SPEA UNDERGRADUATE HONORS THESIS

The Effect of Person-Centered Care on Elder Abuse in Long-Term Care Facilities

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Abstract

The long-term care industry in the United States has evolved greatly from its beginnings in the early 1920s as almshouses to the modern facilities that exist today. In 1954 the Hill Burton Act introduced federal grants to nursing homes built in conjunction with hospitals in an effort to eradicate almshouses. However this created hospital-like and institutional environments with substandard care for seniors. In the 1970s the government began to regulate the industry after investigating allegations of abuse and poor care. Person-centered care is the most recent industry trend aiming to improve quality and care through gradual facility transformation from the traditional model of institutional and standardized medicine to a model focusing on individualized care for all residents. This model consists of a socio-residential component that emphasizes the facility's role as the resident's home as well as a focus on human factors such as autonomy, independence, dignity and self-esteem.

While nursing homes have advanced greatly in the care they provide for their residents, elder abuse is still an underreported and understudied threat. Elder abuse appears in the form of physical, sexual, psychological, or financial abuse, as well as abandonment and neglect. As the Baby Boomer generation enters into long-term care facilities this will be a prevalent issue that could affect a large proportion of the population. Thus, it is imperative that this issue is addressed through culture change. This study aims to examine whether or not characteristics of person-centered care can help to lower the incidence of abuse within long-term care facilities.

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History of Nursing Homes

The concept of nursing homes for the elderly has evolved greatly over time. The English Poor Law of 1601 instilled a responsibility in the states to provide welfare to its citizens, thus creating almshouses for the deserving poor that could not care for themselves (SSA, 2017). English settlers brought this idea to American, creating almshouses in the United States. These facilities originally housed those that were not able to contribute to society and frequently consisted of "corruptions, mismanagement, deplorable living conditions and maltreatment of inmates" (Phelps, 2005). The individuals that lived in these facilities were not valued by society and so their care was not a priority at the time. Towards the end of the 19th century however, charity movements by women and religious groups worked to provide alternate housing options for certain segments of the almshouse population such as orphans and the insane. Left to themselves, impoverished, frail and often sick, the elderly began to make up nearly 70% of the remaining Almshouse residents (Haber, 2011). The government made their first initiative to eradicate the remainder of these facilities in 1935 with the Social Security Act. This act created grants to states for Old Age Assistance (OAA), which provided public assistance to the elderly in the form of income support. In order to get rid of almshouse in the United States, "the act prohibited the payment of OAA funds to residents of public institutions" (Institute of Medicine, 1986). Private institutions however, were still able to receive these payments on behalf of residents and thus grew rapidly; individuals consequently converted buildings to house and care for the elderly.

Prior to the 1950s few nursing home facilities provided adequate skilled nursing services or were licensed. A 1954 amendment to the Hill-Burton Act provided and attempt to further develop the industry by providing funding for the construction of skilled nursing facilities in

conjunction with hospitals, though this created facilities with hospital-like structures (Institute of Medicine, 1986). In 1956, a Social Security Act amendment allowed for these new facilities to receive OAA payments. It was not until after facilities began receiving federal funds that the government would begin to investigate quality issues in these institutions. The Medicare and Medicaid programs were introduced in 1965 and vastly expanded funding to skilled nursing homes. With greater funds, the U.S. Department of Health, Education and Welfare developed standards that needed to be met before facilities could qualify for payment by the program, though few qualified (Institute of Medicine, 1986). This resulted in the first major federal attempt to regulate the industry and the care provided.

The 1970's brought many recurring scandals about poor nursing home conditions and resident abuse into the media. With poor media surrounding the industry and Congressional committees reviewing allegations there was need for tighter regulation and oversight over facilities. The 1972 amendments to the Social Security led to changes in "regulatory and reimbursement policy" (Hawes & Phillips, 1986). In addition "states became more stringent about requiring nursing home compliance with federal standards…[and implemented] stricter licensing requirements" (Hawes & Phillips, 1986). Standards required nursing homes to have licensed administrators, regulated the facility environment and defined care requirements. Specifically states cracked down on Life Safety Code building and fire safety regulations in order to curb the frequent tragedy of fires in small, private facilities that were converted from previous home, farm houses and hotels. Policy changes, regulation and greater advocacy brought the industry out of an unacceptable state and into what is known today as a fair alternative for individuals that need skilled nursing services.

Person-Centered Care

Person-centered care is the most recent culture change movement in long-term care that is an attempt to shift the industry from an institutionalized structure to a more personal, individualized one. The 1970s and 1980s exposed prior scandals and short comings in the system. Congressional investigations found that many facilities were negligent and failed to meet federal regulations put in place to ensure resident well-being. The government attempted to correct this with federal regulations and greater oversight, focusing their efforts on ensuring facilities med the minimum standard of care and corrected any code deficiencies they may have. In 1987 the Nursing Home Reform Act that defined this standard was incorporated into the Omnibus Budget Reconciliation Act (OBRA) requiring "that each nursing home resident 'be provided with services sufficient to attain and maintain his or her highest practicable physical, mental and psychosocial well-being'" (Koren, 2010). This law was one of the first to explicitly define the standard of care for residents.

While these policy changes ensured compliance with the Centers for Medicare and Medicaid Services (CMS) conditions of participation, or minimum industry standards, little was done to ensure an enjoyable stay for residents. These changes ensured just care but neglected to foster quality care or emphasize quality of life, thus carrying on the negative stigma around facilities. Recent efforts to change the culture in the industry and how facilities appear to their residents and communities attempt to form nursing homes into a preferable alternative for the elderly. The goal of person-centered care is to create a home-like setting for residents that are not able to live independently. The shift involves facilities being viewed "not as health care institutions, but as person-centered homes offering long-term care services" (Koren, 2010). Thus

industry changes in the past worked more towards regulating the standard of care, while the current cultural change is more focused on creating the best environment for residents.

Person-centered care is multidimensional construct that aims to create the best quality care through three components: socio-residential factors, clinical care and overarching human factors. Douglas Singh (2016) defines the socio-residential factor as occurring when the physical environment the resident lives in is considered to be the resident's home. To create such an environment, the living space should include personal and social spaces, aesthetic décor and conveniences such as a barber stop or beauty salon incorporated in the facility design. The environment should also provide individuals privacy, safety, cleanliness and comfort. Such an environment should allow residents equal opportunity to pursue individual interests and/or social interaction and engagement. The final aspect that makes up the socio-residential factor is choice of meals that fulfill nutritional requirements, are palatable and are attractively served. According to Singh (2016), the clinical aspect should consist of individualized care that is compliant with evidence-based practice standards. The final component of person-centered care consists of an emphasis of human factors in the delivery of service. Singh (2016) describes this as autonomy, independence, dignity and self-esteem being promoted and blended into all aspects of a patient's care and life and in facility.

Culture change involves the gradual transformation of facilities from the traditional nursing home model (the sick role model) that emphasized institutional and standardized medicine, to patient centered care. The traditional nursing home model dictated uniformity and expected residents to succumb to the control of medical personnel. Singh described the sick-role model as an institutional orientation to patient care with four main components:

> "(1) rigid daily routines; (2) social distance between staff members and the patient; (3) care practices that lend to depersonalization, such as loss of privacy; and (4) 'blocking routines' that require patients to do certain things at prearranged times, mainly for the convenience of the staff."

Culture change on the other hand switches the focus from the organization to the resident. It consists of integrating elements of patient centered care, creating an environment that offers positive stimulation and distraction while minimizing negative distractions and stressors, allows residents time and place for solitude and reflection and shifting the mindset of management and associates so that associates feel valued and empowered by management.

While the industry is moving towards person-centered care through culture change, there are many challenges that prevent a full transformation. First off, clinical care must follow best practices, up-to-date standards, use of appropriate technology and comply with regulatory requirements. There is a strong regulatory burden in which inadequate Medicaid financing limits a facilities ability to obtain necessary resources and regulations create a culture of paranoia in a facility in which regulations become a focus. Facilities were created to function as a cost effective alternative to home health care, though because of their large populations they must function effectively and efficiently which does not always cater to individualized care. One of the largest constraints that facilities face from being able to fully move to patient-centered is patient-related constraints in conjunction with conflicting rights. Compromise is necessary in a facility because with any large population there will be conflicting preferences; not every patient can have their way at all times. Some patient conditions will attribute to a combative or wandering behavior that may also contribute to this restraint on resident preferences.

The long-term care industry has a colorful past in the United States and around the world, though it has evolved greatly from its initial origins to the structures that exist today. Many governmental initiatives have been implemented over the past century in an attempt to regulate the industry and make it a safer and overall better care option for seniors. While many advances have been made there is still further room for improvement. Skilled nursing facilities are not seen as deplorable today; however, abuse of residents still remains a pressing issue. The following section will examine the existing literature that has examined elder abuse.

Literature Review

Elder abuse is a prevalent issue in society that is vastly underpublicized by the general public and the scientific community. While there has been great focus in research and public campaigns for other types of abuse such as domestic abuse or child abuse, elder abuse is one that remains under-researched and under-acknowledged. The purpose of this review is to examine the limited resources available to draw conclusions about current knowledge in the field. Ten different articles and studies are included in this review regarding definitions, prevalence and causes of elder abuse. Of the ten forms of literature examined, six are random sample studies meant to test the prevalence of elder abuse, one is a synthesis of literature following a national report and three are articles examining the theoretical aspect of the issue.

One of the prominent issues in the study of elder abuse that there is no universal definition used. While there are several definitions that are used repeatedly in various studies, there is no consensus at the federal level of which definition should be used, nor is it clearly defined as to what constitutes elder abuse. Four of the studies used another organization's definition for their research, two studies created their own working definition of elder abuse and four of the studies did not have a general definition for elder abuse but rather merely stated the

components they were studying. For example, both Lachs and Pillemer (2004) and Stevens et. al. (2013) utilized the U.S. National Academy of Sciences definition:

> "(a) intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended), to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder, or (b) failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm."

Another study used the American Medical Association's definition of "an act of commission or omission that results in harm or threatened harm to the health or welfare of an older adult" (Castle, Ferguson-Rome & Teresi, 2015). Shinan-Altman and Cohen used the World Health Organization's definition of "a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust and which causes harm or distress to an older person" (Shinan-Altman & Cohen, 2009). Additionally Castel, Ferguson-Rome and Teresi's synthesis analyzed 42 different sources and the definition of elder abuse they used. While they concluded that "few factors appear in these definitions" the two most common factors included were trust, seen in 23.8% of definitions and harm, seen in 45.2% of definitions (Castel, Ferguson-Rome & Teresi, 2015). Despite there not being consensus in the field on a single working definition of elder abuse, it can be concluded from these sources that generally elder abuse occurs when there is harm caused to an elder by a trusted individual.

An additional conflict that arises is components of abuse the author defined. Since there is no universal definition, each author had the authority to determine what components of abuse they would use. Nine of the ten studies included physical and psychological abuse as prominent forms examined. Only Lachs et. al. (1997) chose to not further define "abuse" through subcategories. Three authors chose to use the five categories of physical abuse, psychological

abuse, financial abuse, sexual abuse and neglect exclusively; two other studies utilized these five categories as well as others. Shinan-Altman and Cohen (2009) also included violation of rights in their study and Castel et al (2015) utilized the category of abandonment and self-neglect in addition to the five categories listed above. Pillemer and Moore (1989) chose to use only the physical and psychological abuse in their study because of the ambiguity of the definition for elder abuse. The lack of a consistent definition of not only what elder abuse means, but also of what constitutes abuse, contribute to the inconsistency seen in studies. If a study is only measuring limited aspects of abuse, the results cannot be generalized to other populations under the blanket term of "abuse". For example by the conclusion of "poverty, minority status, functional disability and worsening cognitive impairment were risk factors for reported elder mistreatment" drawn by Lachs et. al (1997) is not generalizable to all situations because the authors only examined elder abuse as consisting of abuse, neglect and financial exploitation.

Out of the ten pieces of literature examined, six were studies that contained primary data. These studies give insight into the prevalence of elder abuse by examining abuse in many different settings including community based and institutional based settings, nation-wide, state-wide and city-wide studies as well as domestic and foreign studies. Acierno et. al (2010) studied a one year prevalence rate in the United States through a stratified random sample of 5,777 community-based adults age 60 and older. Lachs et. al. (1997) and Pillemer and Finkelhor (1988) also studied community-based adults; Lachs et. al. (1997) utilized data from 2,812 adults age 65 and older in the state of Connecticut and Pillemer and Finkelhor (1988) studied 2,020 Boston community-based residents age 65 and older. Three studies focused on elder abuse in nursing homes on the other hand, examining nursing home employees, rather than the elderly. Shihan-Altman and Cohen (2009) conducted a study in Israel that used data from 208 nursing

aides in 18 different nursing homes throughout the country. Goergen (2004) studied 361 employees in 27 nursing homes throughout the state of Hesse, Germany and Pillemer & Moore (1989) studied 577 nurses in 31 nursing homes throughout the state of New Hampshire.

While each study focused on a different population, nearly all were conducted in a similar manner. Acierno et. al. (2010) utilized a stratified random-digit dialing in an area probability sample to conduct phone interviews across the United States. This study was aiming to test the prevalence of abuse over a year, as well as possible correlates for each form of abuse. Similarly, to determine the scope of abuse, the study in Boston also used a stratified random sample for phone or in person interviews of "community-dwelling elderly persons in the Boston metropolitan are… [selected through] an annual listing of the residents of every dwelling" (Pillemer & Finkelhor, 1988). The study in Connecticut on the other hand conducted a nine year retrospective study on the prevalence of elder abuse by examining ombudsman reports (Lachs et. al. 1997). Both the Shihan-Altman and Cohen (2009) and Pillemer and Moore (1989) conducted random sample surveys of nursing homes to survey staff about abuse they had witness in their facilities or committed themselves. Goergen however utilized three different methods for his study including interviews of staff, residents and others in eight randomly selected facilities, a questionnaire survey from 361 employees in 27 nursing homes and a case analysis of abuse and neglect (Goergen, 2004). Five out of the six studies utilized random sample surveys to conduct their data under various goals, while two studies utilized case reports of abuse for their data. Generally, the studies that took place in a nursing home setting primarily surveyed staff to discern prevalence of abuse committed by staff and the causes of such, while the community-based studies aimed to find the general occurrence of elder abuse and associated risk factors for the elderly.

Nine of the ten studies included a stated metric of the prevalence of elder abuse; the tenth study focused instead on the definition and theoretical aspect of the topic. Pillemer and Finkelhor (1988) concluded an incidence rate of 32 per 1000 from their random sample study in Boston. This particular rate was cited in three of the four articles that did not use primary data, thus showing the generally accepted prevalence rate in secondary elder abuse research to be 3.2%. Lachs et. al. (1997) found a lower incidence rate of 1.6% in their retrospective analysis of ombudsmen reports, from which they concluded the primary risks for elder abuse to be poverty, minority status, functional disability and worsening cognitive impairment. At the other end of the spectrum, a nation-wide community-based study found that "11.4% of respondents indicated that they had experienced at least one form of the commonly used categories of mistreatment in the past year" (Acierno et. al., 2010). While each of these community-based studies focused on different population scales, two of the three studies showed similar prevalence despite utilizing two different methods of research. However, the data differs significantly in the three nursing home based studies that surveyed staff about abuse they had witnessed and committed themselves. In Pillemer and Moore's (1989) study, "36% of the sample had witnessed at least one incident of physical abuse in the preceding year" and "81% of respondents had observed at least one psychologically abusive incident in the preceding year." Additionally 10% of respondents reported committing physically abusive acts and 40% reported committing at least one psychologically abusive act (Pillemer & Moore, 1989). Goergen found that 70% of staff interviewed and 71.5% of staff surveyed had been abusive or neglectful at least once, with one in five self-reporting physical abusive behavior. This German study also found a 38.5% prevalence rate from an inspector case analysis in the nursing homes (Goergen, 2004). Shinan-Altman and Cohen (2009) found a mean score of 3.24 out of 4 of staff attitudes that condoned abusive

behaviors. While the community based study focused risk factors on the physical ailments and living arrangements of the elder, such as dementia or living with a mentally ill individual, the facility based studies geared their risk factors towards staff, such as burnout and low job satisfaction. The disparity between studies could lie in their difference of definitions.

Due to the limited amount of research on this topic, there are many knowledge gaps that result. Out of the research presented in this study only half, or three, of the primary data sources examined abuse within long-term care facilities. As the Baby Boomer generation continues to age and more individuals utilize services offered by long-term care facilities, I believe it is important to fill this gap. It is important to identify prevalence of abuse within these facilities clearly and thoroughly so that steps can be taken to efficiently and effectively increase resident safety by preventing elder abuse. The current culture change going on within long-term care facilities is that of person-centered care which refocuses a facility from an institutional environment and method of care to an individualized one. However since it is a culture change that alters most if not all aspects of care, I believe it is important to examine the potential effects it could have on elder abuse within facilities. With a large segment of the population soon entering into old age, it is necessary to have safe facilities that will not jeopardize a resident's well-being.

Hypothesis

This study will examine potential impacts that person-centered care can have on the incidence of abuse in long term care facilities and aim to answer the question, does the implementation of person-centered care lower the incidence of abuse in nursing homes. Elder abuse is a prominent issue and concern for individuals over sixty-five. As an increasingly large proportion of the population reaches retirement and nears the stage where a nursing home stay is

a greater possibility, it is important that the current industry trends provide the best and safest environment for prospective residents. This study will aim to prove that person-centered care is beneficial to current and potential nursing home residents by analyzing how its components counter abuse in facilities.

Methodology

The dependent variable in this analysis is elder abuse and the independent variable is person-centered care. Elder abuse is a multidimensional concept that can be broken down into five different types of abuse: physical abuse, sexual abuse, neglect, exploitation and emotional abuse. The elder abuse statistics utilized in this paper come from the National Ombudsman Reporting System (NORS) under the Administration for Community Living (ACL). Thus the definition for elder abuse this paper will follow will be from the ACL's Administration on Aging (AoA) program. The AoA (2016) broadly defines abuse as:

- **Physical Abuse** – inflicting physical pain or injury on a senior, e.g. slapping, bruising, or restraining by physical or chemical means
- **Sexual Abuse** – non-consensual sexual contact of any kind.
- **Neglect** – the failure by those responsible to provide food, shelter, health care, or protection for a vulnerable elder
- **Exploitation** – the illegal taking, misuse, or concealment of funds, property, or assets of a senior for someone else's benefit.
- **Emotional Abuse** – inflicting mental pain, anguish, or distress on an elder person through verbal or nonverbal acts, e.g. humiliating, intimidating, or threatening.

Elder abuse was measured by the NORS, collected through web-based submissions received via the Ombudsman Reporting Tool Portal. This service, provided under Title VII of

the Older Americans Act (OAA) provides annual reports of report data received through the Ombudsman Reporting Tool Portal (AGing Integrated Database, 2017). Nursing home population data was pulled from the CMS Nursing Home Data Compendium 2015 Edition. This source combined information from CMS's database for survey and certification information, data from the United States Census Bureau and the Minimum Data Set for clinical data collected on residents of Medicare- and Medicaid-certified nursing homes (CMS, 2015). The definition and components of person-centered care used in this paper are from Douglas Singh, though analysis was conducted from descriptions of the culture change found in various journal articles.

Elder Abuse Today

The population structure in the United States is in transition with an increasingly large proportion of the population entering old age. Baby Boomers, born post World War II make up a significant portion of the population and have begun to transition to retirement age. In 1900 there were roughly 3.1 million adults age 65 and older, making up 4.1% of the total population at that time. In 2010 there were 40 million adults age 65 and older, making up 13% of the population. By 2050 the 65+ population is expected to reach 88.5 million individuals, making up 20.2% of the total U.S. population (AoA, 2014). Between 1900 and 2050 the population of individuals age 65 and older is expected to increase 16.1% due to medical advances and increased life expectancy in the United States. However there has only been a 4.2% increase in the population of individuals aged 85 and older between 1900 and 2050.

In 2014, 1.4 million individuals in the United States lived in nursing homes. Of those individuals, 15.5% were under the age of 65, 16.5% were between the ages of 65 and 74, 26.4% were between the ages of 75 and 84, 33.8% were between the ages of 85 and 94 and 7.8% of the residents were 95 or older (CMS, 2015). Only around 3% of individuals 65 and older reside in

nursing homes. However once individuals reach the age of 85 the percentage who reside in nursing homes increases to around 10%. In 2014, of the 1.19 million residents who were age 65 and older, 49% or 584,988 were age 85 or older (CMS, 2015). If this trend continues, by 2050 there will be roughly 2.3 million seniors age 65 and older and roughly 500,000 seniors age 85 and older will reside in nursing homes. While only a small proportion of the total United States population utilize nursing home services, they impact a large number of individuals each year.

In 2014, the NORS recorded a total of 136,763 complaints from nursing homes across the United States. Of those complaints, 10,453 were considered a violation of residents' rights, specifically abuse, gross neglect or exploitation. Abuse allegations made up 7.46% of the official complaints received for nursing homes. The number of abuse complaints has decreased from 2000, though is higher than the number of complaints in 2012 and 2013. For the 1.4 million residents who received care in a skilled nursing facility in 2014, roughly 1 in 100 faced an incident of abuse that was correctly reported to the proper authority. Holding all else constant and merely accounting for the expected increase in elders age 65 and older, by 2050 the number of abuse complaints received per year could increase to 17,097. While only a small proportion of the entire population is affected by elder abuse, the population increase alone still indicates that there are 17,097 reported incidents of abuse resulting in some kind of harm to a vulnerable elder.

Not only is this an issue because it involves a human rights violation of a vulnerable population, but resident abuse also has drastic financial implications. The average cost of a semi-private room in a nursing home is $66,795 per year with Medicaid paying for 45% of the cost for 65% of nursing home residents (AARP, 2007). The majority of funding for nursing homes is not paid by private clients but rather the federal government. Thus if abuse is a

legitimate threat in facilities, multiple stakeholders are affected. In 2015, nursing facilities received $45.5 billion from Medicaid (Kaiser Family Foundation, 2016). Ineffective and unsafe care is a liability for the government and can put a strain on the system. The National Center on Elder Abuse (NCEA) (2017) found that "adverse events in nursing homes – due largely to inadequate treatment, care and understaffing – lead to preventable harm and $2.8 billion per year in Medicare hospital costs." Elder abuse of all forms has many direct and indirect consequences that adversely impact those affected. The financial repercussions are just one of the many results of elder abuse, but the financial burden is what will greatly strain the system if it remains an issue in coming years.

There are current federal programs aimed at preventing elder abuse, neglect and exploitation, though limited funding prevents a widespread impact. The following section will dissect the transformations person-centered care brings to facilities. It will examine the potential effects on the causes of abuse to see if the current culture change has the potential to lower the current incidence rate of abuse in skilled nursing facilities.

Analysis

Causes and Risk Factors of Abuse

Elder abuse, as previously defined, consists of five different elements: physical abuse, sexual abuse, neglect, exploitation and emotional abuse. Generally, an incident is considered abuse if there was an intentional act that resulted in harm to the senior, committed by a trusted individual. Lachs and Pillemer (2004) found that major risk factors for elder abuse included a shared living situation, dementia and social isolation. High stress, lack of support and depression can also lead one to commit elder abuse. Specifically looking at staff as the culprit of elder abuse in long-term care facilities, one study found that "situational characters (e.g., burnout and

level of conflict) were found to be the most important predictors of abuse…[as well as] isolation, poor training, low morale, low salaries and staff shortages" (Payne & Fletcher, 2008). However according to the NCEA (2017) abuse of facility residents by other residents is not more common than abuse by nursing home staff, though further research is still required.

Resident-to-resident aggression (RRA) consists of negative and aggressive physical, sexual or verbal interactions that are unwelcome and may cause physical or psychological distress in the recipient (Rosen, Pillemer, & Lachs, 2008). While this is not classified as elder abuse, RRA has many similar characteristics and holds a similar spectrum as elder abuse. Both are reported to result in adverse health conditions for the abused and a diminished quality of life. Rosen, Pillemer, & Lachs (2008) identified behavior disturbance, moderate functional dependency and cognitive impairment as potential risk factors for resident to resident aggression. This study also found that a resident's environment affected the potential risk for aggressive behaviors; residents with cognitive impairment in smaller, high density facilities were more likely to exhibit disruptive behaviors (Rosen, Pillemer, & Lachs, 2008).

A study by Rosen et. al. (2008) found that resident-to-resident aggression (RRA) in nursing homes occurred most frequently in dining and resident rooms; in their study 47% of 103 participants mentioned seeing RRA in dining rooms and 48% of the 103 participants seeing RRA in resident rooms. In addition the most participants (24%) witnessed RRA in the afternoon, followed by the second highest percentage of participants (10%) witnessing RRA in the evening. Out of the RRA witnessed, 72% of participants mentioned seeing verbal abuse, 64% witnessed physical abuse and 18% had witnessed sexual abuse, mainly an individual attempting to get into bed with another resident (Rosen et. al., 2008). While multiple forms of RRA were witnessed at different times of the day in different settings, there are patterns the level of aggression followed.

The Effect of Person-Centered Care

The different components of person-centered care work together to create the best experience possible for nursing home residents. Each component is aimed at targeting a specific part of care in order to provide the best overall situation for residents; each of these in turn work together to benefit the resident. The first element of person-centered care is the socio-residential factor. This factor focuses on the physical environment that the residents live in, emphasizing balance and choice. Home-like and familiar environments are emphasized with bigger spaces to prevent over-crowding. This would in turn help ease the stress felt by individuals with cognitive impairments. The new environments emphasized in this culture change provide space for not only social interaction but also personal time. While this can offer individuals better opportunities to prevent social isolation within their new home, the increased emphasis on privacy and personal space has the potential to decrease RRA in resident rooms and communal spaces. If individuals feel more comfortable and at peace in their environment, then they are less likely to become agitated with others, compared to individuals who are already uncomfortable and unhappy in a setting.

Person-centered care proved to be a "cost-effective means of reducing the level of agitation in people with dementia in residential settings" through greater staff training (Stein-Parbury et. al., 2010). Often time individuals with dementia are thought of as losing their 'self' as their memory and cognitive function diminish which can further isolate these individuals from a normal social life. Individuals with dementia can demonstrate disruptive behavior, creating a frustrating environment for those around them. However when facilities incorporate an inclusive setting that supports an individual's needs for comfort and self-worth, it can enhance an individual's sense of self-worth and in turn reduce the incidence of disruptive behavior (Stein-

Parbury et. al., 2010). Disruptive behaviors can include aggression and agitation which in turn can lead to abusive behaviors either by stressed staff members or by the disruptive individual towards others. In addition if staff are better trained to cater towards the unique needs of residents with dementia, this can decrease the potential for disruptive behaviors. For example, if staff uniquely care for each of their residents, recognizing different functional and cognitive levels and specific individual limitations they will be able to better communicate and provide the best quality care for that individual.

Person-centered care also incorporates an element of staff empowerment; when staff feel supported and empowered, they in turn will be able to best meet the needs of their residents (Koren, 2010). Simple adjustments that benefit and create a better experience on residents can create a better environment for staff as well. If residents are more satisfied with their experience, that in turn can decrease staff stress. In addition better training to help staff understand individual perspectives in aging can increase their patience while working with residents. This is important to prevent negative interactions that can escalate to abusive behaviors. This trend encourages staff members to learn resident's unique personalities and teaches them to interpret responses and behaviors so that they can adjust care and practices accordingly.

A study by Radka Buzgova and Katerina Ivanova (2009) found that when nurses were stressed they were more likely to yell, communicate improperly, use patronizing or humiliating language or verbally assault a resident. The study also found that physical abuse was likely to occur in the forms of excessive use of physical restraints or not relieving pain (Buzgova & Ivanova, 2009). These findings could be countered again with the implementation of person-centered care, in which residents' needs are individually understood, thus creating clearer communication and expectations of what patient interactions should look like.

Culture change works within facilities to create the best individualized experience possible for each resident. Another aspect of person-centered care that will work to combat abuse is the emphasis on human rights such as autonomy. When residents feel that they have a voice, they can feel more at ease and in control of their situation. While many residents are limited by physical and cognitive restrictions that come with aging, they are still individuals that should be treated with dignity and respect. Contradictory to the sick-role model, this method of care allows individuals to have a say in their day, their environment and their care. Maintained autonomy helps and individual hold onto the life that they held prior to moving into the facility which in turn can lower potential aggression and frustration if they do not have to greatly change habits and preferences that they have held throughout the majority of their life.

Limitations

Elder abuse is an understudied occurrence with limited statistical data and few empirical and clinical studies completed on the subject. There are many limitations in the collection of data in this field due to the sensitivity of the topic. As previously discussed in the literature review one of the large issues in the field is the lack of a universal definition to specify what constitutes abuse, which components are classified as abuse and what population parameters the term "elder" falls into. Without clear guidelines on what constitutes abuse as well as the stigma that surrounds it, incidents frequently go unreported. In addition, cases can occur in which there is question about the presence of intent, the extent of harm and whether or not that act can be classified as an incident of abuse.

According to the NCEA "elder abuse research includes older persons with various mental, physical and social vulnerabilities and involves collecting information that could have negative legal, financial and social consequences for the older persons and caregivers being

studied" (2017). Confidentiality and protecting resident rights can become problematic when trying to collect raw data in these sensitive situations and for those who do attempt to measure incidence of abuse there is no benchmark data to measure initiative outcomes against. Thus it is difficult to reach concrete conclusions about this occurrence in society and remains and understudied phenomenon in academia.

Conclusion

Nursing homes have appeared in many different forms with various priorities over time. From their origin as almshouses in the 19th century to the skilled nursing facilities that exist today, facilities have shifted from a last resort to a common option for senior care. The current population is aging rapidly and within the next thirty years the elder population is expected to double in size. The population of individuals age 65 and older will increase from 13% of the population in 2010 to 20.2% in 2050 shifty the demographic make-up of the country drastically. If current trends continue as they are than the next thirty years will bring occupancy in nursing homes up from 1.4 million residents per year to 2.3 million residents per year. With a large number of the individuals utilizing the system it is important that nursing homes provide the best care possible.

Elder abuse currently is an issue that affects roughly 7 per 1000 nursing home residents across the country. Over 10,000 reported ombudsman complaints were related to abuse, neglect, or exploitation in 2014 which translates to over 10,000 individuals falling victim to abuse in a setting where their protection is a legal right. Not only does this constitute a human rights violation in a vulnerable population but it also puts a financial strain on the system. Medicaid is made available to nursing home residents to fund the care that the need, however if elder abuse

in facilities remains constant it will be instead funding a system that falls short of effectively protecting its residents.

Person-centered care is the newest culture change in the industry that is attempting to gradually transform facilities to provide the best quality care possible to its residents. This change focuses on three major components of care within nursing homes: the socio-residential factor, individualized care and an emphasis on human rights. Each of these components work both uniquely and together to create an environment and care plan in which the residents are the prime focus. When residents are treated with greater respect, preserving their dignity, they will be less likely to exhibit aggressive behaviors. Individualized care can offer a higher quality care through an in-depth understanding and adaptions to unique resident needs. Thus this trend should help decrease the incidence of abuse in nursing facilities that is often triggered by high stress, depression and social isolation.

In conclusion person-centered care is different from previous trends in long-term care, but in theory offers the greatest quality of care to residents. As a large number of elders begin to require higher levels of care and assistance with activities of daily living, they can be assured that the newest culture change in facilities across the country will work to provide them an experience better than what those who came before them had. Specifically the new culture change of person-centered care should help increase resident satisfaction and decrease aggression, thus lowering the potential for resident abuse either by other residents of by staff who do not understand how to handle certain resident behaviors. This trend should offer a safe outcome for elders who will need services from skilled nursing facilities.

Works Cited

AARP Public Policy Institute. (2007). Fact Sheet: Nursing Homes. Retrieved from: https://assets.aarp.org/rgcenter/il/fs10r_homes.pdf

Acierno, R., Hernandez, M. A., Amstadter, A. B., Resnick, H. S., Steve, K., Muzzy, W., & Kilpatrick, D. G. (2010). Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: The National Elder Mistreatment Study. American journal of public health, 100(2), 292-297. Retrieved from: http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2009.163089

Administration on Aging (AoA). (2014). Projected Future Growth of the Older Population. Retrieved from: https://aoa.acl.gov/Aging_Statistics/future_growth/future_growth.aspx

Administration on Aging (AoA). (2016). What is Elder Abuse? Retrieved from: https://aoa.acl.gov/AoA_Programs/Elder_Rights/EA_Prevention/whatIsEA.aspx

AGing Integrated Database. (2017). Resources: Data Sources. Retrieved from: http://www.agid.acl.gov/Resources/DataSources/

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

Castle, N., Ferguson-Rome, J. C., & Teresi, J. A. (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. doi: 10.1177/0733464813492583

Centers for Medicare and Medicaid Services (CMS). (2015). CMS Nursing Home Data Compendium 2015 Edition. Retrieved from: https://www.cms.gov/Medicare/Provider-Enrollment-and-

Certification/CertificationandComplianc/Downloads/nursinghomedatacompendium_508-2015.pdf

Goergen, T. (2004). A multi-method study on elder abuse and neglect in nursing homes. The Journal of Adult Protection, 6(3), 15-25. Retrieved from: http://search.proquest.com/docview/212023416

Haber, C. (2011). Nursing Homes: History. Retrieved From: http://medicine.jrank.org/pages/1243/Nursing-Homes-History.html

Hawes, C., and Phillips, C. D. (1986). The Changing Structure of the Nursing Home Industry and the Impact of Ownership on Quality, Cost, and Access. Available from: https://www.ncbi.nlm.nih.gov/books/NBK217907/

The Henry J. Kaiser Family Foundation. (2016). Distribution of Fee-for-Service Medicaid Spending on Long Term Care. Retrieved from: http://kff.org/medicaid/state-indicator/spending-on-long-term-care/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Institute of Medicine (US) Committee on Nursing Home Regulation. (1986). Improving the Quality of Care in Nursing Homes. Retrived from: https://www.ncbi.nlm.nih.gov/books/NBK217552/

Koren, M. J. (2010). Person-Centered Care For Nursing Home Residents: The Culture-Change Movement. *Health Affairs, 29(2), 312-317*. doi: 10.1377/hlthaff.2009.0966

Lachs, M. S., & Pillemer, K. (1995). Abuse and neglect of elderly persons. New England Journal of Medicine, 332(7), 437-443. Retrieved from: http://www.nejm.org/doi/full/10.1056/NEJM199502163320706

Lachs, M. S., & Pillemer, K. (2004). Elder abuse. The Lancet, 36(9441), 1263–1272. doi:10.1016/S0140-6736(04)17144-4

Lachs, M. S., Williams, C., O'Brien, S., Hurst, L., & Horwitz, R. (1997). Risk factors for reported elder abuse and neglect: a nine-year observational cohort study. The Gerontologist, 37(4), 469-474. Retreived from: http://gerontologist.oxfordjournals.org/content/37/4/469.full.pdf+html

National Center on Elder Abuse (NCEA). (2017). Research: Statistics/Data. Retrieved from: https://ncea.acl.gov/whatwedo/research/statistics.html

Payne, B. K., & Fletcher, L. B. (2005). Elder abuse in nursing homes: Prevention and resolution strategies and barriers. *Journal of Criminal Justice*, *33*(2), 119-125.

Phelps, M.D. (2005). Almshouses. In *Encyclopedia of Chicago*. Retrieved from: http://www.encyclopedia.chicagohistory.org/pages/1735.html

Pillemer, K, & Finkelhor, D. (1988). The Prevalence of Elder Abuse: A Random Sample Survey. The Gerontologist, 28(1), 51-57. doi: 10.1093/geront/28.1.51

Pillemer, K., & Moore, D. W. (1989). Abuse of patients in nursing homes: Findings from a survey of staff. The Gerontologist, 29(3), 314-320. Retrieved from: http://gerontologist.oxfordjournals.org.proxyiub.uits.iu.edu/content/29/3/314.short

Rosen, T., Lachs, M. S., Bharucha, A. J., Stevens, S. M., Teresi, J. A., 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.

Rosen T, Pillemer K, Lachs M. Resident-to-Resident Aggression in Long-Term Care Facilities: An Understudied Problem. *Aggression and violent behavior*. 2008;13(2):77-87. doi:10.1016/j.avb.2007.12.001.

Shinan-Altman, S., & Cohen, M. (2009). Nursing aides' attitudes to elder abuse in nursing homes: The effect of work stressors and burnout. The Gerontologist, 49(5), 674-684. Retrieved from: http://gerontologist.oxfordjournals.org/content/49/5/674.short

Singh, Douglas A. Effective Management of Long-Term Care Facilities. Burlington: Jones & Bartlett Learning, 2016. Print

Social Security Administration (SSA). (2017). Historical Background and Development of Social Security. Retrieved from: https://www.ssa.gov/history/briefhistory3.html

Stein-Parbury, J., Chenoweth, L., Jeon, Y. H., Brodaty, H., Haas, M., & Norman, R. (2012). Implementing Person-Centered Care in Residential Dementia Care. Clinical Gerontologist, 35(5), 404-424. doi:10.1080/07317115.2012.702654

Stevens, M., Biggs, S., Dixon, J., Tinker, A. & Manthorpe, J. (2013), Interactional perspectives on the mistreatment of older and vulnerable people in long-term care settings. The British Journal of Sociology, 64: 267–286. doi:10.1111/1468-4446.12017