Abuse of residents in nursing homes: results of a staff questionnaire

In this article...

- Facts around abusive practices in nursing homes
- Responses from 156 nursing home staff to an anonymous questionnaire on abuse
- Reasons why abuse in nursing homes is continuing despite safeguarding policies

Keywords: Abuse/Older People/Safeguarding/Governance/Policy

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Abstract

This article presents findings from a research project exploring the extent and causes of abuse in independent-sector nursing homes for older people. A questionnaire was issued to nursing and care staff recruited to five newly opened nursing homes to determine the frequency and nature of any abuse they had witnessed in homes where they had previously worked. A high number of respondents reported witnessing abuse, suggesting changes to current governance and external scrutiny are required.

Citation


In 2000, a formalised safeguarding policy that explicitly included abuse in nursing homes was introduced in England (Department of Health, 2000). Sixteen years later, local authorities continue to receive safeguarding alerts from independent-sector nursing homes and there has been no reduction in the incidence of abuse, indicating little progress in prevention. In recent years, evidence of abuse in several care homes in recent years has been recorded using concealed video cameras in England and Wales (for example, Bit.ly/MirrorObanHouse, Bit.ly/BBCWrexall, Bit.ly/BBCBraintree, Bit.ly/BBCBethshan, Bit.ly/WSussexOrchidSCR, Bit.ly/BBCKeldgate).

The DH’s (2000) safeguarding policy made local authorities the lead agencies for coordinating responses to abuse. However, when abuse occurs in nursing homes, other professionals are invariably involved in investigations and remedial actions; these can include hospital- or nursing home-based nurses, community nurses and NHS safeguarding leads – who often are qualified nurses.

This article presents findings from the literature review and questionnaire elements of a mixed-methods study undertaken to better understand the extent of, and reasons for, abuse in independent-sector nursing homes for older people, and thereby better protect residents from abuse, as opposed to reacting once it has occurred.

Literature review

Prevalence of abuse

Research on the prevalence of abuse of older people in nursing homes is limited, and many studies are old and/or were undertaken outside the UK. However, the literature does suggest abuse in nursing homes may still be a common occurrence.

Pillemer and Hudson (1993) determined that, among 221 randomly selected care staff in nursing homes for older people, 2% had slapped a resident, 10% had pushed or grabbed a resident, 17% had excessively restrained a resident and 8% had threatened to hit a resident in the preceding month. The College of Nurses of Ontario (1993) determined that, among 1,608 nursing and care staff, almost 50% had witnessed abuse of older people in a range of healthcare settings; although not all respondents were employed in nursing homes, 36% had
Many older people who live in nursing homes are the victims of abuse

Witnessed abuse in such facilities. In Germany, Goergen (2004) identified that 79% of all nursing staff from eight nursing homes reported committing abuse and 69% reported witnessing abuse by others. In Cooper et al’s (2008) systematic review of all available prevalence studies in both domiciliary settings and care and nursing home settings, overall, 16.6% of staff admitted having committed psychological abuse, 10% admitted to physical abuse and 80% reported witnessing others committing abuse in the home where they worked. Cambridge et al (2006) found that 51.9% of all reported abuse of older people had occurred in nursing and care homes, compared with 42.2% in people’s own homes.

Evidence of abuse had previously been unearthed by Jenkins et al (2000) after analysing calls made to the Action on Elder Abuse helpline between 1997 and 1999. They found almost 30% of calls related to abuse in care and nursing homes or hospitals, yet only 4–5% of those over retirement age reside in such settings at any one time (Office for National Statistics, 1999). They also found that 29% of abusers identified were paid care workers, and 362 calls reported abuse in formal care settings, compared with 148 in people’s own homes. AEA (2006) later showed that, during a six-month period in 2005, 29.4% of alerts across nine local authority areas came from nursing and care homes.

Staff attitudes

Attitudes of nursing home staff towards residents that might explain acts of abuse have received little attention from researchers. Lee-Treweek (1996) cited care staff categorising residents as “the disliked” or “the confused”, and describing residents in “fixed, one-dimensional terms” such as “cold”, “mean”, “vicious” and “evil”. Although staff provided the necessary physical care, they denied residents emotional support; today, this behaviour would be construed as psychological abuse or neglect.

These findings echo earlier work by Evers (1981), who showed that staff classified some older female residents on NHS long-stay hospital wards as “awkward Alices”, these residents therefore received neglectful treatment. Both DeHart et al (2009) and Tomita (1990) found residents in nursing homes were labelled “disgruntled”, “unreasonable”, “demanding” or “full of self-pity” and, consequently, were treated unkindly. Maben et al (2012) determined that acutely ill older people in hospitals were categorised by staff as either “poppets” (a term of endearment) or “pups” (a pejorative term meaning awkward or demanding) and were treated accordingly, either with care and affection or in a “dehumanising” way.

Due to limited research on the extent of and reasons for abuse, much of what is currently known has been derived from investigations and serious case reviews conducted after instances of proven abuse, including that which had been covertly filmed. What is known confirms that some older people still experience abuse in nursing homes.

Study design

Mixed-methods approach

It was clear at the design stage that the research should be informed by the perceptions of nursing home owners, managers, nursing staff and care staff. It would also have been useful to collect the perceptions of residents, but obtaining informed consent from people whose cognitive ability might be compromised was deemed unfeasible in the allocated time.

The obvious method of gathering data was face-to-face interviews. However, there was a risk that, being interviewed on the street, participants would exhibit “socially desirable responding” (Mitchell and Jolley, 2007) and say what they believed the researcher wanted – or ought – to hear, rather than the truth. As such, a mixed-methods approach was conceived in which, as well as face-to-face interviews, a questionnaire was distributed to newly appointed staff in five recently opened nursing homes. The interviews were conducted with staff working in different nursing homes; these findings will be discussed in articles to be published in future issues of Nursing Times.

Questionnaire

The questionnaire allowed participants to:
- Quantify occurrences of abuse they had witnessed or suspected in nursing home(s) in which they had previously worked;
- Explore its nature.

It included the definition and type of abuse used for the study (which matched those used in the DH’s (2000) guidance), and asked respondents to quantify occurrences of abuse they had witnessed or suspected. For witnessed abuse, they were asked to indicate:
- Abuse type (physical, psychological, financial, neglect, sexual or other);
- Whether it happened once or repeatedly;
- Whether it occurred during the day or at night;
- How long ago it happened (in the past 12 months, 1-3 years ago or >3 years ago).

Respondents could also provide more detailed descriptions if they wished.

Rationale

The rationale behind this design was to overcome participants’ fear of retribution from employers, managers or peers, which is often given as a reason people feel they cannot disclose abuse (Owen et al, 2012). It was not known before distributing the questionnaire whether any occurrences of abuse would be revealed but, from an ethical perspective, it was judged that the method might uncover data that would otherwise remain hidden as nursing homes are often difficult to penetrate for research purposes (Davies et al, 2009).

It was also hoped that the findings would help shape responses to abuse at a primary, preventive level; current responses remain at a secondary and tertiary reactive level (Kalaga and Kingston, 2007). These factors were considered likely to help protect older people from abuse in the future.

Settings and population

Between 2011 and 2015, five new nursing homes for older people opened in four local authority areas known to the researchers. The managers of these homes were approached to explain the nature of the research and request their participation; all agreed that their home would participate.
Each home was given enough questionnaires to distribute to all nursing and care staff recruited, along with information sheets explaining that the questionnaire was to be completed anonymously and neither personal details nor names of previous workplaces were required.

Questionnaires were distributed by managers during or shortly after new staff members’ induction to the home, and were returned to the researcher using a postage-paid envelope provided. The managers of each participating nursing home were also invited to complete the questionnaire; the majority returned were completed by care staff (89.1%), with the remaining 10.9% completed by registered nurses.

Only questionnaires from staff who had previously worked in independent-sector nursing homes (97% of respondents) were included in the analysis.

### Results

#### Questionnaires

Table 1 shows the estimated number of questionnaires distributed in each home and the number returned. Most respondents (n = 138, 88.5%) indicated they had witnessed and/or suspected abuse in nursing homes where they had previously worked. Of these, 7.3% previously worked in nursing homes for older people and 92.7% in nursing homes for older people with dementia.

### Table 1. Information gathered

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### Table 2. Characteristics of witnessed abuse

#### Staff who witnessed abuse, n (%)*

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<th>Random nursing home identifier</th>
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<td>20 (63.3)</td>
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<td>23 (82.1)</td>
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<td>109 (79.0)</td>
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</table>

#### Type of abuse witnessed:

- **Physical**
  - 7
  - 11
  - 18
  - 15
  - 15
  - 88

- **Psychological**
  - 20
  - 20
  - 18
  - 15
  - 15

- **Financial**
  - 1
  - 0
  - 0
  - 0
  - 0
  - 1

- **Neglect**
  - 17
  - 14
  - 8
  - 9
  - 11
  - 59

- **Sexual**
  - 0
  - 0
  - 0
  - 0
  - 0

- **Other**
  - 0
  - 0
  - 0
  - 0
  - 0

#### Abuse occurred:

- **Once**
  - 2
  - 3
  - 3
  - 6
  - 4
  - 18 (16.5)

- **Repeatedly**
  - 22
  - 22
  - 17
  - 19
  - 19
  - 99 (90.8)

#### Abuse witnessed:

- **During day**
  - 18
  - 17
  - 16
  - 17
  - 18
  - 86 (91.5)

- **At night**
  - 1
  - 6
  - 2
  - 7
  - 5
  - 21 (22.3)

#### Abuse witnessed:

- **In past 12 mths**
  - 7
  - 14
  - 17
  - 19
  - 20
  - 77 (69.0)

- **1-3 yrs ago**
  - 8
  - 11
  - 5
  - 6
  - 6
  - 36 (28.6)

- **>3 yrs ago**
  - 2
  - 0
  - 0
  - 0
  - 0
  - 3 (2.4)

### Witnessed abuse

Table 2 shows the numbers of respondents who reported witnessing abuse per nursing home, and the characteristics of that abuse. Of the 138 respondents who reported abuse, 109 (79.0%) said they actually witnessed it.

Psychological abuse was the most common type witnessed (47.6%), followed by neglect (31.9%) and physical abuse (20.0%); one respondent reported having witnessed financial abuse, while there were no reports of sexual or other forms of abuse. Respondents had often witnessed more than one type of abuse; the majority (90.8%) had witnessed repeated acts while 16.5% had witnessed isolated abuse (some witnessed both); 91.5% reported witnessing abuse in the day and 22.3% at night.

Sixty-nine per cent of respondents had witnessed abuse in the previous 12 months, 28.6% in the 1-3 years before completing the questionnaire, and 2.4% more than three years earlier. The questionnaires were completed between 2011 and 2015 so most of the witnessed abuse took place relatively recently.

#### Examples of witnessed abuse

Respondents who reported witnessing abuse were prompted to describe its nature in free-text responses. Table 3 shows all examples cited; some respondents gave free-text responses, which included:

- “The senior carer and her cronies took delight in the senior carer cleaning this man’s toenails with a fork, then putting it on the dinner table to watch another resident eat their dinner with it.”

- “It wasn’t uncommon for the care staff to lark about and put the wrong dentures in people’s mouths so they looked funny, y’know, like a man’s teeth in a woman’s mouth.”
‘New’ restraint practices

Some free-text responses also described specific practices, including two restraint practices not previously identified by researchers. These were witnessed in the 12 months before the questionnaire was completed:

- The “cocoon” – an arrangement of bed sheets and a draw sheet that prevented residents from “interfering” with their continence aid and creating a “mess” of excrement and urine after being “put to bed”. Respondents reported this as applied routinely, particularly to residents with dementia, with the knowledge of the nurse in charge. It meant staff did not need to check residents’ continence needs overnight and the cocoon would remain undetected by casual, visual inspection. This was described by four respondents, who had previously worked in different local authority areas and were therefore unlikely to have been employed in the same nursing home.

- “Hooking” or “snagging” – used to restrain residents needing to excrete by stretching their vest and hooking it to the protruding ends of the bolts that secure the toilet seat in place. In the examples given, this allowed members of staff to attend to other residents while the hooked/snagged resident remained unsupervised but “secure”. Again, this technique was described as being used with people who had dementia. This was described by five respondents who had previously worked in different local authority areas; two referred to it as “snagging” and three as “hooking”.

Discussion

The completed questionnaires give a unique insight into some private-sector nursing homes. Although the sample size is small, the findings suggest the abuse of older people continues to occur and evade detection despite the existence of governance, safeguarding and regulations.

The questionnaires revealed previously unidentified abusive practices in some independent nursing homes. These practices are not readily detectable by current governance arrangements and regulatory methods, whether routinely or in connection with safeguarding investigations. This is, in part, because perpetrators of abuse are likely to be aware that external observers are conducting checks and can maintain an ‘institutional display’ while being observed (Goffman, 1961). It is also partly because much abuse takes place behind closed doors, due to the intimate nature of care, and/or at night. This hinders oversight by management and regulatory authorities – particularly at night, when this is often reduced or non-existent. That said, it also appears that qualified nurses – who, in some cases, may have been the highest level of management – may sometimes have been active or complicit in the abuse.

These practices are occurring despite the introduction of the DH’s (2000) formal safeguarding policy 16 years ago and formal regulation of nursing homes being in place since 1983. We need to:

- Recognise that current governance, regulatory and safeguarding regimes are failing some older people who live in nursing homes;
- Ascertain why this abuse is enduring;
- Work out how this abuse can be effectively tackled.

Organisational cultures

The Care Quality Commission (2013) has placed renewed emphasis on how organisational culture can influence the quality of care and occurrence of abuse. Open cultures with good leadership, such as encouraging people to speak out about abuse, are being promoted in the nursing home sector as having benefits (Social Care Institute for Excellence, 2011). However, there still is a misconception that a nursing home’s organisational culture can be truly grasped through what is seen, felt and heard (Tuckett, 2007). Positive organisational cultures may maintain an apparent ethos of person-centred care but, as shown in this study, some more-negative aspects may remain hidden. Everyday abusive practices, often used just to ‘get the job done’, are not readily detectable using current methods of governance and scrutiny.

Organisational artefacts

Schein (2004) identified organisational artefacts as the readily observable aspects of an organisation’s culture – for example, written procedures for nursing home staff. However, Schein also described “tacit assumptions” that are unseen features of the organisation’s culture, existing as part of the relationships and interactions of staff members – for example, whether or not staff really are expected to adhere to written procedures in practice. These tacit assumptions are not easily detected by conventional methods of management scrutiny, safeguarding inquiry or regulatory activity. This may explain why abuse sometimes occurs in nursing homes despite their apparent compliance with standards of care (Cambridge et al, 2006).

Table 3. Examples of witnessed abuse

<table>
<thead>
<tr>
<th>Abuse type</th>
<th>Examples (n)</th>
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<tbody>
<tr>
<td>Psychological abuse (total = 95)</td>
<td>Denying choice (15) ● Ignoring residents (14) ● Threatening with physical violence (14)</td>
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<td></td>
<td>Withholding affection (9) ● Tormenting verbally (6) ● Threat of eviction (6) ● Taunting about a physical disability or loss of bodily function (12) ● Taunting about sexual needs (3) ● Threat of catheterisation (3)</td>
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<tr>
<td>Neglect (total = 102)</td>
<td>Not giving drinks (14) ● Leaving residents in wet pads (14) or wet beds (9) ● Not giving food (9) ● Not washing residents (8) ● Not attending to oral hygiene (7) ● Falsification of food/fluid intake records (7) ● Falsification of ‘SKIN bundle’ records (6) ● Rough handling (7) ● Leaving residents undressed (6) ● Leaving and forgetting residents on toilet (6) ● Leaving residents unnecessarily sat in wheelchairs (5) ● Placing call button out of reach (4)</td>
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<tr>
<td>Physical abuse (total = 67)</td>
<td>Physical restraint (12) ● Forcing residents to get up against their wishes (7) ● Concealed physical restraint (6, eg tying residents to chairs with tights) ● Pinching (5) ● Rushing with feeding (5) ● Using proscribed lifting methods (6), slapping on arms or legs (5) ● Pulling hair (5) ● Slapping on face (4) ● Over-medication (4) ● Punching arms or legs (2) ● Punching chest (2) ● Giving unprescribed medication (2)</td>
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For more articles on caring for older people, go to nursingtimes.net/olderpeople
Nursing homes often publicise positive evaluations from the older people they look after, and state they are cared for with respect and dignity. Statements of purpose and patient charters featuring these declarations are further examples of organisational artefacts, as are care plans, risk assessments and fluid intake charts. Despite such declarations, abuse continues to take place in some nursing homes. At times, the nature of this is disturbing – such as when it is premeditated or when staff tacitly assume the use of techniques like the cocoon and hooking/snagging is acceptable. These practices may then become the norm to meet needs, but will not show in organisational artefacts, such as care plans, that are presented to regulators and investigators as a measure of the quality of care provided.

The deterrence environment

The origins and resilience of abusive practices in nursing homes may be further explained by the ‘deterrence environment’, described by Harris and Benson (2006) as the perceived certainty of detection combined with the perceived severity of punishment: the higher the chance of getting caught and the harsher the expected punishment, the more staff will be deterred from committing abuse.

Some abusive practices witnessed by respondents in this study happened behind the closed doors of bedrooms, bathrooms and toilets, and/or at night; clearly, in such cases, the likelihood of detection is low. Furthermore, the interviews revealed that respondents often perceived potential consequences for perpetrators of abuse as negligible. It would seem that, in nursing homes, the deterrence environment is weak.

Conclusions

The anonymous questionnaire method was used to determine the extent of abuse in independent-sector nursing homes for older people, and the forms it may take. Data analysis revealed that abuse continues to occur and is sometimes premeditated and/or severe. Its persistence is, in part, due to the fact that relevant agencies are steered by policy and legislation that leads them to react to abuse after it has taken place and scrutinise only the superficial artefacts of organisations, either routinely or following allegations of abuse. As a result, the fundamental factors that lead to abuse remain largely unchallenged.

Until it is acknowledged that the governance, safeguarding and regulatory processes currently used to evaluate the quality of older people’s care in private-sector nursing homes are often ineffective, abuse will continue. With this acknowledgement will come recognition that tackling abuse requires difficult policy-driven, corrective action that would likely upset both the for-profit nursing home sector (which already struggles to recruit and retain suitable staff) and the organisations responsible for its external oversight (who exist to maintain and improve safety and quality, but are not always doing so).

Box 1 lists some recommendations for improvement.

More effective ways of assessing the suitability and capability of staff employed to provide care would be required, along with new, and likely costlier, techniques of governance and regulation that look beyond appearances. If this is not done, the health and social care economy must accept that the abuse of older people in nursing homes will continue.

References


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● The ethics of using cameras in care homes.

Bit.ly/NTCamerasCareHomes


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● The ethics of using cameras in care homes.

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