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# A national cross-sectional study of community nurses and social workers knowledge of self-neglect

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## Abstract

**Background:** self-neglect (SN) is a global health and social problem affecting societies, which is largely hidden, under-reported and underresearched. Community nurses (CNs) and social workers (SWs) need to be knowledgeable about SN.

**Objective:** to determine CNs and SWs sources and level of SN knowledge.

**Methods:** quantitative, descriptive and cross-sectional.

**Subjects:** CNs and SWs working in the community with older people at risk of SN.

**Settings:** participants were recruited from four Health Service Executive (HSE) areas in Ireland.

**Instrument:** a questionnaire was developed to elicit levels and sources of SN knowledge. A postal survey was used.

**Results:** of the 566 questionnaires posted, 339 responded (Nurses (N)  $N = 305$ ; SWs  $N = 34$ ), a 60% response. SWs had statistically higher knowledge scores ( $P = 0.002$ ), and difference in average scores between CNs and SWs was statistically significant ( $P = 0.037$ ). There was a statistically significant difference between practice and personal experience ( $P = 0.44$ ), and use of literature/books ( $P = 0.037$ ) between CNs and SWs, with SWs using both sources more. Higher knowledge scores were significantly associated with number of SN cases, higher education and gender.

**Conclusion:** there is a need for interdisciplinary training on SN.

**Keywords:** self-neglect, knowledge, community nurses, social workers, older people

## Introduction

Globally self-neglect (SN) is a serious and complex public health issue that is poorly understood and under recognised. There is no agreed standard definition for SN [1, 2]. SN is characterised by profound environmental neglect and cumulative behaviours and deficits that can threaten the persons health, safety and well-being [3]. SN is categorised as part of elder abuse and is mandated for reporting in many US state statutes. In contrast, SN is not included in elder abuse definitions in Europe or Australia, and there is no mandatory reporting [2, 4, 5]. SN does not involve a third party, and thus, its inclusion as a category of elder abuse is controversial [2]. SN cases are predominantly managed by CNs and social care professionals in the community. Responses to SN can be impeded by divergent perspectives, poor understanding and poor knowledge of legal frameworks [6–8]. Some health and social care services have published policy guidelines, so that complex and extreme SN cases can be included in safeguarding procedures [2, 9]. While SN can occur across the lifespan, the focus of research has predominantly been on elder SN. Different international contexts, definitional issues and ambiguity have contributed significantly to wide disparity in reporting of SN [10, 11]. A US population-based cohort study identified a prevalence rate of 9% for SN. Prevalence was significantly higher in men aged over 85 years (10.1%) compared with women (7.5%) [11].

Cognitive impairment, executive dysfunction, depression, reduced physical function [12, 13] and alcohol and substance abuse are associated with SN [14]. SN is also associated with significantly greater mortality [15], higher use of health services [16] and nursing home placement [17]. No empirical research to date has examined knowledge of SN held by CNs and SWs who work in the community. Thus, the aim of this research was to examine sources and level of SN knowledge in these professional groups.

## Methods

A quantitative, descriptive cross-sectional design was used to collect data from 1st February 2013 and 30th May 2013. A convenience sample of CNs and SWs from four HSE community areas was identified and recruited by Directors of community services and community organisations. The questionnaires were mailed by the Directors to 566 professionals (Public Health Nurses = 330; Community Registered General Nurses (CRGNs) = 78; Community Mental Health Nurses (CMHNs) = 90; Senior Case Workers (SCW) = 28; SWs = 30) for self-completion.

Questions on sociodemographic factors, sources of SN knowledge and 12 items on knowledge of SN were included in the questionnaire. This was constructed following a comprehensive review of the literature (see Supplementary data, Appendix 1 available in *Age and Ageing* online for Self-Neglect Knowledge Questionnaire). A pilot study was conducted after ethical approval was obtained. Participation was

voluntary, informed consent was obtained, no names or personal details were included ensuring confidentiality and no incentives were offered to participants.

## Data analysis

The Statistical Package for the Social Sciences was used to analyse data using descriptive and inferential statistics. The Mann–Whitney  $U$  test was used to investigate whether there were differences in the sources of knowledge used by CNs and SWs. Independent  $t$ -tests were used to examine differences between the groups. The  $\chi^2$  test was used to investigate whether there were differences in the knowledge of CNs and SWs for each individual question. The association between knowledge score and the ordinal demographic variables was assessed using Spearman's rank correlation coefficient, and the association between knowledge score and the binary demographic variables (gender, professional group) was assessed using the point biserial correlation coefficient. Multiple linear regressions were used to simultaneously investigate the effect of all the demographic variables on the knowledge score.

## Results

A total of 339 questionnaires were returned, levels of responses differed across groups (PHNs  $n = 215/65\%$ ; CRGNs  $n = 46/59\%$ ; CMHNs  $n = 44/49\%$ ; SCW  $n = 18/64\%$ ; SWs  $16/53\%$ ) and overall response was 60%. Eight-nine per cent of participants had contact with SN cases in the last 12 months. Table 1 summarises the demographic information. See Supplementary data, Appendix 2 available in *Age and Ageing* online for Table of Knowledge of SN by Professional group. Men had a higher per cent of correct knowledge scores than women had, and the differences were statistically significant ( $P = 0.001$ ). Multiple linear regression demonstrated that the difference in average knowledge scores between CNs and SWs was statistically significant; on average, SWs scored 5% higher than CNs. Table 2 shows the relationships between demographic variables and knowledge score. Those who were educated to postgraduate level, men and participants with 3–5 cases in the last 12 months had significantly higher knowledge scores.

Sixty-six per cent of participants had not participated in a SN workshop in last 12 months. Participants' main source of knowledge related to practice and personal experience (61%) and a small per cent used literature/books (24%) and media (19%). There was a statistically significant difference between practice and personal experience and use of literature/books between CNs and SWs, with SWs using both sources more often. See Supplementary data, Appendix 3 available in *Age and Ageing* online for Table of Sources of knowledge on SN by professional group. Only 48% of participants knew about the policy on SN and 38% knew about legal responsibility and SN.

Table 1. Sociodemographic factors

	<i>n</i> (%)
Gender ( <i>n</i> = 336)	
Male	25 (7.4)
Female	311 (92.6)
Age group ( <i>n</i> = 336)	
25–34 years	44 (13.1)
35–49 years	183 (54.5)
50–64 years	109 (32.4)
Professional group ( <i>n</i> = 339)	
Public health nurse	215 (63.4)
Community registered general nurse	46 (13.6)
Senior case worker	18 (5.3)
Social worker	16 (4.7)
Community mental health nurse	44 (13.0)
Highest level of education completed ( <i>n</i> = 324)	
Diploma	46 (14.2)
Bachelor degree	30 (9.3)
Postgraduate diploma	188 (58.0)
Masters	60 (18.5)
HSE region ( <i>n</i> = 340)	
HSE South	168 (49.4)
HSE West	47 (13.8)
HSE Dublin Mid Leinster	86 (25.3)
HSE Dublin North East	39 (11.5)
Years experience in current position/post ( <i>n</i> = 334)	
1–5 years	73 (21.9)
5–15 years	209 (62.6)
15+ years	52 (15.6)
Number of self-neglect cases you had contact with in last 12 months ( <i>n</i> = 331)	
0	38 (11.5)
1–2	104 (31.4)
3–5	112 (33.8)
5–15	60 (18.1)
16–25	7 (2.1)
25+	10 (3.0)

Discussion

This is the first study that specifically asked CNs and SWs about sources and level of SN knowledge. Overall, both CNs and SWs had good knowledge of SN. But results indicated that SWs’ knowledge was at a higher level. This result is different to the only study on knowledge of SN sourced in the literature, where Masters in SW students (*n* = 58) had low SN knowledge [6]. Postgraduate education and contact with 3–5 SN cases were significantly associated with higher knowledge scores. However, CNs were not well informed about policy and legal aspects of SN and may have mistakenly confused ‘legal responsibility’ with ‘duty to care’. This is not surprising as professionals are often unaware of policies and best evidence that they can draw on when working with SN cases [2]. SN has been described as a ‘grey area’ [7] that gives rise to many ethical challenges and dilemmas [7, 18–21].

The main sources of SN knowledge for participants related to practice and personal experiences. This suggests that the National Centre for the Protection of Older People (NCPOP) website, in Ireland, or other databases were not being used by

Table 2. Multivariate analyses to investigate relationships between demographic variables and knowledge score

Variable	Coefficient (95% CI)	<i>P</i> value
Professional group		
Nurses	0	0.037
Social workers	5.05 (0.31 to 9.80)	
Gender		
Female	0	0.014
Male	6.08 (1.26 to 10.90)	
Age group		
25–34 years	0	0.625
35–49 years	0.46 (–3.49 to 4.42)	
50–64 years	1.76 (–2.67 to 6.18)	
Highest level of education		
Undergraduate level	0	0.021
Postgraduate level	3.59 (0.55 to 6.63)	
Years’ experience in current position/post		
1–5 years	0	0.058
5–15 years	4.05 (0.70 to 7.40)	
15+ years	3.88 (–0.68 to 8.44)	
Number of self-neglect cases you had contact within last 12 months		
0	0	0.005
1–2	–0.58 (–4.92 to 3.76)	
3–5	4.64 (0.37 to 8.92)	
5+	3.27 (–1.39 to 7.93)	

participants to support knowledge development. This is disappointing as empirically based knowledge needs to guide assessment and interventions to improve effectiveness [22].

The findings of the study have implications in relation to effectively responding to SN. Education and training together with mentored clinical experience are critical to increasing competency and skills of professionals relating to SN [23]. After all, the detrimental effects associated with SN are extensive: poorer health, increased use of healthcare services [16, 24], mortality, increased risk for caregiver neglect and multiple forms of elder abuse [25].

There are a number of limitations to this research that relate to the sample, questionnaire and singular geographical region. The sample was a convenience sample, and there is no way of understanding how people self-selected to participate. While the sample was large, 40% of those approached did not participate, and it is not known why they made this choice. A possible explanation may be that they did not have contact with or sufficient experience of SN cases. The questionnaire was newly developed, and while based on a comprehensive literature review and a pilot test, it may not have captured all elements relating to knowledge of SN.

In summary, this study has highlighted the need for interdisciplinary in-service training by health services. This should include awareness of web/database resources to build capacity and skills for effective SN practice. Postgraduate university curricula for health and social care professionals need to include SN as a core element in curriculum, and interdisciplinary training is necessary.

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## Key points

- SWs had statistically higher knowledge scores than CNs.
  - Higher knowledge scores were significantly associated with number of SN cases, higher education and gender.
  - A strategic approach to interdisciplinary in-service training and development.
  - University postgraduate curriculum needs to include SN as a core element.
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## Conflicts of interest

None declared.

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