# Leadership and the Propensity for Abuse in Long-Term Care Facilities

Dissertation Manuscript

Submitted to Northcentral University

School of Business

in Partial Fulfillment of the

Requirements for the Degree of

DOCTOR OF BUSINESS ADMINISTRATION

by

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July 2019



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# Abstract

There is extensive research on elder abuse, but research also contains evidence that many healthcare providers in long-term care facilities incorrectly care for residents within the facility. While the types of leadership style have been shown to affect the care provided to each resident, leadership style is seldom noted as a link to the propensity for abuse. In this dissertation leadership style is defined as four styles directive, supportive, participative, and achievement oriented. The researcher used the quantitative method to examine each form of leadership and the effect that each had on the propensity for abuse. The surveying of 54 licensed healthcare professionals (RN, LPN, and CNA) was completed through the Qualtrics Research Center with each participant responding to questions based on the Path-Goal Leadership Questionnaire and the Caregiver Abuse Screen. The results of this study identified no statistically significant relationship between leadership style and the propensity for abuse in long-term care facilities. Recommendations for future research are increasing the sample size to decrease the chance for skewness in data and adjusting the p-value from .05 to .1. Qualitative studies on leadership and the propensity for elder abuse could result in the identification of a variation in results.



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Acknowledgements

I want to thank God Almighty for blessing me and allowing me to pursue my Doctorate. I want to thank my Mom (Peggy) and my encourager from afar (Barbara) and all the fantastic individuals who crossed my path and provided words of encouragement during this doctorate journey.

Additionally, I would also like to thank my dissertation chair, Dr. Thompson, for all of his motivating words and phone calls; my dissertation committee, Dr. Brian Allen, for keeping me on the right path, and Dr. Marie Bakari for keeping me straight behind the scenes. Everyone that touched my life during this challenging yet satisfying journey holds a special place in my heart. Again, a huge thank you to every one of you!

On a final note, this dissertation is dedicated to my Father in Heaven, Gene Roberts, you are loved and missed but never forgotten; how I wish you could see me walk across that stage, and I could hear you say one more time “You can make it!”



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## Chapter 1: Introduction

Envision that family members are subject to admissions into a long-term care facility and then experiences incidents of abuse after the death of a spouse. Is this what people envisage for the family members they love? Gerontologists in Great Britain were the first to bring mistreatment of the elderly to the forefront in 1975; whereas, at this time it was coined granny bashing (Roberto, 2016). The notion of elder abuse was introduced within the United States in the 1970s and 1980s and other locales such as China, Canada, and Great Britain in recent years (Baker, 1977; Burns, Hyde, & Gillette, 2013; and Burnston, 1975). It was at this time, that the abuse of the aging generation was brought to light in the homes and facilities where seniors were experiencing violence or ill-treatment at the hands of their caretakers. The growth of the elderly population has brought about multiple changes from social affairs, to political reinforcements, and economic sanctions. Conversely, the scope of the issues surrounding the requirements and mandates of the estimated 44 million individuals aged 60 and above have amplified the demand for the nation's healthcare providers, administrators, and society as a whole (Mosqueda, Hirst, & Sabatino, 2016).

Organizational policies and governmental regulations are continuously being revamped in an attempt to secure the quality of life for the aging generation. Nonetheless, as society focuses on enhancing the lives of the elderly, mistreatment and neglect of the elderly within the long-term care (LTC) facility continue to be investigated less than incidents of child abuse and domestic violence (Eliopoulos, 2015). Incidents of elderly abuse are a significant issue within any given long-term care institution in the State of Georgia, as revealed by Eliopoulos (2015). Abuse within the facilities that many call home continues to be a great concern as many individuals experience mistreatment enforced by persons responsible for providing the

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continuation of care for the 'greying' generation (Charpentier, & Soulieres, 2013). While focusing on the continuum of attention required for the elderly, multiple authors have revealed that the culture of a long-term care facility can be recognized for providing minimal treatment such as, failing to provide water, food, or medicine, and consisting of numerous accounts of elderly abuse (Bern-Klug & Sabri, 2012; Castle, Ferguson, & Teresi, 2015; Chen, 2012). Declining health, loss of a caregiver, increases in lifespan, and the failure to recognize and report are factors associated with the continuation of elder abuse (Abolfathi-Momtaz, Hamid, Ibrahim, 2013).

**Statement of the Problem**

This study examined the effects that perceived leadership had on the propensity for abuse at long-term care facilities. Elder mistreatment is one of the most crucial elements facing the aging generation of today. Elder abuse is a violation of an older person's individual right to be safe and free from violence (Dong & Simon, 2013; Roberto, 2016). Mistreatment can include intentional physical harm, financial exploration, sexual exploitation, and psychological abuse (Dong & Simon, 2013; Roberto, 2016). Despite the fact that regulations and mandates have been established to curtail the mistreatment of the elderly, elderly abuse continues to rise at an astronomical rate (Albolfathi-Montaz et al., 2013). The lack of effective and efficient leadership within an organization can lead to a loss of concern and a decrease in employee morale, thus creating an environment that lacks in corporate direction and objective achievement, ultimately leading to demise of the organization and the failure of the leader (Doe, Ndinguri, & Phipps, 2015). The negativity associated with ineffective leadership, or effects of leadership styles such as the autocratic leadership style, can lead to situations of abuse towards others. For example, negativity can lead to feelings of fear between the staff and residents and the potential for

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making decisions without consulting team members (Giltinane, 2013). Underperformance, as a result of leadership absence, can also result during the reign of an autocratic leader (Fiaz, Ikram & Saqib, 2017). Underperformance can impact the lives of many individuals within the confines of the long-term care facility. For this paper, leadership was defined as the ability to motivate through the exhibition of appropriate behavior and social relationships and the capability to cultivate such behavior in others through effective communication and individual support (Brown, Trevino & Harrison, 2005; Munro & Thanem, 2018).

Subsequently, abuse has resulted in multiple health issues such as mental anguish, physical injuries, and a vast number of premature deaths (Mosqueda et al., 2016). Studies disclose that approximately 1 in 10 Americans sixty years of age and older have incurred at least one episode of abuse (Frazão, Correia, Norton, & Magalhães, 2015). According to documentation, a deficiency in reporting incidents of elder mistreatment has been identified with only 1 in every 14 incidents of abuse being reported to the appropriate authorities, while an approximation of 5 million geriatric residents are being abused on a yearly basis (Frazão et al., 2015).

Employees and family members alike often plead obliviousness in comprehending and identifying elder abuse, and many organizations decline to address or report incidents of ill-treatment. Burns, Hyde, and Gillette (2013) found that the abuse and maltreatment of the elderly continue to occur regardless of the policies, procedures, and agendas established to eliminate incidents of ill-treatment. Other scholars such as Burns, Pillemer, Caccamise, Mason, Henderson, Berman, and Lachs (2015) have identified the significance of the problem within the field of healthcare and caretaking. In addition to this association, Enguidanos, Deliema, Aguilar, Lambinos, and Wilbur (2014) have identified barriers associated with the implementation of

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policies and procedures. However, to date, there has been a minute amount of research on the risk factors associated with the victim and the abuser.

The exposure to abusive situations results in various implications on the professionals with the apparent connection between the exposure of abusive situations and the demeanor of the individuals (Band-Winterstein, Goldblatt, & Alon, 2014). Professionals exposed to the acts of elder abuse must be conscious of their demeanor, attitudes, and emotions. Individuals in a position of providing care or guidance may begin to question their own beliefs and action when exposed to abusive situations. One may question whether to become involved by reporting, questioning whether the act was abuse, or just avoiding the situation as if nothing occurred (Band-Winterstein et al., 2014). Involvement in the case of elder abuse may result in acts of inhumanity, disrespect, neglect, paternalism, and avoidance of responsibilities for the older generation (Band-Winterstein et al., 2014; Trevitt & Gallagher, 1996). Connections between professional behavior and elder mistreatment warrant the need for improvising in policies and procedures, and improvement in training and education within the long-term care facility (Band-Winterstein et al., 2014).

A connection between leadership and elder abuse was examined from the perspectives of the caretaker with the intent to eliminate the occurrences of elder abuse within the long-term care facility through the increase of training and materials. Elder abuse is predominantly new in the studies relating to violent behavior; however, the abuse of an older person is the most expensive, fatal, understudied and underreported condition within the field of violent conduct (Dong, 2015). Abuse of the elderly results in approximately 10% of older adults in the United States personally feeling the wrath of the abusive caretaker (Rosay, & Mulford, 2016). Nursing home admittance rates have quadrupled as a result of elder abuse with the hospitalization rate tripling. Medicare

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and Medicaid cost, along with other public program price tags, have increased as the burdens of ill-treatment have been placed on the health system. Emergency room visits and emergency transports have placed a multitude of financial burdens upon public entities, health, and society as a whole with economic difficulties reaching tens of billions of dollars (Mosqueda et al., 2016). A possible cause of this issue is the inability to distinguish abuse from other forms of behavior. Elder abuse is difficult to detect in many situations as with the subtle manifestations and identifiers that can lead to other health-related issues and problems (Anetzberger, 2012).

**Purpose of the Study**

The purpose of this study was to examine leadership styles, decisions and the influence each has on abuse in healthcare facilities. More precisely, training solutions contained such topics as leadership pitfalls, employee management, leadership strategies, employee workloads, elder mistreatment, and employee conduct as appropriate in the light of the finding of this research. The examination of the relationship between leadership and abuse lead to opportunities to work internally and alongside the community on ways to develop a patient-centered facility. The data collected in this examination provided healthcare professionals with information relating to the proceedings for identifying and alleviating elements contributing to the inefficiency in reporting and studying abusive behavior within the healthcare realm of long-term care professionals. Collected data was advantageous in enhancing the opportunity for healthcare industries which focus on elderly patients to increase their knowledge level and change business practices toward a safer, more accountable practice model.

**Organizational Behavior**

The identification of the risk factors associated with the abuse and the aging victim, was also a critical element in the examination of the institutional setting, as each component can be a

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potential for hazardous factors (Roberto, 2016). Many factors related to the facility leads to the outbreak of an abusive situation. For example, factors that may lead to these occurrences can be linked to the unprofessional and insensitive approaches of the caregivers/personnel assigned to provide care to the resident, an inadequacy in caregivers (lack of attention to the resident), lack of administrative concern, lack of employee motivation (lack of interest) and may also lead to additional responsibilities imposed upon the employee which ultimately leads to employee burnout (Roberto, 2016). An additional factor associated with elder abuse is the potential for an employee to suffer from employee burnout- A correlation between exhaustion, cynicism, and lack of effectiveness ((Roberto, 2016). Overwork (long hours), role conflict (unidentified roles and tasks), and ambiguity are often associated with emotional exhaustion, depersonalization and a decline in providing quality care (Mo & Shi, 2017). A link between the emotional and physical state of healthcare personnel has to be attributed to a decreased quality of care and may lead to aggressiveness toward elder residents (Mo & Shi, 2017). Elder individuals within long-term care facilities are often vulnerable and powerless, and personnel is underqualified, overworked, and underpaid. A combination of these elements can lead to elder abuse (El-Nady, 2012).

## Theoretical Framework

### Theoretical Background

Two major theories were used in this study to help understand the link between leadership style, employee performance, and the causes of elder abuse and mistreatment within the long-term care facility. These approaches included situational leadership theory and Path-Goal Theory. Situational Leadership Theory identifies the link between increased burdens placed upon the caregiver as the individual ages or health declines creates an intensifying atmosphere that leads to abusive situations (Albothi-Momtaz et al. 2013). Situational leadership

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theory also notates the ability of a leader to deal with specific conditions as the situation occurs (Asamani et al., 2016). The situational leadership theory provides specific elements regarding leader flexibility as situations vary (Asamani et al., 2016), 1) initially prioritizing tasks and responsibilities; 2) assessing employee skills and motivational factors; 3) ultimately, defining the leadership style (directing, coaching, supporting, or observing) based on the circumstance as defined by the Path-Goal Theory of Leadership (Asamani et al., 2016). The path-goal leader considers employee skills and motivates employees through empowerment and assurance before assigning responsibilities and tasks (Northouse, 2013). Ultimately, the path-goal approach is essential as it was used to precisely identify the role of the leader in the situational context of elderly abuse. Path-Goal Theory recognized the need for diagnosing the functions that followers need to have fulfilled to allow for motivation, quality performance, and job satisfaction (Schriesham & Neder, 1996) and situational leadership theory established the leadership style that fits the circumstance. The leader effectively integrates each activity and event by examining all members of the organization and connects their behavior to the path/goal of the organization as a whole.

Scholars use the Path-Goal Theory as a format for describing ways in which leaders provide encouragement and support to their followers in reaching their goals through the providing of a clear and direct path (Hall, 2013). Leaders can direct their followers by establishing the direction through the elimination of any roadblock (situation) that decreases the followers' ability to reach the goal - increase follower motivation through the reward system. Variations in the Path-Goal Leadership Approach will be dependent upon the situation, including the follower's capability and motivation, as well as, the complexity of the tasks and other contextual factors (Hall, 2013). The situational approach to leadership identifies a continuously

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changing role of adaptability to each situation with the focus on employee development (Lynch, 2015). Flexibility is contingent upon employee needs and the leader's ability to coach, direct, support, and delegate employee paths (Asamani et al., 2016).

Similarly, the path-goal theory specifies that the leader is responsible for assessing specific situations and portraying a leadership style of direction, support, participation, and achievement by employee needs (Lynch, 2015). Strong similarities exist between the two theories as each method specifies the need to be flexible and choose a leadership style accordingly (Asamani et al., 2016). The Path-Goal theory was used here as it provides clear prescriptions of four different situational paths that are clearly defined and used in prior research (Bakola et al., 2016; Özdemir, 2017; Szilagyi, & Sims, 1974).

Long-term facilities are often the chosen location for keeping the old generation safe while providing a continuation of care (World Health Organization, 2008). Aging can be a very challenging journey that requires patience, trust, and understanding. The employees within a long-term facility face providing the elderly with the elements of care, concern, and empathy. However, the increased demand associated with inadequate staffing and lack of knowledge in the area of elder abuse, are subjectively primary reasons for the growth of elder abuse.

Many individuals think of physical violence with the mention of elder abuse. In the healthcare field professionals (such as physicians, nurses, and any other persons providing care to the elderly) are responsible for observance, addressing, and eliminating elder abuse regardless of their position or title. Health administrators must ensure that elder abuse and procedures for reporting are identified during the group assemblies while providing continuous training and education on the subject. Many primary deterrents are of critical importance during the decision-making process associated with the reporting of elder abuse. The concern of the long-term care

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facility and health care professionals is understandable a finely-honed correlation, between a patient-centered environment and the provisions of quality care; the reporting of elder mistreatment ruins in a matter of minutes. The process of reporting and investigating abuse can serve as a form of communication, bringing to light, incidents of violence; thus, discouraging continuing or future abuse (Dong, 2015). Evaluating and reporting elder abuse is multifaceted, and the benefits associated with reporting must be well-adjusted with the risks of reporting (Dong, 2015). Healthcare professionals are extensively educated in the aging, considering, and distinguishing of geriatric ill-treatment and the devastating effect on the individual, household, public, and health systems, health professionals are justifiably responsible for integrating routine screenings of elder abuse to improve the quality of care (Dong, 2015).

**Nature of the Study**

A quantitative research approach was taken using the Path-Goal Leadership Theory and Questionnaire to measure employees' perceptions of their manager's leadership style. As noted by (Hayyat, 2012), employee motivation is at the forefront of leader responsibilities; goal attainment and employee motivation are also vital components of leadership (Hayyat, 2012). The instrument used was the path-goal leadership questionnaire. The Path-Goal Questionnaire (Appendix A) is beneficial in the achievement of participant information regarding the various Path-Goal Leadership styles (directive, supportive, participative, and achievement-oriented (House & Dressler, 1974; Indvik, 1985).

**Caregiver Abuse Screen**

The Caregiver Abuse Screen (CASE) (Appendix B) is an instrument used in the detection of elder abuse (Abolfathi Momtaz, 2013; Reis, 1995; Reis & Nahmiash, 1995; Nelson, Nygren &Mcinerney, 2004). The process is applicable to all healthcare providers of seniors, whether

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abuse is suspected or not. “Yes”, responses are great indicators of abuse and neglect that may otherwise go unnoticed. Survey questions included topics regarding employee responsibilities and the objectives for completing each task. His/her identifiers replaced personal identifiers, and a coding process was used to identify each questionnaire (D. Nahmiash, personal communication, April 15, 2018). In addition to identifying current acts of abuse CASE screen (Appendix B) may be a deterrent to developing incidents of abuse (Abolfathi Momtaz et al. 2013; Reis & Nahmiash, 1995). This survey was used to establish a link between the staff and resident and the occurrences of abuse.

**Research Questions**

**RQ1**. Is there a statistically significant relationship between the directive style of leadership style and the propensity for elder abuse in long-term care facilities?

**H1o.** There is no statistically significant relationship between Directive style leadership and the propensity for elder abuse in long-term care facilities.

**H1A.** There is a statistically significant relationship between Directive style leadership and the propensity for elder abuse in long-term care facilities.

**RQ2**. Is there a statistically significant relationship between the supportive style of leadership style and the propensity for elder abuse in long-term care facilities?

**H2o.** There is no statistically significant relationship between Supportive style leadership and the propensity for elder abuse in long-term care facilities.

**H2a.** There is a statistically significant relationship between Supportive style leadership and the propensity for elder abuse in long-term care facilities.

**RQ3**. Is there a statistically significant relationship between the participative style of leadership style and the propensity for elder abuse in long-term care facilities?

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**H3o.** There is no statistically significant relationship between Participative style leadership and the propensity for elder abuse in long-term care facilities.

**H3a.** There is a statistically significant relationship between Participative style leadership and the propensity for elder abuse in long-term care facilities.

**RQ4**. Is there a statistically significant relationship between the Achievement-Oriented style of leadership style and the propensity for elder abuse in long-term care facilities?

**H4o.** There is no statistically significant relationship between Achievement-Oriented style leadership and the propensity for elder abuse in long-term care facilities.

**H4a.** There is a statistically significant relationship between Achievement-Oriented style leadership and the propensity for elder abuse in long-term care facilities.

Situational leadership theory posits that managers who are flexible and able to adapt their style to the situation are the most effective managers. The more specific Path-Goal Theory identifies four different styles that leaders might adopt, given the circumstances. An effective leader will be flexible and adapt the style that is the most appropriate for the circumstances. A leader who tends towards a having one dominant style out of the four will be less effective in all circumstances. While the first four hypotheses appears in the null, expectations are that having a dominant style will be less effective and lead to a greater propensity for elder abuse. The fifth hypothesis also appears in the null, with expectations that a leader who uses each of the 4 styles as appropriate, will be more effective and this will lead to a lower propensity for elder abuse.

**Significance of the Study**

Hypothetically 700,000 cases of elder abuse and neglect are reported within the United States, indicating a significant health policy impervious to humanizing strategies and directives for elder abuse and neglect (Dong, 2015). Throughout the past several years, a multitude of

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studies reveal the mistreatment of the aging generation. The State of Science Conference in 2010, World Elder Abuse Awareness Day was established in 2012, and the Institute of Medicine (IOM) two-day workshop in 2013 were all held to broaden the focus on elder mistreatment (Dong, Chen, Fulmer, & Simon, 2014). Regardless of these political activities elder abuse continues to be on the rise with counts of reporting remaining significantly lower (Dong et al., 2014). Mistreatment of the elder generation results in the expenditure of relatively billions of dollars annually and represents for many hospitals stays and emergency room visits (Mosqueda et al., 2016).

For this reason, the continued studies are of value to many individuals. As a result of the variations in defining elder abuse, it is advantageous to assist professionals and non-professional people with becoming more acclimated to the behavior and actions associated with mistreatment and the multiple forms of elderly abuse (Roberto, 2016). The risk factors and intervention procedures for assessing and identifying are of importance. Therefore, attentiveness and teaching are essential steps in reducing elderly abuse (Roberto, 2016).

In addition to increasing awareness regarding elderly abuse, it is crucial to identify potential risks factors and predictors that may lead to an individual becoming a victim of abuse or a perpetrator. Identifying risks factors that result in a person becoming more vulnerable to abuse is a vital element to reducing and eliminating elder abuse (Burnes et al., 2015). Risk factors that result in abusive situations can exist in the life of the senior adult as well as the perpetrator. Therefore, it is essential to recognize the factors associated with each side of the incident.

Elder abuse is a noteworthy concern, and caregivers, family members, and society as a whole must realize that seeing and suspecting abuse mandates reporting to the authorities to

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safeguard the elderly. This study provided a more in-depth scope of the problem by looking at the leader's role, a vital element in developing and reforming policies and programs designed to deliver care and safeguard the graying generation.

**Definitions of Key Terms**

**Path-Goal Leadership.** Path-Goal leadership assumes that leaders can adapt and change leadership styles as deemed necessary as situational change occurs (Northouse, 2013). The theory suggests the possibility of relationship variables such as organizational environment (task, work culture, and authoritative system); and subordinate characteristics (locus of control, experience, and capabilities) (Northouse, 2013). As determined by Northouse (2013), path-goal leadership theory is beneficial in aligning leadership to situations with the intent to assist subordinates with goal attainment. Leaders may exhibit four different styles as appropriate to the situation, and these are Directive Style, Supportive Style, Participative Style, and Achievement Oriented Style.

**Elder abuse.** Recognized as the intentional act of causing physical, emotional, sexual, and financial harm, including neglect, constitutes an elder violation, by a caretaker or any individual responsible for the safeguarding and well-being of the geriatric person (Phillips & Ziminski, 2012). Elder abuse can include excessive screaming and ridicule that include the act of verbally threatening the elderly along with the notion of continuously laying blame on the individual can lead to seclusion, pain, and emotional distress (Robinson & Brown, 2016). This study, examines elder abuse as the propensity to commit abuse.

**Sexual abuse.** Any unwanted exposure to explicit physical contact. Identifying factors associated with sexual assault consist of bleeding and irritation in the genital area and increased discomfort with personal care (Elder Abuse, 2016).

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**Emotional abuse.** Psychological abuse can be the result of excessive yelling or verbal threats, humiliation, ridicule, or continuous blaming, resulting in emotional distress or pain (Robinson & Brown, 2013).

**Neglect.** Elderly neglect refered to the failure of caregivers to fulfill their obligations to provide the needed care and necessities for individuals within their care. Neglect is recognized at two levels, with active negligence resulting from the purposeful act of withholding attention and needs. This form of neglect arises from the potential to make a financial gain, interpersonal conflict, or the notion of decreasing one's responsibility to allow for a 'break' during one's schedule (Roberto, 2016)

**Passive neglect.** The failure to provide necessary care due to lack of resources, caregiver stress, and lack of training in the area of geriatrics result in passive neglect. Neglect is the failure to provide care that is necessary for the physical and emotional well-being, as well as, welfare and safety of an individual (Elder Abuse, 2016). Indicators of neglect are pressure sores, desiccation, poor continence care, and desertion (Elder Abuse, 2016).

**Physical abuse.** The physical acts of hitting or any form of physical violence and deprivation that causes physical harm to the body of an individual. Indicators of physical abuse include bruising, skin lacerations, and fearfulness toward specific staff members (Rosen Bloemen, LoFaso, Clark, Flomenbaum, & Lachs, 2016). Physical abuse involves not only the infliction of pain but also the inappropriate use of drugs such as overmedicating, restraining or confining (alienating to room or restricting movement from the bed) (Rosen et al., 2016).

**Sexual abuse.** Physical contact of an elder person without obtaining their permission (Ramsey-Klawsnik & Teaster, 2012). The act of sexual assault can include the presentation of

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pornographic material, forcing the individual to undress against their will, and physical, sexual acts (Ramsey-Klawsnik & Teaster, 2012).

**Summary**

Elder abuse is increasing annually at an alarming rate (Roberto, 2016) and continues to affect many individuals as they are forced into long-term care facilities to receive the continuum of attention through the remainder of their lives (Roberto, Teaster, McPherson, Mancini, & Savla, 2015). Leadership holds a significant role in the culture of an organization; therefore, employing the right leadership style is essential to the outcome of the organization as well as for the resident that calls the organization 'home'. As recognized throughout this study, a significant component in identifying the signs of elder abuse lies within the knowledge provided to individuals responsible for providing care for the elderly. This research was beneficial in gaining an insight into the lived experiences of care providers and the process in which they perceive and respond to incidents of elder mistreatment. The completion of this study provides opportunities for accessing reporting procedures, the frequency of reporting, and revamping of policies, aligning training, and reformation within the healthcare industries.

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# Chapter 2: Literature Review

## Society and Business Recognition of Abuse

There are many important characteristics when studying literature on elder abuse in the elder care industry. This section includes society and business recognition of abuse, an examination of elder abuse and the elder care industry, the effects of leadership in elder care environments, and training from the healthcare employees' perspective. As recognized in various long-term care facilities, leadership, and adequate staffing are valuable characteristics for quality of care (Havig, Skogstad, Kjekshus, & Romøren, 2011). The increase of an individual's lifespan brings about the importance of focusing on the severity of elder abuse and issues associated with the quality of life and safeguarding of an elder person. Approximately 2.5 million vulnerable individuals within the confines of a long-term care facility are at imminent risk of being abused (Roberto, 2016). Elderly mistreatment is under-recognized, underreported, and concealed. Healthcare professionals, nurses, and physicians among them are exclusively unaware of the various forms and indicators of elder abuse that occur and of the proper procedures to take when abuse is suspected (Roberto, 2016). Evidence has it that the oppression of the aging generation is an issue at the predominantly long-term facility within the state of Georgia. Increase in age, loss of the primary caregiver, and debilitating illnesses are three contributing factors to elder abuse (Roberto, 2016).

Abuse within the limits of an organization designed to provide quality care for the elderly continues to overshadow the period of life once described by many as the 'golden years.' These debilitating acts of violence have been hidden behind the pulled curtains, closed doors, and sealed charts of long-term care facilities for decades (DeLiema, Navarro, Enguidanos, & Wilber, 2015). The introduction of granny bashing in the 70s and 80s opened the eyes of many scholars,

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executives, and families alike (Donavan, 2004). As more individuals enter long-term care facilities due to aging, sickness, or failure to care for oneself, elder abuse will continue to be on the increase (Abolfathis et al., 2013). As recognized throughout literature, addressing matters of the elderly is becoming more imperative. (Roberto, 2016). As a result of the lack of knowledge about elder abuse, it is advantageous to assist professionals and non-professional individuals with becoming more acclimated with the varying definitions associated with and forms of elderly abuse (Roberto, 2016). This study examined the risk factors and intervention procedures for assessing, identifying elder abuse. Therefore, attentiveness and teaching are essential steps in reducing elderly abuse (Roberto, 2016).

Institutional abuse is a form of violence or neglect that affects the elderly upon admission into long-term care facilities for the continuation of attention. Institutional abuse continues to exist regardless of the policies, procedures, and specifications made to curtail the occurrences (Burns et al., 2013). The burdens of care placed upon the caregiver are significantly higher among the providers of care to the victimized individual; for this reason, the understanding of elder abuse is vital to the future of the long-term care facility (Rosen, 2014). Policies and procedures have been negatively affected as much of the revamping, and improvement of policies and procedures reach completion in the political realm (Rosen, 2014). Approximately seven hundred thousand incidents of elder abuse are reported in the United States, indicating a significant need for revamping strategies and objectives to expand the focus on elder abuse and neglect (Dong, 2015). Elderly abuse cases materialized following the identification of child abuse in the 1970s as an epidemic classified as granny bashing (Roberto, 2016). Incidents of elder abuse identifies as a close resemblance to domestic violence; closer than child abuse within

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the 1980's. Many changes associated with policies regarding elder abuse were initiated in the 1980s as a means of eliminating elder abuse (Cox, 2015; Roberto, 2016).

In consequence, the definition of elderly abuse began to change, resulting in a more challenging concept of research as there remained no consistency in what constituted abuse. To complicate the analysis reporting and documenting procedures, even more, the introduction of the law enforcement and social agencies identified elder violence as a criminal offense instead of a social issue (Cox, 2015). This shift in power resulted in more law enforcement and distinctive legal involvement. Nonetheless, procedures for identifying and reporting continue to need revamping and addressing (Roberto, 2016). For this reason, it was necessary to address additional solutions to curtail the aggressive actions of the perpetrator. A vast problem has arisen in the care of the elders; elder abuse is more prevalent than people realize. The incidents of abuse are underreported, with approximately one in ten elderly having experienced the wrath of violence annually (Rosay & Mulford, 2016). As noted by Rosay and Mulford (2016) elder abuse is a critical challenge in that the incidents remain hidden as many people fail to report occurrences, while others lack the knowledge to recognize the existence of elder mistreatment (Rosay & Mulford, 2016).

**Abuse by the Numbers**

It is of great difficulty to imagine an accurate portrait of the extensiveness of elder abuse within the United States. According to statistics, approximately six percent of today's geriatric population have felt the wrath of elder mistreatment and ill-treatment while twenty percent of the population is at risk of being exposed to the debilitating nature of abuse (Cairns & Vreugdenhil, 2014). Literature divulges that 1 in 10 geriatrics patients/residents 60 years of age or older has suffered at the hands of an abusive caretaker (Elder abuse statistics, 2016). However, the

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abundance of incidents outweighs the number of reports filed/documented annually (Erlingsson, Ono, Saske, & Saveman, 2012). Approximately 1 in 14 incidents of abuse are reported to the mandated consultants, while an estimated 5 million older persons are suffering within abusive situations every year (Erlingsson et al., 2012).

**Abuse Defined**

The identification of ill-treatment is consistently dependent upon the interpretation of the viewer, as variations in the definition have led to the lack of comprehending the acts of behavior consistent with abuse (Harrison & Frampton, 2017). As identified in multiple studies, a significant obstruction to understanding elder abuse lies within the varying and inadequately developed definition of elder abuse. However, through recent research, a consistent definition has been construed. The constituents that indicate elder abuse can include 1) the purposeful act of inflicting harm or creating the risk of potential injury to a vulnerable elder by an individual responsible for and trusted to ensure the well-being and safeguarding of an older person (Schuster & Krah, 2016). Other indicators of abuse can include the failure to meet the needs of a person significantly or to safeguard them from harm or injury (Schuster & Krah, 2016).

**Physical Abuse**

Elder abuse is described as any harm or injury to an individual age 60 or above. Damage can result from the intentional slapping, shoving, or seclusion of an elder person. Ultimately, including the loss of social connection, and theft of valuable items, and the loss of quality care leading to the demise of the individual (Schuster & Krah, 2016). As noted by previous studies from the World Health Organization (2008), elder abuse is an occurring act or a single incident of ill-treatment toward an elder individual where a bond of trustworthiness has developed. For this reason, the damage is consistent with the description established by Mosgueda, et al., (2016),

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where Mosgueda et al., identifies elder abuse as an act of ill-treatment toward a person who is unable to speak out and report acts of debilitating behavior, resulting in the continuation of deprivation to the aging society.

**Emotional Abuse**

Emotional abuse is typically interrelated to other forms of ill-treatment; conversely, this type of maltreatment is a form of interpersonal violence that includes varying types of non-physical abuse such as threatening or coercive acts of intimidation, humiliation, harassment, and social isolation (Robinson & Brown, 2013). Incidents of elder abuse, also known as psychological abuse, can be recognized among residents of long-term care facilities; with emotional abuse being one of the most damaging and least reported forms of elder abuse (Roberto, 2016). According to Roberto (2016), the acts of caregivers, volunteers, family members, and any employee in the facility can lead to elder abuse. Emotional abuse can entail many layers of psychological or emotional distress caused by the care provider (Roberto, 2016). Emotional abuse can occur in various formats such: continuous humiliation and ridiculing; projecting of demeaning behaviors (habitual blaming or scapegoating); continuous screaming and yelling (distress); and frightening or ignoring residents (creating fear) (Kruzel, 2016)

Social isolation occurs at rates between 10 and 43 percent with approximately 20 percent of resident's experiences social isolation, whether in the home or the long-term care facility (Kruzel, 2016). Incidents of social isolation are significantly related to mortality, increased injuries from falls, heart diseases such as coronary artery disease, stroke, or suicide (Kruzel, 2016). Abuse of any form during the latter stages of an older person's life can be detrimental to the quality of life and desire to live (Kruzel, 2016).

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**Statistics of Emotional Abuse**

One source explains that 2.5 million Americans experienced elder abuse in 2006 (Elder Abuse, 2013). However, studies from 2012 indicate that incidents of elder abuse and neglect and emotional abuse recognized within 435,195 cases (Elder abuse statistics, 2012). The 2010 study identified 5,961,568 incidents of elder abuse; indicating that approximately 9.5% of older persons experienced abusive or neglectful situations during 2010 (Elder abuse statistics, 2012).

Additional statistics revealed that the average age of an abuse victim was approximately 78 years of age (Elder abuse statistics, 2012). Females fall victim to violence more often than males with roughly 67.3% being abused; 66.4% were caucasian descent; 18.7% were black, and 10.4% were Hispanic. The variations in age, gender, and race can be indicative of cultural differences and willingness to report incidents of abuse (Roberto, 2016).

**Indicators of Emotional Abuse**

Aging victims of emotional abuse made present with these identifying factors: 1) hopelessness and fearfulness and agitation; 2) frequent mood changes; 2) seclusion (avoiding the public); 3) prevented from making one's own decision; and 4) the eating and sleeping habit can change abruptly (Kruzel, 2016).

Older individuals continuously fall victim to emotional abuse and frequently present with symptoms of anxiety and depression (Begle et al., 2011; Smith & Freyd, 2014). Emotional abuse may result in a more detrimental change in mental health among the elderly. The effects of emotional abuse can be indicative of "negative psychological symptoms and functional impairment" (Roberto, 2016).

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**Sexual Abuse**

Sexual assault includes forcing an older person to participate in the act of sexual nature without consent (Grant & Benedet, 2016; Nazarko, 2011). Sexual abuse occurs when senior adults are involved in a sexual situation; they did not consent to, or if they are in a state of mind that alters their level of comprehension. Sexual abuse behaviors may include touching, kissing, raping, or being forced to view explicit videos or documents (Grant & Benedet, 2016; Nazarko, 2011).

**Financial Abuse**

As the population of older persons continues to increase, financial exploitation among the elders will intensify (Burns et al., 2017). Elder financial exploitation consists of elder financial abuse and elder financial scams. The improper or illegal use of finances, by a person entrusted by the older person, such as a family member, caretaker, or friend results in financial abuse toward the elderly (Burns et al., 2017).

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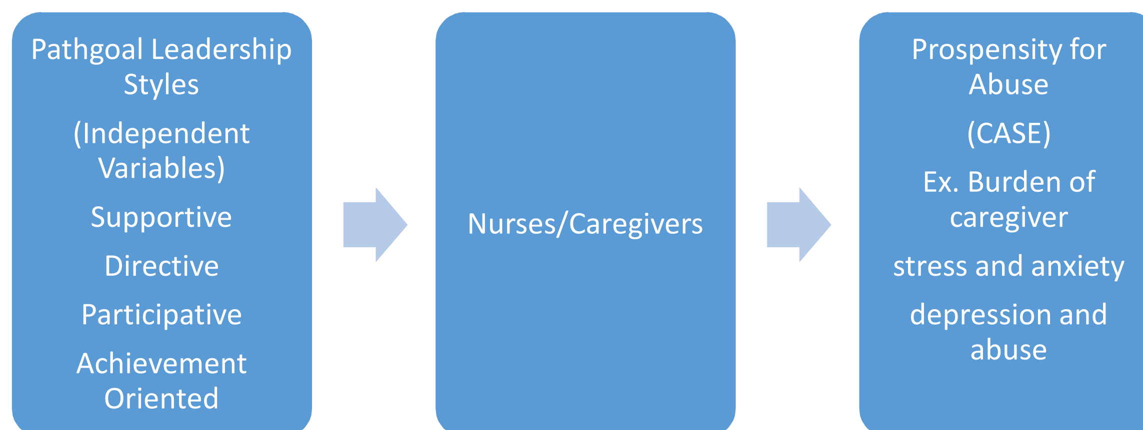


Table 2.1**:** Perceived Path-Goal Styles as perceived by nurses (left box) and the propensity for abuse as measured by nurses on the CASE (right box).

**Theoretical Framework**

Situational Theory and the Path-Goal Theory were used in this study to help understand the link between leadership, employee performance, and elder abuse within the long-term care facility. Situational Leadership Theory identifies a relationship increased burdens placed upon the caregiver as environments build up and lead to abusive situations (Albothi-Momtaz et al. 2013). Situational leadership theory also notates the ability of a leader to deal with situations as the occurrences take place. (Asamani et al., 2016). The situational leadership theory provides specific leadership flexibility in 1) initially prioritizing tasks and responsibilities; 2) assessing employee skills and motivational factors; 3) ultimately, defining the leadership style (directing, coaching, supporting, or observing) based on the circumstance as defined by the Path-Goal Theory of Leadership (Asamani et al., 2016). The path-goal leader considers employee skills and motivates employees through empowerment and assurance before assigning responsibilities and

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tasks (Northouse, 2013). The path-goal approach is essential in the identification of the leadership role in the situational context of elderly abuse. Path-Goal Theory recognized the need for diagnosing the functions that followers need to have fulfilled to allow for motivation, quality performance, and job satisfaction (Schriesham & Neder, 1996) and situational leadership theory established the leadership style that fits the circumstance.

**Application.**

Kim and Krishna (2014) revealed the implementation of situational Theory in multiple avenues such as in health well-fare communication regarding well-being or health; cataclysm communication; structural communication, and non-profit communication. The concept of Situational Theory has been expanded to include the variables associated with situational motivation in problem solving and decision-making. Modifications in the original variables related to recognizing the problem, acknowledging the limits related to implementations, recognizing all that are involved (target audience), recognizing the entirety of the situation were complete in the attempt to explain the variable of communication in the effort to resolve a problem (Kim & Krishna, 2014).

The focus of the Situational Theory was enhanced to include the concept of life's problems, decision-making, and individual outspokenness during the assessment of a situation (Kim & Krishna, 2014). Situational Theory is applied to the field of healthcare to determine the interactions between the characteristics of an individual and the behavior presented as a result of a particular situation (Morse, Sweeney, & Legg, 2015). The concept of Situational Theory is applied to healthcare and is used for the idea of comparing healthcare experiences and in the comprehending of meaningful outcomes in healthcare.

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The application of Situational Theory is beneficial in the examination of morality and deterrence in the prospect of college-level cheating (Cochran, 2016). As pointed out in the application and linking of the theory in health care an insufficiency in the levels of health care and academics exist due to the changing in an environment and human behavior (Cochran, 2016).

**Path-Goal Theory.**

Path-goal theory is a refined situational leadership theory that identifies a path for followers to achieve objectives within the workplace (Pennsylvania State University World Campus, 2017) and prescribes a distinct set of four different roles that leaders might adopt - the appropriate style or path that will lead to the desired outcomes or goals. The leader's role, as indicated by the Path-Goal Theory is to provide psychological support and component supplementation in the work culture to allow for the achievement of organizational tasks and goal achievement (Northouse, 2016). Three components, according to Northouse (2016), are vital to effective leadership and additive of path-goal leadership. The first component is the need for affiliation; structure preference, and control (measures followers' perceptions); 2. Unique design (designation of the task, the team was developing (assigning roles based on abilities); 3) organizational structure (adapting leadership behavior based on the mission).

## Role of the Leader

**Specific Roles.**

Leadership can play multiple roles, as identified by Schaubroeck, Shen, and Chong (2017). For example, Autocratic (Authoritarian) leadership style has been identified as a leadership style associated with destructive behavior and often considered an inappropriate form of leadership. Autocratic leaders are extreme leaders possessing a characteristic of dominance

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and having absolute power over the team in its entirety; thus, the situation leaves no room for suggestions or input from team members (Schaubroeck, et al., 2017). Subsequently, dominance and absolute power may lead to cultures of dictatorship and control with no outlets for participation in the decision–making process (Schaubroeck et al., 2017). Gaps and distances develop between team members and the autocratic leader during the reign of an authoritarian leader (De Hoogh, Greer, & Den Hartog, 2015). The distance between the leader and subordinates is associated with the intent to identify specific roles and responsibilities among the members of the team. Autocratic leadership roles are often associated with control, dictatorship, and dominance (Schaubroeck et al., 2017). As identified by Monks and Coyne (2011), the autocratic leadership style is developed upon power and control and often results in the acceptance of fearfulness and hostility. In such facilities such as care homes, the use of fear and intimidation by staff can lead to a detrimental environment of violence (Monks & Coyne, 2011).

**Leadership in General.**

Many researchers have looked at leadership in various ways. Some have taken on a specific style of leadership, while others focus on general guidance. For example, Al-Sawai (2013), described leadership as an "individual's behavior when directing and influencing groups and adapting to change”. While others such as Leonard (2017) recognizes leadership as the result of "commitment and effort". Additional research by Pidgeon (2017) and Stifner (2015), note that to be a leader one must encompass the ability to articulate orders with clarity and consistency" while maintaining the capabilities to ensure that orders are carried out to achieve the goal.

Additional researchers such as Fink-Samnick (2017), have examined the role of a toxic leader. Often described as the “dark side” of leadership, abusive leadership has shown to be a detriment to organizational outcomes (Fink-Samnick, 2017; Harris, Harvey, Harris, & Cast,

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2013). Toxic leaders (present with aggressive or hostile behavior), results in detrimental environments, cultures that are dependent upon threats and harassment as measures for reaching the establish objectives instead of gaining knowledge from educational and training opportunities (Fink-Samnick, 2017). As noted by Hogh, Howel, & Carneiro (2011), mistreatment and emotional abuse are elements of a toxic leader.

**Leadership Roles.**

Long-term care facilities set out with the intentions of providing quality care and safe-keeping for the old generations, but despite the positive inclinations, severe issues with mistreatment and abuse continue to exist within the long-term care facility (Frazaio et al., 2015). Failure to install a capable leader "can lead to the demise of an organization" (Giltinane, 2013). Ineffectiveness and absence in the leadership role can lead to a decrease in employee morale, fearful situations, and underperformance within an organization (Doe et al., 2015; Giltninae, 2013). Therefore, organizations and communities alike depend on the capabilities of a leader and their ability to do an adequate job (Chiu, 2016). A leader is an individual to whom others look for supervision, direction, and incentive (Gunnarsdóttir, 2014).

For this reason, it is beneficial for individuals in a leadership role to have the aptitude to make decisions efficiently while focusing on the right of the people and the organization. The purpose of a leader supports an individual who is hard-working and dedicated to the overall good of the team and stakeholders. An activity such as described through the path-goal theory portrays character, competence, compassion, and courage (Gunnarsdóttir, 2014).

However, many incidents denote a link between leadership roles and elder abuse as noted by Reader and Gillespie (2013), a variance of proximal factors such as workload and employee dissatisfaction are identifying factors associated with resident mistreatment and distal

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(institutional) factors such as leadership (Reader & Gillespie, 2013). Additional indicators of a correlation between leadership and elder abuse are identified by increased work responsibilities, stress, and less than adequate administration. Thus, resulting in staff restrictions in providing quality care, as well as creating employee burnout, discouragement, and detachment, ultimately leading to incidents of elder abuse (Reader & Gillespie, 2013). Other authors such as Killick and Taylor (2012), indicate that elder abuse begins with a top-down decision making and policy implementation combined with street-level policies. For example, essential systems (at the executive level) show a need for reporting (Dong, 2015), staff members identify the abusive situation and choose not to say because of the resident requests or other circumstantial information (Killick & Tayler, 2012).

**Path-Goal Theory**

As recognized by Vroom (1964), employee motivation has been an ongoing issue for leaders throughout history. The ability of a leader to understand what motivates individuals and groups alike is a considerable accomplishment. Forming and sustaining an atmosphere where each employee has a chance to fulfill their goals, requirements, and desires while contributing to a more significant cause is critical. Even though a leader creates the applicable structural culture and inspires individuals toward motivation, it is the responsibility of the individual to spur on momentum. However, an active leader recognizes elements of motivation and develops reward systems that coincide with the principles of each. Some aspects of motivation are 1) financial gain; 2) encouraging words; 3) personal recognition, and 4) positional advancement. The responsibility of an individual leading with the path-goal leadership style has the burden of recognizing employee skills and match individuals/employees to occupations that best fit their skills. As a result, matching the persons to professions based on personal skills further motivates

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the individuals by providing an opportunity to use his or her own/natural skills. Motivated employees are more likely to be determined, motivated, and inspired to provide high-quality care and performance (Asamani et al., 2016).

A leadership theory that will take into account all situations in which past research has not been able to research adequately is the Path-Goal Leadership Theory (Asamani et al., 2016; Hall, 2013). Path-Goal Leadership Theory is a situational theory that takes into account the needs, skills, and capabilities of one's subordinates to align responsibilities to achieve a goal (Hall, 2013). Path-Goal Leadership Theory recognizes that one of the essential duties of a Path-Goal Leader is to "enhance the mindset of subordinates which results in increased motivation leading to improved performance and increased job satisfaction among assistants" (Asamani et al., 2016). Leaders can outline a path of clarity for subordinates by eliminating any situational roadblock that can lead to one's inability to achieve the goal; 2) align subordinate responsibilities with capabilities; and have the ability to adapt to situations as they occur while continuing to focus on follower needs, skills, and the complexity of the task (Hall, 2013). Leadership can impact long-term organizations and potentially lead to elder abuse. Thus, indicating the need to identify the association of elder abuse and leadership. There are four types of leadership styles in the Path-Goal theory, and they are Directive, Supportive, Participative, and Achievement Oriented (Northouse, 2015).

According to Northouse (2015), the path-goal theory can explain how a leader perceives a situation, interacts with subordinates, the task at hand, and the situation. The path-goal theory suggests that the performance and gratification of members are improved when the focus is on the supporter's motivation (Northouse, 2015). The motivation of employees according to the path-goal theory appears to be in correlation with the ability of a leader to adjust their behavior

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to fit the situation, to enable followers to reach defined goals, and completion of tasks (Northouse, 2015). Employee motivation is at the forefront of leadership responsibilities as the achievement of targets and completion of tasks are vital to the field of leadership (Hayyat Malik, 2012).

The Path-Goal Leadership Questionnaire (Appendix A) is one of the various techniques that has been useful in the measuring and comprehension of path-goal leadership (Indvik, 1985). The questionnaire is useful in gaining information for respondents regarding directive, supportive, participative, and achievement-oriented leadership styles (House & Dressler, 1974; Indvik, 1985). According to research, two areas of influence exist in the interactions between the leader and the follower (Jacob et al., 2017). One influence results in the employee performing by the leader's requests by receiving rewards or benefits (Jacob et al., 2017). Leadership is essential in promoting employee awareness and patient-centered care (Jacob et al., 2017). An additional influence is the enjoyment of job (inspirational) when leader presents in a manner with acknowledgments and praise that encourages employees to take on new and challenging tasks (Choudhary, Naqshbandi, Philip, & Kumar, 2017). How a participant scores on each of the styles, as well as, the importance that each score on the various leadership styles is beneficial in recognizing the ability of a manager to adjust his behavior to adapt to the situation or need of his/ her followers. The matching of appropriate leadership style to the situation is advantageous to employee motivation as improvements in motivation lead to an increase in task completion and actual achievements (Northouse, 2015). The benefits, such as employee morale and performance, of the Path-Goal theory, become evident as leaders gain an understanding of their scores on the leadership questionnaire and learn to adapt to the situation the path-goal theory (Choudhary et al., 2017. The four approaches (directive, supportive, participative, and achievement-oriented)

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described through the structure of the path-goal theory identifies a leader's ability to affect employees in multiple ways. The path-goal theory is a process of defining a leader's most dominant style of leadership (Northouse, 2015). The structure of the theory consists of four approaches for defining the most efficient style as they affect the motivation of followers as each approach as the ability to add structure to rewarding, and structuring employee motivation. These structures of the Path-Goal process are directive, supportive, participative and achiever-oriented leadership styles (Northouse, 2015).

**Associated Risk Factors for Elder Abuse**

The prominence of violence is significantly higher within the healthcare entities as identified through the identification of factors (age, health, and lack of independence) and protective profiles (policies and procedures for protecting the elderly) (Burns et al., 2015). Abusive behavior toward the elderly continues to increase extensively and remains inadequately informed, concealed, and subsequently unrecognized (Policastro & Payne, 2014). As noted by Policastro and Payne (2014), healthcare executives and staff members should be held accountable for reporting incidents of abuse. On the other hand, research also reveals that individuals such as physicians, certified nursing assistants (typically the first line of care and treatment within a nursing home), are exclusively unfamiliar with the extent of elder abuse and the various forms of ill-treatment (Policastro & Payne, 2014). Statistics uncover that incidents of an abusive nature are a significant concern within the majority of long-term care facilities (Erlingsson et al., 2012). Abuse of the older male is less likely to be recognized or reported due to cultural beliefs and traditional characteristics such as manliness and impassiveness (Melchiorre et al., 2016). However, information revealed through historical data discloses that elderly males ranging between the ages 80 and above are more prevalent to being abused at a

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rate higher than that of females within the same age range (Melchiorre et al., 2016). Subsequently, 63.2% of the elderly gentlemen have been the victim of more than one episode of abuse while 66.2% are victims of constant abuse (Ghodousi, Maghsoodlo, & Mohsen Sadat Hosein, 2011).

Additionally, increasing awareness regarding elderly abuse is crucial to identifying potential risk factors and predictors that may lead to an individual becoming a victim of abuse or a perpetrator (Burnes et al., 2015). Identifying risk factors that may result in a person becoming more vulnerable to abuse is a vital element in reducing and eliminating elder abuse (Burnes et al., 2015). Risks factors associated with abusive situations exist in the life of the senior adult as well as the perpetrator (Burnes et al., 2015). Therefore, it is essential to recognize the factors associated with each side of the incident.

In addition to identifying the risk factors associated with the abuse and aging victim, it is also critical to examine the institutional setting for potential hazards factors (Tanaka et al., 2015). Many factors related to the facility can lead to the outbreak of an abusive situation. For example, Tanaka et al. have identified factors associated with elder abuse are unprofessional and insensitive approaches of the caregivers/personnel assigned to provide residential care (2015). Risk factors can also be associated with inadequacy in caregivers (lack of attention to the resident), lack of regulatory concern (may lead to lack of employee motivation (lack of interest), and additional responsibilities imposed upon the employee may lead to employee burnout (Tanaka et al., 2015).

There remains no single explanation for elder mistreatment; however, multiple studies have identified contributing factors such as isolation, poor health, living arrangements, and increase responsibility as factors that may contribute to the growth of elder abuse (Alizadeh-

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Khoei, Sharifi, Hossain, Fakhrzadeh & Samili, 2014). According to Alizadeh-Khoei et al., many factors can be intertwined with the occurrences of abusive behavior; therefore, individual assessments must be periodically completed on long-term care residents (2014). Description of risk factors for elder abuse is advantageous to the development of a stable foundation for prevention and treatment programs within long-term care facilities (Alizadeh-Khoei et al., 2014).

**Residential Factors**

As noted by Mosqueda, Hirst, & Sabatino (2016), individuals 85 and beyond are more likely to become a victim of ill-treatment than persons of other ages, while people affected by the debilitating effects of dementia are also at a higher level of being succumbed to the consequences of an abusive situation. Females are subsequently the majority of older individuals experiencing abuse at the hands of a care provider (National Alliance for Caregiving and AARP, 2015); other minority groups include African Americans and Latinos (Mosqueda et al., 2016). Potential risk factors associated with physical and emotional abuse are relative to separation or divorce, low-income or poverty status, and functional impairment (Burns et al., 2015). The World Health Care Organization has identified a multitude of factors such as decreased physical and mental health, social isolation, and lack of family support, ageism, and institutional situations in variable settings (2015). Essentially recognition of potential risk factors associated with elder abuse is prevalent in identifying and improving educational protocols (Shrivastava, Shrivastava, & Ramasamy, 2016)

**Facility Factors**

To what extent does the environment of a long-term care facility lead to elder abuse? Particular participants may feel less stress during select hours on particular days in which individual abusers do not work. The examination of these variables also provided a notion of

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defining who undergoes more abuse, male or female, type of abuse, and at which interval do the incidents take place (Wang, Brisbin, Loo, & Straus, 2015). Regarding the workplace, deviance and bullying (abuse) have also been the focus of various scholars. However, there remains a lack of research and the impact that unethical behavior such as residential bullying has on the delivery of care and the individual in the care of the healthcare provider investigating the acts of dishonest performance (Hutchinson, Jackson, Walter, & Cleary, 2013). The experiences of bullying and unacceptable behavior or the witnessing of such behavior and the chain of events associated with such actions can have detrimental effects on the patient, family, and staff (Hutchinson et al., 2013). Hutchinson et al., (2013), claim that individual's subjected to situational pressures knowingly become involved in the unacceptable behaviors.

The study conducted by Hutchinson et al., (2013), indicated that elder mistreatment is the concept of controlling a patient through detrimental actions instead of focusing on the well-being of the patient. The act of monitoring a patient through unacceptable means is a callous disregard for the concern of the patient, harmful impacts on healthcare practices, and the failure to disassociate unethical behavior from the objective of the organization. As revealed through this study healthcare providers have the potential to present in a manner of showing concern for the patient while projecting unethical behavior such as abuse to control the patient; therefore, having no regard for the safety and well-being of the patient, while creating potential risks factors for that organization and all involved (Hutchinson et al., 2013). Employees on all levels within long-term healthcare facilities have the potential to 'run' from accountability associated with the abuse of the elderly, while the administrators are reluctant to intervene due to the fear of legal responsibilities and possible court appearances (Roberto, 2016). For this reason, elder abuse continues to be a topic of insufficient study and a predominantly 'hidden' form of ill-treatment

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(Roberto, 2016). All fifty states do not mandate the reporting of abusive situations involving the elderly; only 44 states require that health care professionals report the suspicions of abuse and neglect (Daly, Schmeidel, & Jogerst, 2012).

Healthcare providers admit to witnessing the acts of elderly abuse but fail to report the incidents to the appropriate authorities (Daly et al., 2012). Research presented by Bird et al., (2010), revealed that 7 out of 28 injured patients ranging in ages 60 and above were victims of abuse or neglect, but only two cases had recorded intervention procedures. The insufficiency in reporting lies partially on the shoulders of the physicians as in the study completed by Rosenblatt et al., (1996), doctors only report 2% of all suspected incidents of abuse and neglect. Other areas of insufficiencies in reporting lie on the shoulders of state authority, as recognized by Phillips, Guo, and Kim (2013), incidents among long-term care facilities within the United States are more prevalent than recently reported. Phillips et al., (2013) conducted studies at various long-term care facilities in Arizona indicating that elder abuse reports were rare; however, citations at 7% of the surveyed facilities included 598 allegations of elder mistreatment, with 372 incidents being substantiated but received citations for charges other than mistreatment. Results of the studied revealed the severity of underreporting and under recognizing at a state level (Phillips et al., 2013).

**Culture Factors**

To what extent do changes in culture, policies, and reporting procedures increase safety and ethical business practices? Cultural factors play an abundant role in the implementation of policies and procedures with a long-term care facility, as noted by Boucher (2016), cultural awareness is advantageous to decreasing health care disparities. Understanding the concept of an individual's culture will enable caregiver's opportunities to provide a more quality oriented

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treatment. Organizational culture is an important component of an organization as the culture of a business is critical to enhancing employee performance and satisfaction as well as improving employee morale (Levitt, 2015). The culture of an organization is a combination of learned philosophies, ethics, guidelines, and customs, along with symbols and ethnicities that govern the behavioral of an organization (Northouse, 2015).

Measuring the culture of an organization is a difficult feat. Nonetheless, the culture of an organization is the contributing factor to the elements and behavior that make up the entirety of an organization. Culture is a factor in developing multiple facets of a an entityincluding the sense of identity, boundaries, and separating features.. The feeling of identity is the concept of identifying with the organization and members ((Levitt, 2015). The unique qualities of an organization are allocated only to the members of the selected entity; thus, creating a sense of identity (Levitt, 2015). Northouse notes that culture, through the sharing of common goals, helps to develop the boundaries of an organization (2015). Hence, individuals within the group are focusing on the same purpose. The uniqueness of the culture provides members with the feeling of belonging through the intertwining of the common goal. Levitt (2015) noted the desire to perform at a higher level attributes to this sense of belonging. .

**Inadequate Resources**

Inadequate resources and lack of training have been identified as obstructions to perceiving, addressing, and prohibiting, elder abuse (Howes & Kimmell, 2009; Lowndes & Struthers, 2016. Many senior adults experience incidents of abuse and neglect at the hands of individuals accountable for assuring a safe and healthy environment. Some occurrences of ill-treatment and neglect are on the increase with consequences of detrimental endings (Halphen & Burnett, 2014). Inadequate resources and lack of training have been identified as obstructions to

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perceiving, addressing, and prohibiting, elder abuse (Howes & Kimmell, 2009; Lowndes & Struthers, 2016). Lowndes and Struthers recognized inadequate staffing, lack of legal involvement, and unlicensed staff as barriers to effective intercession and deterrence (2016).

Many senior adults experience incidents of abuse and neglect at the hands of individuals accountable for assuring a safe and healthy environment. Some occurrences of ill-treatment and neglect are on the increase with consequences of detrimental endings (Halphen & Burnett, 2014). Such components as organizational structure and risks factors are associated with elder abuse. Lowndes and Struthers (2016) examined awareness among employees regarding abuse, neglect, and the intent to identify the gaps in elder abuse training. The cultures of long-term care facilities lack the upholding of residential well-being and quality care beneficial to ensuring the best healthcare for elder residents (Nakrem, 2015; Paul & Sahadev, 2016). The overall treatment and care of the residents of a long-term care facility can be affected by the allocation of resources (or lack of funds), number of available beds (overall goal is to retain a specific capacity), and inadequate pre-admission assessments (overlooking particular illnesses and needs) (Acuerno et al., 2009; Buttugieg et al., 2015; & Wang et al., 2015).

**Training**

Elder abuse is a single or continuous act or lack of appropriate intervention that causes harm or distress to the older person (Touza-Garma, 2017). Nurses and other healthcare providers have a vital role in identifying and reporting abuse (Touza-Garma, 2017). These healthcare professionals are usually the frontline caregivers and the first in contact with medical and social skills to recognize signs and systems of abuse; however, the percentage of reporting remains low (Touza-Garma, 2017). Many researchers have identified an association between failure to report and the lack of knowledge in the area of elder abuse (McCreadie, Bennett, Gilthorpe, Houghton,

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& Tinker, 2000; Joubert & Posenelli, 2009; & Touza-Garma, 2017). Touza-Garma has acknowledged that the knowledge and skills of healthcare professionals have been described as an element of detection; while the training of the healthcare providers is an effective means of improving abuse recognition (2017). For this reason, preparation is known as a means of improving healthcare provider knowledge of elder abuse and the identification of incidents of mistreatment (Dow et al., 2013; Pillemer et al., 2011).

**Characteristics of the Perpetrator**

While comprehending the features of the facility is valuable to the decrease of abusive situations, understanding the perpetrator is also of value. The danger of becoming a perpetrator correlates with multiple situations affecting the individual at various communal, individual, and interpersonal levels. Multiple levels are associated with the dangers of becoming a perpetrator such as lack of formal or societal support; dependence upon alcohol or drugs or mental illness; Potential perpetrators are incapable of handling the stress brought on by the responsibilities of providing care to the older persons or lack the training and knowledge to provide quality care; thus leading to abusive behavior (Roberto, 2016; Touza-Garma, 2017). On the communal level, a potential to become a perpetrator begins with lack of control surrounding the decision-making process and treatment; and has limited access to respite care and support services such as financial and legal assistance (Roberto, 2016; Touza-Garma, 2017). The institutional level correlates with the lack of empathy and sympathy toward the residents (negative attitudes, ageism, and intergenerational conflict) (Roberto, 2016; Touza-Garma, 2017).

**Nurses**

Perpetrators of abuse involve anyone in the position of authority or trust over an individual (Pillemer & Moore, 1989). A perpetrator can be a member of an aging persons'

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family, a friend, or a paid employee, such as the nurse (Pillemer & Moore, 1989). Many researchers have revealed an association between nurse and elder abuse. For example, a survey conducted by Pillemer and Moore (1989), found that 36 percent of the staff had witnessed an incident of violence such as excessive slapping, punching, or shoving. While ten percent of the team admitted to being the perpetrator of such acts of abuse (Pillemer & Moore, 1989). Schmeidel, Daly, Rosenbaum, Schmuch, and Jogerst have identified nurses and other healthcare providers such as the physician as perpetrators through their failure to report incidents of abuse (2012). Nurses look to others to deal with the abusive cases, or they look for other reasons behind the declining of a patient's health (Schmeidel et al., 2012). Physicians acknowledge that time restraints and physician-patient relationship outweighed the importance of pursuing incidents of abuse

**Leaders**

As the leader of a multidisciplinary team such as that of a long-term care facility, one is in a position to prevent and recognize elder mistreatment (Liao & Mosqueda, 2006). Long-term care administrators must establish cohesion between leadership strategy and quality of care (Willis, 2017). Failure to develop an interconnection between organizational management and environment design can lead to the inability to safeguard and provide quality of care for the elderly (Quality of Care, 2011). Poor working conditions, a significant regiment of responsibilities, and lack of organization and task alignment can lead to higher incidents of abuse (Band-Winterstein, 2015).

**Predominance of Abuse**

Approximately four million 'graying' individuals are subjected to physical, psychological, and financial abuse annually (Wolfe, 2003). However, the entirety of the phenomena is not

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recognized in these statistics as an estimation of 23 cases go unreported for each case reported (Pillemer et al., 2016). Due to the multitude of cases, solutions for ending elder abuse are short-lived while others remain in effect, but in need of reinforcement. Researchers and scholars argued that little progress has occurred in recognizing the causes and consequences of elder abuse. However, the understanding gained from previous studies identified the importance of reporting and becoming involved. Contrarily, many remain 'outside' of the incident instead of reporting and taking action due to the fear of 'getting involved' and the fear of meddling and repercussions and for this reason, fail to realize that getting involved can be the difference between life and death for an abuse victim (Pillemer et al., 2016). The issue of elder abuse is of considerable significance and services are rendered to victims on an as-needed basis and only when deemed necessary. Even though the rendering of treatment and assistant is a significant component to eliminating abuse, the services rendered to victims of ill-treatment can appear too biased as healthcare personnel provides the medication only as they deem necessary (Burns et al., 2015). This concept for receiving treatment and services may lead to many victims not seeking help due to the lack of services/treatment available.

## Protections against Abuse

### Preventions and Regulations.

Many agreements have been authorized to ensure the safety and protection of the aging population.  Facilities established for the continuum of care such as long-term care units are not secluded from adhering to the established guidelines and protocols. The aging generation of today is made up of multiple members of society, ranging from parents to grandparents from all economic and cultural backgrounds.

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Nevertheless, with the declining of one's physical and cognitive abilities, individuals are at a higher risk of being mistreated and abused (Elder Mistreatment and the Elder Justice Act, 2009). In recent years policies have been developed, and others have been revamped, as a matter of bringing to the forefront the seriousness of elder abuse within the healthcare field. Changes have taken place within Medicare, Medicaid, and the Older Americans Act, thus, increasing the awareness of elder mistreatment and abuse. Experts acknowledged that becoming more familiar with the aspects of elder abuse can be advantageous to make changes regarding policies associated with elder abuse (Phelan, 2015).

**Activities of Daily Living (ADL'S).**

A primary concern during the pre-assessment stage of a nursing home admittance relies upon many qualifications such as the assessment of activities of daily living (Fong, Mitchell & Kohn, 2015). The measuring of an individual's ability to perform particular tasks such as bathing, dressing, and eating is beneficial in predicting the admission of an older person as the risk of admission is fivefold for an individual with 3+ ADL limitations and only twice as likely for an individual with 1-2 constraints (Marcel, Satterfield, Ostfeld, Wallace, & Havlik, 1993.; Fong et al., 2015). Activities of Daily Living include routine activities such as bathing, and dressing, activities that individuals must be able to do to live independently (Fong et al., 2015). Personal care functions also include being able to recognize the need to go to the restroom, and to have the ability to move from one place to another, such as throughout the home. More complex activities include the management of finances, performing chores such as cleaning and cooking (Fong et al., 2015).

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**Adult Protective Services.**

State-mandated services such as the Adult Protective Services, are deemed responsible for investigating all reports of elder mistreatment and neglect of individuals sixty-five years of age and older or an adult over the age of eighteen with disabilities not currently residing in long-term care facilities. Georgia mandates that all suspected incidents of mistreatment must be reported to the appropriate authorities and failing to report an offense punishable by law (Adult & Protective Services, 2017).

**Long-Term Care Ombudsmen**

The Long-Term Ombudsman Program (LTCO) of Georgia is an entity separate from the Georgia Division of Human Resources and Aging Services as governed by federal Older Americans Act and Georgia law (State Ombudsman Program, 2017). Ombudsman services of Georgia are non-profit contractual services with agencies responsible for supporting quality treatment in health care, training of healthcare professionals, and improving access to long-term care services. Cox (2015) recognizes The Elder Protection and Abuse Prevention Act of 2012 as a layout for strengthening federal resources at the state level and assisting with responding to and eliminating incidents of abuse. Endorsements of the Elder Protection and Abuse Prevention Act would govern the refining of the definition of elder abuse and would require the standardization of state protocols, assessment tools, and reporting requirements (Cox, 2015).

A majority of states currently have directives in place regarding elder abuse recognition and reporting; however, The Act would improve state Adult Protective Services through the implementation of screenings into Congress as part of senior programs (Cox, 2015). As individuals age, they become vulnerable to mistreatment, and violations of their human rights, the rights of quality care and protection, the critical elements that remain at risk for many aging

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adults. Consequently, elder mistreatment and abuse has received substantial attention; thus, the lack of standardized guidelines and curriculum continue to impede the elimination of elder abuse (Cox, 2015).

Prevention of elder abuse requires a multifaceted effort requiring professional involvement in all areas. Many locales such as the United States have established mandated reporting laws and coordinated resources to assist with the financial, health, and legal needs of the older person (Gassoumis et al., 2015). Structured policies and procedures have been established among a multitude of long-term care facilities that identify abuse and the procedures for reporting abusive behavior (Gassoumis et al., 2015). Many attempts have been established to eliminate the occurrence of elder mistreatment; however, situations are continuing to occur, indicating more avenues of prevention (Pillemer et al., 2016).

**Elder Justice Act**

Elder abuse is covered up, unreported, and unrecognizable more today than in previous years (Elder Mistreatment and the Elder Justice Act, 2009). As part of the Affordable Care Act of 2010, the Elder Justice Act was the most advantageous bill enacted in an attempt to combat elder abuse with the rewarding of $770 million and economic sanctions being set aside for four years to provide provisions for protecting the seniors of the United States (Lindberg, Sabatino, & Blacato, 2011). The creation of this act established the awarding of $500 million to Adult Protective Services. The formation of the Elder Justice Act ensured the addressing of elder safekeeping and protection at multiple levels Through the creation of the act, and a coordinating council was established to advocate for the old through the administering of programs for promoting elder justice. The development of the Elder Justice Council stands as a defender of the elders in raising awareness through teaching, comprehension, and sanctions to the Department of

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Human Service on issues of abuse, neglect, and exploitation of the aging generation (Lindberg et al., 2011).

Section two of the Elder Justice Act addresses the reform and enhancement of long-term care facilities with sizable portions of section two focusing on the funding at state and local levels of the Adult Protective Services for gathering data in the best practices and providing technical support at the local and national levels (Willard, 2011). The enactment of the Elder Justice Act brought about a focus on the recruitment, retention, and training of long-term care personnel, along with the revamping of management practices, and implementation of the electronic recording of health records (Lindberg et al., 2011). Additional provisions of the act focus on the protection of the long-term care residents through provisional grants to state agencies responsible for evaluating and surveying complaints of abuse and neglect (Lindberg et al., 2011).

As with understanding the perpetrator, comprehending, defining, and identifying elder abuse are vital to managing the source and depleting the incidents of ill-treatment (Touza-Garma, 2017). As the current literature shows, there remains a lack of standardization in the definition of elder abuse. However, healthcare providers, families, the victim, and society as a whole can play a significant part in eliminating the misuse of the elderly. Individuals can take part in the identification and implementation strategies of improving the reporting process, revamping the screening system, and intervening when needed and become involved with the intent to prevent the continuation of elderly abuse within the parameters of the long-term care facility (Touza-Garma, 2017).

As scholars and researchers alike continue to explore and examine the scope of elderly abuse, the extent of such debilitating incidents will become a known issue instead of a hidden

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epidemic (Gagnon, Deprnce, Srinivas, Hasche, 2015). Regulations and Codes of Practice are in place for mandating that healthcare practitioners and others responsible for providing the care of elderly persons must report all uncertainties and occurrences of geriatric abuse (Reyes-Ortiz, Burnett, Flores, Halphen & Dyer, 2014). Regardless of the lack of provisional reporting procedures and documentation, elder abuse continues to be a debilitating issue with today's nursing homes (Roberto, 2016). The research and identification of elder abuse and risk factors associated with the incidents of mistreatment have been downplayed, covered up, and altogether unmentioned in past years (Rizzo et al., 2014). However, scholars and practitioners alike have recognized the devastation, debilitation, and death associated with acts of an abusive nature (Rizzo et al., 2014; Roberto, 2016). For this reason, uncovering risk factors related to and occurrences of elder abuse may lead to the elimination of current abusive situations and distinguish any future development of new cases (Rizzo et al., 2014).

## Elder Abuse and the Elder Care Industry

### Essential Facilities.

The demand for long-term care facilities has increased as a result of the rise in population within the United States (Kulik, Ryan, Harper, & George, 2014). Along with the increased need follows the employment of inadequately trained personnel (Buttiegieg, Rathert, & Eiff, 2015). The increased need for long-term care facilities and high unemployment rates has led to the employment of workers who lack the required skills and knowledge to care for the elderly (Buttiegieg et al., 2015). The lack of education and training can have a detrimental effect on the residents and ultimately lead to incidents of abuse (Buttiegieg et al., 2015). The great demand associated with providing quality care to vulnerable individuals, such as the elderly results in

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stressful and demanding working environments within the long-term care facility (Paul & Sahandev, 2016).

The demand of caring for the elderly and the stress of insufficient staffing often results in employee burnout and a decrease in caretaker-resident engagement and an increase in abusive situations within long-term care facilities (Paul & Sahandev, 2016). Paul and Sahandev (2016) identify that organizations such as nursing homes are often in a vicious cycles associated with the intent to increase profits.Attempts to increase profits result in decreased staff, increased workloads, and employee stress, often indicators of increased incidents of elder abuse and employee turnover (Paul & Sahandev, 2016). Ultimately the loss of staff and continuous staff turnover result in a loss of revenue at approximately five percent due to repetitive hiring and training within the long-term care facility (Paul & Sahandev, 2016).

Van Puyvelde, Caers, Dubois, and Jegers (2015) recognize an association between long-term care facilities and cost-cutting decisions to decrease fiscal spending and increase financial profit; ultimately, at the sacrifice of elder safety and treatment. Increasing elder abuse awareness among healthcare professionals is not only beneficial in enhancing detection and reporting procedures but is also advantageous in changing the attitudes of the professionals toward the reporting of abusive incidents (Touzma-Garma, 2017). Training and raising awareness in the decision-making process and stratagems among healthcare providers who encounter offensive is of vast importance. The overall care of the residents within a long-term care facility can be affected by the allocation of resources (or lack of funds), number of available beds (overall goal is to retain a specific capacity), and inadequate pre-admission assessments (overlooking particular illnesses and needs) (Acierno et al., 2009; Buttugieg et al., 2015; & Wang et al., 2015).

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Healthcare facilities designed to provide care for the elderly struggle to overcome performance and unfortunate treatment circumstances. Continuously providing patient care based upon experience instead of evidence-based medicine and consistently repeating the same mistakes leads to less than efficient patient care which ultimately signifies a lack of cohesion between leadership strategy and quality care (Sadatsafavi & Walewski, 2013; Willis, 2017). The long-term care staff is progressively under great hardships to function more proficiently and successfully and has to respond to the challenges associated with poor quality patient care, insufficient training, and increased incidents of elder abuse (Roberto, 2016). Long-term care administrators must give attention to the combined effect of organizational management and environmental design as controlling expenditures (through the decrease of elder abuse cases and litigation) and ensuring quality services are imperative to corporate sustainability (Sadatsafavi & Walewski, 2013).

**Profits and Elder Mistreatment.**

Organizational ownership may be a relevant component to elder abuse in the realm of a for-profit entity as opportunities arise to take advantage of residents through delivering less than quality care and at times sacrificing the safety and well-being of the residents to increase profits (Van Puyvelde, Caers, Du Bois, & Jegers, 2015). According to Schmitt (2002) and Van Puyvelde (2015), many benefits have increased in for-profit facilities, often at a gain of 20 to 30 percent. In an attempt to remain cost efficient for-profit, long-term care facilities have approximately 32 percent fewer health care providers and 47 percent more insufficiencies than not for profit services (Quality of Care, 2011). Paul and Sahadev (2016) have emphasized multiple issues in nursing homes, identifying particular insinuation of poor service quality, inadequate administration, physical and mental abuse among the elders within a long-term care

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facility. According to Castle (2006) and Paul and Sahadev (2016), the cultures of long-term care facilities lack the safeguarding of residential security and excellence of care needed to ensure the adequate treatment of an older person. Implementing quality attention and safety-oriented cultures within a nursing home is contingent upon the continuous assessment of residential physical and psychological needs, as well as, assessing the conditions of the resident's family (Paul & Sahadev, 2016). Not-for-profit long-term facilities cannot distribute profits throughout the entirety are most likely to guarantee quality care and behave with more ethical mannerisms (Van Puyvelde et al., 2015).

A foundation of entrepreneurship is that for-profit entities are granted the autonomy to ensure that quality services are provided (Jacobsen et al., 2016). The general concept of for-profit organizations is to ensure that healthcare providers are providing quality care to residents to retain a competitive edge on other long-term entities (Jacobsen et al., 2016). Regrettably, for older persons, maintaining for-profit entities has led to insufficiency in care within the nursing home industry (Jacobsen et al., 2016). Quality of Care recognizes that initial problems arise as organizational leaders place revenue and profit above the well-being of the residents (2011). The insignificant nursing staff is the principal predictor of low nursing home value and residential care (Quality of Care, 2011).

**Effects on Long Term Care Facilities.**

Other areas such as a surplus of room and bed availability with long-term care facilities can result in residential admission without proper assessment, required for sufficient placement (Acierno, Hernandez, Muzzy, & Kenneth, 2009). A failure in adequately assessing a resident can lead to displacement and a lack of necessary care (Wang et al., 2015). Ultimately, individuals with cognitive disorders require treatment plans that differ from individuals who seek minor

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assistance with daily living skills. Limitations in bed availability can lead to admission into a facility that fails to provide quality care; thus, leaving the resident susceptible to ill-treatment and neglect (Acierno et al., 2009). Areas such as management and spending can also be associated with abuse within the long-term care industry (Buttigieg et al., 2015). A lack of adequate resources or quality equipment leads to elder abuse as the need for required care is dependent upon multiple services and equipment. Areas of management and personnel can overlook acts of mistreatment due to employee burnout and stress; thus, leading to an increase in occurrences as reporting, reprimanding, and retraining fails to take place (Buttigieg et al., 2015).

The topic of elder abuse must be addressed and become a subject of conversation among the business executives within a long-term care facility as approximately 30% of long-term care facilities receiving citations due to occurrences of elder abuse; the debilitating incidents are a severe issue (DeLiema et al., 2015). Incidents of abuse can have a detrimental effect on the lives of the victims and can lead to the demise of a long-term care facility. With the increase in population and the tripling of older persons, from 4 million to 14 million by 2040, the pressure is on the healthcare providers (DeLiema et al., 2015). Additional stress on the caregiver results in an unstable environment and ultimately, a higher chance of abuse was occurring. The further need for treatment increases the workload among the care providers, placing a burden on the current employees and organization. Long-term care facilities provide significant degrees of care for the older persons that are typically unable to reside on their own. Yang (2015), identifies extensive supervision within the facility where residents require an advanced degree of attention to perform daily activities, among needs. The nursing home or long-term care facility is designed with the intent to provide continuous day and night care for individuals that are unable to care for themselves due to age, sickness, or incapacity (Siejko et al., 2017).

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**Leadership and the Effect on Elderly Care**

The basis of the Path-Goal Leadership Theory is the identification of specific behavior mannerism based on the situation (Northouse, 2013). The Path-Goal Model can best be described as the process of behavior selection as leaders adapt to fit the needs of the employee and the organizational environment so that they can best lead the employee to achieve daily work objectives (tasks) (Northhouse, 2013). The foundation of the Path-Goal Theory is the leader's ability to adapt to a situation and lead their workforce to goal obtainment (Northhouse, 2013).

**Directive Leadership.**

The first approach is the directive approach. The directive leader will be more valuable to employees and followers that have a sense of desire to achieve (Hayyatt & Malik, 2012). The directive leader clarifies the principles of performance, rules, and regulations (Hayyatt & Malik, 2012). The directive leader makes employees aware of expectations and the procedures for performance improvement and enhancing one's skills and abilities. For example, employees that are unsure of their responsibilities are provided clarity and direction by the directive leader.

**Supportive Leadership.**

The second approach is the supportive style of leadership. The supportive style of leadership is adjustable to meet the needs of their followers through employee empowerment and employee/ follower correlation (Northouse, 2015). The supportive leader takes into consideration the emotional state, personal needs, and preferences of their employees (Northhouse, 2015). This leadership style is ideal for task and situations that may be stressful and time-consuming such as caring for the geriatric resident.

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**Participative Leadership.**

The third approach, as described under the path-goal theory, is the participative approach. The characteristics of a participative leader include taking on the entirety of the team when making decisions (Northouse, 2015). Even the final decision in the process of decision making takes into consideration the viewpoint of each member (Lam et al., 2015). The goal of participative leaders is to work in close relation with their followers while focusing on building a rapport with each team member (Northouse, 2015). The participative leader takes into consideration the behavior styles of those in whom he/she is accountable; each style can be contributed to the decision-making process (Lam et al., 2015). The objective of a participative leader is to include all followers in the course of making decisions while focuses on the placement of additional options, support, and conclusion on problem-solving and decision-making (Lam et al., 2015). The inclusion of employees in decision-making has proven to be valuable to the motivation of employees as their level of importance increases with the chance to be involved in making decisions within the organization (Lam et al., 2015).

However, the participative style of leadership has also proven to hurt the motivation of employees, as many individuals lack the desire to delegate. As a result, this type of leader has the desire to include a particular group of followers in the decision-making process instead of the entire organization (Lam et al., 2015). The inclusion in the area of decision-making requires the sharing of knowledge, and the risk of being blamed for the negative outcome (Lam et al., 2015). This form of leadership takes into consideration the thoughts and recommendations retrieved from employees and shows a relationship between them and the direction in which the organization is proceeding. The participative leader is responsible for gathering ideas and suggestions from subordinates during the decision-making process while the focus of

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achievement-oriented leaders lies in structuring challenging goals and motivating employees to achieve those (Lam et al., 2015).

### Achievement Oriented Leadership.

Achievement oriented leaders push their followers to perform at their highest-level potential (Northouse, 2015). This style of leadership portrays a level of confidence that depicts the belief that followers can achieve and accomplish challenging goals. The followers of this leader present with high expectations to succeed regardless of the complexity of the challenges (Northouse, 2015). The achiever-oriented leader expects the employee to be at his/her highest level of performance (Northouse, 2015).

Institutional leaders must develop human resource policies that reflect their principles and improve the relationship between administration and staff. Leadership Development (2015) recognizes the need for improvements to programs that address the current procedures or requirements. Such practices should focus on abilities, skills, training, development, and performance management. However, most critical factors in overcoming the challenges within long-term care facilities are to recognize the gaps between employee education and recognition of abuse to achieve the objective of decreasing incidents of elder abuse through strategic training, identification, and reporting protocols (Cadmus & Owoaje, 2012).

## Leadership and Decision Making

Organizational leadership and performance hold a significant role in the culture of an organization; therefore, employing the right leadership is essential to the outcome of the team as well as for the resident that calls the group home (Popescu, 2016). As recognized throughout this study, a significant component of identifying the signs of elder abuse lies upon the members responsible for providing care for the elderly. Following the examination of the importance of a

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caretaker, , it was also essential to review the foundation of the employee. As a result, employment of adequate and appropriate staffing is essential during the onboarding process. Leader behavior has a significant impact on employee self-identity and behaviors (Popescu, 2016). Institutional based organizations have a significant part of the healthcare field, upholding and supporting, the aging generations of today (Cloutier, Cox, Hampden, Kobayashi, Cook, Taylor, & Gaspard, 2016). As people are living longer, and the cycle of care is growing with complexity, it is essential that organizations have the right leadership to implement changes, whether new policies and procedures or a complete organizational overhaul.

Decision-making procedures within a long-term care facility lead to ethical and demanding challenges (Peer, 1999; McKenzie, 2017). The organization environment can be a predetermining factor to quality and safety in patient care (McKenzie, 2017). Increase scrutinizing, and accountability has created situations where healthcare providers should be held accountable for their actions (McKenzie, 2017). The vital component of decision- making is the recognition that organizations are systems made up of individuals that are affected by any decision at the leadership level (McKenzie, 2017). Leaders face the role of making decisions that affect all that is involved. For this reason, a structural approach is beneficial in making quality decisions. Familiarity with applications for helpful strategies to provide healthcare personnel with decision-making skills is advantageous to the role of leadership and organizational outcomes (Heidari & Shanbazi, 2014).

**Continuation of Care and Protection**

The elders of today are more active and visible and project independence; however, there continues to be the need for many others to receive the continuum of care from family members or employees within a long-term care facility. As the population of elders continues to grow, the

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cases of abuse continue to rise. Resulting from the need for continuing care and protection, as previously mentioned, many aspects are conclusive to the treatment of the elders (Elder Mistreatment and the Elder Justice Act, 2009). While Alon and Berg-Warman (2014) recognize that no one should experience violence and abuse; members of the family or the staff entrusted in providing care for the older generations should acknowledge that protection and prevention of elder abuse require the involvement of many people; from the members of a resident's family, legal and financial professionals, and health care professionals, at all levels.

**Training Gaps**

The lack of public awareness and training leaves millions of people, oblivious to procedures for preventing and eliminating elder abuse. Without adequate training, service providers in various fields lack the knowledge to identify and discourse elder abuse. Provisional training based on the area and programs is vital to the linking of care providers at all levels of residential care. Many domains must be addressed, by raising awareness through the enactment of government laws to the raising of cultural awareness among the weak and diminished areas of society to ensure that the elder generation received adequate care. According to researchers addressing culture change with a focus on patient-centered care, and individual needs and requirements is essential. While the national training curriculum should focus on the revamping of current protocols and training curriculum. This current study addressed training and experience with an intent to provide a link between education (lack of or abundance of) and abuse.

Collaboration between the organization's ability to become engaged in the diversity and understanding of the community's culture through the interdisciplinary learning and collaboration with the end of life care in patients with cognitive disabilities and terminal illnesses

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will result in more quality efficient and safety measured care. Healthcare establishments must implement clinical and nonclinical proficient training to ensure that patients of all cultural backgrounds receive quality patient care. As a health entity, a focus on the philosophical and cultural needs of the patient can aid in creating a positive outcome of well-being (Ratnapradipa, Middleton, Wodika, Brownm & Preihs, 2015). The education of healthcare professionals and care providers regarding elder abuse is critical to the safeguarding of the increasing population of older persons (Du Mont, Macdonald, Kosa, Elliot, Spencer, & Yaffe, 2015). Experts acknowledge a lack of familiarity and skills in defining, diagnosing, and reporting elder abuse (Anetzberger, 2012; Band-Winterstein, Glodblott, & Alon, 2014; Dong, 2015; Touza-Garma, 2017).

**Absence of Reporting**

Some estimates indicate that physicians only report 2% of suspected cases of elder abuse even though they are amongst a group of mandated reporters (Hoover & Polson, 2014). Multiple factors lead to the failure to report, such as the lack of comprehending the extent of and revelation of elder abuse. Other factors associated with the absence of reporting are the lack of time (from the physician's perspective), lack of trust in the systems designed for reporting, and the fear of violating a patient's rights (Schmeidel, Daly, Rosenbaum, Schmuch, & Jogerst, 2012; DeLiema et al., 2015). Contrary to this revelation, social workers and mental health professionals are said to report abuse at 25% for the social worker and 26% for the nurses (Schmeidel et al., 2012; DeLiema et al., 2015). Estimates reveal the reporting of only 1 in 5 occurrences of abuse (Abuse of older, 2017).

The insufficiency in reporting lies partially on the shoulders of the physicians as in the study completed by Rosenblatt et al., (1996) and DeLiema et al. (2015), doctors only report 2%

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of all suspected incidents of abuse and neglect. DeLiema et al., (2015) recognize that failing to report is acclimated to the perceptions of future resident-physician trust, resident self-sufficiency, and privileges, as well as resident-healthcare provider confidentiality. Other reasons for not reporting are the fear of becoming involved in a criminal case, while others do not want to get involved (DeLiema et al., 2015). Additional factors such as the characteristics of the facility (number of staff members, resident to caregiver ratio, and turnover rate) and staff (age, gender, education) can be leading characteristics of elder abuse and non-reporting (DeLiema et al., 2015).

The potential for exposure to elderly abuse increases among those individuals who are more vulnerable due to mental deficiency, physical or mental disabilities, and social isolation (Dong, 2015). Residents have the potential of being identified as 'in the way,' incompetent and unable to correspond with the younger generation, and even a 'bother' to the healthcare providers. For these reasons, the aging individual is secluded to the confines of the room and left to 'fend' for themselves. As a result of this perception and behavior, evaluations associated with elderly abuse, and the aspects of identifying and reporting acts of ill-treatment and neglect is of a complex nature (Dong, 2015). The advantages of identifying and reporting are substantially higher than those associated with not reporting. Due to the nature of the issue, assessing for abuse and neglect should be of primary importance in the area of healthcare (Dong, 2015).

**Employee Obligations**

Public medical providers such as nurses employed within long-term health facilities are responsible for the observing, anticipating, addressing, and improvement of standard guidelines regarding the vulnerable groups such as the elderly (Phillips & Ziminski, 2012). Phillips and Ziminski acknowledge that even though many nurses are sanctioned to be assessors within state-

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maintained facilities, researchers also indicate that few regulations regarding the role of addressing the problem of elder abuse and neglect have been established (2012). Poor assessment skills and education are recognizable factors in the absence of acknowledgment contributing to elder abuse and neglect. Questions referencing employee education and experience were addressed to provide a possible link between employees based on age, education, and experience.

Many health care professionals fail to recognize whether specific occurrences represent an abusive or negligent situation (Phillip & Ziminski, 2012). Clinicians are ethically in authority to portray attentiveness and thoughtfulness regarding conditions of abuse and neglect. For that reason, evaluations begin with the recognition of risk factors and clinical appearances of elder abuse and negligence (Halphen & Burnett, 2014). Clinicians should keep in mind that all signs of injury (bruising, lacerations, etc.), fear, and poor hygiene are not always indicators of abuse or neglect (Halphen & Burnett, 2014). Therefore, clinicians must remain in a mindset to make a distinction between illness and healthy aging from elder mistreatment and negligence (Halphen & Burnett, 2016).

This quantitative study increased awareness among employees regarding abuse, neglect, and risks associated with violence, to examine elder mistreatment from the perceptions of healthcare providers with the intent to identify gaps in elder abuse training. Other goals of this study were to furnish healthcare staff with appropriate conflict intervention strategies and to improve the skills of the team with the commitment to diminish elder abuse while cultivating the quality of life for residents. Abuse of the elderly is a recognizable problem among the aging generation. Insufficiencies among the results lead to a lack of elder abuse screening among the old.  Abusive situations among the elderly are the leading causes of hospitalization, nursing

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home admittance, and mortality. Previous reports identify that 5 to 10 percent of older adults have experienced some form of abuse (Elder Abuse Statistics & Facts, 2018).

**Situational Leadership Theory**

The introduction of Situational Leadership Theory initially received recognition as the Life Cycle Theory of Leadership, and in the 1970s became known as Situational Leadership Model (Luizzi, 2017). Paul Hersey and Ken Blanchard coined situational Leadership Theory as a leadership approach where the behavior of a leader is adjusted to fit the best management style for their followers (Luizzi, 2017). Situational leadership consists of four underlying components related to the individual employee 1) unwillingness or incompetence to do a task; 2) willingness to take on a responsibility but lacking in ability (ex. skills, training, competence) to do so; 3) Lacking in confidence to do a task but competent enough to take on the job; 4) participation in a group or organization is will to take on the work (Luizzi, 2017). Situational leadership is beneficial in allocating employees to possible tasks by abilities and skills while outlining the appropriate leadership style for each situation (Luizzi, 2017).

As noted by Abofathi-Momtaz, Hamid, & Ibrahim (2013); Lynch (2015), Situational Theory is among the original theories used in the examination of elderly abuse and beneficial in the gathering of details and data to the occurrences. The concept of Situational Theory provides an insight into the correlation between burdens placed upon caregivers and the escalating environment that ultimately leads to the occurrence of an abusive condition. Through the collection of data and thematic coding, this study was proficient in providing healthcare providers avenues in the definition, recognition, and reporting of elder abuse. Optimistically, the collection of data regarding elder care  lead to an expansion of acknowledging and revamping business practices toward providing a safer and more accountable practice model.

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The study of elder abuse and neglect is relatively new in the realm of family violence and lacks experientially grounded knowledge in the development of a theoretical framework (Burnight & Mosqueda, 2015). Additional theoretical approaches such as the Social Ecology Theory (Wang et al., 2014); and Stakeholder Theory (Harrison, Frieman, & Sa'de Abreu, 2015) have been utilized in the context of elder abuse and serve as a foundation for exploration and generating a hypothesis in predicting individual behavior and the linking of caregiver characteristics to that of the care recipient. The application of theory is relevant to many levels of research and disciplines such as in the study of elder abuse. Many theories can be of benefit during the investigation of such debilitating incidents associated with the care of the aging generation. The abusive events affecting the elderly cannot be resolved or diminished with the restricting of research of a nursing home or family residence. For this reason, a theory is advantageous in the bringing together of interdisciplinary teams, approaches, and dialogues.

**Communication**

Subsequently, Situational Theory establishes an association between requirements laid upon an individual (burdens or expectations) and the behavior or actions of the person as a result of the conditions (Albolfathi-Montaz et al., 2013). Thus, supporting a relationship between the caring for the aging generation places additional burdens on the caregiver and ultimately may lead to antipathy, downheartedness, animosity, and eventually indignation and abuse toward the care recipient. As in theory and practice, changes in one level leads to changes in other levels. Situational Theory is beneficial in the communication process during the prediction of two behaviors, such as those behaviors projected by the caregiver and the recipient of care. The Situational Theory identifies two communication theories. Two known elements of theory associated with Situational Theory are 1) information seeking; and 2) information process (Lee,

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Oshita, Oh & Hove, 2014). Information seeking occurs as a planned assessment of the environment surrounding a specific topic while information processing is the unplanned revelation of data and the continuation of gathering data through the communication process (Lee et al.., 2014). The communication concept of Situational Theory can include the sharing and transmitting of information regarding a social problem such as elder abuse. The sharing of information can be of benefit in the identification of risk factors that lead to the abuse of the aging generation (Lee et al., 2014).

**Summary**

The population of the world continues to increase at an alarming rate with the need for extended elder care reaching a significant level (Robert, 2016). As indicated by recent studies, the population will increase by 314% by 2050 (Ghodousi, Maghsoodloo, & Mohsen Sadat Hosseini, 2011). Occurrences of and definitions associated with elder abuse may vary among geographical regions; ultimately, abuse within long-term care facilities continue to be of huge concern (Moore, 2016; Roberto, 2016; Sholian, 2015). How these organizations approach the issue of abuse is a crucial factor in understanding and preventing abuse. The flexibility warranted by the path-goal and situational leadership approach is critical to examine a link between the organization's leadership' involvement and caregiver abilities and motivators and is valuable during the process of gathering information. Ultimately, the completion of this study was beneficial in gaining an insight into the lived experiences of care providers and the process in which they perceive and respond to leadership involvement and incidents of elder mistreatment. The completion of this study provided opportunities for accessing organizational structure and decision-making processes with a focus on leadership style and reformation within the long-term care industry.

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## Chapter 3: Research Method

Elder mistreatment is one of the most crucial elements facing the aging generation of today. Even though regulations and mandates are established to curtail the abuse of the elderly, elderly abuse continues to rise at an astronomical rate (Albolfathi-Montaz et al., 2013). The purpose of this study was to examine leadership styles, decisions, and the influence each has on the propensity for abuse in healthcare facilities.

The lack of sufficient and efficient leadership within an organization may lead to a loss of production and a decrease in employee morale (Doe, Ndinguri, & Phipps, 2015; Giltinane, 2013). Thus, creating an environment that lacks corporate direction and phenomenal achievement, ultimately leading to the demise of the organization and the failure of the leader (Doe et al., 2015). Weak leadership or effects of leadership styles, such as the autocratic leadership style, may lead to situations of abuse towards others, fearful situations among the staff, and decision making without consultation among team members (Giltinane, 2013). Underperformance associated with leadership ineffectiveness may impact the lives of many individuals within the confines of the long-term care facility (Doe et al., 2015). More precisely, training solutions addressed such topics as leadership pitfalls, employee management, leadership strategies, employee workloads, elder mistreatment, and employee conduct as appropriate in the light of the finding of this research.

Bern-Klug and Sabri, 2012; Castle, Ferguson, and Teresi, 2015, and Chen, 2012 note a culture of minimal treatment, failure to provide necessities such as food, water, and medication. While Frazão, Correia, Norton, and Magalhães (2015) discloses the prevalence of abuse as 1 in 10 Americans sixty years of age and older were the recipient of at least one episode of abuse. Frazao et al. (2015) noted a deficiency in reporting incidents of elder mistreatment occurred with

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the reporting of only 1 in every 14 incidents of abuse to the appropriate authorities, with an approximation of 5 million geriatric residents experiencing an abusive situation yearly. The research outlined in this chapter addressed the leadership factors related to elder care and abuse progressing towards developing a new leadership program. The following section provided an overview of the research approach and sample of the study, the precautions taken to safeguard the human participants, data collection procedures, data analysis techniques, and the limitations and delimitations associated with the study.

**Research Methodology and Design**

This Quantitative research study was conducted using the Path-Goal Leadership Questionnaire (Appendix A) and the CASE Survey (Appendix B). As discussed by Northouse (2013), in his text Leadership: Theory and Practice, the arrangement of questions provided opportunities to define the leadership style within a selected location. The scores obtained through the questionnaire was beneficial in comparing styles of leadership in an organization (Indvik, 1985, 1988). The comparison of leadership styles wase advantageous to align leaders and task-oriented behaviors such as structure, coordination, clarification of employee responsibilities and monitoring performance to increase the quality of care (Havig, Skogstad, Kjekshus, & Romeren, 2011).

The Caregiver Abuse Screen (CASE) is a tool used in the detection of elder abuse (Abolfathi Momtaz, 2013; Reis, 1995). The use of CASE applied to all healthcare providers of seniors, whether abuse or suspected or not. Any yes responses provided indicators of abuse and neglect that would otherwise go unnoticed. Questions included topics that focused on task completion and job responsibilities. In addition to identifying current acts of abuse, CASE screen may act as a deterrent to potential developing incidents of abuse (Abolfathi Momtaz, 2013).

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Within this research One-Way, ANOVA test was used to establish a link between the staff and occurrences of abuse. One-Way ANOVA (using SPSS Software) was used for this research as the study examined the effect that different forms of leadership styles have on nursing and the propensity for elder abuse. The G Power Analysis is the instrument used to establish the sample size of 54 participants with an effect of .5 with an error of probability of .95 with two groups.

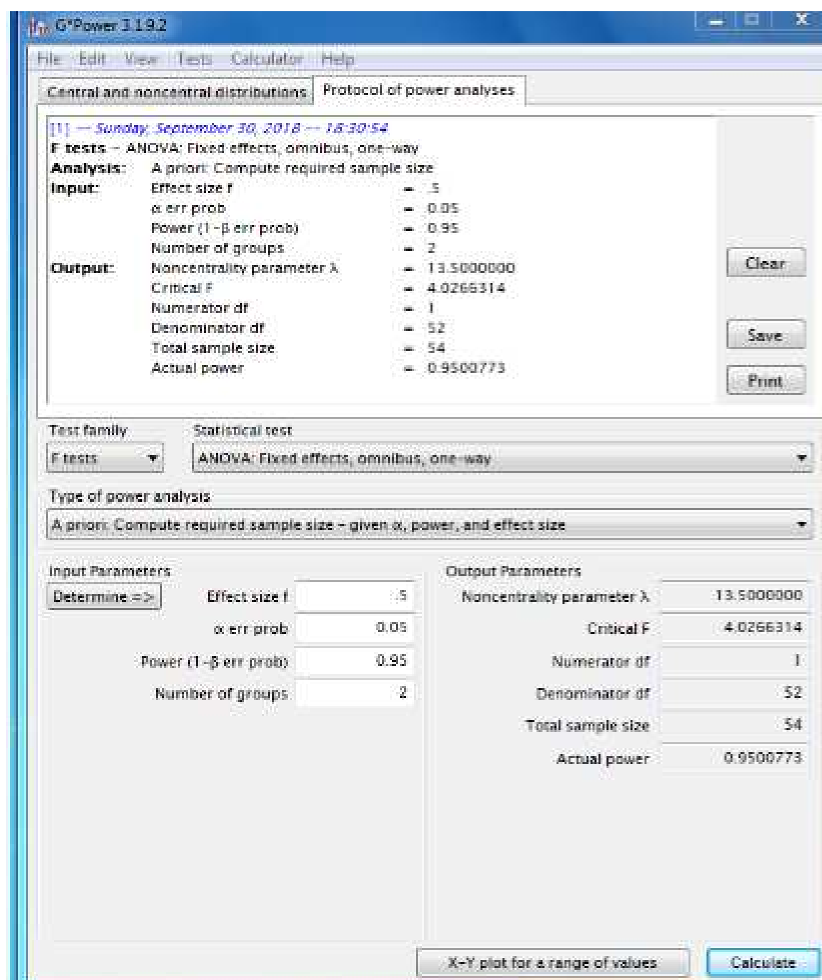


*Figure 3.1* G Power Analysis

**Population and Sample**

The sample size included approximately 54 participants, nursing staff, and was chosen through the connecting survey process provided by Qualtrics Research Core based upon a

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geographical location (specifically the southern states). The sample size included a random pool of participants selected by Qualtrics. The pool was narrowed based upon credentials and certifications.

**Materials or Instrumentation**

For this research, the researcher received written permission to use the Path-Goal Leadership Questionnaire (Appendix A) from the original author, Lim (2016). The original author, Mahmiash granted written permission for the use of the Caregiver Abuse Screen. The Caregiver Abuse Screen (CASE) is among the many methods available for measuring elder abuse and factors associated with the occurrence of abuse (Orfilla et al., 2018; Reichenheim et al., 2009; Reynolds & Bigler, 1999). Answering yes to any questions on the CASE received a score of 1 point. The points then added together to create a score ranging between 0-8. A score of four or more on the CASE may suggest a higher risk for abuse (Reis & Nahmiash 1995; Rivera-Navarro Sepúlveda, Contador, Fernández-Calvo, Ramos, Tola-Arribas, & Goñi, 2018). "However, even a score of one can be indicative of abuse" (Reis & Nahmiash 1995. The CASE method is beneficial in evaluating a relationship between possible physical or emotional abuse and neglect perpetrated by the care provider (Orfila et al., 2018). The use of CASE is well-accepted by participants due to the briefness of the survey and the ability to respond in a natural mannerism; thus, eliminating any defensive notions (Orlifa et al., 2018).

**Operational Definitions of Variables**

**Independent Variables**

Leadership Style. Operationally defined as an individual's ability to persuade, motivate, and lead others to the attainment of specified goals (Comstock, 2014). This was measured using the Path-Goal survey (Appendix A), which identified four different leadership styles. Leadership

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style includes one of four different styles: Directive. Supportive, Participative, and Achievement Oriented.

**Dependent Variable.**

CASE questionnaire scores (Appendix B) measuring the propensity for abuse. The results are a score ranging between 0-8, with a higher score indicating a greater propensity for abuse.

## Study Procedures

This process occurred through several phases, with the Informed Consent forms embedded in Qualtrics with perimeters established that did not allow a participant to move forward without acknowledging that the reading and signing of the form. Data collection transpired through Qualtrics via an online survey process provided by Qualtrics Research Core. The survey material distribution occurred through the Qualtrics Survey Mailer mailer/panels. Next, ANOVA was used to establish a relationship between leadership, nurses' behavior, and elder abuse. The examination was conducted using an Analysis of Variance (one-way ANOVA) to "determine if there was a significant difference" (Blanca et al., 2017) on the (DV) CASE Questionnaire Scores (Propensity for abuse) by (IV) Leadership Styles (participative, directive, achievement-oriented, and supportive).

"One-way ANOVA is an applicable statistical analysis when the objective of the research is to assess if mean differences exist on one continuous dependent variable (Propensity of abuse-Case Questionnaire Scores) by an independent variable (leadership styles-directive, participative, achievement-oriented, and supportive) with two or more discrete groups" (Blanca et al., 2017; Statistics Solutions, 2013). The dependent variable in this analysis is the propensity for abuse-CASE Questionnaire Scores), and the leadership styles variable (participative, directive,

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supportive, achievement-oriented leadership styles) are the independent variable. ANOVA is used to minimize Type 1 errors (false positive) as the overall testing group means against each other is completed simultaneously, where the alpha remains at .05. This collection process provided an explanatory view denoting the forms of abuse and employee behavior that commonly takes place within the facility. The transformative perspective gave a 'picture' of abuse through the sequential use of quantitative surveys.

**Data Collection and Analysis**

The data was collected through a web-based survey approach via Qualtrics with an online survey process provided to an unknown number of the eligible participant by Qualtrics Research Core. Each item was distributed using the Qualtrics Survey to a minimum of 54 nurses, including Registered Nursing (RN), Legal Practical Nurses (LPN), and Certified Nursing Assistants (CNA). Qualtrics embedded consent forms with perimeters establishing that a participant could not move forward without acknowledging that the reading of the form and signed.

Data were downloaded and analyzed using descriptive and basic inferential statistics, generating a report. Data was reversed and renamed according to the directions provided within the Path-Goal Questionnaire where totals were summed to generate scores associated with the high, medium, or low risk for abuse. Yes answered were given 1 point as directed in the Caregiver Assessment Survey and summed to establish a score between 0-8 indicating the risk for abuse with a score of four or more indicating a higher risk for abuse.

Gathering data occurred through the generation of descriptive statistics, such as the mean, standard deviation, and the confidence interval. In order to answer the hypotheses and research questions the statistical analysis ANOVA was computed in order, to compare the means of the groups. The statistical test ANOVA was chosen since the ANOVA test tends to have less Type 1

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error, so it is considered more conservative, and it is used to compare three or more variables to test for statistical significance (Statistics Solutions, 2013). The ANOVA analysis tested for statistical significance across the group of means for the data, such as if there is any statistical relationship between leadership style and the propensity for abuse. The ANOVA was unable to be used due to the requirement of a normal distribution of the variables, therefore, the Kruskal Wallis H test, which is also known as the one-way ANOVA on the ranks was used to analyze the data. The SPSS software was used to compute the statistical analysis.

**Assumptions**

The study was developed under the premise of this objective to be true: long-term care leadership culture can impact elder abuse when leadership informs decisions explicitly made to affect residents (De Chesnay et al., 2014). The study assumed that elder abuse occurred from a multifaceted interaction between leadership, employee, and the needs of the elders. Errors in data analysis may occur, as a result of the mannerisms of data presentation and environmental/contextual issues may have the potential to impact older residents negatively, identifying a problem, and a needed solution is advisable. Subsequently, the assumption that served as the foundation of this study was not the only assumption made.

Assumptions about the research population included that the participants would make a reasonable attempt to discuss their aspects leadership within the facility because most participants have a genuine interest in participating in the study and do not have ulterior motives such as impressing other staff members of gaining special treatment for family members. Ultimately, a plan was put in place to ensure honesty. Participation was on a volunteer basis and of a volunteer nature established in the Informed Consent Form informing participants that participation was on a volunteer basis and a volunteer nature in which they could withdraw from

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at any time. Participants were guaranteed to be free from adverse repercussions if they chose to opt out of the study.

**Limitations**

The research dealt exclusively with healthcare professionals and their scope of leadership capabilities within the long-term care facility. To maintain validity, study results did not apply to inferences concerning non-elder care providers such as emergency services or non-geriatric related facilities. Other limitations of the study may exist due to unknown elements associated with the active site that could lead to biases in responses from the participants (De Chesnay et al., 2014). As a result of the participant involvement with the elderly residents, some recollections and emotions may be questionable. Participants might uphold clear bias regarding the concept and significance of elderly individuals. The number of participants, locations, time, and funding resulted in study limitations. Limitations were also associated with the fear of uncovering elder abuse within an organization and the fear of retaliation with additional limitations recognized during the process of establishing avenues to present surveys to participants. Gaining site permissions was the initial limitation as administrators declined to become involved in the study due to a potential of involving residents and other staff members. The process of reviewing potential survey programs for presenting surveys to potential participants resulted in financial obstacles. Lastly, gaining access to participants and the distribution of the survey resulted in many limitations during the process of gathering data. Establishing an account with Qualtrics Research Core relieved all facilities of their duty to participate and included an additional layer of data security through the process of using an online survey and questionnaire distribution.

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To deal exclusively with healthcare professionals and their scope of leadership capabilities within the long-term care facility created limitations of the study may exist due to unknown elements associated with the active site that could lead to biases in responses from the participants (De Chesnay et al., 2014). As a result of the participant involvement with the elderly residents, some recollections and emotions may be questionable. Participants might uphold clear bias regarding the concept and significance of elderly individuals. The number of participants, locations, time, and funding resulted in study limitations.. Limitations are also associated with the fear of uncovering elder abuse within an organization and the fear of retaliation.

Additional limitations followed the process of establishing avenues to present surveys to participants. Gaining site permissions were the initial limitation as administrators declined to become involved in the study due to a potential of involving residents and other staff members. Financial obstacles arose during the process of reviewing potential survey programs for presenting surveys to potential participants. Lastly, gaining access to participants and the distribution of the survey resulted in many limitations during the process of gathering data. Establishing an account with Qualtrics Research Core relieved all facilities of their duty to participate and included an additional layer of data security through the process of using an online survey and questionnaire distribution. The smaller number of participants placed limitations on the data; resulting in skewed data. Limitations were also associated with $p<.05$, where using a more relaxed standard of $p<.1$, the results would be significant.

This study was conducted to identify if a statistically significant relationship exists between leadership style and propensity for abuse and specifically the association between Directive, Supportive, Participative, and Achievement Oriented and abuse in long-term care

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facilities. The results of this study fill a void in long term care facilities by providing evidence that can be used to identify:

- Whether a specific leadership is associated with abuse with the findings being that Leadership is not;
- Four specific styles and the data analysis data system/report-embedded supports that increase healthcare professionals' data analysis accuracy;

**Delimitations**

Research on other areas of abuse such as child abuse and domestic violence could have been chosen; however, my interest focuses only on the geriatric generation because of the significant number of abuse cases and with the increasing number of elders being admitted into long-term care facilities elder abuse continues to rise. Researching different leadership styles between various long-term care facilities without the variation in healthcare personnel created a delimitation of the study due to the inclusion of only participants holding a nursing license (RN, LPN, CNA). Delimitations resulted from the restrictions due to the particular demographics and the exclusion of participants from other demographics such as doctors, specialists, or additional healthcare workers (inclusion and exclusion criteria). A further delimitation existed in the selection of only open-ended Likert scale responses with specifically short timeframes in the survey, to avoid recall bias.

The topic of study being extensive, there was a probability that producing information would be complicated. In the face of all complications, every effort was made to attain pertinent data. Although the research scope focused on leadership, delimitations could be associated with the age, length of employment of the participant and their closeness to the residents. However, this process was beneficial in gaining informative answers and allow the researcher to identify

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why healthcare providers within long-term care facilities fail to provide quality care to the residents.

**Ethical Assurances**

The undertaking of scholarly research entails multiple steps to contemplate to ensure validity and moral value. As individuals, we are known to entertain independent opinions and notions. For this reason, each endeavor in a scientific study should include specific costs and formats for ensuring that research will be carried out with carefulness and truthfulness. Ethics and integrity must be applied at all stages of scientific research, from the introduction of the study through to the revelation of findings. The process of retaining integrity can consist of challenges at various levels; for this reason, each level as noted by the University including accessing, reviewing, and formatting occurred.

The ethical aspect of research is a shared responsibility, among all that are involved (Caruth, 2015). The first assessment of ethics originated during the ancient Greek Era with academia continuing the concept of comprehending and obtaining current information and applying it to the scientific research of today (Caruth, 2015). Scientific research is a group effort with many individuals having a responsibility; however, the application of ethics begins with the researcher. Duties started with the familiarization of the ethical obligations required for completing research on human participants and becoming more familiar with available resources such as the Belmont Report, APA Manual, and Code of Ethics. The application of ethics and integrity was advantageous to the establishment of right and wrong (actions, procedures, and safeguarding, etc.) while promoting the best outcome for the participants and researcher involved.

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Developing a study about the observation of human participants has been met with multiple challenges from failure to respect the participant, to the breach of confidentiality, and other difficulties such as failing to obtain consent and retaliation against the participant (Halphen & Burnett, 2014). Two areas of the study are responsible for the most significant challenges, the population study that includes older individuals with a multitude of physical, mental, and social impairments and the second issue begins with obtaining the data. The method of research involves human subjects (nurses -directly and geriatric residents indirectly). However, the current study is strictly about the business of leadership in elder care with a focus on the propensity for abuse, in long-term care facilities. Researcher and staff interactions took place without the inclusion of the residents. However, additional risks to the caregivers could arise during the research as a result of the sensitivity of the subject matter. The study involved health and community care services, data, facilities, and persons. Thus, posing risks of unintentional confidentiality breaching in many areas such as:

Employees are disclosing information that can be relevant to the residents; therefore, an analysis was restricted to private places to avoid disclosing data relevant to patient information, and while remaining mindful of surroundings as to prevent a HIPPA (Health Insurance Portability and Accountability Act) violation. HIPPA establishes a privacy rule protecting the medical and personal health information of residents (avoiding a breach of confidentiality) (Shay & Goldfield, 2013). Before the research, the addressing of ethical considerations took place with the presentation of confidentiality paperwork advising of all measures to obtain ethical considerations regarding HIPPA requirements.

Authorization Requirements- HIPPA requirements were also met through the presentation of written consent for the use or disclosure of any patient information. If the

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participant was unsure if disclosure of information will be of a violation, it was best to retain prior authorization before releasing any data. Most breaches are preventable through the implementation of procedures and protocols, ensuring that all individuals involved in the research are aware of HIPPA and all potential risks involved in the investigation. A Certificate of Liability was obtained to help decrease the chances to participants by increasing the level of protection for maintaining confidentiality (Wolf et al., 2015). The Certificate of Liability does not cover all risks associated with privacy.

For this reason, as a researcher, other mechanisms and procedures for protecting privacy in this proposed research were examined. Other problems may exist in the collection of data as accessing information regarding financial status, and personal information can be a risky endeavor. Exposing such information as, economic situation and negative staff behavior, can increase abuse (financial) and the potential for physical injury. Before the beginning of this objective measures were taken to ensure the protection of the participants and staff members. In this paper, I addressed the process of securing that ethics and integrity continued throughout the entirety of the dissertation process.

**Summary**

Elder abuse is a pervasive and international concern to public health, yet, a gap remains in the research, recognition, reporting, and revamping of organizational characteristics associated with the well-being of the older person. The description of and reasons behind the occurrences of elder abuse can be allocated to multiple possibilities and by various entities. However, it is imperative to prepare alternatives and measures for employing effective leaders to ensure the quality of continuum care for the elderly, as failing to implement change will lead to the

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prolongation of incapacitating behavior witnessed and felt by the individuals to vulnerable to interconnect without help.

Elder abuse is a severe health issue within the long-term care environment as indicated by national and international documentation (Alzadeh-Khoei et al., 2014; Burns et al., 2016) that shows a dire concern for the older generation. Multiple studies have suggested a significance between elder abuse and employee burnout, stressful working conditions, and lack of skills and knowledge ((Roberto, 2016). On the other hand, explaining the causal connections between abuse and these risk factors does not increase the comprehension of how organizational behavior and leadership style can impact abuse rates within the long-term care entity. For this reason, examining the causal effect through a phenomenological approach was advantageous to the well-being of the geriatric generation.

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## Chapter 4: Findings

This study aimed to examine leadership styles, decisions, and the influence each had on abuse in long-term care facilities. A total of 56 email invitations were mailed anonymously to current LPN's, RN's, and CNA's through the Qualtrics Research Center with a response rate of 100%. Initial results ensued through the Qualtrics reporting process, with 56 responses received. To this aim, the current chapter included sample demographics and findings of the statistical analyses conducted to answer the following research questions.

**RQ1.** Is there a statistically significant relationship between the directive style of leadership and the propensity for elder abuse in long-term care facilities?

**H10.** There is no statistically significant relationship between directive style leadership and the propensity for elder abuse in long-term care facilities.

**H1a.** There is a statistically significant relationship between directive style leadership and the propensity for elder abuse in long-term care facilities.

**RQ2**. Is there a statistically significant relationship between the supportive style of leadership and the propensity for elder abuse in long-term care facilities?

**H20**. There is no statistically significant relationship between supportive style leadership and the propensity for elder abuse in long-term care facilities.

**H2a**. There is a statistically significant relationship between supportive style leadership and the propensity for elder abuse in long-term care facilities.

**RQ3.** Is there a statistically significant relationship between the participative style of leadership and the propensity for elder abuse in long-term care facilities?

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**H30.** There is no statistically significant relationship between participative style leadership and the propensity for elder abuse in long-term care facilities.

**H3a.** There is a statistically significant relationship between participative style leadership and the propensity for elder abuse in long-term care facilities.

**RQ4.** Is there a statistically significant relationship between the achievement-oriented style of leadership and the propensity for elder abuse in long-term care facilities?

**H40.** There is no statistically significant relationship between achievement-oriented style leadership and the propensity for elder abuse in long-term care facilities.

**H4a.** There is a statistically significant relationship between achievement-oriented style leadership and the propensity for elder abuse in long-term care facilities.

## Validity and Reliabilty of the Data

### Validity and Reliabilty

Basis of the sample size was on the power of 0.95 with an error of probability of 0.05 with an effect size of .5 and two individual groups of participants indicated a sample size of 54. The actual number of samples collected for the study was 56 samples. Post hoc analyses did not take place due to no differences within the sample data as each participant was either an RN, LPN, or CNA before the initiation of the survey. Elimination of data or omitted responses did not occur due to a rule established in the survey requiring that a participant must hold a nursing license (RN, LPN, or CNA). Any participant not holding this licensure resulted in disqualification before beginning the survey.

Laerd (2016) acknowledges that several methods are available for assessing normal distribution of data. The methods fall into two categories graphical and statistical. Four common instruments are:

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**Graphical - Q-Q probability plots**. Quantile-quantile plat or graphical tool used for checking data plausibility and normality (Chambers, Cleveland, Kleiner, &Tukey, 1983). Visual check allowing us to view at a glance the plausibility of an assumption and to recognize where the assumption was violated (Chambers et al., 1983).

**Graphical - Histogram.** The figure used for showing the underlying frequency distribution (shape) of a set of data or for inspecting distribution for normality or skewness (Laerd, 2016).

**Statistical - Kolmogorov-Smirnov test.** It is used for non-parametric testing of probability distributions used in comparing two samples or a sample with reference probability (Laerd, 2016).

**Statistical - Shipiro-Wilk test.** It is used for normality testing or deviations from a comparable normal distribution. Also, used in testing for problematic outliers that could predispose results (Laerd, 2016).

Initial testing using an Analysis of Variance (one-way ANOVA) was completed to determine the normal distribution of data. Lack of normal distribution was indicated by the tests of normality (Table 4.1). The null hypothesis was rejected as a result of sig — 000 where Kolmogorov-Smirnov and Shapiro-Wilk indicate p<.000.

| | Kolmogorov-Smirnov[a] | | | Shapiro-Wilk | | |
|---|---|---|---|---|---|---|
| | Statistic | df | Sig. | Statistic | df | Sig. |
| Caregiver accumulative variable added together | .196 | 54 | .000 | .872 | 54 | .000 |

a. Lilliefors Significance Correction

Table 4.1 *Failure to Show Normal Distribution – Test of Normality*

Testing of normality of distribution indicate that this variable CASE (caregiver accumulative) was not normally distributed (Figures 4.1, Figure 4.2). A skewed distribution in

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the dependent variable is indicated as the data does not match a bell curve. Therefore,  selection of a non-parametric test occurred as the results indicated a violation of one of the parametric tests, and ANOVA was eliminated from the study, indicating further testing through non-parametric measures. As a result of the Rejection of the null hypothesis rejection resulted in the selection of the Kruskal Wallace testing.

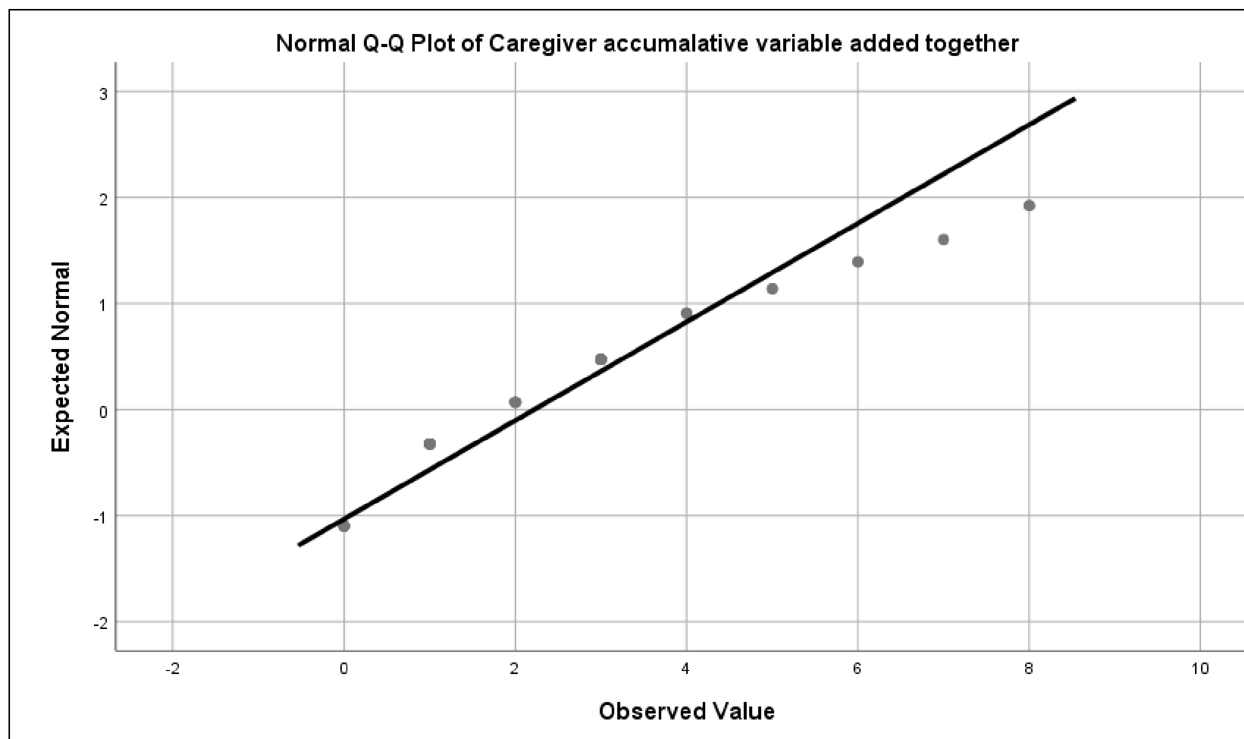


*Figure 4. 1*. Q-Q Plot for normality testing caregiver propensity for abuse.

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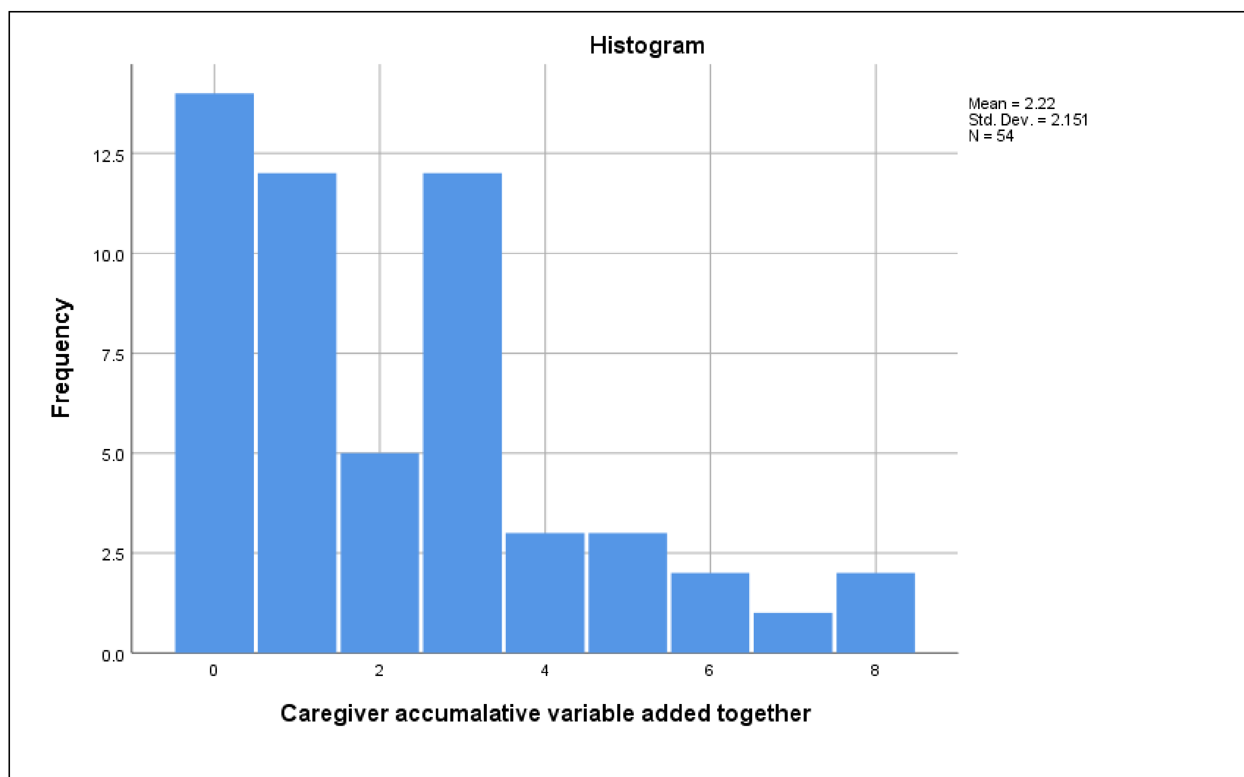


*Figure 4.2*. Right Skewness identified in normality testing caregiver propensity for abuse.

The following four assumptions must be met prior to testing data using the Kruskal Wallis Test: (1) measuring the dependent variable must occur at the ordinal or continuous level through Likert Scales or additional ranking scales (Case Questionnaire Scores); (2) the dependent independent variable must consist of at least two or more categorical independent groups (leadership styles); (3) independent observations must be present, no relationship can exist between the groups; each variable cannot include the same participant. Different participants in each group; and (4) variations (different shapes) in histogram indicate comparing mean ranks instead of the median. I tested this for its assumption result showed that each had different distributions because of that I am comparing mean ranks instead of median.

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**Results**

"A one-way ANOVA is an applicable statistical analysis only when the objective of the research is to assess if mean differences exist on one continuous dependent variable by an independent variable with two or more discrete groups with normal distribution" (Blanca et al., 2017; Statistics Solutions, 2013) with the Case Questionaire as the dependent variable and the independent variables as directive, participative, supportive, and achievement-oriented leadership styles. ANOVA is used to minimize Type 1 errors (false positive) as the overall testing group means against each other is completed simultaneously, where the alpha remains at .05. ANOVA testing was the first instrument chosen for establishing a relationship between leadership, nurses' behavior, and elder abuse.

**Research question 1/hypothesis.**

This section includes a summary of the finding for each of the particular research questions and their related accepted or rejected hypotheses.

The findings concerning RQ1, is there a statistically significant relationship between the directive style of leadership style and the propensity for elder abuse in long-term care facilities? The results indicated there is not a statistically significant relationship with a significance of 0.545 (Figure 4.6) between Directive style leadership and the propensity for elder abuse in long-term care facilities. The results allowed for accepting the null hypothesis Ho and supporting the conclusion that there is not a statistically significant and robust relationship between the Directive Leadership Style and the propensity for abuse. Because the overall test results below (Figure 4.3 Figure 4.4, and Figure 4.5) show the variations in distribution levels of the non-parametric Kruskal Wallis H Test which was conducted to compare the means of the four groups: (Figure 4.3, etc.)

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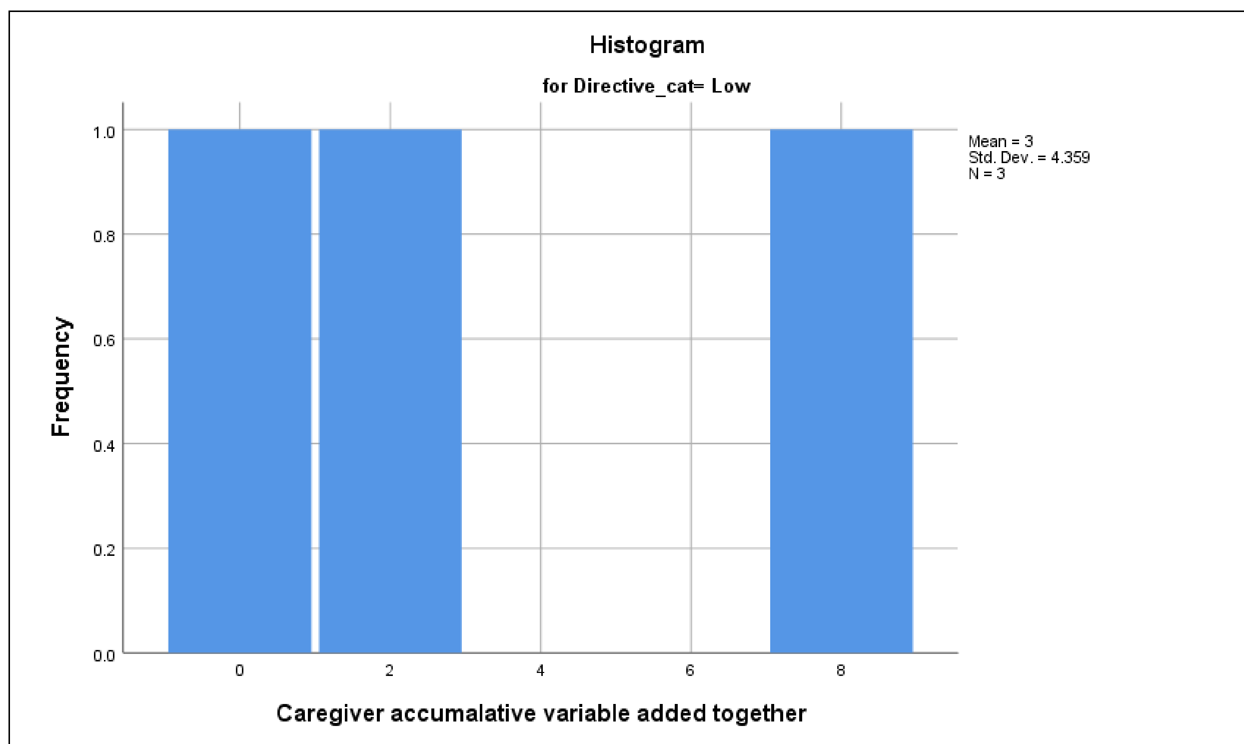


*Figure 4.3* Nurses with low Directive leadership style supervisors

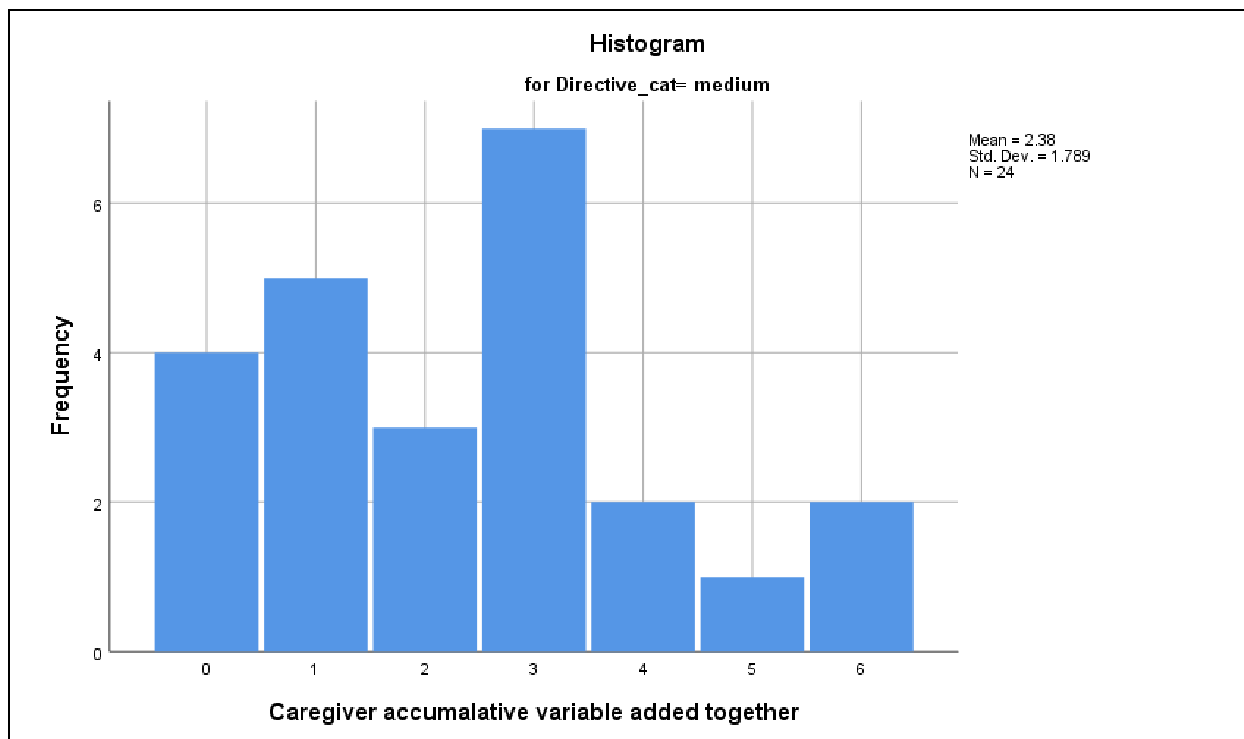


*Figure 4.4* Nurses with medium Directive leadership style supervisors

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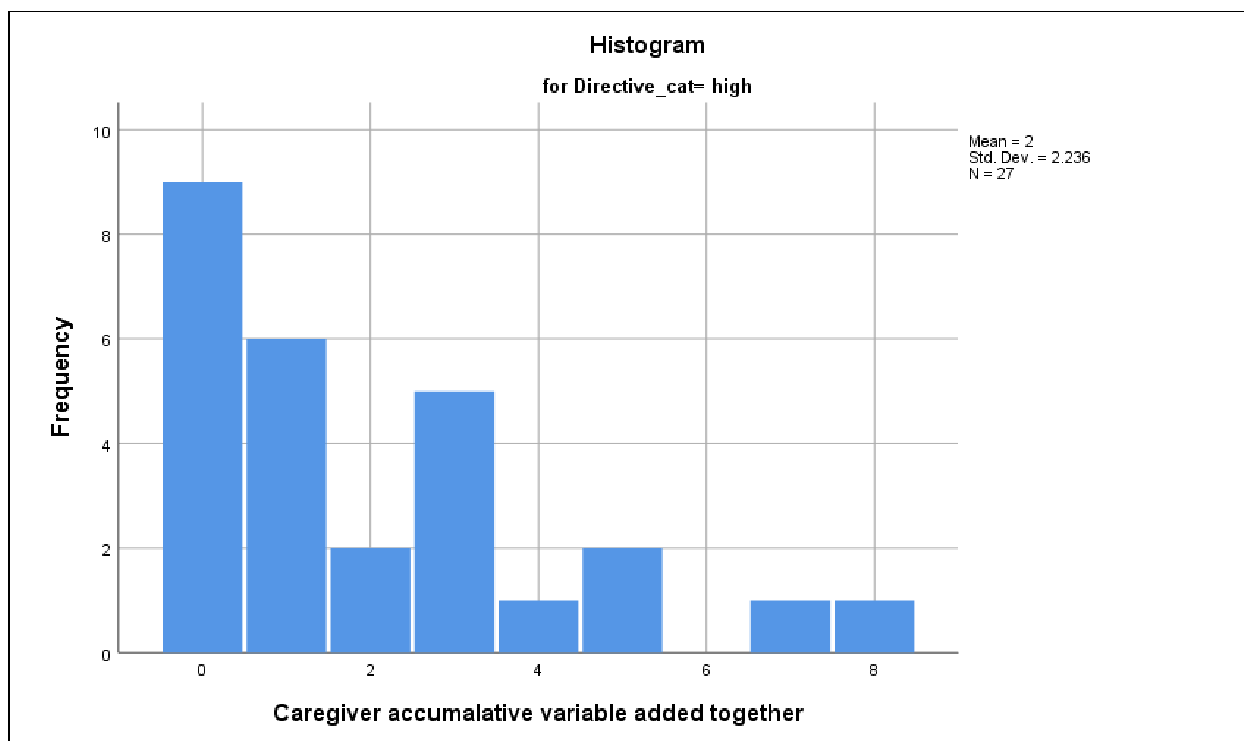


*Figure 4.5* Nurses with High Directive leadership style supervisors

These three distributions in these categories, low (Figure 4.3), medium (Figure 4.4), and high (Figure 4.5) are not the same shape; therefore, as indicated by Kruskal Wallis H Test assumption 4 mean ranks should be tested instead of median ranks. Here is how I interpreted the results for the Kruskal-Wallis Test (Figure 4.6) for Directive Leadership Style.

There is not a statistically significant relationship with a significance of 0.545 (Figure 4.6) between Directive style leadership and the propensity for elder abuse in long-term care facilities. Based on the results from SPSS comparison of three interaction groups transpired: high (nh=27), medium (nm=24), low (nl=3) The Kruskal-Wallis Test was non-significant H (2) =1.215, p=0.545. For nurses who have a low directive supervisor, the mean rank for the propensity for abuse is 27.17 compared to 30.04 for medium directive supervisors and 25.28 high directive supervisors. Tests results indicate a non-significant difference between directive

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leadership style and the propensity for abuse; for this reason, we failed to reject the null hypothesis.

**Test Statistics[a,b]**

| | Caregiver accumulative variable added together |
|---|---|
| Kruskal-Wallis H | 1.215 |
| df | 2 |
| Asymp. Sig. | 0.545 |

a. Kruskal Wallis Test
b. Grouping Variable: Directive leadership organized in categories

**Ranks**

| | Directive leadership organized in categories | N | Mean Rank |
|---|---|---|---|
| Caregiver accumulative variable added together | Low | 3 | 27.17 |
| | medium | 24 | 30.04 |
| | high | 27 | 25.28 |
| | Total | 54 | |

*Figure 4.6* Kruskal-Wallis mean results for nurses with Directive Leadership Style supervisors

**RQ2**.

RQ2. Is there a statistically significant relationship between the supportive style of leadership style and the propensity for elder abuse in long-term care facilities?

The null and alternative hypotheses for this question is as listed below:

- There is no statistically significant relationship between Supportive style leadership and the propensity for elder abuse in long-term care facilities.
- There is a statistically significant relationship between Supportive style leadership and the propensity for elder abuse in long-term care facilities.

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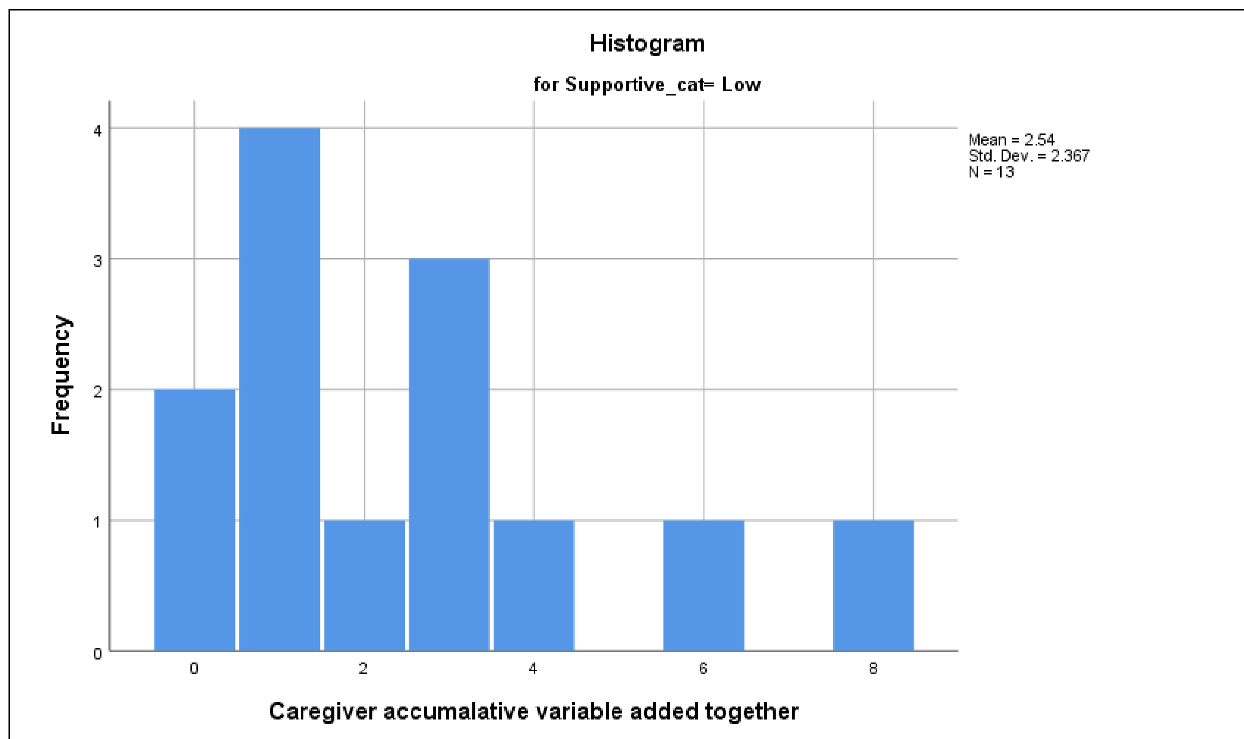


*Figure 4.7* Nurses with low Supportive leadership style supervisors

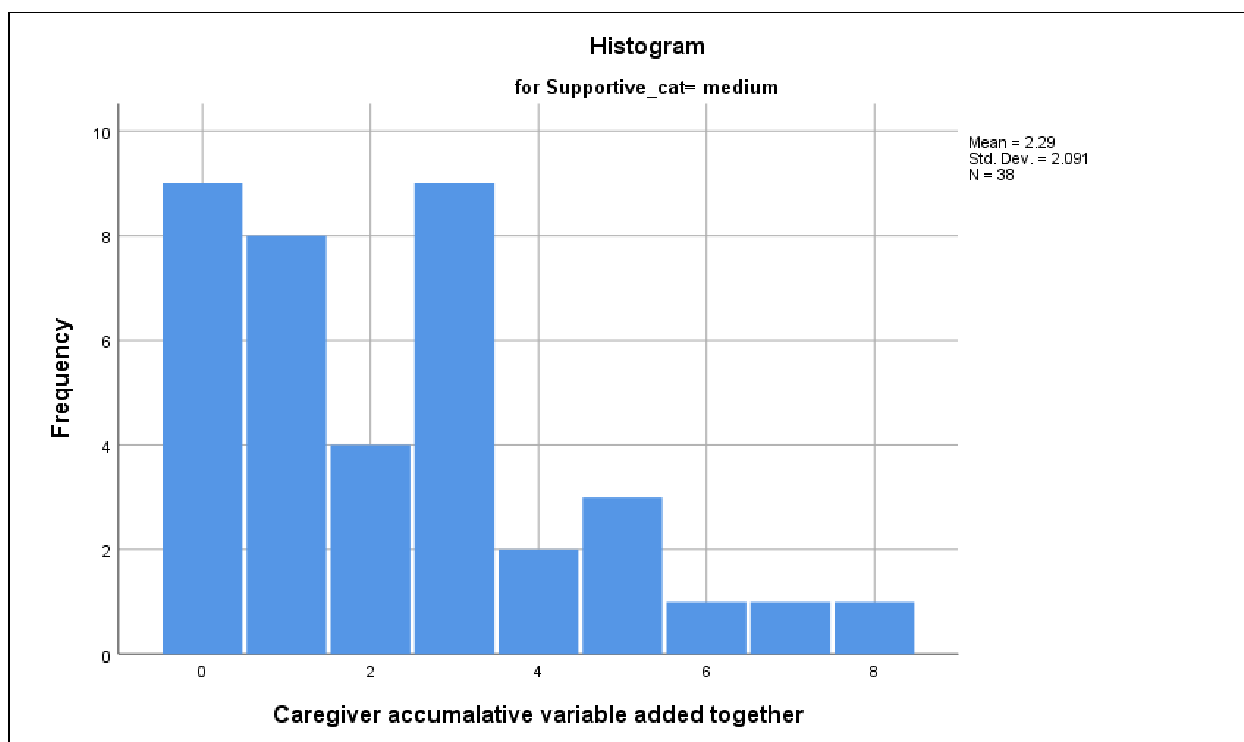


*Figure 4.8* Nurses with medium Supportive leadership style supervisors

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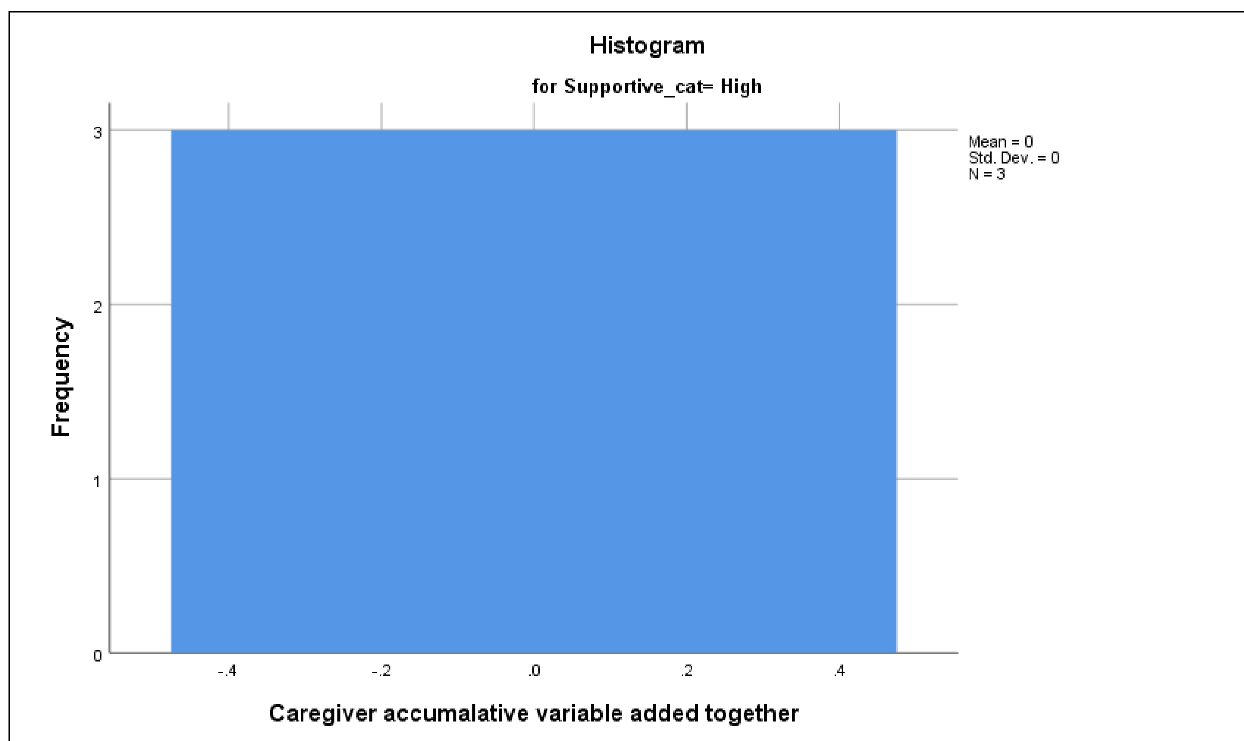


*Figure 4.9* Nurses with High Supportive leadership style supervisors

These three distributions in these categories, low (Figure 4.7), medium (Figure 4.8), and high (Figure 4.9) are not the same shape; therefore, as indicated by Kruskal Wallis H Test assumption 4 mean ranks should be tested instead of median ranks. Here is how I interpreted the results for the Kruskal-Wallis Test (Figure 4.10) for Supportive Leadership Style.

There is not a statistically significant relationship with a significance of 0.066 (Figure 4.10) between Supportive style leadership and the propensity for elder abuse in long-term care facilities. Based on the results from SPSS comparisons of three interaction groups occurred: high (nh=3), medium (nm=38), low (nl=13) The Kruskal-Wallis Test was non-significant H (2) =5.443, p=0.066. For nurses who have a Supportive low supervisor, the mean rank for a propensity for abuse is 29.81 compared to 28.29 for Supportive medium supervisors and 7.50 Supportive high supervisors. Tests results indicate a non-significant difference between directive

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leadership style and the propensity for abuse; for this reason, we failed to reject the null hypothesis.

**Test Statistics**[a,b]

| | Caregiver accumulative variable added together |
|---|---|
| Kruskal-Wallis H | 5.443 |
| df | 2 |
| Asymp. Sig. | 0.066 |

a. Kruskal Wallis Test

b. Grouping Variable: Supportive leadership organized in categories

**Ranks**

| | Supportive leadership organized in categories | N | Mean Rank |
|---|---|---|---|
| Caregiver accumulative variable added together | Low | 13 | 29.81 |
| | medium | 38 | 28.29 |
| | High | 3 | 7.50 |
| | Total | 54 | |

*Figure 4.10* Kruskal-Wallis mean results for nurses with Supportive Leadership Style supervisors

**RQ3.** Is there a statistically significant relationship between the participative style of leadership style and the propensity for elder abuse in long-term care facilities?

The null and alternative hypotheses for this question is as listed below:

- There is no statistically significant relationship between Participative style leadership and the propensity for elder abuse in long-term care facilities.
- There is a statistically significant relationship between Participative style leadership and the propensity for elder abuse in long-term care facilities.

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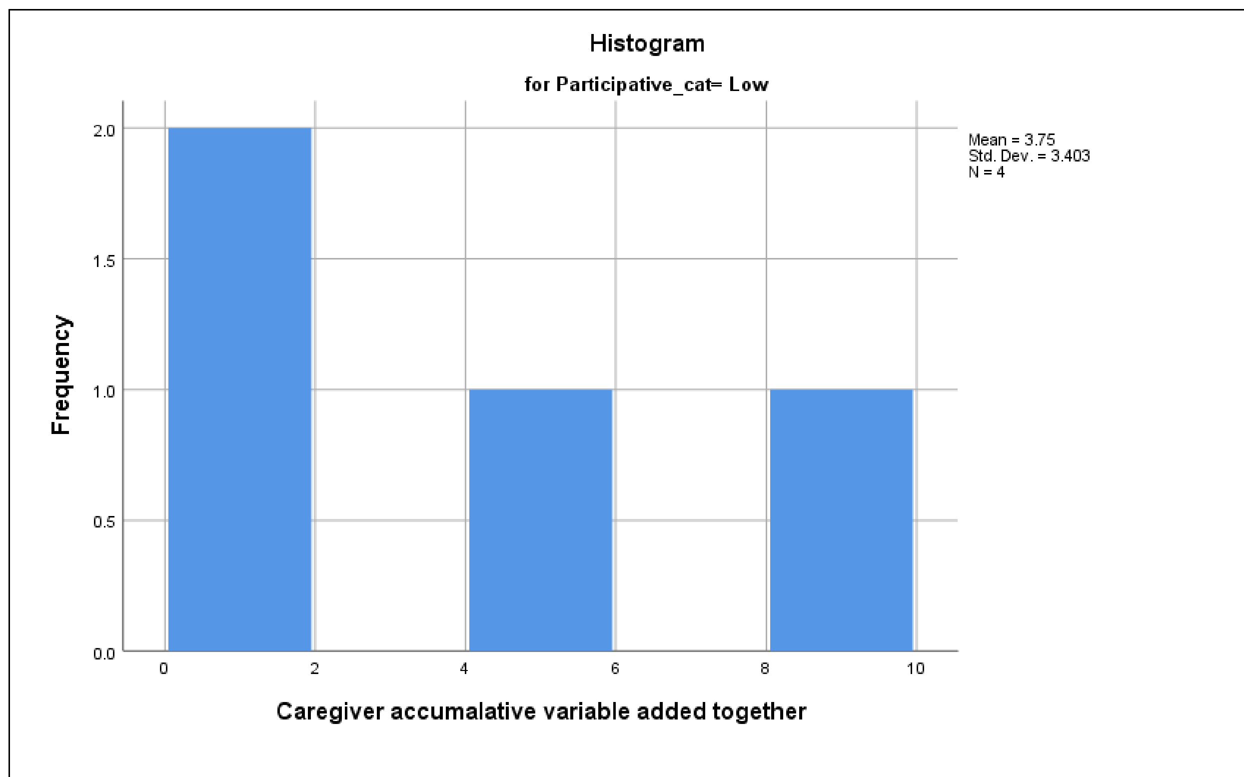


*Figure 4.11* Nurses with low Participative leadership style supervisors

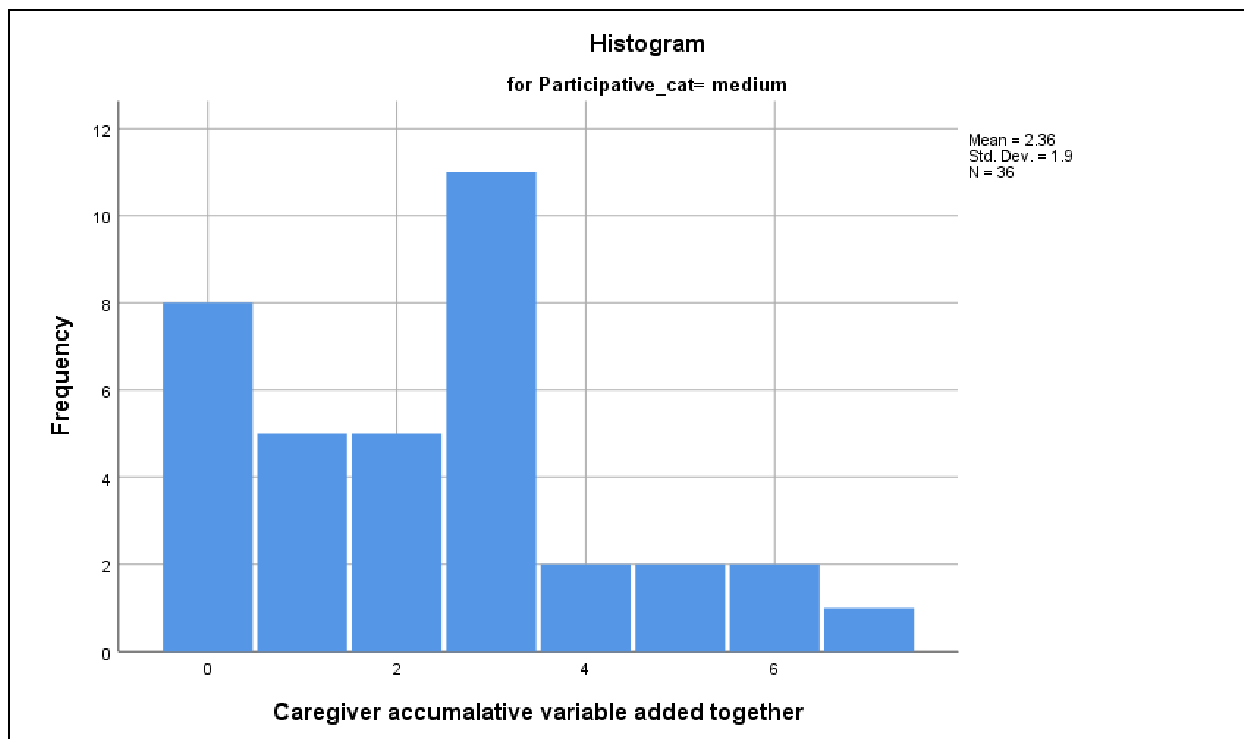


*Figure 4.12* Nurses with medium Participative leadership style supervisors

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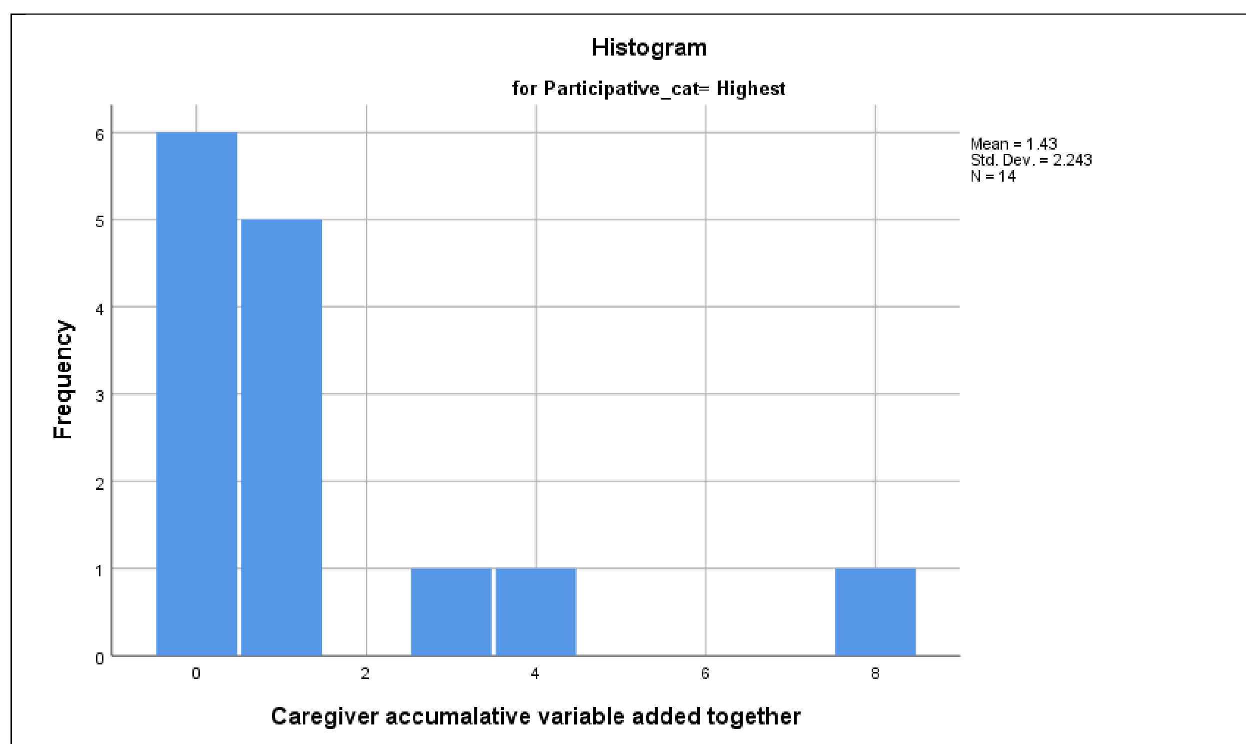

*Figure 4.13* Nurses with high Participant leadership style supervisors

These three distributions in these categories, low (Figure 4.11), medium (Figure 4.12), and high (Figure 4.13), are not the same shape; therefore, as indicated by Kruskal Wallis H Test assumption 4 mean ranks should be tested instead of median ranks. Here is how I interpreted the results for the Kruskal-Wallis Test (Figure 4.14) for Participative Leadership Style.

There is not a statistically significant relationship with a significance of 0.092 (Figure 4.14) between Participative style leadership and the propensity for elder abuse in long-term care facilities. Based on the results from SPSS comparisons of three interaction groups occurred: high (nh=14), medium (nm=36), low (nl=4) The Kruskal-Wallis Test was non-significant H (2) =4.767, p=0.092. For nurses who have a low Participative supervisor, the mean rank for the propensity for abuse is 35.63 compared to 29.42 for medium Participative supervisors and 20.25 Participative high supervisors. Tests results indicate a non-significant difference between

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directive leadership style and the propensity for abuse; for this reason, we failed to reject the null hypothesis.

| **Test Statistics**[a,b] | Caregiver accumulative variable added together |
|---|---|
| Kruskal-Wallis H | 4.767 |
| df | 2 |
| Asymp. Sig. | 0.092 |
| a. Kruskal Wallis Test | |
| b. Grouping Variable: Participative leaders organized into categories | |

| **Ranks** | | | |
|---|---|---|---|
| Participative leaders organized into categories | | N | Mean Rank |
| Caregiver accumulative variable added together | Low | 4 | 35.63 |
| | medium | 36 | 29.42 |
| | Highest | 14 | 20.25 |
| | Total | 54 | |

*Figure 4.14* Kruskal-Wallis mean results for mean ranks results for nurses with Participative Leadership Style supervisors

RQ4. Is there a statistically significant relationship between the Achievement-Oriented style of leadership style and the propensity for elder abuse in long-term care facilities?

The null and alternative hypotheses for this question is as listed below:

- There is no statistically significant relationship between Achievement-Oriented style leadership and the propensity for elder abuse in long-term care facilities.
- There is a statistically significant relationship between Achievement-Oriented style leadership and the propensity for elder abuse in long-term care facilities.

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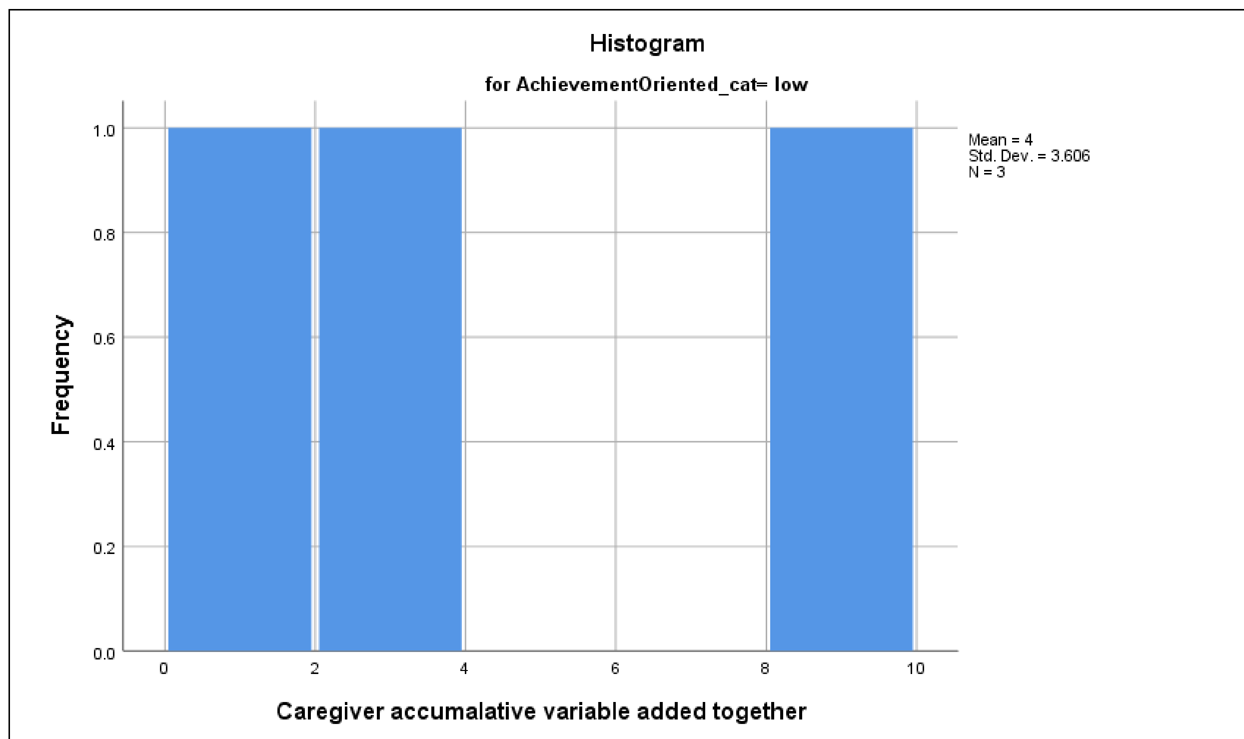


*Figure 4.15* Nurses with low Achievement-Oriented supervisor

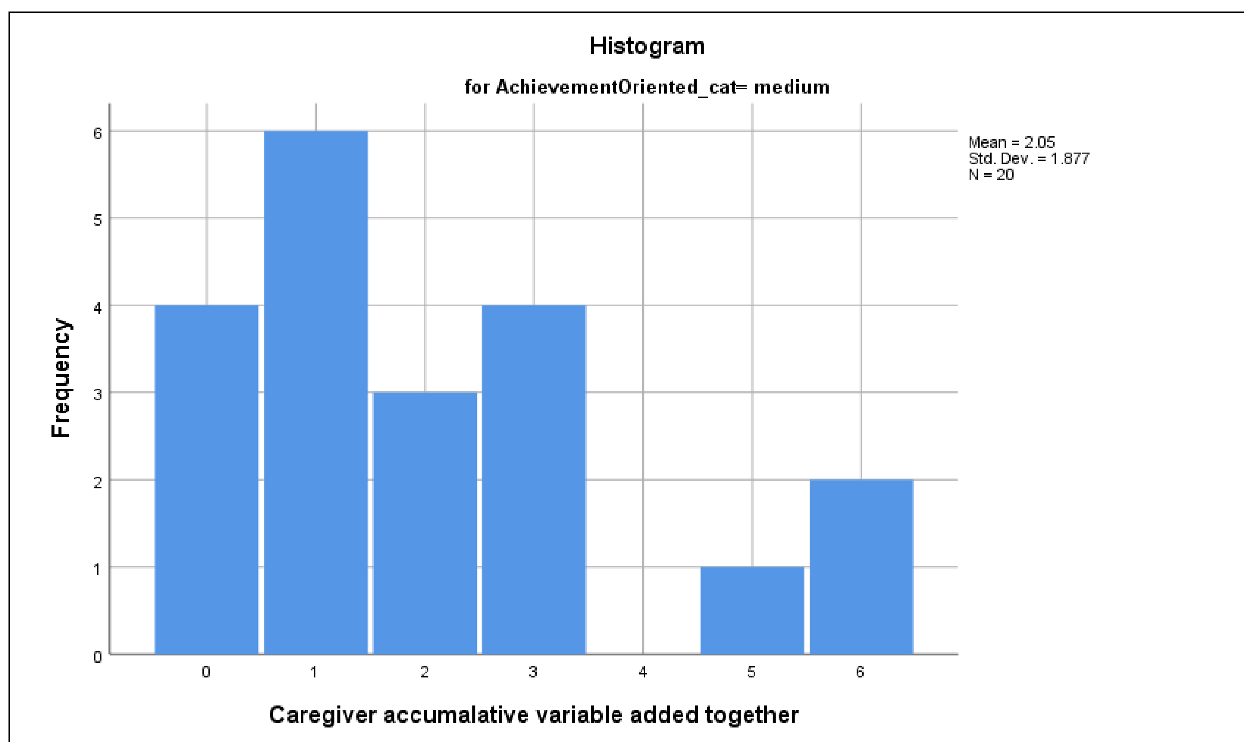


*Figure 4.16* Nurses with medium Achievement-Oriented supervisor

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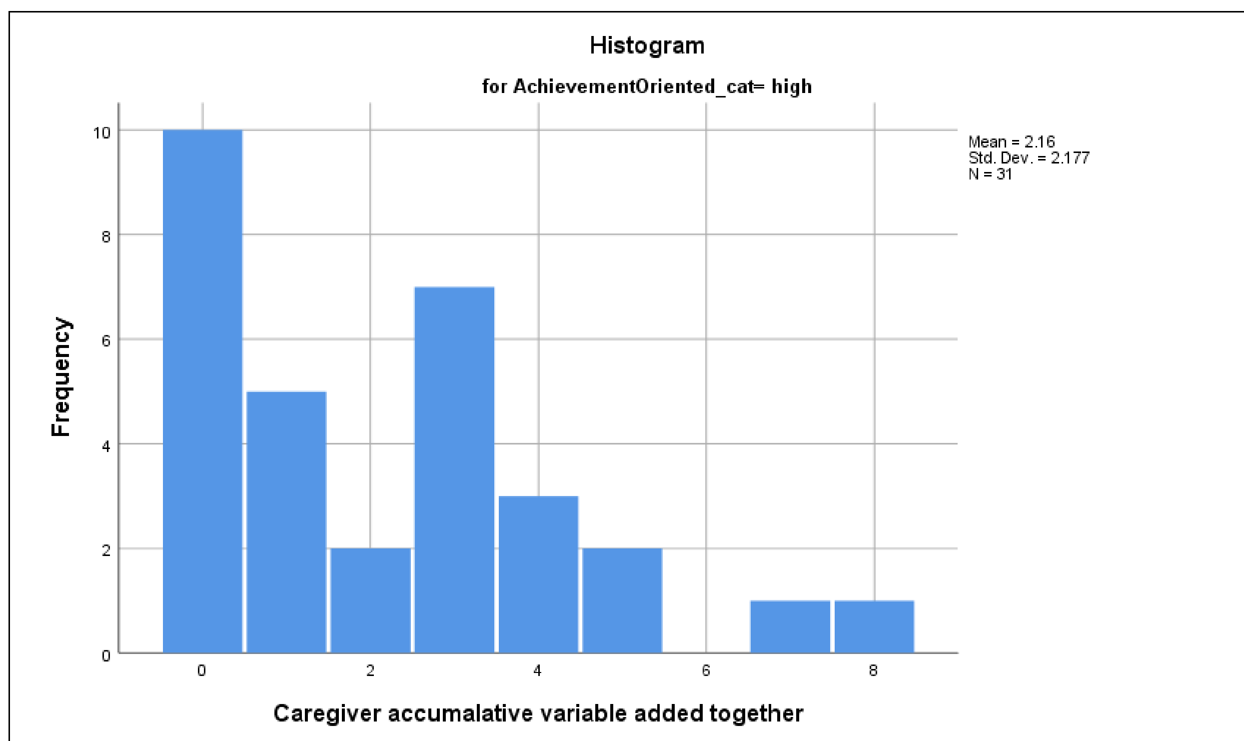


*Figure 4.17* Nurses with a high Achievement-Oriented supervisor

These three distributions in these categories, low (Figure 4.15), medium (Figure 4.16), and high (Figure 4.17) are not the same shape nor variability; therefore, as indicated by Kruskal Wallis H Test assumption four mean ranks should be tested instead of median ranks. Here is how I interpreted the results for the Kruskal-Wallis Test (Figure 4.18) for Achievement-Oriented Leadership Style.

There is no statistically significant relationship with a significance of 0.535 (Figure 4.18) between Achievement-Oriented style leadership and the propensity for elder abuse in long-term care facilities. Comparisons of three groups occurred in SPSS: high (NH =31), medium (nm=20), low (nl=3). The Kruskal-Wallis Test was non-significant H (2) =1.250, p=0.535. For nurses who have a low Achievement-Oriented supervisor, the mean rank for the propensity for abuse is 37.17 compared to 26.95 for medium Participative supervisors and 26.92 high Achievement-

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Oriented supervisors. Tests results indicate a non-significant difference between directive leadership style and the propensity for abuse; for this reason, we failed to reject the null hypothesis.

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| Test Statistics[a,b] | Caregiver accumulative variable added together |
|---|---|
| Kruskal-Wallis H | 1.250 |
| df | 2 |
| Asymp. Sig. | 0.535 |

a. Kruskal Wallis Test

b. Grouping Variable: Achievements Oriented Leaders organized into categories

**Ranks**

| Achievements Oriented Leaders organized into categories | | N | Mean Rank |
|---|---|---|---|
| Caregiver accumulative variable added together | low | 3 | 37.17 |
| | medium | 20 | 26.95 |
| | high | 31 | 26.92 |
| | Total | 54 | |

*Figure 4.18* Kruskal-Wallis mean results for nurses with Achievement-Oriented Leadership Style supervisors

**Evaluation of the Findings**

The theoretical framework in this study stemmed from the situational theory, and as expected expected in this research, leadership style would not have an effect on the propensity of elder abuse in long-term care facilities, that is, that leadership would not have an effect on the propensity for elder abuse through employee behavior. Thus, indicating that the propensity of elder abuse is indicative of other elements within the long-term care facilities. Results indicate no significant relationship between leadership style (low, medium, and high) concentrations on caregivers' propensity for elder abuse.

**Summary**

The purpose of this study was to examine leadership styles and the influence each has on the propensity for abuse in healthcare facilities. The examination of the relationship between leadership and abuse will lead to opportunities to work on the identification of other elements that may be leading to elder abuse within long-term facilities. This study provided statistical

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results to healthcare professionals disproving a relationship between leaders and the propensity for elder abuse. The collected data can be beneficial in improving the opportunity for healthcare industries which focus on elderly patients to increase their knowledge level and change business practices toward a safer, more accountable practice model. One research question in this study addressed the relationship between leadership style and the propensity for elder abuse. In the final analysis, there was not a relationship between leadership style and the Caregiver Accumulative Score, resulting in the retaining of the hypothesis.

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# Chapter 5: Implications, Recommendations, and Conclusions

The purpose of this study was to examine leadership styles, decisions, and the influence each has on the propensity for abuse on long-term care facilities. Studies show that leadership style impacts the quality of care provided to long-term care residents, and ultimately, the outcomes for each within a long-term care facility (Orellana, Manthorpe, & Moriarty, 2017). There is a considerable need for research identifying how leadership style relates to the propensity of abuse in long-term care facilities (Burns et al., 2015; Dong, 2015).

Many situations signify a relationship between leadership roles and elder abuse (Reader & Gillespie, 2013). Some of those situations are workload, employee satisfaction, and mistreatment of the resident are identifying factors associated with institutional factors such as Leadership (Reader & Gillespie, 2013). Before the “Leadership style on Propensity for Abuse Study,” it was unclear whether leadership style affected the propensity for abuse. Many researchers such as Moore, Mayer, Chiang, Crossley, Karlesky, and Birch (2019), identified a relationship between “employee misconduct, leadership, and the influence that leaders have over employees’ moral cognition” (p.140). Amirkhanyan, Meier, O’Toole, Dakhwe, and Janzen (2018) identified significant and positive relationships between leadership and service quality.

The quantitative study was used to examine the effect that leadership has on nursing and the propensity for elder abuse. Four forms of leadership identified by the Path-Goal Leadership Questionnaire (Directive, Supportive, Participative, and Achievement Oriented) were used as dependent variables while the independent variables established by the Caregiver Abuse Screen (CASE) in evaluating a relationship between occurrences of abuse and leadership style. The research design allowed for framing influences by presenting each of the four leadership styles in

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various hypothetical formats. The study also allowed for the measurement of relationships between leadership style and the propensity for abuse.

The minimum required sample size originated using the power of 0.95 with an error of probability of 0.05 with an effect size of .5 and two individual groups of participants indicated a sample size of 54. The actual number of samples collected for the study was 56 samples. Post hoc analyses were not conducted due to the exclusivity of the data as the study dealt solely with participants was identified as an RN, LPN, or CNA before the initiation of the survey. The conducted study occurred without the elimination of data or omitted responses due to a rule established in the survey requiring that a participant must either hold a nursing license (RN, LPN, or CNA). Any participant not holding this licensure reached the disqualification stage before beginning the survey.

To minimize Type 1 errors (false positive), ANOVA was used to test group means against each other, where the alpha remains at .05. ANOVA testing was the primary instrument chosen for establishing a relationship between Leadership, nurses' behavior, and elder abuse. Steps were taken by the researcher to ensure the adherence to ethical practices, protection from harm, and informed consent. Significant steps were taken at each level of the doctoral process to instill precaution and truthfulness to meet the moral criteria of scientific studies. The steps included preventing plagiarism, ensuring privacy and confidentiality, implementing ethical measures for data handling and storing, and remaining aware of procedures for eliminating mistakes and negligence to attain IRB approval.

**Implications**

The implications associated with the four styles of leadership Directive, Supportive, Participative, and Achievement-Oriented will help answer the four research questions and

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potentially identify any statistically significant relationship between leadership style and the propensity for abuse in long-term care facilities. The questions to answer in order to explore the potential differences in the propensity of abuse between the four types of leadership styles include the following four research questions; “Is there a statistically significant relationship between the directive style of leadership style and the propensity for elder abuse in long-term care facilities?” “Is there a statistically significant relationship between the supportive style of leadership style and the propensity for elder abuse in long-term care facilities? “Is there a statistically significant relationship between the participative style of leadership style and the propensity for elder abuse in long-term care facilities? “Is there a statistically significant relationship between the achievement-oriented style of leadership style and the propensity for elder abuse in long-term care facilities?

**Research Question 1.** “Is there a statistically significant relationship between the Directive style of leadership and the propensity for elder abuse in long-term care facilities?”

Data originated from the Qualtrics Research including survey results from the Caregiver Assessment and the Path-Goal Questionnaire. Registered Nurses, Licensed Practical Nurses, or Certified Nursing Assistants were provided electronically distributed surveys with 56 surveys returned. Based on the responses from the participants, the primary theme of Information emerged. The SPSS Version 25.0 software analyzed the results of the data. Based on these results, indications are that there is a non-significant difference between Directive Leadership categories low, medium, and high in the propensity for caregiver abuse resulting in the rejection of the alternative hypothesis.

**H10.** There is no statistically significant relationship between Directive Style Leadership and the propensity for elder abuse in long-term care facilities.

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**H1a.** There is a statistically significant relationship between Directive Style Leadership and the propensity for elder abuse in long-term care facilities.

The purpose of the first research question was to understand better how Directive Leadership affected the propensity for abuse based on the low, medium, and high leadership style concentrations. The study determined that the abuse level of harm mean rank was 27.17 for the low, 30.04 for the medium, and 25.28 for the high categories of Leadership (Fig. 4.6). There is a difference of 2.87 between low and medium and 4.76 between medium and high. However, the Kruskal-Wallis H Tests did not show a statistically significant relationship based on the leadership categories of low, medium, and high. The results of this study do not represent a statistically significant relationship. Contrary to previous research that indicates a significant relationship between Leadership and the propensity for elder abuse. (Safety organizing, 2015). As identified by previous researchers, smaller study groups result in limitations to data collection (Safety organizing, 2015). The size of this sample study could have resulted in limitations on the control variable and the results (Safety organizing, 2015). This study omitted many participants in all categories (high, low, medium categories of the Path-Goal Questionnaire) due to restrictions placed on participant qualifications. Smaller sample size or since one group of participants (nurses) was analyzed instead of different healthcare personnel results in study limitations. Increasing the sample size would result in a larger sample group and would generate more substantial outcomes and an increase in collected data.

**Research Question 2.** "Is there a statistically significant relationship between the Supportive style of leadership and the propensity for elder abuse in long-term care facilities?

Research question two was answered by analyzing the results of the data that was collected and processed by the SPSS Version 25.0 software. As determined by these results, it

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was concluded that there is no statistically significant relationship between the leadership categories low, medium, and high and Supportive Leadership and the propensity for abuse resulting in the rejection of the alternative hypothesis.

**Ho.** There is no statistically significant relationship between Supportive Style Leadership and the propensity for elder abuse in long-term care facilities.

**H1a.** There is a statistically significant relationship between Supportive Style Leadership and the propensity for elder abuse in long-term care facilities.

The study determined the accumulative caregiver results for supportive leadership mean rank 29.81 low, 28.29 for medium, and 7.50 for high leadership categories (Fig. 4.10). That is a difference in mean rank of 1.52 between low and medium, and 20.79 between medium and high. As indicated, the Kruskal-Wallis H Test did not show a statistically significant relationship in the mean ranks for Supportive leadership categories. The results although are not representing a statistically significant relationship and do not align with previous researchers who suggested that leadership style affects the propensity for caregiver abuse in long-term care facilities through an association with employee morale, misconduct, and the effects of leadership on moral cognition (Moore et al., 2019). The results could be the result of restrictions placed on the styles of leadership. Additional leadership styles could be analyzed to determine additional effects.

**Research question 3.** "Is there a statistically significant relationship between the Participative style of leadership and the propensity for elder abuse in long-term care facilities?

Research question three was answered by analyzing the results of the data that was collected through Qualtrics survey distribution and processed by the SPSS Version 25.0 software. As determined by these results, there is no statistically significant relationship between

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the leadership categories low, medium, and high and Participative Leadership and the propensity for abuse resulting in the rejection of the hypothesis.

**Ho.** There is no statistically significant relationship between Participative Style Leadership and the propensity for elder abuse in long-term care facilities.

**H1a.** There is a statistically significant relationship between Participative Style Leadership and the propensity for elder abuse in long-term care facilities.

The purpose of the third research question was to understand better how Participative Leadership affected the propensity for abuse based on the low, medium, and high leadership style concentrations. The study determined the accumulative caregiver results for Participative Leadership mean rank 36.63 low, 29.42 medium, and 20.25 high (Fig. 4.14). That is a difference in mean rank of 6.21 between low and medium, and 9.17 between medium and high. Conversely, the Kruskal-Wallis H Test did not show a statistically significant relationship in the mean ranks for Participative Leadership and the propensity for caregiver abuse as previous research indicates. The results do not represent a statistically significant relationship between Participative Leadership thus, identifying a contrast with previous studies such as this article where Reader and Gillespie, (2013) identify an association between leadership style and the propensity for caregiver abuse in long-term care facilities through an association with workload, employee satisfaction, employee performance and mistreatment of the resident, identifying factors associated with institutional Leadership (Reader & Gillespie, 2013; Lam, XU & Chang, 2015). The results did not address the problem and purpose as a relationship between abuse citations and factors associated with Leadership was not identified by the study results.

**Research question 4.** "Is there a statistically significant relationship between the Achievement-Oriented style of leadership and the propensity for elder abuse in long-term care facilities?

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Research question four was answered through by analyzing the data collected through the Qualtrics Research Center and processed through SPSS Version 25.0 software. Based on the results, indications are that there is not a statistically significant relationship between Achievement-Oriented Leadership style and the propensity for caregiver abuse resulting in the rejected of the alternative hypothesis.

**Ho.** There is no statistically significant relationship between Achievement-Oriented style leadership and the propensity for elder abuse in long-term care facilities.

**H1a.** There is a statistically significant relationship between Achievement Oriented style leadership and the propensity for elder abuse in long-term care facilities.

The purpose of the fourth research question was to understand better how Achievement Oriented Leadership affected the propensity for abuse based on the low, medium, and high leadership style concentrations. The study determined the accumulative caregiver results for Achievement Oriented Leadership mean rank 37.17 low, 26.95 for medium, and 26.92 for high leadership categories (Fig. 4.18). That is a difference in mean rank of 10.22 between low and medium, and 0.03 between medium and high. However, the Kruskal-Wallis H Test did not show a statistically significant relationship in the mean ranks for Achievement-Oriented leadership categories.

The results however did not identify a statistically significant relationship between Achievement-Oriented Leadership and the propensity for abuse but do however, identify an association after relaxing the p-value and the improvement in results of scientific research (Benjamin, Berger, Johannesson, Nosek, Wagenmakers, Berk, Johnson, 2017; Travers, Cook, & Cook, 2017); relaxing the p-value to .01 instead of the current .05 would change the significance of this study. Setting the p-value at .1 instead of .05 would allow results to approach significance.

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However, with .05 being the set value, the results remain non-significant. Changing the p-value would change the significance of Achievement-Oriented Style leadership. The study results are indicative enough to bring awareness to the long-term home industry that there are potential issues found in the treatment of the residents within long-term care facilities and the reasoning for the incidents are beyond the scope of leadership style.

**Recommendations for Practice**

A vital recommendation for practice is to establish measures for continued monitoring to identify other possible causes of abuse. Studies completed by Yon, Romero-Gonzalez, Mikton, Huber & Sethi (2019), indicate the vitality in continuous monitoring and surveillance within institutions to prevent elder abuse. "Prevalence of elder abuse in institutions such as long-term care facilities is high," thus, "continued monitoring is crucial to identifying additional forms of abuse and the occurrence of elder abuse" (Yon et al., 2019, p.61).

**Recommendations for Future Research**

There are two recommendations for further research include repeating the study with a more significant number of healthcare personnel and changing the p-value threshold from the 0.5 to .1.

**Recommendation 1.** While this research did collect adequate responses to meet the power requirements (minimum n of xx) due to limited finances and time restraints, Qualtrics research data omitted additional survey questions. Also, replications of this study would be of benefit to include increasing the sample size by distributing additional surveys to a larger group of participants.  The first recommendation is to conduct a similar study on a larger scale. Thiese, Ronna, and Ott (2016) state that "the larger the study sample, the more chance a significant relationship will be identified." As Faber and Fonseca (2014), states "sample size should be

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neither too large or too small as both have limitations and can result in compromising results" "Samples that are too small may prevent the results from being inferred while samples that are too large can amplify the detection of differences that are not clinically relevant" (Faber & Fonseca, 2014).

**Recommendation 2.** Another avenue for further study would be to relax the current p-value from .05 to .01. Also supported by Thiese et al., (2016), the smaller the P-Value, the stronger the evidence against the null hypothesis. Gronau, Duizer, Bakker, and Wagenmakers (2017) indicate that the "standard deviation is affected by the average term in the study set and the mean as the closer the numbers the smaller the standard deviation-the more significant the quantities, the larger the standard deviation". Results are "strongly affected by size of the prior for standard deviation as closeness in numbers results in a smaller standard deviation and the larger the width the larger the standard deviation" (Gronau et al., 2017). For this reason, making a change in the P-Value of this study could lead to a significant relationship between each leadership style and categories low, medium, or high. Thus, indicating a relationship between leadership style and the propensity for abuse.

**Conclusions**

As the elderly population rises, the prevalence of abuse cases will grow immeasurably (Baker, 1977); however, minimal studies examining elder abuse continue in long-term care settings. Compared to research on other areas of abuse research in the long-term is still in the stages of infancy (Pillemer, Burnes, Riffin, & Lachs, 2016). This study was developed to examine leadership styles, decisions, and the influence each has on abuse in Long-term care healthcare facilities. This chapter consists of several sections, including a brief review of the study process and findings, implications, limitations, recommendations for further research,

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practically and academically. Four implications were discussed one implication for each question. Results of the study include to recommentations for future research.

The notion that leadership style affects the propensity for abuse in long-term facilities is generally rejected in this study, although elder abuse is one of the most crucial elements facing the aging generation of today. The negativity associated with ineffective leadership or the effects of leadership styles can lead to situations of abuse towards others; for example, situations of fear among the staff, and decision making without consultation among team members. The results of this study indicated a non-significant relationship between leadership style and the propensity for abuse in long-term care facilities. Hopefully, future research will identify a link between leadership style and the propensity for abuse. Until then, opportunities for individuals to recognize, respond, and report incidents of elder abuse remain.

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# Appendices

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Appendix A: Permissions for Questionnaire and Survey Use

On Thu, Jan 25, 2018 at 5:40 AM, lim vincent <limvincent888@gmail.com> wrote:

Audrey,

Do you mean the questionnaire? Sure you can. We also borrow it from someone else.

Good luck on your dissertation. Do send me a copy when you are done.

Best,Vincent

Julie Indvik <JIndvik@csuchico.edu>

Fri, Jan 26, 2018, 4:27 PM

Audrey,

I assume you mean the version reprinted in Peter Northouse's book on leadership theory. If so, yes, you may use it. Be sure to cite my dissertation as well as all the sources cited in Peter's book.

Best wishes with your research. Julie Indvik, Ph.D.

On Sun, Apr 15, 2018 at 2:31 PM, **Daphne Nahmiash** <daphnenah@gmail.com> wrote:

I don't know much about your theoretical model so I can't be very helpful. I wonder how you will define leadership and the diverse leadership styles and it may be difficult to assess why a particular leadership style affects the numbers of abuse cases versus other factors such as environmental conditions. I do however find the topic very interesting.so let's keep talking and I'll be interested in your progress. Regards Daphne

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Appendix B: Path-Goal Leadership Questionnaire

**Questions and Questionnaires**

Path-Goal Leadership Questionnaire (used with permission from Vincent Lim C.S and Indvik, J., 1985). *A path-goal theory investigation of superior-subordinate relationships*.

LEADERSHIP SCALE

This Section contains questions about the leadership styles of your manager/supervisor. Indicate how often each statement is true of your manager's leader behavior. Please describe your immediately manager/supervisor as accurately and as objectively as possible.

**Please chose one for each line**

1 = Never; 2 = Hardly ever; 3 = Seldom; 4 = Occasionally; 5 = Often; 6 = Usually; 7 = Always

(1) My Manager/Supervisor lets subordinates know what is expected of them.

1 = Never; 2 = Hardly ever; 3 = Seldom; 4 = Occasionally; 5 = Often; 6 = Usually; 7 = Always

(2) My Manager/Supervisor maintains a friendly working relationship with subordinates.

1 = Never; 2 = Hardly ever; 3 = Seldom; 4 = Occasionally; 5 = Often; 6 = Usually; 7 = Always

(3) My Manager/Supervisor consults with subordinates when facing a problem.

1 = Never; 2 = Hardly ever; 3 = Seldom; 4 = Occasionally; 5 = Often; 6 = Usually; 7 = Always

(4) My Manager/Supervisor listens receptively to subordinates' ideas and suggestions.

1 = Never; 2 = Hardly ever; 3 = Seldom; 4 = Occasionally; 5 = Often; 6 = Usually; 7 = Always

(5) My Manager/Supervisor informs subordinates about what needs to be done and how it needs to be done.

1 = Never; 2 = Hardly ever; 3 = Seldom; 4 = Occasionally; 5 = Often; 6 = Usually; 7 = Always

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(6) My Manager/Supervisor lets subordinates know that he expects them to perform at their highest level.

1 = Never; 2 = Hardly ever; 3 = Seldom; 4 = Occasionally; 5 = Often; 6 = Usually; 7 = Always

(7) My Manager/Supervisor acts without consulting his subordinates.

1 = Never; 2 = Hardly ever; 3 = Seldom; 4 = Occasionally; 5 = Often; 6 = Usually; 7 = Always

(8) My Manager/Supervisor does little things to make it pleasant to be a member of the group.

1 = Never; 2 = Hardly ever; 3 = Seldom; 4 = Occasionally; 5 = Often; 6 = Usually; 7 = Always

(9) My Manager/Supervisor asks subordinates to follow standard rules and regulations.

1 = Never; 2 = Hardly ever; 3 = Seldom; 4 = Occasionally; 5 = Often; 6 = Usually; 7 = Always

(10) My Manager/Supervisor sets goals for subordinates' performance that are quite challenging.

1 = Never; 2 = Hardly ever; 3 = Seldom; 4 = Occasionally; 5 = Often; 6 = Usually; 7 = Always

(11) My Manager/Supervisor says things that hurt subordinates' personal feelings.

1 = Never; 2 = Hardly ever; 3 = Seldom; 4 = Occasionally; 5 = Often; 6 = Usually; 7 = Always

(12) My Manager/Supervisor asks for suggestions from subordinates concerning how to carry out assignments.

1 = Never; 2 = Hardly ever; 3 = Seldom; 4 = Occasionally; 5 = Often; 6 = Usually; 7 = Always

(13) My Manager/Supervisor encourages continual improvement in subordinates' performance.

1 = Never; 2 = Hardly ever; 3 = Seldom; 4 = Occasionally; 5 = Often; 6 = Usually; 7 = Always

(14) My Manager/Supervisor explains the level of performance that is expected of subordinates.

1 = Never; 2 = Hardly ever; 3 = Seldom; 4 = Occasionally; 5 = Often; 6 = Usually; 7 = Always

(15) My Manager/Supervisor helps subordinates overcome problems that stop them from carrying out their tasks.

1 = Never; 2 = Hardly ever; 3 = Seldom; 4 = Occasionally; 5 = Often; 6 = Usually; 7 = Always

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(16) My Manager/Supervisor shows that he has doubts about subordinates 'ability to meet most objectives.

1 = Never; 2 = Hardly ever; 3 = Seldom; 4 = Occasionally; 5 = Often; 6 = Usually; 7 = Always

(17) My Manager/Supervisor asks subordinates for suggestions on what assignments should be made.

1 = Never; 2 = Hardly ever; 3 = Seldom; 4 = Occasionally; 5 = Often; 6 = Usually; 7 = Always

(18) My Manager/Supervisor gives vague explanations of what is expected of subordinates on the job.

1 = Never; 2 = Hardly ever; 3 = Seldom; 4 = Occasionally; 5 = Often; 6 = Usually; 7 = Always

(19) My Manager/Supervisor consistently sets challenging goals for subordinates to attain.

1 = Never; 2 = Hardly ever; 3 = Seldom; 4 = Occasionally; 5 = Often; 6 = Usually; 7 = Always

(20) My Manager/Supervisor behaves in a manner that is thoughtful of subordinates' personal needs.

1 = Never; 2 = Hardly ever; 3 = Seldom; 4 = Occasionally; 5 = Often; 6 = Usually; 7 = Always

**Scoring**

Reverse the scores for Items 7, 11, 16, and 18.

Directive style: Sum of scores on Items 1, 5, 9, 14, and 18.
Supportive style: Sum of scores on Items 2, 8, 11, 15, and 20.
Participative style: Sum of scores on Items 3, 4, 7, 12, and 17.
Achievement-oriented style: Sum of scores on Items 6, 10, 13, 16, and 19.

**Scoring Interpretation**

Directive style: A common score is 23, scores above 28 are considered high, and scores below 18 are considered low.
Supportive style: A common score is 28, scores above 33 are considered high, and scores below 23 are considered low.
Participative style: A common score is 21, scores above 26 are considered high, and scores below 16 are considered low.

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> Achievement-oriented style: A common score is 19, scores above 24 are considered high, and scores below 14 are considered low.

The scores you received on the Path–Goal Leadership Questionnaire provide information about which styles of leadership you use most often and which you use less often. In addition, you can use these scores to assess your use of each style relative to your use of the other styles.

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## Appendix C: Caregiver Assessment Survey (CASE)

**CAREGIVER ABUSE SCREEN (CASE)**

Purpose: To screen for abuse through multiple sources, for instance, through caregivers, care receivers, and/or abuse interveners, rather than only through professional reporting. It is designed specifically for community use.

Instructions: The CASE has eight items to ask nurses of which "yes" or "no" are the answers. A caregiver may complete the questionnaire. Answering yes to any questions receives a score of 1 point. The points are tallied together to create a score ranging between 0-8. A score of four or more on the CASE may be conservatively considered as suggestive of a higher risk for abuse. However, even a score of one can be indicative of abuse. According to the CASE, the caregivers are asked to answer screening questions for physical, psychological, and financial abuse or neglect (Abolfathi Momtaz, Hamid, & Ibrahim, 2013).

Please answer the following questions as a helper or caregiver: YES NO

1. Do you sometimes have trouble making a patient control his/her temper?

2. Do you often feel you are being forced to act out of character or do things you feel bad about?

____ ____

3. Do you find it difficult to manage a patient's behavior? ____ ____

4. Do you sometimes feel that you are forced to be rough with a patient? ____ ____

5. Do you sometimes feel you can't do what is really necessary or what should be done for your patient? ____ ____

6. Do you often feel you have to reject or ignore a patient? ____ ____

7. Do you often feel so tired and exhausted that you cannot meet your patient's needs?

____ ____

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8. Do you often feel you have to yell at your patient? ____ ____

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