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Review Article

Human Rights of Residents in the Nursing Home Sector: A Rapid Review of the Evidence

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Abstract

Background: Human rights are rights and freedoms that all people should enjoy. People should be treated with fairness, respect, equality and dignity. Within nursing/residential care settings, complying with human rights entitles and empowers residents with fundamental rights and freedoms in decisions about their care and support. **Aim:** To review the evidence about systems or models of upholding human rights in nursing homes globally. **Method:** A rapid review method was utilised, streamlining or omitting specific systematic review methods to produce evidence for stakeholders in a resource-efficient manner. **Results:** The screening of evidence identified 86 peer-reviewed publications for inclusion in this rapid review. The PRISMA diagram in Figure 1 outlines the screening process. The papers were divided into the main themes of: Autonomy, Freedom of Movement (FoM), Quality of life (QoL), Dignity, Restraint, Spirituality, Sexual expression, Elder abuse, and Elder care. **Discussion:** The review highlighted that human rights in older people in nursing homes is well researched in terms of reviews and qualitative work, with some cross-sectional studies of relevance and some randomised controlled trials published within the 20-year timeframe of this rapid review (2004-2024). Dignity and respect are the cornerstones of nursing care among residents of nursing homes which require effective communication and a good nurturing environment to be able to live as comfortably as possible in nursing homes during the final stage of their life. **Conclusion:** This rapid evidence review will enable a guiding approach which will empower care providers to better apply human rights principles into their practice.

Keywords: Human rights; Dignity; Respect; Rights-based approach; Nursing homes; Patient-centred care; Ireland

Background

Human rights are the basic rights and freedoms that all people should enjoy. Human rights are about people being treated with fairness, respect, equality and dignity. Within the nursing home sector, human rights are about residents having a say over their lives and taking part as fully as possible in decisions about their care and support [1]. There are universal declarations of human rights and human rights Acts in Europe and the United States of America (USA), however there are still concerns that older people in nursing homes globally, are not being treated with the care and dignity that they deserve [2-4].

The issue of human rights in Nursing homes has become a significant concern, especially during and since the COVID-19 pandemic [2,5-7]. There are a range of human rights issues facing residents in nursing homes. In the past, human rights in nursing / residential care homes research have focussed on physical restraint, however, other human rights such as the rights to be free from violence, abuse and neglect, freedom of movement, considering choice are now issues of interest when considering care conditions in nursing /residential care homes [8,9]. Nursing /residential care

homes can differ regarding medical care and in Ireland nursing homes are staffed by fulltime nursing staff.

FREDA is a human rights-based approach to healthcare which was introduced in the United Kingdom following the Human Rights Act of 1998 [2,10]. FREDA stands for fairness, respect, equality, dignity and autonomy (FREDA). In essence, the FREDA human rights-based approach is the process by which human rights can be protected in clinical and organisational practice by adherence to the underlying core values of fairness, respect, equality, dignity and autonomy.

Fairness is the quality of making judgments that are free from discriminatory practices. There is a link between fairness and the principle of equality [10].

Respect is the objective and impartial consideration of other people's rights, values, beliefs and property. Respect applies to the person as well as their value systems and implies that these are fully considered before decisions are made that may override them [10].

Equality relates to the state of being equal, especially in terms of status, rights, or opportunities. Equality overlaps with respect 10. Dignity in care means the kind of care which supports and promotes, and does not undermine, a person's self-respect regardless of any difference [10].

Autonomy is regarded as one of the four fundamental ethical principles of healthcare. Autonomy incorporates the principle of self-determination. A person is enabled to make free choices about what happens to them. This is the freedom to act and the freedom to decide, based on sufficient, relevant and clear information and opportunities to take part in the decision-making process [10].

The **FREDA** approach has also been adopted in Ireland by the Health Information and Quality Authority [1]. This human rights-based approach to care and support is underpinned by a legal framework and human rights treaties which countries including Ireland have agreed to uphold. This legal framework places a responsibility on health and social care providers at an organisational and individual practitioner level to uphold the human rights of people using their services. The aim of this rapid review is to discover the evidence about systems or models of upholding human rights in nursing/residential care homes globally.

Materials and Methods

A rapid review method was utilised for this review. A rapid review is a form of knowledge synthesis that accelerates the process of conducting a traditional systematic review through streamlining or omitting specific methods to produce evidence for stakeholders in a resource-efficient manner.

Main question: What is the evidence about contemporary systems and good governance approaches to human rights adherence for nursing/residential care home residents globally?

Sub-question: What are the outcomes from studies that report on human rights?

Sub-question: Is there any economic impact of introducing human rights into management and administration of nursing/residential care homes?

Eligibility criteria

The eligibility criteria for inclusion of papers in this rapid review are described in the Population, Intervention, Comparison and Outcomes (PICO) Table (Table 1) [11].

	Inclusion criteria	Exclusion criteria
Population	Older people/residents of nursing homes	People not living in nursing homes (Studies focusing solely on non-residential care settings)
Phenomenon of Interest	Papers related to human rights in nursing homes	Papers not related to human rights
Context	Service delivery of nursing home care globally	Services not relevant to nursing home care
Outcome measures	Studies that report on relevant outcomes related to human rights. Primary outcome(s): dignity, equity, respect. Sub-outcomes: economic impact (cost-effectiveness, etc), economic benefits (reduction in lawsuits, penalties, etc).	Studies unrelated to the dignified care of the residents in homes. (Studies that do not report on relevant outcomes related to human rights, or economic impacts).
Study design	Any evidence of human rights in nursing homes	Studies not focussed on human rights in nursing homes mainly.
Countries	We will include studies from around the world.	No country was excluded.
Language of publication	English	All languages other than English.
Publication date	January 2004 to August 2024	All papers prior to January 2004.
Publication type	Published and preprint	Unpublished material.
Other factors	Staff issues for example retention, cultural, and environmental factors affecting human rights in nursing homes.	

Table 1: Eligibility Criteria (PICO Table).

Incorporating data from existing reviews

Existing systematic reviews were included in the rapid review.

Literature search

Evidence sources

The following databases were searched for papers of interest:

- PubMed (including MEDLINE)
- EMBASE
- CINAHL
- PsycINFO
- Social Sciences Citation Index
- Web of Science
- Relevant grey literature

A draft search strategy was prepared and adapted for each of the databases. The search strategy was reviewed by an Information Scientist, Royal College of Surgeons, Ireland.

Search Strategies

The search strategies for all database searches can be found in Appendix 1.

Reference management

Covidence reference management software was used as the main systematic review management tool and to remove duplicates [12]. Mendeley was used for in-text citations.

Study selection process

Two reviewers screened 100% of titles and abstracts independently. After this, the level of agreement was assessed with disagreements settled by discussion and consensus. During independent screening, the lead researchers (MC & ML) consulted with the other two reviewers to come to an agreement on the final inclusions if there was a disagreement.

Data extraction

Data extraction was based on the outlined eligibility criteria. We extracted details/characteristics on the study country, study design, type of intervention, type of economic evaluation, and number of participants, relevant costs and outcomes (see Eligibility Criteria) and study settings.

Assessment of methodological quality

Critical appraisals were conducted on all selected peer-reviewed studies using the Joanna Briggs Institute Quality Appraisal Tools [13].

Results

Overview of the evidence base

This rapid review included 86 studies, which are presented in the PRISMA diagram in Figure 1 [14]. The papers were divided into n = 9 themes including Autonomy, Freedom of Movement (FoM), Quality of life (QoL), Dignity, Restraint, Spirituality, Sexual expression, Elder abuse, and Elder care. The data extraction table is presented in Appendix 2.

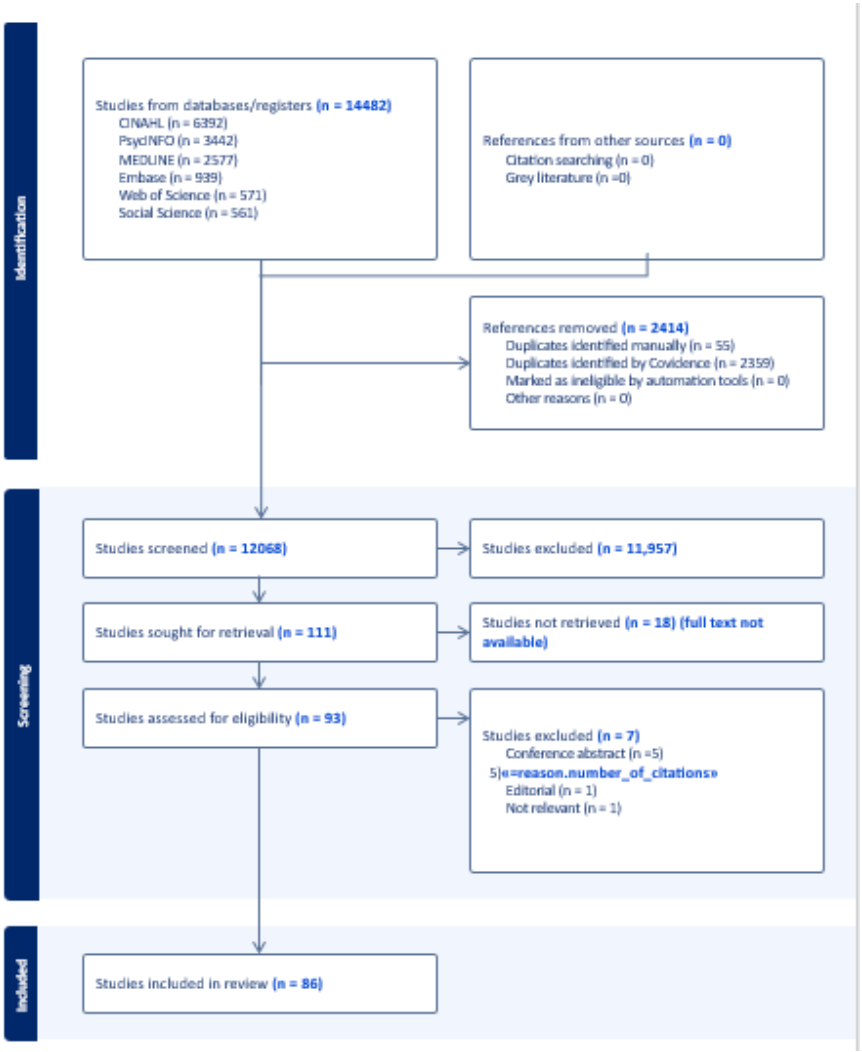

Figure 1: PRISMA diagram of included studies.

Type of study	Review or Systematic review	Cross-sectional study (or case study or mixed methods study*)	Qualitative study	Quantitative study (Cohort or Survey)	Randomised Controlled Trials
	1. Aguilar (2017)	1. Chien et al., 2022	1. Bayer et al., (2005)	1. Bellenger et al (2017)	1. Koczy et al., (2011)
	2. Anand (2022)	2. Dong et al., (2021)	2. Caspari et al., (2018)	2. Bellenger et al (2019)	2. Lee et al., (2020)
	3. Boyle (2009)	3. Dunbar et al., (2022)	3. Charpentier and Soulieres (2013)	3. Bloemen et al (2015)	3. Oye and Jacobsen (2018
	4. Castle et al., (2015)	4. Estevez-Guerra et al., (2017)	4. Choe et al., (2017)	4. Botngard et al., (2020)	4. Testad et al., (2016)
	5. Cleland et al., (2021)	5. Heinze et al., (2011)	5. Evans et al., (2018)	5. Burack et al., (2012)	
	6. Duffy et al., (2024)	6. Komorowski et al (2024)	6. Fekonja et al., (2022)	6. Diaz Diaz et al., (2023)	
	7. Emmer De Albuquerque Green et al., (2018)	7. Murphy (2007)*	7. Hall et al (2014)	7. Kor et al., (2018)	
	8. Emmer De Albuquerque Green et al., (2022)	8. Roos et al., (2022)	8. Heggestad et al., (2013)	8. Kloos et al., (2019)	
	9. Enmarker et al., (2011)	9. Redmond et al., (2022)	9. Heggestad et al., (2015)	9. Morgan (2012)	
	10. Haunch et al., (2021)	10. Sandgren et al., (2020)	10. Heward et al., (2022)	10. Oosterveld-Vlug et al., (2016)	
	11. Hirt et al., (2022)	11. Wang et al., (2020)	11. Hoek et al., (2020)	11. Patomella et al., (2016)	
	12. Hofmann and Hahn (2014)		12. Hoy et al., (2016)	12. Teeri et al., (2008)	
	13. Holst and Skar (2017)		13. Hutchinson et al., (2024)	13. Van Leimpd et al., (2024)	
	14. Lane and Harrington (2011)		14. Jen et al., (2022)	14. Vitorino et al., (2019)	
	15. Lee et al., (2021)		15. Leyerzapf et al., (2018)	15. Wang et al., (2018)	
	16. Lennox and Davidson (2013)		16. Nakrem et al., (2011)		
	17. MacKinlay (2008)		17. Ostaszkiewicz et al., (2018)		
	18. Morrison-Dayan (2024)		18. Oye et al., (2016)		
	19. Pu and Molye (2020)		19. Roos et al., (2023)		
	20. McDonald et al., (2015)		20. Saarnio and Isola (2010)		
	21. Moilanen et al., (2020)		21. Slettebø et al., (2017)		
	22. Morrissey et al., (2022)		22. Steele et al., (2022)		
	23. Phelan (2015)		23. Thys et al., (2019)		

	24. Phelan (2018)		24. Tuominen et al., (2016)		
	25. Sherwin and Winsby (2011)		25. Woolford et al., (2020)		
	26. Steele and Swaffer (2022)				
	27. Torossian et al (2021)				
	28. Van der Geugten and Goosensen (2019)				
	29. Van der Weide et al., (2023)				
	30. Van Leimpd et al., (2023)				
	31. Welford et al., (2010)				
N = 86 papers in total	**31**	**11**	**25**	**15**	**4**

Table 2: Evidence map of the included studies.

An evidence map of the literature is presented in Table 2, which categorises the evidence according to study type. The studies were critically appraised by the four investigators, according to study type using the Joanna Briggs Institute critical appraisal checklists (see Appendix 3). Most studies included were of moderate to high quality, with just a few low-quality studies included. No studies were discarded based on their overall quality. The table of abbreviations can be seen in Appendix 4.

Guidance documents

Guidance documents include the Universal Declaration of Human Rights, the Human Rights Act [2,3].

Elements of the human rights guidance are presented in **Table 3**.

Human rights guidance documents	Year	Key elements of the guidance documents
The International Covenant on Economic, Social and Cultural **Rights** (ICESCR). [15]	1966	The International Covenant on Economic, Social and Cultural Rights (ICESCR) is a key international treaty adopted by the United Nations General Assembly in 1966 and came into force in 1976. It aims to protect and promote a wide range of economic, social and cultural rights including freedom from fear and other cruel, inhuman, or degrading treatment or punishment ICESCR includes Article 12, which protects the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
Universal human rights guidance [3]	2024	The Universal Declaration of Human Rights (UDHR) outlines fundamental human rights to be universally protected. **Universality:** Human rights are universal and apply to all people, regardless of nationality, ethnicity, or any other status. **Indivisibility**: All rights are equally important and cannot be ranked in order of importance. **Interdependence:** The enjoyment of one right often depends on the enjoyment of others.

The European Convention on Human Rights [16]	2024	The European Convention of Human rights protects the rights to: • Life, freedom and security • Respect for private and family life • Freedom of expression • Freedom of thought, conscience and religion • Vote in and stand for election • A fair trial in civil and criminal matters • Property and peaceful enjoyment of possessions.
The Irish Constitution, also known as Bunreacht na hÉireann [17]	1937	The Irish Constitution, includes several articles that outline and protect fundamental human rights: **Personal Rights:** Articles 40 to 44 of the Constitution set out fundamental personal rights. These include the right to equality before the law, the right to life, personal liberty, freedom of expression, freedom of assembly, and freedom of association. **Equality Before the Law:** Article 40.1 states that all citizens shall be held equal before the law, meaning the State cannot unjustly discriminate between citizens. **Right to Life:** Article 40.3 specifically recognises and protects the right to life. **Personal Liberty:** Article 40.4 guarantees the right to personal liberty, except in accordance with the law. **Freedom of Expression:** Article 40.6.1.i protects the right to freely express views and opinions, though this right can be restricted in the interests of public order and morality. **Freedom of Assembly and Association:** Articles 40.6.1.ii and 40.6.1.iii protect the rights to peaceful assembly and to form associations or unions.
Human Rights Act [2]	1998	The Human Rights Act 1998 is a significant piece of legislation in the UK that incorporates the rights set out in the European Convention on Human Rights (ECHR) into domestic British law. The key features of the Act are: **Fundamental Rights and Freedoms:** The Act sets out the fundamental rights and freedoms that everyone in the United Kingdom is entitled to. These include the right to life, freedom from torture, right to a fair trial, and freedom of expression. The Act includes several key articles from the ECHR, such as: **Article 2**: Right to life **Article 3:** Freedom from torture and inhuman or degrading treatment **Article 5:** Right to liberty and security **Article 6**: Right to a fair trial **Article 8:** Respect for private and family life **Article 10:** Freedom of expression **Article 14:** Protection from discrimination.
Guidance on Human-Rights-based Approach in Health and Social Care Services [18]	2019	The Human-Rights-based Approach in Health and Social Care Services in Ireland is based on the FREDA human rights-based approach. This is a process by which human rights can be protected in clinical and organisational practice by adherence to the underlying core values of fairness, respect, equality, dignity and autonomy (FREDA).

Towards a Restraint Free Environment, Department of Health, Ireland[19]	2020	This policy document outlines a national strategy for promoting a restraint-free environment in designated centres for older people in Ireland. Underlying the policy are the principles of equality, fairness, respect, dignity, autonomy and participation.

Table 3: Elements of human rights guidance.

Autonomy

Seven of the included studies were related to autonomy of residents in nursing/residential care homes [20-26]. Of these, four studies were reviews of various kinds, with none being systematic reviews [23-26]. One was a qualitative study 20 and two were cross-sectional studies [21,22]. Maintaining the autonomy of residents with dementia in nursing/residential care homes can be challenging with the evidence highlighting [20] three areas of the need to balance safety and risk against the individual needs of residents: physical environment; preservation of dignity; and the individual versus the group. Firstly, the physical environment created a tension between safety and accessibility to the outside world, which meant that some nursing/residential care homes provided highly structured or limited access to outdoor space. Secondly, balancing between an individual's autonomy and the need to protect their residents' dignity and thirdly, individual's needs were framed by the needs of other residents to the extent that on some occasions the needs of the general population of a home were prioritised above individual needs.

A quantitative study conducted in Dutch nursing homes found that 'autonomy', 'relatedness' and 'competence' were related to both the well-being measures used in the study, although autonomy had the strongest relationships. Only autonomy and competence were uniquely associated with depressive feelings, and only autonomy was uniquely associated with life satisfaction. The moderate correlation of autonomy with satisfaction with life ($r = .43$) was significantly stronger than the weak correlation of competence, with satisfaction with life ($r = .23$, $z = 2.07$, $p = .04$) and marginally significantly stronger than the weak correlation of relatedness with satisfaction with life ($r = .29$, $z = 1.87$, $p = .06$). For completers-only, autonomy also had stronger correlations with life satisfaction than relatedness with life satisfaction, but this difference was not significant ($z = 1.13$, $p = .26$) [22].

A cross-sectional study explored to which extent autonomy was supported within staff-resident interactions [21]. The findings indicate that autonomy seemed to be supported by staff in 60% of the interactions. However, missed opportunities to engage residents in choice were often seen. These mainly seem to occur during interactions in which staff members took over tasks and seemed insensitive to residents' needs and wishes. Differences between staff approach, working procedures, and physical environment were seen across nursing/residential care home locations, which may support or impede resident autonomy and gaining resident consent and engagement in care activities appeared greater when staff actively supported resident autonomy. The main challenges seemed to exist in supporting autonomy for residents with severe cognitive impairment in the Netherlands [21].

The four review papers on the theme of autonomy were published between 2010 and 2023. The evidence suggests there are six attributes of autonomy for older people. These were: (1) Residents are involved in decision-making while their capacity is encouraged and supported. (2) Residents delegate their care needs based on the right to self-determination, and this can be achieved through (3) negotiated care planning, which is encouraged through open and respectful communication and (4) including families or significant others when the resident is cognitively impaired. (5) The residential unit operates a culture and atmosphere of flexibility within an ethos of supporting resident dignity. (6) Meaningful relationships are enabled by the presence of regular and motivated staff, and these relationships enhance the opportunities of residents to be autonomous [26].

Evidence identified that to truly attend to the needs and interests of frail older persons who require the care associated with residency in nursing/residential care homes, there is a need to change the conceptual framework within which many facilities function and be more attentive to the need to correct the damage of oppressive ageism, such as negative attitudes towards older people and overlooking older people. In addition, research results indicate that the problem does not lie primarily with specific caregivers or institutional managers, but rather with the cultural space occupied by nursing/residential care homes for older citizens [24].

A recent review identified that nursing support for the autonomy of older people in residential care needs to be focused on in eight diverse ways: 1. Protecting people's rights to make their own decisions. 2. Acting as advocates; 3. Respecting older people's wishes; 4. Providing opportunities; 5. Fostering independence; 6. Providing information for older people and their families; 7. Individualising care practices; 8. Protecting safety) and barriers relating to these diverse ways need to be overcome [23]. In a review of interventions for people with dementia in nursing/residential care homes, four themes were identified: 1. preferences and choice: interventions for supporting autonomy in nursing/residential care homes and their results, 2. personal characteristics of residents and family: people with dementia and their family

being individuals who have their own character, habits and behaviours, 3. competent nursing staff each having their own level of knowledge, competence and need for support, and 4. interaction and relationships in care situations: the persons involved are interrelated, continuously interacting in different triangles composed of residents, family members and nursing staff. The findings identified that results from interventions on autonomy in daily-care situations are likely to be just as related not only [27] to the characteristics and competencies of the people involved, but also to how they interact. Autonomy support interventions appear to be successful when the right context factors are considered [25].

Freedom of movement

Eight studies were included under the theme of 'Freedom of movement' [28-35]. Of these eight studies, n = 4 were reviews [28-30,33]; n = 2 were qualitative [32,35] n = 1 was a longitudinal study [33], and n = 1 was a case study using Australia as an example [31].

The reviews were a mixture of general literature reviews and one systematic review (SR) [28-30, 33]. The adequacy of the Deprivation of Liberty Safeguards (DoLYS) for protecting the liberty of residents in social care settings and associated regulation was examined [29]. Findings indicate that the capacity of the safeguards to adequately protect the liberty of residents with dementia may be limited due to insufficient resourcing and a lack of critical independence and the model of regulation adopted in the UK has prioritised economic efficiency over safeguarding the right to liberty of vulnerable residents in care institutions [29]. The review published in 2022 aimed to expose the deaths and harms experienced by older people living in care homes in seven European countries during the first 10 months of the COVID-19 pandemic using the European Convention on Human Rights lens [28]. The identified human rights violations included the right to life, liberty and security, respect for private and family life, prohibition of torture, and general prohibition of discrimination. These violations were viewed as an abject disregard for older people's human rights [24]. A 2024 review aimed to demonstrate how a human rights-based framework can provide guidance to governments in approaching issues involving the protection of older people's need for social connection in aged care [30]. Social participation can be better protected and social isolation countered in the Australian residential aged care context through implementing international human rights law (IHRL). The authors recommend that federal, state and local governments and community organisations should engage in educational campaigns and other measures, including dementia awareness programmes.

A Systematic Review was conducted to examine how to enhance the human rights of people living with dementia in seven countries. Findings indicated that there were micro-level interrelated and compounding factors that contributed to human rights abuses of people living with dementia, such as limits on freedom of movement and community access of people living with dementia [28]. Violations of human rights included immobilisation and neglect of residents also limited and segregated recreational activities [33].

Examination of free will and having control of bedtime, dressing, privacy and social life with relatives, receiving help when needed, having an impact on meals, hygiene, free movement, meaningful action and social life. Promoters included older people's attitudes, behaviour, health, physical functioning as well as nurses' ethical conduct. Barriers to free will were nurses' unethical attitudes, institution rules, distracting behaviour of other residents, older people's attitudes, physical frailty and dependency [32]. A qualitative study exploring whether residents felt that their dignity was maintained and respected discovered that 'Autonomy or paternalism', 'inner and outer freedom' and 'dependence as an extra burden' were key. Findings suggest that it is important and valuable for nursing/residential care home staff to consider how they can help older people feel that they still have their freedom, as many residents felt constraint [35].

A quantitative longitudinal study investigated whether and to what extent increased freedom of movement is associated with the positive health of nursing home residents with dementia over time in The Netherlands [34]. Research findings indicate that increasing freedom of movement for nursing/residential care home residents with dementia is associated with improved health outcomes, both immediately and over time. Most dimensions of the residents' health improved after moving from a closed nursing home to a semi-open nursing home with significant improvement over time for agitation and the quality-of-life subscales 'care relationship' and 'feeling at home' [34]. The reparations for harms experienced in residential aged care were examined to seek a solution for a comprehensive approach to reparations, which includes not only compensation and rehabilitation for individuals but also collective reparations such as public apologies and education to prevent future harms [31].

Quality of life

Four of the included studies focussed on quality of life (QoL) as a main outcome [36-39]. One was a rapid realist review, one was a survey, one was a cross-sectional study, and one was a qualitative study. A study investigated the QoL of nursing/residential care home residents in 11 domains along with resident satisfaction with the nursing home and nursing home staff. After accounting for cognitive and physical functioning, among the QOL domains, dignity, spiritual well-being, and food enjoyment remained

predictors of overall nursing/residential care home satisfaction. Additionally, dignity remained a significant predictor of residents' satisfaction with staff. However, although dignity was significantly related to both satisfaction measures utilised, spiritual well-being and food enjoyment were also significant positive predictors of residents'' overall satisfaction with the nursing/residential care home. The domain of spiritual well-being may relate to perceptions of the nursing/residential care home as a "good place" for people to be [36].

A rapid realist examined the relationship between staffing and quality care in nursing/residential care homes [37]. Results indicate that quality is influenced by staff behaviours and behaviours are contingent on relationships nurtured by long-term care facility environment and culture. In addition, leadership has an important influence on how organisational resources (sufficient staff effectively deployed, with the knowledge, expertise and skills required to meet residents' needs) are used to generate and sustain quality-promoting relationships. Also, leaders (at all levels) through their role-modelling behaviours can use organisational resources to endorse and encourage relationships (at all levels) between staff, residents, co-workers and family [37].

A cross-sectional study investigating person-centred care, communication and autonomy of nursing/residential care home residents found that only one-fifth of the older persons reported been able to do the things they liked to do, in felt in control of their future, indicative of minimal autonomy [39]. Recommendations advised that nursing/residential care home staff should frequently offer, invite and involve residents in interactions by asking for their opinions, involving the older person in meaningful everyday activities, care planning and offering choices. In addition, the evidence suggested that frail older persons seemed to have no or little fear of death or dying which could facilitate conversations about death and dying according to the needs of frail older persons.

A qualitative study examined what quality of life domains are most important to older adults in residential care. Findings indicate that physical and psycho-social aspects are important for older adults' quality of life with six key quality of life domains identified: independence, mobility, pain management, social connections, emotional well-being, and activities. Further research is required to test these domains with a more diverse sample of older adults living in residential aged care settings, in particular, older adults from culturally and linguistically diverse communities [38].

Dignity

Dignity was the focus of 16 of the included papers in this rapid review. Human dignity is a universal value ascribed to human beings. The concept of dignity is related to respect and equality [40]. Within this theme of 'dignity', n = 9 were qualitative studies [27,41-48]; n = 3 were reviews [49-51]; and n = 3 were quantitative studies including surveys and cross-sectional studies [47,52,53].

Examining the voice of older people regarding dignity identified that for dignity of older people to be enhanced, communication issues, privacy, personal identity and feelings of vulnerability need to be addressed. Education of all professionals should pay attention to practices that enhance or detract from the experience of dignity. Policies and standards need to go beyond the merely mechanistic and easily quantifiable, to identify meaningful qualitative indicators of dignity in care. Of particular importance and relevance was the notion of 'dignity of personal identity' and demonstrating respect was to treat someone as though they were an individual, with a history, a unique identity and personal relationships [41].

A study exploring dignity and care for people with dementia living in nursing/residential care homes found that residents felt that their freedom was restricted, and they experienced feelings of homesickness and perceived as lacking autonomy and considered a threat to personal dignity. To protect and enforce the dignity of persons with dementia living in nursing/residential care homes, residents should be viewed as whole and individual persons [44].

A study investigating the maintenance of dignity found that issues of dignity as embedded in the daily interactions between care providers and residents [43]. Treating residents with respect, promoting their independence, autonomy, choice and control whilst minimising risk, and ensuring privacy helps residents of care homes maintain dignity. Focusing on fostering dignity can be a starting point for improving the quality of care and quality of life of residents. However, it is important to remove the gap between the rhetoric of dignity-conserving care and the reality experienced by residents in these and other care settings. This could be achieved by providing care homes with sufficient resources along with quality assurance programs, which provide leadership, support, and training for staff [43].

Dementia in nursing homes was investigated by Heggestad et al., (2015) who noted that care which focuses on the residents' personhood, combined with a relational focus, is of immense importance in maintaining the dignity of people with dementia living in nursing homes [54].

Maintaining dignity was constituted in a sense of vulnerability to the self and elucidated in three major interrelated themes: Being involved as a human being, being involved as the person one is and strives to become and being involved as an integrated member of society. Maintaining dignity in nursing homes from the perspective of the residents can be explained as a kind of ongoing identity process based on opportunities to be involved and confirmed in interaction with significant others [45]. Enjoyable activities

in nursing homes can foster experiences of dignity in nursing through meaningful participation and enjoyable individualised activities and. Nurses should collect information about resident's preferences for participation in activities and tailor the activities to the individual [48].

A study investigating the understanding and expectations about quality continence care was linked to beliefs about incontinence being an intractable and undignified condition in nursing/ residential care homes. The key theme to emerge was "protecting residents' dignity" which was supported by the following six subthemes: (i) using pads, ii) providing privacy, (iii) knowing how to "manage" incontinence, (iv) providing timely continence care, (v) considering residents' continence care preferences and (vi) communicating sensitively. Toileting is resource intensive. Providing residents with timely toileting assistance and changing continence accessories when soiled or saturated protected residents' dignity. Resource issues such as lack of staffing are a challenge in maintaining dignity and continence care [46].

Dignity of risk (DoR) principles to improve dignity and quality of life for vulnerable persons were explored and identified [27] our interrelated components: the person, taking risks, choice, and the process. Explanations of DoR are consistent with person-centred care in which a client's choices and values are considered a necessary part of care to support autonomy and meaning in life. The exception is the participants' inclusion of the key role risk has in daily life for older vulnerable persons. Recognising vulnerable clients make choices that involve risk, often termed "positive risk taking," is instrumental for those persons with cognitive and physical disabilities to manage their health. This approach supports independent living in accordance with the personal values of the individual [27]. A qualitative study from Slovenia examined the care of the residents in nursing homes. The authors were interested in exploring the concepts of dignity, care and respect [42]. Findings suggested that disrespectful care, evoked feelings of inferiority and insignificance among bedridden residents of the nursing home [42].

A study by Roos et al. (2023) regarding dignity and well-being of older persons highlighted the importance of preserving their identity. Residents indicated it was important to be able to manage daily life, to gain support and influence and to belong to a social context. The participation of different professionals working together is essential for implementing person-centred care (PCC) [47].

The reviews investigated dignifying and undignifying aspects of care for people with dementia (including Alzheimer's and related dementias (ADRD). Good privacy practice in care homes is to make available single-occupancy bedrooms for residents [41,51]. Residents should be given the opportunity to personalise their room with furniture and other belongings, adding a sense of ownership over the space. Staff should also knock on doors before entering or agree with the resident when it is permissible to enter. Surveillance technology such as cameras in common room locations can infringe on people's right to privacy [41]. Undignifying aspects of care are characterised by unsuccessful processes of acknowledging and conciliating with the changing person with dementia and can threaten dignity in people with severe dementia because of their total care dependency [51]. Vulnerability towards undignifying care practices is reinforced by the lack of reciprocity in the care relation and diminished conversation and communication skills. It was noted that formal and informal caregivers can contribute to preserving the dignity of people with dementia, especially in the later stages of the disease [51].

A scoping review examining interventions to enhance dignity was either inconclusive, lacked rigour, or had no lasting effect. More research is needed to objectively measure the dignity of care home residents and examine the effectiveness of interventions aimed at promoting dignity [50]. Key themes in dignity in care have been identified as maintaining independence, individual respect and personal care, however, more needs to be done regarding dignity in care work in Wales [53]. Evidence suggests that undermining dignity is a crucial step toward more effective dignity-conserving care which will benefit people living in long-term care institutions [55]. A study investigating dignity among older adults in long-term care facilities found that dignity is associated with disease-related factors and socioeconomic factors (including previous residence) [52]. However, no significant association was found with age, gender, religion, marital status, educational level, occupation, and type of health insurance. When the material needs became a problem, the spiritual needs were no longer pursued. Economic status also influenced physical and psychological conditions [52].

A cross-sectional study investigated factors associated with dignity and well-being among older people living in residential care homes [56]. Findings indicate that respondents who had experienced disrespectful treatment, those who did not thrive in the indoor-outdoor-mealtime environment, those who rated their health as poor and those with dementia had higher odds of being dissatisfied with dignity and well-being. To promote dignity and well-being, there is a need to improve the prerequisites of staff regarding respectful attitudes and to improve the care environment. The person-centred practice framework can be used as a theoretical framework for improvements, as it targets the prerequisites of staff and the care environment [56].

Restraint

Twenty studies relating to restraint met the study inclusion

criteria. Thirteen were systematic reviews, four were descriptive surveys and three were qualitative studies. Eight studies related to the use of physical restraints. These are: Physical restraints and identifying its risk factors [57] , the duration of restraint, physical health and restraint and the risk of falling [58]; policy and practice relating to the use of restraint and reduction of restrictive practices in Ireland [59,60] aggressive behaviour occurring due to physica restraint, psycho-active drugs (chemical restraint) and falls [60] context specific physical restraint and human rights policy and enforcement [61] physical restraint, dignity, autonomy, risks, benefits, use of full enclosure on side rails and legislation [62] ethical considerations in the use of physical restraint [63] and deaths attributed to physical restraint, reported to Coroners, in Australia over a 13-year period [64].

Seven studies presented on nurses' perception and their restraint knowledge and education. These related to the perceptions of nursing staff on the use of direct and indirect physical restraint [65]; reduction in the use of restraint and the educational initiatives put in place to reduce restraint in residents with dementia [66]; staff knowledge, attitudes and practices of restraint use) [67,68] the relationship between nurses' knowledge levels, attitudes and intentions regarding physical restraint [68] restraint use relating to resident rate of falls and nursing staff levels [69] effectiveness of a tailored 7-month training intervention in reducing restraint use, agitation, and antipsychotic medications [70] and how education influences formal and informal restraint use [71].

Five studies related to the resident characteristics that led to restraint use and ensuing consequences [72]; restraint used and organisational interventions [73] nurses training for resident depression [74]; approaches to managing aggression [75] and aggressive behaviour and dementia [76].

Use of physical restraints

Eight studies related to the use of physical restraints and identifying its risk factors. A mixed methods study found [57] that physical restraints usage was 26%, and use of waist belts and wrist restraints were used by over half of the respondents [57]. However, just 62% of physical restraints were signed with informed consent and 89% did not have nursing documentation. It was also found that 72% of physical restraints were caused in efforts made by staff to prevent falls and 14% had physical complications. Findings point to the elevated level of nursing staff using physical restraint as resulting from a lack of training, standards and regulations, especially in reporting and decision-making [57].

Chien et al. (2022) explored the rate of physical restraint and associated risk factors and identified that 30% of respondents had been previously restrained. The factors contributing to a higher than usual physical restraint rate were clinical characteristics including older age, lower cognitive function, higher dependence and dementia. It was also found that residents with the most behaviour and psychological symptoms were associated with an increased restraint rate. The percentage of residents with severe dementia was higher in residents who had been restrained compared to the group not being restrained (79% *vs* 50 %) [58].

Dunbar et al. (2022) determined the incidence and type of restrictive practice (RP) use in nursing homes in Ireland [59]. Findings reveal 70,663 reported uses of RP over the 12-month period (November 2019 -October 2020). Five hundred and fifty nursing homes (90.5%) reported using at least one RP in the 12-month period, meaning 58 (9.5%) nursing homes reported using no RP in the 12-month period. Most nursing homes (n = 527; 86.7%) reported using at least one physical RP; environmental RP (n = 298; 49%); chemical RP (n = 233; 38 %); and 'other' (n = 109 (18 %). In the physical RP category, bedrails were the most frequently reported (63.7%). For environmental RP, the most frequently reported RP type was door lock and the second most frequent was window lock. When combined, door lock and window lock accounted for most types within this category (90%). Under chemical RP, no drug was specified in most notifications (85%). Where a drug was specified, the majority (96%) were: antipsychotics and anxiolytics. The 'other' RP category described restrictions such as motion alarms (devices that notify staff if a person is mobilising) and listening devices. The theme of liberty and autonomy was the third most frequently reported type (n = 278; 12.6%).

An RCT by Koczy et al. (2011) explored the effectiveness of a multifactorial intervention to reduce the use of physical restraints with use at the start of the intervention was higher in the intervention group (7%) than in the control group (5%) [60]. Findings indicated that 70% were aged 80 and older presenting with severe dementia and limited physical mobility. More than 90% of the study population was categorised as needing a medium or high need for care with the intervention group requiring more nursing assistance than the control group on the mobility and cognition scales. No effect was observed on the number of psychoactive drugs taken or in change of behaviour [60].

A mixed methods study aimed to develop and prioritise recommendations to reduce and prevent the use of physical restraints among nursing home residents and to rank the recommendations according to perceived importance, feasibility, and impact [61]. Fifteen recommendations were highlighted. The three recommendations ranked as most important were that: a single definition be mandated for describing "physical restraint"; the use of physical restraint acts as a trigger for mandatory referral to a specialist aged care team and ensuring that the profile and competencies of nursing home staff are appropriate to meet the complex needs of residents with dementia, thus obviating the need

to apply physical restraint. It was also recommended that more staff training and improved staff to resident ratios were needed and that families have a role to play in the issue of restraint/no restraint of residents [61]. A literature review aimed to identify the factors that influence nurses' use of physical restraint on people aged over 60 years living in nursing homes [63]. The review identified the ethical considerations made by nurses when using physical restraints and the policies on physical restraint required. Nurses need to understand the nursing culture that perpetuates restraint use, and to consider patient-centred nursing as an instigator for change. Use of physical restraint was associated with 'patient safety' and 'nurses' workload.' Restraint use was found to have a higher profile in acute and residential care, due to frequent, ritualised practice, and nurses' automatic response to using restraint. There is an obligation to question if this decision is in the best interest of the patient or the nurse as nurses need to know how to balance moral and safety issues to effectively make decisions on restraint use [63].

Bellenger et al. (2017) investigated the nature and extent of physical restraint deaths in accredited nursing homes, and attributed to physical restraint, reported to Coroners, in Australia, over a 13-year period, with five deaths due to physical restraint reported over this timeframe [64]. All residents had impaired mobility, had restraints applied for falls prevention and 80% had dementia. Neck compression and entrapment by the restraint were the mechanism of harm in all cases, resulting in restraint asphyxia and mechanical asphyxia, respectively. The types of physical restraints used were lap belts and bed rails. Four deaths occurred amongst individuals residing as permanent residents for seven months or longer. No standards govern the use of restraint in nursing homes in Australia. A 'restraint free' model of care in nursing homes was recommended [64].

Nurses' perception, restraint knowledge and education

A study explored the perceptions of nursing staff on the use of physical restraints in institutional care of older people [65]. The main outcomes identified related to decision making and ethical and physical issues around restraint. Findings indicated direct and indirect restraints were being used in addition to traditional methods of restraint, such as belts and locked doors. Nursing staff used indirect restraint by removing the patient's mobility aid. Factors contributing to the use of restraints included requests by the patient's family members to use restraint to ensure the patient's safety and for social reasons, and due to lack of legislation on the use of restraint. It was also found that the use of restraints caused feelings of guilt among the nursing staff but was seen to make older patients feel more secure [65]. Educational initiatives were also a factor in restraint use. A similar finding was found by Pu and Moyle (2022) exploring the reduction in the use of restraint and the educational initiatives put in place to reduce restraint in residents with dementia in residential aged care facilities [66]. Findings demonstrated the prevalence of restraint use in people with dementia as being high with the prevalence of restraint use varying from 31% to 65% depending on different operational concepts. In addition, results identified that people with dementia were at a higher risk for restraint use, that the decision-making process for restraint use was ignored in the literature and the effect of staff educational interventions to reduce restraint use was inconsistent due to varying delivery duration and content [66].

Nurses' knowledge was also explored by Kor et al., (2018) in a survey of 298 staff, working in four nursing homes in Hong Kong, to understand whether there were any changes in nursing home staff's knowledge, attitudes, and practices of using physical restraints [67]. Findings indicated a significant improvement in terms of attitudes and practice of using restraints. Overall, staff had satisfactory knowledge of the daily application of physical restraints, such as the operational procedure and daily assessment. Just 6.6% of respondents were aware that residents had a right to reject the use of physical restraints, and 70% believed that there were no good alternatives to restraints. Respondents showed appropriate attitudes in their ethical practice of daily use of physical restraints [67].

A study exploring nurses' knowledge of restraint by Redmond et al. (2022) identified the relationship between nurses' knowledge levels, attitudes, and intentions regarding physical restraint [68]. Findings indicated that nurses' knowledge and attitudes predicted nurses' intentions not to use restraint, with attitude being the stronger predictor of intention. Falls risk caused the greatest variation in intention to use physical restraint. A significant positive relationship existed between knowledge and attitudes, with both preventing restraint use. Education was significant in predicting knowledge and attitudes, yet years of experience did not [68].

Heinze et al. (2011) explored how nurses used their clinical judgement to assess the risk of falling in 76 nursing homes (n = 5521) and 15 hospitals (n = 2827), in Germany [69]. The study investigated factors related to the use of restraints and whether the rate of qualified nurses was an influencing factor in their use. Findings indicated that the prevalence of restraints (bed rails and/or belts) was 9% for hospital patients and 26% for nursing home residents. In the nursing homes, the restrained residents were significantly younger, more care dependent, had less falls and were more often urinary incontinent, disoriented and on bedrest. The number of qualified nursing staff had no major influence on the use of physical restraints. Lower nurse staffing ratios were not related to higher frequencies of restraint use in hospitals or nursing homes [69]. A Randomised Controlled Trial (RCT) undertaken by Testad et al. (2016) explored the use of training and education on

restraint and included twenty-four care homes with 274 residents [70]. The study evaluated the effectiveness of a tailored 7-month training intervention "Trust before Restraint," in reducing the use of restraint, agitation, and antipsychotic medications in residents with dementia. Findings report a statistically significant reduction in the use of restraint, both prior to and during the intervention periods, in both intervention and control groups, with a tendency for greater reduction in the control group. Educational initiatives to reduce restraint and focus on person-centred care highlight the potential success of national training programmes.

Øye and Jacobsen (2020), identified various kinds of informal restraint [71]. The RCT measured to what extent the education intervention worked (effect), while qualitative approaches examined contextual factors in relation to the education intervention and use of formal and informal restraint, based on field observations in four different nursing homes within a sample total of 24 nursing homes. Findings identified five different forms of informal restraint use: diversion of residents' attention; white lies; persuasion and interpersonal pressure; offers and threats, identified as actions by staff against residents' will by limiting their freedom of movement, personal preferences and dignity. Also identified was 'grey-zone restraint' which comprised actions by staff towards residents which lie between formal and informal restraint. The use of informal restraint can be explained by institutional circumstances such as location, architecture, and institutional collectivist constraints in relation to resident care [71].

Resident characteristics influencing restraint

Three studies related to resident characteristics and restraint usage [71-73]. A systematic review analysed factors associated with nursing home residents' characteristics which could lead to physical restraint, and the consequences of physical restraint use in this population [72]. Findings indicate that residents with low cognitive status and serious mobility impairments were at elevated risk of restraint, as well as residents with previous fall and/or fracture. Restrained residents had low activities of daily living (ADL) scores, severe cognitive impairment, higher walking dependence, falls, pressure ulcers and incontinence. Repeated verbal and physical agitation were found to be positively associated with restraint use. Further educational and training programmes were recommended to enhance nurses' knowledge and awareness of restraint-associated consequences.

An RCT investigated the restraint being used in 24 nursing homes in Norway, and under what organisational conditions staff used restraint [71]. The overall investigation showed a low-level use of restraint in the 24 nursing homes (n = 274). The percentage of residents subject to at least one form of restraint was 19%. Findings indicated that the use of restraint related to the characteristics of individual residents, such as agitation, aggressiveness and wandering. A similar study also undertaken in Norway identified that restraint use was also explained by organisational conditions such as resident mix, staff culture and available human resources. A fluctuating and dynamic interplay between different individual and contextual factors determined whether restraint was used or not in particular situations with residents living with dementia [73].

Restraint use in depression and dementia

A study examined the effectiveness of multiple, face-to-face, brief training sessions in improving nurses' knowledge, attitudes, and confidence in providing care for depression. The main findings were that the training programme was effective in improving nurses' knowledge, attitudes, and confidence in providing care. Significant differences were found between groups concerning improvement in nurses' knowledge of late-life depression, attitudes towards depression, and confidence in providing depression care. Results indicated that brief, targeted training sessions can effectively enhance nurses' ability to care for older adults with depression in LTCF's [74].

A systematic review explored aggression in dementia and found that the type of dementia did not determine the character or severity of agitation in residents' behaviour. In addition, findings suggested that violence could be described as connected to a premorbid personality and was often related to the residents' personal care, and if the origin of violent actions was the residents' pain, it was possible to minimise it through nursing activities. To satisfy the needs of good nursing care, an important aspect is for staff to acquire knowledge and understanding about aggressive and violent behaviour and its management and to use a person-centred approach when delivering care [75].

Aggressive behaviour in older residents living with dementia was investigated by Holst and Skär (2017) with results identifying four categories: formal caregivers' views on triggers of aggression, expressions of aggression, the effect of aggressive behaviours on formal caregivers and formal caregivers' strategies to address aggression. The results indicated that aggressive behaviour may lead to negative feelings in formal caregivers and nursing home residents and that caregivers prefer person-centred strategies to handle aggressive behaviour while pharmaceuticals and coercion strategies were used as a last resort [76].

Spirituality

Two of the included studies focussed on spirituality as a human right [77,78]. Evidence from a review indicated that there is a need to educate nurses about spirituality in the nursing role especially when those with religious beliefs are residents in

nursing homes [78]. Also, there is a requirement for undergraduate and postgraduate nursing programmes to address central issues of ageing and spirituality. The relationship between nurses and patients should be the guiding basis for practice [77].

The study by Vitorino et al. (2019) focused on belief in God and spiritual/religious coping [78]. The physical environment was significantly associated with positive spiritual/religious coping alone and differed between the two studied samples. "Feeling safe in daily life" and "having access to health services" were positively associated with positive spiritual/religious coping behaviours in nursing home residents. Higher satisfaction with access to healthcare services enhanced positive spiritual/religious coping behaviours among nursing home residents. Nursing homes provided continuous access to registered nurses who administered medications. Nurse technicians and formal care providers assisted residents with washing, dressing, bathing, and eating. Nursing homes were equipped with readily available psychologists, chaplains, nutritionists and physiotherapists. Healthcare students were present all year round. Nursing home residents reported higher perceived health than community dwelling residents. Unlike community dwelling residents, nursing home residents had around-the-clock healthcare services and support. "Having access to information needed in their day-to-day lives" and "adequate transport" were significant among community dwelling residents and enhanced positive spiritual/religious coping behaviours. The authors noted that spirituality and religiosity should be considered an important part of geriatric and gerontological social care planning. Spirituality and religions are a particularly important part of day-to-day life in Brazil, especially among older people [78].

Sexual expression

Five of the included papers were focused on sexual expression of care home residents. Of the five papers, two were reviews [79,80] and three were qualitative studies [81-83].

Evidence from a review distinguished that there is a need for greater discussion and debate on sexuality and dementia and how the complex issues this raises should be responded to, particularly from service user perspectives [80]. The importance of staff training and knowledge of legislation and policy to manage these issues effectively was highlighted [80].

In addition, evidence suggests that sexual expression in older adults is recognised as a basic need that should be supported. Barriers such as lack of privacy and staff discomfort contributed to the feelings of loneliness among residents [79].

Qualitative studies exploring sexual expression all focussed on the rights of older residents to sexual expression [81-83]. Leyerzapf et al. (2018) investigated the experiences and needs of Lesbian, Gay, Bisexual and Transgender (LGBT) older people in residential care homes [82]. Four themes emerged: organisation of gay-friendly care; social exclusion, (in) visibility, and difference; safety, feeling at home, and being oneself; and shared experiences between LGBT and heterosexual residents. LGBT respondents highlighted social exclusion and the need to feel safe and at home. Exclusive LGBT activities promoted empowerment, but mixed activities were essential to address stereotypes and heteronormativity, which negatively impacted LGBT residents. There is a need for better understanding and shared responsibility among LGBT and heterosexual residents and professionals [82].

A study focussing on sexual expression and nurses' experience dealing with intimate and sexual expressions of residents in an individual way, focused on setting and respecting their own sexual boundaries and those of residents and family members [83]. Depending on their comfort level with residents' expressions, nurses responded in three ways: active facilitation, tolerance and termination. Nurses' responses depended on contextual factors, including their individual experiences with sexuality, the nature of their relationship with the residents involved, the presence of dementia and the organisational culture of the facility. Similarly, a qualitative study conducted by Jen et al. (2022) found that attitudes and emotional responses of staff have shifted in a more sex-positive and supportive direction and policies are more common; Existing policies vary in coverage, and staff training often focuses on liability rather than the broader experience of sexual expression [81]. There is evidence that LGBTQ residents' sexual expressions can provoke different, sometimes discriminatory, responses. Most facilities do not have specific policies in place, and those that exist are varied in their coverage. Staff trainings around sexuality are also focused on issues related to liability rather than the broader experience of sexual expression and there is evidence to suggest that sexual expressions of LGBTQ residents will provoke different, and at times discriminatory responses [81].

Elder abuse

Twelve of the included papers focussed on elder abuse; eight were review papers [31,84-90] three were quantitative studies [91-93] and one was a qualitative study [94].

The eight review papers discussed neglect, emotional abuse, and physical violence against older persons. The evidence suggests there are many conflicting definitions of elder abuse in the literature and many theoretical and conceptual models need further elaboration. The rates of elder abuse are probably inaccurate and under-reported and resident-to-resident abuse (RRA) was identified as an important aspect of elder abuse [84,87]. A scoping review investigating RRA by McDonald et al. (2015) noted that

such abuse is a significant and under-recognised issue [31,87]. RRA can take many forms, including physical, verbal, and sexual aggression, and it has profound consequences for both the victims and the aggressors. Recommendations for further research require better recognition, reporting, and management of this type of abuse to improve the quality of life for residents in long-term care homes.

A review by Hirt et al. (2022) investigated RRA in nursing homes and findings suggesting that there is an imbalance between excessive demands and coping resources which may increase the risk of abuse [86]. In addition, findings identified that a change in culture is needed to establish safe reporting and critical case reviews. Similarly, findings from a review by Duffy et al. (2024) suggest that comprehensive safeguarding strategies to prevent and address elder abuse in residential settings can be developed, promoting the well-being and safety of older people [85]. Prevention and management of elder abuse in residential care homes involves multiple stakeholders including healthcare professionals, administrators, family members and family caregivers, safeguarding authorities, legal authorities, regulatory bodies, government agencies, academics and older people themselves and their advocates [85].

Evidence examining intersectionality and elder abuse identified that short and long-term policy interventions must include a commitment to human rights – health, dignity, safety, and inclusiveness [88]. A review by Phelan (2015) noted that person centred care must be delivered so that human rights are articulated and adopted as standard [89]. Independent regulatory bodies are essential components of policy implementation. Policy must direct that staff have regular training in sensitive communication care delivery, risk management, dementia complexity and conflict. Balancing residents' autonomy, will, and preference is needed [89]. A further review by Phelan (2018) investigated the role of the nurse in detecting elder abuse and neglect [90]. Risk factors for elder abuse were identified as: older person functional dependence/ physical disability, poor physical health, cognitive impairment, poor mental health, low income, gender, age, financial dependence and race/ethnicity. Older persons need to be positioned as equal human beings, who have equal rights and entitlements.

A review published in 2022 by Steele & Swaffer (2022) investigated reparations for harms experienced in residential aged care [31]. To ensure that reparations support the prevention of further harm in aged care, the design of redress could form part of broader government strategies directed toward increasing funding and access to community-based support, care, and accommodation, and enhancing the human rights of people with dementia [31].

A study investigating elder abuse found that physical abuse by a non-resident was the most common type of abuse/neglect reported (28%) [91]. Overall, abuse/neglect complaints decreased and this reduction in reporting was seen for all types of abuse/neglect complaints ($P < 0.05$) except for financial exploitation. Training for ombudsmen, staff, families, and residents about other types of abuse and neglect, improved understanding of the reasons for decline in reporting, and the expansion of the NORS database to allow for more comprehensive analysis are needed. Evidence examining elder abuse and its impact on quality of life in nursing homes in China found that elder abuse was common in nursing homes in China. Having a religion and depressive symptoms were independently associated with elder abuse [92]. Results indicate that appropriate strategies and educational programmes should be developed for health professionals to reduce the risk of elder abuse [92].

A qualitative cross-sectional exploratory study was conducted in Norway between October 2018 and January 2019, by Botngård et al., (2020) [93]. Findings indicate that 76% of nursing staff reported having observed at least one incident of abuse committed by other members of staff, and 60.3% admitted that they had perpetrated at least one incident of abuse against a resident during the past year. 57.8% had observed at least one incident of neglect by other staff, with 40.1% observing staff commit neglectful acts on two or more occasions. The most-frequent reported acts were neglecting oral care (35.4%), ignoring a resident (35.1%), delaying care (29.3%), and prohibiting a resident from using the alarm (20.2%) [93]. The qualitative study found that the perceptions of the residents in institutional settings about abuse were conditioned by sensationalistic media coverage and were limited to physical mistreatment. The elderly participants tended to legitimise day to day infringements on their rights as minor violations in comparison to 'real' (physical) acts of violence reported in the media [94].

Elder care

Human rights in elder care were highlighted in 10 of the included papers. Of these, one was a review [95], four were quantitative studies [96-99] and five were qualitative studies [100-104]. A review examined the quality of care in aged care and identified key themes as salient to the quality-of-care experience, which include treating the older person with respect and dignity; acknowledging and supporting their spiritual, cultural, religious and sexual identity [95]. In addition, findings suggested the skills and training of the aged care staff providing care; relationships between the older person and the aged care staff; social relationships and the community; supporting the older person to make informed choices; supporting the older person's health and well-being; ensuring the delivery of safe care in a comfortable service environment; and the ability to make complaints and provide feedback to the aged care organization [95]. The elderly care quantitative studies

were conducted between 2007 and 2023 in Finland [99], Ireland [97], Spain [96,98], and Sweden [98]. A mixed-method study investigated the factors which facilitated or hindered quality of care in Long Term Care Settings (LTCS) in Ireland [97]. The six factors, which facilitate quality, were 1) an ethos of promoting independence and 2) autonomy; 3) a homelike social environment; 4) person centred, holistic care; 5) knowledgeable, skilled staff; knowing the person and 6) adequate multidisciplinary resources. The three factors that hindered quality care; were: 1) a lack of time, 2) patient choice and 3) resistance to change, bound by routine. The provision of planned social activities was identified by nurses as a key element of quality care for older people [97]. A study which investigated patient integrity identified that social factors emerged as the most important item restricting the maintenance of patient integrity [99]. Other key restricting factors were the inability of patients to make decisions, forgetfulness and difficulties with expressing themselves. Staff shortages were identified as a key factor restricting the maintenance of patient integrity. Staff shortages led to time pressure leaving nurses without enough time to concentrate on the needs of the patients [99].

A study investigating thriving and not thriving in nursing homes found that residents with higher levels of thriving had shorter length of stay at the facility, higher functioning in Activities of Daily Living and less cognitive impairment, lower frequency of behavioural and psychological symptoms and higher assessed quality of life ($P < .002$) [98]. The ability to walk and possibilities to spend time outdoors were higher among those with higher levels of thriving. The results highlight the importance of increasing experiences of thriving in nursing home environments [98].

A cost study found that the daily cost per user for residential care is €53.72. Results highlighted that the current public pricing for residential care in Spain is insufficient to cover the actual costs of providing care, particularly for centres catering to physical disabilities, intellectual disabilities and mental illnesses [96]. Five qualitative studies investigated the care in residential home care settings in Austria [103] Canada [101] Norway [104], South Korea [100], and the UK [102]. The interpersonal factors of direct nursing care and resident outcomes of nursing care were investigated by Nakrem et al. (2011) [104]. Interpersonal aspects have a major influence on nursing care quality. Caring relationships between nurses and residents in which their integrity was protected and put great emphasis on support from the nursing staff to uphold their social relationships. Many areas of nursing home care of importance to the residents depended on the direct efforts of the nurses, such as receiving care with acknowledgement for remaining functions, being treated with respect or simply having someone to talk with. The dependency of the nursing staff was generally accepted, but it created an extra vulnerability. Power and control in everyday situations were placed on the nurses in their interactions with the residents. The diversity of the residents' needs, varying from palliative care to social stimulation, adds complexity to nursing care [104].

In South Korea, barriers to implementing an ethical nursing practice for older adults in long-term care facilities were investigated by Choe et al. (2018) [100]. Five main themes emerged: 1) emotional distress, 2) treatments restricting freedom of physical activities, 3) difficulty coping with emergencies, 4) difficulty communicating with the older adult patients, and 5) friction between nurses and nursing assistants. The significant challenges that nurses face include conflicts between professional values and institutional policies, inadequate staffing, and lack of support for ethical decision-making [100]. A qualitative study examined the concept of human rights in relation to care homes for older people was examined qualitatively [101]. This study highlighted five types of approaches in the academic literature: the anti-institutional, the legalistic, the care quality, the equality approach, and the issue-based approach. A commonality within the literature was that care homes were mostly viewed as inherently risky places for the protection of human rights, especially in the light of perceptions of residents as 'vulnerable' and 'disadvantaged' [101]. A qualitative study conducted in the UK aimed to contribute to the knowledge gap about current practice of care home managers in supporting residents with dementia to orientate and navigate care environments [102]. Three themes emerged 1). Aligning strategies with need, 2) Intuitive learning and 3) Managing within the wider business context. Although managers were aware of some design principles they frequently relied on intuitive learning and experience to inform their choice of interventions for orienting residents with dementia. Managers also mentioned a lack of time to seek out orientation specific training and guidance, resulting in a low uptake of guidelines and audit tools in practice [102]. A qualitative study conducted in Austria aimed to explore the effectiveness of the Austrian National Preventive Mechanism (NPM) between 2017 and 2019 [103]. Accessibility with mobility aids was sufficient in 87% of the institutions, but assistance for persons with visual or hearing impairments was solely in 20-40% of the institutions. An understaffing with nursing assistants (–5.2 fulltime equivalents in Carinthia) and home helpers (–1.6 in Carinthia and Styria) was present. Less than 20% of the personnel received advanced training related to dementia and neuropsychiatric care. While 50% of the residents were diagnosed with a psychiatric disorder, approximately 36% received support from an appointed legal guardian. Of the monitoring visits 58.1% were conducted due to anonymous complaints and urgent referrals. The median processing times of the NPM and the provincial governments exceeded 250 days 103.

Discussion

The main research question: "What is the evidence regarding contemporary systems and models of human rights of nursing home residents globally?" was investigated using a rapid review of the literature method. Using the search strategy co-developed between the authors and the information specialist, we collected peer reviewed literature and guidance documents related to human rights. Eighty-six studies were included in this rapid review. These studies were selected on the basis that the evidence will inform health and social care providers with strategies to improve and inform human rights standards within nursing homes in Ireland. Quality of care papers were reviewed as well as papers focusing on elder abuse, and physical and chemical restraints. Papers focusing on nursing home residents' rights to spirituality, sexual expression, freedom of movement and quality of life were also reviewed.

Elder care

The elder care studies provided valuable insights into the multifaceted nature of residential care and underscored the need for holistic, person-centred approaches to improve the quality of life for individuals [95].The included studies stressed the importance of social relationships and community involvement, but also highlighted challenges in care [85]. A recurrent theme in the literature was that nursing homes are often seen as risky environments for safeguarding human rights, particularly given the perceptions of residents as 'disadvantaged' or 'vulnerable'.

The challenges were issues such as staffing ratios and time pressures that hinder the maintenance of patient integrity [99]. Opportunities for outdoor activities and a homelike atmosphere contribute to higher levels of thriving among residents of nursing homes [98]. Only one included study from Spain highlighted the financial challenges in providing adequate care, particularly the costs associated with caring for people with physical and intellectual disabilities [96]. Economic conditions must be considered in future economic studies in relation to human rights in the nursing home sector.

Elder abuse

Elder abuse is emotional or physical abuse, neglect or violence against older people and the evidence suggests that this is a worldwide issue [92,93]. The rapid review findings suggest that elder abuse is a complex issue [84] and there is a need for comprehensive strategies involving multiple stakeholders [85]. There is a need for more directed training and to protect older adults [89,90].

Dignity

Dignity is a concept related to equality [40]. The included reviews and qualitative studies focussed on dignity, and the notion of 'dignity of personal identity' [41]. To protect the dignity of persons living in nursing homes, they should be viewed as whole and individual persons. However, there was still tension between stated policy and what occurs in terms of dignity [43]. This tension with regards to dignity was also noted by evidence from Roos et al. (2023) and Slettebo et al. (2017) [47,48]. Dignity in nursing homes should be maintained by firstly, fostering dignity through meaningful participation and secondly, fostering dignity through experiencing enjoyable activities, both individual and socially with others. Issues such as incontinence should be openly discussed, and patient choices should be realised [46].

Independent living should be in accordance with personal values [27]. Disrespectful care evokes feelings of inferiority or insignificance in the nursing home residents [42]. Evidence from studies testing interventions to enhance dignity found there was a lack of rigour and had no lasting effect and that more research is needed to investigate the effectiveness of interventions aimed at the promotion of dignity [50]. In addition, evidence suggested that person-centred care could be used as the framework for promoting dignity [47].

Spirituality

In increasingly secular societies, spiritual and religious coping beliefs are not so readily understood by members of society who are not religious, or who have a different religious background to those being cared for in a nursing home. This means that training is needed on how diverse cultures deal with dying and death. Knowing how spiritual or religious beliefs may benefit the residents and their families may be important for person-centred care [77,78]. Findings from the included studies indicate the need for spiritual and religious coping behaviours for people of different faith groups and cultures.

Sexual expression

Sexual expression of residents is a human right which has come more to the fore during the past decade [79,80] and the rights of the LGBTQ+ community of elderly people are also becoming more recognised [81].

Physical or chemical restraints

Physical restraints were of grave concern within the reviewed literature, with some physical restraints being seen as abuse of the residents within care homes. Main physical restraints noted were bed guards, locking doors and windows, and the use of belts to restrain dementia patients with aggressive behaviours. The included studies highlighted the prevalence of the use of physical restraints in care home settings along with the need for better training, standards and regulations to protect the autonomy and

well-being of residents [58,63,66]. Greater consideration should focus on when and how may physical restraints be used. Asking the questions – when is it appropriate? For how long? What are the long-lasting effects? What are the Local or Global guidelines? Informed decisions should be based on good knowledge of existing health conditions and limiting the use of chemical restraints which tend to be over-used. The evidence indicates that although no drug was named in 85% of cases reviewed, the majority (96%) were antipsychotics and anxiolytics [59]. Further consideration should be on when is it appropriate to use chemical restraints and what are the side effects, again having awareness of Local or Global guidelines.

Autonomy

Autonomy is related to the characteristics and competencies of the people involved in the care of the individual and how the carer and individual resident interact. Interventions to support autonomy appear to work best when relevant contextual factors such as the characteristics and competencies of the people involved and how they interact, are considered [25].

Freedom of movement (FoM)

The qualitative studies emphasised the need for better protection of FoM movement and human rights in care settings, particularly for vulnerable populations such as individuals with dementia [31,34].

Quality of life (QoL)

QoL is important for feelings of dignity. The older person should feel like they are being listened to with regards to their own care, as well as feeling that they are treated with dignity and respect. Other key QoL domains identified in this review were: independence, mobility, pain management, social connections/social support networks, emotional well-being, and activities [38]. The QoL studies emphasised the importance of dignity, staff interactions and person-centred care in enhancing the QoL of nursing home residents [39]. Nursing/residential care home staff need to promote and improve QoL to include choice and preferences for activities of daily living such as mealtimes, participating in community and social events, as well as life enhancing activities such as music and creative arts.

Conclusions

This rapid review highlighted that the area of human rights has been the focus of many research studies over the past 20 years in terms of methods; reviews and qualitative work, with cross-sectional studies of relevance and some randomised controlled trials. The findings indicate that nursing/residential care home staff understand the principles of human rights, but many challenges are faced within healthcare settings, which may infringe on and impact on the ability to fully uphold human rights. This happens especially when ratios of nursing/residential care home residents to staff are low, or when there are other challenges, such as the COVID-19 pandemic restrictions (including the lack of suitable personal and protective equipment). Dignity and respect are the cornerstones of nursing care and residents of nursing/residential care homes need honest communication and a good nurturing environment to be able to live as comfortably as possible during their final life stage. As well as improved staff to resident ratios, more staff training is needed on the concepts of 'dignity' and 'respect' and the complexities in the approaches required in context'. Families also have a role to play in demonstrating autonomy about the use of restraint/no restraint with family members and advocating for their QoL.

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Ethical guidelines

Ethical approval was not required for this rapid review as it involved the analysis of publicly available data and did not include any direct interaction with human participants.

Conflict of interest

The authors declare no conflicts of interest.

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