Preventing Patient Abuse: Why Abuse Happens and How to Stop It

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INTRODUCTION

A substantial amount of literature and policies regarding patient abuse focuses on the elderly; however, patient abuse is not limited to this population. Patient abuse can occur in other vulnerable populations including children and people with intellectual disabilities and can even occur among adults under the age of 60. With elderly abuse being such a large focus of patient maltreatment, many patient abuse and neglect definitions and laws largely address only maltreatment within the older population. Additionally, within those definitions of elderly abuse laws, a number of states address physical abuse or sexual abuse but give less attention to other forms of abuse including emotional/verbal abuse, financial abuse, and neglect. Understanding patient abuse among vulnerable groups and adults under the age of 60 is vital in order to identify recommendations to combat and prevent abuse among all groups.

The abuse of patients, such as health care staff striking patients, is not as uncommon as nurses and other health care staff members might think (Creighton, 1976). A director of nursing services reported having to deal with a number of incidents in which frustrated nurses lashed out at patients. In one incident, an R.N. slapped a mother in labor who was screaming despite being given pain medication and assurance that her labor was going as expected (Creighton, 1976). In another incident, an LPN grabbed and shook a child, leaving bruise marks, for throwing his toys around the playroom and hitting other children because his mother left the room (Creighton, 1976).

While the abusive acts in the cases presented above are legally prohibited, not all acts of undesirable conduct are addressed by law, so they must be prohibited in policy to establish and uphold standards of behavior (Centers for Medicare and Medicaid Services, 2017). “Abuse of patients can and does occur on pediatric wards, when children cry and act in certain ways because they are frightened and lonely; on obstetrical wards, when women are frightened or cry out in pain; and on geriatric wards, when senility has reduced patients to a state considered repugnant by many” (Nations, 1973, p.51). Regardless of the state of the patient, all patients in health care facilities have a right to be treated with respect, care, and dignity and deserve a safe setting for the best possible care (Atrium Health, n.d.; Nations, 1973).

PREVALENCE OF PATIENT ABUSE

Despite a large portion of patient abuse occurring with the elderly population, there is a gap in the literature on the prevalence of abuse in nursing homes and residential facilities for the seniors (Yon et. al., 2019). To help close this gap, researchers estimate the prevalence of patient abuse among the elderly using meta-analytical methods based on available publications. In community settings, it is estimated that one in six adults over the age of 60 was the victim of patient abuse during the past year (Yon et. al, 2017). In institutional settings, the rates of abuse are much higher, with two-thirds of staff admitting to having committed elder abuse in the past year (Yon et. al., 2019). With

the expectation that the global population of people aged 60 and older will more than double from 900 million in 2015 to approximately 2 billion by 2050 (United Nations, 2015), it is predicted that elder abuse will also increase in many countries (World Health Organization, 2020).

Estimating the prevalence of patient abuse, as a whole, and among specific groups is difficult because of limited research and data on abuse among groups outside of the elderly population. For future studies, researchers have called for more research quantifying the frequency of abuse allegations at institutions nationwide (Feldman et. al., 2001). While Feldman and colleagues (2001) focused on child abuse and neglect, the future directions they identified can be applied to all patient populations. These include: nationally and institutionally quantifying the frequency of abuse allegations, developing and evaluating staff training materials to prevent allegations, and sharing experiences to minimize risk to patients and staff (Feldman et. al., 2001).

TYPES OF PATIENT ABUSE

Verbal Abuse

Verbal abuse can be categorized as a form of psychological or emotional abuse. In Canada, for individuals age 16 and older, the Protection for Persons in Care Act (PPCA) defines verbal abuse as mistreatment involving harassment, threatening, intimidation, humiliation, coercion or restriction from social contact causing emotional harm (Nova Scotia Department of Health and Wellness, 2020). Elder abuse is defined similarly, as a form of psychological abuse, often accompanied by physical abuse, carried out with the intention to cause emotional pain or injury (Lachs & Pillemer, 1995). Examples of verbal abuse include threats and insults and statements to humiliate the patient. The threat of abandonment or institutionalization is also a form of psychological abuse (Lachs & Pillemer, 1995).

Physical Abuse

Physical abuse is the act of intentionally causing physical pain or injury (Lachs & Pillemer, 1995). In elderly patients, the most common acts of physical abuse include hitting, striking the patient with objects, and slapping (Lachs & Pillemer, 1995). These same physical acts can also take place in other vulnerable patient groups where the patient is not able to protect themselves. Any physical act, such as slapping, hitting, burning, tying up or binding, and rough handling, that results in pain, discomfort or injury is a form of physical abuse harm (Nova Scotia Department of Health and Wellness, 2020).

Sexual Abuse

Sexual abuse is any form of nonconsensual sexual contact with a person (The National Center on Elder Abuse at The American Public Human Services Association, & Westat, Inc., 1998). If an individual is incapable of providing consent, then sexual contact with that person is considered sexual abuse (The National Center on Elder Abuse at The American Public Human Services Association, & Westat, Inc., 1998). Sexual abuse includes, but is not limited to, sexual assault or battery, such as rape, coerced nudity, sodomy, and sexually explicit photography (The National Center on Elder Abuse at The American Public Human Services Association, & Westat, Inc., 1998). For patients age 16 and older, the PPCA defines sexual abuse as any form of sexual contact, activity or behavior that occurs between a patient or resident and a health care provider (Nova Scotia Department of Health and Wellness, 2020). Notably, the definition provided by the PPCA does not mention consent and implies that any form of sexual contact or behavior between a health care provider and a patient or resident is a form of abuse. Also, pediatric patients, as minors, cannot legally consent to any form of sexual contact. Those with intellectual disabilities and who are not physically able to speak for themselves due to a medical condition also cannot provide consent for sexual contact.

Financial Abuse

Financial abuse is the act of material exploitation or the misappropriation of a patient's money or property (Lachs & Pillemer, 1995; Nova Scotia Department of Health and Wellness, 2020). Financial abuse can include theft of pension or Social Security checks, using threats to force the patients to sign wills or other legal documents, or coercing a patient in any financial matter (Lachs & Pillemer, 1995).

Neglect

Lachs and Pillemer (1995) define patient neglect in the elderly population as the failure of the needs of the elderly person being met by the designated caregiver. In the PPCA, neglect can fall under section 3(1)(g), a type of abuse where the caregiver fails to provide adequate care, medical attention, nutrition or necessities of life without valid consent (Nova Scotia Department of Health and Wellness, 2020). Although patient neglect is increasing as an issue of public concern, the concept of patient neglect is poorly understood (Reader & Gillespie, 2013). A caregiver neglecting a patient can be intentional if the caregiver is purposefully failing to attend to the patients' needs in order to cause harm or punish the patient, such as by willfully withholding food or medication (Lachs & Pillemer, 1995). Neglect can also be unintentional, as the caregiver may genuinely be unaware that they are neglecting the patient or may not be able to care for the patient (Lachs & Pillemer, 1995).

Intentional and unintentional patient neglect can be further categorized under two aspects of patient neglect: procedure neglect and caring neglect. Procedure neglect refers to when health care staff fail to achieve the objective standards of care (Reader & Gillespie, 2013). Examples of procedure neglect include failing to feed, hydrate, or

adjust a bedridden patient as needed (Reader & Gillespie, 2013). Additionally, failing to complete required checks on patients also falls under procedure neglect. Staff may commit procedure neglect as a result of system errors or due to a lack of care for the patient (Reader & Gillespie, 2013). Caring neglect consists of acts that lead the patient or their family to believe that staff members do not care about the patient's well-being (Reader & Gillespie, 2013). Caring neglect includes acts such as not providing assistance when a patient is eating, dismissing a patient's concerns, or not treating a patient with respect (Reader & Gillespie, 2013). In cases of neglect, difficult questions arise about the caregiver, their exact responsibilities to the neglected patient, and if the neglect was intentional or unintentional (Reader & Gillespie, 2013).

Patient neglect continues to be an issue despite the technological and organizational advances of the 21st century (Reader & Gillespie, 2014). From patient complaints to scandals, instances of patient neglect are becoming more and more concerning. For example, the United Kingdom's National Health Service (NHS) receives more than 100,000 complaint letters per year (The NHS Information Centre, 2012), and many of these letters refer to instances of patient neglect ((Reader & Gillespie, 2014). Additionally, in a hospital scandal that took place at the NHS's Mid-Staffordshire Foundation Trust, approximately 1,200 patients died from 2005 to 2008 because of inadequate care (Francis, 2013a). All of this has led to an increased number of hospital recommendations for improving care in the UK (Francis, 2013b). The recommendations in the report by Francis (2013b) could be beneficial to many healthcare organizations and institutions that are dealing with patient neglect reports and complaints and are overall looking to prevent such instances.

VICTIMS OF ABUSE

Elderly

Elder abuse is the mistreatment of an older adult in which their health or safety is at risk (Hildreth et. al., 2011). More specifically, the World Health Organization (2020, n.p.) defines elder abuse as "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person." Elder abuse can be categorized by the type of abuse, the type of abuser, or the type of setting in which it occurs (Gorbien & Eisenstein, 2005). The type of abuse includes psychological, physical, sexual, financial, and neglect; the type of abuser includes family members, and informal or formal caregivers; and the type of settings can be categorized as in a community or at an institution (Gorbien & Eisenstein, 2005). The main risk factors placing elderly patients at risk for abuse include dementia, being a woman, and being over the age of 74 (Juklestad, 2001; World Health Organization, 2011; Yon et. al., 2019).

People with Intellectual Disabilities

As Thompson and Wright (2001, p.7) wrote, “People with learning disabilities have previously been called mentally handicapped. What makes them special is that they have needed help and support all of their lives. This is different to people who need help just late in life, for example, if they get dementia. People with Down’s Syndrome often get dementia, but they have usually needed extra support all of their lives.” People with intellectual disabilities may experience abuse in a community setting or in an institutional setting. Those with learning disabilities who live in a residential facility for the elderly are at increased risk of abuse: “In addition to the risks associated with having a learning disability, many are with limited safeguards because of poorly trained staff, the infrequent visits of family, friends and social workers, and limited activities outside the home” (Thompson & Wright, 2001, p.18).

In a case study on patient abuse among clients in a residential unit for patients with learning disabilities, a staff nurse was accused by other colleagues of verbal/emotional abuse, physical abuse and sexual abuse (National Library of Medicine, 1999). The staff nurse faced eight charges including teasing residents, using inappropriate methods when feeding residents, inappropriate sexual contact with a resident, using inappropriate materials to clean a resident, and displaying inappropriate behavior at an event for residents (National Library of Medicine, 1999). This case study highlights the importance of nurses taking responsibility and reporting their colleague(s) if they are aware of inappropriate behaviors. Additionally, this study examined events of procedure neglect, as the staff nurse failed to properly feed and clean residents. Caring neglect was also evident through inappropriate behavior and sexual contact, as well as not treating the residents with respect. In settings where individuals suffer from intellectual disabilities, not all residents have the mental capacity or the courage to speak out against a staff member. In these settings, it is important for the organization to emphasize that neglect or abuse in any form will not be tolerated and to support nurses who report their colleagues who may be committing any form of abuse.

Pediatric Patients

Child abuse can be defined as any form of neglect or maltreatment that results in non-accidental harm or injury to a child (Atrium Health, n.d.). While children of all ages can experience child abuse, it is typically more common among children younger than 6 years old and those between the ages of 12 and 14 (Atrium Health, n.d.). In the United States, more than 3 million cases of maltreatment are reported annually, with more than 1 million of these cases confirmed (Atrium Health, n.d.). Medical personnel and other professionals, such as teachers and daycare providers, report more than 50 percent of child abuse allegations (Atrium Health, n.d.).

Feldman and colleagues (2001) reviewed a series of cases from 1982 to 1996 from their hospital archives on accusations of hospital staff abusing pediatric patients. Additionally, the researchers mailed surveys to 108 members of the National Association of Children’s Hospitals and Related Institutions (NACHRI) to obtain information regarding

their experience with staff abuse allegations from 1990 to 1995, in addition to employment screening and training policies on staff abuse. When examining the hospital case series, it was found that, while sexual abuse complaints mainly involved older children, with an average age of 12.4, physical abuse allegations involved infants to adolescents (Feldman and colleagues, 2001). When looking at the pediatric patients who were the victims in physical and sexual abuse allegations, common risk factors included underlying chronic illnesses, underlying motor or cognitive disability, being in an anesthetized or heavily sedated state, past abuse, and psychiatric illnesses (Feldman and colleagues, 2001). Risk factors were also identified among the families of the victims, including mental illness, substance abuse, personal abuse history, legal issues, and issues with the health care provider (Feldman and colleagues, 2001).

Of the 27 hospitals that responded to the survey, 60 percent of the respondents reported allegations of patient abuse by staff (Feldman and colleagues, 2001). About a third of the allegations were proven as the staff members involved used unacceptable physical or verbal violence, or inappropriately sexually touched the pediatric patients (Feldman and colleagues, 2001). Additionally, while a child protection team was established at most of the institutions, only a third of the institutions required a team evaluation and management of the cases (Feldman and colleagues, 2001). The remaining institutions varied in where the cases were delegated. It was also found that only 19 percent of the institutions had written policies on how accusations should be managed internally, and some hospitals indicated they only reported the accusations to protective services if legally mandated (Feldman and colleagues, 2001).

Measures to prevent child abuse by staff using prescreening measures and training varied among the institutions. Criminal background checks mandated by the state or screening services from police or outside agencies were used for prospective employees in two-thirds of the institutions (Feldman and colleagues, 2001). However, many of the institutions did not provide training for employees on reducing the risk of abuse accusations and incidents (Feldman and colleagues, 2001). With many of the accusations being a result of patient and family misinterpretation of the appropriateness of the medical service being provided, it is important to be proactive in explaining procedures and alerting patients and families of physical contact before a service is provided (Feldman and colleagues, 2001). Proper disclosure of the steps involved in the service will aid in preventing patient abuse accusations and incidents and put the patient and family at ease. Additionally, knowing a patient's history of victimization and having an extra attendant in the room to reduce patient discomfort will also reduce the risk of patient abuse accusations (Feldman and colleagues, 2001). Averill and colleagues (2001) also noted that providing proper training to staff members will help to reduce accusations and incidents.

Institutions that care for children should have a system in place to efficiently and effectively manage abuse accusations and incidents (Feldman and colleagues, 2001). Having a system in place will not only benefit the institution, but it will also provide the staff member involved an understanding of the process and give the victim and their family a sense of comfort knowing that the accusation is being taken seriously.

Adults

Non-elderly adult abuse is an aspect of patient abuse that is not widely addressed. LaRocco (1985) discussed patient abuse in a manner that can apply to all patient populations, regardless of setting or how vulnerable the patient is. Although adult abuse for individuals under the age of 60 is not widely mentioned in the research, it can include those who are mentally ill, have an intellectual disability, or are sedated or under the influence, as well as individuals who are being taken advantage of by staff members or caregivers. While abuse may seem less likely among adults under the age of 60, this is not a safe assumption. Abuse against any patient group, whether in a community or institutional setting, cannot be tolerated, and healthcare professionals need to be aware that abuse can take place in any patient group, regardless of age, setting or mental capacity.

SETTINGS OF ABUSE

Institutional Settings

Rates of elder abuse and neglect are higher in institutional settings as compared to community settings (Yon et. al., 2019). Institutional settings where elder abuse occurs include hospitals, nursing homes and long-term care facilities (Yon et. al., 2019). Although elder abuse is prevalent in institutional settings, research on this issue is still in the early stage of development (Pillemer et. al., 2016). In a meta-analysis based on staff reports from four studies, approximately two in three staff admitted to committing elder abuse within the past year (Yon et. al., 2019). When broken down by types of abuse as reported by staff, the rate of psychological abuse was 32.5 percent, followed by neglect (12 percent), physical abuse (9.3 percent), and sexual abuse (0.7 percent) (Yon et. al., 2019).

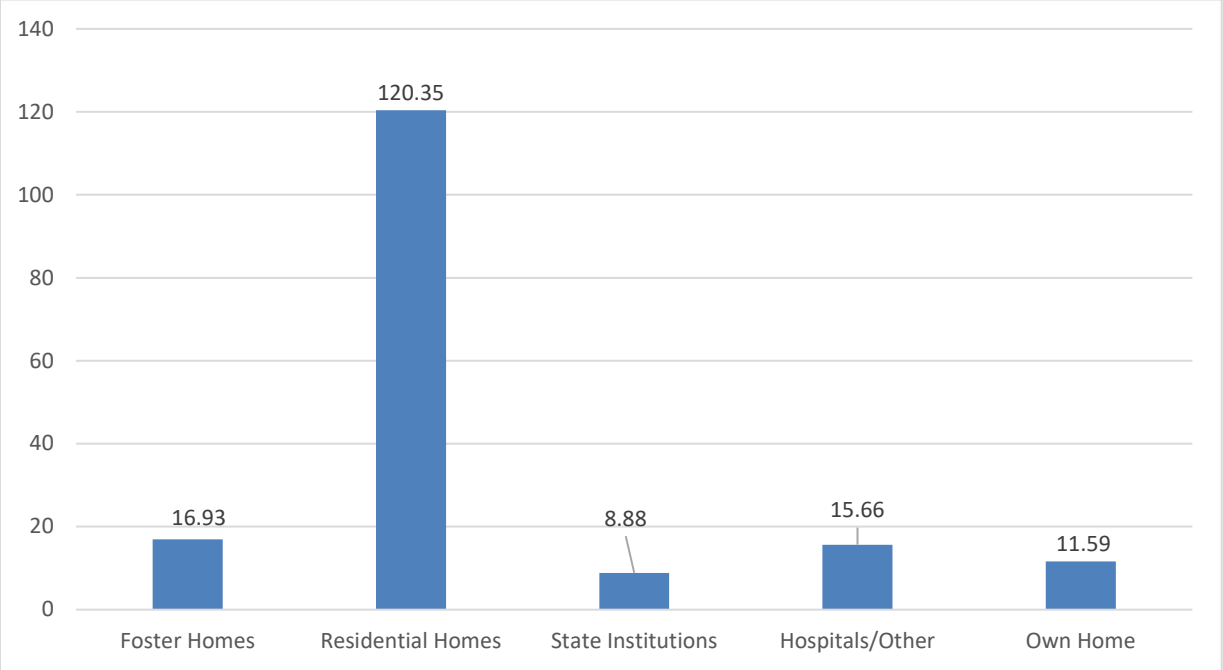
While there was not enough evidence to report the overall prevalence of abuse based on self-reported data from elderly patients, an analysis of abuse subtypes showed that psychological abuse was the most common at 33.4 percent (Yon et. al., 2019). Physical abuse followed at 14.1 percent, then financial abuse (13.8 percent), neglect (11.6 percent), and sexual abuse (1.9 percent) (Yon et. al., 2019). There are limited studies on the prevalence of elder abuse in institutional settings, and the current studies project a wide range of prevalence rates (Yon et. al., 2019). The rates from Yon and colleagues (2019) do not capture the overall rates of elder abuse and neglect in institutions and do not show the full extent of the issue of elder abuse in institutional settings. Given this limited amount of research, future studies should clearly define the population of study, the sources of abuse (staff-to-resident abuse, resident-to-resident abuse, or visitor-to-resident abuse), characteristics of the institution (staff-to-patient ratios, care guidance, ratio of trained staff, etc.), use of measurement tools, and data collection methods (questionnaires vs. face-to-face interviews) (Yon et. al., 2019). Overall, additional research on elderly abuse in institutional studies will aid researchers

and policymakers in creating an environment where the rights of elderly adults to live without prejudice, abuse and violence will be protected (Yon et. al., 2019).

When looking at abuse in institutional settings, it is important to keep in mind groups outside of the elderly and those with learning disabilities. Abuse can take place among patients in a normal hospital setting, as highlighted by Kendrick & Taylor (2000). However, there are other settings to consider, aside from hospitals and elderly homes, when discussing patient maltreatment. In a study by Spencer and Knudsen (1992), researchers compared in-home abuse rates from 1984-1990 in Indiana to maltreatment rates in foster homes, residential homes, and state institutions and hospitals. In hospitals and other facilities, residential homes and foster homes, the rates of maltreatment were higher than for children who lived at home (Spencer & Knudsen, 1992). Sexual abuse was the most common form of abuse in hospitals and residential homes, followed by physical abuse and neglect (Spencer & Knudsen, 1992). However, in state institutions, neglect was more common, followed by sexual abuse and physical abuse (Spencer & Knudsen, 1992). Contrarily, in foster homes, physical abuse was more common, followed by sexual abuse and neglect (Spencer & Knudsen, 1992). To protect children in institutional settings from abuse, Kendrick and Taylor (2000) identified three safeguards: listening to children, providing staff with the proper training and support, and using external systems of monitoring, inspection and standards.

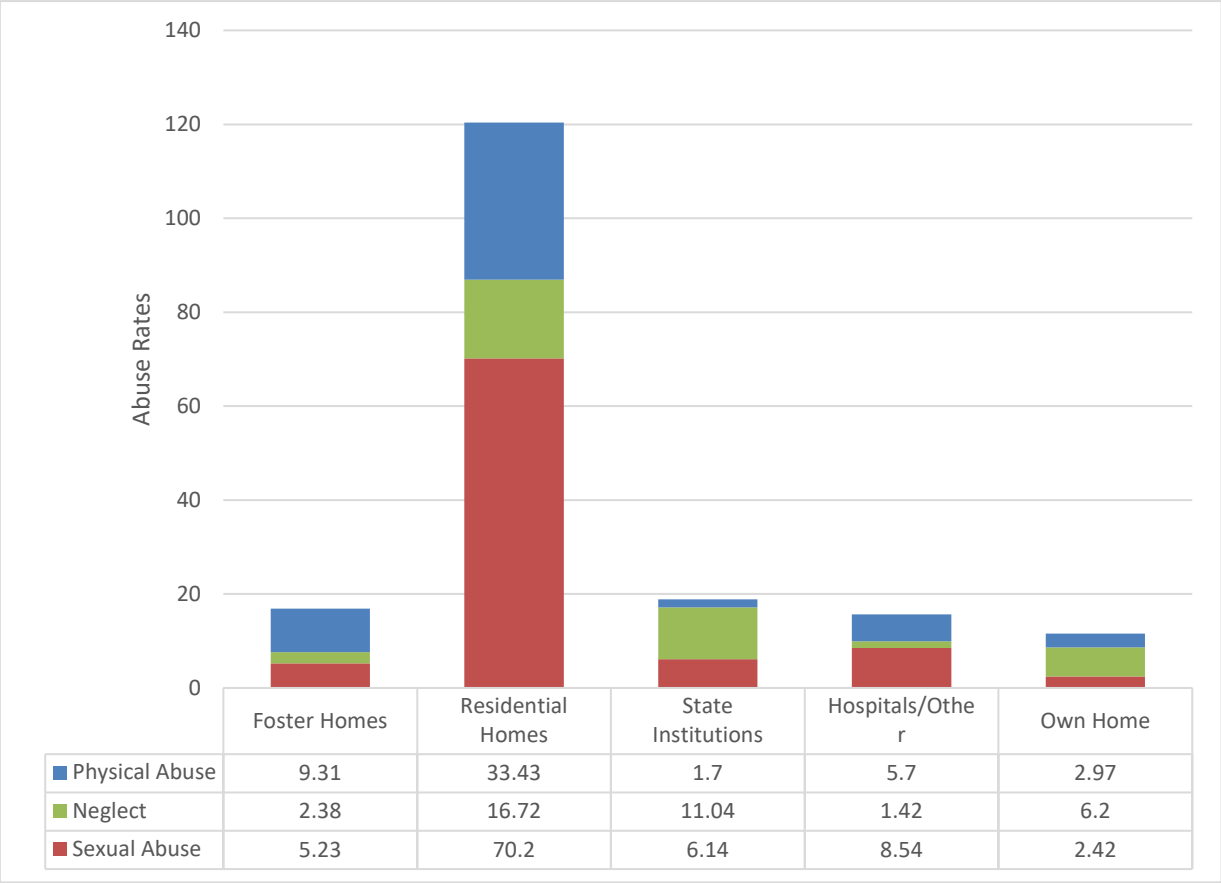
Figure 1: Total Abuse by Setting

Mean number of substantiated/indicated child maltreatment reports by total abuse



Note: Rate per 1,000 children for various settings

Figure 2: Type of Abuse by Setting
Mean number of substantiated/indicated child maltreatment reports by type of abuse



	Foster Homes	Residential Homes	State Institutions	Hospitals/Other	Own Home
Physical Abuse	9.31	33.43	1.7	5.7	2.97
Neglect	2.38	16.72	11.04	1.42	6.2
Sexual Abuse	5.23	70.2	6.14	8.54	2.42

Note: Rate per 1,000 children for various settings

Community Settings

While elder abuse is more prevalent in institutional settings, it also takes place in community settings. In a meta-analysis conducted in 2017 of 52 studies from 2002 to 2015, researchers found that, in community settings across the world, an estimated one in six older adults experienced a form of abuse within the past year (Yon et. al., 2017). The type of abuse reported by elderly residents was financial (13.8 percent), psychological (11.6 percent), neglect (4.2 percent) physical (2.6 percent), and sexual (0.9 percent) (Yon et. al., 2017).

In community settings, elderly patients may not have access to the help they need because of the position of the abusers. There also may be patients in other vulnerable groups in community settings or private homes who are abused by their caretaker or someone who is in contact with them, and they may not be able to report their abuse to get the help they need. Caretakers who are also abusers can use neglect or physical, financial, verbal or sexual abuse to control the patient. In community and private home settings, patients may not have access to a healthcare provider, may not be able to

voice their concerns, may be fearful of their caretaker or abuser, and/or may not have access to the resources needed to get assistance with escaping an abusive relationship.

RISK FACTORS FOR PATIENT ABUSE

LaRocco (1985) states that the causes of abusive behavior can be divided into three categories: the staff member, the setting, and the patient. Some staff members involved in direct patient care are underpaid, poorly educated, and dealing with personal problems. All of these factors may play a role in how they deal with a demanding patient (LaRocco, 1985). Other factors that contribute to patient abuse by staff include caregiver stress when feeling overwhelmed by caring for the elderly patient, caregivers with a history of substance abuse or a history of abusing others, and caregivers who are emotionally or financially dependent on elderly patients (Hildreth et. al., 2011). The setting itself can also contribute to patient abuse. In institutional settings, the indiscriminate hiring of employees, lack of training for unskilled staff, insufficient staff, lack of managerial supervision, and tolerance of unacceptable behavior can lead to patients being cared for inadequately (LaRocco, 1985).

Health care settings that lack proper training for staff on how to care for, treat, and handle patients and that lack standard policies and procedures for reporting patient abuse also place their patients at risk for abuse by not holding their staff members accountable. Lastly, some characteristics of patients and/or their families may make abusive behavior more likely (LaRocco, 1985). As previously noted, there are several things that place elderly patients at risk for abuse. In addition to dementia, being a woman, and being older than 74 years old (Juklestad, 2001; World Health Organization, 2011; Yon et. al., 2019), elderly patients who are physically dependent on others and/or suffer from depression, loneliness, or a lack of social support are at higher risk (Hildreth et. al., 2011). Additionally, patients who are abusive toward staff members and cause distress or harm to staff members through physical or verbal abuse, including racial slurs, spitting, hitting or kicking, may be more likely to suffer abuse themselves (LaRocco, 1985). However, provocation does not excuse abusive behavior from staff members (LaRocco, 1985). Adults and patients who are in vulnerable groups, such as children and those with intellectual disabilities, as well as those in a vulnerable state (i.e., under the influence, sedated, etc.) are also at risk for abuse.

RECOMMENDATIONS

LaRocco (1985) recommended that institutions establish environments where there is concern for patients. Institutions can show concern by having nursing and hospital administration make frequent patient contacts to assess patient satisfaction (LaRocco, 1985). In addition to making patient contacts, establishing a patient centered environment where the patient advocate is a visible employee who has direct and

immediate access to administration is another measure that can be taken to prevent patient abuse (LaRocco, 1985). Additionally, “all patient complaints should be thoroughly investigated and disciplinary action for staff initiated as necessary” (LaRocco, 1985, p.28). Efficiently responding to all patient abuse accusations and incidents and conducting thorough investigations will allow an institution to quickly clear up any misunderstanding related to the accusation or discipline or dismiss the accused staff member, if appropriate.

Feldman and colleagues (2001) designed a list of recommendations for institutions and staff members on how abuse incidents and accusations should be handled when they arise and how they can be prevented (Table 1). While Feldman and colleagues (2001) focused on child abuse and neglect, these recommendations can be applied to all patient groups, whether in institutional or community settings, to aid in properly handling accusations and preventing abuse by staff members and caregivers.

Table 1: Recommendations for Institutions and Staff Regarding Allegations of Abuse

Institutional Issues ● Have an abuse accusation evaluation policy. ● Train staff to be aware of their personal responsibility to report and how to activate the abuse evaluation. ● Train employees to feel personally responsible for the safety of all children. ● Screen prospective employees for a history of substance abuse or perpetration of past abuse or interpersonal violence. ● Recognize staff stress and mental difficulties and act to relieve them. ● Train staff, especially non-professional members, in patient “boundary” issues. ● Have a patient restraint policy and staff training in its implementation. ● Promptly notify the involved physicians, site supervisors, and hospital administrators that a complaint has occurred. ● Brief and debrief the accused and his or her colleagues.
Individual Staff Issues ● Conduct sensitive examinations in formal hospital settings, with an attendant. ● Say what you are doing and why before you do it. ● Recognize patient anxieties because of past abuse experiences. Chaperone in any questionable situation. ● Use caution with mentally ill, sedated, or intoxicated patients. Recognize problem families and develop a hospital clinical safety plan. Handle fragile patients carefully.

In addition, recommendations made by the World Health Organization (2020) to respond to and prevent abuse include mandating the reporting of abuse to authorities; providing self-help groups for victims of abuse, as well as caregivers and healthcare staff who may be overwhelmed by their responsibilities; using safe houses and

emergency shelters to separate victims of abuse from abusive environments (i.e., residential homes and foster care); providing psychological programs for abusers; providing patients with the numbers of helplines to provide them with information and referrals; and providing caregiver support interventions.

PREVENTION STRATEGIES

Overall, the goal of the recommendations to institutions and staff regarding allegations of abuse (Table 1) is to prevent abuse in institutional and community settings and among all patient groups, rather than simply respond to accusations and incidents. According to the World Health Organization (2020), many strategies have been implemented, mainly in high-income countries, to take action against and prevent elder abuse. These strategies can be applied in all settings to prevent patient abuse among all groups. Some examples include public and professional awareness campaigns to educate the public on abuse; screening to identify potential abuse victims and abusers; providing respite care to caregivers when they are feeling overwhelmed; providing stress management programs to caregivers and staff members in institutional settings; providing caregivers with training on dementia; and requiring institutional facilities to define and improve their standards of care (World Health Organization, 2020). Establishing a system of checks and balances, providing proper training on patient care and handling, clearly communicating to staff members their responsibility to patients, instructing staff to clearly communicate procedures to patients and their families, having a standard policy on abuse and procedures to follow up on abuse accusations, and creating a patient-centered environment for institutional and community settings can work toward preventing patient abuse and strengthening the relationship between staff members, caregivers and patients.

An additional prevention strategy that should be explored involves hospital security and how they can be used to help prevent patient abuse. When reviewing “Security Personnel Practices and Policies in U.S. Hospitals: Findings From a National Survey,” Schoenfisch and Pompeii (2016) examined the characteristics and responsibilities of hospital security teams, components of hospitals’ workplace security policies, and hospitals’ security personnel training in workplace violence recognition and prevention. Of the 340 hospitals examined, more than half (55%) had all of the components for workplace violence policy that are recommended by the Occupational Safety and Health Administration, including recordkeeping, worksite analysis, management commitment, employee involvement, hazard prevention and control, and safety and health training (Schoenfisch & Pompeii, 2016). It is possible that if more hospitals included all of the recommended components, incidents of harm against patients could be reduced. While the details of hospital security personnel training were not specified, there needs to be a balance between employee health and safety and patient safety and satisfaction. In addition to training on employee safety, security personnel should be trained to recognize suspected instances of patient abuse and neglect. Although security personnel do not interact with patients in the same manner as health care professionals,

they should be encouraged to report instances of suspected patient abuse or neglect and the health care professional involved.

PATIENT RESOURCES

If possible, patients and/or their families should first take abuse accusations to a managerial staff member at the institution where the incident took place. If they need additional help, there are many resources available, from the major organizations listed below in the United States and Canada to local groups that offer additional services and information.

- Eldercare Locator is a public service of the U.S. Administration on Aging connecting patients to services for elderly adults and their families.

  Phone: 1-800-677-1116 (toll-free)
  Email: eldercarelocator@n4a.org
  Webpage: https://eldercare.acl.gov

- The National Center on Elder Abuse through the Administration for Community Living offers information on how to report abuse and how to detect, stop and prevent abuse, as well as resources on training, awareness, where to get help, and federal and state abuse and neglect laws.

  Phone: 1-855-500-3537 (toll-free)
  Email: ncea-info@aoa.hhs.gov
  Webpage: https://ncea.acl.gov

- The National Adult Protective Services Association is an organization present in all 50 states that provides services to victims of maltreatment among the elderly and other vulnerable adult populations.

  Phone: 1-217-523-443
  Webpage: www.napsa-now.org

- The National Domestic Violence Hotline assists victims and survivors of domestic violence by offering help to anyone who is a victim of abuse, providing information on where to get legal help, and offering resources for abusers looking to get help.

  Phone: 1-800-799-7233 (toll-free, 24/7)
  Phone: 1-800-787-3224 (TTY/toll-free)
  Webpage: www.thehotline.org/get-help

- The U.S. Department of Justice provides information on U.S. law and enforces federal law.

  Phone: 1-202-514-2000
  Phone: 1-800-877-8339 (TTY/toll-free)
  Email: elder.justice@usdoj.gov
  Webpage: www.justice.gov/elderjustice

- Seniors Safety Line, a 24/7 resource that offers support in more than 150 languages for seniors who are experiencing abuse

  Phone: 1-866-299-1011
  Webpage: http://www.elderabuseontario.com

- Retirement Homes Regulatory Authority, an organization where elderly individuals or their family members can file a complaint if a complaint filed at a retirement home has not been resolved.

  Phone: 1-855-ASK-RHRA (275-7472)
  Webpage: http://www.rhra.ca/en/information-for-retirement-home-residents/complaints/

- Seniors' INFOline, a group that provides information on elder abuse

  Phone: 1-888-910-1999
  TTY: 1-800-387-5559

- Kid's Help Phone, an organization that allows children to call in and chat about anything and that will connect them to the proper resources for additional help.

  Phone: 1-800-668-6868
  Webpage: https://kidshelpphone.ca

- Canadian Child Welfare Research Portal, a webpage to help individuals locate their local child welfare authority and the authority's contact information.

  Webpage: https://cwrp.ca/provincial-and-territorial-assistance

- Child Abuse Hotline, a 24/7 helpline to report child neglect, abuse or sexual exploitation.

  Phone: 1-800-387-KIDS (5437)

- Interior Health, an agency that responds to reports of Adult Abuse and Neglect

  Phone: 1-844-870-4754

Webpage:
https://www.interiorhealth.ca/YourHealth/AdultSeniorsHealth/AdultAbuseNeglect/Pages/GettingHelp.aspx

CONCLUSION

Patient abuse can consist of neglect, physical, sexual, financial, and verbal abuse and can take place in any institutional or community setting among any vulnerable group. While patient abuse refers to the intentional harm of a patient, neglect is when a patient's necessary needs are not being met by a staff member or caregiver. Research, policies and laws on patient abuse and neglect should aim to highlight that abuse takes place in all patient groups and should expand their resources to address all types of abuse in children, the elderly, those with learning disabilities, adults under 60, and other vulnerable groups.

To combat patient abuse by staff and prevent future abuse, institutions are responsible for establishing a patient-centered environment. This involves not only developing policies and procedures to address abuse accusations and create an environment where abuse of any form will not be tolerated, but also training staff to properly care for patients and providing support for staff members and caregivers who feel overwhelmed by the responsibilities of their role. While there is no excuse for patient abuse of any kind, understaffed institutions, faulty systems, undertrained staff, and a lack of management oversight are all institutional factors that place a patient at risk of abuse. Institutions that lack policies on patient abuse are inappropriately placing complete trust in their staff, even though patient abuse can be an issue among some of the most professional staff members (Nations, 1973). Additionally, patient behavior must also be addressed. While staff members and caregivers committing patient abuse because they were provoked by the patient is inexcusable, documenting patient behavior may help staff be more aware of the kind of patient they are dealing with.

The main goals of future research on patient abuse by staff should be to (i) conduct more prevalence studies on patient abuse by staff, (ii) further study patient abuse by staff in other vulnerable populations to include pediatrics, patients with learning disabilities, and adults under the age of 60 who have suffered from abuse in institutional or community settings, (iii) continue to study elder abuse as it is a public health concern, and (iv) conduct more interventions on eliminating patient abuse so that they may be studied and applied in other settings. Conducting more research on patient maltreatment across all patient groups in institutional and community settings will aid in the development of more inclusive policies addressing different types of abuse and settings where abuse can occur. Apart from researchers, patients and their families must be sure to accurately report patient maltreatment events. Ultimately, management and healthcare professionals in community and institutional settings must work together to keep patients safe.

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