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Research Progress on the Prevalence and Influencing Factors of Elder Abuse in Long-Term Care Facilities

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Abstract

Against the backdrop of accelerating population aging, long-term care (LTC) facilities have emerged as an integral component of elderly care provision. Elder abuse in institutional settings constitutes a serious public health and human rights issue, directly impairing the physical and mental health and quality of life of older adults. This paper systematically reviews the epidemiological status of elder abuse in LTC facilities both domestically and internationally, synthesizes the multifaceted influencing factors from the perspectives of older adults themselves, care staff, institutional management, and socio-cultural context, and summarizes existing prevention and intervention strategies at the micro, meso, and macro levels. Current evidence indicates that the overall prevalence of elder abuse in LTC facilities remains relatively high globally, with psychological/emotional abuse being the most common type, while resident-to-resident elder mistreatment (R-REM) also warrants particular attention. Cognitive impairment and disability status are individual vulnerability factors for victimization; caregiver burnout and low empathy are important drivers of abusive tendencies; institutional staffing shortages, inadequate remuneration, and deficient management systems amplify abuse risks; and ageism, weak regulatory oversight, and social isolation constitute macro-level contributing factors. Existing interventions include educational training and psychological support for caregivers, optimization of staffing and management protocols at the facility level, and strengthening of policy regulation and public awareness at the national level. At present, there is still a lack of localized, practical and systematic intervention programs. Future work should be based on the actual situation of the elderly care service industry, improve the risk identification, incident reporting and case management mechanism, and establish a prevention and control system with the collaborative participation of multiple stakeholders, so as to effectively protect the rights and dignity of the elderly in institutions.

Keywords

Elder abuse; Long-term care facilities; Nursing homes; Prevalence; Influencing factors; Interventions.

1. INTRODUCTION

With the acceleration of global population aging, long-term care facilities have assumed an increasingly prominent role in elderly care systems. According to United Nations data, in 2022, individuals aged 65 years and above accounted for approximately 10% of the global population, a proportion projected to rise to 16% by 2050 [1].Meanwhile, the OECD report Health at a

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Glance 2023 indicates that in 2021, the average proportion of the population aged 80 and above across OECD member countries was 4.8%, and this proportion is expected to double to 9.8% by 2050 [2]. Against this backdrop of deepening demographic aging, the safety and rights protection of older adults in LTC facilities have garnered increasing international concern.

Elder abuse has been explicitly defined by the World Health Organization (WHO) as a serious public health issue and a human rights challenge. WHO 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" [3]. Its types primarily include physical abuse, psychological/emotional abuse, sexual abuse, financial exploitation, and neglect. Abusive behaviors not only severely violate the fundamental human rights of older adults but may also lead to depression, anxiety, post-traumatic stress disorder, increased morbidity and mortality, and significantly diminished quality of life [3]. A study in the United States showed that elder abuse generates substantial annual economic losses [4].

Although elder abuse has attracted increasing attention, existing evidence suggests that the prevalence of abusive behaviors in LTC facilities is substantially higher than in community settings. A systematic review and meta-analysis encompassing multiple countries revealed that 64.2% of LTC staff admitted to having perpetrated some form of abuse in the past year [5]. The pervasiveness, concealment, and severe consequences of abuse in institutional settings underscore the urgency of systematic research. In this context, this paper systematically reviews the epidemiological status and influencing factors of elder abuse in institutional settings both domestically and internationally, with a particular focus on summarizing response strategies and research progress from three levels—individual/caregiver, institutional management, and social/policy, so as to provide reference evidence for constructing an abuse prevention and control system in China's LTC facilities.

2. PREVALENCE OF ELDER ABUSE IN LONG-TERM CARE FACILITIES

The prevalence of elder abuse in LTC facilities remains relatively high globally, yet reported rates vary considerably across studies due to marked differences in research design, definitions of abuse, sources of reporting, and recall periods. WHO has noted that rates of abuse among older adults in nursing homes and long-term care centers are considerably high [3]. A systematic review and meta-analysis of studies on elder abuse in institutional settings reported a pooled prevalence estimate of 64.2% based on staff self-report data—that is, nearly two-thirds of institutional staff acknowledged having perpetrated some form of abuse against older adults in the past year [5]. However, when based on older adults' self-reports, the limited number of available studies precludes calculation of a reliable overall prevalence estimate [6].

Prevalence rates vary significantly across different reporting sources. Relatives and staff typically report higher rates of abuse, whereas older residents self-report relatively fewer incidents; official registration systems tend to capture only the most severe cases, thus yielding lower prevalence rates, particularly for physical abuse, sexual abuse, and neglect. For instance, staff-witnessed abuse rates have been reported as high as 44% within a 4-week period, but as low as 1.4% over a 12-month period in some studies [6].

3. DISTRIBUTION CHARACTERISTICS OF DIFFERENT TYPES OF ABUSE

In institutional environments, the prevalence of different types of abuse varies markedly, with psychological/emotional abuse generally being the most common. WHO pooled data indicate that, based on older adults' self-reports in institutional settings, psychological abuse ranks highest (33.4%), followed by physical abuse (14.1%), financial abuse (13.8%), and neglect (11.6%), with sexual abuse lowest (1.9%) [3]. Data based on staff self-reports similarly show

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psychological abuse as the most frequent (32.5%), followed by neglect (12.0%), physical abuse (9.3%), and sexual abuse (0.7%) [5].

In addition to staff-to-resident abuse, resident-to-resident elder mistreatment (R-REM) represents another significant form of abuse in institutional contexts that cannot be overlooked. A U.S. study on R-REM in nursing homes found that over a one-month surveillance period, approximately 20% of nursing home residents experienced at least one abusive incident from another resident, with verbal aggression being the most common, followed by physical aggression [7]. Another systematic review estimated R-REM prevalence between 12% and 23% [6].

4. INFLUENCING FACTORS OF ELDER ABUSE IN LONG-TERM CARE FACILITIES

4.1. Individual Factors Related to Older Adults

Certain characteristics of older adults constitute the vulnerability basis for victimization. Cognitive impairment is one of the most prominent risk factors. Studies indicate that older adults with cognitive impairments such as dementia are at significantly higher risk of abuse, with risk increasing as dementia severity worsens and agitated behaviors escalate [8,9]. The degree of disability also constitutes an important risk factor: older adults with limitations in activities of daily living and those exhibiting psychiatric and behavioral symptoms are more likely to become targets of abuse [10]. Regarding demographic characteristics, widowed or divorced older adults face higher abuse risk than those who are married or never married [8]. Additionally, older adults with low levels of social support are more vulnerable to abusive situations [10].

Certain behaviors of older adults themselves may also precipitate abuse. Research has found that verbal or physical aggressive behaviors in institutionalized older adults are significantly associated with higher rates of emotional abuse [11,12]. This finding suggests that abuse often does not occur as a unidirectional perpetrator-victim relationship but may progressively escalate in the context of interactive tension.

4.2. Caregiver/Staff Factors

Caregivers are the direct perpetrators of abusive behaviors in LTC facilities, and their individual characteristics and psychological states play key roles in the occurrence of abuse. Among these, burnout is a repeatedly validated core risk factor. A cross-sectional study of 241 caregivers from 24 LTC facilities in Zhejiang Province, China, found that 40.7% of caregivers exhibited abusive tendencies; structural equation modeling demonstrated that burnout was a direct driver of abusive tendencies, with care difficulties and care stress indirectly affecting abusive tendencies through the exacerbation of burnout, and the model explaining 83% of the total variance in abusive tendencies [13]. Another study of 481 nurses and nursing assistants in France further confirmed that emotional demands and poor-quality relationships with colleagues were strong predictors of caregiver burnout, neglect, and abusive behaviors, with burnout mediating the relationship between work environment and abuse [14].

Beyond burnout, caregivers' personal competence and cognitive levels are also closely associated with abusive tendencies. A survey covering 428 caregivers from 13 LTC facilities across three provinces in China showed that 32.94% of caregivers exhibited abusive tendencies; monthly income, familiarity with laws protecting older adults' rights, empathy capacity, and nurse-patient caring interaction levels were all independent influencing factors [15]. Research focusing on caregivers of disabled older adults further found that education level, possession of professional certification, years of experience in elderly care, number of older adults under care, and positive feelings influenced abusive tendencies among caregivers in LTC facilities [16].

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These findings suggest that enhancing caregivers' professional competence, psychological resilience, and legal awareness has potential preventive value in reducing abuse risk. Furthermore, caregivers' own developmental experiences also influence abusive behaviors—those reporting poorer childhood quality are more likely to perpetrate neglect [12], indicating the profound impact of early life experiences on professional care behaviors.

4.3. Institutional Factors

Resource allocation and management quality at the institutional level are important structural factors constraining the occurrence of abuse. Staff generally attribute the stress they experience to staffing shortages and time pressure [17]. Empirical research supports this association: there is a significant correlation between abusive behaviors and higher patient-to-registered-nurse ratios, and increases in the number of qualified nurses are associated with reduced risk of resident abuse [18]. When nursing staff are insufficiently allocated, the risk of both R-REM and staff-to-resident abuse increases significantly [19], and higher workloads are associated with higher rates of emotional abuse and neglect [11].

Managerial support is equally crucial. Research indicates that lack of managerial support is significantly associated with psychological abusive behaviors [12]. Regarding facility ownership type, caregivers in publicly owned but privately operated facilities exhibited the strongest abusive tendencies [15], consistent with findings on neglectful care [20]. Previous research also shows that older adults in for-profit nursing homes have a higher probability of experiencing abuse than those in non-profit facilities; non-profit facilities tend to prioritize resident well-being and care quality over profit maximization, thereby providing higher-quality care services [21,22].

Furthermore, the completeness of institutional training systems directly affects the incidence of abuse. Lack of necessary training for staff to manage aggressive and challenging behaviors in older adults is an important contributor to abuse. Strengthening systematic training can effectively enhance caregivers' alertness to and recognition of abusive behaviors, deepen their understanding in this area, and thereby reduce the incidence of elder abuse [23].

4.4. Socio-Cultural Factors

The occurrence of elder abuse in LTC facilities is influenced not only by individual and institutional internal factors but is also deeply embedded in the broader socio-cultural context. Ageism and social prejudice constitute the most fundamental risk factors at the socio-cultural level. Ageism operates through pervasive cultural stereotypes and institutionalized discrimination against older adults [24]. In LTC facilities, ageism intertwines with the dehumanization of older adults, allowing abusive behaviors to be tolerated or even normalized in daily operations. A Swedish qualitative study found that caregivers, driven by ageist attitudes, tended to overlook older adults' medical needs or symptoms, attributing them to signs of normal aging—constituting both ageism itself and neglect of medical needs [25].

Inadequate policy, legal, and regulatory frameworks are also important macro-level risk factors. The OECD report noted that although most countries have established several mechanisms to address abuse, few systematically measure whether long-term care is safe, effective, and responsive to care recipients' needs [26]. A qualitative study from Uruguay revealed that contributing factors to institutional abuse included insufficient safety standards, lack of standardized care models, and absence of regular inspections; the absence of effective mandatory reporting systems leads to substantial underestimation and concealment of abusive incidents [27]. Some studies have also found that even when relevant protocols exist, LTC facilities often lack uniform implementation standards for handling abuse cases, leaving staff confused and reluctant to complete proper paperwork and interventions [19].

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Weak social support networks and social isolation among older adults are equally significant concerns. Low levels of social support and social isolation have been shown to correlate with elder maltreatment in institutional settings [28]. After admission to facilities, older adults often experience diminished family support, restricted social participation, and severed emotional bonds. Those lacking external supervision and family visitation are at significantly higher risk of abuse. Moreover, insufficient public attention to older adults' rights and limited public awareness of elder abuse make such behaviors more difficult to detect and stop [23].

5. RESPONDING STRATEGIES FOR ELDER ABUSE IN LONG-TERM CARE FACILITIES

5.1. Micro-Level: Individual and Caregiver Interventions

At the micro level, educational training is a core means of enhancing caregivers' capacity for abuse identification and prevention. Theory-based educational interventions—including theoretical training, group discussions, and forum theater—can significantly improve healthcare providers' awareness of elder abuse and enhance their ability to identify, report, and manage related issues [29]. A cluster randomized trial of a staff training intervention targeting R-REM in LTC facilities showed that intervention group staff demonstrated significantly improved knowledge and recognition rates post-training, and longitudinal evaluation further confirmed the training's sustained effectiveness in enhancing knowledge, recognition, and reporting [30]. Additionally, an abuse prevention curriculum developed by Pillemer and Hudson for nursing assistants demonstrated reduced self-reported abusive behaviors and significantly lower conflict behaviors among staff after training [31]. Training programs for caregivers of older adults with dementia have also been shown to improve caregivers' attitudes toward older adults and help manage residents' behavioral symptoms [32].

Beyond professional skill development, caregivers' psychological states and emotional capacities are also important intervention targets. Research suggests that cultivating patience, compassion, conscientiousness, and positive attitudes in caregivers can enhance their capacity for empathy with elderly residents [23]. Meanwhile, role ambiguity, role conflict, and burnout have been shown to increase caregivers' abusive behaviors [33]. To address this, researchers recommend psychological interventions—including emotion regulation, relaxation techniques, and self-compassion training—to build resilience among LTC staff [34]. Furthermore, establishing close linkages among the institution, older adults, and their families is considered conducive to promoting healthy aging in institutional settings, reducing abuse risk at the relational level.

5.2. Meso-Level: Institutional Management

While micro-level interventions focus on enhancing individual caregiver capacity, the meso level focuses on optimizing the organizational environment to provide structural support for caregivers. Optimizing human resource allocation and scientific scheduling are fundamental facility-level measures for abuse prevention. Staffing has been identified as an important predictor of staff perceptions of patient safety in LTC facilities [35]. Research indicates that well-established rules and institutional protocols are effective interventions for preventing adverse events and ensuring resident safety [36]. Rational scheduling involves allocating workloads, supporting work-life balance, and implementing shift systems [37]; thus, facility managers should take into account both patient needs and caregivers' physical and mental capacity in developing scientific scheduling plans.

Economic incentives are also important levers. Increasing caregivers' wages and benefits helps prevent abuse—higher wages can improve staff attitudes and productivity, both of which are associated with better care quality. Research shows that a 10% increase in the average

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hourly wage of direct care workers is associated with a 7.1% higher likelihood of a facility receiving a high-quality rating [38].

In terms of institutional development, LTC facilities should establish comprehensive abuse prevention and response protocols, investigation and management procedures, and mandatory reporting systems. Research indicates that contributing institutional factors include inadequate safety standards, lack of standardized care models, and insufficient regular oversight; therefore, facility managers need relevant knowledge, skills, and communication strategies to effectively identify and address misconduct, and comprehensive reviews of facility regulations are urgently needed to safeguard older adults' legal rights [27]. Facility leaders play a key role in abuse prevention—they can actively participate through their own actions, staff education, and work environment optimization, such as developing assessment tools that promote systematic organizational learning and fostering an open, non-blame culture [39].

5.3. Macro-Level: Social and Policy Responses

Macro-level interventions are dedicated to providing institutional guarantees and social support for abuse prevention and control in LTC facilities. Strengthening policy, legal, and regulatory frameworks is the fundamental safeguard for macro-level prevention. WHO recommends enhanced supervision and regulation of long-term care facilities, promotion of a culture of respect and dignity, and provision of support systems—including information, advocacy, and legal support—for residents and their families [3]. Establishing robust mandatory reporting systems is key to improving detection rates of abusive incidents; WHO explicitly calls for mechanisms mandating reporting of abuse to authorities. Furthermore, new United Nations guidelines have prioritized addressing elder abuse as a component of the Decade of Healthy Ageing (2021–2030) [40], signaling that abuse prevention and control has risen to a priority position on the global public health agenda.

Strengthening social support and public awareness is equally indispensable. Research has found that higher levels of social support and deeper social network embeddedness have significant protective effects against elder abuse risk [41]. Community members should participate in regular visits, volunteer activities, and intergenerational programs to raise public awareness, improve care for older adults, and reduce ageism. These societal-level efforts, combined with institutional culture building, can form a more powerful protective network.

6. CONCLUSION

Elder abuse in LTC facilities is an undeniable reality in the context of population aging, characterized by both concealment and substantial harm. It not only causes physical injuries to older adults but also induces psychological trauma such as depression and anxiety, elevates mortality risk, and increases the societal healthcare burden. Global and domestic epidemiological data indicate that the actual prevalence of abuse in institutional settings is relatively high, with psychological abuse being the most prevalent type, while resident-to-resident mistreatment also warrants sufficient attention. However, due to variations in survey methods and reporting sources, true prevalence rates are likely underestimated.

Elder abuse in LTC facilities is not attributable to a single factor but results from the interplay of multiple levels—individual, caregiver, institutional, and socio-cultural. Impaired cognitive function, disability, and weak social support heighten older adults' vulnerability to abuse; caregiver burnout, low empathy, and insufficient professional competence drive abusive tendencies; inadequate staffing, low remuneration, and deficient management systems further amplify risks; and societal ageism, regulatory loopholes, and imperfect mandatory reporting mechanisms provide an environment conducive to the emergence and concealment of abusive behaviors.

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Existing interventions have formed a micro-meso-macro framework: at the micro level, professional training and psychological resilience building for caregivers; at the meso level, optimization of human resources and internal case management procedures; and at the macro level, policy, legal, and public awareness initiatives for systemic safeguarding. However, current research in this field still has limitations, with most studies focusing on descriptive accounts of prevalence and influencing factors, while localized intervention practices and empirical studies remain relatively scarce. Future abuse prevention and control in LTC facilities cannot rely solely on internal institutional management; rather, it requires multi-stakeholder collaboration among government, facilities, caregivers, families, and society at large. This should include improving the closed-loop system of risk screening, incident reporting, investigation, and case resolution; dismantling ageist attitudes; balancing caregiver rights protection with the protection of older adults' rights; and truly safeguarding the dignity, safety, and quality of life of institutionalized older adults.

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REFERENCES

[1] United Nations, Department of Economic and Social Affairs, Population Division. (2022). World population prospects 2022: Summary of results (UN DESA/POP/2022/TR/NO. 3). United Nations.

[2] OECD. (2023). Health at a glance 2023: OECD indicators. OECD Publishing. https://doi.org/10.1787/4dd50c09-en

[3] World Health Organization. (2024, June 15). Abuse of older people. https://www.who.int/zh/news-room/fact-sheets/detail/abuse-of-older-people

[4] Hall, J. E., Karch, D. L., & Crosby, A. (2016). Uniform definitions and recommended core data elements for use in elder abuse surveillance. Version 1.0. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

[5] Yon, Y., Ramiro-Gonzalez, M., Mikton, C. R., & others. (2019). The prevalence of elder abuse in institutional settings: A systematic review and meta-analysis. European Journal of Public Health, 29(1), 58–67. https://doi.org/10.1093/eurpub/cky023

[6] Agaliotis, M., Morris, T., Katz, I., & others. (2025). Global approaches to older abuse research in institutional care settings: A systematic review. PLoS ONE, 20(3), e0290482. https://doi.org/10.1371/journal.pone.0290482

[7] Lachs, M. S., Teresi, J. A., Ramirez, M., & others. (2016). The prevalence of resident-to-resident elder mistreatment in nursing homes. Annals of Internal Medicine, 165(4), 229–236. https://doi.org/10.7326/M15-2472

[8] Ding, H., Chen, Y. J., Li, W. T., & others. (2019). Prevalence and associated factors of abuse of ageing demented individuals in elder-care institutions. Journal of Nursing Science, 34(18), 15–18.

[9] Rababa, M., Eyadat, A., ALBashtawy, M., & others. (2025). Elder abuse and associated factors among nursing home residents with dementia. Journal of Cross-Cultural Gerontology. Advance online publication. https://doi.org/10.1007/s10823-025-09547-0

[10] Zheng, Y., Zhong, Y. L., Liu, C. X., & others. (2024). Correlation of the abuse tendency with nursing ability and social support among caregivers of older adults with dementia in nursing homes. Chinese Journal of Geriatrics Research (Electronic Edition), 11(1), 45–50.

ISSN: 2472-3703 DOI: 10.6911/WSRJ.202609_12(9).0010

[11] Blumenfeld Arens, O., Fierz, K., & Zúñiga, F. (2017). Elder abuse in nursing homes: Do special care units make a difference? A secondary data analysis of the Swiss Nursing Homes Human Resources Project. Gerontology, 63(2), 169–179. https://doi.org/10.1159/000446781

[12] Botngård, A., Eide, A. H., Mosqueda, L., & others. (2021). Factors associated with staff-to-resident abuse in Norwegian nursing homes: A cross-sectional exploratory study. BMC Geriatrics, 21, 244. https://doi.org/10.1186/s12877-021-02186-8

[13] Huang, J., Yang, Y., Chen, Y., & others. (2026). Caregiver-related risk factors contributing to abuse tendency in nursing homes: A structural equation model. Journal of Clinical Nursing, 35(1), 386–396. https://doi.org/10.1111/jocn.17124

[14] Andela, M., Truchot, D., & Huguenotte, V. (2021). Work environment and elderly abuse in nursing homes: The mediating role of burnout. Journal of Interpersonal Violence, 36(11–12), 5709–5729. https://doi.org/10.1177/0886260519847744

[15] Shi, C. H., Li, X. Y., Chen, M., & others. (2025). Abuse tendency and associated factors among caregivers working in nursing homes. Journal of Nursing Science, 40(10), 60–64.

[16] Yang, M. F. (2019). Study on the abuse tendency and related factors of caregivers of disabled elderly people in old-age care institutions [Master's thesis]. Guangdong Pharmaceutical University.

[17] Goergen, T. (2001). Stress, conflict, elder abuse and neglect in German nursing homes: A pilot study among professional caregivers. Journal of Elder Abuse & Neglect, 13(1), 1–26. https://doi.org/10.1300/J084v13n01_01

[18] Goergen, T. (2004). A multi-method study on elder abuse and neglect in nursing homes. The Journal of Adult Protection, 6(3), 15–25. https://doi.org/10.1108/14668203200400017

[19] Mileski, M., Lee, K., Bourquard, C., & others. (2019). Preventing the abuse of residents with dementia or Alzheimer's disease in the long-term care setting: A systematic review. Clinical Interventions in Aging, 14, 1797–1815. https://doi.org/10.2147/CIA.S215177

[20] Le, F. (2023). A study on the latent profile analysis and factors influencing neglect of elderly caregivers [Master's thesis]. Shandong University.

[21] Gil, A. P., & Capelas, M. L. (2022). Elder abuse and neglect in nursing homes as a reciprocal process: The view from the perspective of care workers. The Journal of Adult Protection, 24(1), 22–42. https://doi.org/10.1108/JAP-06-2021-0024

[22] Corlet Walker, C., Druckman, A., & Jackson, T. (2022). A critique of the marketisation of long-term residential and nursing home care. The Lancet Healthy Longevity, 3(4), e298–e306. https://doi.org/10.1016/S2666-7568(22)00043-7

[23] Shi, C., Li, X., Chen, M., & others. (2025). Certified nursing assistants' perceptions of and suggestions to prevent elder abuse in residential aged care facilities: A qualitative study in Hunan Province, China. BMC Public Health, 25(1), 1687. https://doi.org/10.1186/s12889-025-19947-8

[24] Pillemer, K., Burnes, D., & MacNeil, A. (2021). Investigating the connection between ageism and elder mistreatment. Nature Aging, 1(2), 159–164. https://doi.org/10.1038/s43587-021-00039-5

[25] Ludvigsson, M., Wiklund, N., Swahnberg, K., & others. (2022). Experiences of elder abuse: A qualitative study among victims in Sweden. BMC Geriatrics, 22, 256. https://doi.org/10.1186/s12877-022-02943-0

[26] OECD/European Commission. (2013). A good life in old age? Monitoring and improving quality in long-term care. OECD Publishing. https://doi.org/10.1787/9789264190128-en

ISSN: 2472-3703 DOI: 10.6911/WSRJ.202609_12(9).0010

[27] Figueredo Borda, N., & Zabalegui Yarnoz, A. (2015). Perceptions of abuse in nursing home care relationships in Uruguay. Journal of Transcultural Nursing, 26(2), 164–170. https://doi.org/10.1177/1043659614526341

[28] Marzbani, B., Ayubi, E., Barati, M., & others. (2023). The relationship between social support and dimensions of elder maltreatment: A systematic review and meta-analysis. BMC Geriatrics, 23, 869. https://doi.org/10.1186/s12877-023-04508-7

[29] Mohd Mydin, F. H., Choo, W. Y., & Othman, S. (2021). The effectiveness of educational intervention in improving primary health-care service providers' knowledge, identification, and management of elder abuse and neglect: A systematic review. Trauma, Violence, & Abuse, 22(4), 944–960. https://doi.org/10.1177/1524838019891574

[30] Teresi, J. A., Ramirez, M., Ellis, J., & others. (2013). A staff intervention targeting resident-to-resident elder mistreatment (R-REM) in long-term care increased staff knowledge, recognition and reporting: Results from a cluster randomized trial. International Journal of Nursing Studies, 50(5), 644–656. https://doi.org/10.1016/j.ijnurstu.2012.10.003

[31] Pillemer, K., & Hudson, B. (1993). A model abuse prevention program for nursing assistants. The Gerontologist, 33(1), 128–131. https://doi.org/10.1093/geront/33.1.128

[32] Baruah, U., Varghese, M., Loganathan, S., & others. (2021). Feasibility and preliminary effectiveness of an online training and support program for caregivers of people with dementia in India: A randomized controlled trial. International Journal of Geriatric Psychiatry, 36(4), 606–617. https://doi.org/10.1002/gps.5456

[33] 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. https://doi.org/10.1093/geront/gnp062

[34] Han, S. J., & Yeun, Y. R. (2024). Psychological intervention to promote resilience in nurses: A systematic review and meta-analysis. Healthcare, 12(1), 73. https://doi.org/10.3390/healthcare12010073

[35] Ree, E., & Wiig, S. (2019). Employees' perceptions of patient safety culture in Norwegian nursing homes and home care services. BMC Health Services Research, 19, 607. https://doi.org/10.1186/s12913-019-4459-7

[36] Li, C., & Shi, C. (2022). Adverse events and risk management in residential aged care facilities: A cross-sectional study in Hunan, China. Risk Management and Healthcare Policy, 15, 529–542. https://doi.org/10.2147/RMHP.S362044

[37] Kossek, E. E., Rosokha, L. M., & Leana, C. (2020). Work schedule patching in health care: Exploring implementation approaches. Work and Occupations, 47(2), 228–261. https://doi.org/10.1177/0730888419898771

[38] Allan, S., & Vadean, F. (2023). The impact of wages on care home quality in England. The Gerontologist, 63(9), 1428–1436. https://doi.org/10.1093/geront/gnac184

[39] Myhre, J., Saga, S., Malmedal, W., & others. (2020). React and act: A qualitative study of how nursing home leaders follow up on staff-to-resident abuse. BMC Health Services Research, 20, 1111. https://doi.org/10.1186/s12913-020-05960-1

[40] World Health Organization. (2022). Tackling abuse of older people: Five priorities for the United Nations Decade of Healthy Ageing (2021–2030). World Health Organization.

ISSN: 2472-3703 DOI: 10.6911/WSRJ.202609_12(9).0010

[41] Burnes, D., Pillemer, K., Rosen, T., & others. (2022). Elder abuse prevalence and risk factors: Findings from the Canadian Longitudinal Study on Aging. Nature Aging, 2(9), 784–795. https://doi.org/10.1038/s43587-022-00264-2