private (*n* = 199)	*p*-value	Alive (*n* = 223)	Not alive (*n* = 80)	
Variables	% (*n*)	% (*n*)	% (*n*)		% (*n*)	% (*n*)	*p*-value
Symptoms	48.3 (153)	46.6 (54)	48.7 (97)	0.707	39.0 (87)	76.3 (61)	<0.001*
Information	46.1 (146)	44.8 (52)	46.2 (92)	0.809	44.4 (99)	56.3 (45)	0.069
Medication	43.5 (138)	39.7 (46)	45.2 (90)	0.336	39.5 (88)	57.5 (46)	0.005*
Making decisions	39.7 (126)	44.8 (52)	36.2 (72)	0.130	39.9 (89)	38.8 (31)	0.856
Lack of monitoring	38.8 (123)	32.8 (38)	41.7 (83)	0.115	39.0 (87)	36.3 (29)	0.663
Movement/activity	32.2 (102)	22.4 (26)	37.2 (74)	0.007*	35.4 (79)	23.8 (19)	0.055
Help with nutrition	30.3 (96)	21.6 (25)	34.7 (69)	0.014	28.3 (63)	36.3 (29)	0.182
Secretions	25.2 (80)	24.1 (28)	25.6 (51)	0.769	26.9 (60)	20.0 (16)	0.222
Restrictions	24.9 (79)	28.4 (33)	22.6 (45)	0.247	24.7 (55)	27.5 (22)	0.617
Washing	24.9 (79)	17.2 (29)	26.1 (52)	0.070	24.2 (54)	17.5 (14)	0.217
Dressing	21.1 (67)	16.4 (19)	23.6 (47)	0.168	21.1 (47)	22.5 (18)	0.790
Position care	20.8 (66)	18.1 (21)	21.6 (43)	0.456	19.3 (43)	22.5 (18)	0.538
Expectations for action taken							
Unit	45.4 (144)	43.1 (50)	47.2 (94)	0.478	43.9 (98)	47.5 (38)	0.584
Resident	39.1 (124)	43.1 (50)	36.7 (73)	0.260	47.1 (105)	22.5 (18)	<0.001*
Elderly care	12.0 (38)	14.7 (17)	10.6 (21)	0.281	7.6 (17)	23.8 (19)	<0.001*

*statistically significant.

activities (Saarela et al., 2017), observing symptoms and medication (Aitken et al., 2020; Halonen et al., 2019; Resnick et al., 2018) have been reported to endanger older people's rights to have their comprehensive care needs met (World Health Organization (WHO), 2017). It is noteworthy that nurses have reported to have limited awareness (Myhre et al., 2020) and competencies to identify different forms of neglect in older people's care in residential settings (Bloemen et al., 2015; McCool et al., 2009; Myhre et al., 2020; Reader & Gillespie, 2013; Winterstein, 2012). However, individual nurses are responsible for their own work (Kangasniemi et al., 2015) and it should be noted that unintentional neglect does not necessarily diminish that responsibility (Woollard & Howard-Snyder, 2016), but they need to have both personal and organisational resources to carry out care tasks and meet their moral responsibilities (Kearns, 2020). Because older people who live in residential care settings are in a vulnerable position, staff should have comprehensive competencies to evaluate and anticipate their care needs. However, it is need to be aware that some organisations caring for older people may decrease staff costs by accepting nurses with lower degree levels.

Previous studies noted that neglect often occurred in residential care due to a mismatch between older people's care needs and the organisational resources that were available. These mismatches could also be down to organisational factors that meant nurses had high workloads and risked burnout (Fearing et al., 2010; Reader & Gillespie, 2013) or exposed them to unethical working cultures (Fearing et al., 2010; Hutchison & Kroese, 2015). Our study showed that organisational problems were reflected by problems related to nutrition. For example, mealtimes were poorly organised or the need for proper food or diets were ignored. In addition, complaints about unclear protocols on observing symptoms, and on medication care and documentation, pointed to questions about insufficient organisational structures and support for care. This suggests that neglect in care should be examined a part of the activities of the entire organisation. Nurse managers need competencies to prevent, notice and solve cases of neglect (Myhre et al., 2020). In addition, service providers are responsible for self-monitoring (Kotkas, 2016) and monitoring strategies are needed at an organisational level to prevent (Bloemen et al., 2015; Moore & Browne, 2017) and detect neglect in care at an early stage and develop solid complaint handling by the organisation.

In this study, most of the complaints were made by family members (91%), but previous studies have reported that an average of 38% were made by residents, followed by relatives or friends (20%, Bloemen et al., 2015). Previous studies have also reported that relatives made complaints because residents were afraid that complaining would worsen their situation (Bollig et al., 2016) or not have any effect (Tuominen et al., 2016). The high percentage of complaints made by family members in our study could have been due to the ill-health or incapacity of residents. However, residents should be made aware of their right to complain (Bloemen et al., 2015), not least because some residents do not have families who can raise

issues for them. There is a serious need for research on complaints practices for older people in residential care, including those who are cognitively impaired and those who do not have families or whose families are not involved in their lives.

More than a third of the complainants in our study had previously made a legally-based complaint on the same issue. This highlight the crucial role that complaints play in monitoring older people's care, but also raises questions about how effective the quality monitoring system is (Gil, 2019). At a European level, most countries do not systematically collect residents' complaints as a source of information on quality measures (OECD/European Commission, 2013; Spasova et al., 2018). However, it has been shown that residents' complaints were an important mechanism for identifying and responding to abuse when care was neglected in older people's residential care. That information can be used to develop effective education, supervision and complaint handling (Bloemen et al., 2015; Gil, 2019) and to detect neglect in older people's care at an early stage and address it.

4.1 | Strengths and limitations

One strength of our study was that our analysis was based on complaints made to the Finnish supervisory authorities over a two-year period. We systematically collected data using a structured observation matrix and pilot-tested it with 16% of the documents to identify any improvements that were needed. The limitations of this study were related to the observation sheet and data (Bowen, 2009). We used an inductive observation sheet to collect the data because the complaints were not provided in a structured format and there were variations in the expressions and terminology used by the individual complainants (Murray & Sixsmith, 2002). Thus, background information on the older people or care facilities were not systematically collected and analysed. In addition, the complaints covered a short period of time (2018–2019) and their aim was to express dissatisfaction with the care that older people received, not produce data for research purposes (Bowen, 2009). This mean that the details that were provided varied and that conceptualisation of the phenomenon was not possible during the analysis phase. Three researchers were involved in the data collection and double check of data, in order to decrease the interpretation bias of the heterogeneous data (Bowen, 2009).

5 | CONCLUSION

Our analysis of national data explored complaints about how older people's care was allegedly neglected in residential care and how this posed serious risks to their basic care needs, dignity and safety. Complaints are one way of identifying the quality of services that older people receive and they provide crucial knowledge that can improve our understanding of how care can be neglected in these settings. In addition, the knowledge that is provided can be used to develop strategies that ensure that older people's basic rights are respected when they are in residential care. Most of the complaints were made by the older person's next of kin, or other family members, which raises concerns about what happens when residents do not have families who can speak on their behalf. That is why it is vital that residents feel able to voice their own concerns easily and without fear of any negative repercussions. In future, more knowledge is needed on how organisations use information from complaints and how they respond to complaints, in order to prevent neglect in older people's care. Comparative research on complaint strategies in Europe would provide a wider understanding of best practice and ensure that the rights of older people were protected in residential care.

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CONFLICT OF INTEREST

None.

AUTHOR'S CONTRIBUTION

Mari Kangasniemi: Conceptualisation, design, aquistion of data and analysis, interpretation of data, drafting the manuscript, critical revision of the manuscript, final approval. Oili Papinaho, Tanja Moilanen: Conceptualisation, aquistion of data and analysis, interpretation of data, drafting the manuscript, critical revision of the manuscript, final approval, agreeing accuracy and integrity of the work. Helena Leino-Kilpi, Helena Siipi, Sakari Suominen: Conceptualisation, interpretation of data, critical revision of the manuscript, final approval, agreeing accuracy and integrity of the work. Riitta Suhonen: Conceptualisation, design, interpretation of data, drafting of the manuscript, critical revision of the manuscript, final approval, agreeing accuracy and integrity of the work.

DATA AVAILABILITY STATEMENT

Author elects to not share data.

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