

NATIONAL CENTER ON ELDER ABUSE

# **Nursing Home Abuse Risk Prevention Profile and Checklist**

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NATIONAL ASSOCIATION OF STATE UNITS ON AGING



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The National Center on Elder Abuse (NCEA) serves as a national resource for elder rights advocates, adult protective services professionals, law enforcement and legal professionals, medical and mental health providers, public policy leaders, researchers, and concerned citizens. It is the mission of NCEA to promote understanding, knowledge sharing, and action on elder abuse, neglect, and exploitation.

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# Preface and Acknowledgments

This *Nursing Home Abuse Prevention Profile & Checklist* is an easy-to-use, yet comprehensive tool that has been designed not only to root out the “hidden” risks to vulnerable nursing home residents, but also to inspire and catalyze action.

Prevention requires dedication, tenacity, and teamwork. Local prevention teams, we hope, will use this *Profile & Checklist* resource tool to talk about abuse risks openly, figure out what is at the root of those risks, and ultimately guide problem solving in the next phase. Prevention teams would ideally include the local nursing home management, Medicare Fraud Control Unit representatives, long term care ombudsman staff, the state’s licensure/certification inspectors, and representatives from adult protective services.

This prevention resource tool can be individualized to suit local circumstances. Nursing Home Abuse Risk Prevention Profile – Part One describes three classes or groups of risk factors: 1) Resident risks, 2) Social risks of relationships, and 3) Facility administration. Part Two presents a self-evaluation checklist with instructions, which can serve as a springboard for creating a safer environment. The last section, Abuse Prevention Strategies – Part Three discusses ideas for team action. In addition, appendixes at the end summarize the research theory behind nursing home abuse prevention.

Several people contributed to the development of the *Nursing Home Abuse Risk Prevention Profile & Checklist*. A special thanks to principal author Virginia Dize, associate director for Home and Community Based Services at the National Association of State Units on Aging, for the time she gave in shaping the tool.

The National Center on Elder Abuse is indebted to the late Dr. Rosalie Wolf, a past president of the National Committee for the Prevention of Elder Abuse, for her thoughtful advice and critical examination of prevention and intervention research. Sara Aravanis, in addition to her work as the Center’s Director, supplied the vision and leadership for the initiative.

During the process of writing, we benefited from the critique, insights, and suggestions of perceptive reviewers, in particular, Barbara Doherty, the director of the Minnesota Board on Aging, Adult Protective Services Program, who orchestrated a statewide pilot test. We were fortunate also to have the assistance of the National Adult Protective

Services Association's summary of useful discussion group comments on the role of adult protection in prevention. A special thanks to Sarah Greene Berger of the National Coalition for Nursing Home Reform for her expert review of the manuscript and, in particular, the concepts behind the resident risk factors.

Funding for the project was provided by a grant from the U.S. Administration on Aging (Grant No. 90-AP-1244) and the Centers for Medicare & Medicaid Services (formerly Health Care Financing Administration), U.S. Department of Health and Human Services. Opinions and points of view expressed in this document are those of the authors and do not necessarily reflect the views or policies of the U.S. government.

## Introduction

*Many patients are at risk because one out of four nursing homes every year is cited for causing death or serious injury to a resident, according to government figures.*

*CBS NEWS · TRACKING ABUSE IN NURSING HOMES  
MON., 30 JUL 2001*

**D**espite the fact that many nursing facilities in the United States provide good care to frail and vulnerable elders, almost every day incidents of abuse and neglect of nursing home residents are reported in the nation's newspapers.

Advocates for nursing home residents commonly refer to a trajectory in which poor care leads to neglect and, ultimately, if poor care is not improved, residents suffer serious harm or abuse. Identifying and stopping neglect is seen as the first step in stopping abuse. By asking the right questions, and knowing what the risks are, preventive measures can be taken to protect residents.

“Risk” implies *probability* of harm. In the nursing home, abusive acts can be physical (hitting, slapping, shaking, or nonconsensual sexual contact). Emotional abuse (verbal assaults, humiliation, and threats) can be just as painful. Most debilitating of all are the effects of poor care and careless or deliberate physical or medical neglect. In the most severe cases, the consequences can be life threatening.

### **NURSING HOME ABUSE**

1. Physical abuse

2. Verbal/emotional  
abuse

3. Sexual abuse

4. Neglect  
(Physical/Medical)

5. Exploitation –  
Personal property  
abuse

What gives rise to abuse? No one knows for sure why one person and not another would abuse. Staffing levels, resources, and quality vary so much between nursing homes, no risk factor alone has ever been proved to cause abuse. Nor does the absence of a risk factor make abuse impossible. However, research has uncovered a range of risk factors, or *correlates* of abuse, which taken together put residents in greater jeopardy. For example:

- The chance of abuse or neglect is more likely in a facility with a **high percentage** of residents with **dementia** and a **low staff ratio**.
- **Poorly trained** aides are less likely to be able give quality care for residents who have **dementia** and exhibit behavioral symptoms such as hitting, kicking, tearing things, or who are **physically dependent** when the **staff ratio is low** and they are being asked to work double shifts.

In truth protecting residents is complicated, particularly since the effects of negligent care, abuse, or mistreatment are not always visible. Occasionally perpetrators

are family or friends known to the resident. Residents who are visibly upset also have been known to physically attack attending staff and fellow residents.

Nursing home staff must strive diligently to recognize and understand the factors that put residents in danger. Three broad categories of risk have been identified as major contributors to nursing home injuries and abuse:

**Category 1: Facility risk factors.** Numerous studies have shown that poor staffing and institutional indifference create fertile conditions for abuse. Critical risk prevention factors, according to professional opinion, focus on abuse prevention policy, staff training, staff screening, staff stresses and burnout, staff ratio and turnover, history of deficiencies or complaints, culture/management, and physical environment.<sup>1</sup>

**Category 2: Resident risk factors.** Studies have shown that some residents of nursing homes can be more vulnerable to abuse than others. Behavioral symptoms associated with dementia, unmet needs, and high degrees of dependence (social isolation) are the biggest risk factors for residents.

**Category 3: Relationship risk factors.** Another safety area has to do with the quality of residents' relationships with family and their caregivers. Residents who rarely receive visits may be more vulnerable, since there is no one from outside the facility to regularly check on their care. However, in some situations, over-zealous family members may actually impede the provision of care. Similarly, the risk rises if resident-staff interaction includes past conflicts, or there is little time available to develop personal relationships.



As part of a first line of defense, professionals who care about or have responsibility for quality care in nursing homes *must* think through the potential risks which residents face daily. This publication is a resource and a starting point for such a discussion. Its premise is proactive. Its goals are twofold, first to encourage you to look beneath the surface at nursing home realities and abuse risks, and second to spur preventive action. It is aimed toward nursing home administrators and directors of nursing, professional licensing boards; adult protective services agencies, long term care ombudsman programs, and Medicaid fraud control units.

To make it easy for you to find the information you need, we've separated this resource into three sections.

In *Nursing Home Abuse Risk Prevention PROFILE*, we identify potential safety issues and risk factors, which are strongly predictive of abuse in nursing homes. Risk profile data enable you to judge the strength of the evidence on which the risk

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<sup>1</sup>*Culture/management* (the nursing facility's "culture" of acceptable behaviors and commonly held attitudes) and *physical environment*, both of which are categorized as facility risk factors, were identified by professional experts but not in the literature.

factors were based. *The Abuse Risk Prevention CHECKLIST* will help you locate potential trouble spots. The better you know the danger signals, the more interventions can be targeted to prevention. In the final section, *Abuse Prevention Strategies* for action are presented. These ideas and suggestions emerged from a review of the research literature, the teleconference of Adult Protective Service Administrators and/or the focus group and survey conducted by the State of Minnesota under this project.

## **A Word about Collaboration**

Elder abuse prevention must be an all out team effort. Five professional groups involved in nursing home administration, oversight and advocacy contributed to this collaboration tool. NASUA is indebted to the nursing home administrators and staff, state licensing and certification staff, adult protective services program staff, state and regional long-term care ombudsmen, and Medicaid fraud control unit staff who shared their knowledge.

While we encourage individual action initiatives to assess risks, enhance protections, and intervene for residents, collaboration is vitally important. Many of the actions for reducing nursing home abuse risk can only be initiated in cooperation. The collaborative model we recommend is a seven-step approach<sup>2</sup>:

### **Step 1**

The first step is to assemble a team of advocates who will work together on risk prevention. Include nursing home administration and staff as well as ombudsman, adult protective services, licensing, and Medicaid fraud experts.

### **Step 2**

Negotiate an agreement with team members, which clearly defines roles and responsibilities and explicitly states goals.

### **Step 3**

Gain input through open communication and brainstorming with team members.

### **Step 4**

Discuss and seek out a fuller understanding of abuse risks in the nursing home.

### **Step 5**

Generate creative ideas for prevention of abuse.

### **Step 6**

Build consensus and agree on action steps and a plan for follow-up.

### **Step 7**

Combine knowledge, perspectives and skills to reduce risks.

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<sup>2</sup> Adapted from Naomi Karp and Erica F. Wood, *Keep Talking, Keep Listening: Mediating Nursing Home Care Conflicts*, American Bar Association, Commission on Legal Problems of the Elderly, October 1997.

## Roles and Responsibilities

- **Nursing facilities** are accountable for the quality of care and quality of life of vulnerable residents. Nursing home administrators, directors of nursing, and staff members have access to information and data that can help them identify whether abuse risks exist in the facility. Sources of information include:

Facility policies, training and orientation curriculum, internal resident grievances, personnel files, staff performance reviews, facility customer satisfaction surveys, incident and deficiency reports, Long Term Care Minimum Data Set (MDS), resident assessment data, nurses' notes and resident records, care plans, and quality improvement reports.

Nursing facilities might use the *Abuse Risk Prevention Checklist* to obtain a comprehensive picture of potential abuse risks that exist in the facility.

- **Licensing and certification agencies** enforce state and federal laws and regulations governing licensing of long term care facilities. Evaluators complete periodic standard inspections of nursing homes, investigate complaints, and issue citations and deficiency notices to facilities for violations. Besides having access to the information found in the nursing home survey report, licensing files, and Nursing Home Compare ([www.medicare.gov/NHCompare/home.asp](http://www.medicare.gov/NHCompare/home.asp)), the licensing and certification office has authority to review a variety of nursing home-specific information. Examples are:

*Note:* The checklist is not intended as an official inspection or audit checklist, or for use in a licensing agency's required oversight activities.

Deficiency reports, survey data, facility policies, nurses' notes and resident records, the Long Term Care MDS and resident assessment data, resident grievances, other employee and abuse registries established by the state, and care plans. In addition, the licensing agency may have access to some ombudsman, adult protective services, or Medicaid fraud control information through interagency agreements, as well as data from the Nurse Aide Registry or Abuse Registry.

The *Abuse Risk Prevention Checklist* can be used to identify nursing homes' needs for technical assistance – across the board or only at facilities where there has been a history of problems.

- **The adult protective service program (APS)** in many states conducts investigations in response to allegations of patient abuse and neglect in nursing homes. About 45 percent of APS programs have authority to investigate in all settings. An additional 15 percent have authority to investigate in institutions. APS workers have access to their own complaint files and the registries. Under state law they may access:

Police reports, nurses' notes and residents' records, medical reports, MDS and resident assessments, care plans, and other facility records needed in an abuse investigation.

APS should be able to review the latest nursing home inspection report at the nursing home and may access Nursing Home Compare data online. In addition, APS may have interagency agreements with the ombudsman program, licensing and certification, and Medicaid fraud control unit, providing them access to these information sources. The *Abuse Risk Prevention Checklist* can help APS workers to clue into potential problem areas in a nursing home when they verify an abuse complaint or advise interventions. The *Abuse Risk Prevention Profile* can serve as a stand-alone resource for training APS front line staff about elder abuse.

- **The long term care (LTC) ombudsman program** investigates and resolves complaints made by or on behalf of nursing home residents concerning their health and welfare, safety, and rights. The ombudsman program also maintains a “regular presence” in facilities by making regular visits to monitor residents’ care and provide information and education on long-term care services and conditions in nursing homes. In addition to the information contained in their files, ombudsmen have access to:

Nurses’ notes and residents’ records, the MDS and resident assessments, care plans (all of which may be accessed with the resident's permission or with permission of a court ordered guardian) and other facility data pertinent to complaint investigations.

Ombudsman programs may have agreements with licensing and certification, APS, and the Medicaid fraud control unit which permit sharing of some data. The *Abuse Risk Prevention Checklist* could be used by ombudsman programs to identify facilities that present a higher risk of abuse. Ombudsmen might then target such facilities for in-service training or a more frequent schedule of volunteer visits.

- **The Medicaid fraud control unit** is empowered to investigate Medicaid fraud and patient abuse in facilities that receive Medicaid payments. Medicaid fraud investigators have access to:

Medicaid complaint and investigative files, law enforcement records, as well as a number of information sources maintained by the nursing home, including residents’ records.

Investigators also have access to the nursing home survey report, Nursing Home Compare data, and may be able to access information from the Nurse Aide Registry. If there is an interagency agreement with licensing and certification, the ombudsman program or adult protective services, the unit may also have access to some of the information maintained by those programs. The *Abuse Risk Prevention Checklist* could help expedite technical assistance. The checklist might also be used to train new Medicaid fraud investigators about the problems of nursing home abuse.

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## A Note About Sources

Risk projections and intervention strategies identified in this *Profile & Checklist* come from three primary sources:

- A literature survey conducted by world-renowned expert and older victims' advocate, Rosalie S. Wolf, Ph.D., former president of the National Committee for the Prevention of Elder Abuse.
- A National Association of Adult Protective Service Administrators' focus group convened to obtain expert consensus about the adult protective service role in the prevention of nursing home abuse.
- A focus group facilitated by the Minnesota Board on Aging to identify safety issues and risk factors related to abuse in long term care settings.

# Nursing Home Abuse Risk Prevention Profile

## I. Facility Risk Factors

**Risk Factor #1: Abuse prevention policy.** Studies show abuse is more likely to occur and to go unreported in nursing homes that have no abuse prevention policy. Employees must be able to recognize the signs and symptoms of abuse and believe that they can report allegations to management without suffering negative consequences themselves. An abuse prevention policy is a public statement that a facility is committed to open communication and to a facility-wide culture that recognizes and supports the dignity of residents.

Procedures for hiring and training staff should be an integral part of abuse prevention policy (*see Risk Factor # 5: Staff training and Risk Factor #6: Staff screening*). An abuse prevention policy should include the following elements, at a minimum:

- information on how to recognize abuse;
- detailed procedures for reporting abuse allegations and assurance in facility policy that staff will not be punished for reporting;
- staff training requirements to ensure safety and prevent abuse; and
- appropriate and prompt steps by management to stop the abuse, investigate, and report abuse to appropriate agencies when it occurs.

## RISK PROFILE DATA

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- A method of selecting and training staff that puts particular emphasis on witnessing and reporting abuse is necessary for preventing abuse. (Payne and Cikovic, 1995)

Source: B. K. Payne and R. Cikovic, *Journal of Elder Abuse and Neglect*, 1995.

**Risk Factor #2: Staff education and training.** To assure resident safety, staff training is crucial. Training should be frequent, not a “one-shot” intervention, and trainers must be well educated and provide consistent information. Besides improving competence and knowledge, training also offers a vehicle for building self-esteem, which also may help to reduce stress and burnout. Research demonstrates that training can also prepare staff to respond appropriately to difficult situations, such as dealing with physically combative residents, which have the potential to trigger abuse. As well,

it can provide them with conflict resolution and other coping skills, and increase staff empathy and competence.

Experts recommend the following topics in training:

- Communication skills and anger management
- How to respond appropriately to the different cultural and ethnic issues likely to be encountered in the nursing facility
- How to care for residents with dementia, mental illness or behavioral symptoms
- Facility policies and procedures, particularly policies for reporting abuse
- How to recognize abuse, neglect, and exploitation

#### **RISK PROFILE DATA**

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- 11,331 complaints reported in 32 states during 1998 were examined by the U.S. Office of Inspector General, Department of Health and Human Services. Analysis revealed that the primary abusers were aides and orderlies. A major cause of abuse was that staff lacked training to handle stressful situations. What's more, the study found that the majority of state oversight agencies and advocates perceived abuse as a serious growing problem, while nursing home administrators and industry representatives viewed abuse and neglect as minor.
- Recommended abuse prevention strategy: Staff education. (Saveman, et al., 1999)
- Curriculum content for abuse prevention: Understanding resident abuse; identification and recognition of types of abuse; possible causes of abuse; cultural and ethnic perspectives and implications for staff-resident dynamics; resident abuse of staff; legal and ethical issues regarding reporting; intervention strategies for abuse prevention. (Hudson, 1990)
- Staff training should emphasize witnessing and reporting abuse. (Payne and Cikovic, 1995)
- Adult Protective Service Administrators note that staff training on behavior management (how to handle combative residents or wanderers) is not adequate. Attending staff typically are not trained to handle heavy care residents. Training also does not address reporting requirements. (National Center on Elder Abuse, 2000)

- Training recommended in creative problem solving, conflict resolution, and staff supervision. (Goodridge, Johnson and Thomson, 1996)
- Training recommended in techniques for dealing with difficult situations/stressful conditions and to increase coping skills, self-esteem, conflict resolution, and stress management. (Braun, et al., 1997)
- Training recommended in the care of aggressive patients. (Shaw, 1998)

Sources: **U.S. Department of Health and Human Services**, *Office of the Inspector General's Survey*, 1998; **B. Saveman**, et al., *Journal of Elder Abuse and Neglect*, 1999. **B. Hudson**, *Journal of Elder Abuse and Neglect*, 1990. **B. K. Payne and R. Cikovic**, *Journal of Elder Abuse and Neglect*, 1995. **National Center on Elder Abuse**, *Adult Protective Service Role in Prevention*, 2000. **D. M. Goodridge**, et al., *Journal of Elder Abuse and Neglect*, 1996. **K. L. Braun**, et al., *Journal of Elder Abuse and Neglect*, 1997. **M. Shaw**, *Journal of Elder Abuse and Neglect*, 1998.

**Risk Factor #3: Staff screening.** When low staff ratios and high turnover drive facilities to fill vacancies in a hurry, skills may be “less than optimum” necessary. Pre-employment screening – including checking references and conducting criminal background checks – is essential to ensure that applicants who are not suited to care for vulnerable elders are not hired. People who would be inappropriate are people who lack empathy, who have no real interest in the welfare of the residents for whom they care, who are disrespectful or controlling, who have known substance abuse, domestic violence or criminal histories. An important strategy for preventing abuse is asking questions to learn the job applicant’s:

- feelings about caring for elders;
- how they might react to an abusive situation;
- their work ethic;
- how they handle anger and stress; and
- history of alcohol or substance abuse.

#### RISK PROFILE DATA

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- The stress of work leads to inappropriate behavior management (implies the need for staff screening). (Pillemer and Moore, 1990)
- Test for job suitability at the time of employment. (Saveman, et al., 1999)

- Screen potential staff using a role play or other technique to identify feelings about caring for elders, reaction to abusive situations, work ethic, anger and stress management, history of substance abuse. (Shaw, 1998)

Sources: **K. Pillemer and D.W. Moore**, *Journal of Elder Abuse and Neglect*, 1990. **B. Saveman**, *Journal of Elder Abuse and Neglect*, 1999. **M. Shaw**, *Journal of Elder Abuse and Neglect*, 1998.

**Risk Factor #4: Staff stresses/burnout.** The research tells us that stress and burnout take on special emergency in light of what is known about physical and psychological abuse. Hostility directed toward residents may stem from stressful working conditions. For staff, low wages, too much work for too few people, inflexible, work schedules, a perceived lack of supervisory support, poor communication between management and employees are pressure points. Invariably, stress becomes the breeding ground for abuse.

**REDUCING THE RISK**

Promoting respect and self-esteem is an essential component of any stress reduction program.

This is not to say that attending staff are never abused themselves. At times they are subjected to physical and verbal assaults by the residents for whom they care, and past abuse of staff by a resident is likely to increase the chances that staff will improvise approaches to hands-on care. Often the staff's stress is amplified by grief over the loss of a resident. Negative emotions can undermine care. Adding to this are personal problems ranging from alcohol or drug addictions, to being abused (outside the job), to poverty.

Nursing home caregivers are exposed to countless stressful situations daily. To combat stress, experts advise that facilities adopt the following preventive strategies:

- Increase wages.
- Develop a career ladder for direct service staff.
- Include nurse aides as members of the care team.
- Encourage registered and licensed professional nurses to help with hands-on care, especially when nurse aides are struggling to complete tasks.
- Improve communication between management and employees and departments.
- provide “strong leadership that stresses human kindness”

The experts believe one of the best tools for lowering stress is to keep the nursing home well staffed. The strategy makes it less likely that staff will have to work double shifts. Another thing it can do is to reduce heavy reliance on outside contract workers.

**RISK PROFILE DATA**

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- The level of staff burnout is a predictor of physical and psychological abuse. The stress of work may lead to inappropriate behavior management. (Pillemer and Moore, 1990)
- The level of staff burnout in nursing homes matched those of other health care workers. Nursing assistants could expect to be physically assaulted nine times per month and psychologically abused eleven times. A slight correlation was found between burnout and conflict. (Goodridge, Johnson, and Thomson, 1996)
- Inadequate staff supervision, poor communication among staff regarding changes in residents' needs, and unclear expectations for staff are among the factors leading to increased incidence of abuse and neglect, according to Adult Protective Services Administrators. (National Center on Elder Abuse, 2000)
- Senior staff absences, lack of interest, preoccupied with events in their own lives, in the position for very long time were found to contribute to staff stress. (Clough, 1999)
- Recommendations for reducing staff stress: enhance communication and collaboration between direct and administrative staff; better salaries; build self-esteem; respect and understanding for staff and their family needs (e.g., health benefits, sick time, child care, job stress support programs, DV, substance abuse); a program of rewards and upward mobility. (Shaw, 1998)
- To address staff stress, provide support to help staff deal with abusive situations, facilitate teamwork, and provide systematic supervision. (Saveman, et al., 1999)
- Elevate nurse aide status and implement a reward system. (Braun, et al., 1997)

Sources: **K. Pillemer and D.W. Moore**, *Journal of Elder Abuse and Neglect*, 1990. **D. M. Goodridge**, et al, *Journal of Elder Abuse and Neglect*, 1996. **National Center on Elder Abuse**, *Adult Protective Service Role in Prevention*, 2000. **R. Clough**, *Journal of Elder Abuse and Neglect*, 1999. **M. Shaw**, *Journal of Elder Abuse and Neglect*, 1998. **B. Saveman**, *Journal of Elder Abuse and Neglect*, 1999. **K. L. Braun**, et al., *Journal of Elder Abuse and Neglect*, 1997.

**Risk Factor #5: Staff Ratio/Turnover.** Many experts cite inadequate staffing and staff turnover as contributing factors in increased abuse risk. Unfortunately, all parts of the long term care system are affected by workforce shortages. So far, no “quick fix” has been found. The shortage most obviously impacts the supply of nurse aides, but a lack of registered and licensed professional nurses is also a problem. Inadequate staffing means each staff person will have too many residents to care for. The problem of low staff numbers may be exacerbated on later shifts and weekends, when nursing facilities are most likely to struggle to maintain adequate staffing.

Labor shortages affect not only staff, but also residents. When caregivers have to work double shifts, they are more likely to be overtired and stressed, and less able to handle difficult situations. Over-reliance on nursing pool or temporary staffing, coupled with rapid turnover, makes it impossible for staff to get to know the residents. They end up not knowing residents’ care needs, preferences, likes or dislikes.

Consistency of staffing is especially important for residents who have dementia. Caregivers who do not have ongoing personal relationships with residents are more likely to maltreat those in their care. If supervision is inadequate, there may be more instances of abuse (including residents striking one another, as well as staff abuse of residents) and less chance that incidents will be reported.

#### RISK PROFILE DATA

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- Long term care ombudsman program complaint data show a relationship between complaints about under-staffing and poor care. (Paton, et al., 1994)
- “Scandals” in residential care are connected to staffing shortages, sicknesses, high turnover, little supervision, senior staff absenteeism, and staff in the same post for a very long time. (Clough, 1999)
- A shortage of staff or a heavy reliance on use of pool staff ranked high as contributing factors that lead to abuse and neglect in nursing homes, in the opinion of Adult Protective Services Administrators. (National Center on Elder Abuse, 2000)
- High staff turnover and low staff-resident ratios contribute to resident abuse in nursing homes. (U.S. Department of Health and Human Services, Office of the Inspector General, 1998)
- Reduction in staff workload is recommended to reduce abuse. (Braun, et al., 1997)

- Adequate levels of staffing reduce the risk of abuse in nursing homes. (Shaw, 1998)

Sources: **R.N. Paton**, et al., *Journal of Elder Abuse and Neglect*, 1994. **R. Clough**, *Journal of Elder Abuse and Neglect*, 1999. **National Center on Elder Abuse**, *Adult Protective Service Role in Prevention*, 2000. **U.S. Department of Health and Human Services**, *Office of the Inspector General's Survey*, 1998. **K. L. Braun**, et al., *Journal of Elder Abuse and Neglect*, 1997. **M. Shaw**, *Journal of Elder Abuse and Neglect*, 1998.

**Risk Factor #6: History of Deficiencies/Complaints.** An increased risk of abuse is found at nursing homes that have a history of serious noncompliance, particularly if abuse has occurred in the facility in the past. Facilities that fail to inform residents of their rights and how to make complaints if the residents have a problem increase the risk of abuse. Less than vigorous enforcement of the regulations could also increase the risk.

#### RISK PROFILE DATA

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- Problem nursing homes were identified as those that experienced previous and current licensure difficulties. (Menio, 1995)
- The number of previous complaints was a predictor of “scandalous care” in residential facilities. (Clough, 1999)

Sources: **D.A. Menio**, *Journal of Elder Abuse and Neglect*, 1995. **R. Clough**, *Journal of Elder Abuse and Neglect*, 1999.

**Risk Factor #7: Culture and Management.** A nursing home’s “culture” (what the organization is all about: goals, traditions, values, shared attitudes, sanctions) is a crucial factor in determining the success or failure of efforts to prevent abuse.<sup>3</sup> In a closed structure, which doesn’t acknowledge that anything bad can happen, where, in practice, staff’s version of events is given more credence than what a resident says, where problem solving is largely reactive, the potential for abuse is high. The way that residents view reality must be understood. Within a closed culture, residents may feel intimidated by being “talked down to,” feel neglected by being cared for in an impersonal manner, or turned off by “extremely benevolent, smothering care.”

Leadership has a strong hand in safety, and studies have found that residents are at increased risk when directors of nursing and administrators are out of touch with the care being provided; equally so when absentee decisions are made by a corporate office. Entrenched practices are hard to change without upper management support and active participation of staff at all levels. Residents may be negatively impacted when policies are harsh, inflexible, or unevenly enforced, when communication among departments and between direct service staff and administrators is lacking, or when administrators are perceived as weak or inept.

#### RISK PROFILE DATA

- Facility culture was cited by Adult Protective Services Administrators as a factor associated with abuse, neglect and exploitation. A culture that has a "reckless disregard" for residents' welfare may be described as a nursing home where: the expectations set for staff are unclear; residents' service plans are not followed; abuses are ignored resulting in "larger" abuses; staff are reluctant to take responsibility for reporting abuse or report co-workers. (National Center on Elder Abuse, 2000)

Source: **National Center on Elder Abuse**, *Adult Protective Service Role in Prevention*, 2000.

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<sup>3</sup> For an in-depth discussion of “culture” in the nursing home, see Barbara Frank, *Ombudsman Best Practices: Supporting Culture Change to Promote Individualized Care in Nursing Homes*, National Long Term Care Ombudsman Resource Center, November 1999.

**Risk Factor #8: Physical Environment.** Studies have shown that the facilities with a “strong institutional flavor” or an outdated building design create risks for residents. Poor physical elements include long or narrow corridors, inadequate lighting, crowded rooms (with more than three residents), many floors and stair wells, long distances between dining and residents’ rooms. Narrow hallways can cause residents to accidentally bump into each other, leading to physical confrontations. Long hallways have been implicated in residents wandering away, which poses safety risks.

Nurses’ stations located at the end of long corridors may present special challenges, too, in terms of supervising care. Crowded rooms limit residents’ privacy and their sense of control over their own space, and may engender roommate conflicts. The location of a nursing home on a busy street or high crime area may also add risks, particularly if there is no central entrance to screen visitors.

**RISK PROFILE DATA**

- Crowding, facility not designed for heavy-care residents and poor building maintenance were identified by Adult Protective Services Administrators as contributing factors associated with abuse, neglect and exploitation. (National Center on Elder Abuse, 2000)

Source: **National Center on Elder Abuse**, *Adult Protective Service Role in Prevention*, 2000.

**II. Resident Risk Factors**

**Risk Factor #9: Unmet need (behavioral/cognitive symptoms).**

Researchers who have studied causes of abuse have found that, too often, abuse occurs in nursing homes where there are particularly vulnerable residents. Repetitive behaviors, sexual acting out, attempted escapes – all present enormous challenges to direct care staff who care for vulnerable, dependent elders.

Caregivers of nursing home residents with dementia often deal with the most challenging care needs and behavioral symptoms. On the one hand, these residents need a great deal of support. On the other, they can become physically or verbally aggressive. Elders who assault staff or residents are at risk not only of others striking

**DETERMINING THE RISK**

Dependence may be a substantial risk factor for abuse.

back, but a vicious circle of abuse may ensue – with resident behavior, such as aggression, breeding conflict, which, in turn, leads to residents being more aggressive.

Helplessness is also a risk factor. Alzheimer’s residents, for example, often are unable to express their needs or to report maltreatment by staff, another resident, a therapist, or a visitor. Likewise, when older

people are bedridden, or confined most of the time to a wheelchair, they can become more isolated and more vulnerable.

The resident’s risk status is directly related to an individual’s particular constellation of behaviors and nursing care needs. If a resident is demanding or “difficult” – if they are passive or withdrawn – that dependence may lead to a huge amount of caregiver stress (*see Risk Factor #3: Resident-staff interaction*). Such conditions as mental illness or paranoia may cause residents to behave in ways that are irritating to staff. Sensory difficulties (i.e., deaf or hard of hearing, vision impaired, nonverbal) also present special challenges since these residents will have difficulty describing what happened to them if they’ve been abused. They may also become frustrated, angry, and sometimes violent when they are unable to communicate their needs.

### RISK PROFILE DATA

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- Resident behavioral symptoms, such as cursing, kicking, or pushing others, predict physical and psychological abuse. (Pillemer and Moore, 1990)
- Citing concerns about resident-to-resident abuse, Adult Protective Services Administrators note an increase in younger mentally ill residents in nursing homes; in some states, judges are ordering older convicted felons into nursing homes. (National Center on Elder Abuse, 2000)
- Available data indicate a correlation between resident aggression and an increase in conflict of staff with residents (Goodridge, Johnson, and Thomson, 1996)
- Adult Protective Service Administrators found a correlation between the number of totally incontinent residents in a facility and an increased risk of abuse. (National Center on Elder Abuse, 2000)
- Problem nursing homes often have particularly vulnerable residents. (Menio, 1996)

Sources: **K. Pillemer and D.W. Moore**, *Journal of Elder Abuse and Neglect*, 1990. **National Center on Elder Abuse**, *Adult Protective Service Role in Prevention*, 2000. **D. M. Goodrich**, et al, *Journal of Elder Abuse and Neglect*, 1996. **D.A. Menio**, *Journal of Elder Abuse and Neglect*, 1996.

### III. Relationship Risk Factors

**Risk Factor #10: Resident-visitor frequency.** Studies have shown that residents who rarely if ever receive visitors are at greater risk of being mistreated, physically neglected or harmed. Residents who lack capacity and those who are increasingly dependent due to complex care needs may be neglected by busy staff members who don't always have time to provide all the individualized care they need.

<b>DETERMINING THE RISK</b>	Being lonely and isolated can increase the risk. Residents depend on family members and friends to keep watch.
Infrequent visits are associated with increased risk for being neglected or abused.	In rare circumstances, too much family involvement can be problematic— especially in cases when a family member (or friend) is always present and controls how or when care is provided. It is not unusual for families to feel a sense of guilt after placing a loved one in a nursing home. In stressful situations, they may alienate or make unreasonable demands of staff, perhaps because they do not understand or cannot accept these feelings. There may be a long-standing family conflict with questions raised about which family member is best able to act on the resident's behalf.

Family may also bring to the nursing home their own problems, such as chemical dependency, inappropriate sexual behavior, or a history of mental illness, or they may themselves be victims of abuse. Some residents have been abused by family or friends before entering the nursing home. Extra precautions may be necessary to prevent such occurrences from happening in the facility. Family members' financial dependence on a resident or an accumulation of unpaid bills for care when a family member or friend is handling the resident's financial affairs may be indicators of exploitation.

#### RISK PROFILE DATA

- Adult Protective Services Administrators note that residents who lack the capacity to consent and have no involved family or friends are more likely to be overmedicated and be underserved. (National Center on Elder Abuse, 2000)
- Problem nursing homes are those where residents get few visitors. (Menio, 1996)
- “Scandalous care” may result when residents have few visitors or rarely go out. (Clough, 1999)

Sources: **D. A. Menio**, *Journal of Elder Abuse and Neglect*, 1996. **National Center on Elder Abuse**, *Adult Protective Service Role in Prevention*, 2000. **R. Clough**, *Journal of Elder Abuse and Neglect*, 1999.

**Risk Factor #11: Resident staff interaction.** Researchers have found that the quality of resident staff interaction is often related to the relative dependency of the resident. Residents who are extremely physically dependent or cognitively impaired usually are able to exercise only limited control over their lives, which may prompt them to lash out.

Caring for these residents is a demanding job. Many residents rely on staff for what they will eat or wear, when they will be bathed, whether or not they will participate in an activities program. Intimate care may be provided by staff of the

**DETERMINING THE RISK**

A broad view of abuse includes recognition that limitations on personal choice may be considered psychological abuse, and that falls and unexplained injuries could be indicators as well.

opposite sex. The cultural attitudes and most basic values of residents and staff may be in conflict. Language barriers may exist. Racial prejudice may exacerbate already difficult care situations.

Some residents have behavior symptoms that staff and other residents find intolerable. When tensions build up, the behavior can set the stage for serious problems with relationships. Sexual acting out, screaming, wandering, ransacking other residents' rooms, hitting, and cursing can cause already over-stressed caregivers to lose patience and even strike back. Residents may also put up resistance or be overly demanding.

Stress is a two-way street. In the nursing home, residents struggling to cope and keep a sense of worth can become completely demoralized by staff hurrying or taking too long, thoughtlessness, or needs being neglected.

Relationships for better or worse play a powerful role in residents' lives. Evidence shows that good relationships with residents reduce risk of injuries and abuse. When caregivers have a manageable workload, they have time to interact with residents and really get to know them. If the relationship is good, staff will respect residents' choices and desires for control over their lives. Poor relations present a risk factor. At a minimum, staff must have enough time to provide needed care. Barriers that can thwart this goal include low staffing ratios, high turnover, and over-reliance on labor pools, as well as problems of life (serious or everyday) that are brought into the workplace (*see Risk Factor # 8: Staff ratio/turnover*).

**RISK PROFILE DATA**

- Characteristics of problem nursing homes include (1) practices that do not honor the dignity of older persons in dressing and toileting, (2) residents not

positioned frequently, (3) lack of quality care (i.e., range of motion exercises not done, decubitus ulcers developed). (Menio, 1996)

- Types of complaints that indicate a risk of abuse include (1) problems with resident care (physical abuse, inadequate hygiene, neglect), (2) resident rights violations (personal items stolen, not treated respectfully), (3) problems with food, nutrition (not assisted with eating, food unappetizing), (4) medications not given as ordered or incidents of overmedication, (5) physician services inaccessible. (Paton et al., 1994)
- Care problems may result when residents are regarded by staff as demanding. (Clough, 1999)
- Adult Protective Services Administrators say that neglect can often be traced to failure to follow service plans. (National Center on Elder Abuse, 2000)
- A lack of resident choice (residents lacking self-determination, control and autonomy regarding program participation) is associated with abuse. (Hall and Bocksnick, 1995)
- Covert elder abuse in nursing homes is associated with loss of personal choice, restraint usage, baths given at times convenient to staff but not acceptable to residents, residents left alone for long period of time, labeling residents, thoughtless practices, and staff hurrying. (Meddaugh, 1993)
- Limitations on individual choice may be viewed as psychological abuse. (Payne and Cikovic, 1995)
- Staff attitude and behavior toward residents impacts the quality of care. (Clough, 1999)
- Good care depends on (1) staff seeing the resident as a person and accepting the family's involvement on behalf of the person, and (2) increased social and involvement of staff. (Duncan and Morgan, 1994)
- Time to nurture staff-resident relationships is necessary for abuse prevention. (Shaw, 1998)

Sources: **D.A. Menio**, *Journal of Elder Abuse and Neglect*, 1996. **R.N. Paton**, et al., *Journal of Elder Abuse and Neglect*, 1994. **K. Pillemer and D.W. Moore**, *Journal of Elder Abuse and Neglect*, 1990. **B.L. Hall and J.G. Bocksnick**, *Journal of Elder Abuse and Neglect*, 1995. **D.I. Meddaugh**, *Journal of Elder Abuse and Neglect*, 1993. **B.K. Payne and R. Cikovic**, *Journal of Elder Abuse and Neglect*, 1995. **R. Clough**, *Journal of Elder Abuse and Neglect*, 1999. **National Center on Elder Abuse**, *Adult Protective Services Role in Prevention*, 2000. **M.T. Duncan and D.L. Morgan**, *The Gerontologist*, 1994. **M. Shaw**, *Journal of Elder Abuse and Neglect*, 1998.

# Nursing Home Abuse Risk Prevention Planning

## Step-by Step Instructions

1. **Create a partnership** of stakeholders for prevention of nursing home abuse including: adult protective services, nursing home administrator and key staff, internal and external mediators, nursing home licensure and certification inspector, and a representative from the Medicaid Fraud Control Unit.
2. **Hold first meeting of nursing home abuse task force.** As a first step, invite each risk stakeholder to offer their specific views about nursing home vulnerabilities and resident abuse. Identify differences in definitions and perspectives, both in what constitutes abuse and the extent of the problem. Next introduce the *Risk Prevention Profile and Checklist* and the initiative. Discuss the pros and cons of a risk assessment. Identify the desirable outcomes. Decide how to use the tool. Obtain support and commitment from all parties.
3. **Set up a schedule of follow-up meetings** for completing the next steps below.
4. **Review the *Abuse Risk Profile & Checklist*** individually, and then convene a group meeting to discuss. Make sure partners have a common understanding of the problem of nursing home abuse and agree on the factors most likely to be involved in cases of abuse.
5. **Complete the *Checklist*.** Since it is unlikely that any member of the team alone will be able to answer all questions, we suggest pooling information and perspectives; more than one meeting, in fact, may be required.
6. **Discuss results.** Reach consensus on the abuse risks that most need to be addressed. This discussion may require more than one meeting. There may be some disagreement about the greatest risk factors. Following a frank discussion, stakeholders should reach consensus on a priority list of three to five factors to work on together.
7. **Identify and prioritize action steps** to be taken alone and as a group to reduce the risk of abuse. Although participating organizations will collaborate on the priority list, team members may decide to pursue their own agendas as well.
8. **Act!**

9. **Evaluate.** Were the goals met? Which goals were not fully met? Review the action steps and risk prevention inventory. If necessary, adjust strategies.

## Information Sources for Assessing Risk

The first step in abuse prevention is to identify what’s really happening in the facilities. While this list is not all-inclusive, some information sources and references that should help include:

### I Reports, complaints, data

- Nursing home survey report
- Licensing records
- Nursing Home Compare data
- Complaint data\*/resident grievances
- Police reports
- Nurse Aid Registry
- Abuse registry
- Criminal background checks

(\**Note: **Complaint data** may include complaint data of the ombudsman program, adult protective services, Medicaid fraud control unit, the licensing/certification agency or data on complaints, which are reported directly to the nursing home.*)

### II Facility records, policies, reports

- Facility policies
- Facility personnel records/staff performance reviews
- Facility incident reports
- Quality improvement reports

### III Training information

- Training curriculum for certifying nurse aides
- Facility’s training and orientation curricula
- Requests for facility staff training that come via the ombudsman program, licensing and certification, adult protective services, Medicaid fraud control unit

### IV Resident and family information

- Nurses’ notes/residents’ records
- Medical reports
- MDS and resident assessments
- Care plans
- Customer satisfaction surveys
- Resident and family council minutes

# Nursing Home Abuse Risk Prevention Checklist

Complete the following questionnaire. For the purposes of this exercise, you can respond to Column A—“Check here if the item applies to you”—in one of two ways. Based on observation or evidence verified by others, check each item on the list that applies if (1) the risk factor described is present in a specific nursing home, or (2) the risk factor is generally found in most of the nursing homes in the state or region.

In column B, rank each of the risk prevention factors on a scale of 1 to 5 by degree of risk. The ratings are as follows:

1. Strongly agree
2. Agree
3. Neither agree nor disagree
4. Disagree
5. Strongly disagree

Once you have completed your inventory, take a long look at where the risks are most acute. You will probably notice patterns.

- In the *Resident Risk Prevention* category, a score of **mostly 1s and 2s (or few 4s and 5s) means that there is a high risk that abuse will occur.**
- In the *Relationship Risk Prevention* and *Facility Risk Prevention* categories, **the opposite is true. A high number of 4s and 5s (or few 1s and 2s) would indicate there is a high risk** to resident safety.

If areas of concern are identified, begin making changes to lessen the risk of possible abuse.

# Checklist

A <i>Check here if the item applies to you</i>	B <i>Rate from 1 to 5 for degree of risk</i>	<b>I. FACILITY RISK PREVENTION FACTORS</b> <b>Risk Factor #1: Abuse Prevention Policy</b>
_____	_____	The facility has an abuse prevention policy.
_____	_____	The facility's policies underscore the dignity and worth of all residents.
_____	_____	Definitions of abuse, neglect, and exploitation are consistent with OBRA and the state's adult protection legislation.
_____	_____	Nursing staff and aides who report abuse are guaranteed confidentiality.
_____	_____	Residents and families who report abuse are guaranteed confidentiality.
_____	_____	The procedures to follow in response to an abuse allegation or incident are clear.
_____	_____	The abuse prevention policy includes specific time frames for responding to abuse allegations.
_____	_____	The abuse prevention policy includes requirements for making reports to (1) protective services, (2) licensing and certification, (3) law enforcement, and (4) others, consistent with federal and state law.
_____	_____	The abuse prevention policy identifies potential actions that may be taken to remedy abuse.
_____	_____	Procedures for follow-up with the complainant following investigation of an abuse allegation are clear.
_____	_____	Changes in residents' behavior are monitored.
_____	_____	Falls and accidents are routinely investigated to determine cause.
_____	_____	There are procedures in place for safeguarding residents' valuables.
		<i>Information sources:</i>
		<ul style="list-style-type: none"> <li>• Observations and impressions</li> <li>• Facility policies</li> <li>• Nurse Aide Registry</li> <li>• Abuse Registry</li> </ul>

ABUSE RISK PREVENTION PROFILE AND CHECKLIST

- Nursing home survey report
- Licensing records
- Complaint data/resident grievances
- Customer satisfaction survey

A	B
<i>Check here if the item applies to you</i>	<i>Rate from 1 to 5 for degree of risk</i>

**Risk Factor #2: Staff Training**

_____	_____	Orientation for new staff includes information on how to recognize and report abuse.
_____	_____	All levels of nursing staff are educated to handle stressful situations, including dealing with aggressive and combative behaviors of residents.
_____	_____	Direct service staff members are trained to recognize the warning signs of abuse, neglect, and exploitation, and are given information on the possible causes of abuse.
_____	_____	All levels of staff are told how to report abuse and that reports are confidential, as per procedures in the facility's Abuse Prevention Policy and the state's elder abuse and adult protection laws.
_____	_____	Training on cultural diversity, ethnic differences, and language barriers is provided for all levels of staff to help reduce the isolation of residents.
_____	_____	Staff members are trained to use creative problem solving and conflict resolution techniques to handle aggressive resident behaviors and other difficult caregiving situations.
_____	_____	Training includes techniques on how to manage stress.
_____	_____	Training is provided to improve staff capacity to communicate with residents and families.
_____	_____	Staff members are trained in every aspect of care for medically fragile residents ( <i>e.g.</i> , various therapies, diseases, dementia, and total care).
_____	_____	Respect for the dignity and worth of every resident is emphasized in staff training.
_____	_____	Incentives are provided to encourage staff to attend in-service training or obtain training outside the facility.
_____	_____	Supervisors are trained to identify signs of staff stress and burnout.

ABUSE RISK PREVENTION PROFILE AND CHECKLIST

A	B
<i>Check here if the item applies to you</i>	<i>Rate from 1 to 5 for degree of risk</i>

**Risk Factor #3: Staff Screening**

_____	_____	The facility screens all prospective employees to ensure their suitability to work with vulnerable elders before they begin work (including checking criminal records, the Nurse Aide Registry, and Abuse Registry).
_____	_____	“Pool” nurses and nurse aides/temporary workers who work in nursing facilities are screened.
_____	_____	Job applicants are asked to describe how they feel about caring for others.
_____	_____	Job applicants are asked to describe how they might react/respond to an abusive situation.
_____	_____	Job applicants are asked to describe how they handle anger and stress.
_____	_____	Job applicants are asked if they have ever had personal experience or work experience with death or care of the dying.
_____	_____	Job applicants are asked about their attitudes toward work.
_____	_____	Before a job offer, job applicants are screened for prior history of substance abuse or any indications of current substance abuse problems.

*Information sources:*

- Observation/impressions
- Facility personnel records/staff performance reviews
- Criminal background checks/police reports
- Nurse Aide Registry
- Abuse Registry
- Nursing home survey report
- Complaint data/resident grievances

ABUSE RISK PREVENTION PROFILE AND CHECKLIST

A	B	
<i>Check here if the item applies to you</i>	<i>Rate from 1 to 5 for degree of risk</i>	
_____	_____	<b>Risk Factor #4: Staff Stresses/Burnout</b>
_____	_____	Staff experiencing symptoms of job burnout or other stresses have access to support groups.
_____	_____	Staff members who appear to be experiencing personal problems have access to counseling.
_____	_____	If an abuse incident occurs in the facility, counseling and support are offered to help staff cope with the situation and understand how such situations can be prevented.
_____	_____	Direct service workers have opportunities for advancement.
_____	_____	Workers get annual pay increases based on performance.
_____	_____	Supervisors (registered nurses and licensed professional nurses) routinely assist with direct care when the direct care staff is short-handed.
_____	_____	Direct service workers are consulted prior to assigning schedules.
_____	_____	Direct service workers participate in resident and family conferences.
_____	_____	Staff members who seek more information and training to help them perform on the job are given assistance and support.
_____	_____	Direct service workers are recognized publicly for their contributions ( <i>e.g.</i> , annual employee banquet, employee of the month/year recognition).
_____	_____	Direct service workers have the opportunity to contribute ideas and suggestions for improving care.
		<i>Information sources:</i>
		<ul style="list-style-type: none"> <li>• Observation/impressions</li> <li>• Facility policies</li> <li>• Facility personnel records/staff performance reviews</li> <li>• Nursing home survey report</li> <li>• Licensing records</li> <li>• Complaint data/resident grievances</li> <li>• Customer satisfaction surveys</li> </ul>

ABUSE RISK PREVENTION PROFILE AND CHECKLIST

A	B
<i>Check here if the item applies to you</i>	<i>Rate from 1 to 5 for degree of risk</i>

**Risk Factor #5: Staff Ratio/Turnover**

_____	_____	The facility hires sufficient numbers of qualified staff to meet the care needs of each resident.
_____	_____	The turnover rate for nursing aides is low.
_____	_____	The turnover rate for directors of nursing is low.
_____	_____	“Pool”/contract workers are rarely used to fill nursing care gaps caused by staffing shortages.
_____	_____	The nursing facility rarely asks staff to work extra hours or double shifts.

*Information sources:*

- Observation/impressions
- Facility staffing records
- Nursing home survey report
- Licensing records
- Nursing Home Compare data
- Complaint data/resident grievances
- Customer satisfaction surveys

**Risk Factor #6: History of Deficiencies/Complaints**

The facility received *few or no* deficiencies in the most recent licensing inspection “survey” report.

Ombudsman files for the facility record *few or no* verified complaints of abuse, neglect, or exploitation.

There have been *few or no* substantiated reports of abuse, neglect, or exploitation by adult protective services.

There have been *few or no* prosecutions of abuse, neglect, or exploitation by the Medicaid Fraud Control unit.

The nursing home’s files record *no* evidence of abuse, neglect, or exploitation.

*Information sources:*

- Observation/impressions
- Facility incident reports
- Nursing home survey report

- Licensing records
- Nursing Home Compare data
- Complaint data/resident grievances
- Customer satisfaction surveys

A	B
<i>Check here if the item applies to you</i>	<i>Rate from 1 to 5 for degree of risk</i>

**Risk Factor #7: Culture/Management**

_____	_____	The staff and administration recognize that abuse <i>could</i> occur in the nursing facility.
_____	_____	Residents feel they can report problems to the administration without fear of retaliation.
_____	_____	Direct service staff members believe they can tell their supervisor about care problems they have observed without fear of retaliation.
_____	_____	Total confidentiality is guaranteed to anyone who makes a complaint (residents, family, or staff).
_____	_____	The facility management is willing to seek outside assistance (from the corporate office, the ombudsman, licensing) to help with difficult resident care problems.
_____	_____	The nursing home administrator is empowered to make changes in policy or practices without approval from corporate headquarters.
_____	_____	Each resident's care plan is tailored to meet his or her needs.
_____	_____	The nursing home has a philosophy of care and respect for all residents and family members.

*Information sources:*

- Discussion with residents
- Observation/impressions
- Nursing home policies
- Nursing home survey report
- Licensing records
- Nursing Home Compare data
- Complaint data/resident grievances
- Customer satisfaction surveys

ABUSE RISK PREVENTION PROFILE AND CHECKLIST

A  
Check here if  
the item  
applies to you

B  
Rate from  
1 to 5 for  
degree of risk

**Risk Factor #8: Physical Environment**

_____	_____	The hallways and corridors are wide and spacious to meet the needs of residents. Residents do not have to walk down long corridors.
_____	_____	Rooms with 3 or more residents are uncommon.
_____	_____	The nursing facility has good lighting.
_____	_____	Residents' rooms are located close to the dining room.
_____	_____	The nursing facility does not have multiple levels.
_____	_____	The nurse's station is located in close proximity to residents' rooms.
_____	_____	The nursing facility is not located in a high crime area.
_____	_____	Visitors to the nursing facility are required to check in at a front entrance before going to a resident's room.

*Information sources:*

- Discussion with residents
- Observation/impressions
- Nursing home policies
- Nursing home survey report
- Complaint data/resident grievances

A  
Check here if  
the item  
applies to you

B  
Rate from  
1 to 5 for  
degree of risk

**II. RESIDENT RISK FACTORS**

**Risk Factor #9: Unmet Need (Behavioral/cognitive symptoms)**

**BEHAVIORAL SYMPTOMS OF UNMET NEED**

_____	_____	Wandering: repetitive movements, seemingly oblivious to safety.
_____	_____	Distressed behavior – visibly upset <i>Expressed verbally:</i> Demanding, irritating, physically or verbally combative, i.e., loud, critical, argumentative, complaining, or cursing.
_____	_____	<i>Expressed physically:</i> Hitting, kicking, pushing, scratching, tearing things, grabbing, sexual acting out, sexual contact without consent, disrobing in public.
_____	_____	<i>Other:</i> Vocal noisiness, screaming, banging, self-abusive acts, smearing or throwing food or feces, hoarding, rummaging through others' belongings.

ABUSE RISK PREVENTION PROFILE AND CHECKLIST

**COGNITIVE SYMPTOMS OF UNMET NEED**

- \_\_\_\_\_ \_\_\_\_\_ Confusion, disorientation, inability to express needs or accurately describe or report events.
- \_\_\_\_\_ \_\_\_\_\_ Escalating anxiety symptoms, acts fearful, passive, submissive, or timid.
- \_\_\_\_\_ \_\_\_\_\_ Inability to recognize danger or exit in an emergency.
- \_\_\_\_\_ \_\_\_\_\_ Past history of mental illness.
- \_\_\_\_\_ \_\_\_\_\_ Acts depressed, withdrawn, or prefers isolation.

**OTHER RISK FACTORS**

- \_\_\_\_\_ \_\_\_\_\_ Frailty and physical dependence, confinement to bed, severe mobility limitations (e.g., obese resident requires help from 2 to 3 aides to get out of bed).
- \_\_\_\_\_ \_\_\_\_\_ Sensory deficits (deaf, hard-of-hearing, visually impaired).
- \_\_\_\_\_ \_\_\_\_\_ Language or communication barriers experienced by limited English or non-English speaking residents.

*(Note: The evidence shows that certain resident behaviors and emotional and cognitive symptoms can increase the risk of nursing home abuse. Keep in mind the intent here is not to “blame the victim”, but rather to find the underlying causes of a behavior (unmet need) and to create a care plan that is personalized for the individual’s needs.)*

*Information sources:*

- Observations/impressions
- Nursing home survey report
- Licensing records
- Nursing Home Compare data
- Complaint data/resident grievances
- Ombudsman observation/APS reports
- Police reports
- MDS and resident assessments
- Nurses’ notes/residents’ records
- Medical reports
- Care plans

A	B
<i>Check here if the item applies to you</i>	<i>Rate from 1 to 5 for degree of risk</i>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

### III. RELATIONSHIP RISK PREVENTION FACTORS

#### Risk Factor #10: Resident–Visitor Frequency

Residents receive regular visits (1 to 2 times a week) from family and friends.

Residents are not isolated (*e.g.*, residents have visitors and regular contact with staff and other residents).

Residents receive regular visits from an ombudsman.

The ombudsman program is willingly available to monitor residents’ care and advocate on residents’ behalf.

Staff members do not label visitors or callers as complainers or troublemakers.

There is no evidence that residents were abused by family members or friends before coming to the nursing facility.

There is no evidence of current family conflict or of abuse by family members or friends of residents while in the facility.

*Information sources:*

- Observation/impressions
- Abuse Registry
- Nursing home survey report
- Licensing records
- Complaint data/resident grievances
- Ombudsman observation/APS reports
- Police reports
- Customer satisfaction surveys
- MDS and resident assessments
- Nurses’ notes/residents’ records
- Medical reports
- Care plans

ABUSE RISK PREVENTION PROFILE AND CHECKLIST

A	B	
<i>Check here if the item applies to you</i>	<i>Rate from 1 to 5 for degree of risk</i>	
_____	_____	Care staff work with the same group of residents consistently, providing continuity of care that allows staff to build personal relationships. Residents feel secure.
_____	_____	Staff turnover is low. There are <i>few or no</i> unfilled staff vacancies.
_____	_____	The ratio of qualified staff to residents is high, with day and night cover.
_____	_____	“Pool” nurses or nurse aides are rarely used.
_____	_____	Privacy for dressing, bathing, and toileting is assured.
_____	_____	Residents who need help with eating are given assistance.
_____	_____	Residents who are unable to dress themselves are asked by staff on duty what they want to wear.
_____	_____	Staff feed residents at a pace that makes the resident comfortable.
_____	_____	When residents are served food they don’t like a substitute is offered.
_____	_____	Baths are given at a time that suits the resident’s convenience.
_____	_____	Residents get to decide when they will get up and when they will go to bed.
_____	_____	Nursing home workers and residents speak the same language.
_____	_____	The cultural values of staff and residents are the same.
_____	_____	Residents are not physically combative toward staff ( <i>e.g.</i> , hitting, kicking, spitting, or scratching).
_____	_____	Residents do not use racially offensive or insulting language toward staff.
_____	_____	Residents do not curse or use other insulting language when addressing staff.
_____	_____	Residents do not physically or verbally resist care.
		<i>Information sources:</i>
		<ul style="list-style-type: none"> <li>• Observation/impressions</li> <li>• Nurse Aide Registry</li> <li>• Abuse Registry</li> <li>• Nursing home survey report</li> <li>• Licensing records</li> </ul>

## ABUSE RISK PREVENTION PROFILE AND CHECKLIST

- Complaint data/resident grievances
- Ombudsman observation/APS reports
- Customer satisfaction surveys
- MDS and resident assessments
- Facility personnel records/staff performance reviews
- Nurses' notes/residents' records
- Medical reports
- Care plans
- Quality improvement reports
- Resident and family council minutes

## Scoring the Checklist

The total score will determine what risk category the nursing home falls. The risk factor categories are as follows:

RISK CATEGORY	SCORE	RISK LEVEL
<b>I. Facility Risk Prevention Factors</b>		
<b>II. Resident Risk Factors</b>		
<b>III. Relationship Risk Prevention Factors</b>		

*(Note: The scale for Resident Risk is different from the Relationship and Facility Risk categories. To assess level of resident risk, see evaluation instructions on page 24.)*

# Strategies for Abuse Prevention

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Creating safe nursing homes requires strong leadership from providers and staff. The ultimate responsibility remains theirs. At the same time, prevention has the best chance of success if others are engaged in the process. Partners should represent the nursing home, licensing and certification, adult protective services, the ombudsman program, and the Medicaid fraud control unit.

The following are examples of abuse prevention activities. They are intended to spark thinking and discussion by the team:

## **Strategies for Leadership: Abuse Prevention Policy**

- Develop a protocol on how to care for combative residents and provide in-service training to staff on the protocol.
- Create a committee or task force to study workforce shortages and develop initiatives to address the problem.

## **Strategies for Increasing Resident/Family Involvement**

- Survey residents and work with family councils to identify the types of choices residents want and make changes in nursing home policies and practices, as appropriate. Work with residents and family councils to identify the types of choices they want to make and develop strategies for implementing those changes in the nursing home policies.
- Develop a volunteer program to match volunteers with residents who don't have regular visitors and ensure that volunteers understand how to report care problems they encounter.

## **Strategies for Building Skills and Competencies: Abuse Prevention Training and Support**

- Evaluate the experience and skill level of nursing home staff. Additional education may be necessary to ensure the safety of residents.
- Offer an in-service training program for direct service staff on how to recognize abuse and the process for reporting complaints. Make time available for staff to attend training.
- Offer a training session on abuse prevention at a nursing home conference.

- Develop nursing home staff support groups either for a specific facility or to support staff from multiple facilities.
- Offer training for staff on conflict resolution techniques.
- Provide comfortable training area. Provide separate trainings for line staff, supervisors, and administrators.
- Have trainees sign confidentiality agreements.
- Offer training for new nursing home administrators and directors of nursing on creating culture change in nursing homes.

### **Strategies for Increasing Awareness**

- Support nursing homes' efforts to recognize and support staff by participating in their awards ceremonies or develop a competitive, statewide recognition award for outstanding care by direct service staff.

### **Strategies for Collaboration**

- Identify facilities with a high concentration of vulnerable residents (dementia, aggressive, highly dependent); target those facilities for a mailing on abuse and abuse prevention; and offer training and assistance.
- Identify funding sources for nursing homes that have an institutional appearance to help them make changes to address abuse risks in the physical environment that exist.
- Develop a list of facilities with exemplary abuse prevention policies and make the list available to all nursing homes statewide or use as a referral source for facilities that have a problem with abuse or want to reduce the risks for abuse.
- Develop a model abuse prevention policy.
- Develop guidelines on staff screening which nursing homes may voluntarily adopt.
- Identify facilities that provide training on abuse recognition and reporting. Share the information with other nursing facilities and temporary agencies that provide staff to nursing homes.

# Utilization Tips from the Minnesota Experience

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The National Association of State Units on Aging (NASUA) developed the *Nursing Home Abuse Risk Prevention Profile & Checklist* to identify safety issues and risk factors related to abuse in facilities and residential settings. The *Profile & Checklist* encourages the use of existing information, promotes collaboration among the various agencies involved in responding to abuse, and assists users in locating trouble spots where abuse prevention activities could be initiated.

The State of Minnesota was selected as a test site to help identify variables for the risk tool and to test it in a demonstration phase. A state advisory committee was convened under the auspices of the Minnesota Board on Aging. The advisory committee was charged with overseeing the project, obtaining input from focus groups to identify abuse risk factors, testing the risk assessment tool in several settings, contributing to the development of the final version of the tool, and issuing a final report highlighting the various stages of their state project.

The following utilization tips give guidance on how to understand and apply the risk tool, with lessons learned from the Minnesota experience.

## 1. Collaboration

Collaboration is a key strategy to prevent abuse, neglect, and exploitation of nursing home residents. Effective collaboration recognizes the value of different perspectives, experiences, and expertise, which can deepen understanding. Working with pivotal stakeholders increases knowledge of other agencies' roles, and paves the way to referrals that are more successful and cooperation when individual cases arise.

A strong collaboration will create a process of shared accountability. It focuses on creating a common sense of purpose and is easier to achieve if the players in the state are familiar with each other and trust each other.

### Minnesota experience:

- Establishing the collaborative atmosphere will be particularly important when seeking nursing home administrator and staff participation. It will be important to give assurance that the use of the *Profile & Checklist* is ultimately intended to benefit residents by preventing abuse, neglect and exploitation from occurring.

- Maintain collaboration by focusing on the purpose of doing a risk assessment throughout the process. Participants should be assured that the purpose of the risk prevention tool is NOT to identify problem facilities or residents, nor to develop more regulations, but to help create a safer environment for vulnerable elders.
- Stress that the resource is a starting point and an excellent analytical tool for understanding potential safety risks and coming up with creative solutions.

## 2. Key Participants

**Project Coordinator.** This person will have the lead for promoting the use of the tool. The project coordinator's responsibilities include the following: 1) Making sure all participants in the group feel equally invested in the process, 2) encouraging their attendance at every meeting, and 3) assuring logistics are taken care of, notes taken are disseminated, and ideas for prevention resulting from the risk assessment are recorded and prioritized.

**Project Implementation Group.** This group will review the tool and field test or guide its use in a pilot site. Members invited to participate should represent policy, program, and direct care providers, thus providing input about nursing home abuse risk factors from a cross-section of experts.

### **Minnesota experience:**

- It is essential for the project group to include representatives from each of the following five primary fields:
  1. Adult protective services
  2. Nursing home licensure and certification
  3. Nursing home administrators and/or staff
  4. Long term care ombudsmen
  5. Medicaid Fraud Division
- It may be beneficial to expand membership if the project group is not fully representative of stakeholders in the state or locality. Additional participants who could enhance the discussion include front line staff, nursing assistants, health facility inspectors, and law enforcement.
- Scheduling conflicts may affect meeting attendance. To ensure what needs to be done gets done, Minnesota recommends that each project group member designate both an official representative and an alternate making it more likely that at least one person will be able to attend each meeting.
- Try to identify and tap into an existing core advisory group. An Attorney General Task Force on Nursing Home Quality, for instance, or an interagency

elder abuse coordinating committee may already be working together on abuse prevention issues. One of these groups may be interested to use the *Profile & Checklist*. These advisory groups will be well versed on the issues, and they may offer (as well as gain) new perspective through participation.

### 3. Getting Started

At the first project meeting, the project coordinator should accomplish the following:

- Provide an orientation to the project,
- Facilitate the group members' discussion of risk factors for abuse in institutional settings, and
- Provide an orientation to the *Profile & Checklist*.

Subsequent meetings should focus on identifying the ways the tool will be used, soliciting feedback about how it was used, and developing plans for implementation of prevention activities.

### 4. Project Orientation/Kickoff

The project coordinator should take the lead from the outset to encourage the buy-in of the group. The orientation agenda should include time to discuss any fears, either real or anticipated, about the initiative.

#### **Minnesota experience:**

- It is important to acknowledge that many participants will be apprehensive about a special project and use of the *Profile & Checklist*. Many may fear that its purpose is to identify problem facilities or to develop more regulation.
- The project coordinator should assure the project group that the purpose of the exercise is NOT to propose new laws or regulations as solutions. The aim is to help *assess* risk and to develop a *collaborative* process for identifying issues for problem solving.
- Use every opportunity to emphasize the importance of different perspectives throughout the process.
- Record minutes for each meeting so that all comments about the process and the risk tool are available for the team to review, and especially to keep all members up to date on decisions.
- Aspire to include all members in every step of the process, but realize that it may be necessary to avoid further delays by moving forward in the process with the available participants.

## 5. Discuss Risk Factors for Abuse in Long Term Care Settings

The project coordinator should facilitate the group's initial discussion of individual and environmental risk factors. The discussion should focus on these questions:

1. What characteristics of a nursing home resident, or an individual closely involved in the resident's life (such as a relative or friend), do you think might put that resident at risk of being abused, neglected or financially exploited?
2. What characteristics of a nursing home (the facility, its policies, or employees) do you think might put its residents at risk of abuse, neglect, or financial exploitation?
3. Are you currently collecting any information that would help flag those concerns? Where might you find the documentation?
4. What protections do you have in place to reduce a resident's risk for abuse, neglect and financial exploitation? Which of those do you think are the most effective? Which are the least effective?

### Minnesota experience:

Divide into small groups. Each group should spend about 45 minutes discussing the four questions. Each group's responses should be reported back to the larger group. The project coordinator should identify common perceptions and distinct responses of each group.

## 6. Review *Abuse Risk Prevention Profile & Checklist*

The project coordinator should distribute and briefly review the *Profile & Checklist* noting the various sections, highlighting research findings and construction of the *Checklist*. It would also be important to note several areas where the small group discussion and recommendations support the *Profile & Checklist* items. Close the first meeting by asking group members to further familiarize themselves with the resource and be prepared to discuss the initial piloting of the tool at the next meeting

## 7. Implementation Phase: Pilot Test Risk Tool

Utilization of the *Nursing Home Abuse Risk Prevention Profile & Checklist* can be approached in two ways:

1. The project group as a whole could use the tool and discuss the findings;  
or
2. The tool could be used for a specific geographic area or a particular facility.

(*Note: See Step-by-Step Instructions, p.19.*)

**Minnesota experience:**

- Recruit facility volunteers to be a pilot group for the utilization tool. If no facility volunteers come forward, approach facilities directly to ask that they implement the risk tool.
- Give clear instructions for both the risk tool and the ranking scale (see *Profile & Checklist, page 21*).
- Use the project group to get the word out about the opportunity to pilot test the *Profile & Checklist*.
- Encourage state ombudsman in partnership with adult protective services, facility representatives, and others to use the risk tool with specific facilities and/or geographic areas.
- Anticipate delays throughout the process but take steps to make sure the process is completed in a timely and efficient manner.

**8. Discuss Findings, Assess the Pilot Project Experience**

**Minnesota experience:**

- Solicit feedback, comments, and ideas from participants regarding the risk assessment tool, after implementation.
- Discuss findings from the piloting of the tool, prioritize the identified abuse and neglect issues, and brainstorm prevention strategies with an emphasis on partnerships, avoiding new laws and regulations, and trying to keep costs down.

**9. Analyze Outcomes, Identify Next Steps**

Schedule a final project group meeting after strategies are put in place. Identify lessons learned, benefits, and effects on elder abuse risk factors.

**Minnesota experience:**

- Consider whether the risk tool can be replicated at the local level with multidisciplinary groups – with family counsels and nursing home staff together.
- Brainstorm about possible prevention strategies that resulted from use of the risk tool. Develop follow-up plans for using the tool in other areas of the state and/or with different groups.

ABUSE RISK PREVENTION PROFILE AND CHECKLIST

## Bibliography

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- Allen, P., K. Kellett, and C. Gruman. Elder Abuse in Connecticut's Nursing Homes." *Journal of Elder Abuse and Neglect* 15, no. 1 (2003): 19-42.
- Braun, K. L., et al. "Developing and Testing Training Materials in Elder Abuse and Neglect for Nurse Aides." *Journal of Elder Abuse and Neglect* 9, no. 1 (1997): 1-15.
- Brower, H. "Physical Restraints: A Potential Form of Abuse." *Journal of Elder Abuse and Neglect* 4, no. 4 (1992): 47-58.
- Clough, R. "Scandalous Care: Interpreting Public Enquiry Reports of Scandals in Residential Care." *Journal of Elder Abuse and Neglect* 10, no. 1/2 (1999): 13-27.
- Duncan, M. T., and D. L. Morgan. "Sharing the Caring: Family Caregivers' Views of Their Relationship with Nursing Home Staff." *The Gerontologist* 34 (1994): 235-244.
- Goodridge, D. M., P. Johnson, and M. Thompson. "Conflict and Aggression as Stressors in the Work Environment of Nursing Assistants: Implications for Institutional Abuse." *Journal of Elder Abuse and Neglect* 8, no. 1 (1996): 49-67.
- Hall, B. L., and J. G. Bocksnick. "Therapeutic Recreation for the Institutionalized Elderly: Choice or Abuse." *Journal of Elder Abuse and Neglect* 7, no. 4 (1995): 49-60.
- Hawes, C. "Elder Abuse in Residential Long Term Care Facilities: What Is Known About Prevalence, Causes, and Prevention." Testimony before the U.S. Senate Committee on Finance. Washington: June 18, 2002.
- Hudson, B. "Ensuring an Abuse-Free Environment: A Learning Program for Nursing Home Staff." *Journal of Elder Abuse and Neglect* 4, no. 4 (1990): 25-36.
- Magee, R. et al. "Institutional Policy Use of Restraints in Extended Care and Nursing Homes." *Journal of Gerontological Nursing* 19, No. 4 (1993): 31-39.
- Meddaugh, D. I. "Covert Elder Abuse in the Nursing Home." *Journal of Elder Abuse and Neglect* 5, no. 3 (1993): 21-23.
- Menio, D. A. "Advocating for the Rights of Vulnerable Nursing Home Residents: Creative Strategies." *Journal of Elder Abuse and Neglect* 8, no. 3 (1996): 59-72.
- Paton, R. N., R. Huber, and F. E. Netting. "The Long Term Care Ombudsman Program and Complaints of Abuse and Neglect: What Have We Learned?" *Journal of Elder Abuse and Neglect* 6, no. 1 (1994): 97-115.
- Payne, B. K., and R. Cikovic. "An Empirical Examination of the Characteristics, Consequences and Causes of Elder Abuse in Nursing Homes." *Journal of Elder Abuse and Neglect* 7, no. 4 (1995): 61-74.
- Phillips, C., C. Hawes, and B. Fries. "Reducing the Use of Physical Restraints in Nursing Homes: Will It Increase Costs?" *American Journal of Public Health* 83, no. 3 (1993): 342-348.

ABUSE RISK PREVENTION PROFILE AND CHECKLIST

- Pillemer, K., and D. W. Moore. "Highlights from a Study of Abuse of Patients in Nursing Homes." *Journal of Elder Abuse and Neglect* 2, no. 1/2 (1990): 5-29.
- Saveman, B., et al. "Elder Abuse in Residential Settings in Sweden." *Journal of Elder Abuse and Neglect* 10, no. 1/2 (1999): 43-60.
- Schnelle, J. F., S. F. Simmons, and M. G. Iry. "Risk Factors That Predict Staff Failure to Release Nursing Home Residents from Restraints." *The Gerontologist* 32, no 6 (1992): 767-770.
- Sellers, C., E. Folts, and K. Logan. "Elder Mistreatment: A Multidimensional Problem." *Journal of Elder Abuse and Neglect* 4, no. 4 (1992): 5-23.
- Shaw, M. "Nursing Home Resident Abuse by Staff: Exploring the Dynamics." *Journal of Elder Abuse and Neglect* 9, no. 4 (1998): 1-21.
- Vinton, L. "Services Planned in Abusive Elder Care Situations." *Journal of Elder Abuse and Neglect* 4, no. 3 (1992): 85-99.
- U.S. Department of Health and Human Services. Office of Inspector General's Survey. *Resident Abuse in Nursing Homes: Understanding and Preventing Abuse*. Washington, D.C.: U.S. Department of Health and Human Services, 1998. (OEI-06-88-00360.)

## Nursing Home Abuse Risk Prevention Checklist

Complete the following questionnaire. For the purposes of this exercise, you can respond to Column A—“Check here if the item applies to you”—in one of two ways. Based on observation or evidence verified by others, check each item on the list that applies if (1) the risk factor described is present in a specific nursing home, or (2) the risk factor is generally found in most of the nursing homes in the state or region.

In column B, rank each of the risk prevention factors on a scale of 1 to 5 by degree of risk. The ratings are as follows:

1. Strongly agree
2. Agree
3. Neither agree nor disagree
4. Disagree
5. Strongly disagree

Once you have completed your inventory, take a long look at where the risks are most acute. You will probably notice patterns.

- In the *Resident Risk Prevention* category, a score of **mostly 1s and 2s (or few 4s and 5s) means that there is a high risk that abuse will occur.**
- In the *Relationship Risk Prevention* and *Facility Risk Prevention* categories, **the opposite is true. A high number of 4s and 5s (or few 1s and 2s) would indicate there is a high risk to resident safety.**

If areas of concern are identified, begin making changes to lessen the risk of possible abuse.

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## TRAINING EVALUATION

Please help us make sure this training is as good as it can be by completing this anonymous rating form. Your feedback is very important. It will only take a couple of minutes.

Participation in this course evaluation is voluntary and anonymous. No one will be able to link your responses to you, and your participation, or non-participation, will not affect your job, your training, or any benefits to which you may be entitled. You can stop at any time, and simply turn in this sheet as instructed. Gathered responses will be reviewed to help the trainer(s) improve the training, and the ratings of all trainees will be aggregated for the federal report the project must submit. Other than the knowledge that you have helped us with the project, and our gratitude, there is no direct benefit to you, nor are there any risks.

If you are willing to participate, please check the box that best corresponds with your opinion about the questions below. Thank you very much for your help.

TRAINER(S):	DATE:	TRAINING SITE:			
TRAINING:					
Please rate the Trainer(s) in the following areas:	Very Low	Low	Moderate	High	Very High
Knowledge of topic?					
Use of teaching methods interesting?					
Ability to relate training to practice?					
Effective use of time?					
Responsiveness to group?					
Overall, how much did you learn from this training:					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
A lot	A little	Nothing, I knew it already			

What would improve the presentation by the trainer(s)? Please comment.

What would improve the content of the training? Please comment.

# Resources

## Web site Resources for Training

<http://www.apa.org/pi/aging/eldabuse.html>

Report from Utah APS

[http://www.cwda.org/downloads/ditl\\_report.PDF](http://www.cwda.org/downloads/ditl_report.PDF)

Report from California APS – very good

[www.asaaps.org/basics/index.php](http://www.asaaps.org/basics/index.php)

What is elder abuse or abuse of disabled (vulnerable) adults?

<http://www.ncall.us/resources.html#ARTICLES>

Articles on Domestic Abuse in later life.

Recent data also available.

Cultural issues to consider in domestic abuse.

<http://elders.uaa.alaska.edu/reports/2nd-year.htm>

Look at paper #3. “Alaska Native Elders and Abuse: Creating Harmony by Voicing Traditions of Listening”

<http://itde.vccs.edu/uploads/nur/114/agerelatedchanges/agerelatedchanges.html>

Provides a list of “Age Related Changes”

<http://www.seniorresource.com/ageproc.htm#lnk>

“Positively Getting Older” – shows traits of positive aging

[http://mentalhealth.about.com/cs/aging/a/mellow\\_p.htm](http://mentalhealth.about.com/cs/aging/a/mellow_p.htm)

“Negative Emotions Mellow with Age” a review of a longitudinal study

<http://www.wcadv.org/>

There are multiple articles about abuse, domestic violence and interventions.

<http://www.ncall.us/resources.html>

“Abuse in Later Life Fact Sheet” There is good information about abuse and characteristics of the victim and perpetrator.

## Web site Resources for Training, continued

[http://www.dfps.state.tx.us/Not\\_Forgotten/prevention\\_kit\\_cd.html](http://www.dfps.state.tx.us/Not_Forgotten/prevention_kit_cd.html)

This site has a helpful kit of printable brief sheets on abuse prevention. It is a training kit for the state of Texas but has information that is applicable when talking about abuse issues and prevention. This site also has 3 pages of lists on caregiver burnout. There is no copy write permission to hand these out but could be a good reference as a trainer.

<http://www.elderabusecenter.org/pdf/2-14-06%2060FACT%20SHEET.pdf>

This site provides an overview of the most recent research as of 2/14/06 of elder abuse. "Abuse of Adults Aged 60+ 2004 Survey of Adult Protective Services"

<http://www.hss.state.ak.us/dsds/aps.htm>

This is the website for Adult Protective Services in Alaska.

<http://hss.state.ak.us/dsds/>

This is the website for Division of Senior and Disability Services

<http://www.hss.state.ak.us/dph/CL/bgcheck/default.htm>

This website is for the new back ground check unit that is with Public Health.

<http://www.terranova.org>

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*Abuse: The Resident's Perspective* – 20 minutes \$159 Residents report what they feel is abuse and their list of concerns may surprise your staff.

*Elder Abuse: The Real Definition Abusive Physical Interactions* – 20 minutes \$159 Care Providers discuss unacceptable physical interactions; use of force when an older person cannot or will not cooperate; grabbing, hitting or pushing a resident; and rough manner.

*Kind Hands* – 60 minutes \$89 Wendy Lustbader is speaking to home health aides and certified nurse aids who work in nursing homes.

# Sources

## *Prevention of Abuse and Neglect of Vulnerable Adults in Skilled Nursing Facilities*

**A growing older population** – Moody, H.R. (2002). *Aging: Concepts and controversies*. Thousand Oaks, CA: Pine Forge Press

**Age-related physical and psychological changes** – Moody, H.R. (2002). *Aging: Concepts and controversies*. Thousand Oaks, CA: Pine Forge Press

**Cultural guidelines** – Anand, R. (1999). *Cultural competence in health care: A guide for trainers*, 2nd ed. Washington D.C.: national Multicultural Institute

**Risk factors for abuse** – Pillemer, K., Menio, D.A., & Keller, B.H. (2003). *Abuse-proofing your facility*. Clifton Park, NY: Frontline Publishing

Bonnie, R.J., and Wallace, R.B. (Eds). (2003). *Elder mistreatment: Abuse, neglect and exploitation in an aging America*. Washington D.C.: The National Academies Press

**Caregiver risks for abusing** – Bonnie, R.J., and Wallace, R.B. (Eds). (2003). *Elder mistreatment: Abuse, neglect and exploitation in an aging America*. Washington D.C.: The National Academies Press

**Nursing home abuse** – U.S. Administration on Aging, Department of Health and Social Services, National Center on Elder Abuse (2005). *Nursing Home Abuse: Risk Prevention Profile and Checklist*. Washington, D.C.: National Association of State Units on Aging

**Risk prevention profile** – *Nursing Home Abuse Risk Prevention profile and Checklist (2005)*. Washington, D.C., National Association of State Units on Aging.

## Videos

Rabins, Peter V. (1999-2006). *Abuse Triggers Video Series*, VideoPress. Baltimore, MD: University of Maryland School of Medicine

Vanden Bosch, James (1998). *Choice and Challenge: Caring for Aggressive Older Adults Across Levels of Care*, Chicago, IL: Terra Nova Films, Inc. and Abbe, Inc.

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