Workplace Violence and Worker Injury in Elderly Care Settings: Reflective of a Setting Vulnerable to Elder Abuse?

Brian K. Payne
Jonathan K. Appel

ABSTRACT. Many incidents of injury, assault, and abuse occur in health care settings. To better examine the situational context of the workplace, this paper examines whether workers providing care to elderly persons experience injuries that are consistent with the “for-profit” and “interpersonal conflict” explanations of elder abuse or neglect. Using data from the Bureau of Labor Statistics, results indicate that nursing home workers and home health care workers have higher rates of workplace injuries resulting from assaults and overexertion than do other workers. The data suggest that there are unique structural and situational...
INTRODUCTION

Workers in the health care industry are at increased risk for violence, and the Occupational Safety and Health Administration (2003) notes, “for many years, health-care and social service workers have faced a significant risk of job related violence” (p. 1). Data show that there were 69 homicides in the health services from 1996 to 2000 (Occupational Safety and Health Administration, 2004).

Although homicide in the workplace may attract more attention, most of the incidents of workplace violence consist of nonfatal assaults. For example, data from 2000 indicate that 48% of all nonfatal injuries from work-related assaults and violent acts occurred in health care and social services setting (Occupational Safety and Health Administration, 2003). In one study, Elliott (1997) found that health care workers are 16 times more likely to experience violence than are other service workers. The vast majority of these incidents were in hospitals, nursing and personal care facilities, and residential care services. Caregivers in hospitals and nursing homes are at a particular risk for incidents of nonfatal violence resulting in injury. Although the risks of the health care and social service industry worker are increasingly a focus, there has been little systematic examination of the impact of workplace violence on care recipients (Arnetz & Arnetz, 2000).

In addition to increased alarm about workplace violence in health care, concern about elder abuse has also been escalating over the past two decades. Elder abuse was initially called “granny battering” in reference to crimes occurring in a health care setting (Payne, 2000). Since its original conceptualization, researchers and experts have come to recognize that elder abuse occurs in community settings as well as health care settings. Indeed, it is believed that up to 2 million older persons fall prey to abuse each year (Payne, 2000). Most agree that when
individuals are victims of elder abuse, they are often victims of several of the different types of elder abuse. An elderly person who is neglected is often also being physically abused, or one who is sexually abused is often emotionally abused. When these cases occur, victims often do not report them to the authorities for a number of reasons. Some victims may fear retaliation from the offender. Other victims may fear that they will be worse off if they report the abuse because they might be moved to a less desirable location. Some victims may be unable to communicate and subsequently unable to share information about the abuse.

Much of the research that has been done on elder abuse has focused on the abuse of elderly persons in community settings (Comijs, Pot, Smit, & Jonker, 1998). To be sure, several recent studies have considered different types of elder (patient) abuse occurring in long-term care settings (Payne & Cikovic, 1995). In summarizing the research on elder abuse, Hawes (2003) concludes there is general agreement that abuse and neglect are widespread across residential long-term care settings, with a significant amount of underreporting of cases.

Because of the increased concern for both workplace violence and elder abuse in the health care services, this paper seeks to examine the assault and injury rates for those who work with the elderly. This examination hopes to differentiate structural and situational factors present in elder care settings that may make it vulnerable to violence and elder abuse.

**Explanations for Elder Abuse in Community Settings**

It is necessary to consider elder abuse in the community and patient abuse separately because the explanations for the abuses in the two settings vary by setting and abuse type. The traditional explanations for elder abuse in community settings are described as follows:

**Dependency.** Dependency explanations suggest that the elderly person may be dependent on and vulnerable to the caregiver. However, research suggests that it may actually be the caregiver who is dependent on the elderly person, especially in financial abuse cases (Anetzberger, 1987; Franco, Gray, Gregware, & Meyer, 1999; Godkin, Wolf, & Pillemer, 1989; Greenberg, McKibben, & Ray mond, 1990; Neale, Hwalek, Goodridge, & Quinn, 1997; Pillemer, 1985; Pillemer & Moore, 1989).

**Cycle of violence.** Cycle of violence explanations suggest that the violence experienced by the older person may be symptomatic of a history of violence in the family. Originally, it was believed that the older person
was abused because their adult offspring were retaliating for child abuse they had experienced. No research has borne out this suggestion.

Caregiver burden. Caregiver burden explanations suggest that the caregiver is abusive because of the stress that the caregiver endures providing care to the aged individual. This explanation, however, is seen as a simplification (Korbin, Anetzberger, & Eckert, 1989).

Intra-individual. Intra-individual explanations suggest that the source of abuse is something within the aggressor or the victim. For the aggressor, research suggests that a history of drug abuse or mental illness contributes to abuse (Bruce, 1994; Lachs & Pillemer, 1995; Paris, Meier, Goldstein, Weiss, & Fein, 1995; Vinton, 1991; Wolf, 1996). For the victim, it has been found that the presence of Alzheimer’s or dementia increases the risk of abuse (Chen, Bell, Dolinsky, Doyle, & Dunn, 1981; Coyne, Pontenza, & Berbig, 1993; Griffin & Williams, 1992; Kilburn, 1996; Lachs & Pillemer, 1995; Paris et al., 1995; Pedrick-Cornell & Gelles, 1982). Also, those with other disabilities are at a higher risk of abuse (Curry, Powers, & Oschwald, 2004).

Explanations of Patient Abuse in Long-Term Care Facilities

Explanations of patient abuse in long-term care facilities have focused on broader dimensions. Three common explanations that have been offered for patient abuse include institutional characteristics, staff characteristics, and situational characteristics (Pillemer & Bachman-Prehn, 1991). These dimensions are concerned about workplace conditions that increase the vulnerability to elder abuse. Because this paper considers whether employees working with elderly persons experience injuries that would be consistent with these explanations of elder abuse or neglect, each explanation is addressed as follows:

Institutional characteristics. Institutional characteristics are concerned with whether certain qualities of the long-term-care setting increase the likelihood of abuse or neglect of patients. Qualities that have been tested to see whether they influence elder abuse include the size of the nursing home and whether it is for profit or non-profit (Jenkins & Braithwaite, 1993; Pillemer & Bachman-Prehn, 1991). Pillemer and Bachman-Prehn surveyed nursing home employees and found that the characteristics of the home were not related to physical abuse of patients. However, Jenkins and Braithwaite have found that whether a long-term-care setting is for profit or non-profit is related to patient neglect. Describing the impact of
profit, Jenkins and Braithwaite suggest, “Pressure for lawbreaking comes from the top down and from profits” (p. 221).

Staff characteristics. Staff characteristics are explanations that suggest that something about the staff causes or leads to abuse. Pillemer and Bachman-Prehn’s (1991) research on physical abuse found no significant characteristics among those employees who abused patients. A survey of nursing home employees focusing on self-reported nursing home thefts, however, found that job dissatisfaction, attitudes towards the elderly, low salaries, being an aide as opposed to another type of professional, and being male were related to whether thefts occurred (Harris & Benson, 1996). Examining patient abuse cases prosecuted by the justice system, other studies have also found that males and aides have higher rates of patient abuse (Payne & Cikovic, 1995; Payne & Gainey, 2002).

Situational characteristics. Situational characteristics refer to qualities associated with the interaction that may have precipitated patient abuse. A telephone survey of 577 nurse’s aides and licensed practical nurses by Pillemer and Moore (1989, 1990) supported the importance of situational characteristics. Results of the interviews showed that stress, patient conflicts, and patient aggression toward staff were factors contributing to the physical abuse of residents by staff. Regarding stress, the authors suggest that the respondents felt “burned out” because they did not have enough time to perform their expected duties. Patient conflict entailed conflicts over eating habits, hygiene, toileting, and unwillingness to dress. Describing the potential for conflict, Keller (1996) writes, “[R]esidents’ behavioral problems and communication deficits may trigger negative reactions by caregivers” (p. 110). Only 20% of the respondents indicated no conflicts with the residents. Regarding aggression, the authors found that only 11% of the staff had not been insulted or sworn at during the prior year and only 13% were not pushed, grabbed, or pinched in the preceding year. Based on their findings, Pillemer and Moore (1989) report that the relationship between patient and staff may be the most important factor determining the type of care patients receive.

A study by Goodridge, Johnston, and Thomson (1996) of 126 nursing assistants found that assistants were “physically assaulted by residents 9.3 times per month and verbally assaulted 11.3 times per month” (p. 49). They found a relationship between staff burnout and reported aggression from residents, as well as a relationship between conflict with residents and resident aggression. It is believed that pain, lack of family or visitors, loss of hope, and low self-esteem are factors that make residents aggressive against nursing home staff (Keller, 1996).
Crumb and Jennings (1998) cite figures from the Bureau of Labor Statistics suggesting that about 17 out of 100 nursing home employees experienced nonfatal injuries in 1994. Consequently, they note, this profession is more dangerous than construction, electrical work, mining, or auto repair. As Pillemer and Moore (1990) point out, “It is fair to say that few other occupations involve such a high degree of interpersonal conflict” (p. 26).

Using the data from the phone surveys of the 577 nursing home workers, Pillemer and Bachman-Prehn (1991) used multivariate regression techniques to determine whether facility characteristics, staff characteristics, and situational characteristics predicted the existence of elder abuse. Their findings indicate that situational characteristics such as burnout and level of patient-staff conflict were the most important predictors of patient abuse by staff.

It seems that nursing home neglect is caused at least in part by a demand for profit, whereas physical abuse may be attributed to the patient-staff conflict. For the conflict and neglect relationships to be accurate, we would expect nursing home workers to have higher rates of injuries due to nonfatal assaults and overexertion. Reports of nonfatal workplace assaults most often take the form of hitting, kicking, or beating, with squeezing, pinching, and scratching as the next most frequent type (Toscano, 1996). Overexertion is classified as work-related musculoskeletal injuries that occur on the job, and is most often cited nationwide for work-related injuries resulting in lost work time (U.S. Department of Labor, 1997). Many of the patient-handling injuries in the health care industry are classified as overexertion, whereas patient aggressions that result in injuries are classified as assault. With regard to assaults, if high patient conflict is occurring, one would expect that nursing home workers would have higher rates of workplace injuries from assaults. With regard to overexertion, if for-profit nursing homes are placing demands on workers, one would expect workers to have higher rates of overexertion.

It is natural to question whether those who work with the elderly have higher rates of assault and higher rates of overexertion than those who work in comparable industries as well as higher rates than all other workers combined. If their rates are the same as the general population of workers, we would expect other workers to experience as many injuries from assault and overexertion. In line with this thinking, the current study addresses these three questions: (1) What are the rates of assault and injuries from overexertion among nursing home workers? (2) How do their rates of assault and overexertion compare to the rates experienced
by similar workers? And (3) how do those rates compare to the rates of violence in hospitals and private industry? Addressing these questions will help to demonstrate if there are unique rates of violence and injury in nursing homes, consistent with a demanding high conflict setting.

**METHODS**

To address these questions, data were obtained from the Bureau of Labor Statistics (www.bls.gov). The Occupational Safety and Health Act of 1970 required employers in the United States to report data on workplace injuries to the Bureau of Labor Statistics. Since 1972, the Bureau of Labor Statistics annually reports on the number of workplace injuries, illnesses, and fatalities. In addition, the Bureau of Labor Statistics maintains data on all kinds of injuries experienced by all workers in which the worker missed at least one day of work. The data can easily be broken down by injury type and occupation. Data on nonfatal assault injuries and overexertions were solicited for five occupational groupings between the years 1993 and 2002. These occupations included (1) nursing home workers, (2) home health care workers, (3) hospital workers, (4) workers in doctor’s offices, and (5) all workers in private industry in the United States. The broad category of “private industry” in this study represents the total data collected annually from about 176,000 private industry establishments, and included the other four categories as well as over 800 additional occupations. These occupational groupings were selected so that comparisons could be made between nursing home workers, similar employees, and the overall population of workers in the private sector.

**RESULTS**

The relationship between nonfatal assaults involving days away from work and various health care professionals can be seen in Figure 1. Nursing home workers have higher rates of assault victimization than any of the other occupational groupings. A few patterns are noteworthy. First, note that health care workers in general are more likely to be victims of assault than other workers. Second, note that the extent of assaults against nursing home workers has reduced to half between 1995 and 2002. In 1995, the rate of assault for nursing home workers
was 41 per 10,000 workers, as compared with 3.6-10,000 workers in the total of all private industry occupations. In 2002, however, nursing home workers are still six times more likely than all other workers to miss work because of an assault. Also note that assaults are extremely rare in doctor’s offices.

The rate of overexertion cases between the five occupational groups are shown Figure 2. As with assaults, nursing home workers’ rates of overexertion are far higher than the other occupations. Also like the assaults, overexertion cases have decreased significantly in the 1990s. Still, however, overexertion remains a problem for nursing home workers. In fact, in 2002, the most recent year for which data were available because of changes in reporting mechanisms, nursing home workers were nearly five times more likely to experience overexertion than the total population of private industry workers.
DISCUSSION

Obviously, those who work in nursing homes are more likely to experience assault and overexertion than other health care workers and far more likely than all workers to experience injuries from these actions. Three questions warrant consideration: (1) Why have the injury rates declined in the 1990s? (2) Why are health care workers in general and nursing home workers in particular at such a high risk of assault and overexertion? And (3) how do these findings relate to elder abuse?

As far as explaining why the injury rates have declined in the 1990s, it is tempting to suggest that the decline is nothing more than a reflection of a general decline in violence that occurred in the United States during the same timeframe. Indeed, in the 1990s, the rates of robbery, rape, murder, and assault declined significantly. Politicians attributed the decreases to stiffer sentencing policies and a tougher response to crime in
general. Some criminologists, however, predicted the decline based on the proportion of 18-24 year olds in our society (Steffensmeier & Harer, 1991). Of course, the proportion of 18-24 year olds would have nothing to do with the drop in injuries in nursing homes. Tougher punishment policies also likely had little influence on assaults in these settings. Note that overexertion cases also decreased during this timeframe. The fact that assaults and overexertions decreased suggests that something else may have led to the decline.

One possibility is that rates decreased because of better training and improved oversight by federal officials. For nursing homes, it was the early 1990s when researchers called attention to the problem of patient abuse and staff conflict. Subsequent to that research and increased widespread attention to the problem, it is possible that nursing home administrators as well as state and federal regulators followed different measures to prepare nursing home workers. In particular, it may be that they were better prepared to deal with conflict than they were in the past. At the same time, it may be that they were better trained on how to avoid overexertion as well.

An additional possibility is that workers may simply be tolerating the offenses more. They simply may not be reporting the offenses to their bosses, or they may not be missing work because of the offenses. If they are more tolerant of the offenses or simply not missing work because of them, then their levels of assault and overexertion would actually be stable.

It is also important to consider the high rate of assaults and overexertion in the health care field in general and nursing homes specifically. According to the National Institute for Occupational Safety and Health (1996), risk factors for workplace violence include contact with the public, exchange of money, having a mobile workplace, working alone or in small numbers, working late at night or during early morning hours, working in high-crime areas, working in community-based settings, and working with unstable or volatile persons in health care, social service, or criminal justice settings. Many of these factors would increase the risk of violence in health care settings. Nursing home workers usually work alone and have a great deal of contact with the public. Hospital workers face a similar plight. Home health care workers work alone, have contact with the public, have a mobile workplace, may have to go into high-crime areas, and may carry money. Based on these factors, one might expect home health care workers to experience assault more often. Yet, it appears that they have lower rates of reported assault than nursing home
workers. This may be a result of the fact that nursing home workers may confront more difficult patients on a more regular basis.

One might suggest that the poor selection of workers may contribute to the high level of assaults in nursing homes. It has been noted that because of extensive demand and high turnover rates, screening nursing home assistants for histories of abusive or criminal behavior is especially difficult (Wunderlich, Sloan, & Davis, 1996). Nursing home patients could be assaulting workers as retaliation for patient abuse.

As noted earlier, Pillemer and Bachman-Prehn (1991) found that staff conflict was a significant factor leading to patient abuse, whereas Jenkins and Braithwaite (1993) suggested that the demand for profit caused neglect in nursing homes. Data from the Bureau of Labor Statistics cited in the current study suggest that nursing home workers have high rates of being assaulted. The data are congruent with research that supports the notion that nursing home workers face a high level of conflict.

It is interesting, however, that nursing home workers’ rates of assault and overexertion are higher than those experienced by home health care workers. This suggests that it is something about the nursing home environment that generates violence and overexertion. What this means is that structural factors may work with the situational factors to promote conflict in nursing homes. This could also make the setting vulnerable to patient abuse. This notion is consistent with Nelson and Cox (2004), who express concern that nursing homes are “a virtual hotbed of conflict” (p. 86). These authors note, “interpersonal conflict, often spiraling to violence and abuse, is one of the most daunting challenges facing nursing home administrators and their departmental heads” (p. 85).

Structural and situation factors in nursing homes and its relationship to patient abuse is something that should be addressed in future research. A direct test of assaults resulting in later abuse would be warranted in light of the data presented in this paper. Indeed, to prevent patient abuse, it may be necessary to understand and reduce assaults and overexertion against nursing home workers.

REFERENCES


Submitted: September 23, 2004
Revised: January 11, 2005
Revised: February 2, 2006
Accepted: February 15, 2006

doi:10.1300/J146v14n04_03