Because of their significant dependence on others for their care, nursing home residents are potentially vulnerable to abuse and/or neglect. The topic of elder mistreatment, whether in the nursing home or other living environments, received little attention from clinicians and researchers until the past 2 decades. Original research is now emerging that sheds light on the scope of the problem and the challenges to timely prevention, identification, and management. Practitioners may use this information to recognize and change factors associated with a higher likelihood of nursing home mistreatment. (J Am Med Dir Assoc 2007; 8: 610–616)

Keywords: Elder mistreatment; elder abuse; neglect; nursing homes

Although estimates of the prevalence and incidence of elder mistreatment vary widely, it is likely that at least 3% to 4% of Americans 65 years or older have suffered some form of mistreatment in their later years.1–4 Despite having a prevalence that is likely on par with that of child abuse, standardized definitions of elder mistreatment were not published until the early 1990s (see Table 1).5 Researchers have established the detrimental health effects of abuse and neglect, such as frequent emergency department visits and a threefold increase in mortality.6,7 However, much remains unknown in this area, as outlined in the recent report from the National Research Council, Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America.8

Even less is known about elder mistreatment specifically involving nursing home residents. This sizeable population is particularly vulnerable to abuse and neglect because most suffer from cognitive impairment, behavioral abnormalities, or physical limitations that have been reported as risk factors for abuse and neglect.1,2,9–16 Vulnerability in nursing homes is heightened because many residents are unable to report abuse or neglect, or they are fearful that reporting may lead to retaliation or otherwise negatively affect their lives.17,18 Staff surveys in nursing homes suggest that mistreatment is a significant concern. A 1987 survey of 577 nursing home staff members from 31 facilities found that more than one third (36%) had witnessed at least one incident of physical abuse during the preceding 12 months.19 Ten percent of the surveyed staff members reported they had committed such acts themselves. In addition, 81% of the staff reported that they had observed and 40% had committed at least one incident of psychological or verbal abuse during the same 12-month time period. A follow-up study reported similar findings.20

Regulatory and safety monitoring reports give us additional insight into the scope of the mistreatment problem in nursing homes. The Long-Term Care Ombudsman program reported that 10% of its complaints nationwide involve allegations of abuse, gross neglect, or exploitation, and 27% involve concerns about inadequate care.21 An analysis report of the federal Online Survey Certification and Reporting System (OSCAR) data system in 2001 by the Special Investigations Division of the House Committee on Government Reform asserts that abuse of residents “is a major problem in U.S. nursing homes.”22 The report concluded that during a 2-year period, nearly one third of all certified facilities had been cited for some type of abuse violation that had the potential to cause harm or had actually caused harm to a resident.

This review focuses on original research articles concerning elder mistreatment in the nursing home environment. Particular attention is paid to the types of mistreatment, risk factors and markers for mistreatment, and interventions aimed at reducing the incidence of mistreatment.
Another qualitative study differentiated between “reactive” and “sadistic” abusers, and discussed the concept of “immunity” to aggressive resident behavior. Twenty-one semi-structured interviews were conducted with nursing home staff and adult protective service workers who investigated mistreatment within nursing homes. The concept of “developing immunity” emerged from the analysis of interview data. The authors found that staff can (1) develop and sustain immunity, (2) develop but lose immunity, and (3) never develop immunity. The first group, who can develop and sustain immunity, typically have positive work experiences and have positive feelings about the work they do. A stable personal life also helps them to develop immunity. Those who lose or never develop immunity have trouble with professional and personal demands. Especially problematic for these people is dealing with the heavy workload associated with working in nursing homes. Job satisfaction and burnout were also associated with deliberate abusive behavior in another study. Inappropriate physical restraint and bed rail use may also be considered mistreatment. Several case series have explored the circumstances around accidental deaths due to physical restraint use and bed rails, occasionally involving an attempt to conceal the cause of death. Another report documented a decrease in physical restraint use after the Omnibus Budget Reconciliation Act of 1990, but continued bed rail use despite a lack of evidence for fall prevention. A study of specialized dementia units documented a significant decrease in physical restraint use without a corresponding increase in pharmacologic restraints.

### Sexual Abuse

Several case series document incidents of sexual abuse in nursing homes; often, these are incidents between residents, but staff members may also be perpetrators. In several of these cases the responsible staff member had a prior criminal record of rape or sexual abuse of residents at other facilities, and was hired without a background check thorough enough to discover the record. Arrests and convictions are rare. For instance, one study found that in only 6% of the cases was the perpetrator prosecuted and there was only one conviction. However, efforts are under way to develop a database of forensic markers of sexual abuse in older adults in order to...
improve detection and conviction rates. For instance, genital bruising may be sometimes misinterpreted as accidental. Victims often exhibited nonspecific symptoms associated with younger rape victims, such as fear, confusion, or a loss of appetite.

**Psychological Abuse**

Incidents and patterns of psychological abuse, including such actions as intimidation and isolation, are well documented in the literature, and are likely more prevalent than physical abuse. Aggressive residents (sometimes labeled by staff as “bad”) and a stressful work environment have been shown to be associated with a higher likelihood of psychological abuse. Work stress may be more closely related to psychological abuse than it is to physical abuse and Shaw found that, in general, workload stress can preclude a worker’s ability to sustain or even develop an immunity to aggressive behavior of residents. One article discussed the concept of “polite abuse,” including actions such as residents sleeping in their wheelchair rather than a bed, or always being taken last to an event or meal. These examples may be a result of understaffing, poor training, or overt acts.

**Neglect and Poor Care Quality**

Neglect in the nursing home may certainly overlap with concepts of psychological abuse (eg, social isolation) and disparities in quality of care. In many cases, particularly those involving pressure sores, malnutrition, and dehydration, care providers and researchers may have difficulty making a distinction between acts of neglect and examples of poor care quality. Using the consensus definition in Table 1 (physical neglect is the failure to provide the goods or services necessary for optimal functioning or to avoid harm), such a distinction is moot. This review will discuss pressure sores and nutrition/hydration issues separately below (see Table 3 as well).

**Pressure Sores**

Dramatic case reports and case series have been published focusing on pressure sores in the nursing home. New residents presenting to a nursing home often have preexisting pressure sores, but differing opinions exist about whether all new pressure sores should be considered evidence for neglect. Some authors argue that pressure sores are very difficult to avoid in certain circumstances, while others consider them clear indicators of poor care quality and/or neglect. This disagreement is discussed in detail in several original studies and a prior Journal of the American Medical Directors Association review, and outlined in Table 4. That being said, the degree of variation in incidence rates between institutions, as well as the ability to significantly alter pressure sore incidence with systematic care changes, suggest that facility and staff factors play a major role in the development of pressure sores. Individual resident risk factors also clearly exist, such as impaired mobility and dependence on others for activities of daily living; increased attention to skin care in these residents may lower the incidence of pressure sores (see Table 5).

**Nutrition/Hydration Issues**

Malnutrition and dehydration are common in nursing homes. Dysphagia is also a common occurrence and may

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**Table 3. Underlying Problems and Associated Outcomes of Neglect in Nursing Homes**

<table>
<thead>
<tr>
<th>Problems</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Institutional level</em></td>
<td></td>
</tr>
<tr>
<td>• Inadequate staffing levels</td>
<td>• Malnutrition</td>
</tr>
<tr>
<td>• Lack of supervision</td>
<td>• Pressure sores</td>
</tr>
<tr>
<td>• Lack of food preference (not ethnically sensitive)</td>
<td>• Dehydration</td>
</tr>
<tr>
<td>• Switch to liquid diet without adequate assistance with solid food</td>
<td>• Higher mortality rates</td>
</tr>
<tr>
<td><em>Individual level</em></td>
<td></td>
</tr>
<tr>
<td>• Low dietary intake</td>
<td></td>
</tr>
<tr>
<td>• Dysphagia and poor oral health</td>
<td></td>
</tr>
</tbody>
</table>

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**Table 4. Differing Opinions on Pressure Sores and Their Association with Poor Care**

- A majority of wound care experts (62%) believe that pressure ulcers will develop in high-risk patients.
- Despite pressure ulcer prevalence, associated morbidity, and the use of pressure ulcers as a formal nursing home quality indicator, there remains a lack of consensus on whether these wounds directly relate to negligent care.
- If a pressure ulcer is not preventable, it should not be considered a quality indicator (QI) and should only be considered a QI if an individual is a low- or no-risk patient.
- Nearly all pressure sores can either be prevented or effectively treated. Given this, the presence of a pressure sore indicates a nursing injury.
- Pressure sores are largely preventable and advanced pressure ulcers indicate poor care.

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**Table 5. Risk Factors and Prevention Strategies for Pressure Sores**

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Prevention Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>Better skin care provision</td>
</tr>
<tr>
<td>Non-whites</td>
<td>More favorable staffing patterns</td>
</tr>
<tr>
<td>Presence of preexisting higher stage pressure ulcers</td>
<td>High expenditures for clinical care</td>
</tr>
<tr>
<td>Mobility impairments</td>
<td>ADLs, activities of daily living.</td>
</tr>
<tr>
<td>Inability to perform ADLS</td>
<td></td>
</tr>
<tr>
<td>Impaired biological function</td>
<td></td>
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<tr>
<td>Decreased consciousness</td>
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<tr>
<td>Malnutrition</td>
<td></td>
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<tr>
<td>Fecal incontinence</td>
<td></td>
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<tr>
<td>Diabetes mellitus</td>
<td></td>
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<tr>
<td>Feeding difficulties</td>
<td></td>
</tr>
</tbody>
</table>

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Table 6. Sample Interventions Aimed at Reducing Nursing Home Mistreatment

- CARIE (Coalition of Advocates for the Rights of the Infirm Elderly): An 8-hour training session with 8 separate modules. Training involved open discussion and role-playing regarding elder mistreatment in nursing homes. Most of the participants (93%) found the session helpful and most (93%) felt comfortable openly discussing resident abuse issues.20
- SANE (Sexual Assault Nurse Examiners): Nurses are trained to assess and care for elderly victims of sexual assault. This training includes collecting forensic evidence and coordinating all the professionals involved (e.g., attorneys, law enforcement, social workers) in order to improve the prosecution and subsequent conviction of these types of cases.39
- British randomized controlled trial: Nursing home employees who attended a seminar learned more about managing elder abuse than employees who read written material. Additionally, trained staff demonstrated a more positive attitude toward the elderly than untrained staff. The amount learned was inversely proportional to the individual’s initial knowledge base, leading to the conclusion that training should be individualized based on new employees’ knowledge and skill levels.74

be underappreciated by nursing home staff.55 Residents with lower calorie intake have a higher mortality rate, even adjusting for comorbid conditions.34,36 The withholding of nutrition or hydration, particularly at the time of consideration of feeding tube placement, may often be an appropriate end-of-life decision agreed on by the care team and the resident or his/her representatives. However, reports cite the deliberate or neglectful withholding of food and fluids from residents who wish to eat or drink.55,56 In one of these studies, a pattern was observed of poor oral health, dysphagia, and inadequate staffing leading to weight loss, a pureed diet, and decreased appetite for regular food.55 A lack of food preference (e.g., an exclusively Western diet offered to a Chinese resident) also led to significant weight loss. It was often observed that when a resident had a family member assisting with meals, the resident did not lose weight. Fluid intake was observed to be inadequate in almost all the residents observed, often because fluids were out of reach or without straws. Another report showed hypernatremic dehydration to be associated with fluid deprivation and with indicators of poor care quality.67

Violation of Personal Rights and Financial/Material Issues

The balance between personal autonomy and the provision of adequate care for residents is an ever-present issue in the nursing home. Several examples of rights violations are included in the sections above, in which acts of restraint use or role-playing regarding elder mistreatment in nursing homes. Most of the participants (93%) found the session helpful and most (93%) felt comfortable openly discussing resident abuse issues.20

Table 7. Perception of Ombudsmen

- Feel most effective in promoting residents’ rights and welfare, and least effective dealing with financial exploitation and nutrition/hydration issues.60
- 51% of ombudsmen perceive abuse to occur only occasionally.81
- View elder abuse more serious than police officers do, and more serious than patient theft or street crimes.82
- Believe the most important factors causing abuse (in descending order of importance) are stress, vulnerability, greed, lack of values, lack of training, and workload.81
- Perceive restraining to more abusive than nursing home administrators.81
impaired adults has been shown to improve attitudes among nursing home staff.74 Conflict resolution and stress management training, which can be split into 8 modules of 6 to 8 hours each, have cut abuse reports 24% to 55% and improved job satisfaction in several studies.20,75,76 Improved job satisfaction and attitudes would presumably result in lower job turnover and more successful hiring for open positions, which in turn would improve care. Higher job turnover rates in nursing homes have been shown to be associated with worse quality of care, including higher rates of pressure sores, psychoactive drug use, and restraint use.77–79 Lower staff ratios may similarly diminish care quality, although that may depend on the specific type of staff member.79,83

Oversight and the Role of Ombudsmen

The number of long-term care ombudsmen rapidly increased after legislative changes in 1987 guaranteed that residents have access to ombudsmen and that ombudsmen have access to resident records. Their opinions and perceptions are outlined in Table 7. A 1987 article documented an increased complaint/bed ratio in homes with ombudsmen, but this was specific to complaints other than abuse concerns.84 A more recent study (since the 1987 legislative changes) reported a longitudinal increase in mistreatment reports and subsequent substantiation of these reports.85 These authors also found an association with more letters of reprimand, but no increase in higher level sanctions was observed. The increased presence of ombudsmen and their increasingly electronic record keeping has led to further information regarding elder mistreatment in the nursing home. Researchers have used ombudsmen program records to study the demographics, definitions, types, and prevalence of nursing home mistreatment.86–89 Data from the National Association of Medicaid Fraud Control Units may also hold promise as a centralized source of mistreatment information.90

Suspicion and Reporting

Medical directors and other nursing home physicians may be the only regular contacts a victim has aside from the abusive or neglectful caregiver. However, despite being mandatory reporters nearly everywhere, physicians make up a small minority of the overall referrals for suspicion of mistreatment (1.3% of complaints made to ombudsman programs in the late 1990s).21 A Canadian study documented many barriers that primary care physicians perceived as a hindrance to reporting suspected mistreatment, including ignorance of the definition of abuse and the clinical signs.91 One must remember that a report of suspicion is just that; it is a suspicion or concern, not a conviction beyond a shadow of a doubt. Those who receive the report will then investigate further and search for evidence. Initial documentation items that may assist investigators are listed in Table 8. State-by-state contact information, including a separate institutional/nursing home contact if applicable, is available at the following Web site: http://www.nceaa.ao.gov/NCEARoot/Main_Site/Find_Help/State_Resources.aspx.

CONCLUSION

Nursing home mistreatment can be a complex phenomenon, often involving an overworked caregiver, in an underfunded care environment, mistreating a functionally dependent resident who is unable or unwilling to seek help. Although there would need to be a major overhaul of the long-term care system to address many of the reimbursement and staffing issues that contribute to high job turnover and poor staff morale, most states are currently facing ongoing budget crises that will likely lead to further cuts in Medicaid coverage. Therefore, efforts to identify and prevent nursing home mistreatment must focus on working within the current system, and several examples of innovative training programs are presented in this article. Research has only begun to define the full scope of the problem and its underlying etiologies, and further study will continue to inform these educational and clinical efforts. Although much remains to be studied, it is encouraging to see an increase in interest and publications over the past decade.

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REFERENCES


