Preventing Abuse, Neglect, and Exploitation of Residents in Nursing Homes

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ECRI Institute and* Annals of Long-Term Care: Clinical Care and Aging (ALTC) *have joined in collaboration to bring* ALTC *readers periodic articles on topics in risk management, quality assurance and performance improvement (QAPI), and safety for persons served throughout the aging services continuum. ECRI Institute is an independent nonprofit that researches the best approaches to improving health care.

About 1.4 million people are living in 17,000 US nursing homes (NHs) on any given day. An additional 7 million receive assistance with activities of daily living.[1] Many of these people are at high risk of abuse and neglect because of chronic diseases that limit their ability to care for themselves, which in turn increases the demands on overworked staff. Fifty percent of NH residents have significant cognitive impairments, such as Alzheimer disease,[2] and many do not have relatives living nearby who can monitor their health and safety.

Preventing the mistreatment or neglect of long-term care (LTC) recipients is a concern for any risk manager or organizational leader. Inadequate training of staff, understaffing, difficulty recruiting adequate staff, and low pay contribute to the challenge, as do the increasingly complex care needs of residents, failure to report abuse, and lax enforcement of state and federal laws.

Risk managers should be knowledgeable of all federal and state statutes and regulations regarding abuse and neglect, including Medicare and Medicaid regulations, state licensing laws, criminal codes, adult protective services statutes, and accreditation standards. Existing policies should also be reviewed to ensure compliance with regulations and standards, especially concerning hiring, reporting, and investigating.

Types of Abuse, Neglect, and Exploitation

Abuse, neglect, or exploitation of vulnerable adults is not a homogeneous issue. It has multiple facets. According to the Centers for Disease Control and Prevention (CDC), there are at least 5 types of elder abuse (CDC considers an elder to be someone older than 60 years). These types of abuse include the following:[3]

Physical abuse. The intentional use of physical force that results in acute or chronic illness, bodily injury, physical pain, functional impairment, distress, or death. Physical abuse may include but is not limited to such acts of violence as striking, hitting, beating, scratching, biting, choking, suffocation, pushing, shoving, shaking, slapping, kicking, stomping, pinching, and burning.

Sexual abuse or abusive sexual contact. Forced and/or unwanted sexual interaction (touching and nontouching acts) of any kind with an older adult. These acts also qualify as sexual abuse if they are committed against an incapacitated person who is not competent to give consent.

Emotional or psychological abuse. Verbal or nonverbal behavior that results in the infliction of anguish, mental pain, fear, or distress. Examples of tactics that may exemplify emotional or psychological abuse include behaviors intended to humiliate, threaten, isolate, or to take unwanted control of an older adult.

Neglect. Failure by a caregiver or other responsible person to protect an elder from harm or the failure to meet needs for essential medical care, nutrition, hydration, hygiene, clothing, and basic activities of daily living or shelter, which results in a serious risk of compromised health and/or safety. Examples include not providing adequate nutrition, hygiene, clothing, shelter, access to necessary health care, or failing to prevent exposure to unsafe activities and environments. Neglect can be acute, chronic, or self-induced.

Financial abuse or exploitation. The illegal, unauthorized, or improper use of an older individual's resources by a caregiver or other person in a trusting relationship for the benefit of someone other than the older individual. This includes depriv-

AFFILIATIONS: *Patient Safety, Risk, and Quality—Aging Services, ECRI Institute, Plymouth Meeting, PA*
DISCLOSURES: *The author has no relevant financial relationships to disclose.*
ACKNOWLEDGEMENTS: *ECRI Institute gratefully acknowledges John C West, JD, MHA, DFASHRM, CPHRM, Principal, West Consulting Services, LLC, the author of the article from which this column is excerpted.*
CORRESPONDENCE: *To contact ECRI Institute directly for more information about their tools and services, please email ECRI's Continuing Care Risk Management at ccrm@ecri.org.*
CITATION: *Ann Longterm Care.* 2018;26(3):11-13. doi:10.25270/altc.2018.06.00034

ing an older individual of rightful access to, information about, or use of, personal benefits, resources, belongings, or assets.

Addressing Staff-Related Risks

Abuse, neglect, and exploitation can originate with anyone in the resident's life, including family members, other acquaintances, and, of course, LTC facility staff. To protect residents, organizations should ensure that their hiring and training processes are focused on avoiding hiring staff who may be more likely to abuse residents and promptly identifying and responding to any suspected abuse.

Emphasis should be placed on conducting background checks of potential LTC facility employees before employment and periodically thereafter. Preemployment screenings that include reference and criminal background checks are essential to ensure that applicants who are ill-suited to caring for older individuals are not hired. In addition, check state licensing boards for nursing personnel and certified nursing assistant (CNA) registries for any exclusion or sanction. Because employees sometimes work at more than one facility, these checks should be performed periodically during employment. Personnel files need to be audited periodically to ensure that they show evidence of required checks.

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Once they are hired, staff members should be trained to recognize the factors unique to themselves that lead to stress in the workplace and either avoid these triggers and/or learn manage their stress in productive and affirmative ways. For example, stressors in the environment may include heat, noise, or understaffing; staff should seek ways to improve the environment to modify these stressors. The capabilities of the staff and facility should be matched to the needs of residents. For example, the appropriate institution for an individual with severe behavioral problems associated with dementia or other conditions is one in which the staff has been adequately trained to deal with these problems. Staff can work with combative or aggressive residents' physicians to see if a resident's behavior can be modified. Staff members can also be given additional training to work with combative or aggressive residents; if necessary, consideration should be given to housing these residents on a separate unit where staff can receive specialized training. It is also helpful to keep in mind that a resident who is aggressive or combative with one staff member might not act out with another staff member.

Training Staff on What, When, and How to Report Incidents

Most states require only "reasonable suspicion" that abuse has occurred to trigger a report, so facilities should not require hard evidence of abuse before reporting. Additionally, reporters are normally provided with qualified immunity if they report their suspicions, which means that they will not be held liable for making a report unless they knew that the report was false (eg, they wanted to get another caregiver in trouble).

Staff members sometimes hesitate to publicly report their suspicions, but they may feel freer to report through the incident reporting system. Staff should be trained in reporting procedures and timelines, and it is vital to ensure that staff know what constitutes an issue that must be reported.

Virtually all states provide protection for whistleblowers who are disciplined or retaliated against for reporting matters affecting public health and safety. Resident abuse is a matter of public health and safety. Any employee's employment should be terminated only for an objectively reasonable reason (eg, unreliability, poor work performance, complaints by residents), but this is crucial for employees who have reported abuse.

Accurate, factual, and objective documentation of suspected abuse is extremely important. An investigation file should be started immediately, and all written statements and notes about the incident should be placed in this file. The nature of the allegation should be documented, as well as how the suspicion of abuse or neglect came to be raised (eg, abuse was observed by another staff member, overheard in discussion, reported by the alleged victim or another resident, observed by surveyors). The resident's observed mental and physical state after the alleged incident should be documented if known (eg, later in the day, the resident was observed to be eating well, in good spirits, and self-ambulating to activities). This will help measure the duration of the effects of an occurrence and will facilitate the investigation process. The documentation should show that the suspicion was immediately and decisively acted on and record precisely what actions were taken and by whom (eg, the resident was examined immediately, the employee was suspended or reassigned pending the investigation). The time, date, and circumstances in which the problem was first discovered or suspected should be recorded—such documentation will be important to demonstrate the facility's promptness in responding to the problem.[4]

The American Medical Association has guidelines on documenting the care provided to victims of domestic violence that can be helpful in documenting care provided to victims of elder abuse. These include the following[5]:

- Chief complaint and description of the abusive event, using the resident's own words whenever possible, rather than the physician's assessment. "Resident states 'The CNA hit me with her fist'" is preferable to "Resident claims to have been abused."
- Complete medical history, including all medications taken.
- Relevant social history.
- A detailed description of the injuries, including type, number, size, location, resolution, possible causes, and explanations given. If applicable, the location and nature of the injuries should be recorded on a body chart or drawing.
- A description of the resident's affect (eg, evasiveness, vacancy, failure to make eye contact, agitation) when discussing indications of abuse, rather than simply "resident denies abuse."
- Results of all pertinent laboratory and other diagnostic procedures.
- Results of imaging studies.
- Color photographs, if applicable, and if the resident consents to having pictures taken. Photographs should be taken prior to providing care, if possible.
- If the police or adult protective services is called, the resident's consent or refusal to consent should be documented, as well as the name of the investigating officer and any actions taken. Because many reporting statutes have specific reporting timetables, the documentation of the call needs to be accurately dated and timed.

Conclusion

Risk managers and other leaders should never assume that their facilities are immune to the occurrence of resident abuse. By screening for staff who may be unfit to care for older adults and training staff to recognize and report suspected abuse, organizations can reduce risks to their residents and to themselves. By creating a culture in which staff report all suspected adverse events and near misses, including suspicions of resi dent abuse, organizations can increase their chances of identifying and rectifying abusive behavior quickly.

Importantly, organizations should not underestimate the role that residents and families can play in abuse prevention and recognition efforts. Residents and families should be encouraged to share their stories, no matter how badly it may reflect on the facility. Residents and families should receive contact information on admission and periodically thereafter regarding which employees of the facility can listen to their complaints. The administrator should have an open-door policy for residents and families who wish to speak to him or her. Regardless of the recipient of the complaint, all staff members need to know how to handle complaints to ensure that they are taken seriously. ◆

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