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Staff Burnout and the Neglect of Elderly Residents in Care

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This is to certify that the doctoral dissertation by

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Walden University
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Abstract

Staff Burnout and the Neglect of Elderly Residential Care Patients

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MS, Sage University, 2012

BS, Sage University, 2010

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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Abstract

There is increasing concern about patient neglect in nursing homes as nursing home staff become burnt out. Although there has been research on burnout in nursing home staff and neglect, little research has been done to understand the specific connection of burnout and neglect through the lived experiences of staff members. Underpinned by Maslach's theory of burnout, the purpose of this qualitative study was to explore the lived experiences of nursing home staff who experienced burnout before and after they witnessed neglect of elderly patients. Nine semistructured interviews were conducted with elderly care staff who had experienced burnout and witnessed burnout and neglect in their work. Participants included eight females and one male. Through thematic analysis, four themes emerged: lack of staff support, well-being of residents, compassion for working with elderly and unintentional actions. These findings show that nursing home staff felt burnout was linked to not having enough staff, and that can lead to neglect. Neglect was found to be unintentional. This study shows that many people working in the field of elderly care want to be in the field to help but they become burnt out and then do not want to do the job. These findings can impact positive social change and aid to the ever-growing field of elder care by understanding what can lead to burnout and how burnout can lead to unintentional neglect. This research can help elder care agencies and their staff understand burnout experienced and the neglect taking place and use this understanding to determine what can be done to mitigate these problems.

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Dedication

This doctoral study is dedicated to my parents, Bob and Holly and my brother, Mike, who have supported me throughout my life and given me the inspiration and ambition to pursue my goals. I also dedicate this to my partner Bob and his daughter June. Two people who have been critical in my life and in this process. I would not be here today without their support and encouragement from day one.

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Chapter 1: Introduction to the Study

Burnout is the point at which employees can no longer handle the demands placed on them, accompanied by a loss of a sense of meaning in the work they do (McCormack & Cotter, 2013). Stress alone does not cause burnout (McCormack & Cotter, 2013). There are times and situations where people can flourish in stressful, demanding circumstances if they feel valued and appreciated and their work has significance (McCormack & Cotter, 2013). Burnout, specifically with nurses, is happening at a higher rate for people who are in direct care professions (Kandelman et al., 2018). Maslach's theory of burnout suggests that there are three dimensions that cause burnout in a staff member: emotional exhaustion, depersonalization, and reduced personal accomplishment (Maslach & Jackson, 1981).

Research has shown that burnout is linked to issues of elderly residents in care (Neuberg et al., 2017). At this time, while there is research examining the link between the burnout of direct care staff members and the abuse of elderly patients, more research is needed to understand this connection in relation to the different types of abuse, such as neglect (Blumenfeld et al., 2017; Hall et al., 2016). Although burnout, mistreatment, and abuse have been extensively researched, there has been less research focused solely on the direct connection between burnout and neglect. The benefit of this research study, then, is that it can help develop a better understanding of burnout and help reduce the cases of neglect occurring in residential care facilities for elderly clients. This chapter includes a brief overview of the background, problem statement, purpose, research

question, theoretical framework, nature of the study, key terms, assumptions, scope, and limitations.

Background

What is currently known about the actual nature of abuse of elderly people in care homes has come from the investigations that have followed instances of abuse, neglect, and mistreatment in care homes (Moore, 2017). Therefore, understanding of the topic is limited. Although there is research on the causes of abuse to elderly people, there is still a need for research into the different causes of specific types of abuse, mistreatment, or neglect (Hall et al., 2016). Furthermore, despite there being an empirical link between staff burnout and mistreatment, abuse and neglect (Cooper et al., 2017), more studies are needed to examine specific types of abuse or mistreatment, such as neglect, and the link it has with staff burnout.

Previous studies have examined elder abuse and neglect (Cooper et al., 2018). However, there is still a lack of adequate analysis investigating institutional abuse and the risk factors, along with the low reporting rates (Frazão et al., 2015). Additionally, Cooper et al. (2018) found that staff reported more abusive and neglectful behaviors in residential homes with higher staff burnout depersonalization scores. In that study, over half of the elderly residential staff surveyed reported carrying out or observing abusive or neglectful behaviors. Cooper et al. noted that their findings were “just the tip of the iceberg” (p. 2) and that there needs to be additional research to help with prevention efforts. Therefore, the current study focused on elder neglect in residential homes and the connection to

burnout to understand the relationship of burnout to elder neglect, thus contributing to possible prevention efforts that can be made.

There have also been issues in previous studies regarding the definition of forms of abuse, neglect, and mistreatment (Castle et al., 2015). Previous studies have often identified abuse, mistreatment, and neglect as being similar, but the exact definition has also varied. This is part of the reason that an extensive amount of research has not been done on the connection between burnout and types of mistreatment. Previous researchers have identified abuse in different ways; some include neglect as abuse, whereas others understand it as a distinct type of mistreatment (Castle et al., 2015).

Cooper et al. (2018) conducted a study that examined 92 nursing homes throughout England, and they found that abuse or neglect was reported in all but one of the care home units. This statistic conveys how widespread neglect of the elderly is. Several factors can lead to abuse, mistreatment, and neglect of residents in care. McDonald et al. (2012) found that some of the most common factors that have been linked to abuse and mistreatment of people in care include generational violence, stress, financial factors, and structural factors of the organization such as size or ageism. Stress on staff is a leading cause of abuse, neglect, and mistreatment (MacDonald et al., 2012). Stress can also be a leading cause of burnout in residential caregivers, but it is not the only condition that leads to mistreatment (MCormack & Cotter, 2013). Additional factors relating to abuse, mistreatment, and neglect include stressful work situations, lack of care personnel, and poor team culture (Wangmo et al., 2017).

Caregivers who are overwhelmed and have an indifferent or a distanced attitude toward their job and their patients were more likely to neglect or behave in an abusive way with those in their care (Andela et al., 2018b). Being overwhelmed by the responsibility can be part of the reason that a staff member who works in a direct care profession, specifically in a residential care facility, begins to experience burnout. The rate of burnout is higher for nurses working in nursing homes than for those in geriatric hospital wards (Kandelman et al., 2018). Burnout is considered one of the main causes of elder mistreatment in nursing homes (Neuberg et al., 2017). One of the types of elderly mistreatment is neglect. If the caregiver is not able to cope with the stress in their working environment, conflicts with their elderly residents are inevitable. Conflicts can include different kinds of mistreatment, including abuse and neglect.

In much of the previous research, elder abuse is often represented as a solitary incident rather than a repeated event that encompasses many forms. Researchers have recognized that many studies examining abuse are given little attention to issues of scale and scope (see Castle et al., 2015; Hutchison & Kroese, 2015). In more recent research, Wangmo et al. (2017) found that participants saw neglect as the most common form of mistreatment against their patients. However, it is still seen as part of the larger picture of mistreatment and abuse and has not been studied as an individual act or incident.

Although there is currently research into elder abuse and neglect and the connection to staff burnout, the field is ever-evolving, and the population continues to increase, meaning more people are in care now than ever before. This is an important topic to continue to research and review. Research needs to focus on the effects of

burnout, including the neglect that could result from staff burnout (Cooper et al., 2018). Residents in care are more vulnerable to abuse and neglect than those who can care for themselves at home (Radkieqicz & Korzenioqski, 2017). It is important to research the link between staff burnout and neglectful incidents of elderly residents. This can impact future research and prevention methods used in health care settings. Andela et al. (2018b) noted that there is a significant impact of caregiver burnout on the elder abuse process. Therefore, it is important to continue this work of researching how burnout contributes to specific types of abuse.

Problem Statement

The elderly population continues to increase as the years go on (World Health Organization [WHO], 2016). As people grow old, their level of independence decreases, and therefore, they become more dependent on others for their care. This can lead to an elderly person having to utilize the services in a care setting. When an elderly person is in a care setting, they may be completely dependent on someone else for care, leaving them vulnerable to abuse and neglect by the caretakers (Blumenfeld et al., 2017).

Working in the direct care field can be very enervating and cause burnout in staff. Staff burnout is a serious problem in society for people who are in the human services field (Hen et al., 2012; Shin et al., 2014). Burnout is considered one of the main causes of elder mistreatment in nursing homes (Neuberg et al., 2017). Burnout can result in poor job performance, staff turnover, depression, anxiety, decreased job satisfaction, and depersonalization (Shin et al., 2014). Previous research has shown that burnout has a direct connection to poor job performance, lack of work commitment, low job

satisfaction, and higher turnover (Shin et al., 2014). When a staff member is not fully committed to their work, it can lead to mistakes and a lack of follow-through with duties (Shin et al., 2014). Regarding patient care, neglect is defined as "the intentional or unintentional failure to provide basic living conditions and necessary care and attention" (Neuberg et al., 2017, p. 190). In a residential care setting for the elderly, neglect includes withholding of necessary food, clothing, and medical care to meet the physical and mental needs of an elderly person (Andela et al., 2018b). Unintentional neglect can come from the inability to provide care, whereas intentional neglect occurs when a staff deliberately fails to fulfill the expected care responsibilities (Andela et al., 2018b).

Over the last several years, the health care field has seen an increase in job dissatisfaction, turnover, and stress/burnout of staff (Rosenstein, 2017). These negative thoughts and feelings in staff are leading to a negative impact on their job and the patient outcomes of care (Rosenstein, 2017). Studies have been conducted that link burnout of staff to the neglect of patients in care. Hall et al. (2016) conducted a systematic review of healthcare staff burnout and patient safety and concluded that there is a link between staff burnout and patient safety. However, Hall et al.'s research was on staff burnout and patient safety across a selection of different residential care settings. They determined that as staff burnout increases, the safety of the residents is at risk. Hall et al. concluded that more research is needed to examine the direct link with different types of patients, including elderly residents, their safety, and staff burnout.

Purpose Statement

The purpose of this qualitative study was to explore the lived experiences of nursing home staff related to burnout before and after witnessing the neglect of elderly patients. To do so, I looked at the connection between burnout in staff and neglect of elderly residents in care. I conducted interviews to gather employee experiences in relation to neglect that took place and the burnout that the staff may have experienced before and after witnessing that neglect when they were working in a care setting for elderly people. Whereas other studies have examined burnout and mistreatment or abuse (see Hutchison & Kroese, 2015), this study helped to start to address the gap identified in the literature by specifically looking at the neglect of elderly residential clients and its connection to staff burnout.

Research Question

The purpose of this study was to research how burnout is linked to the neglect of elderly patients from the point of view of staff members who witnessed the burnout and neglect. The following research question directs the study:

RQ: What are the lived experiences of nursing home staff related to burnout before and after witnessing neglect of elderly patients?

Theoretical Framework

The theoretical framework for this study was Maslach's (1976) multidimensional theory on burnout. Maslach and Jackson (1981) defined burnout as "a syndrome of emotional exhaustion and cynicism that frequently occurs among individuals who do 'people-work' of some kind" (p. 99). Maslach and Jackson described burnout as having

three dimensions: emotional exhaustion, depersonalization, and reduced personal accomplishment. With emotional exhaustion, staff members' emotional resources are depleted, and they start to feel like they can no longer give themselves fully to the job and the client. With depersonalization, the staff member will start to feel negative and cynical attitudes and feelings toward their clients. Lastly, with the feeling of reduced personal accomplishment, the staff member starts to feel unsatisfied and unhappy about their work and job, as well as feeling negative about themselves in regard to the work with the client.

Maslach's multidimensional theory on burnout was developed as a bottom-up method, using people's actual realities and their experiences in the workplace to develop this framework and the three dimensions (Maslach, 1998). Through Maslach's theory on burnout, researchers recognized that burnout has very serious consequences for staff and their clients (Maslach & Jackson, 1981). This model speaks to six areas of the work-life that are used to help explain burnout (Maslach et al., 2001). These include workload, control, reward, community, fairness, and values (Maslach et al., 2001). The more a staff member is matched in their job to these six items, the less likely they are to experience burnout, whereas the less connections they have, the more likely, they are to experience burnout (Maslach et al., 2001). Maslach's theory was applicable to this study because it helped to identify the connection between staff burnout and the neglect of elderly residents in their care.

Nature of the Study

The nature of this study was qualitative, using thematic analysis. This methodology is based on Braun and Clarke's (2006) method of thematic analysis for psychological research, which is a method of identifying, analyzing, and reporting patterns that are found within a data set. Thematic analysis is not tied to any theory, which makes this a suitable method of analysis for this study. I used a latent approach underpinning the thematic analysis. With a latent approach, the researcher can examine the underlying ideas, assumptions, and conceptualizations of the data to analyze themes (Braun & Clark, 2006). This works with the current study as it helped to identify themes that emerge from interviews. Such themes may link staff burnout to the neglect of elderly residents in care. I identified staff through means of social media and local residential facilities. I conducted nine interviews. Interviews were held in person or over a video chat session. Geographic location was not specific to my residential area as the use of video chats allowed me a broader area from which to recruit participants.

Definitions of Key Terms

Abuse: An act of commission or omission that results in harm or threatened harm to the health or welfare of someone (Castle et al., 2015).

Burnout: Maslach and Jackson (1981) defined burnout as a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment; it is a reaction to chronic job stress associated with those who work with people in some manner.

Depersonalization: Depersonalization represents negative feelings of cynicism, lack of empathy, and emotional detachment from the client (Shin et al., 2014).

Direct care professional: A staff member who has direct contact with the elder patient on a regular basis.

Emotional exhaustion: The inability to feel compassion towards clients or patients or feel attachment to a job (Shin et al., 2014).

Elderly: A person over the age of 65 (MacDonald et al., 2012).

Elderly mistreatment: Serious, potentially fatal events or circumstances that occur with older adults and that are caused by others in the elder's environment (Castle et al., 2015).

Neglect: The intentional or unintentional failure to provide basic living conditions and necessary care and attention (Neuberg et al., 2017).

Personal accomplishment: A person's feeling of competence and personal achievement in their job (Shin et al., 2014).

Residential care facility: A nursing home, long-term care residential home, or assisted living home for elderly people (Castle et al., 2015).

Assumptions

For this study, I assumed that burnout is linked to the mistreatment of elderly people in residential care; this is based on previous research. I assumed the sample of participants who took part in the study would be able to identify neglect in their job and that they have reported it. When I reached out to gather participants, I used the previously discussed assumptions and criteria. While they were being interviewed, I assumed that

they had witnessed the events under study, and that was the baseline for the interview. I also assumed that the participant sample were honest and truthful in answering all questions to the best of their professional and personal ability. I trusted that the staff I spoke with were honest in the neglect that took place and the burnout experienced and were not exaggerating the circumstances or downplaying the situation for fear of retaliation or loss of job status. I assumed they were honest in speaking about their experiences.

Scope and Delimitations

For this study, I specifically used staff members who have worked in direct care services for elderly people in residential long-term care facilities. The staff members had to have witnessed the neglect taking place, and this neglect had to be reported through the proper channels and chain of command for their agency. The staff who participated had also attested to having witnessed staff burnout taking place in the agency, more specifically witnessing the burnout of the person who was neglectful to that elderly resident.

Previous studies have addressed abuse and mistreatment of elderly residents and the link to burnout, but the scope of this study is specific to neglect. Other forms of mistreatment are outside of this study's scope. Direct care staff were the only participants interviewed for this research. Office staff, janitorial staff, or others who do not have direct contact with residents were not included in the participant groups. Only elderly clients in long-term residential care were the focus of this study. Those who work in long-term care with younger participants or participants who are disabled and in long-

term care were not included. Elderly people who are not in long-term care but are being cared for by nurses or direct support professionals in another type of residence were also not included in this research.

Limitations

Some limitations to this study included dealing with ongoing or current incidents of neglect. For example, if there were internal investigations or criminal proceedings, staff may be less inclined to take part in this study. There may also be a conflict if staff still work at the residence where they witnessed the neglect and experienced burnout. They may be afraid to speak out about it or scared of possible retaliation. I maintained confidentiality with staff members when speaking about their experiences, and the legal caveats to confidentiality were and will be respected. If there were any active cases with law enforcement or prosecution, participants may not have been able to discuss this. In order to identify a location where neglect has been known to have taken place, staff must recognize it and accept this reality.

Moreover, not all cases of abuse and neglect of patients are officially reported. This could impact data collection and the ability to gather staff participants. With regard to data collection and participants, all collected data were based on self-reporting. Therefore, bias was expected in the participants. The participants had insight into incidences of neglect. If there were individuals who understood neglect and burnout but did not realize this is what took place, they would not participate in this study, thereby possibly biasing the sample to staff who worked in care homes where the neglect was more obvious.

The sample size for this study, 8–10 participants, could be a limitation in terms of the range of data collected. As qualitative studies generally have a smaller sample size than mixed-methods or quantitative, this is a limitation for the current study. However, qualitative researchers agree that the study can be trustworthy if data saturation is reached (Creswell & Creswell, 2017). This current study reached data saturation at nine interviews.

With all studies, researcher bias may cause limitations or concerns in a study. A possible bias in the current research is that I, the researcher, have worked for several direct service professions. I have spent a lot of my professional career working in direct services with vulnerable populations. This could be a bias as I have experienced the effects of burnout on myself in this field, and I have witnessed the neglect of residents. While researcher bias is a limitation, I developed a plan to eliminate or reduce this bias. This is discussed in detail in chapter 3.

Significance

This research study focused on the identified gap between burnout and neglectful incidents of elderly residents in care. This research is unique and important in that I look at neglectful incidents only. I separate this form of abuse from other forms of abuse when focusing on the mistreatment of elderly residents and the burnout of staff. Doing so helped to gain a better understanding of the impact of burnout on staff neglect. As mentioned, significant research has previously been conducted on abuse and neglect as well as mistreatment by staff on residents in care (Andela et al., 2018b; Hutchison & Kroese, 2015; Neuberg et al., 2017). However, there is limited research on the different

types of mistreatment that can happen. In this study, I aimed to start to fill this gap by specifically researching neglect as a special form of abuse and the relationship to staff burnout. Although a qualitative study may not fill the gap entirely, it started the process and allowed for additional research to be conducted.

Research into this issue can help organizations and staff members in elderly care facilities to understand their jobs, burnout, and the issues that may be taking place. Organizations and leadership can address the burnout in staff before it becomes neglect against residents. By recognizing that burnout may lead to neglect, staff members in elderly care can limit and lower the number of neglectful incidents before it becomes a larger issue.

Summary

The current literature has not fully addressed the issues of burnout and neglect when related to elderly residents in care. Instead, researchers have focused on abuse and mistreatment as a lump issue with a connection to burnout. Therefore, it is important to research the possible link and how that can be addressed. Researchers have found that burnout is related to the mistreatment and abuse of elderly residents in care. Staff members who are experiencing burnout are more likely to abuse and neglect a resident in their care. In this study, I explored the links specific to the neglect of elderly residents who have been committed by those direct support staff members experiencing burnout.

This study can help by contributing to the ever-expanding knowledge of burnout. It may also contribute to social change by impacting how staff are managing their burnout. This study may help employers better understand burnout and neglect, allowing

them to serve their residents and staff. Understanding the link between burnout and neglect can also allow for better work environments and improved client interactions. This may have a large impact on the quality of care and quality of life for elderly residents who rely on others for care.

Chapter 2 includes an in-depth review of the background and previous research done in the field. It will also include a discussion on how that research revealed the gap in the literature that is addressed through this study. Chapter 2 will address research related to burnout and mistreatment/abuse by staff of elderly residents in care as well as the history of burnout and research related to burnout experienced by staff working in care facilities.

Chapter 2: Literature Review

The effects of burnout on staff and the care they provide to clients has been a subject of many studies in the past, including research specific to the elderly population (Andela et al., 2018b; Hall et al., 2016; Hen et al., 2012; Neuberg et al., 2017; Shin et al., 2014). However, most of this research has focused on the generic treatment of clients and has not addressed specific types of mistreatments resulting from burnout. Many studies have linked burnout to mistreatment, including abuse and neglect, and several studies have linked burnout to neglect (Hall et al., 2016; Shin et al., 2014). Conversely, very few researchers have studied only burnout and neglect of elderly residents in care as a separate type of abuse or mistreatment. Many of the previous studies have identified mistreatment, abuse, and neglect categories as one entity in the research (Hall et al., 2016; Shin et al., 2014). The purpose of this qualitative study was to explore how staff burnout can result in the neglect of elderly people who are receiving care in a residential care facility.

I begin this chapter with a review of how the literature was found. The next section details the literature related to Maslach's theory of burnout. This is followed by a review of the literature addressing burnout and its effects on staff and the mistreatment of elderly residents, including neglect. Lastly, I conclude this chapter with a review of the current literature and the gaps. I justify the need to research the effects of staff burnout and how it directly links to the neglect of elderly residents in care.

Literature Search Strategies

Literature articles and books for this study were found through various Walden University database resources. The databases used included PSYCH Info, ScienceDirect, Sage Journals, and Thoreau Multi-database search. Publication dates for the literature reviewed were between 1970 and 2020. Selected articles revealed a need for research in the field of neglect by staff members who have experienced burnout from their job when it comes to elderly people in residential care facilities. Several articles have addressed elderly abuse and neglect as well as burnout in staff, but little research addresses only neglect and the connection to staff burnout. Keyword searches included *elderly, elder, mistreatment, direct care staff, abuse and neglect, neglect, staff, burnout, nursing home, healthcare,* and *residential care setting.* The articles selected that are older were based on relevance to the topic and Maslach's theory of burnout. Other articles were selected based on relevance to the topic and the current literature.

Theoretical Foundation

There is no standard or universal definition for burnout. The average person believes burnout to be an individual-level issue, meaning that the person who puts too much pressure on themselves or strives to do too much will burn out (Maslach, 2003a). Research has suggested that burnout is much more than an individual; it includes interpersonal or institutional characteristics as well (Maslach & Leiter, 1997).

Research into burnout began in the 1970s. The concept of burnout was introduced by Freudenberger (1974), who first researched burnout as a lack of motivation and a loss of emotional connection to an individual who is providing care to another in a healthcare

or human service setting. In the latter 1970s and into the 1980s, Maslach (1998) followed this by looking more deeply into burnout and the emotional stressors that cause it. Maslach also assessed the impact burnout has on the staff members who are working in the healthcare and human services' field. Maslach's theory of burnout was the theoretical foundation for this study.

In her early research on burnout, Maslach (1978) focused on the relationship between caregiver and client. Maslach found that a difficult relationship between the caregiver, and the client could lead to burnout. She noted that this was a result of the client's diagnosis, symptoms, behaviors, reactions to staff, and the agency rules about client and staff relationships. Maslach found that these factors impacted the quality of care given by the staff to the client. Maslach explored how a staff member and client relationship was impacted by burnout, including how it led to a decreased quality of care.

Over the last 40 years, Maslach has strengthened the research and understanding of burnout. Over the years, more systematic ways have been developed to research burnout and its impact. This has been done through a series of quantitative data collection with surveys and questionnaires (Maslach et al., 2001). Through this, the Maslach Burnout Inventory (MBI) was created and used in research. The MBI is used to measure burnout in staff in the healthcare and human services setting (Maslach & Jackson, 1981).

Maslach and Jackson (1981) described burnout as having three dimensions: emotional exhaustion, depersonalization, and reduced personal accomplishment. Emotional exhaustion is a state in which staff members' emotional resources are depleted, and they start to feel like they can no longer give themselves fully to the job and

the client (Maslach & Jackson, 1981). The staff member feels strained in their work and unable to complete the tasks or do everything as expected of them. Emotional exhaustion is the initial response that an individual has to the stressors in their job (Leiter & Maslach, 1999). Research shows that staff report this as the most common of the three dimensions of burnout (Maslach et al., 2001). Emotional exhaustion can lead to staff becoming depersonalized or detached from their work (Maslach, 2003a).

The second dimension, depersonalization, occurs when a staff member feels negatively about their job and may lead to the development of cynical attitudes and feelings toward their clients (Maslach & Jackson, 1981). This can lead to the staff being indifferent in their day-to-day work, their job duties, and tasks (Maslach & Leiter, 1997). Consequences of depersonalization include a lack of caring in the staff for their own well-being or the ability to carry out job functions, including the job function of caring for another individual (Maslach & Leiter, 1997). Depersonalization creates indifferent attitudes among staff members and can affect their ability to do their work. A consequence of depersonalization is that it can result in neglect for patients.

The final dimension of burnout is a lack of personal accomplishment. A staff member experiencing a lack of personal accomplishment may feel dissatisfied and unhappy about their work and negatively about themselves in regard to the work with the client (Maslach & Jackson, 1981). If an individual is emotionally exhausted, they may feel they cannot work efficiently, and this leads to a lack of personal accomplishment (Maslach et al., 2001). An overdemanding work environment can lead to exhaustion or cynicism related to the job. This can cause the staff to feel less effective or not at all

effective in their work (Maslach et al., 2001). All three components of Maslach's theory of burnout need to be present for someone to experience burnout.

Currently, the most commonly used definition of burnout is a condition that is composed of emotional exhaustion, depersonalization, and the lack of personal accomplishment (Maslach & Jackson, 1981). The combination of these three aspects in a worker's life is what causes staff members to burnout. The demands of the job are what led to emotional exhaustion (Maslach, 2003b). This is when a staff member feels emotionally and physically stressed (Maslach & Leiter, 1997). The first response to a stressor in a worker's job is the emotional exhaustion component (Maslach & Leiter, 1997). Researchers have shown that individuals report more emotional exhaustion than the other two dimensions; thus, making this domain the most analyzed of the three (Maslach et al., 2001). However, this does not mean that this one piece of burnout defines burnout (Maslach et al., 2001). Emotional exhaustion, in turn, leads to detachment from personal identity due to the stresses and strain from work (Maslach, 2003a). The result of detachment leads to a reduction in personal accomplishment (Maslach, 2003a).

The second dimension of burnout is depersonalization. This refers to an individual's reaction of distancing themselves from their work to prevent further emotional exhaustion (Maslach & Leiter, 1997). Those that are more emotionally exhausted display more depersonalization in their day-to-day job duties (Maslach et al., 2001). As an individual develops increased depersonalization, they will be less able to engage in the demands of their job, less willing to help others, and will distance themselves from their clients (Maslach et al., 2001). The individual who portrays this

negative attitude often finds it easier to care less (Maslach & Leiter, 1997). The consequences of depersonalization towards their work affected not only their personal well-being but also their ability or inability to carry out the requirements of the job (Maslach & Leiter, 1997).

The third dimension of burnout is a lack of personal accomplishment (Maslach & Leiter, 1997). Growing unhappiness with work leaves individuals feeling inadequate. This, in turn, can lead to feeling less accomplished and the individual becoming more overwhelmed with the demands of work (Maslach & Leiter, 1997). Researchers have suggested that the relationship between lack of personal accomplishments to the other dimensions of burnout is complex (Maslach et al., 2001). In some instances, inefficacy arises due to emotional exhaustion and cynicism; however, in other situations, inefficacy comes in conjunction with emotional exhaustion and cynicism (Maslach et al., 2001). Thus, exhaustion by itself is not burnout.

These three dimensions are the components of the stress response that ultimately lead to burnout (Maslach, 2003a). Inefficacy results from an individual's inability to access resources to assist with their personal needs and to feel effective, whereas emotional exhaustion and cynicism result from the demands of work and conflicts with the social environment (Maslach et al., 2001). Maslach's theory was applicable to this study because it helped identify the connection between staff burnout and the neglect of elderly residents in their care.

Burnout

Early burnout research explored the mental health aspects of burnout for someone working in the human services' field. Over time, researchers began to investigate the complexities of the relationship between staff and client (Maslach et al., 2001). The severity of the client's symptoms and issues, the client's prognosis for a cure, and the organizational rules all affected the staff and client relationship, which then impacted burnout rate (Maslach, 1976).

Over the last 40 years, research into burnout has evolved to include other occupations outside of the human services' field as well as a wide variety of populations. This has provided a more unified approach to the study of burnout. A major contribution to the study of burnout is the use and development of a systematic approach. This includes the use of collecting quantitative data through surveys and questionnaires (Maslach et al., 2001). One of the major contributions to the study of burnout was the development of the MBI (Maslach & Jackson, 1981). There are currently several versions of the MBI that can be used in the measurement and study of quantitative data related to burnout. The MBI-GS is a general survey related to any profession; the MBI-HSS is used specifically for the human services' field, and the MBI-Educators is used to study teachers (Maslach, 2003a).

Many researchers currently use a multidimensional model when they are investigating burnout. There are six areas of the work-life that researchers use to explain how different staff experienced burnout (Maslach et al., 2001). These areas are workload, control, reward, community, fairness, and values (Maslach et al., 2001). Workload and

control are reflected in the demand-control model of job stress (Leiter & Maslach, 2011); reward refers to the power of reinforcements to shape an individual's behavior (Leiter & Maslach, 2011); the area of community captures all the work on social support and interpersonal conflict; fairness is reflected by research on equity and social justice (Leiter & Maslach, 2011); and values represent the cognitive-emotional power of job goals and expectations (Leiter & Maslach, 2011).

In terms of work-life, individuals in the human service field often have difficulty separating their work from personal lives (Leiter & Maslach, 1999). Work–life balance is critical to the individual but to organizations as well. Working long hours, doing multiple tasks at once, and taking on additional duties can create exhaustion and overload (Maslach & Leiter, 1997). Work overload occurs when an individual lacks the required skills or understanding to perform specific types of tasks (Maslach et al., 2001). This also occurs when a caregiver is overworked with too many cases and not enough resources, time, or help to complete their tasks. Due to the emotional aspect of the job, which results in individuals having to "display emotions inconsistent with their feelings" (Maslach et al., 2001, p. 414), providing care for others can contribute to overload. In relation to the three dimensions of burnout, workload is linked most evidently to emotional exhaustion (Maslach et al., 2001).

It is impossible for an individual to have control over every area of their work. However, having little or no control can be detrimental to staff productivity (Maslach & Leiter, 1997). A reduction in personal accomplishment is often caused by an individual's mismatch in control. This can result from insufficient resources or the ability to carry out

the job (Maslach et al., 2001). A worker wants to have some control over how they do the job (Maslach et al., 2001). Control is also affected by individuals losing a sense of independence in their work (Leiter & Maslach, 2001), and a loss of control has been linked to increased emotional exhaustion.

Reward can refer to extrinsic rewards such as financial compensation or intrinsic rewards such as recognition (Maslach et al., 2001). Insufficient reward refers to the lack of compensation an individual receives for the job they do (Maslach et al., 2001). The reward element is closely associated with a reduction in personal accomplishment (Maslach et al., 2001). Factors such as economic instability mean that organizations sometimes struggle to reward individuals in compensation of salary, which means that individuals do more work and receive less reward (Maslach & Leiter, 1997). A reward within the job for a caregiver can be many things. One of the major ways a manager or supervisor can reward their employees is by acknowledging that they are doing well in their job tasks (McCormack & Cotter, 2013). Reward can also come from feeling a sense of accomplishment in the job and being challenged with its duties (i.e., stimulating and changing; McCormack & Cotter, 2013).

An individual succeeds in their work environment if that environment fosters a sense of community (Maslach et al., 2001). A loss of community occurs when individuals are enduring struggles with others at work or through a sense of isolation. In recent years, this feeling has been heightened as employees interact less with people and more with technology (Maslach et al., 2001). The connection between what the individual's expectations are in regard to social supports and the actual social supports available to

them is directly related to burnout (Leiter & Maslach, 1999). Support from a manager has been connected to exhaustion in workload (Leiter & Maslach, 1999). Peer support has been linked to personal accomplishment and efficacy (Leiter & Maslach, 1999).

Fairness in an organization refers to the respect, trust, and openness an employee perceives to contribute to a fair work environment (Angerer, 2003). If an individual does not feel like they are being treated fairly or equally by the organization, they experience distrust and stress (Angerer, 2003). Inequitable pay or workload, cheating, or favoritism given within an organization are all examples of a lack of fairness in the work environment (Maslach et al., 2001). Ineffective procedures to resolve grievances and disputes also lead to unfairness (Maslach et al., 2001).

An inconsistency in what an organization does and an employee's ethical values, often lead to conflicts with the individual and the job (Maslach et al., 2001). For instance, an organization's actual work practices may differ greatly from their mission statements, or customer service is neglected to increase profits. This leads to a conflict for the employees (Angerer, 2003; Maslach et al., 2001). The employee's values and work ethic are compromised by the "short-term survival-and-profit value system" some organizations employ (Maslach & Leiter, 1997, p. 55). Conflicting values between employee and organization leads work to be unsuitable (Leiter & Maslach, 1999). When a caregiver does not believe in the mission or vision of the agency, the caregiver can feel they do not belong. Another conflict can arise when an organization does not value the care of someone over the dollar amount or the numbers. It can put a strain on the staff member, making them feel they are not suited there. This contradiction leads to

exhaustion, cynicism, and reduced personal accomplishment (Leiter & Maslach, 1999). Research has shown that the area of values plays an important mediating part in the other five areas, as it is associated with all three dimensions of burnout (Maslach et al., 2001). A conflict in values, therefore, may lead to conflicts in other areas of work life.

A mismatch in any of these areas with staff can cause staff to burn out. Conversely, when there is more alignment in these areas between staff and organization, employees have a more positive work engagement and work-life (Leiter & Maslach, 1999). It may not be feasible to expect a "perfect fit between person and job" in all areas of work-life; however, a "balance between mismatches is what's most critical" (Maslach & Leiter, 1997, pp. 151–152). Burnout is not a specific flaw in the person, but rather burnout is a combination of the individual characteristics, personal characteristics, and institutional characteristics (Maslach, 2003b).

Consequences of Burnout

Job stress is a mediating factor in the manifestation of the burnout syndrome (Maslach & Leiter, 2008). According to the National Institute for Occupational Safety and Health (NIOSH, 2009), recent surveys have indicated 40% of workers felt their job was very or extremely stressful, and 26% reported being burned out by their jobs. Maslach's three dimensions have been researched extensively and have been the foundation for the concept of burnout most studied to date (Maslach et al., 2001).

Burnout has been linked to numerous mental and physical health issues such as anxiety, decreases in self-esteem, depression, feelings of vulnerability, irritability, headaches, backaches, lethargy, insomnia, as well as gastrointestinal difficulties (Shin et

al., 2014). Moreover, behavioral symptoms emerge in response to burnout, such as absenteeism, poor job performance, staff turnover, depression and anxiety in the workplace, decreased job satisfaction, and depersonalization (Shin et al., 2014). Previous research has shown that burnout has a direct connection to poor job performance, lack of work commitment, low job satisfaction, and higher turnover (Shin et al., 2014). When a staff member is not fully committing to their work or their job, it can lead to mistakes and a lack of follow-through on duties (Shin et al., 2014).

The cost for organizations as a result of burnout, including employee turnover, advertising new positions, training for new hires, worker's compensation benefits, sick leave, employee mistakes, employee theft, fraud, as well as health-related expenses, has been estimated annually to exceed billions of dollars (Maslach & Leiter, 1997; Shin et al., 2014).

Hall et al. (2016) conducted a systematic review of healthcare staff burnout and patient safety and concluded that there is a link between staff burnout and patient safety. Over the last several years, the health care field has seen an increase in job dissatisfaction, turnover, and stress/burnout of staff (Rosenstein, 2017). These negative emotions in staff are leading to a negative impact on their job and the patient outcomes of care (Rosenstein, 2017). When a staff member is unhappy, and their job is impacted negatively, the work they produce is less than adequate, and can lead to abuse and neglect.

Due to the intense and demanding nature of the work, staff experience negative emotional consequences and there is a shift in the way they view others, an inability to

see the positive side of individuals suffering from problems, and an increase in emotional detachment (Maslach, 2003). All of this can lead to a person having a lack of emotional attachment to their job, and it causes them to start to neglect their job. When staff members lack emotional attachment, they are more likely to mistreat their clients. This is a severe and growing issue for the elderly who are receiving care (Andela et al., 2018a). In fact, the WHO (2016) reported that an average of one-in-six elderly people are being abused.

Abuse in the Elderly Population

Elder abuse in institutions constitutes a serious public health problem. It has long-lasting, negative consequences for both the abused and the abuser. The study of elderly abuse is also particularly important because of the increasing number of older people in the United States. The United States Bureau of Census (2010) noted that there were 40.3 million people 65 years or older, which represents an increase of 5.3 million over the 2000 census results. Persons 75 to 84 years old represented 13.1 million people of the population. In the United States, 32.4% of the population are persons 65 years and older. Older adults of age 85 to 94 numbered 5.1 million, which made up 12.6% of the population 65 years and over. Finally, older adults aged 95 years and over were reported to number 425,000 persons, or 1.1% of the older adult population (United States Bureau of Census, 2010). There is a drastic increase in the number of older people in the United States, directly leading to a drastic increase in the need for elderly resident care. The elderly population in the United States is increasing more rapidly than any other age group (Centers for Disease Control and Prevention [CDC], 2016). More specifically, the

CDC (2016) predicted that by 2030 one-in-forty-eight Americans would be age 65 or older. Furthermore, the CDC noted that one-in-ten elders would experience abuse.

Elder abuse is defined as an "intentional act, or failure to act, by any person in a relationship who violates an expectation of trust that causes or creates a serious risk of harm to an older adult" (CDC, 2016, p. 195). Over time, the definition of elder abuse has expanded to include five types of abuses (defined further below): (a) physical, which includes acts carried out with the intention to cause physical pain or injury, (b) sexual assault, (c) emotional or psychological abuse acts carried out with the intention of causing emotional pain or injury, (d) material exploitation, involving the misappropriation of the elder's money or property, and (e) neglect, or the failure of a designated caregiver to meet the needs of a dependent older person (WHO, 2016). In 2016, the WHO labeled elderly maltreatment as a set of repetitive actions that arise in situations where trust is broken through acts that cause emotional and physical harm to the individual.

Of the five types of elder abuse, physical abuse is the most measured mistreatment type (WHO, 2016). Physical abuse is defined as "one or more events within a designated prevalence period" (WHO, 2016, p.196). The WHO (2016) found that elder physical abuse rates were as follows: Canada (0.5%) and the United States (1.4%) reporting the lowest prevalence rates of elder physical abuse, followed by Europe (1.67%).

Sexual abuse is a more difficult type of elder abuse to measure, as many studies have incorporated their own set of screening questions to determine elder sexual abuse, as

a result, there is less consistency with this aspect (Pillemer et al., 2016). Sexual abuse was reported as the lowest in Nigeria (0.04%), followed by the United States (0.5%), Mexico (0.8%), and Europe (1.0%).

Similarly, emotional and psychological abuse can be difficult to measure as it can be subjective. The Conflict Tactic Scale (CTS) addresses emotional and psychological abuse and is the most common tool used to measure this type of elder abuse (Pillemer et al., 2016). Generally, emotional and psychological abuse is defended as being ten or more emotional or psychological events within a year. India reported high emotional abuse (10.8%), whereas Canada (1.4%), United States (1.5%), and Europe (2.9%) had lower mean rates (Pillemer et al., 2016).

Standardized tools have been unavailable to screen for elder financial abuse, and studies have been inconsistent with their definition of financial abuse and their timeframe for measurements. Studies are inconsistent in how many incidents qualify as financial abuse; some studies feel it is one incident; other studies feel it needs to be several incidents (Pillemer et al., 2016). Financial abuse is one of the most prevalent forms of abuse; Nigeria and Israel reported the highest rates of financial abuse at 13.1% and 6.4%. Mexico had the lowest prevalence of financial abuse (2.6%), whereas mean rates across Europe (3.8%), and the United States (4.5%) fell in the middle (Pillemer et al., 2016).

While there are several methods to determine neglect against a client, very few studies actually utilize any of these standardized methods (Pillemer et al., 2016). There was also inconsistency in studies as to what quantifiably defined neglect. While some studies would define it as one incident, others defined it as ten or more incidents within a

year (Pillemer et al., 2016). The lowest rates of neglect were reported in Canada (0.4%), Europe (0.5%), and the United States (1.1%). India reported the highest neglect prevalence (4.3%) (Pillemer et al., 2016).

Research also reveals that elder abuse and maltreatment are often passed over or forgotten when compared to other forms of abuse, such as child or domestic abuse (Biggs & Haapala, 2013). With the elderly population, a major factor to their health and well-being is dependency. As their level of independence decreases, it increases the dependence of the elderly individual; therefore, increasing the need for care and the risk for cases of elderly abuse (Dong et al., 2013).

Social concepts such as social status, living arrangements, and physical condition are factors that may escalate or lead to the abuse of elderly individuals (Burnes et al., 2016). As people continue to get older, so do the chronic illnesses that plague them. This then increases the chances for more cases of abuse to occur, because many of these elderly individuals become dependent in their day-to-day activities (Fraga et al., 2014). Results of several studies have shown that those in the elderly sector of the population are at a higher risk of illness, and the loss of physical ability needed for everyday living. This creates a relationship of dependency between the elderly individual and the staff (Halvorsen et al., 2017). Therefore, by creating this need for dependency, there is an increase in the likelihood that they will be victims of abuse or neglect. Andela et al. (2018b) determined that elderly abuse consists of two components: neglect and abusive behaviors. Their conclusion is different from most other studies because they differentiate neglect from other forms of collective abuse.

Burnout is considered one of the main causes of elder mistreatment (abuse and neglect) in nursing homes (Neuberg et al., 2017). Kandelman et al. (2018) conducted an observational survey to study burnout in nursing home caregivers. This survey was used to quantify burnout level (MBS) and potential risk. One of the aims of their study was to assess the risks of burnout for nurses working in the nursing home care setting. The study's results showed that 29% of caregivers had high scores on emotional exhaustion, and 18% had high scores on depersonalization items, and the burnout rate was 40% (49 participants out of 124), which indicates that burnout is present at high rates in nursing home staff. While Kandelman et al.'s study used the MBI and theory of burnout, it was different from this current study, which is qualitative and looks at the correlation between burnout and neglect.

Elder abuse is also predicated on several individual-level risk factors. Each of these risk factors can make an elderly individual more susceptible to abuse or neglect. This high-level individual risk-factor includes functional dependency and disability, poor physical health, cognitive impairment (dementia), poor mental health, and low income (WHO, 2016). These risk factors put elders at a higher risk of being a victim of abuse.

There are several direct links between the risk factors and each of the types of abuse. Across several studies, it was found that the greater the elder adult's dependence or disability, the greater the risk was for elder abuse, specifically emotional and financial (WHO, 2016). Poor physical health was consistently associated with elder abuse across almost all counties. It was directly related to financial abuse and neglect in the United States and Canada (WHO, 2016). Due to ethical limitations, many studies do not include

elderly clients with dementia or cognitive impairments. However, of the few that included them, there are high rates of abuse and neglect within elderly populations who have cognitive impairments or dementia (WHO, 2016). Significant physical or cognitive impairment in combination with an inability to speak up for themselves or fear of retaliation was found to place older people in vulnerable situations (Taylor et al., 2014). Low income and the ability to afford quality health care is directly related to abuse and has been known to predict neglect in the United States (WHO, 2016). Several risk factors can put an elderly person at greater risk for abuse and neglect when in care.

There are also several strong risk factors that a perpetrator or abuser can possess that would make them more likely to abuse, or that would put the elderly person at a greater risk of being abused. These risk factors for abusers include mental illness, substance use, and abuser dependency (WHO, 2016). Having poor mental health or a psychological disorder, specifically depression or anxiety, is very common in elder abuse perpetrators. In the US, studies have found that caregiver depression is predictive of physical abuse (WHO, 2016). Drug and Alcohol abuse and misuse have been linked to elder abuse, most commonly, financial and verbal abuse (WHO, 2016). When an abuser experiences these different types of risk factors, they are more likely to engage in elder abusive and neglectful behaviors.

Elderly people who are abused will, on occasion, refuse to report the abuse or mention it. Taylor et al. (2014) found that participants perceived the vulnerability of elder people directly relating to the need for help and support and found that standing up for themselves might have repercussions for the person's health or safety. They found that in

some cases, elderly persons felt a lack of respect by the younger generations, including grandchildren. Taylor et al. concluded that participants felt very different about abuse within the family versus abuse within a care setting. Participants in that study noted that people who were living in the care of their own family and were being abused by them were refusing to disclose this abuse. Participants noted that elders were reluctant to report because they did not want to hurt their loved ones and family members, or get them in trouble. Taylor et al. also noted that many participants stated that the abuse happened gradually and over time, and that many of these participants did not see the abuse as abuse.

Copper et al. (2018) completed a quantitative study in the United Kingdom using the Modified Conflict Tactics Scale and the MBI. This study focused on person center services and the abuse and neglect taking place in elderly care homes. They found that while staff in these residential homes reported positive care behaviors in the care setting, many reported that there was an infrequent use of person-centered approaches. Copper et al. did not distinguish between witnessing the abuse/neglect or being the perpetrator. Copper et al. showed that many staff in residential care settings are witnessing or experiencing abuse and neglect, and that it is linked to burnout. Which is what this study is aiming to do with witnessing or perpetrating neglect. Being able and willing to stand up for oneself was also relevant in determining if elderly clients had felt they had been a victim of elder abuse. It is important to recognize that older people may fear being ostracized, criticized, rejected, or mocked if they speak out. This also leads them to be more vulnerable and susceptible to abuse and neglect.

Neglect in the Elderly Population

In a recent study by Cooper et al. (2018), focusing on 92 nursing homes through the United Kingdom, researchers found that some abuse or neglect was reported in all but one. Neglectful behaviors were most common, and very few care home workers reported actual or threatened physical abuse. Abuse that impacted the older person's emotional well-being was deemed the most damaging (Taylor et al., 2014). Neglect is defined as "the intentional or unintentional failure to provide basic living conditions and necessary care and attention" (Neuberg et al., 2017, p. 190). In residential care settings for the elderly, neglect comprises withholding of necessary food, clothing, and medical care to meet the physical and mental needs of an elderly person (Andela et al., 2018b). Unintentional neglect results from an inability to provide care, whereas intentional neglect occurs when staff deliberately fail to fulfill their expected care responsibilities (Andela et al., 2018b).

A study by Andela et al. (2018b) examined neglect and abusive behaviors by considering caregiver burnout and the work context of these professionals through the Job-Demands-Resource Model. They found that emotional demands and poor-quality relationships with colleagues and team supervisors were the most predictive variables for caregiver burnout, neglect, and abusive behaviors among the elderly. Using the Demands-Resource Model, the study correlations indicated that high job demands and lack of organizational resources was associated with a higher risk of neglect and abusive behaviors; caregivers who are overwhelmed and exhausted often adopt an indifferent or a distant attitude toward their clients.

Neglectful incidents can range from not responding in a timely way to a call from a patient alarm to clients getting pressure and bedsores and medication errors (Wangmo et al., 2017). Wangmo et al. (2017) conducted a qualitative analysis with 23 nurses at an elderly residential facility in Switzerland. They found that the participants saw little to no abuse in their careers. However, the participants noted witnessing neglectful incidents on more than one occasion. Their study noted neglect as the most common form of mistreatment against clients, but there was no link to what might have led to this neglect. The study still looked at every other form of mistreatment and abuse.

As noted previously, several studies have looked at the connection between burnout and elder mistreatment, and several studies have examined elder mistreatment, but little has been done on the individual types of mistreatment. Castle et al. (2015) conducted a systematic review of literature related to elder abuse in a residential setting and noted that publications varied in their use of the terms, with many using maltreatment, mistreatment, and neglect as synonyms for abuse, and others using the terms in more specific ways. This is further complicated by the fact that there are many types of abuse and mistreatment, and neglect may be one of them, but it is not necessarily the same as other forms. Therefore, there is a need to research neglect as a consequence of burnout individually. This systematic review found that many studies examined all types of abuse. Some studies focused on one type of abuse, while other research has focused on the causes of abuse. Limited research was found that connected staff burnout and neglect together (i.e., one type of abuse and the cause). My study looks at addressing

this gap in the literature by looking at burnout as a cause of neglect and the correlation between them through a qualitative analysis.

A comprehensive review by McDonald et al. (2012) of current literature highlights gaps in the knowledge. When surveyed, this study found that over 70% of staff reported that they had at least once acted in an abusive or neglectful way. Psychological abuse and neglect were the most common forms reported by over 50% of the caseworkers. Approximately 70% of staff reported they had observed at least one incident of abuse or neglect by their coworkers. In the in-depth interviews, 70% of nursing staff reported that they had engaged in one incident of abuse or neglect, and 77% had witnessed one or more incidents. Within this study, they found that 95% of residents said that they had either experienced neglect or witnessed the neglect of other residents. This is important as this is a large number of people who have both engaged in and witnessed abuse or neglect in a facility. The data in this study shows that neglect is taking place at alarmingly high rates. It is important to look specifically at neglect, as this study will do.

Several things can lead to neglect of a resident. Blumenfeld et al. (2017) found that there was no significant relation between verbal or physical aggression of residents on the staff members and neglect by care workers to the residents. Increase in stress due to higher workloads or more difficult residents was associated with an increase in both observed emotional abuse and neglect. In contrast, there was a relationship between nursing care facilities with a better “teamwork and resident safety climate” and lower rates of neglect (Blumenfeld et al., 2017). Blumenfeld et al. (2017) suggested that

neglecting residents could be a strategy for balancing the emotional exhaustion they feel within their work. Emotional exhaustion is one element of burnout, and, according to Blumenfield et al. (2017), it is associated with higher rates of emotional abuse and lower levels of staff tolerance to stressful situations. Emotional exhaustion is part of experiencing burnout for staff members. Therefore, the connection can start to be made between burnout and neglect of elderly clients.

In the Cooper et al. (2018) study, they found that 51% of the staff had witnessed or perpetrated some form of abuse and neglect in the elderly residential home. Within this 51%, neglect was most frequently reported. The most common neglectful incidents included: making a resident wait for care, avoiding a resident with challenging behavior, giving residents insufficient time for food, and taking insufficient care when moving residents. Cooper et al. (2018) also concluded that abusive and neglectful behavior was reported more frequently by staff in residences with higher staff burnout.

Research showed that the intentionality of the perpetrator was important in respondents' views of what was or was not perceived as abuse (Taylor et al., 2014). This implies that elders in care do not always view an action as abusive if the intent behind it was accidental. This can be especially important when it comes to neglect, as it is not always something that is intentional. Burnout can impact the staff member, and therefore, the neglect is unintentional. An action might be regarded as acceptable in order to allow the elder person to continue living at home, while the same action might be regarded as unacceptable if it were done with malice or in another setting (Taylor et al., 2014). This is important because a lack of understanding in medical care can lead to neglect, as well as

an elderly person wanting to live at home and ignoring what mistreatment may be happening to stay in the home. However, it is important to remember that abuse and neglect can happen to an elderly person who is in residential care as well.

Abuse and Neglect in the Elderly Institutional Care Settings

While many studies examine elder abuse and neglect, there is still a lack of adequate analysis that investigates institutional abuse and the risk factors, along with the low reporting rates (Frazão et al., 2015). Myhre et al. (2020) found that there are three types of patient safety issues within an institutional setting for elderly care. These include resident-on-resident abuse, abuse from relatives, and abuse from staff or caretakers. Myhre et al. (2020) did a qualitative exploratory study using focus groups that consisted of 28 nursing home leaders. They found that nursing home leaders saw resident to resident abuse as a normal part of being in a care setting, they saw family abuse as a private matter, and they saw staff to resident abuse as unthinkable. Staff to resident abuse was found to be difficult to talk about by nursing home leaders, and it was viewed as not being in accordance with the trust they had placed in their employees. A leader places trust in their employee to care for the elderly. Trust is also placed on the staff member from the elderly client and their family to care for that patient. By abusing the elderly client, they are breaking this trust. The topic of elder abuse and neglect also feels like a difficult topic to discuss with employees for the leaders in elderly residential settings. Elder abuse and neglect are a large safety issue in residential care settings, and are often overlooked (Myhre et al., 2020). The consequence of nursing home leaders overlooking elder abuse and neglect is that it leaves the elderly open to further abuse and incidents of

neglect. Myhre et al. (2020) found that elder abuse is often overlooked because care managers lack the relevant knowledge and strategies to identify and adequately manage abuse and neglect in nursing homes. This means that incidents may continue to happen, leading to elderly residents experiencing multiple incidents of abuse and neglect. This is an area that warrants further research.

Using forensic medical reports, Frazão et al. (2015) conducted a retrospective study examining elder physical abuse that took place in a residential setting. In their study, they found that 30.5% of the forensic medical reports indicated insufficient staff training or inexperience in patient handling techniques. This is a known risk factor found in this and many other studies for abuse and results in low numbers of staff being able to attend to residents' needs, which in turn leads to excessive workload, stressful work environment, and professionals burning out (Frazão et al., 2015).

Even though there is a consensus within communities that elder mistreatment in institutions exists, little has been done to research the issue (Phillips et al., 2013). Among that, very limited research has been done in the United States. In particular, there is very limited data on the topic in recent years. Phillips et al. (2013) note that "From a scientific perspective, we know almost nothing about mistreatment in residential care facilities, but multiple reports suggest mistreatment is a serious problem" (pp. 20–21). This shows that elders are being mistreated, but there are limited studies, limited reporting of the abuse, and little to no connection to what really causes or impacts the abuse and neglect. Phillips et al. (2013) did a quantitative analysis of mistreatment in elderly residential care facilities (RCF) and determined that physical abuse, and neglect are the two most

common forms of alleged abuse and the two most common forms of substantiated abuse. Physical deterioration was found in 25.5% of the cases involving neglect, and physical deterioration led to increased and more severe health issues. It was also found that citations or violations were the lowest for neglect. The data from this study points to a very serious need for more research in institutional settings, and that neglect is linked to almost all types of abuse and is frequently overlooked.

Understanding why institutional abuse and neglect occur is more critical than understanding prevalence as it will help to expand preventive strategies and promote timely detection and diagnosis of these cases (Frazão et al., 2013). Many studies have looked at what impacts staff and what leads them to commit abuse and neglect. This study address this gap and specifically studies burnout and neglect in elderly residential settings.

Witnessing Abuse and Neglect

As I discussed earlier, violence against elderly populations is widespread. Many staff will witness abuse or neglect while working in an institutional setting. The Blumenfeld et al. (2017) study in Switzerland shows that 50.8% of the participants had witnessed emotional abuse more than once a week within the four weeks before the study, and neglect was observed by 23.7% over the same time period. Witnessing abuse and neglect can have an impact on staff members' well-being. Staff who witness abuses are more likely to become indifferent to the abuse and experience emotional exhaustion, a key component of burnout.

Unfortunately, with that, we know that many people who are witnessing these acts of abuse and neglect among the elderly are not reacting to them (Radkiewicz & Korzeniowski, 2017). Radkiewicz and Korzeniowski (2017) conducted a qualitative study in Poland looking at attitudes of first responders on the violence they witnessed toward elderly people in the care of family. They looked at two methods of coping with the violence they had witnessed: justification for violence and indifference to the violence. They found that the people who had witnessed the abuse and violence against the elder were more likely to take an indifferent approach to it. Their study found that the people witnessing the violence found it easier to be indifferent to what was happening than to try to justify what had happened or why (Radkiewicz & Korzeniowski, 2017). With an indifferent attitude toward the abuse of elderly people, the person witnessing the abuse avoided any personal reaction to it, thus taking them away from further issues or the threat to them (Radkiewicz & Korzeniowski, 2017). This final point is closely connected to burnout, as a key component of burnout is depersonalization. When a member of staff becomes depersonalized, they take an indifferent approach to the job, and the Radkiewicz and Korzeniowski's (2017) study revealed that people witnessing abuse are doing the same. We can therefore start to make the connection that witnessing abuse can also lead to burnout as it can cause the person to take an indifferent approach to the abuse happening.

Staff Issues That Impact Abuse and Neglect

There are several issues staff may encounter or experience, and each will have an impact on how they treat clients and the possibility of them abusing or neglecting these

clients. Wangmo et al. (2017) conducted a qualitative analysis and found that institutional factors relating to abuse, and neglect include: stressful work situations, lack of care personnel, and poor team culture. Each of these factors impacts the overall institution and the ability of its workers to do their job. Ultimately, these things can lead to the increase of abuse and situations of neglect because the staff in these institutions are not equipped with enough resources, including enough educated staff, for the job to be done well.

With regard to staff, there are both macro and micro issues that impact the care of elderly people. Wangmo et al. (2017) found that on the macro-level of the institution, there were several factors that result in abuse and neglect. These factors included a very demanding, stressful work situation, a lack of work personnel, and a work environment that does not match the general abilities of its patients. For example, older patients are generally slower and need more time to complete tasks, but the staff work in an environment that demands an efficiency, speed and often entails high stress. Participants noted that staff had many responsibilities that they must fulfill, including medically relevant care responsibilities and non-medical roles as care providers, and it was difficult to keep up with all of them. If a staff member could not keep up with those demands, or they felt they were not doing a fast-enough job, or they started to become stressed, then they began to feel emotionally exhausted. If they were responsible for several things, including medical needs, then they became overwhelmed and either forgot to do a task or did it quickly, without thinking it through fully, and, therefore, there was a high chance of a neglectful incident occurring.

Castle et al. (2015) noted in their review that in regard to the problem of under-reporting of abuse, staff are often unable to detect abuse because of a lack of education and/or training. Staff training plays a crucial role in reducing the number of elder abuse victims in residential long-term care facilities. At the micro-level of the caregiver, several participants mentioned that abuse and neglect incidents were more often done by care providers who lack experience, as well as caregivers who do not have education or training (Wangmo et al., 2017). A few participants in the Wangmo et al. (2017) study noted that caregivers who abuse and neglect generally do not know their personal limits, and therefore, do not know how to control their behaviors when they become overwhelmed. Participants in this study described individuals as lacking critical thinking; they are often unable to understand what the correct thing to do is regarding the medical treatment of the client (Wangmo et al., 2017). In this case, a lack of education and understanding of proper medical needs and treatment can lead the staff to be unable to adequately care for the elderly patient. Workload, emotional demands, and low-quality relationships with colleagues and team supervisors were directly related to caregiver burnout, as well as to a higher risk of abuse and neglect toward the elderly (Andela et al., 2018b). Job demands and a general lack of organizational resources are also highly related to elderly abuse through burnout (Andela et al., 2018b).

Studies in nursing homes have emphasized the importance of high-quality relationships among the different health care professionals in the prevention of caregiver burnout and elderly abuse (Andela et al., 2018b). These studies differ from the current study as my study will be a qualitative study using the Maslach Theory of Burnout. It

focuses on the neglect of a caregiver and not abusive behaviors. This study links burnout to the neglect that is happening in elderly residential settings.

Burnout and the Impact on Services Provided

Burnout and its impact are measured well through a qualitative analysis, as it allows for the best understanding of incidents taking place. Neuberg et al. (2017) conducted a quantitative study in Croatia looking at burnout syndrome and its association with mistreatment, abuse, and neglect in nursing homes using a questionnaire. The burnout syndrome was assessed in 171 nursing professionals using the MBI for Human Services Survey (MBI-HSS). High emotional exhaustion was reported by 43.9%, high depersonalization by 22.2%, and low personal accomplishment by 39.8% of the respondents. During this study, they found that 39% of caregivers witnessed ignoring a resident when they called, and 38% witnessed a caregiver neglecting to turn or move a resident to prevent pressure sores. This indicates that neglect is taking place in staff who are burnt out. However, it is still considered to be neglect under the scope of mistreatment and abuse. This current study address that gap through a qualitative studying using thematic analysis.

Thematic Analysis in the Research

When researching a sensitive topic, especially one that requires disclosure and discussion, qualitative thematic analysis is beneficial in identifying themes and patterns. This type of method allows for a deep understanding of the factors that surround abuse and neglect (Wangmo et al., 2017). It allows the researcher to be able to view people's ideas and experiences too. Several research articles on the topic of elder mistreatment and

abuse use a qualitative thematic analysis. Agunbiade (2019) used a thematic analysis to examine physical abuse and neglect, as well as prevention strategies in Nigeria. This study used 16 focus group discussions, as well as six semistructured interviews. They did identify that care denial, and emotional distances were two of the more common forms of neglect mentioned by elderly participants. They also identified reasons why elderly people believe they are more vulnerable to this type of abuse and neglect, including the lack of any formal legal or religious intervention that would protect older people against abuse and neglect (Agunbiade, 2019).

Using thematic analysis, abuse and neglect toward older patients was deemed unacceptable and participants in studies recognized that abuse and neglect happen frequently, especially neglect (Wangmo e. al, 2017). With qualitative thematic analysis, researchers are able to provide a comprehensive picture of circumstances that surround the abuse and neglect of elderly clients (Wangmo et al., 2017).

When researchers use a qualitative approach and thematic analysis, they are able to get detailed explanations from participants. This allows for a more thorough understanding of the topic. Taylor et al. (2014) conducted a thematic qualitative study using focus groups with 58 elderly participants in Ireland. They explored how older people conceptualize elder abuse. In this study, the researchers could take a deep look at the reasons the elderly feel they are abused and why they may not disclose information. After using a qualitative thematic analysis, several themes were identified, which allowed the authors to gain an understanding about elder abuse in families and how elderly people view the abuse against them. This qualitative study utilized semistructured interviews and

a thematic analysis in order to provide a better understanding and exploration of how burnout is connected to elder neglect.

Summary

Elderly abuse is a serious social problem that is worldwide in its severity. It affects millions of lives in the caregiver and elderly populations, as well as their families. While there is literature on elder abuse and burnout, there is limited research that makes the connection between the neglect and burnout. Elderly abuse consists of two components: neglect and abusive behaviors. Limited research explores the differences of the two as separate entities. Both institutional abuse and neglect committed by professionals still lack proper analysis of their risk factors (Andela et al., 2018a).

Elderly people living in a residential setting have become a high-risk group for abuse (Buzgová & Ivanová, 2009). Nursing care of elderly people and their care standards within residential facilities must be based on professional ethics. Those in institutional care have the right to dignified care and to participate in making decisions about their own lives (Buzgová & Ivanová, 2009).

DeDonder et al. (2016) explained that it was also essential to classify the type of abuse as there are different types of abuse, such as frequent and one-off situations of abuse. According to Dong (2013), one-in-ten elderly individuals will experience abuse. In addition, elder abuse is estimated to have only a small percentage of cases reported, which increases the difficulty of adequately being able to study elderly maltreatment (Dong, Chen, Chang & Simon, 2013). With the consequences of burnout so high, it is

imperative to obtain a greater understanding of the concept of burnout and the connection with the abuse and neglect that is happening.

As the population increases and, therefore, the elderly population also increases, it is more important than ever to understand burnout and its impact on the neglect of those in care. Residents in care deserve the best care. By understanding this and looking at the connection of neglect and burnout, organizations can create and enforce policies to guide their staff and prevent burnout and mitigate neglect. Chapter 3 will present the methodology and research design of this study.

Chapter 3: Research Method

Several studies in the past have examined staff burnout and the abuse and neglect of elderly residents in care (Hall et al., 2016). Negative thoughts and reactions such as dissatisfaction, stress, and burnout of staff may lead to an adverse impact on job performance and the outcomes of patient care (Rosenstein, 2017). However, there is a need for research that examines specific types of abuse and neglect because that is where the present gap in the literature is (Hutchison & Kroese, 2015). Burnout has also been explored in several previous studies; however, it is not specifically linked to only neglect. This current qualitative study examines the link between staff burnout and neglect of elderly residents in care facilities, as described by staff who have witnessed the burnout and neglect by their co-workers. Staff who work in high demand human services fields, such as care facilities, have been known to experience significant burnout. That burnout impacts their job and how they treat their clients (Hutchison & Kroese, 2015). In this study, I explored how burnout is connected to the neglect of residents in care.

This study is a qualitative thematic analysis with the purpose of addressing the gap in the current literature on the connection between staff burnout and neglect of the elderly residents in their care. In the subsequent sections, I discuss the following: the research design of the present study, the role of the researchers, sample selection, instrumentation, data analysis, ethical considerations, and the threats to validity.

Research Design and Rationale

The purpose of this qualitative study was to explore how staff burnout features in neglect of elderly people who are receiving care in a residential care facility. I conducted

interviews to gather employee experiences in relation to neglect that took place, and the burnout that the staff may have experienced while they were working in a care setting for elderly people. Whereas other studies have examined burnout and mistreatment, this study addressed the gap identified in the literature as being specifically the neglect of elderly residential clients and its connection to staff burnout (see Hutchison & Kroese, 2015).

RQ: What are the lived experiences of nursing home staff related to burnout before and after witnessing neglect of elderly patients?

The aim of this current study was to gather information on how staff burnout is experienced before and after witnessing the neglect of elderly residents in care through interviews of staff who worked at facilities where neglect took place. This enabled me to explore the burnout staff were experiencing before and after witnessing the neglect and the types of neglect that took place. By interviewing the staff, I explored the types of neglect that took place against elderly residents in care linked to the burnout of staff before and after witnessing the neglect.

Central Phenomenon

The central phenomenon explored in this study is the impact burnout has on staff neglect of elderly residents in care. Maslach and Jackson (1981) defined *burnout* as a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment; it is a reaction to chronic job stress associated with those who work with people in some way. A *residential care facility* is defined as a facility where the elderly live long-term. In this study, *staff member* is defined as someone who works in an

elderly residential care setting and is in direct contact and care of the elderly clients. This could be a nurse, nurse's aide, or direct care staff member. The impact of staff burnout on the care of residents has been studied in the past. This study specifically looked at the impact of burnout on the neglect of residents. Previous research does not separate neglect from other types of abuse and their causes.

Research Tradition

A qualitative study looks at analyzing data that is not numerical. It looks at understanding concepts, experiences, and opinions. This can be done through in-depth interviews and is a suitable methodology for the current study as it focuses on the experiences of staff. This research study looked to explore the connection between burnout and neglect of elderly care through the experiences of direct care staff.

In this qualitative study, I used thematic analysis: a qualitative research method that allows the researcher to identify, organize, and analyze themes that are found within a specific data set (Braun & Clark, 2006). Thematic analysis allows the researcher to organize and describe the data found in rich detail (Braun & Clark, 2006). Additionally, the method allows for flexibility, is quick and easy to learn, is highly accessible, can highlight the similarities and differences in the data set, and can help in developing and informing policy (Braun & Clark, 2006). Another benefit to thematic analysis is that it is not grounded to any other pre-existing framework and can be used within different frameworks, which allows it to be used in different ways (Braun & Clark, 2006). Thematic analysis is a suitable method for exploring experience and perceptions in qualitative reach, which was the aim of this study. The intent of this current study was to

be able to capture the experiences staff members had regarding burnout and the neglect on their elderly residents as a direct result of that.

Furthermore, thematic analysis was suitable for this study as I used an interview approach to speak with staff members. Nine semistructured interviews took place, which allowed the staff an opportunity to discuss their observations and experiences of neglect and burnout in a free flow manner. Interviewees were able to use their own words and their own ideas to formulate answers, allowing for the richest data to be found. Thematic analysis allows the researcher to look at the meaning behind the themes (Braun & Clark, 2006). This is consistent with the research method that this study followed, allowing a better understanding of the connection between staff burnout and neglect.

Data saturation refers to the quality and quantity of the data that are collected in a study. Data saturation reaches its peak when no new information can be collected, or when no new themes can be observed, and the study can then be replicated. The nine semistructured interviews allowed for enough information to be gathered and analyzed. In order to analyze the digital transcripts and mitigate bias, I used NVivo software, which is ideal for researchers doing qualitative studies. NVivo is a qualitative computer analysis software that can be used to analyze and find insights in qualitative interviews. It is ideal for unstructured or structured interviews and can provided a deep analysis on a small or large scale (NVivo, 2021). These qualities made NVivo software the best option for the current study.

Rationale

Other types of qualitative traditions were considered. Thematic analysis fit best for this study. I looked at using interpretative phenomenological analysis (IPA) and grounded theory as they are other methodologies that seek to describe patterns (Braun & Clark, 2006). IPA is used with phenomenological epistemology and is about understanding people's everyday experience of reality. This method does not apply to the current study as I was not looking at personal experiences about which participants ascribe meaning. This study focused on a very specific type of incident (that does not happen every day to them) and their perception of it.

Grounded theory comes in different versions, but its goal is to generate a plausible theory that explains the phenomena grounded in the data; it examines more of a social process than individual experience (Braun & Clark, 2013). Grounded theory would involve a more direct approach from myself, including back-and-forth interviews and observation through data collection and analysis. Furthermore, in this study, I did not seek to develop a new model or theory in the current study. In-depth interviews about experiences were more appropriate for this study to gather data and then code and analyze them.

Role of the Researcher

As the only researcher for this study, I was able to identify patterns and themes that can be used to describe the topic. As I used a semistructured interview method, I developed open-ended interview questions (see Appendix), which enabled the participants to tell their stories and answer questions in their own words and manner. This

also allowed them the freedom to discuss what they want and allow room for additional information to be considered.

As the researcher, I had direct contact with all the participants in this study, and I had no prior relationship with any of the participants. I do have personal experience working in direct care and witnessing staff burnout and abuse, and neglect. This could be considered a bias. However, at no point did I discuss this with the participants, and it did not impact the questions or results. I ensured this by staying on the topic, asking the interview questions as intended, and allowing for the participant to speak and answer freely. My own experiences and information were kept private.

In addition, I kept a personal journal of the interview to ensure that I remained neutral in the process, as well as to ensure that I was able to understand my own emotions and thoughts throughout the interview and data collection process. A possible bias I was aware of was that I previously worked as a victim advocate for disabled people who were abused and neglected at the hands of their caretaker; I know that staff do experience burnout easily, and I know that neglect is taking place by caretakers. However, I know that I have this bias and recognize it, and I did not let this impact the interview process or the analysis.

Methodology

This section will discuss the population selection, how participants were selected. This section will detail out what criteria was required to participate. It will also discuss the instrumentation used for gathering data in this study.

Participant Selection Logic

The main criteria for selection were as follows: (a) participants were currently working or previously worked in direct care of some form with elderly patients in long-term care, (b) participants had to have been working in the area of elderly care for a minimum of 3 years, (c) participants had to have committed or witnessed neglect taking place, (d) participants had to have witnessed or experienced burnout in themselves or co-workers, and (e) this neglect had to have been reported through local procedures.

Instrumentation

Data were collected through semistructured open-ended questions. I utilized social media to recruit participants. All interviews were recorded. Interviews were conducted via video chat. Due to current parameters surrounding the pandemic, all interviews needed to be conducted via video chat, even if participants were local to my current location. By recording the interviews and transcribing them later, I was able to ensure trustworthiness through accurate data collection and information.

I developed several questions to lead the semistructured interview. These included background questions about the participant, questions pertaining to the research question (including information on burnout, neglect), and then the job duties of the participant. Questions are available in the Appendix.

Procedures for Recruitment, Participants, and Data Collection

I recruited all participants through social media by posting my flyer on Facebook, Instagram and Twitter. I conducted searches online and through social media platforms to find direct care workers in the human services' field who have worked with the elderly

residents. I also utilized Facebook support groups for these professions, and I reached out to see whether the "Aging Life Care Association" would send out an email to members, but they did not respond before all requitements were completed.

I asked all interested parties to contact me directly via phone or e-mail. I then asked preliminary questions to ensure that they met the minimum standard of this study and to ensure ethical standards could be met. I ensured that they had been in the field for at least 3 years, had seen neglect of elderly residents, and that it had been reported appropriately. I then worked with them to schedule a time to conduct the 30- to 60-minute interview. Following this, I sent each participant the consent form.

I was in direct contact with all participants throughout the process. I informed them that, if at any time they needed to, they could reach out to me and that I would provide supportive information for resources post-interview. These organizations are listed in the consent form. I informed them that I may need to contact them again for clarifying information, follow-up, or member checking. I also informed them that they could withdraw prior to data collection if they needed to. I provided a timeline for the study and a summary of the findings once they are completed if they wish.

Data Analysis Plan

By using thematic analysis, I was able to code the data into themes, and I could understand the impact of staff burnout on neglect. I conducted nine semistructured interviews. I recorded all interviews. I also took detailed notes from the interviews as well as kept a journal. This allowed me to have the best data set possible and organize my

data into patterns (Braun & Clark, 2013). Using NVivo software helped me to analyze the transcribed data into themes and to eliminate any bias.

For thematic analysis, Braun and Clark (2006) offer a six-step phased process that includes six phases used to define the themes in the data: (a) familiarization with the data; (b) assigning codes that shape content; (c) discovering patterns or themes within the codes; (d) reviewing the themes; (e) defining the themes; and (f) producing the report. With Phase 1, the researcher needs to familiarize themselves with the data. I did this by recording the data, reading and re-reading or listening to the interviews, taking notes, and writing down initial ideas (Braun & Clark, 2006). Phase 2, generating the initial codes, is about coding the interesting features that are emerging in the data in a systemic way. This is done through the entire data set and then collecting data in regard to each code (Braun & Clark, 2006). Phase 3, finding themes, is where the researcher collates the codes in potential themes and organizes the data in relation to that theme (Braun & Clark, 2006). Phase 4, reviewing the themes, is where the researcher checks the themes to see if they work in relation to the coded extracts found earlier in the rest of the data set. This phase is also when the researcher develops the thematic map of the analysis (Braun & Clark, 2006). Phase 5 is clearly defining and naming the themes. This is the ongoing analysis to refine the specifics within each theme and to look at the overall story the themes are telling. This is when the researcher develops a clear definition and name for each theme (Braun & Clark, 2006). Phase 6, the final phase, is producing the report. For this final analysis, I selected the most vivid and compelling examples and produced the scholarly

report of the analysis (Braun & Clark, 2006). All six phases are critical in a qualitative thematic analysis study.

Issues of Trustworthiness

Trustworthiness is critical to research. It validates the worth of a study and gives value to the reader (Lincoln & Guba, 1985). In order to do create trust, the research must first establish credibility, transferability, dependability, and confirmability (Creswell & Creswell, 2017).

Credibility

Credibility is the first step that a researcher needs in order to establish trustworthiness within their study (Creswell & Creswell, 2017). According to Lincoln and Guba (1985), credibility is confidence in the truth of the findings. Lincoln and Guba found that a researcher can establish credibility through prolonged engagement, negative or deviant case analysis, and member checking. For this study, I did this by ensuring that there was a reliable sample size of at least eight interviews. I also used prolonged engagement by speaking with a range of different people in interviews. On top of this, I have previously oriented myself with the situation, and I have been in the field and am an academic student in this area. I established credibility in this study by ensuring that all participants met the standard qualifications for this study and by ensuring ethical practices were met during the entire study. I did member checking throughout and following this study to ensure the accuracy of their information and background. Member checking is where I checked the validation of the respondent's answer. If needed, to

ensure credibility, I referred the transcripts back to participants and followed up with them for clarification.

Transferability

Transferability shows that the findings have applicability in other contexts (Lincoln & Guba, 1985). I did this by providing a detailed analysis of the themes and results so that other researchers can take them and apply them to their studies. Transferability can be obtained through rich descriptions as well. This can be done by gathering very detailed accounts of the experiences (Lincoln & Guba, 1985). This study ensured transferability by gathering detailed accounts of burnout and neglect through staff during interviews. I include the steps leading up to the data collection, the interview process, and my thoughts. This will allow other researchers to utilize this information in their studies.

Dependability

Dependability is being able to show that the findings are consistent and could be repeated (Lincoln & Guba, 1985). This can be done by ensuring that I use techniques that are understandable and repeatable through other studies (Creswell & Creswell, 2017). Dependability can also be done through an inquiry audit (Lincoln & Guba, 1985). These are used to ensure validity of the research study (Lincoln & Guba, 1985). This will provide an outsider the opportunity to check the accuracy of the data. I did this by explaining every step of the process, and detailing each step, so that others can employ the same methods if needed in order to repeat this study.

Confirmability

Confirmability is a degree of neutrality or the extent to which the findings of a study are shaped by the respondents and not researcher bias, motivation, or interest (Lincoln & Guba, 1985). Some techniques for confirmability are audit trail and reflexivity. An audit trail is documenting all the steps throughout the research process. I used an audit trail throughout the entire study. Everything was documented and interviews recorded. This will allow others to follow the steps I took during the process. Reflexivity means not allowing bias or beliefs to interfere with the results. In terms of reflexivity, I have identified my own bias and beliefs, and I did not allow that or my own experience or background to interfere with the study or results. I kept a journal of my own personal thoughts and feelings to ensure that I am being objective and ensuring confirmability.

Ethical Procedures

To ensure ethical standards, I submitted the proposal for this study to the Walden University Institutional Review Board (IRB) for review and obtained their approval to proceed with the study (IRB Approval No. 01-25-22-0725408). Since this study does include incidents of neglect of a vulnerable population in a care setting, I spoke with the IRB to ensure ethical standards have been met before starting. I am aware that there could be ethical issues surrounding this topic. I needed to ensure that all incidents of neglect that are discussed have been reported through the proper local channel, per agency guidelines. If the neglect has not been reported, the staff cannot participate in this study, and all participants received a consent form to sign. The consent form explained that each

participant is voluntary, and that they can withdraw from the study prior to data collection. It also explained that their names will not be discussed or used in this study.

Participants were made aware of confidentiality. I explained to each participant that if there are any disclosed incidents of abuse that are not reported, they will have to be reported. I discussed with them that while no names will be published in the dissertation, my chair, and other members might be privy to information for purposes of guidance. I discussed this at the beginning of every interview and reminded them that they can stop at any time. At the beginning of each interview, I also ensured that they give me consent to conduct the interview with each participant and received their consent for recording the interview.

Due to the difficult nature of the topic, it could cause a distressed response in participants. Therefore, when discussing neglect or abuse in detail, I observed body language as well as nonverbal cues to ensure that all participants felt safe and comfortable. Had I noticed discomfort during the interview, I would have reminded participants that they can pause or end the process at any time. I provided a list of support hotlines on the consent form for them to use following the interview if necessary.

Summary

This chapter explained the methodology of the current study by discussing the research tradition and rationale for this study as it relates to burnout of staff and the neglect that is caused on elderly residents in care. I also discussed my role as a researcher within this study, as well as the possibility of bias, issues of trustworthiness, and ethical procedures. All measures were taken to reduce any bias that may occur, as well as to

promote the highest quality of ethical standards and procedures for the participants in this study.

Chapter 4: Results

Studies in the past have examined staff burnout and the abuse or neglect of elderly residents in care (Andela et al., 2018b; Hall et al., 2016; Hen et al., 2012; Neuberg et al., 2017; Shin et al., 2014). Many studies have linked burnout to mistreatment, including abuse and neglect, and several studies have linked burnout to neglect (Hall et al., 2016; Shin et al., 2014). However, many of these studies focus on a generic connection to abuse or neglect and not on the direct connection between burnout and neglect of staff caring for elderly clients. The purpose of this qualitative thematic study was to examine the link between staff burnout and neglect of elderly residents who are in care facilities, as described by staff who have had witnessed the burnout and neglect by their co-workers.

The research question for this study was: What are the lived experiences of nursing home staff related to burnout before and after witnessing neglect of elderly patients? In this chapter, I discuss the setting in which the study took place, the demographics of participants, the process of data collection, and the data analysis process. The final item discussed in this chapter will be the study results.

Setting

All interviews took place via a free secure internet videoconferencing platform called Zoom (https://zoom.us). All interviews were conducted using audio only, no video recording software was used. Participants did not disclose their location or where they were having the conversation. One person stated they were in their car; this was for privacy purposes. One person stated they were at their mother-in-law's home, in order to have childcare for the interview. It was not disclosed by any participant where they were

geographically located. For scheduling purposes, all participants did note their time zone in the initial conversation, but no specific locations were stated. The research was not conducted in any place that the researcher has had a role or affiliation, and there were no incentives for participation. All participants were found via social media recruitment. To my knowledge, there were no influences of the participants or their experiences that would have impacted their involvement in the study that would affect results.

Demographics

This study included nine semistructured interviews. Eight of the participants identified as female, one participant identified as male. All participants were over the age of 30. The youngest participant was 32, and the oldest participant was 64. The mean age of participants was 48 years. All interviews where originally estimated to take 30–60 minutes. No interview lasted the full hour. All interviews were completed in between 15 and 45 minutes. The time of the interview was dependent on the participant and their experience and responses to questions asked. The interview that was shorter in time (15-minutes) seemed to be because the participant spoke in less detail and was more concise in their response. I also believe that talking about neglect can be a difficult topic and therefore some participants did not speak in great detail to some questions.

Participants in this study had a range of experience in the field. The shortest amount of time in the field was 3 years, whereas other participants had worked over 30 years in the field. One participant was in the same job and agencies for 8 years, whereas others had worked at two or three agencies. Three of the nine interviewees were retired, and the other six were still working in the field of elder care.

All participants received a consent form via e-mail and responded back to that e-mail "I consent." Once they consented to participate, a time was set to do the interview. All interviews were audio recorded via the Zoom platform for transcription purposes, but no video recording software was used or needed. All interviews where transcribed after the interview via NVivo software and researcher review.

Data Collection

In order to recruit participants, I posted to several social media platforms. Starting with Facebook, I posted the recruitment flyer on several public Facebook groups for elderly care and nurses. Recruitment took a total of 4.5 months. The recruitment flyer was posted three times per week on 10–15 public Facebook profiles. Instagram and Twitter posts were also used. During the third month participant collection began to slow down, and fewer people had been reaching out to participate. I received IRB approval to reach out to 10 local and national elder care associations/organizations to ask that they send the recruitment flyer to members. However, by the time associations responded, recruitment had been completed. Therefore, no flyers were sent from the organizations with the recruitment flyer. Overall, 13 people reached out to participate. Four people did not qualify, or they changed their mind and declined to be interviewed. The first person had only been working in the field with elderly for one-and-a-half years, so they did not qualify. Three other people reached out and then decided that they did not want to participate.

The nine semistructured interviews were conducted as audio only via Zoom. Audio recordings of interviews were saved onto the my personal locked and password-

secured computer and on my private cloud drive. Interviews were saved in two locations to mitigate the risk of files being damages or corrupted. Interviews were recoded for the purposes of transcribing and data collection analysis.

Data Analysis

Data collection for this study reached saturation after the ninth interview was completed and transcribed. For this study, I used semistructured interviews in order to understand the lived experiences of nursing home staff before and after witnessing neglect. Once all interviews were conducted and transcribed, data analysis started. I used NVivo software for initial transcription and analysis. I then listened to all interviews several times in order to understand that data, as well as to confirm the transcription and make any edits needed as well as for the data analysis. All data were analyzed using the six phases of thematic analysis as described by Braun and Clark (2006). Through this analysis, I found four main themes and 19 subthemes.

Phase 1 of Braun and Clark (2006) thematic analysis is for the researcher to become familiar with the data. In order to become completely familiar with the data, I listened to the recordings multiple times. This allowed me, as the researcher, to fully understand each participant interview and their responses. Although this part of the process took several months and was time consuming, it was valuable in that it helped me become deeply immersed in the data and be able to fully code it.

Phase 2 of the process is to begin the coding of the data (Braun & Clark, 2006). My plan for coding was to use NVivo software as the primary method for data analysis. However, NVivo was used for only the initial analysis. Then manual analysis was used to

confirm the coding. When I began to code the data manually, I became even more familiar with the data set, allowing me to understand the participants and their responses even greater.

Phase 3 is to review the codes and begin to develop themes (Braun & Clark, 2006). Since NVivo was only used for initial data analysis, manual data analysis and coding was used as the primary data analysis tool. This was done by intense review of the interviews, transcripts, and member checking. By doing manual data analysis of the interviews and transcripts, I was able to gain a greater understanding of the data. This allowed me to manually begin to take the codes and create groups. Through these groups, I was able to me to start to see the themes and subthemes of the data collected.

Phase 4 of Braun and Clark's (2006) thematic analysis process is to review themes. During this phase, I created a list of themes and then subthemes. Themes were developed in Phase 3 and then subthemes emerged during this process. By manually coding the data, and listening to the interview recordings several times, I was able to immerse myself in the data set and develop the subthemes and begin the review of them. During this phase ,I ensured that the themes created were meaningful to this study and the research question.

During Phase 5, I began to define these themes using a thematic map. I began by looking at the broad themes and how they can be defined. I wrote a detailed analysis of each theme and looked at this in the context of how they related to the data set. I was able to use this to develop names for each theme. This will help anyone who is reviewing this study understand the idea of the research.

The final phase of Braun and Clark's (2006) thematic analysis is to produce the report. I began to write up the data in a way that would bring together the connection of burnout and neglect while telling the story of the lived experiences of staff before and after witnessing neglect for all nine of the participants who were part of this study. Using all interviews, transcription, and data analysis, I was able to find four main themes and nineteen subthemes (see Table 1). The four main themes focused on lack of staff support, well-being of residents, compassion for working with elderly and unintentional actions. The nineteen subthemes were able to capture consistencies across different participant responses. These findings will be discussed in Chapter 5.

Table 1

Themes and Subthemes

Themes	Subthemes
Lack of staff support	Low staffing
	Mandated/mandatory overtime
	Double shifts are regular
	Untrained supervisors to support staff
	Doing the job of others instead of their own (covering)
	Low pay/compensations
Well-being of residents	Providing basic care instead of therapy
	Lack of ability to connect or spend time with clients
	Clients avoiding staff
	Medications missed
	Skipping care not required
Compassion for working with elderly	There to just do a job
	Low staff morale
	Burnout connected to staff attitudes
	High staff callouts and quitting
	Short-tempered staff members
Unintentional actions	Neglect is not always intentional
	Staff not trained to do certain job roles
	Staff become so burnt out they just act or react

Evidence of Trustworthiness

Ensuring trustworthiness for qualitative data is critical to research as it helps to ensure the study is accurate and provides value to the reader (Lincoln & Guba, 1985). Trustworthiness is established through credibility, transferability, dependability, and confirmability (Creswell & Creswell, 2017). Throughout this study, credibility, transferability, dependability, and confirmability were met through sample size, saturation, detailed analysis, and detailed documentation of the process.

Credibility

Credibility is the first step to ensuring trustworthiness of the research study. According to Lincoln and Guba (1985), credibility is confidence in the truth of the findings and can be found through prolonged engagement and member checking. To ensure credibility for this study, the first step was to ensure I had a sufficient sample size. I expected to do at least eight interviews to hit saturation and credibility. For this study, credibility and saturation was met at nine interviews. I also ensured everyone who participated in the study met the minimum qualifications set forth and that all ethical standards were met by following the IRB approvals.

Prolonged engagement is when the researcher spends time to engage participants prior to the interview and allows them to become familiar with them, in order to avoid misinterpretation and allow for participants to feel comfortable talking about a difficult topic. For this study, I did this by having a little small talk at the beginning of the interview. I engaged participants in talk about the weather and asked them how they are feeling. This seemed to make everyone feel comfortable to speak with me. I then always

thanked them for meeting with me and reminded them they can take a break during the interview if they need a few moments to decompress due to the difficult topic. I also reminded them that everything was confidential. All participants thanked me for the option, but all seemed very comfortable with the interview, and no one needed a break during the interview. I was also able to ensure prolonged engagement by speaking to different people.

Member checking is another way to ensure credibility in a study. Member checking was planned for this study. The original plan was to reach out to participants as needed by reaching out to them to follow-up or ask clarifying questions and if needed I would refer the transcript to them. I set up a method of communication with all participants for this at the end of each interview. All participants preferred to be called for member checking to discuss anything if needed. This was done as a preference to the participants. I then sent the transcript via email. None of the participants noted any issues or changes with regards to transcripts.

Transferability

Transferability shows that the findings have applicability in other contexts (Lincoln & Guba, 1985). This was accomplished in this study through a detailed analysis of the data into themes and subthemes. This will allow other researchers to be able to replicate this study, apply to other research with related topics or the reader will be able to interpret the results. By listening to the audio recordings multiple times, re-reading transcripts, and manually analyzing, I was able to create rich description and codes and form them into themes and subthemes using quotes and direct details from participants.

By doing this and creating detailed data analysis, other researchers will be able to use parts of this study in future studies.

Dependability

Dependability means to show that the findings are consistent and could be repeated (Lincoln & Guba, 1985). For this study, details have been provided for every step of the process. Through the entire process, notes were also taken to help ensure accuracy of data. By detailing out the process of this study and proving information on each step, I ensured that other researchers are able to employ the same methods that I used in their own study or to replicate this study.

Confirmability

Confirmability is a degree of neutrality or the extent to which the findings of a study are shaped by the respondents and not researcher bias, motivation, or interest (Lincoln & Guba, 1985). To ensure confirmability in this study there is an audit trail that was kept showing. This audit trail describes that data collection process every step of the process. This audit trail includes the audio recordings, transcripts, researcher notes, NVivo data coding, manual coding and the write up of data collection and results. This will eliminate any bias that could have been present. I also ensured reflexivity, as I identified my own possible bias prior to the start of this study. I kept a journal through the entire process, this allowed me to eliminate bias and ensure I was being objective and had confirmability and trustworthiness.

Results

The purpose of this study was to gather information on how staff burnout is experienced before and after witnessing the neglect of elderly residents in care through interviews of staff who worked at facilities where neglect took place. This was done through nine semistructured interviews. The interviews all consisted of six demographic questions and 24 questions (see Appendix) about their experiences related to the research question: What are the lived experiences of nursing home staff related to burnout before and after witnessing neglect of elderly patients and then two conclusion questions?

All participants reached out as a response to the flyer that was posted on various social media platforms and groups. The flyer for recruitment was posted to various public Facebook groups for nurses and elder care staff, Instagram, and Twitter. Once they reached out via phone or email, I confirmed that they had met the qualifications. One person of the thirteen did not meet the qualifications, they were thanked for reaching out and offering. Once this was confirmed, they got sent the consent form. They then wrote back via email “I consent” to confirm that they consented to the study. Of the original thirteen that reached out, at this phase three of them did not want to continue and asked to withdraw. They were thanked for their time and not contacted further. Nine people responded back “I consent”. Once they consented, a date and time was set up to do the interview via online platform Zoom. A few times during the process people had to reschedule the interview, delaying the process of data collection. No interviews were done in person due to COVID-19.

As this was a semistructured interview, not all participants answered the questions in the exact same order. As this study was about the lived experiences of staff, I would ask follow-up questions and some participants would tell stories or share thoughts. At times they would answer a future question while answering another one. Participants were informed that some questions may seem repetitive, or answers may seem repetitive, and that it was okay to repeat an answer or confirm that their statement earlier in the interview was the same answer. For example, one participant was very eager and excited to be a part of the study, she began sharing her thoughts and stories at the start of the interview. As I wanted everyone to feel comfortable, I allowed this and asked the questions needed as she spoke and then demographic questions at the end of the interview. Through these semistructured interview recordings and transcripts, using Braun and Clarks (2006) thematic analysis, four themes emerged. These themes are as follows: lack of staff support, well-being of residents, compassion for working with elderly, and unintentional actions.

Theme 1: Lack of Staff Support

Participants in this study discussed that almost all shifts in elder care facilities are low in staff. They felt that there needs to be more staff working each shift (staff to client rations needed to be increased) in order to meet the needs of the residents. Therefore, they felt that there are not enough people working in these elder care facilities to complete all the work that needs to be done. Due to a lack of staff, they felt that work is not being completed or elderly clients or patients are not getting the care, as there are not staff.

Subtheme 1.1: Low Staffing Ratio

When it comes to staff to client ratios, eight of the participants noted that staff shortages or low staff ration was a problem in their agencies. P8 described burnout as "I think it has been an issue for decades, and I think it continues to be an issue due to the fact that of staffing shortages and the inability to retain staff, the high staff turnover." Participants talked about turnover and low staffing ratios in relation to people just up and quitting or walking out the door during their shift, that lead to not enough staff working the floor and caring for elderly clients in their care. With COVID protocols and the impact that COVID had on nursing homes, many staff had become overworked and stressed on the job, and could not handle it, so they would leave or quit without notice. These issues would lead units that cared for elderly patients to be low staffed. When ratios are low, there is not enough staff to cover all the job duties that need to happen. P1 stated that "I would say neglect is a huge thing because short staffing" and "It's not just burnout it's also to the fact of we are so short staffed, so they're in such a rush, they may not know that they're neglecting." Therefore, staff are doing what they know is critical to life rather than providing quality of living care, which can lead to neglect. When asked what can be done to help mitigate stuff burnout and neglect, seven participants said better staffing ratios. More staff on each shift to cover all the duties and therefore if someone calls out, there is back up and other to help.

Subtheme 1.2: Mandated/Mandatory Overtime

Participants noted that the agencies they worked for mandated overtime. What this means is that if they needed to have more staff on for coverage, the agency can force

or mandate you to stay and continue to work, or come back for another shift the next day, even if they worked an 8-hour shift, a 12-hour shift or even a full double shift already (16-hour). Forcing someone to work this many shifts, can cause someone to become tired which can lead to emotional exhaustion. P7 noted that "I worked overtime and night shift a couple of times and the staff there would make up bed chairs with like blankets and pillows and sheets and go to sleep. I did too." According to Maslach and Jackson (1981) one of the three dimensions of burnout is emotional exhaustion. When asked follow-up questions about mandatory overtime, P6 said "It was for 16 hours a day. It was awful and well… I got a little burnout." They were forced to stay for extra shifts, causing home life to also be affected. P3 said "you get tired of going in and cover the shifts and covering the people that aren't showing up. And in that kind of thing, I did experience some burnout in that sense that you just get tired at some point, and I wished it would all go back to normal." They missed their kids' school events or couldn't have dinner with their family. This caused them then also become dissatisfied with their work environment. When someone didn't have a choice in the matter, they were less happy to be at that agency or working, which is also part of the third dimension of burnout, lack of personal accomplishment (Maslach & Jackson, 1981).

Subtheme 1.2: Double Shifts Are Regular

Due to low staffing ratios, and several participants stating they had mandatory or mandated overtimes, a staff member working on an elderly care unit was likely to be working a double or even a triple shift. Some working upwards of 80 hours a week. P8 noted that because there where so many people mandated to do shifts that

> everybody would know when somebody was working in double or triple or repeated doubles or repeated triples. And you would try to keep an eye on them just to make sure that they weren't doing medication or that they weren't falling asleep.

This is going to cause a burden on the other staff who are working on that shift. If staff are focused on making sure other staff are doing their job or covering for them, even when there is enough staff, care requirements for the clients or patients are going to get looked over and missed, meaning that clients could become neglected, intentional, and unintentional. P8 noted that "it's physically exhausting and anything in the caregiver field is going to be physically exhausting, not just mentally exhausting." This is important because the physical exhaustion from working over 16 hours in one day can result in caregivers not being able to lift their clients or patients. The result is that the client may not receive adequate care and opens the possibility to neglect.

Subtheme 1.4: Untrained Supervisors to Support Staff

When working in the health care field, especially with elderly clients, training is critical, for all positions in an agency. When someone is unaware of how to do their job, they are going to make mistakes. P5 said that "my personal experiences are there's a lot of people that don't have a good educational background." Education can also help someone understand their job, and what needs to happen. It can also lead to better supervisors. A study by Andela et al. (2018b) found that emotional demands and poor-quality relationships with colleagues and team supervisors were the most predictive variables for caregiver burnout, neglect, and abusive behaviors among the elderly. When

asked what can be done to help mitigate stuff burnout and neglect, three participants said better training for staff and supervisors. P7, who worked their way from a direct care CNA to a RN supervisor, running a unit stated that

> I found is that the way to engage people is to actually do a better job in training our supervisors, because it's managers and supervisors and if you have a good manager or supervisor, you'll knock yourself out to do a good job, but you have to train them to help their staff.

Subtheme 1.5: Doing Job of Others Instead of Their Own (Covering)

When you have staff out on leave, maybe even for neglectful incidents, that means that someone else must do that job. P8 said that

> It was like a cycle. Somebody would abuse or neglect and it would be reported and they were taken off the shift and then we were short even more people and then more people were working forced overtime and then more people were getting more tired and we didn't have other staff to help fill in the gaps when somebody was removed from work due to a potential abusive situation.

When you have this kind of cycle and then staff are required to cover, it would make them hesitant to want to step up and say they saw neglect or that they were burnt out from the work. It could lead to more burnout and more work. When you also have someone on their second or third double shift of the week, other staff will step up and cover for them. P8 stated that "Staff and supervisors don't want someone who is on a triple shift or working multiple doubles in a row giving medications, as that can lead to a

serious incident." Therefore, you sometimes have people trying to cover responsibilities that are not their own and it can lead to other issues or difficulties.

Subtheme 1.5: Low Pay/Compensations

Being paid enough money to do a job and be able to pay bills is important. When it comes to working with elderly care clients, multiple participants noted that low pay caused turnover and people to leave, they felt that people were not being paid enough to stay at the job where they were being told they had to work multiple shifts and were being forced to do jobs they didn't understand. Working in the health care field can be hard, and they especially felt that direct care workers were not paid enough to do their job. P1 stated that "we were paid $90 a day just for showing up to work … money is a huge motivation for people to go to work again." When asked what can be done to help mitigate stuff burnout and neglect, participants said better or more pay. Participants thought that something that can help not only mitigate burnout but mitigate the things that lead to burnout was paying staff more for the job they are doing. P7 said that "I think it's important for them to be in environments where it pays well to make sure that your staff is well taken care of." It would help to retain or gain enough staff, meaning others where not as stressed at work.

Theme 2: Well-Being of Residents

Staff working in the field of elder care are becoming burnt out and it is impacting their ability to do their job. When they are not able to do their job fully, it is impacting the residents, in the form of neglect. Participants spoke to not being able to spend time with clients and that impacted their job. They also discussed how many residents in care

would avoid staff who became burnt out. Several participants in this study discussed how they had to help other staff do general care for the clients that they were unable to complete their job tasks, like counseling, physical or occupational therapy, or medication dispensing.

Subtheme 2.1: Provided Basic Care Instead of Therapy

Several participants noted that due to low staff ratios, they were unable to do their actual job because they were covering for someone else, therefore clients/patients where not getting their full care. P1 noted that their current role in the agency they work for is a physical therapist, however they found themselves helping with daily care like bathing and feeding, and that several clients/patients where not getting the therapy they needed. P1 stated "they wanted to pay us some therapy overtime just to be an aide for the weekend." This was considered neglect; however, their patients/clients need to eat, use the bathroom, and be cleaned. So, staff would be using their therapy session to ensure the patient had their basic care taken care of. P8 noted that during one of their shifts, they had no one on shift authorized to dispense medication, so they had to do that, which is something they had never done. P9 is an occupational therapist (OT) and stated they would make the therapy sessions with clients around what care needed to happen. So as an OT they would do feedings and bed changes. While clients were getting their basic needs meet, their care was not what it was supposed to be, as they were missing therapy, which participants in this study considered neglectful.

Subtheme 2.2: Lack of Ability to Connect or Spend Time With Clients

In nursing home and elder care facility settings, the staff spend multiple days with the same clients. A client is usually in a nursing home or care facility in a long-term capacity. Therefore, it is common for clients and staff to bond while spending time together. Staff often do this because they realize that it helps their clients feel less lonely. However, when you have an agency with staff who regularly burnout, it can lead to a lack of empathy or time to connect and care for patients. P8 stated that "as having time to socialize with them and care for them and make a connection with them it didn't happen. I mean, I think that just gets pushed off to the back burner and it's all part of the neglect." The third dimension of burnout is a lack of personal accomplishment (Maslach & Jackson, 1981). A staff member experiencing a lack of personal accomplishment may feel dissatisfied and unhappy about their work and negatively about themselves in regard to the work with the client (Maslach & Jackson, 1981). When asked about the impact of this, P6 stated that burnout

> when someone was in that mode, coming through the door was like a big man over their head, saying leave me alone, they were just quick to jump and clients were afraid to ask these staff something because they know that they would get jumped on or told they do it themselves it did impact, relationships; like work relationships, client relationships with the people who were there every day to take care of them.

In addition, there are cases in nursing and elderly care facilities where the patient/client has no family or friends that will visit, so the staff are all they have, making the client and staff relationship even more important.

Subtheme 2.3: Clients Avoiding Staff

Participants in this study discussed how patients who had the ability or comprehension level would actively avoid staff who they could tell where burnt out or unhappy. P6 specifically said

> you actually had the clients that you were working with avoid staff because they could tell they were burnt out … like they were afraid to ask these staff something because they know that they would get jumped on or told they do it themselves.

When asked how patients might react to a staff member who is experiencing burnout, P6 stated "clients would say I don't want to be near them, I want to be away from them." This can lead to an impact on their care. If a client is actively avoiding a staff member, they will not get care, assistance, or the medication they may need. Participants noted that when you work with someone every day, you start to learn their behaviors and clients would pick up on happy moods and bad moods. If a client/patient would refuse to see or work with a staff, that means that another staff might have to cover their duties. This is also going to negatively impact the moral at the agency of the people who live there.

Subtheme 2.4: Medications Missed

Participants noted that when someone gets very burnout or tired on the job, they will start to miss medications, and often not everyone working could give out medications to patients/clients. P6 spoke to neglect as "a lot of it was, bed changes…the

bell was called and they didn't respond, medical not getting done, meds not passed as needs, not brushing their teeth, showering." Participants noted that medication errors or missing medication was one the most common neglectful incidents they saw happen. P8 explained it as

> possible medication errors where they wouldn't get med. It was a lack of good medical care because they weren't getting good medication, or they weren't getting the right medications, or they were being given to the wrong persons or they weren't being given at all. Simply, they were being dispensed incorrectly.

Subtheme 2.5: Skipping Care That Was Not Required

Participants in this study spoke of how they had to prioritize care of the clients. When they were short staffed, or rushed to get things done, they would prioritize what needed to happen first or most importantly. Therefore, staff would look at what had to be done first or for basic care and then other things would not happen. P5 spoke of an experience with oral care and said "In every single facility I've ever been on oral care is skipped and the people do not receive oral care because first of all, I can't see it. And second of all, it's just enough to get them clean and dry." She noted that this is because they do what they need to, what others can see, and they move on to check off the task on their to do list, but this is neglect. Burnout can also lead people to not care for someone or for doing the bare minimum. P6 stated that "when you get burnt out, you have to like get yourself into going to work and then when you get there, you know you should be going above and beyond for your client. And when you're in that mood, there's no above and beyond." In relation to the three dimensions of burnout, workload is linked most

evidently to emotional exhaustion (Maslach et al., 2001). When staff have an increased workload, that they cannot meet, participants noted that they just did what they could.

Theme 3: Compassion for Working With Elderly

Every participant noted that the reason they and those they work with go into the healthcare and elderly care field is because they have a passion for working with elderly patients/clients. Participants spoke to the fact they sometimes they or those they worked with came in to just work or collect the paycheck and stopped caring about the job and the work they did. As participants and those they worked with started to become burnt out, they also started to develop low staff morale. Participants also noted that as time went on and the job became overwhelming and they became burnout, that passion stopped.

Subtheme 3.1: There to Just Do a Job

Participants noted that many of the people they work with are just there to do the job. That they had started out eager and excited but after experiences, like low staff ratios and witnessing neglect, they said they no longer felt eager for the job. Many people are just going to work to collect the paycheck and do what they need to. P6 noted that

> when you get burnt out, you have to like to get yourself into like going to work and then when you get there, you know you should be going above and beyond for your client. And when you're in that mode, there's not above and beyond.

This is emotional exhaustion. Emotional exhaustion is a state in which staff members' emotional resources are depleted, and they start to feel like they can no longer give themselves fully to the job and the client (Maslach & Jackson, 1981). All

participants noted that after witnessing neglect the burnout either got worse or stayed the same. No one said it got better, which also can lead to emotional exhaustion and low staff morale.

Subtheme 3.2: Low Staff Morale

Participants in this study spoke about how as they and others became burnt out, they started to care less about the job and had low morale. P3 stated that when **"**you see something not going the way it's supposed to be doing and someone's actually neglecting your residents, the staff moral just it goes downhill." Depersonalization is the second dimension in Maslach and Jackson's (1981) three dimensions. Depersonalization occurs when a staff member feels negatively about their job and may lead to the development of cynical attitudes and feelings toward their clients (Maslach & Jackson, 1981). Participants noted that this is what they are starting to experience. P5 spoke on the morale impact saying that "indirectly it affected the morale because everything just sucks. It almost for me and specifically the place I worked the longest, it almost became a culture of burnout and a culture of neglect."

Subtheme 3.3: Burnout Connected to Staff Attitudes

Participants spoke during their interviews on how burnout impacted their attitudes, both with morale and with client care and interactions. When staff have an indifferent attitude toward the abuse of elderly people, the person witnessing the abuse avoids any personal reaction to it, thus taking them away from further issues or the threat to them (Radkiewicz & Korzeniowski, 2017). P9 stated that "I had a co-worker for once who would have a few too many the night before and try to come in to work the next day.

And you know, her job performance suffered. But that was because she was just trying to handle her personal life and work-life and she coped with alcohol." Participants noted this when they talked about burnout. They said it was part of the job, or what they saw every day, so it was normal. P2 stated,

> I'm just I'm not caring for people the way that I normally care for people. I just, I make more errors with them. I know I can just not be a team player, which I normally am with my, my co-workers. So, it's just I'm just not … not me.

As an individual develops increased depersonalization, they will be less able to engage in the demands of their job, less willing to help others, and will distance themselves from their clients (Maslach et al., 2001).

Subtheme 3.4: High Staff Callouts and Quitting

Participants in this study spoke on how they have seen high rates of staff calling out sick (call outs) and staff quitting without notice, some even noted that people would walk out during their shift and would not return. P4 said that as "staff became burnt out they would call out more frequently." Call outs means that there was not enough coverage on the floor, therefore they would not be able to keep up with the workload and number of clients, leading to the clients care not being fully taken care of and then staff becoming more frustrated and exhausted. P1 noted this has been especially increased due to COVID restrictions and protocol. P8 stated that **"**we've had so many people quit over the years. I watch aides specifically constantly quitting because they're just underappreciated, and they have such high demands of taking care of all these patients and doing all this care. And they're paid the least." Caregivers who are overwhelmed and

exhausted often adopt an indifferent or a distant attitude toward their clients (Andela et al., 2018b). P8 also stated that

> one day they'd call in for three or four days in a row, which then creates a heavier burden on the staff that have to cover. It's again, a vicious cycle, and for the agency to try to figure out how to fix this for the staff that are left working because people are calling out is important.

When you have unexpected call outs and people quitting, agencies don't have the ability to get staff for coverage and staff will develop an indifferent attitude or start to show depersonalization. Participants noted that most often, nothing was done to help mitigate their experiences. Two participants noted that agencies need to do more than provide ice cream or a pizza party to help them build morale and feel better about their job.

Subtheme 3.5: Short-Tempered Staff Members

Participants noted that as staff and themselves became burnt out they started to have a short temper and react to clients/patients. When staff are starting out in this field, and they are coming into an agency with burnout and with neglect happening staff can anger easily. P5 described it as "I've never seen a lack of empathy like I have in a nursing home among the workers, and I think a lot of them start out like that, it's their baseline on the double or triple shift." The individual who portrays depersonalization attitude often finds it easier to care less (Maslach & Leiter, 1997). Staff who are especially working multiple shifts in a row or working multiple double shifts several days in a row can

become tired, and it can lead to staff showing depersonalization and they can become short tempered. This also leads to clients/patients who avoid those staff.

Theme 4: Unintentional Actions

Participants in this study did not believe that most staff acted intentionally when it came to neglectful incidents. While some participants noted that there are bad people doing this job, overwhelmingly people do this work because they care, and they want to help. Participants and those they worked with were not always trained to do the jobs they had been asked to do, which could lead to neglectful incidents. Neglect is happening because they don't have staff, they don't know their job duties and they are having trouble keeping up, and it is leading to burnout.

Subtheme 4.1: Neglect is Not Always Intentional

Participants stated that they did not believe people intentionally or maliciously neglected clients. They believed that staff and themselves did not realize the impact of the work. P8 said "I do think the biggest things that I witnessed where the medication errors and staff sleeping and staff not recognizing how tired and burned out they really were and that they were angry for having to work so many hours for being mandated." Staff don't always realize the impact of the job they are doing or the implications of the burnout, especially if they don't notice it. Participants also spoke that neglect wasn't intentional, they just couldn't physically do something, so they had to choose what task was more important in the care of a client/patient.

P6 said that he did not consider sleeping on the job as neglect because as a supervisor he realized how tired and overworked staff are especially on the double or

triple shifts. When asked what could be done to help mitigate burnout, seven of the nine participants said more staff or better staff to client ratios. Due to being overworked and understaffed, neglect was happening, unintentionally. So, participants believe that with more staff all the jobs would be done as they needed to be, and less neglect would happen.

Subtheme 4.2: Staff Not Trained to Do Certain Job Roles

Participants in this study spoke about how they would have to cover for other people or do jobs they were not trained to do. P8 noted that on several occasions they had been asked to pass medications for clients, and they were not trained and did not know the medications for their clients, and if they didn't provide medication, then clients wouldn't have any. P1 is a physical therapist and P9 is an occupational therapist, both participants noted that they were doing the jobs of Certified Nursing Assistants (CNAs) and nursing staff. Neither participant noted they had been trained to do so. When asked how burnout and neglect can be mitigated, two of the nine participants noted that more training and better training can help with staffing and unintentional neglect.

Subtheme 4.3: Staff Become so Burnt Out They Just Act or React

Participants felt that many people did not intentionally commit neglect but that they had become so burnt out and that they would just react to things. Participants also noted that neglect became such a normal part of their day to day that they just didn't react to it anymore. P8 stated that "If somebody was exhausted from overtime or working too many shifts in a row, not having any days off over the course of a couple of weeks, they would be exhausted and tired and potentially sleeping. And then there was a fire drill or a

situation where they had to evacuate for any reason and many times staff would fail the evacuation because they could not do it." All participants also noted that after witnessing neglect, the burnout got worse or stayed the same. There were no procedures in place to mitigate the impact or help them. P9 spoke to that by saying "reporting it to your supervisor and then going from there, you know, just following that chain of command." Participants said they did whatever they had to, if they didn't have to, they did not. When asked about reporting it P9 said "I don't think it really even affected…Like the neglect just becomes like part of the job." Staff had become so burnt out in their work and jobs that they just acted and reacted to the job and what they saw. P5 spoke that staff who became mandated to multiple or double shifts would walk in the door unhappy and would just react to patients/clients, sometimes by yelling at them or not providing care.

Summary

The purpose of this qualitative study is to explore the lived experience of how staff burnout features in the neglect of elderly people who are receiving care in a residential care facility. Nine semistructured interviews were conducted over the course of four-and-a-half months. All participants were recruited from social media postings. After consent was given to participant in this study, an interview was scheduled using Zoom software. Interviews where recorded and transcribed. Once all interviews where done and saturation was met, coding began. Through all this, four themes emerged: lack of staff support, well-being of residents, compassion for working with elderly and unintentional actions. In these themes, nineteen sub-themes emerged.

In Chapter 5, I will be discussing the interpretation of the data including by reviewing all four themes and connecting them to current and past research. I will then discuss the strengths and limitations of this study. I will then how this study will impact positive social change. Lastly, Chapter 5 will explore the impact this study can have on elder care agencies those working in the elderly care field.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this qualitative thematic study was to examine the link between staff burnout and neglect of elderly residents who are in care facilities, as described by staff who have witnessed the burnout of, and neglect by, their co-workers. This study also sought to understand the burnout happening in nursing home staff and how this burnout is connected to the impact on elderly residence in care, specifically neglect. Behavioral indicators have been found in those who experience burnout, including absenteeism, poor job performance, staff turnover, depression and anxiety in the workplace, decreased job satisfaction, and depersonalization (Shin et al., 2014). To understand this phenomenon, I conducted nine semistructured interviews with elderly care staff who had witnessed neglect and experienced burnout to answer one research question: What are the lived experiences of nursing home staff related to burnout before and after witnessing neglect of elderly patients?

Through the data analysis, I identified four main themes and 19 subthemes. The four main themes included lack of staff support, well-being of residents, compassion for working with elderly and unintentional actions. These themes and the subthemes are discussed in detail in Chapter 4. In this chapter, I discuss the interpretation of the findings as they connect to the literature review in Chapter 2. I also discuss the conceptual framework, limitations of this study, recommendations for future studies, implications for social change, and conclusions.

Interpretation of Findings

The literature review presented in Chapter 2 focused on research addressing burnout and its effects on staff and the mistreatment of elderly residents, specifically neglect. In the literature review, I focused on professionals working with elderly populations who experienced burnout, what led to burnout, and what that impact was, including neglect. The literature review also included a review of Maslach's theory of burnout. Although studies in the past have focused on burnout and its impact (see Neuberg et al., 2017; Rosenstein, 2017; Hall et al. 2016) few researchers have looked at burnout and neglect. Therefore, this study adds to the current understanding of the topic by focusing specifically on how burnout is related to neglect of elderly clients through lived experiences of nursing home staff. The findings of this study add to current literature through understanding of the lack of staff support, the well-being of residents, the compassion of staff members working with elderly patients, and unintentional actions of staff on clients.

Theme 1: Lack of Staff Support

Peer support has been linked to personal accomplishment and efficacy (Leiter & Maslach, 1999). Participants in this study stated that staff did not have the support to do their jobs. On regular occasions, they had been asked to do other staff members' jobs, jobs of other professionals, and cover shifts, even after having already completed their own shift. Wangmo et al. (2017) conducted a qualitative analysis and found that institutional factors relating to abuse and neglect include stressful work situations, lack of care personnel, and poor team culture. Each of these factors impacts the overall

institution and the ability of its workers to do their job. Maslach and Leiter (2008) found that job stress can manifest in burnout syndrome. On several occasions during this study, participants stated that staff members walked out of the job in the middle of their shift or just stopped showing up to work, meaning that those who were working during that time were required to provide the care to elderly patients that was originally someone else's job.

Participants in this study noted that there was often not enough staff on shift to ensure that everyone got the care they needed. Blumenfeld et al. (2017) found that increased stress due to higher workloads or more difficult residents was associated with an increase in observed emotional abuse and neglect. Through this research, staff would be forced to work the jobs of others, sometimes on a double shift (two shifts in a row). Staff being asked to do a double shift was due to not having enough staff to cover the shifts to begin with and then when staff completed doubles, they would be tired and overworked. In some agencies, double shifts have become the normal and expected, rather than the exception. Andela et al. (2018b) noted that workload, emotional demands, and low-quality relationships with colleagues and team supervisors were directly related to caregiver burnout, as well as to a higher risk of abuse and neglect toward the elderly. In this study, staff noted that they or their co-workers would be asked to do a job they had not been trained to do or a job they were too tired to complete properly, leading to errors in medication or errors in care, which is unintentional neglect. Support from a manager has been connected to exhaustion in workload and peer support has been linked to personal accomplishment and efficacy (Leiter & Maslach, 1999). Participants in this

study spoke about how they did not have help from other staff, as everyone was overworked, and they had supervisors who were not trained to do the jobs.

Participants in the current study talked about how it felt like a consistent cycle. Cooper et al. (2018) also concluded that abusive and neglectful behavior was reported more frequently by staff in residences with higher staff burnout. Often, the investigation that follows a report of abuse or neglect results in further staff shortages which then requires staff to work longer shifts. Therefore, the staff became overworked for reporting incidents they saw. During this study, no participants noted that burnout got any better after witnessing neglect. This research found that for participants, burnout got worse or stayed the same after witnessing neglect and reporting it. This causes constant stress among the staff. Blumenfeld et al. (2017) suggested that neglecting residents could be a strategy for balancing the emotional exhaustion they feel within their work. We see this in the current study as participants spoke to being unable to lift a client to move them or being unable to move a patient from the bed to bathroom when they had been working 16-or-more-hours in a single day. Therefore, they were not able to complete the tasks that needed to happen, which was considered neglect.

Theme 2: Well-Being of Residents

One study found that abuse that impacted the older person's emotional well-being was deemed the most damaging (Taylor et al., 2014). Participants in the current study felt they had to choose which client received care first and felt they had to pick what care was more important. Often staff would have to choose between giving therapy or giving a client a bath. They would choose the daily care or quality of care task that needed to be

done, but this meant that a client missed out on something. Participants in the current study said this caused stress on the job as well as burnout because they felt they could not give the clients everything they needed.

In relation to the three dimensions of burnout, workload is linked most evidently to emotional exhaustion (Maslach et al., 2001). Researchers have shown that individuals report more emotional exhaustion than the other two dimensions, thus making this domain the most analyzed of the three (Maslach et al., 2001). However, in my study, depersonalization was found to be prevalent. This study found that staff who had been forced to work double or triple shifts, or overtime, would become upset and distant to their job. Due to the intense and demanding nature of the work, staff experience negative emotional consequences and there is a shift in the way they view things, and this can lead to emotional detachment (Maslach, 2003). Negative emotions in staff are leading to a negative impact on their job and the patient outcomes of care (Rosenstein, 2017). When a staff member is unhappy, and their job is impacted negatively, the work they produce is less than adequate, and can lead to abuse and neglect (Rosenstein, 2017). During this study, participants spoke of being forced to work double shifts, mandated to work overtime, and mandated to cover other people's job responsibilities. These issues led to them not wanting to be there, and they started to become burnt out, cynical, and unhappy while working and providing care. In this research, participants noted that these things had led to clients asking to not be around that particular staff or refuse care because the staff member working was angry or frustrated.

Results of several studies have shown that those in the elderly sector of the population are at a higher risk of illness, and the loss of physical ability needed for everyday living. This creates a relationship of dependency between the elderly individual and the staff (Halvorsen et al., 2017). One of the findings of this study is that staff members are unable to spend time with the clients. Maslach (1978) found that a difficult relationship between the caregiver, and the client could lead to burnout. This was a result of the client's diagnosis, symptoms, behaviors, reactions to staff, and the agency rules about client and staff relationships and these factors impacted the quality of care given by the staff to the client (Maslach, 1978). Participants noted that due to the high demand of the job and lack of staff resources, they were unable to spend time bonding and connecting with clients. Often elderly clients in care had little or no family or visitors; therefore, their only connections were staff members who worked with them. Staff in this study spoke about being unable to provide that connection, creating a more depressive and alone state for the clients. This has been especially critical during the COVID-19 pandemic, as agencies were not allowed to give visitors access to patients. Through this study, participants thought that by not making a connection to the clients and developing an indifferent attitude, they were neglecting their basic need for connection.

Theme 3: Compassion for Working With Elderly

This study found that people who went into the care field, especially those working with the elderly, wanted to and had a passion for what they did. Over the last several years, the health care field has seen an increase in job dissatisfaction, turnover, and stress/burnout of staff (Rosenstein, 2017). Similar to the findings of Rosenstein

(2017), this study showed that participants and staff did not begin their careers feeling unhappy but after a while, the stresses and demands of the job caused them to care less. Previous research has shown that burnout has a direct connection to poor job performance, lack of work commitment, low job satisfaction, and higher turnover (Shin et al., 2014). When a staff member is not fully committing to their work or their job, it can lead to mistakes and a lack of follow-through on duties (Shin et al., 2014). After time working in this field, especially through the COVID-19 pandemic, participants in this study noted that they and others just showed up to do a job. One of the three dimensions of burnout is depersonalization. Depersonalization occurs when a staff member feels negatively about their job and may lead to the development of cynical attitudes and feelings toward their clients (Maslach & Jackson, 1981). They came to work because they had to or to collect the paycheck. They wanted to come in, do their job, and leave. They developed indifference toward the job and the clients.

This study found that low staff morale was a big issue when it came to indication for neglect. Participants noted that when someone became burnt out, they would develop low morale for their job and work, and it would impact their work leading to burn out. Andela et al. (2018b) found that emotional demands and poor-quality relationships with colleagues and team supervisors were the most predictive variables for caregiver burnout, neglect, and abusive behaviors among the elderly. Depersonalization speaks to that indifference, or “I don’t care” attitude, which is what was found to be a common factor in low staff morale in this study.

Participants stated that burnout and neglect was something that you just saw in this work, and it was normal. Radkiewicz and Korzeniowski (2017) found that staff with an indifferent attitude toward the abuse of elderly people or the person witnessing the abuse would avoid any personal reaction to it. Participants in the current study felt that burnout was expected, and neglect just happened in this field, and they had to just deal with it. In other words, they stopped reacting to it. When staff are overworked, do not care about the job, and are seeing these things, they begin to frequently call out sick and quit. Several participants noted that people walked out mid-shift or never returned for work. Due to the intense and demanding nature of the work, staff experience negative emotional consequences and there is a shift in the way they view things, and this can lead to emotional detachment (Maslach, 2003). When less staff is working or coming into the job, others are required to work overtime or to cover the job duties of the person who called out.

Theme 4: Unintentional Actions

No participants in this study believed that the people they witnessed committing neglect were intentionally neglectful, but that these individuals could only do so much, and they became burnt out and it led to errors, which were considered neglectful incidents. Unintentional neglect results from an inability to provide care, whereas intentional neglect occurs when staff deliberately fail to fulfill their expected care responsibilities (Andela et al., 2018b). Caregivers who are overwhelmed and have an indifferent or a distanced attitude toward their job and their patients were more likely to

neglect or behave in an abusive way with those in their care (Andela et al., 2018b). This is what this study found as well.

Throughout this study, participants described how they and others were being required to do jobs that they had not been trained to do. With staff members calling out, quitting or staff shortages, participants noted that people were being asked to do jobs like therapy and medication dispersion, when they had not been trained or qualified for those tasks. Wangmo et al. (2017) found that participants with many responsibilities that they needed fulfill had difficulty keeping up with all of them, which led them to become stressed and begin to feel emotionally exhausted. In this research, participants noted that when they had to do jobs they were not trained to do, it would lead to errors happening by accident, but it would be considered neglect because the elderly client did not get what they needed. We know through Maslach's theory of burnout that when someone experiences emotional exhaustion, they start to feel they cannot perform the job fully (Maslach & Jackson, 1981).

Staff who are also working double or triple shifts would be asked to do jobs that required a lot of attention, and they would be unable to provide attention because they had been working so much with little sleep, leading to errors. Wangmo et al. (2017) noted neglect as the most common form of mistreatment against clients. This study considered the unintentional reactions of a burnout by staff member towards clients/patients. When someone starts to experience depersonalization, they are distancing themselves from their work to prevent further emotional exhaustion (Maslach & Leiter, 1997). In this study, participants stated that they do not always think about the reaction or what they are doing.

When they are told to do something, they do it, like passing medication out, which can lead to errors and neglect.

Conceptual Framework

The conceptual framework for this study was Maslach's theory of burnout (1976). Maslach and Jackson (1981) defined burnout as "a syndrome of emotional exhaustion and cynicism that frequently occurs among individuals who do 'people-work' of some kind" (p. 99). Maslach and Jackson described burnout as having three dimensions: emotional exhaustion, depersonalization, and reduced personal accomplishment. This is the definition and base for the current study.

Throughout this study, participants explained how they had experienced emotional exhaustion, depersonalization, and a reduced personal accomplishment. All three of these are part of what leads to burnout in human services. While participants did not use this terminology exactly, they describe their experiences at their jobs in the same way Maslach (1981) defines each of these dimensions. Participants also spoke to four of the six areas of work-life balance. These included workload, control, reward and community. Not all areas of work-life balance need to be present for someone to experience burnout, but the more mismatch in any of the areas they experience the more impacted by burnout they will be. These are discussed below.

Throughout the entire study, all participants spoke to being tired and overworked and being unable to give the job everything they had. This is what emotional exhaustion is according to Maslach (1981). Participants in this study stated that often they felt so overworked and that they had to many tasks to complete, they were unable to complete

them all. Participants explained that at times, staff (themselves included) had to pick and choose what client care would be given. Leiter and Maslach (1999) state that emotional exhaustion is the initial response that an individual has to the stressors in their job and when a staff member feels that they are strained in their work and cannot complete the tasks or do everything as expected of them, they start to experience emotional exhaustion. This can lead to depersonalization or detachment from work, which is the second dimension of burnout according to Maslach (2003a).

While all three dimensions were found present for all participants and staff, depersonalization was the most frequent of the three dimensions present in this study's findings. When participants spoke about burnout, depersonalization was spoken on more than emotional exhaustion and reduced personal accomplishment. Participants noted that staff (themselves included) would start to develop an "I don't care" or an in-different attitude in relation to their job and job duties. This was made worse after witnessing neglect and reporting it. Staff would also be upset and angry when they would be mandated to work double shifts, and this would impact the clients and their care. Depersonalization occurs when a staff member feels negatively about their job and may lead to the development of cynical attitudes and feelings toward their clients (Maslach & Jackson, 1981). This can lead to the staff being indifferent in their day-to-day work, their job duties, and tasks (Maslach & Leiter, 1997).

Several participants spoke to the fact that when a member of staff was angry or frustrated, clients could tell and would ask to not be around that staff member or ask for another staff member to provide care. Participants stated that when this would happen,

clients would not get the care they needed, as there was not enough staff to provide it, which in some cases, was considered neglect. Staff who started to experience depersonalization, or the in-different and “I don’t care” attitude where also noted as being the ones who would be committing neglect, as they would not be focusing and not care about the duties they had to do. Several participants noted that staff members walked out of the job or took a lunch and never returned for their shifts. Depersonalization is also noted as an individual’s reaction of distancing themselves from their work to prevent further emotional exhaustion (Maslach & Leiter, 1997). By walking out of the job or developing the I don’t care” or an in-different attitude, the staff had become to distance themselves from the work and the clients.

Throughout the study, participants stated that often because they couldn’t do the job they wanted and there was no reward for their work, financial and personal, they felt no need to put forward an effort. Participants stated that staff would be hired as a nurse or physical therapist but end up doing the job of the health aid (bed changes and bathing). They felt they could not grow in the agency. Participants also thought that by not being paid enough money and not being praised at all for the work, they felt discouraged and inadequate. Staff would be criticized for a lack of care or doing a job wrong, but never felt they got positive reinforcement. This is what the third dimension of burnout looks like. Maslach and Jackson (1981) noted that staff member experiencing a lack of personal accomplishment may feel dissatisfied and unhappy about their work and negatively about themselves regarding the work with the client. This is what participants stated was happening in themselves and the staff they worked with, before and after witnessing

neglect. Growing unhappiness with one's work leaves the individual feeling inadequate. This can lead to feeling less accomplished and the individual becoming more overwhelmed with the demands of work (Maslach & Leiter, 1997).

The six areas of work-life can help researchers to understand the levels of burnout experienced in participants. The six areas of work-life include workload, control, reward, community, fairness, and values (Maslach et al., 2001). Throughout this entire study, participants spoke to most of these. The common ones spoken on were workload, control, reward and community. They noted that it would be hard to separate their work and their personal life. Many noted that they had a hard time leaving work behind when they got home. That the more they became burnt out the more their home and personal life would suffer.

A balanced work-life is important to the staff as well as the organization. When staff are working long hours, doing multiple tasks at once, and taking on additional duties they can become exhausted and overloaded (Maslach & Leiter, 1997). Workload was the most frequently spoken about area of work-life mentioned during data collection. Participants spoke to being overworked and felt they couldn't keep up with the work and the demands and felt constant stress leading to burnout. Multiple participants spoke to how they and others they worked with would be doing jobs that were not their own. For example, a physical therapist would be doing the job of a nursing assistant or caretaker.

When staff are mandated to do multiple shifts and work of others, they lack control. They are being demanded and told what to do. While control is not something they can have in every aspect of the job, it is needed to feel secure and help with

productivity (Maslach & Leiter, 1997). This can lead to a lack of personal accomplishment, which participants noted several times. They felt they just had a job to do. Reward for the work that someone does in the human services field is critical. The reward can be recognition or financial. In this study, participants noted they never felt rewarded for their work. When asked what they needed or what can be done to help burnout, reward in some form was the answer by all participants. Reward for participants in this study was considered to be recognition for positive accomplishments and financial compensation.

Individuals are more likely to succeed and feel successful in their work when they have a sense of community present (Maslach et al., 2001). Throughout this study, participants stated that they felt they did not have support. Participants even noted they would be angry or upset when people would call out sick or not show up, as it meant they had to do more. Agencies would provide pizza parties or ice cream socials, but it did not help to foster a community, as staff needed support not food. Staff also lost a sense of community when they did not have the time and resources to be able to connect with the clients like they used to.

All three dimension of burnout where experienced by all participants in this study and spoken about by all participants in this study in relation to the people they worked with who committed neglect. The six areas of work-life help to identify the level of burn out someone can be experiencing. So, while not all six areas of the work-life were noted, the more they experienced the more they felt burnout in this study, and four of the six were spoken on.

Limitations of the Study

Qualitative studies generally have a smaller sample size than mixed-methods or quantitative and are generally considered to be less reliable or trustworthy due to the limited sample size (Creswell & Creswell, 2017). The current study included nine self-selected participants. This is considered a limitation of the current study as it was that it was a thematic qualitative study with nine participants. However, trustworthiness was very important in this study and was reached through data saturation.

Another limitation of the current study is the nature of the topic which impacted participant recruitment. Speaking about burnout and neglect can be very difficult. I felt that it was difficult to recruit participants and while I ensured confidentiality, some were still concerned about speaking on what they witnessed and experienced. The topic is also difficult to speak about and can upset some people when they recount incidents they witnessed and burnout they experienced. I believe this impacted the length of some interviews and the recruitment process. One interview only lasted just over 15 minutes, and another around 20 minutes, which I believe is due to the nature of the topic, this participant spoke very quickly and to the point when asked questions. This can be a limitation as the data collected from these two participants is not as detailed.

Another limitation to this study is self-selection bias. All participants were recruited by seeing my flyer posted on social media. They then chose to reach out to me to be a participant in my study. This is a limitation as they all volunteered for this study, meaning that they chose to participate or not. This can mean that the sample is not fully

representative of the entire population. However, after nine interviews, I felt that I had reached saturation as the interview answers where similar with each other.

During the recruitment and data collection process, only one male reached out to participate. This male was interviewed during the study. Therefore, eight of the nine participants were female. This could have impacted the comprehensiveness of the data collected, as males might have a different experience to females. On the other hand, all people who participated in the interview spoke on witnessing burnout and neglect of other staff and spoke about the staff that worked with them, not using gender, or identifying factors of those staff.

While all interviews were conducted via Zoom, not all participants used a camera. Four wished to not interview via video and use only audio. I believe this is due to the nature of the topic and fear of possible retaliation or identification. This is a limitation as I was not able to watch participant reactions to comments or questions. I was unable to observe the body language that may have aided me in being able to understand them and their answers better. However, I ensured confidentiality and was still able to listen for verbal cues and throughout the interviews I did ask if they needed a break or time to process. I also reminded all participants they could ask me to repeat or rephrase questions as they needed. For all interviews, audio only was recorded.

Recommendations for Future Research

As noted through the literature review, there are many studies that look at burnout and many studies that look at abuse and neglect. In fact, there are several studies that research the connection between burnout and neglect. I felt this study was important to

add to the current research to start to specifically understand the link between burnout and neglect. It's a very important topic in an ever-evolving field.

I wanted to address the gap in literature by starting to understand how burnout specifically impacts client care when it comes to neglect. One participant stated that "it's not an issue until it's an issue. When someone is burnt out, no one cares until there is a lawsuit or a death." Other participants spoke to how it was a vicious cycle, that staff would become burnt out, then they would miss medication or commit neglect and be put on leave, and then someone had to cover for them. Then these staff became burnt out. I think more that research into the causes of burnout is critical to continuously understanding this field and to help combat neglect against elderly care patients.

I also think that it is important to not only know what causes burnout, but to understand how we can stop it before it becomes a problem. I think additional research into how we can stop burnout before it comes a problem is needed. Multiple participants noted that staff needed more than an agency party or food to feel good about their job and want to do a better job. In addition to this, quantitative studies to look at the prevalence of burnout and neglect would help to validate the research that has already been done in this field.

In this study, when asked if the burnout got better, worse or stayed the same after witnessing and reporting neglect, every participant said, "stayed the same" or "got worse." This speaks to the process of reporting and the workload following. There needs to be additional research into the process for reporting neglect incidents and the impact that has on staff and how to address that impact. By understanding the process of

reporting neglect, and what might be happening during and after, we can understand what is impacting staff and what staff need to not feel continued burnout or additional burnout. This can help agencies understand burnout and neglect further.

Implications for Social Change

This research study offers several implications that will aid in positive social change. All participants were asked at the end of the interview what they think needs to happen to improve the current situation. They noted that the biggest issue is pay, staffing and hours. Staff are becoming overworked and felt they were not paid enough to do the work they had been doing, causing stress in their life. Agencies need to understand what their workers need to feel valued while doing their job. One participant noted they "needed more than a pizza party or ice cream social to feel validated in the work". Nursing home staff need to feel appreciated for the work they are doing by the agency and supervisors and part of this can be done by paying them what they feel is adequate for the work they are doing. The most common thing participants need is more staff working in the nursing homes, that way they can do the job that needs to happen, they can focus on the clients and their needs, and they can feel accomplished.

Another area of social change is that agencies can see what is causing burnout in their staff and how it is causing neglect. Throughout this study participants spoke to what leads them to feeling burnt out, such as lack of staff, working too much and themselves and supervisors not being trained to do the job. Agencies can use this to guide their current training and onboarding program, they can begin to add additional or more training. Agencies can use this research to understand that current workers are

experiencing a level of exhaustion related to burnout and that something they need to help them is more staff for coverage and/or less mandated overtime.

This research sheds light onto the fact that those working in the field want to be working with elderly clients and they want to help. However, they are becoming burnt out at rapid rates, and it's impacting their jobs. Agencies can use this information to understand that this is happening in many elderly care agencies and it's something that they need to be addressing before it becomes neglect. Since all participants stated that the burnout, they experienced stayed the same or got worse after reporting incidents of neglect, we can understand that agencies also need to address the process for reporting and helping staff feel comfortable. They can review their process and understand what parts might be making staff experience more burnout. They can then address this process to help aid staff in feeling less burnout.

When participants were asked what can be done to help mitigate burnout, more training and supervisor training was stated as very important. Something agencies can take from this study to help mitigate burnout and help employees is additional training on burnout, self-care, caring for elderly and supervisor training on how to help staff who are experiencing burnout. When staff are trained to do different jobs, they can help others. They can also cover shifts for other people safely and adequately. Additionally, when they are trained to do their job in a more comprehensive way, they will feel a better sense of accomplishment within their work.

Conclusions

This study was to research how burnout is linked to the neglect of elderly patients from the point of view of staff members who witnessed the burnout and neglect. By using thematic analysis for this qualitative study, I was able to explore the lived experiences of staff members who experienced burnout before and after witnessing neglect. While other studies have examined burnout and mistreatment, this study addressed the gap identified in the literature as being specifically neglect of elderly residential clients and its connection to staff burnout. Through the analysis four themes emerged: lack of staff support, well-being of residents, compassion for working with elderly and unintentional actions. In these themes, nineteen sub-themes emerged. These themes can also be used to guide future research and understanding to the topic. The research will aid in closing the gap in literature related to understanding the connection between burnout and neglect of elderly patients in care.

As someone that is currently working in the field of human services and strives every day to ensure people receiving care have the best services and as someone who is striving to be an academic scholar, I believe this research is important to help provide quality care to elderly clients. The issue of burnout in staff and the issues of neglect against elderly residence continues to be of great problem in society. These topics cannot go without research. This topic is important and will continue to aid and help the amazing care staff that work in these facilities and elderly clients in care here in the United States.

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Appendix: Demographic and Interview Questions

Demographic Information

1. What is your age?
2. What is your gender?
3. How long have you been working in direct care with elderly populations?
4. How long have you/did you work at the agency where you cared for elderly clients?
5. How long have/did you hold your current position within this agency?
6. Have you held other positions at the agency where you looked after elderly clients?
    a. (If they answer "Yes" follow up with: what other positions have you held?)

Questions related to RQ

(Let participants know all questions pertain to the job they held when they worked with elderly clients and witnessed burnout and neglect).

RQ: What are the lived experiences of nursing home staff related to burnout before and after witnessing neglect of elderly patients?

1. Please discuss with me your thoughts on burnout in staff when working with the elderly residents.
2. Have you ever experienced this burnout within your professional career?

    If yes:

    a. Please describe the burnout and how it felt.

   b. What was the consequence of the burnout for you?
   c. What were the consequence to the burnout for the people you cared for?

3. Did you witness anyone else in your agency experience burnout?

   If yes:

   a. What did that burnout look like?

4. Please discuss some specific examples of burnout you witnessed within your agency or with yourself.
5. What happened to those who became burnt out in relation to how it affected how they treated and cared for patients?
6. What is the impact burnout had on staff within the agency?
7. What behaviors did you see in those who became burnt out?
8. What does neglect look like to you?
9. Have you witnessed neglect within the position you held working with elderly residents?
10. Please explain what neglect looked like or what happened when someone was neglected.
11. Please discuss a specific example of a neglectful incident.
12. Have you witnessed neglect by any of the people who have also experienced burnout, including yourself?
13. How did neglect affect the clients receiving care?

14. Please explain to me how you think burnout and neglect are related? From your experience (make sure it's an observation/experiential answer, rather than an academic one, (i.e., what they read about it, etc.))
15. Please discuss how those who experienced burnout also had committed neglect on the clients they served/cared for.

After witnessing Neglect

1. What steps or actions did you take?
2. Did you still experience burnout after you had taken those steps?

   If yes:

   a. Did the burnout get worse, better or stay the same?
3. Did other staff experience burnout related to witnessing neglect?
4. Where there any actions taken to help mitigate the burnout and experience related to witnessing neglect?

Conclusion Questions:

1. Looking back at your work, what have you learned about burnout and neglect?
2. What do you think can be done to help mitigate burnout in staff working with elderly clients?