

Illinois Department on Aging
**Illinois Long-Term Care Ombudsman Program
Supplemental Training Curriculum**

**Supplemental Module # 8
It Takes a Community to Prevent Abuse and Neglect of
Residents**

Pre-publication Edition I

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PROCESS FOR USING THIS MODULE

The supplemental modules for ombudsmen have been created to accommodate different learning styles and are based on research about how most people learn. The premise on which this module is based is the idea that new information is learned best when there is an opportunity for discussion and to ask questions. This module incorporates individual reading, group discussion, questions on what is not clear to you and an evaluation of what you have learned.

This module is designed to be adaptable to various teaching methods and settings: training/ in-services for ombudsmen or presentations to families or facility staff. This module can be divided into as many training sessions as needed and a variety of methods can be used to present the material, including a lecture method.

After the discussion on the text, the group will be asked to discuss:

1. An incident or condition you have observed or suspected in a facility that might lead to neglect or abuse, including how you would verify this condition.
2. How you would proceed to resolve an issue or case. You may include how you would inform resident/family councils and staff/administration about preventing abuse and neglect.

PURPOSE OF THE MODULE

The purpose of this module is to:

- Identify the terms that are crucial to the role of the ombudsman in dealing with any reported or observed neglect and abuse complaints and the necessity of informing the supervisor.
- Identify what disabling conditions of residents and what situations in institutional settings contribute to neglect.
- Identify the roles of state agencies in addressing abuse and neglect of the elderly within the community, including those people who live within long term care facilities.
- Identify the role of the ombudsman in preventing abuse and neglect by working with the facility concerning situations or conditions that contribute to neglect or abuse.
- Identify the role of the ombudsman in preventing abuse and neglect, especially through education of the community in its role of supporting residents within facilities.
- Identify the role of the ombudsman in developing approaches that would support the residents and families in preventing abuse and neglect, such as the development and support of family councils and stronger resident councils.

SUPPLEMENTAL MODULE #8 IT TAKES A COMMUNITY TO PREVENT ABUSE AND NEGLECT

NOTES: This module applies to nursing facilities. This includes skilled care, intermediate care nursing homes, and hospitals licensed under the Illinois Nursing Home Care Act. The ombudsman must always contact an incapable resident's legal representative, if there is one, concerning access to documents and reporting abuse and neglect to the Department of Public Health, except in cases in which the legal representative is the abuser or is not available or concerned about the neglect of a resident. Contact your ombudsman supervisor for further instructions on this type of case.

In order to have a uniform ombudsman program across the state that serves residents and families in a consistent and effective manner, ombudsmen who handle complaints, concerns and inquires must have frequent communication with their supervisor— regional ombudsman or his/her designee. Especially in instances of complex problems, the supervisor should be contacted to explore strategies that will bring about a satisfactory result for the complainant. The regional ombudsman, in turn, must consult with the state ombudsman on difficult cases to know what has worked to solve similar difficult problems in other parts of the State. When common strategies have not worked, an issue may need intervention from the state office for resolution.

I. INTRODUCTION

A. ABUSE AND NEGLECT OF THE ELDERLY—THE “STICK YOUR HEAD IN THE SAND” APPROACH OF THE GENERAL PUBLIC

Abuse and neglect of children is a national concern. When any evidence of abuse or neglect of children is exposed, the public is "up in arms" and demands improvements. Abuse and neglect of the elderly, however, is not a national topic, except for persons who work in agencies that serve the elderly—health care, protective systems and law enforcement officers.

The general public is uninformed about neglect and abuse of residents in long term care facilities. As more people live longer, there will be more people in congregate settings, including assisted living facilities, supportive living arrangements, nursing homes and other licensed long-term care facilities. “Institutional living, by its nature, creates vulnerability and a potential for abuse,” according to Kathleen Quinn, Chief, Bureau of Elder Rights, Department on Aging, in referring to sexual abuse. Furthermore, the manifestations from a resident’s disability that include dependence on someone else create a second level of vulnerability.

“Institutional living, by its nature, creates vulnerability and a potential for abuse.”

Kathleen Quinn, Chief
Bureau of Elder Rights
Department on Aging

B. RESPONSIBILITY OF THE DEPARTMENT ON AGING

In Illinois, there are two Departments on Aging programs that address abuse and neglect of the elderly. One program is the Elder Abuse and Neglect Program. This program, authorized by the Elder Abuse and Neglect Act (ILCS 320/1 et seq.), applies only to services for Illinois residents who live in the community (not licensed congregate or long-term care settings) age 60 years or older, who have been reported victims of suspected abuse, neglect or exploitation.

The Illinois Elder Abuse and Neglect Act does not include residents who live in licensed long term care facilities. The Elder Abuse and Neglect Program services are provided through local provider agencies and some directly by Area Agencies on Aging with funding from the Department on Aging. All Elder Abuse caseworkers are trained and certified by the Department. In this program, the state funding is based on how many cases of abuse and neglect are received. The budget requested for this program by the Department on Aging for FY 2002 was nearly \$7.36 million.

The long term care ombudsman program is the “other” Department on Aging Program that handles cases of abuse and neglect of the elderly, but only for persons who reside in long term care facilities or congregate living arrangements. There is no state law that requires anyone to report to the ombudsman program instances of abuse or neglect of residents who live in these facilities. However, State law mandates specific persons to report abuse and neglect of residents to the Illinois Department of Public Health (IDPH). Confidentiality requirements require the ombudsman program to follow certain procedures handling abuse and neglect complaints. Additionally, the ombudsman program has other responsibilities regarding abuse and neglect, including the prevention of abuse and neglect and educating residents and their families on:

- what care practices constitute abuse and neglect,
- their right to make a complaint about neglect and abuse to IDPH and/or local law enforcement,
- how to make a credible report to IDPH, and
- their right to ask the ombudsman to make the report on their behalf.

IDPH has the authority to levy a fine against a long term care facility that is found to have abused or neglected one or more residents. The Central Complaint Registry, called the Hotline on the IDPH poster which is posted in facilities, is the IDPH entity that receives reports of abuse and neglect in long term care facilities (see p. 18).

Ombudsmen are trained specifically on how to report abuse and neglect cases to the Department of Public Health as ombudsmen are in the facilities more often than the Department of Public Health surveyors. Ombudsmen are known to the residents and their families and can act as the “eyes and ears” for abuse-free care. When a resident or other person reports abuse or neglect instances to the ombudsman, the ombudsman does not usually know whether it is an isolated event or some evidence of a pattern of abuse or neglect occurring in that facility.

The Institute of Medicine (1995), which studied the ombudsman program nationwide, found that ***volunteers can handle abuse and neglect cases as well as paid ombudsmen if they are trained appropriately and have adequate supervision.*** This module has been developed to train both paid and volunteer long term care ombudsmen.

Well-trained and supervised volunteers in most circumstances can deliver the same ombudsman services as paid staff—if they have the equal authority and receive similar support given to paid ombudsmen.

Institute of Medicine

Neglect and abuse are preventable, and ombudsmen should support a zero tolerance level of neglect.

Each regional ombudsman program should determine under what circumstances an ombudsman, paid or volunteer, should contact the supervisor concerning complaints involving neglect and abuse. For a beginning ombudsman, the ombudsman must contact the supervisor before a complaint is reported to the Department of Public Health Hotline, if at all possible.

State law (210 ILCS 30) says that “any other person” who has “reasonable cause to suspect a resident has been abused or neglected” must report to the Department of Public Health or law enforcement officer. The ombudsman should always attempt to empower the person reporting the abuse or neglect to call the Department of Public Health (IDPH) Hotline, as that person usually knows more details about the situation.

However, because of the confidentiality provision in the Older Americans Act, the ombudsman program cannot report an abuse or neglect issue to the Department of Public Health without the written or oral consent of the resident or legal representative, unless the resident is incapable or the ombudsman has witnessed the abuse and neglect himself. The oral consent of a resident or legal representative must be documented contemporaneously in the case notes.

If the resident and/or legal representative do not consent to report to IDPH or allow the ombudsman to report, and the issue involves the health and safety of other residents or persons, the complaint must be reported immediately to the supervisor. The supervisor is instructed to contact the Office of State Ombudsman who will then make a determination on how to handle the issue based on the presenting factors. These factors include the fears of the victim and complainant, the health and safety of other persons, and the responsibility of the long term care ombudsman program under federal law.

If the ombudsman cannot reach the supervisor and the ombudsman believes that the situation jeopardizes the resident, other residents and/or persons, the ombudsman must act in good faith and do what the ombudsman believes is the right and reasonable action, given the circumstances.

II. WHAT ARE ABUSE AND NEGLECT?

A. THE DEFINITION OF ABUSE

According to Illinois law, abuse means any physical injury, sexual abuse, or mental injury inflicted on a resident other than by accidental means (210 ILCS 30/3/4).

The federal definition of abuse and the accompanying guidelines expands the definition to include verbal abuse, corporal punishment and involuntary seclusion.

An Illinois State TRIAD publication provides the following definitions:

Sexual abuse is a particular form of physical abuse in which sexual activity that is harmful to the resident, emotionally or physically, is initiated by or accepted by staff.

Verbal abuse refers to the use of oral, written or gestured language that includes disparaging and derogatory terms to residents or within their hearing or seeing distance, regardless of age, ability to comprehend or disability.

Mental abuse includes, but is not limited to humiliation, harassment, threats of punishment or deprivation, or offensive physical contact by the facility or staff.

Examples of physical and/or sexual abuse:

- Hitting a resident with the hand, fist, foot or object
- Shoving, tripping, pushing, pulling, scratching, slapping, pinching, cutting, biting a resident
- Raping a resident or forcing resident to participate in other sexual acts
- Inappropriately rubbing or fondling the resident
- Using unnecessary or excessive physical or chemical restraints
- Giving a resident medication not prescribed or forcing a resident to take medication
- Allowing a resident to be abusive to other residents
- Openly sexual remarks to or about an incapable resident or attempts to talk a resident into sexual intercourse, fellatio or cunnilingus
- A staff member exposing his or her genitals to a resident
- A staff member taking nude photographs of residents (Illinois State TRIAD 6)

Examples of verbal/mental abuse:

- A repeated verbal harassment such as name calling, cursing or yelling at a patient in anger

- Isolating a resident inappropriately or denying food or privileges as a part of punishment
- Throwing items at a resident to antagonize, such as throwing drops of water while mimicking the sound of spitting
- Telling a resident that her food is poisoned or threatening to give her a pill so that she doesn't wake up (Illinois State TRIAD p.3).

B. THE DEFINITION OF NEGLECT

Neglect means a failure in a long term care facility to provide adequate medical, personal care or maintenance. This failure results in physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition (210 ILCS 30/3-4).

The federal regulation expands the definition of neglect to include failure to provide goods and services necessary to avoid neglect. The definition of mental injury is expanded to include mental anguish. Added to the federal regulations are mistreatment of residents and misappropriation of residents' property (42 CFR 488.301).

Neglect may or may not be intentional. Neglect could be an effort of a staff member(s) who has decided to punish a resident for some behavior such as demanding too much attention or for being incontinent. Ordinarily this is not the case. Neglect usually occurs as a result of inadequate staffing, inadequate training of staff, inadequate supervision of staff and unavailable services. Neglect occurs when residents are left alone, ignored by staff, left with staff who fail to care for them with good judgment, or put them in dangerous situations.

Examples of acts of neglect or failure to provide necessary services and care:

- Untreated medical conditions
- Complaints of pain or injury are ignored
- Not providing timely, safe or adequate medication
- Inability to access medical or nursing personnel when necessary
- Clothing is dirty, torn, ill-fitting or in need to repair; not providing adequate clothing provided for weather conditions (e.g., no coat in winter, inadequate cooling in the summer)
- Clothing is shared among individuals
- Allowing residents to lie or sit in feces or urine for an excessive amount of time; failed to change disposable briefs, clothes or bedclothes when needed
- Not providing medical help promptly when needed (e.g., resident broke hip and was not seen by doctor until 3 days later, despite complaints of pain)
- Not providing adequate supervision, resulting in danger to the resident;
- Allowing residents to be self-abusive (e.g., to burn themselves with cigarette)
- Not providing adequate hygiene care; not bathing and grooming as needed; few or no personal hygiene items; use of communal personal hygiene items
- Lack of sufficient, appropriate food; limited access to water; residents admitted to the hospital suffering from malnutrition, dehydration

- No scheduled beverage deliveries for individuals who are unable to assist themselves
- Snacks are locked up to prevent access
- A resident is left in the care of a worker who has fallen asleep or is intoxicated while on duty.
- Lack of adaptive devices to meet individual needs (e.g., walkers, wheelchairs, communication devices)
- Toothbrushes are missing or need to be replaced
- A resident is fearful about leaving her room and seems almost panicky when it is time to leave the room. Staff decides to leave the resident alone and the facility social worker/ psychiatrist is not contacted.
- A resident fell several days ago. Her ankle is swollen and bruised, and she complains of pain when walking. Neither the resident's doctor nor family are immediately notified of the fall. X-rays taken five days after the fall reveal a fractured ankle (Illinois State TRIAD p. 4 & 7 and DHHS p. 38).

III. ABUSE AND NEGLECT INDICATORS

(Illinois State TRIAD p.5-7)

A. PHYSICAL ABUSE INDICATORS

The result of physical injuries from assaults, cruel discipline, excessive use of physical/chemical restraints, and unnecessary or incorrect medication, or dosages of medication, may include any of the following signs:

- Marks and/or welts—There may be bruises or other physical injuries because a staff member shook or pushed a resident. A resident may have a handprint-shaped bruise where he or she was slapped across the face, arms or buttocks.
- Burns—Red burn or scald mark may be observed because a resident was placed in a scalding hot tub of water, or is purposefully burned with a cigarette, iron, curling iron or other hot instrument.
- Cuts, punctures, scratches—A resident may have been jabbed with a sharp instrument, such as a pencil or scratched with fingernails.
- Broken bones—These injuries may occur when staff handle residents who have osteoporosis roughly or incorrectly.
- Human bite marks—Bite marks might be the result of a bite from another resident or staff member.
- Internal injuries—A staff member may have given a resident alcohol or drugs that resulted in sickness or internal injury, or an overdose of anti-diarrhea medicine, causing serious constipation.

- Suspicious Scars—The resident may have been the victim of repeated or past abuses.
- Hair loss from someone grabbing/pulling hair
- Black eyes, broken fingernails
- Over or under medicated

B. SEXUAL ABUSE INDICATORS

The ombudsman will rarely observe sexual abuse indicators, but staff and others may report sexual abuse to the ombudsman program. Some of the following examples will only be observed by a staff or family member since the ombudsman cannot examine a resident's body unless asked to do so by the resident or resident's representative. If an ombudsman is requested to look at any part of a resident's genitals or other parts of the body, the ombudsman should have another person, trained as a nurse, in the room when that occurs, such as the director of nursing.

- Pain, itching, or noticeable injury (cuts, bruises, etc.) to a residents genitals, anus, breast or mouth
- Injury to face, neck, chest, abdomen, thighs or buttocks
- Pain experienced during elimination
- Blood in urine or stool
- Gastrointestinal disturbance
- Difficulty walking or sitting
- Torn, stained or bloody underclothing
- Sexually transmitted disease
- Inappropriate displays of affection by the caregiver
- Severe changes in the resident's behavior
 - Flinches at movements
 - Afraid of the opposite gender
 - Pulls away from certain staff members
 - Constant and laborious washing of the hands or brushing of the teeth
 - Upset when bathed, toileted, changed
 - Shame, humiliation, anxiety

C. NEGLECT INDICATORS (Illinois State TRRID p.5-7 and DHHS p.38)

Neglect indicators include:

- Lack of routine or regular evaluations based on individual's need (e.g., eye, dental, etc.)
- Assaultive residents left alone and unsupervised in a hallway or other place in which staff are not present.
- Crowding/concentration of vulnerable adults
- Poor personal hygiene
- Poor dental hygiene—A resident with bleeding gums and some loose teeth
- Dehydration/malnutrition— Unexplained or excessive weight loss
- Pointing to empty plate or glass during meals yields with no response from staff
- Self-injurious behavior prior during or after meals
- Attempts to steal food or beverages from individuals
- Evidence of body odor; scaly skin; oily or dirty hair; dirty or unkempt finger nails; unclipped toe nails; inattention to shaving needs; poor dentition; lack of dentures, when not for personal choice; poor menstrual hygiene; or odor of urine or feces on an individual's person or in his or her living or work area
- Call lights not answered in a reasonable amount of time or remain unanswered
- Lack of staff—Staff continually difficult to locate within the facility
- Pressure sores (decubitus ulcers)—untreated, infected
- Over or under medicated
- Residents congregated in one area (e.g., at the nurses' station or lined in hallway) slumped over in their wheelchairs with no activities
- Residents isolated in their rooms

D. FINANCIAL EXPLOITATION INDICATORS

Financial exploitation indicators include:

- Unusual activity in bank accounts
- Checks signed by a resident who cannot write
- Unmatched signatures
- Changes to advance directives when resident is incapable of making those decisions
- Unusual concern of caregiver in regards to cost of care
- Overdue bills, unpaid bills
- Missing cash or possessions
- Lack of basic amenities such as grooming items and clothing

IV. RISK FACTORS FOR ABUSE

(Illinois State TRIAD p. 8-9)

Abuse in facilities may occur because residents abuse one another, the staff may abuse residents, family members may abuse residents, the guardian or power of attorney may abuse residents or the residents may be abusive toward the staff.

Abuse may be an act of violence such as assault or sexual violence, or it may be non-violent, as in the case of medication errors or falls resulting from failure to follow procedures.

Learning about risk factors can prevent abuse. There are employee risk factors, facility risk factors and resident risk factors. There may be other forces that contribute to the problems such as the weather, time of day, season or holidays.

A. RESIDENT RISK FACTORS

Residents are more at risk to be abused when they have physical or mental conditions for which staff are untrained, or require a high level of care and treatment that staff are unable to provide.

Resident risk factors include:

- Non-verbal/mute
- Incontinent
- Incompetent/ dementia

- History of multiple falls
- History of substance abuse
- Assaultive behaviors, such as “spitters and hitters”
- Verbally abusive
- Racist remarks or actions
- Intrusive—the resident has figured out what “buttons” to push
- Hostile, passive or aggressive
- Argumentative
- Demanding
- Passive
- Receive few or no visitors

Residents who receive no visitors and are incapable of speaking for themselves are most vulnerable and at risk for neglect and/or abuse.

B. EMPLOYEE RISK FACTORS

Employee risk factors include:

- Mental illness
- Alcohol/drug abuse
- Poorly trained
- Insubordinate/power conflicts/rivalry
- Chronic physical illness
- Financial problems
- Roll reversal—looking to the resident to fulfill his or her own needs
- Family problems or history of family violence
- Pattern of excessive absenteeism
- Tardiness or disappearance from job site
- Social isolation

C. FACILITY RISK FACTORS

Facility risk factors include:

- Crowding/concentration of vulnerable adults
- Inadequate staffing levels
- Staff shortages, e.g., least experienced staff required to work holidays when staff is skeletal or when residents are agitated
- Inadequate managerial response to abuse
- Staff poorly paid—low investment in jobs, resentment when demands are made
- Poor role definition/obscure rules of organization
- Use of facility for detention of anti-social persons
- High employee absenteeism
- High personnel turnover; frequent reorganizations
- Poor building maintenance (ventilation, noise, lighting)
- Inconsistently applied standards

- Lack of staff training—which means that staff are not prepared to act wisely or correctly
- Unrealistic budget or reimbursement rates.

V. THE CURRENT SITUATION

A. GOVERNMENT REPORTS OF DEFICIENCIES INDICATE WIDESPREAD NEGLECT

The national media, on occasion, raise the consciousness of the neglect and abuse problems for the general public. But these headlines are too sporadic to make the general public rally for a **zero neglect policy**. For example, *Time Magazine* (October 1997) featured an article entitled “Fatal Neglect” in which there was a general description of the state of neglect in nursing homes across the country. The article stated, “In possibly thousands of cases, nursing home residents are dying from a lack of food and water and the most basic level of hygiene.” CBS aired a segment about tracking abuse in nursing homes (March 2000), which included the following statements:

All citizens must rally for a ZERO NEGLECT POLICY. The neglect and abuse of our “Greatest Generation” is unacceptable.

- Neglect is the silent killer in nursing homes. By some estimates, malnutrition, dehydration, bedsores and infection caused by neglect account for half of nursing home deaths and injuries.
- CBS News analyzed nursing home inspection reports and found more than 3500 homes were cited last year for poor care that could cause dehydration. In almost 500 cases, residents were seriously injured or even died as a result.

B. NEGLECT AND ABUSE CASES IN ILLINOIS

The total number of cases of abuse and neglect of residents in licensed Illinois long term care facilities is unknown.

The deficiencies cited in the annual survey reports and the verified complaint investigations do not total the number of cases of abuse and neglect. They represent a snapshot of what was occurring in that facility at the time of the survey or complaint. They do not represent the total cases of abuse and neglect. No one knows how many cases go unidentified or unreported.

In Illinois, the Department of Public Health annual survey data of nursing facilities for 1999, including data from skilled and

Status of Care in Illinois Nursing Homes:

In 1999

90% of facilities surveyed one or more deficiencies at the “D” level or higher, in which one or more residents were found to have the potential for actual harm.

31 % of the facilities surveyed had a “G” deficiency or higher, in which one or more residents were actually harmed.

intermediate facilities and hospital nursing facilities, show that **90 percent** of facilities had one or more deficiencies at the “D” level or higher. A “D” deficiency is one in which one or more residents were found to have the potential for actual harm. This type of deficiency may be interpreted as a type of neglect.

This same survey data show that **31 percent** of the facilities surveyed had a “G” deficiency or higher. A “G” deficiency is one in which one or more residents were actually harmed. This type of deficiency is a type of neglect, gross neglect, or abuse (I CARE 2-4).

IDPH Report to General Assembly 2000:

*From January 1998 to November 2000
32% of Illinois nursing homes were cited
for “G” deficiencies or above, compared
to the national average of 30%.*

*11.5% of Illinois nursing homes had
citations related to abuse.*

Illinois has a higher percentage of “G” deficiencies than the national average. The national average of G deficiencies is approximately 30 percent whereas Illinois is 32 percent (IDPH 28).

VI. THE OMBUDSMAN’S OBLIGATION IN CASES OF ABUSE AND NEGLECT

Although the general public does not recognize abuse and neglect of the elderly as a national concern, the problem is significant for the residents involved, their families, the physicians and nurses responsible for their care, the state and federal governments, and others charged with the protection and care of these persons who are old, frail and vulnerable. Since each person has a right to quality care, any abuse or neglect of any one resident is intolerable, the cause needs to be identified and steps taken to eliminate the problem. Neglect, whether it is willful or not, can be eliminated. The ombudsman should never be accept or “rationalize” negligent situations; neglect can lead to abuse.

*Neglect,
whether it is
willful or not,
can be
eliminated.*

The ombudsman needs to know how to recognize and handle complaints involving abuse and neglect. In the following pages you will learn

- Approaches the ombudsman should take in handling abuse and neglect cases,
- The requirement for reporting abuse and neglect to the Department of Public Health, and
- What facilities are required to do in order to prevent abuse and neglect.

A. EVEN THE “BEST” FACILITIES MAY HAVE ABUSE AND NEGLECT

To adequately address the issue of abuse and neglect of the elderly, the ombudsman must first acknowledge that abuse and neglect can and does exist in any facility, even in

the “best homes.” What is not clear is why it happens, what constitutes an environment that allows neglect and abuse to occur, and why some people, including some families and residents, are seemingly tolerant of abusive and neglectful situations.

The ombudsman must be well informed about facility deficiencies in order to be alert to the types of problems that could occur in the facility he/she visits. The ombudsman cannot be complacent and think, “I go to a good home and everything is fine. The staff are caring. I know the administrator and she works very hard at making certain that all residents receive care.” This may or may not be true.

The ombudsman must first acknowledge that abuse and neglect can and does exist, even in the best homes.

Recently a volunteer ombudsman reported, “Nothing ever happens in the home I go to. Everything is fine. They have a lot of support from the community and volunteers come in every day.” What this ombudsman did not know was that the facility

had just received an IDPH survey report showing several “G” deficiencies. One deficiency was cited because several residents had an unexplained loss of weight; they were left hungry as a result of not receiving a consistent amount of food portions and lack of assistance in eating. While the ombudsman thought that the facility was excellent, some residents were actually starving. Malnutrition is an all too common type of gross neglect, which should never be tolerated.

Unless the ombudsman becomes well acquainted with a facility, its staff and the residents, he will not know about abuse and neglect of nursing home residents through visiting residents in a casual manner. To be better informed about abuse and neglect in an assigned facility, the ombudsman should be well informed through the Department of Public Health survey reports that show the deficiencies cited and provide descriptions of any abuse and neglect incidences.

What should the ombudsman do, no matter what facility to which he is assigned? Foremost, the ombudsman needs to guard against being co-opted by facilities—lulled into thinking that the same quality of care is being provided at times when the ombudsman is not there. Usually the care looks fairly good on the first shift during the days, Monday through Friday, but facilities often lack staff and the quality of care declines in late afternoon, nights and weekends. The ombudsman needs to talk to residents and families about what happens during these times.

A workshop, *Abuse in Long-term Care Facilities: It Happens in Good Homes*, presented in 2000, included presentations by those working in law enforcement and the Department of Public Health. Examples were given on what to watch for situations, which once identified, could be corrected to prevent abuse and neglect. No ombudsman should be so naïve as to believe that because a long term care facility appears to run well, there is no ongoing neglect in that facility or that abuse cannot occur. **This does not imply that there are no facilities that run well, but the statistics demonstrate that many more have problems than those who do not.**

B. DO RESIDENTS, THEMSELVES, CONTRIBUTE TO THE NEGLECT AND ABUSE PROBLEM?

The author participated in a survey regarding why older people allow themselves to be financially exploited more than younger people. The question was, "What is the reason that people who would not tolerate abuse, neglect and financial exploitation when they were young, tolerate this type of situation when they are old?" The survey was attempting to assess why older people are much more vulnerable than younger people, given the same situation.

Although a report on the survey was never received, other research has shown that abuse and neglect is likely to occur most often in institutional settings. Abuse has been defined as interplay between factors, given sufficient stress. Under certain conditions, people appear to have a greater capacity for abuse than they would even acknowledge. Many, if not most, residents of long term care facilities have behavioral, mental or cognitive difficulties that make them prime targets for abuse and neglect. Other reasons cited for abuse and neglect are fear of retaliation if complaints are made, lack of training of staff on how to cope with behavioral problems of residents, poor working conditions and staff burnout.

C. AN EXAMPLE OF FINANCIAL ABUSE

When an abuse or neglect allegation is reported to an ombudsman, it usually is in the form of a crisis situation, even though the events may or may not be current.

There are many financial abuse situations by long term care facility staff, but not all. Family, friends or others may be abusing a resident. For example, an ombudsman program had a complaint about a resident whose own attorney was financially exploiting her. Also, the resident had authorized her attorney to be her power of attorney. Her doctor believed that she did not have dementia to the extent that it would affect her ability to make decisions. She had one cousin who hesitated to be involved because the resident was a person who always handled her own business affairs. Everyone appeared to be helpless because of her attorney who controlled her assets. He had financially exploited her to the extent that she was eligible for Medicaid assistance.

The resident, who appeared competent, believed that her finances were in good order. She did not know that her federal income taxes were in arrears. Although she had extensive land holdings, she did not know that her bills amounted to more than her assets. The nursing home was about to discharge her for non-payment of about \$40,000. The nursing home had cared for her many months without payment because the nursing home staff somehow believed that her attorney would eventually be able to meet her financial obligations. She eventually entered a hospital from the nursing home and the hospital was not paid.

Would this resident have tolerated this had she been young? Would she have tracked the financial transactions and not had complete trust in the attorney?

Through the ombudsman program, this case against the attorney was finally resolved in court. The ombudsman program spent countless hours in providing assistance to this resident to assure that there was someone, other than her attorney, appointed to oversee her business interests and that she would not have multiple, involuntary discharges.

VII. ILLINOIS LAW REQUIRES CERTAIN PROFESSIONALS TO REPORT ABUSE AND NEGLECT TO THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH

A. REPORTING REQUIREMENTS IN THE LAW

The Illinois law requires any administrator, agent or employee of a long term care facility having reasonable cause to believe any resident with whom they have direct contact has been subjected to abuse or neglect shall immediately report or cause a report to be made to the Department of Public Health. Other professionals are also mandated to report their suspicions, including, but not limited to, physicians, law enforcement officers, registered nurses, certified nurse aides, social workers and emergency room personnel (210 ILCS 30/4).

Facility staff, and other professionals are mandated reporters of abuse and neglect.

The state regulations (77 IL Admin. Code 300.3240) require that any facility employee who becomes aware of abuse shall immediately report the matter to the facility administrator. The administrator, in turn, must report the matter to the resident's legal representative and the Department of Public Health.

If there is credible evidence of the allegation and the perpetrator of abuse is an employee, that employee must be barred from any contact with residents, pending the outcome of the investigation (77 IL Admin. Code 300.3240 (e)).

When the perpetrator of abuse is a resident, that resident's condition must be immediately evaluated to determine the most suitable therapy or need for hospital services.

Allegations of abuse or neglect in unlicensed long term care facilities should be referred to the ombudsman supervisor. (An unlicensed long term care facility is a residence of three or more people, unrelated to the owner, who require personal or nursing care.)

Immunity Provision: Any person, institution or agency participating in good faith in the making of the report, or in the investigation of such a report or in the taking of photographs or x-rays under the Abused and Neglected Long Term Care Facility Residents Reporting Act shall have immunity from liability, civil, criminal, or otherwise, that might result by reason of such actions. (210 ILCS 30/8)

A person required to make reports, or cause reports to be made under the law, who fails to comply is guilty of a Class A misdemeanor. (210 ILCS 30/4)

All information received as a result of a report of abuse, neglect or exploitation, involving the reporter's identity, is maintained as confidential to the full extent allowed by law. (A reporter's identity is not held in confidence if the facility appeals a finding.) (Illinois State TRIAD 10)

B. REQUIREMENTS FOR REPORTING ABUSE OR NEGLECT TO THE DEPARTMENT OF PUBLIC HEALTH AND OTHER AGENCIES

The Illinois Long-Term Care Ombudsman Program may be contacted about any suspected mistreatment of residents and is often asked for assistance in resolving any problems that have occurred or continue to occur within a facility. While there are no exact benchmarks on when alleged mistreatment of a resident becomes neglect or abuse, the ombudsman must gather as many facts about the situation as possible and contact his/her supervisor for further instructions.

Assist and Encourage All Residents, Complainants and Witnesses to Report

The ombudsman program must educate, encourage and assist residents and others to report abuse and neglect of a resident to the Department of Public Health and to other law enforcement agencies as appropriate.

Report When the Ombudsman Has Permission from a Capable Resident

The ombudsman must report alleged abuse or neglect of a resident to the Department of Public Health

- if the resident understands the facts,
- is able to express a free choice,
- if the resident understands the risks and benefits of reporting, and
- if the resident agrees to allow the ombudsman to release his/her identity and any other confidential information.

Report When the Ombudsman Has Permission from a Resident with Limited Decision-Making Capacity

Even if the resident has limited decision-making capacity, the ombudsman will follow the resident's wishes to the extent that the resident can express them, including whether or not to report alleged abuse or neglect to the Department of Public Health.

Procedure for When Capable or Limited Decision-Making Resident Does Not Give Consent

If a capable resident refuses to give consent to the ombudsman to report suspected abuse or neglect to the Illinois Department of Public Health, the ombudsman must attempt to determine why she refused, considering factors such as lack of response by facility to complaints, the resident's fear of certain staff and/or fear that staff will be fired. The ombudsman should contact his supervisor for advice on how to proceed. The regional ombudsman should then consult with the Office of State Ombudsman.

In deciding whether or not to report to the Department of Public Health, the Office of State Ombudsman will consider the impact on the resident, the impact on other residents and the integrity of the ombudsman program.

Procedure For an Incapable Resident Who Has no Legal Representative Available: Assume the Need for Protection

If a resident is incapable of consenting to report, the ombudsman will try to establish evidence to indicate what the resident would have desired and will assume that the resident wishes to have his/her health, safety, welfare and rights protected, and therefore, the ombudsman will make a report to the Department of Public Health.

Notice: *If an allegation of abuse or neglect is reported to the Department of Public Health Hotline and is also reported to the long term care ombudsman program, the ombudsman cannot discuss this allegation with anyone connected with the facility until after Public Health completes its investigation.*

If an ombudsman gives knowledge to a facility about a Department of Public Health survey on a complaint investigation, no matter how subtle, the ombudsman is subject to a fine of \$2000 and discharge as an ombudsman.

C. GUIDELINES FOR MAKING A REPORT TO THE DEPARTMENT OF PUBLIC HEALTH

The Illinois Department of Public Health is the state agency mandated to investigate all allegations concerning abuse or neglect of residents who live in licensed long term care facilities. The reports of abuse and neglect may be telephoned to the Nursing Home Hotline and are required to be sent in writing to the department.

The Illinois Department of Public Health's Hotline is available to receive reports of suspected abuse and neglect, as well as other concerns related to long term care facilities, twenty-four hours a day, seven days a week. If abuse or neglect is reported to the ombudsman, the ombudsman should consider the report to be true but unconfirmed. Thus the terms, "suspected or alleged," are used until the Department of Public Health investigates and makes a finding

When the Department of Public Health conducts an investigation of the report, even when the ombudsman has witnessed the neglect or abuse, the surveyors do not always validate the charge of abuse and neglect. That does not mean that the abuse or neglect did not occur; it means that the IDPH could not obtain sufficient information to substantiate a deficiency at the time of the investigation. In these situations, the

supervisor should be contacted to determine why the Department of Public Health had no finding.

The reports of suspected abuse or neglect are made by:

- Telephone to the Department of Public Health's Central Complaint Registry (Nursing Home Hotline): **1-800-252-4343 or 1-800 526-0844** (TTY)
- Fax to the Department of Public Health's Central Complaint Registry: (217) 785-9182.
- In writing to the Department of Public Health's Central Complaint Registry:
Illinois Department of Public Health
Office of Health Care Regulation
525 West Jefferson St.
Springfield, Illinois 62761

The Hotline operator needs as much information about the problem or incident(s) as possible. The more information that can be provided at the time of the report, the greater the investigator's likelihood of proving that the incident occurred. The person reporting, including an ombudsman, needs to think through the following questions before placing telephone call to assure that the report is as complete as possible. When an ombudsman empowers a resident, family member, friend, or other person to call the Hotline, the ombudsman should inform him/her to be prepared to answer the following questions:

- What are you calling to report?
- What is the resident's and the facility's name?
- What is the facility's address?
- When did the incident/problem occur?
- What day was it? What time of day? What shift?
- When did you become aware of the problem?
- Did you personally see the incident(s)?
- Who told you of the problem? If the complainant wishes to remain anonymous, you must not give the name.
- Do you know of any similar problems/injuries during the last 3 months? If you do, how often and when did it happen?

- Do you know of any other resident who had the same problem or injury within the last three months? If yes, how many, who were they and when did it happen?
- What is the resident's general physical condition? (Is the resident confined to the bed or wheelchair? Can she communicate?)
- Have you observed any difference in the resident's condition or behavior since the problem occurred?
- Was any medical attention given to the resident as a result of the problem/incident? If so what medical attention and when?
- What did the facility do after this injury or problem? (Illinois State TRIAD 11)

D. OTHER AGENCIES INVOLVED IN ABUSE AND NEGLECT INVESTIGATIONS

The Illinois State Police Medicaid Fraud Control Unit has the responsibility to investigate 1) allegations of fraud perpetrated by long term care facility providers; 2) abuse complaints that may be prosecuted criminally; and 3) theft of residents' funds by the provider.

The local police and /or sheriff's department have the responsibility to investigate criminal activities in their local areas. Criminal abuse, neglect, theft, or other criminal activity occurring in a long term care facility should be reported to local law enforcement offices (Illinois State TRIAD 12). An ombudsman shall use the same guidelines on pages 18-21 and request assistance from the supervisor.

VIII. ABUSE AND NEGLECT PREVENTION

A. HOW A FACILITY PREVENTS ABUSE AND NEGLECT

Every facility certified for Medicaid or Medicare residents must develop and operationalize abuse prevention policies and procedures to protect residents from abuse, neglect, involuntary seclusion and misappropriation of their property. This includes policies and procedures for hiring practices, training, and supervision of staff and volunteers, and the reporting and investigation of allegations and occurrences that may indicate abuse.

No facility wants any resident to be abused or neglected. Facilities, in their policies that drive their practices and training of staff, affirm the right of residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. Every facility has a policy that prohibits mistreatment, neglect or abuse of its residents, and attempts to establish a resident-sensitive and secure environment. An example of what a facility will do to prevent occurrences of mistreatment, neglect or abuse of residents is as follows:

- Conduct preemployment screening of employees;

- Orient and train employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of any mistreatment, neglect and abuse;
- Establish an environment that promotes resident sensitivity, resident security and prevention of mistreatment;
- Identify occurrences and patterns of potential mistreatment;
- Immediately protect residents involved in identified reports of possible abuse;
- Implement systems to investigate all reports and allegations of mistreatment promptly and aggressively, and make necessary changes to prevent future occurrences; and
- File accurate and timely investigative records. (Illinois Council on Long-Term Care 1)

A facility intent on preventing abuse and neglect will do the following:

- Communicate clearly and consistently to staff that all residents must be treated with dignity and respect.
- Have an adequate screening mechanism in place to insure that appropriate staff is hired.
- Provide training programs that develop appropriate attitudes in new employees and teach staff about resident behaviors and needs.
- Have adequate staffing levels that are essential to providing quality care.
- Have administrators and supervisors visible, available and supportive to staff.
- Have administrators and supervisors impressed on staff and residents the importance of reporting suspected abuse, neglect and exploitation to the facility. Any criminal behavior should be reported to law enforcement officers.
- All cases of abuse and neglect are quickly reported to the Department of Public Health and staff knows of this requirement.
- Develop a confidential means of reporting that protects staff who report and reduce pressures set by peer groups.
- Deal with minor incidents immediately. Any abuse, no matter how minor, should not be tolerated.
- Have an adequate environmental support, e.g., bathrooms that are safe, pleasant and clean.
- Have supervisors who are competent and supportive.

- Have counseling services for employees with significant personal problems. These services should be available by referral as part of the employee's health services.
- Establish a support system in which staff may report their feelings when they are angry with a resident. The supervisor should be able to assist in suggesting alternatives in providing care or be able to reassign the person.
- Encourage staff and residents to report any situation that is not normal.
- Recognize and reward competent and caring staff.
- Inform the staff about the services of the Long-Term Care Ombudsman Program and encourage staff to use this service. (Illinois State TRIAD 19-20).

Facilities Are Required to Contact Law Enforcement for Certain Situations

Any facility must immediately contact local law enforcement authorities (e.g., call 911) when there has been

1. Physical abuse involving allegations of assault or battery inflicted on a resident,
2. Sexual abuse,
3. A crime committed in a facility by a person other than a resident, or
4. A resident death other than by disease processes.

Registry of Certified Nursing Assistants (CNA's)

The OBRA '87 Nursing Home Reform Law requires states to have a registry of certified nurse aides (CNAs) who have committed abuse, neglect, or misappropriation of resident property to be listed in a State registry. Any CNA listed cannot be employed by a facility. CNAs are added to this registry after investigation, substantiation by Department of Public Health staff, and the finding of guilty of abuse and /or neglect, if upheld by an IDPH Administrative Law Judge, should the CNA appeal. This process does not require a conviction in a court of law.

Illinois then expanded on the federal law through the passage of the Health Care Worker Background Check Act, which was enacted in 1996, requiring all nursing homes to conduct mandatory checks for new employees who are unlicensed direct care staff. Criminal background checks expose persons convicted of various criminal offenses, such as gross neglect of a nursing home resident, sexual abuse, assault and battery, robbery, etc.

Unfortunately, the registry is limited to the State of Illinois and any convictions of a CNA that may have occurred in another state are not reflected in this check. Other personnel working in facilities, such as licensed nurses, kitchen staff and custodians are not required to have a criminal background check. This is a recognized problem by advocates concerned with the safety of residents.

B. HOW OMBUDSMEN PREVENT ABUSE AND NEGLECT

Professionals who have extensive experience in long term care facilities that operate well, and are leaders in the long term care industry, believe that it is crucial to have the ombudsman come to the facility often. Some facilities would like to have the ombudsman every day!!!! These people believe that facilities operate better with more ombudsman program presence. These administrators believe that this kind of service is not only important to the protection of residents against abuse and neglect, but it also helps them to know more about what is occurring in the facility.

Leaders in the long-term care industry not only believe that it is crucial to have the ombudsman coming into the facilities, but that the ombudsman should come more than once a month.

Two obligations of the long term care ombudsman:

- 1) to empower the community, especially family councils, to support the facility in the prevention of abuse and neglect, and
- 2) to follow-up on complaints concerning abuse and neglect.

The overarching duty of a long term care ombudsman as described in the federal law, Older Americans Act, is to “provide services to protect the health, safety, welfare and rights of residents.” Perhaps the most important resident’s right is to be free from abuse and neglect.

C. THE OMBUDSMAN PREVENTS NEGLECT IN FACILITIES

Although the ombudsman has no authority to lift the covers and examine the body of a resident without his/her consent or that of his/her guardian (assure another person is in the room), the ombudsman must be alert to conditions in facilities that most often contribute to neglect.

The ombudsman can recognize situations in long term care facilities, in which neglect is possibly occurring. Examples that put residents in jeopardy of neglect are:

- A facility has staff that does not know the residents and the staff is seemingly distant in their attitude toward residents; this situation tells the ombudsman that something is wrong with the support of the staff at the facility. Overworked, poorly supervised, and poor teamwork can cause distant or antagonistic feelings.
- A facility has a lack of staff and a high turnover of staff, which is usually an indication of job dissatisfaction, unless the pay is lower than that of other facilities. Job dissatisfaction is usually caused by lack of respect, supervision, training and/or support.
- A facility usually or always has a strong urine or excrement odor, that is an indicator that incontinent residents are not being changed and are thus in jeopardy for bedsores and other infections.

- A facility has a chronic situation in which call lights are on, while at the same time there appears to be lack of staff to answer the call lights in a timely manner (five minutes).
- A facility is addressing the issue of lack of staff in an unacceptable manner. Some examples which concern call lights are:
 1. The call lights may not be in the reach of residents; the call light may be put on a shelf or on a windowsill.
 2. The call lights are not adapted for residents with disabilities that prevent them from using a regular call light. For example, if the resident cannot use his hand, is the call light adapted so that he can use his elbow?
 3. The facility may have a system that controls call lights. In one facility, if two or more call lights were on at the same time, the facility had a system that shut off all call lights.
 4. Staff may be turning off call lights without responding to residents' needs.

The question is, how can an ombudsman program do something significant to prevent residents from experiencing neglect or abuse? How can the program do something to bring about some significant changes in the culture of licensed long term care facilities? How can the ombudsman program assist facilities in changing from a hospital (medical) model to a social model, which is more resident-centered?

1. Pioneer Network Practices

Nursing homes were developed according to the medical model in the 1960's. Built like hospitals with long hallways, central nurses' stations, task-oriented staff routines, and sterile environments, nursing homes were intended to treat the diseases of the frail and elderly.

However, residents of nursing homes need far more than basic medical care. Residents need a place that meets social, religious, emotional, occupational, recreational, and cultural needs. Long term care facility residents need a HOME where they can LIVE.

A group of nursing home professional staff, called The Pioneers, proposed innovative strategies to reconstruct the long-term care system and make "deep system change"—culture change.

Every resident, family member, facility staff and administrator needs to be informed that nursing homes can be different! Nursing home residents, including those with dementia, should have, and can have, individualized care in a homelike environment that resembles the lives they lived before entering the facility.

A group of nursing home professional staff, called The Pioneers, envisioned something far beyond the traditional nursing institutions and identified new ways of operating a nursing home. These nursing home administrators proposed innovative strategies to reconstruct the long term care system and make "deep system change"—culture change.

Culture change is a transformation of the whole nursing home atmosphere—the physical environment, staff routines, authority structure, and resident care—into an atmosphere that is “life-affirming, satisfying, humane and meaningful. Culture change has been shown to transform demoralized, dispirited staff into productive teams and dispirited, isolated elders into active members of engaged communities” (Pioneer Network).

Culture change begins with a revolutionized mindset. An administrator who is dedicated to the implementation of Pioneer Practices and who understands that system-wide change is a continual process of change, can set the tone for the facility. An administrator can influence his staff to think creatively and boldly approach care, not according to traditional rules and routines, but according to what will allow each resident to receive individualized care and a quality life as she defines it.

Pioneer Principles

- Respond to spirit, as well as mind and body.
- Put person before task.
- All elders are entitled to self-determination.
- Community is the antidote to institutionalization.
- Do unto others as you would have them do unto you.
- Practice self-examination, searching for new creativity and opportunities for doing better.

Elements of Pioneer Practices

- Residents get what they want—staff follow each resident’s schedule and preferences related to dining, bathing, sleeping, activities, etc.
- Residents and staff are grouped into small communities within the larger facility.
- Permanent staff assignments—staff knows residents well and are part of the facility community.
- Direct care staff is an integral part of the facility’s decision-making team.
- Homelike environment—animals, plants, gardens, homelike decor, kitchenettes, no central nurses’ stations.
- Intergenerational programs—families and children bring life to a facility and allow residents a chance to give care.
- Family and Resident Councils—facility staff listens and respond to the concerns of the councils. Councils are independent and staff only attends meetings when invited.
- Activities—opportunities for spontaneous and scheduled activities all day, every day. Family members, children, animals, and plants create an environment for spontaneous activity and relationship building.

a. *The Effect of Pioneer Practices on Abuse and Neglect*

The implementation of Pioneer Practices can positively impact the lives of residents in regard to the occurrence of abuse and neglect. The Pioneer principle of changing the

mindset of staff from a task-centered focus, to a person-centered focus is the foundation for individualized care that meets residents' needs on all levels—physical, social, mental and emotional. Pioneer facility staff understands that quality of life means more than basic medical care and strive to meet all needs.

The Pioneers emphasize cross-trained interdisciplinary staff teams. With staff teams, the atmosphere of the facility is transformed. Instead of the common problems, such as poor communication among departments, territorialism between departments and individual employees, and lack of attention paid to detail, there is cooperation. Pioneer

Pioneer Practices that reduce abuse and neglect include

- ❖ *Person-centered mindset*
- ❖ *Permanent staff assignments*
- ❖ *Cross-trained staff*
- ❖ *Interdisciplinary staff teams*
- ❖ *Family councils*
- ❖ *Community involvement*

facilities that utilize cross-trained staff teams have employees who support one another, cooperate, and creatively find solutions to care issues and difficult behaviors.

A cooperative staff not only benefits residents' care, but creates an environment in which employees enjoy working. Direct care staff can have job satisfaction, feel connected to residents and supported in their job, including participating as team members in the decisions regarding the resident's care. Pioneer Practices can impact staff retention!

Permanent assignments for the staff teams set the groundwork for the development of a community within the facility. Only with permanent assignments can staff know the residents they care for as individuals. Staff who take the

time to know residents' preferences, personalities, former lifestyles, etc. begin to foster a community spirit. A facility community should incorporate residents, direct care staff, supervisory staff, and residents' families. When everyone involved in the life of a facility is connected through a common goal of providing a quality of life for residents, communication increases, relationships are built, and the quality of care increases. Opportunities for abuse and neglect can be eliminated.

b. Ombudsmen and Pioneer Practices

Ombudsmen are the messengers of Pioneer Network Practices. Every resident, family member, facility staff and administrator needs to know that **nursing homes can be different!** Residents, families and staff must challenge their current assumptions about long term care and dare to expect a nursing home to be a place where one can thrive, not simply survive. Ombudsmen must also learn to expect facilities to meet more than the minimum, as set forth the laws and regulations. Instead, when visiting a facility, expect to witness Pioneer Practices in action. The ombudsman's role as an educator can be the catalyst for systemic change in long term care culture.

2. Family Councils

In many facilities, there is a critical component missing: the involvement of families and the surrounding community in the life of the facility. An essential strategy for an ombudsman is to support families in establishing a family council. A family council is

an **independent (self-led and self-determining)** group of families and friends of residents that together protect and improve the quality of life for residents and provide families with a voice in decisions that affect their loved ones. A family council can be the change agent in a facility.

Experts in the nursing home industry say that a family council is

- The best way for families to address issues in an united effort;
- The best prevention against abuse and neglect;
- The best vehicle for conveying to a facility the need for a change in culture;
- The best way to assist the activity director in obtaining assistance from the community in providing community activities and other activities;
- The best way to provide ongoing appreciation for staff;
- The best way to address systemic issues regarding changes in laws, regulations and policies that affect residents in facilities across the state and nation.

Organized family councils can identify residents that receive no visitors and develop a system for visiting and advocating for these frail and vulnerable residents who are most at risk for neglect and abuse.

a. The Effect of Family Councils on Abuse and Neglect

A family council can decrease abuse and neglect in a variety of ways. Family involvement in a council offers families a chance to know one another and empower one another to be advocates individually for their loved ones, and as a group to address facility-wide concerns.

Families who have been involved in an active family council testify to the support a council can afford. For example, when a daughter, who visits her mother in the nursing home daily, is planning to be out of town for a week of vacation, the daughter knows she can rely on fellow council members to check on, visit with, and address the concerns of her mother during the week.

Organized family councils can also identify residents that receive no visitors and develop a system for visiting and advocating for these frail and vulnerable residents who are most at risk for neglect and abuse.

Because active family members can be a connection to the outside community, a family council should serve as a core group of community individuals interested in residents, with the ability to reach out to other community groups for more support. Church groups and civic organizations need to be more involved in the everyday life of the facility.

With community involvement, the facility should be able to enhance the services they provide for residents. With additional community support, the meal times, the community meetings and the scheduled and unscheduled activities could be more enjoyable and meaningful to residents.

An involved community is also an informed and caring community that can demand quality care for their community members who live in the facility. Increased community involvement equals increased advocacy.

Other benefits of a family council include:

- Two-way communication between the facility and families,
- The council can be a sounding board for the facility regarding new ideas, events, or projects,
- Family input to aid staff in problem-solving,
- Means for staff to know residents and families better—their past experiences, likes and dislikes, etc., and
- The family council may sponsor staff appreciation events.

b. Ombudsmen and Family Councils

If a family council does not currently exist in an ombudsman's facility, the ombudsman should talk with the administrator about best nursing home practices, such as Pioneer Network Practices, which include starting a family council. Identify any concerns about a family council and address those concerns. Ask for the administrator's support in contacting families.

An ombudsman can also choose to identify one or two family members interested in starting a family council and meet together (ombudsman and family members) with the administrator to gain his/her support for the effort.

For councils that are already active, the ombudsman can:

- be in contact with the council leadership at least every other month;
- meet periodically with the council leadership to assess if they need further resources, contacts for guest speakers, contact information for state agencies, advice on law/regulation/policy, help with individual concerns, etc.;
- inform all family members how to contact you about problems or concerns;
- offer to periodically present information on residents' rights, especially to family members of residents who are new to the facility; and
- empower all family members to be their own advocates.

IX. EXAMPLES OF RESIDENT PROBLEMS AND DISCUSSION EXERCISES

When considering what questions to ask when investigating a neglect or abuse complaint that has been alleged, or you have observed, think of questions in terms of what you are trying to achieve:

Determine capability

You will want to determine if the resident can communicate with you and if she is capable.

Empowerment

If the resident is capable, you should attempt to empower the resident or complainant to handle the situation herself. Often the complainant will not hesitate to handle the situation if she has advice and is certain that she knows what to do;

Fact Finding

Finding out the facts will provide the base for further action. Record the facts as precisely as possible, what was said, what occurred, when it occurred, where it occurred, who witnessed the incident, etc.

Underlying issue(s)

In finding out what happened, your goal should lead to discovering the underlying issue(s) of the problem (s).

Confidentiality

In handling a complaint, the ombudsman has to be diligent about protecting the confidentiality of the resident or complainant, if this is requested.

Type of Complaint

You will determine the type of complaint, e.g., individual resident vs. systemic, whether you actually saw the inappropriate behavior or whether it was reported to you, etc. The type of complaint may significantly change your tactics and questions.

Exercise: Follow your instructor's plan or as a group, read the following three examples of resident problems pertaining to abuse or neglect. For each problem, discuss determine which questions need to be addressed to investigate and handle the complaint. Some questions may not apply. The group may think of other questions that are not listed.

For each case, develop step-by-step strategies. Each step/ question proceeds from the previous step/question.

(When you begin to handle a case on abuse or neglect, it is common for you to only have incomplete information about what happened.)

Note: *The word, resident, is used to denote resident or legal representative in the following scenarios.*

Scenario #1: Mr. Smith's assistance in getting out of bed in the morning

At 7:00 a.m. the ombudsman visits the assigned facility. He hears a certified nursing assistant speak in a harsh tone to Mr. Smith, "Harry, get out of bed. Get up now! Don't do that! There! You are nasty! Put your feet on the floor now!" The ombudsman also hears the resident make a yelling sound. The ombudsman considers the tone of the staff member's voice as being rude and she thinks the resident is being forced to do something against his wishes and that possibly the resident is being hurt.

- **Action #1: Empower the resident or complainant to personally take appropriate action with LTCOP assistance as requested.**

Empowerment Strategies:

- Is the resident able to communicate with you?
- Does the resident remember the incident or the subject of the complaint?
- Is the resident depressed and/or physically does not have the strength to advocate for his rights?
- Does the resident appear to have someone who is able to support him as he pursues the complaint such as, family, friends, or designated representative?
- If someone other than the resident, such as a friend, reported the complaint to the ombudsman, does the resident agree that the incident occurred and that he would handle the issue?
- Does the resident appear to be able to relate, in some manner, the problem that has occurred?
- Does the resident understand that he has not lost his right to make personal choices, even though his family, or person serving under an advanced directive does not support his choices?
- Does he know what choices he still has even though he has a state appointed guardian?
- Does the resident know what is written in his care plan?
- Does he know what nursing home services he is supposed to receive?
- Does the resident know that he has basic rights to quality care and a quality of life?
- Does the resident understand that he has a right not to be abused or neglected?
- Does the resident understand that the facility has an obligation to have procedures to see that he is not abused or neglected?
- Under what circumstance, would the resident talk to the nursing home administrator or designee?
- Under what circumstance would the resident call the Department of Public Health Hotline?
- Under what circumstance would the resident want his family or designated representative to help him follow-up on the complaint?
- Under what circumstance would the resident want the ombudsman to help him, e.g., wants the ombudsman to go with him to see the administrator and speak for him?
- Under what circumstance would the resident take this complaint to the resident or family council?

• Action #2: Fact-Finding

- Does the resident appear frightened of the certified nursing assistant? If you directly observed the incident, be sure that you observe the expressions and body language of the CNA and the resident.
- What attempts have already been made prior to resolve actions by this CNA?
- Does the resident exhibit physical indicators of abuse (see III A, p. 9)?
- Is the resident hearing impaired and in response, the CNA, when increasing volume while attempting to lower the voice, creates a harsh tone?

- Does the resident have sufficient pain to warrant his making a yelling sound when he moves? If the resident says that something hurts, the ombudsman should accept that.
- Did the certified nursing assistant insult the resident when the alleged abuse occurred? The resident may not acknowledge that he is insulted.
- What occurred prior to the incident, which may have precipitated the neglect or abuse? For example, the resident may not have wanted to get up and was forced to get up.
- Did the resident insult the CNA? (Spitting, inappropriate touching, etc).
- Has the CNA been trained on what to do with a resident's inappropriate behavior?
- Does the CNA know that inappropriate sexual behavior is a result of some types of dementia or other types of brain disorders?
- Is this the CNA's common response to inappropriate resident behavior when providing care for the resident? In providing care for other residents?

Goal: *If there is abuse or neglect, attempt to determine the root of the problem.*

- **Action #3: Determine the possible underlying issues (reason) for the problem**

- Does the resident have a choice about his daily life, when he wants to get up, when he wants to eat, what he wants to eat, participate in activities he likes, etc.?
- Has the CNA been trained according to the required abuse and neglect detection and prevention training program for staff?
- Have the abuse and neglect detection and prevention materials been used by the facility in daily practice?
- Does the CNA actually know the resident, or the residents' behaviors?
- Does the CNA need additional help with the resident?
- Has the facility investigated the reason for the resident's distress or pain?
- Has the resident's basic toileting needs been met? Does he feel ashamed because he is constantly wet and/ or soiled? For example, even though the resident calls for assistance, the resident is not taken to the bathroom at night.
- Is the resident isolated and depressed?

- **Action #4: Determination of Capability, Assurance of Confidentiality and Residents' Choice**

Is the resident capable of making decisions regarding confidentiality and how to handle the case? Construct your own questions to determine:

- Does he understand the facts?
- Is he able to express free choice and able to know the consequences of his choices?
- Does he understand the risks of reporting and the risks to himself and to others if he does not report?

- If the resident is a capable, does he want the ombudsman to intervene for him and will agree that his name can be used in investigating and resolving the complaint?
- What outcome would the resident like?
- Does he want the alleged abusive CNA to continue to care for him?
- Are there more CNAs who mistreat him?
- Does the resident want a change in his care plan that changes how he is cared for and who cares for him?
- Does the resident want to talk to the administrator, or have the ombudsman talk to the administrator?
- Does he want the issue taken to the resident council or family council?
- Does he want the complaint investigated by the Department of Public Health?
- If there is criminal behavior, does the resident want the incident reported to law enforcement?

Confidentiality—Can Not Use Name of Resident

If the resident is capable, but is not willing for his name to be used, expand this complaint into a systemic investigation.

- Are there other residents who will name CNAs or other professional staff that treat them roughly in providing care or talk in an insulting way?
- What can you tell another agency without revealing the identity of residents?
- Has criminal behavior been involved? If criminal behavior has been involved, you need to call your supervisor to report who will then report to the State Ombudsman who will consider when the public interest outweighs the private interest.
- What type of follow-up do you need to determine if the resident and complainant are satisfied with what you have done to resolve the complaint?

Individual Resident and Systemic Complaint Reporting Requirements

A complaint made by two people, about the same incident, or alleged abuse or neglect, should be considered a “systemic complaint” which is a complaint against the facility, not an individual resident complaint.

When two residents who complain about the same issue such as rough treatment by a CNA, but who will not allow their names to be used, document this as one systemic complaint, which addresses the underlying issues in the facility which allowed this treatment to occur. Use the information from the two residents as the basis for the complaint.

A systemic complaint allows you to talk to anyone, including the administrator and/or call the Department of Public Health and law enforcement officer; however, it is problematic for these investigators to find the problem when no names or identifying information have been provided.

For residents that have requested confidentiality, you must not say anything that would divulge the residents' names or identity. You can talk about Hall 100, but cannot say that one resident has "a rash on her left arm," which may divulge who she is.

Note: In empowering residents or anyone else to call the Department of Public Health on a complaint, do not give the nursing home any information which could inform the facility that a complaint was filed. This would constitute pre-notification and is subject to a fine.

Scenario #2: Mrs. Blumenfeld is allegedly abused

The ombudsman office receives a call from a person who is a friend of Mrs. Blumenfeld, a resident who has lost her hair because of chemotherapy treatments. The friend says that there is a male certified nursing assistant that treats her rudely every day. Not only is he rough when getting her dressed, he takes her wig and throws it on the floor. He thinks this is funny and makes jokes about it as he watches her pick up the wig. She is very upset about the way he treats her.

- Action #1: Empower the resident or complainant to personally take appropriate action with LTCOP assistance as requested.
- Action #2: Fact-Finding
- Action #3: Determine the possible underlying issues (reason) for the problem
- Action #4: Determination of Capability, Assurance of Confidentiality and Residents' Choice

Scenario #3: The ombudsman witnesses the abuse of Mrs. Walker

While walking down a hallway, the ombudsman sees a CNA slap Mrs. Walker on the arm while trying to help her out of her wheelchair for her daily walk. The ombudsman heard Mrs. Walker refuse to stand up by crying, "No! Stop it!" No one else was in the hallway because staff and residents were in the dining room for lunch. Mrs. Walker has Alzheimer's and is not able to communicate clearly.

- Action #1: Empower the resident or complainant to personally take appropriate action with LTCOP assistance as requested.
- Action #2: Fact-Finding
- Action #3: Determine the possible underlying issues (reason) for the problem
- Action #4: Determination of Capability, Assurance of Confidentiality and Residents' Choice

X. SUMMARY

A quality of life in a facility for both the residents and staff is the crucial factor in the prevention of abuse and neglect. When the Medicaid and Medicare laws were passed in the 1960's, nursing homes were built on hospital models under the presumption that most people would go to a facility and then in a short period of time be able to go home.

In the beginning, people did not realize that many residents would live in a facility for years. Now we know the importance of licensed long term care facilities changing to a social model in order to promote a dignity of life. In these models, residents can get better and feel like there is a purpose for living. The medical care in a facility should support the resident's life-sustaining activities. This is true for residents with dementia as well.

Ombudsmen must be educators and protectors in order to combat abuse and neglect. As educators, ombudsmen must inform residents, families, facility staff and the general public of the current situation in long term care and advances in long term care, such as the Pioneer Network Practices, that offer solutions to many of the problems that currently plague the industry. Through the education of residents and facility staff, reports to the ombudsman office of abuse and neglect have increased. They can decrease if facilities take the initiative to become "Pioneer facilities."

Until then, as protectors, ombudsmen can play an important role in both neglect and abuse prevention by educating residents and families of their rights, and establishing and empowering family councils.

Ombudsmen can promote changes in facility systems and policies by following-up consistently with facilities regarding neglect and abuse complaints and the deficiencies cited in the Illinois Department of Public Health reports.

Whether it is a family council in the facility, the local community in which the facility is located, or the entire State of Illinois, if these local, regional and state communities would speak with a united voice and take an active role in the prevention and identification of abuse and neglect, the current status of long term facility care could be transformed.

Ombudsmen can be catalysts for forming family councils and educating local communities, which could establish a new order in the medical model nursing home systems and restore a quality of life for residents.

Ombudsmen are to be the change agents to establish a new culture in long term facility care, one which prevents abuse and neglect. Seize the moment.

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RESOURCES

Department of Health and Human Services (DHHS). *Abuse and Neglect: Detection and Prevention Training Manual.* Washington, D.C.: author, 2001.

Illinois State TRIAD— TRIAD began as a national initiative sponsored by the American Association of Retired Persons, the International Association of Chiefs of Police and the National Sheriff's Association. TRIADs have been developed in communities throughout Illinois and the nation to promote crime prevention for senior citizens. Call the Department on Aging Hotline to find out if there is a TRIAD officer in your community.

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TLC in LTC (Tender Loving Care in Long-Term Care)

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