



Kansas Advocates
for
Better Care

Compassionate Care for Adult Care Home Residents

*Preventing abuse, neglect & exploitation
by learning from recent cases*

funded by a 2006 grant from
The Kansas Department on Aging

TABLE OF CONTENTS

Section		Page
1	Compassionate Care - What Is It?	3
2	Legal Rights of Adult Care Home Residents <i>“Resident Rights”</i>	4 5
3	Legal Definitions of Abuse, Neglect and Exploitation	8
4	Signs and Symptoms of Abuse, Neglect and Exploitation <i>Examples</i>	9 10
5	Reporting Requirements <i>Voluntary Reporters</i> <i>Mandatory Reporters</i> <i>Penalties for Not Reporting</i> <i>Investigating ANE</i> <i>How, When & What to Report</i>	12 13 14
6	Predicting Abuse and Neglect: Risk Factors	15
7	Practicing Compassionate Caregiving <i>Communication</i> <i>Observe Behaviors</i>	17

Section 1: COMPASSIONATE CARE - WHAT IS IT?

Treating frail adults with compassion is about gentleness, kindness, patience. Residents of adult care homes live there because they must have 24-hour care, every day. They cannot perform most daily activities that others perform automatically, without thinking. Many residents also have some type of dementia; they cannot be held responsible for their actions.

Caregivers have the difficult yet honorable task of assisting residents with most all things they need and do. Honor the resident as a whole person at all times. If you choose this vocation, the tasks must be done by assuming the responsibilities of being caregivers.

Definition of concept:

Compassionate care is cheerfully and practically helping those who are suffering or are in need.

Compassionate caregivers go about their work in these ways:

- They focus on alleviating the sources of pain or discomfort in suffering people.
- They express love, grace and dignity to those facing hardships and crisis.
- They serve in difficult or unsightly circumstances and do so cheerfully.
- They recognize and feel value in practical service to others.
- They address the needs of the lonely and forgotten.

Traits or characteristics of compassionate caregivers:

empathetic,
caring,
responsive,
kind,
sensitive,
willing,
helpful,
loyal,
dependable.

Cautions to compassionate caregivers :

- Guard against feeling “unappreciated” since some of the people you help will not show or express any appreciation.
- You may find it difficult to say “no” to requests for extended work hours.
- You may not value or esteem your ability to provide practical help to others.
- You need to be responsive to the priorities of supervisors, administrators, regulatory requirements and the residents, instead of setting your own needs first.

Section 2: LEGAL RIGHTS OF ADULT CARE HOME RESIDENTS

KANSAS ADMINISTRATIVE REGULATIONS FOR NURSING FACILITIES

The following text is taken directly from State regulations KAR 28-39-150 (c) and (d):

(c) **Abuse:** Each Resident shall have a right to be free from the following:

- (1) Verbal, sexual, physical and mental abuse;
- (2) corporal punishment; and
- (3) involuntary seclusion.

Facilities that are not compliant with this regulation receive an inspection deficiency labeled as F-223: “right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.”

(d) **Staff treatment of resident.** Each facility shall develop and implement written policies and procedures that prohibit abuse, neglect, and exploitation of residents. The facility shall:

- (1) not use verbal, mental, sexual or physical abuse, including corporal punishment or seclusion;
- (2) not employ any individual who has been identified on the state nurse aide registry as having abused, neglected or exploited residents in an adult care home in the past;
- (3) ensure that all allegations of abuse, neglect or exploitation are investigated and reported immediately to the administrator of the facility and to the Kansas Department on Aging;
- (4) have evidence that all alleged violations are thoroughly investigated, and shall take measures to prevent further potential abuse, neglect and exploitation while the investigation is in progress;
- (5) report the results of all facility investigations to the administrator or the designated representative;
- (6) maintain a written record of all investigations of reported abuse, neglect and exploitation; and
- (7) take appropriate corrective action if the alleged violation is verified.

Facilities that are not compliant with this regulation receive inspection deficiencies labeled as F-224:

“mistreatment of resident property”; F-225: “facility is not to employ persons who have been found guilty of abusing, neglecting, or mistreating residents”; or F-226: “facility must develop and implement policies and procedures pertaining to abuse and neglect.”

RESIDENT RIGHTS

The Resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. **According to Kansas Administrative Regulations (KAR 28-39-147 to 153) and federal regulations (42CFR 483.10 to 483.15) the home must protect and promote these rights:**

RIGHT TO EXERCISE RIGHTS

- The Resident must be allowed to exercise his/her rights as a citizen and a resident of a care home without interference, coercion, discrimination, or reprisal from the home.
- The Resident has the right to designate in advance a person who will assert resident rights if he/she is unable to do so. (Appoint this person using a Durable Power of Attorney for Health Care Decisions.)
- A court appointed guardian exercises the resident's rights when the resident is adjudged incompetent.

RIGHT TO BE NOTIFIED OF RIGHTS

- Before being admitted to a home, the resident must be informed both orally and in writing of his/her rights, rules of the home, rates and services of the home, and rules concerning Medicaid eligibility.
- Before the home can effect a change in charges or services, the resident must be informed, in writing, at least 30 days before the change takes place.

RIGHTS CONCERNING FINANCES & PROPERTY

- The Resident has the right to manage his/her financial affairs.
- If the Resident deposits funds with the home, it must manage and account for funds properly, including a quarterly written account of transactions on the account and the balance. If more than \$50 is deposited with the home, the home must place the funds in an interest-bearing account in a Kansas financial institution.
- Any resident funds must be transferred to the executor of the resident's estate or to the probate court handling the estate within 30 days of the death of a resident.
- The home must have a written policy about protecting residents' possessions. If property is missing and the home is responsible for its loss, the resident may have a claim against the home to replace the item. Check with an attorney.

RIGHT TO INFORMATION ABOUT CARE

- The Resident has a right to be fully informed about care and treatment and any changes in that care or treatment that may affect the Resident's well-being.
- The Resident has the right to inspect and purchase photocopies of all records pertaining to the Resident upon written request and two days notice (excluding holidays and weekends) to the home.

RESIDENT RIGHTS, *continued*

RIGHT TO MAKE CARE DECISIONS

- The Resident has a right of free choice to (1) choose an attending physician; (2) participate in developing an individual care plan or negotiated service agreement; (3) refuse treatment; (4) refuse to participate in experimental research; (5) choose a pharmacy (but if the home uses a unit dose system to dispense medications, the pharmacy must also use that system.)
- The Resident has a right to check out of the home. (You do not need a doctor's order to leave the home.)
- The Resident has a right to receive notice of changes concerning: (1) physical, mental, or psychosocial status; (2) altering of treatment; (3) transfer or discharge; (4) room or roommate change.
- The Resident has a right to refuse to perform services for the home. The Resident has a right to agree to perform voluntary or paid services for the home if there is no medical reason to contradict that right.
- Each Resident has a right to self-administer drugs (unless the attending physician and the home interdisciplinary team has determined for a particular Resident that this practice is unsafe.)
- The Resident has a right to be free from any physical restraints imposed or psychoactive drugs administered for the purposes of discipline or convenience and not required to treat the Resident's medical symptoms.

Federal interpretation: When physical restraints are used, there shall be a written physician's order which includes the type of restraint to be applied, the duration of the application and the justification for the use of the restraint. The resident's surrogate or representative cannot give permission to use restraints for the sake of discipline or staff convenience, or when the restraint is not necessary to treat the resident's medical symptoms. "Physical restraints" include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, lap cushions and lap trays the resident cannot remove.

- **The Resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment and involuntary seclusion.**

RIGHT TO PRIVACY, CONFIDENTIALITY & DIGNITY

- The Resident has the right to personal privacy and confidentiality of his/her personal and clinical records.
- The Resident may approve or refuse the release of personal and clinical records to any individual outside the facility except when: the Resident is transferred to another health care institution, or record release is required by law or a third party payment contract.
- The Resident has the right to privacy in written communications, including the right to send and receive unopened mail promptly. The Resident has a right of access to stationery, postage and writing implements at the Resident's own expense.
- The Resident has a right to reasonable accommodation of individual needs and preferences except where the health or safety of the Resident or other Residents would be endangered.

RESIDENT RIGHTS, *continued*

- The Resident has a right to examine the results of the most recent survey of the home conducted by Federal or State surveyors and any plan of correction in effect for the home.
- The Resident has the right to visit and communicate with persons of his/her choice in privacy and at any reasonable hour. Immediate access must be given to family members, attending physician, and certain state officials, such as the Ombudsman or a surveyor from KDOA. The Resident retains the right to deny or withdraw consent at any time.
- The Resident has a right to have regular access to the private use of a telephone.
- The Resident has a right to retain and use personal possessions, including some furnishings and appropriate clothing, as space permits, unless to do so would infringe on the rights or health and safety of other Residents.
- The Resident has the right to share a room with his/her spouse when married Residents live in the same home and both spouses consent to the arrangement.
- The Resident has a right to organize and participate in Resident groups in the home, and the Resident's family has the right to meet within the home with families of other Residents.
- The Resident has the right to participate in social, religious and community activities that do not interfere with the rights of other Residents.

RIGHT TO ADDRESS GRIEVANCES

- The Resident has a right to voice grievances with respect to treatment or care, without discrimination or reprisal for voicing grievances, and a right to prompt efforts by the home to resolve grievances, including those with respect to the behavior of other Residents. The facility must post contact information of pertinent government and advocacy organizations.
- The Resident has a right to file a complaint concerning Resident abuse, neglect and misappropriation of Resident property in the home. Residents may file a complaint by calling 800-842-0078. For nursing home residents with developmental disabilities or with mental illness, the telephone number of the Kansas Advocacy and Protection Services, Inc. is 877-776-1541.
- The Resident has the right to contact the Long-Term Care Ombudsman toll-free at 877-662-8362 for assistance with concerns related to the nursing home.

RIGHTS WHEN TRANSFERRED OR DISCHARGED

- The Resident has a right to receive advance notice of transfer or discharge. Residents required to receive this notice are: those whose health has improved and who no longer require the services of the home; those who endanger the safety of individuals in the home; those who fail to pay the home; and those whose needs cannot be met, as documented by their physician. The notice should include the reason and effective date of transfer or discharge (30-day notice and/or may waive) and the location to which the resident is to be transferred or discharged.
- The Resident has the right to an appeal process. The Resident has the right to appeal to the State through the complaint process. The toll-free telephone number for the State Long-Term Care Ombudsman is 1-877-662-8362.

Section 3: LEGAL DEFINITIONS OF ABUSE, NEGLECT AND EXPLOITATION

ABUSE means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish (CFR 483.13(b) and (c). Another definition (K.S.A. 39-1401): “abuse means any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to an adult”, including:

1. infliction of physical or mental injury;
2. any sexual act with a resident when the resident does not consent, or when the other person knows or should know that the resident is incapable of resisting or declining consent to the sexual act due to mental deficiency or disease, or due to fear of retribution or hardship;
3. unreasonable use of a physical restraint, isolation or medication that harms or is likely to harm a resident (“unreasonable” includes the situation where there is a request by the family to use restraint but with no medical order);
4. unreasonable use of a physical or chemical restraint, medication or isolation as punishment, for convenience, in conflict with a physician’s orders or as a substitute for treatment, except where such conduct or physical restraint is in furtherance of the health and safety of the resident or another resident;
5. a threat or menacing conduct directed toward a resident that results or might reasonably be expected to result in fear or emotional or mental distress to an resident;
6. fiduciary abuse; or
7. omission or deprivation by a caretaker or another person of goods or services which are necessary to avoid physical or mental harm or illness.

NEGLECT means the failure or omission by one’s self, caretaker or another person to provide goods or services which are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness.

EXPLOITATION means misappropriation of resident property or intentionally taking unfair advantage of an adult’s physical or financial resources for another individual’s personal or financial advantage by the use of undue influence, coercion, harassment, duress, deception, false representation or false pretense by a caretaker or another person.

Section 4: SIGNS & SYMPTOMS OF ABUSE, NEGLECT AND EXPLOITATION

Some of the signs associated with *physical abuse*:

- bruises, skin tears, swelling, limbs looking out of place
- change in walking, standing or sitting ability
- scratches, tears or irritation around the genitalia
- marks, welts, burns, teeth marks, cuts or scratches.

Some of the signs associated with *psychological abuse*:

- recent or sudden changes in behavior
- unjustified fear
- unwarranted suspicion
- unwillingness to communicate
- denial of situation
- new or unexplained depression
- lack of interest
- change in activity level.

Some of the signs of *neglect*:

- loss of weight due to lack of proper help with eating
- dirt under fingernails, matted hair, body odor, or heavily soiled or stained clothing due to failure to provide proper personal care
- reduced ability to walk due to infrequent assistance with walking
- skin breakdown due to lack of proper incontinent care
- recent or sudden changes in behavior
- unjustified fear
- unwarranted suspicion
- unwillingness to communicate
- new or unexplained depression
- lack of interest
- change in activity level.

Signs of *sexual abuse* also include the indicators for both physical and psychological abuse, especially: scratches, tears, irritation and swelling around the genitalia, changes in walking or sitting ability, or an abnormal discharge.

Some indications of *exploitation*:

- missing clothing
- missing valuables
- missing personal belongings
- no spending money.

Taken from the Coalition of Advocates for the Rights of the Infirm Elderly (CARIE) training publication "Ensuring An Abuse-Free Environment," p. 28.

EXAMPLES FROM KANSAS

Case Review Examples

(Case reviews by KDOA attorneys since July 1, 2003.)

- “...It was written in the resident’s ... record that a mechanical lift had to be used when transferring the resident. The resident had Parkinson’s and her arms were very constricted. Aides had been told that the resident was too fragile to move without a mechanical lift. The witness saw the aides transfer the resident from the bed to the shower chair without a mechanical lift.... After the resident was in the shower chair, the aides scooted her around so that she was further back in the chair. In performing this move, the resident was lifted under each arm and each leg by the aides. During this second lift, a clear grinding or popping sound was heard. The resident became stiff, her legs shook, and her eyes became wide.... By the next day, the resident had a huge bruise from her right shoulder to her right elbow. X-rays determined that the resident’s humerus bone was completely shattered. The resident required surgery to repair her shoulder.”

What kind of ANE is this?

What would you have done?

- “...the C.N.A. jerked the covers off the resident in an attempt to make her get up. When the resident resisted the C.N.A. hit her in the face. When the resident told the C.N.A. that she would have to report her, the C.N.A. replied, “but you won’t.” The resident was afraid to tell what had happened because of the C.N.A.’s veiled threat.... The director of nursing interviewed the resident shortly after the alleged incident occurred. The resident again said that the C.N.A. pulled the covers off of her and tried to force her to get up. The C.N.A. then doubled her fist and hit the resident. Pictures of the witness showed what is commonly referred to as a ‘black eye’....”

What kind of ANE is this?

How would you have acted toward the resident?

- “... a C.N.A. told a resident that it would be a blessing if she just died.... the same C.N.A. told a different resident that he was nasty and it was no wonder “his wife didn’t want to live with him anymore.”... the same C.N.A. told a third resident that she was a “fat, lazy bitch.” The C.N.A. also told the resident to “shut up.”... the same C.N.A. told a fourth resident that she was “headed for the nut house.” ... the same C.N.A. told a resident that her son didn’t love her anymore...”

What kind of ANE is this?

How should this kind of situation be handled?

EXAMPLES FROM KANSAS, *continued*

- “During the night shift... a C.N.A. did not make rounds... Facility policies required C.N.As to make rounds at the beginning of each shift and every two hours thereafter. Failure to make rounds resulted in a resident being left on a bedside commode for seven and a half hours... During the same shift, the same C.N.A. failed to provide stand-by assistance to a resident as required by the resident’s care plan. As a result, the resident fell, fracturing her right shoulder...”

What kind of ANE is this? How should this situation be resolved?

- “... a C.N.A. put a blanket over a resident’s head and held it there for several minutes until confronted by a co-worker...”

What kind of ANE is this? How would you handle this situation?

- “... a C.N.A. used a resident’s stolen credit card to purchase \$800 worth of merchandise from a grocery store... the same C.N.A. used the same resident’s credit card to purchase \$812.30 worth of merchandise from a clothing store... the same C.N.A. was apprehended by law enforcement officers when she tried to use the same resident’s credit card to make more purchases at another grocery store.... the C.N.A. had in her possession four credit cards belonging to the resident..”

What kind of ANE is this? How can this kind of ANE be avoided?

Overview of ANE Cases

“In Calendar Year 2005, KDOA received 4,814 complaints involving health care facilities.”

“Cases involving theft and the misuse of resident cell phones have increased.... KDOA prosecutes almost all thefts.... those prosecutions have involved miniature dolls, collectible dolls, shoes, Christmas gifts, and cell phones.”

Source: William C. Rein, KDOA attorney, 2006.

Section 5: REPORTING REQUIREMENTS

Voluntary Reporter is any person who suspects or believes that an adult is being neglected, exploited or abused, or is otherwise in need of protective services.

Mandatory Reporters: KSA 39-1402(a) requires the following persons to report suspected abuse, neglect, or exploitation **IMMEDIATELY**:

- Any person who is licensed to practice any branch of the healing arts
- A licensed psychologist
- A licensed master level psychologist
- A chief administrative officer of a medical care facility
- An adult care home administrator or operator
- A licensed social worker
- A licensed professional nurse
- A licensed dentist
- A law enforcement officer
- A teacher
- A bank trust officer, and any other officers of financial institutions
- A legal representative who has reasonable cause to believe that a resident is being or has been abused, neglected or exploited
- A governmental assistance provider who has reasonable cause to believe that a resident is being or has been abused, neglected or exploited

Penalties For Not Reporting

- ◆ It is a **class B misdemeanor for a mandatory reporter** to knowingly fail to make a report if he/she **suspects** a vulnerable adult is being neglected, exploited or abused.
- ◆ The penalty for a class B misdemeanor is definite confinement in a county jail, fixed by the court which shall not exceed six months, in addition to or in lieu of a fine which can be up to, but not exceed \$15,000.

Remember that the burden of proof lies with the State, not the reporter. The employer is prohibited from imposing sanctions on an employee who makes a report. Therefore, call even if you only **suspect** an adult is being neglected, exploited or abused. This is true for mandatory **and** voluntary reporters. If a voluntary reporter (such as family member, direct care staff, visitor) reports suspected incidents to a mandatory reporter and has reason to believe that there was no follow up, the voluntary reporter should call 1-800-842-0078.

INVESTIGATING SUSPECTED ABUSE, NEGLECT, AND EXPLOITATION (ANE) IN ADULT CARE HOMES

“Once a report of ANE has been received by the Kansas Department on Aging’s Complaint Program, it is categorized by the seriousness of the allegations.... KDOA uses three broad classifications to determine how quickly an investigation needs to be initiated. **Any complaint of ANE which involves immediate jeopardy to a resident is investigated by KDOA surveyors the day it is received.**”

“Any complaint that does not involve immediate jeopardy to the resident is investigated by the end of the next working day. KDOA allows these complaints to be investigated by the adult care home if the complaint was self-reported by the facility or it was anonymous. The facility must file a written report of its investigation no later than seven days following its first contact with KDOA.... Any complaint which involves general care may be investigated during the next survey inspection, usually between 10 and 180 days following its receipt.”

“... healthcare practitioners and administrators are required to report evidence of ANE to KDOA... In almost all cases, facilities suspend alleged perpetrators pending investigation. Therefore, the alleged victim/resident is removed from immediate harm (such as fear, intimidation, retaliation, and further ANE) until the investigation can be completed.”

“Facility investigations contain a narrative report... Included with the narrative are verified witness statements, facility policies and procedures, resident care records, employee counseling and disciplinary records, pictures of resident injuries, and any other material deemed relevant to the factual and legal issues involved. **The alleged victim must be interviewed within 24 hours where imminent danger is present, within three working days when abuse is alleged, or within five working days when neglect or exploitation is alleged.** The investigation also must be completed within 30 days of receiving the complaint. Finally, **any complaint which alleges a possible criminal act requires immediate, written notification to a law enforcement agency.**”

“... at least three actions may result from an alleged ANE report.

1. First of all, a criminal action for battery, mistreatment of a confined person, theft, or other crime may be filed by the county/district attorney.
2. Secondly, an employment disciplinary action, often involving termination, may be taken by the facility.
3. Finally, KDOA may attempt to have an annotation of ANE placed on the alleged perpetrator’s entry in the Registry so that further employment in adult care homes is prohibited.”

Source: William C. Rein, KDOA attorney, 2006.

How To Report

If you know of a situation, or you even **suspect** an adult care home resident is at risk of harm, you can get help by talking with the Charge Nurse, Director of Nursing, or the Administrator, **and** by calling the KDOA toll-free hotline: (800) 842-0078 (8 a.m. to noon, and 1 to 4 p.m.); The Kansas Attorney General number for reporting abuse, neglect and exploitation: (785) 368-6220, or (800) 432-2310; or SRS: (800) 922-5330 (24/7).

When to Report

- The adult is in a harmful situation or is in danger of being harmed
- The adult is unable to protect himself/herself
- A specific incident or pattern of incidents suggest abuse, neglect or exploitation
- The adult is unable to provide for or obtain the services necessary to ensure safety & well-being, and to avoid physical or mental harm or illness.

What to Report

According to K.S.A. 1402 (b) and the Long-Term Care Regulation Interpretation Guidelines, the report must include:

- Name & address of the person making the report.
- Name & address of the caretaker caring for the resident.
- Name & address of the resident(s) involved.
- Information regarding the nature & extent of the abuse, neglect or exploitation.
- Name of the next of kin of the resident(s), if known.
- Any additional information which might be helpful in the investigation of the allegation & protection of the resident(s) at risk.

A thorough investigation must be conducted by the facility. Facility reports should include: verified witness statements, facility policies and procedures, resident care records, employee counseling and disciplinary records, pictures of resident injuries, and other relevant facts. Injuries of an unknown source must be reported to the State if the facility's immediate investigation demonstrates reasonable cause to believe that abuse or neglect has occurred or is occurring. There must be written evidence of these investigations and the findings, and they must be made available to the State.

Failure to report when reasonable cause exists that abuse, neglect or exploitation has occurred can result in the facility receiving a deficiency or an enforcement action. Health care professionals who fail to report when reasonable cause exists could be referred to the appropriate regulatory board.

Section 6: PREDICTING ABUSE AND NEGLECT

Risk Factors

It is the responsibility of **ALL** staff to monitor **ALL** other staff and residents. The following six major risk factors have been identified as most commonly leading to abusive behavior on the part of nursing facility staff:

Short Staffing: Short Staffing means that caregivers do not have enough time to do their jobs. As a result, caregivers must often give up the most rewarding aspects of their jobs - such as spending time getting to know residents and their preferences - and focus instead on the technical aspects of care. This can lead to a poor attitude and dehumanizing of residents.

Poor Attitude: Staff who do not view residents as individuals, but rather as burdens or tasks to be completed, are much more apt to be abusive. Also likely to be abusive are individuals who view residents as children in need of discipline.

Burnout: Working in a nursing facility is emotionally and physically draining. As a result, nursing facility staff experience very high levels of burnout, which can result in abuse.

Conflict: Few people are prepared for the high degree of conflict that exists in nursing facilities. Conflicts with residents are often commonplace. If nursing facility staff do not have adequate training on the interpersonal aspects of the job, they are apt to become abusive.

Disruptive and Aggressive Resident Behavior: Nursing facility staff are at significant risk of abuse from residents. In one study, 89% of nurses and nursing assistants interviewed said they had been insulted or sworn at by residents; 87% had been pushed, grabbed, or pinched; 70% had been hit or had an object thrown at them; and 47% had been kicked or bitten. Without adequate training on why such behaviors occur and how to deal with them, staff are apt to retaliate.

Lack of Supervision and Failure to Enforce Patient Abuse Laws: Staff are more apt to commit abusive acts if they believe the quality of their work is not being monitored, or that they need not be concerned with consequences from their actions.

From the American Health Care Assn. training publication "Keeping Nursing Facility Residents Safe," pp. 22, 23.

Residents at Risk for Being Abused ⁽¹⁾

- ⇒ abuse others
- ⇒ insult staff or other residents
- ⇒ show demanding or critical behaviors
- ⇒ don't want or accept help from staff
- ⇒ "undo" staff help
- ⇒ may have specialized care issues
- ⇒ show self-pitying behaviors
- ⇒ can't verbalize that they have been abused
- ⇒ may be passive & not functioning at capacity
- ⇒ don't "listen" to staff
- ⇒ would not be expected to notice if things were missing, etc.
- ⇒ are agitated, confused or resist care

Additional Risk Factors: Staff Who May React Abusively ⁽²⁾

- ⇒ have worked too much overtime
- ⇒ are under stress in their personal lives
- ⇒ are drug and/or alcohol abusers
- ⇒ have low self-esteem
- ⇒ do not get along well with co-workers
- ⇒ take things personally
- ⇒ omit breaks/lunch, etc.

Staff Who May Be At Risk for Being Abused ⁽³⁾

- ⇒ tend to rush residents who are cognitively impaired
- ⇒ approach agitated residents with a loud, overly cheerful manner
- ⇒ do not use calm, friendly, non verbal-approaches
- ⇒ are rough in giving care
- ⇒ are impatient
- ⇒ may appear "threatening" to residents

1 From CARIE, 1999, p. 43

2 From CARIE, 1999, p. 46

3 From CARIE, 1999, p. 46

Section 7: PRACTICING COMPASSIONATE CAREGIVING

Preventing abuse, neglect and exploitation (ANE) of frail elders requires more than merely learning about the legal definitions and examples. Knowing what ANE is, and understanding how to avoid causing ANE are two different responsibilities of caregivers. ANE can be avoided by using a proper approach to frail elders, so that any interactions are initiated from the point of view of the frail elder. When using a proper approach, by looking at the world from the frail elder's point of view, caregivers will recognize the need for effective communications toward the frail elder, and the need to observe the frail elders' behaviors. Their behaviors are ways of expressing themselves.

Communication - one way to prevent ANE

The initiation of communication usually lies with the caregiver. This section uses parts of the "Kansas Adult Care Home Nurse Aide Curriculum" to emphasize the preferred manner for staff to interact with residents in the nursing home setting. In general, use common sense when communicating with frail elders.

- Look at the resident; make eye contact and block out other distractions.
- Hold the resident's hand, if appropriate.
- Express acceptance of the resident and his/her thoughts.
- Repeat back what the resident has said to summarize and validate.
- Concentrate on the resident's needs, not on your own needs.
- Use a gentle touch to gain the resident's attention.
- Approach the resident in a slow, non-hurried manner from the front.
- Allow resident to touch you.
- Call residents by names they request.
- Offer two or three choices.
- Praise resident, even if he/she can't talk.
- Avoid talking over one resident to talk with someone else.
- Respect property.

Observe Behaviors - another way to prevent ANE

If you observe **new onset or a change in behavior**, watch for underlying causes such as:

- drug toxicity
- eyes/ears, sensory impairment
- metabolic disturbance or endocrinopathy
- emotional disturbances, especially depression
- nutrition deficiency
- tumors, trauma to the head
- infection
- arteriosclerosis, including vascular disease.

Source: Alzheimer's Association, 2004

If you observe **wandering behavior**, request installing some of the following safeguards:

- Place night lights throughout the facility.
- Place locks out of reach or out of sight. (A simple change in a door latch may be enough to stop wanderers.)
- Cover door knobs to make turning more difficult. The cover should fit loosely, so that only the cover turns, not the knob itself.
- Place warning bells above doors.
- Keep medications and toxic substances out of sight.
- Put hedges or a fence around patio or yard, and place locks on gates.
- Use safety gates to bar access to stairs or outdoors.
- Consider using bean bag chairs, recliners, or geriatric chairs for sitting and resting. (They are comfortable, yet restrictive to the body because of difficulty getting out without assistance.)
- Reduce noise levels and confusion, especially during shift change, meal times, and housekeeping activities.
- Develop indoor and outdoor areas that can be safely explored.
- Augment the person's wardrobe with brightly colored clothing, or sew bicycle reflectors onto jacket sleeves.
- Clearly label all resident's rooms.
- Use signs/symbols to explain the purpose of each room.
- Discourage entry into a room by labeling "Do Not Enter".
- Camouflage exit doors. For example, paint them the same color as walls.
- Paint a 2-foot black threshold in front of the door. It may be perceived as a hole to be avoided.
- Keep a photo of the wanderer, for identification purposes.
- Some people will not go out without a purse, glasses, etc. Hide the article to discourage wandering.
- "Gadgets" that beep or whistle when one claps may help when trying to find a missing person.

Source: Alzheimer's Association, 2004

When caring for **someone with dementia** and you observe confusion, try to follow these suggestions:

- Avoid asking "Don't you remember?"
- If a person demonstrates a new difficult behavior, check physical status (dehydration, infection, hearing loss, etc.). If the person's physical status is normal, check his comfort level (hot, dirty, hungry, etc.)
- Provide a safe/simple/calm/consistent environment.
- Make a task/communication easier by presenting it in simple steps.
- Provide structured routine (especially activities he/she enjoyed in the past.)
- Include exercise in the daily routine.
- Avoid arguing with the person; his reality will never be your reality.
- Understand that you may need to accept behavior and be flexible.

- Distract the person with other activities - have a cup of tea, or go for a walk.
- Employ good communication techniques. Allow enough time; make eye contact; repeat statements and be aware of your non-verbal cues. Give two choices only, such as: “Do you want coffee or tea?”
- Approach from the front. Do not surprise the person from behind.
- Do not take the behavior personally. The person is not in control of his behavior and is likely to forget the incident altogether.
- Note what happens prior to the behavior that may trigger it, e.g., an open door causes the person with dementia to want to go outside. Modify the trigger - close the door or camouflage it so the person forgets it is there, and will not be stimulated to go outside. Also note what happens just after the behavior and the effect on the person. Does the caregiver scold the person or reassure him?

If you observe a person who is having **hallucinations**, be cautious in responding. If the hallucination doesn't cause problems for you, the person, or others, you may want to ignore it.

- **Respond with caution.** Don't argue with the person about what he or she sees or hears. Unless the behavior becomes dangerous, you might not need to intervene.
- **Offer reassurance.** Gentle patting may help reduce the hallucination.
- **Look for reasons or feelings behind the hallucination.** For example, you might want to respond with words such as these: “It sounds as if you're worried” or “I know this is frightening to you.”
- **Use distraction.** You might try to turn the person's attention to other activities, such as listening to music, conversation, drawing, looking at photos or pictures, or counting coins.
- **Respond honestly.** Keep in mind that the person may sometimes ask you about the hallucination. For example, “Do you see him?” or “Can you hear the children laughing?” Try to respond with, “I know that you see (or hear) something, but I don't.” In this way, you're not denying what the person sees or hears.
- **Check out the reality of the situation.** Ask the person to point to the area where he or she sees or hears something. Glare from a window may look like snow. Dark tiles on the floor may look like holes.
- **Modify the environment.** Check for noises that might be misinterpreted, or lighting that casts shadows, or glare, reflections, or distortions from the surfaces of floors and walls
- If the person insists that he or she sees a strange person in the mirror, you may want to cover up the mirror or take it down. **The person may not recognize his or her own reflection.**
- On other occasions, you may want to **turn on more lights and make the room brighter.**



About Kansas Advocates for Better Care

Founded in 1975 as *Kansans for Improvement of Nursing Homes*, the mission continues to be “advocating for *quality* long-term care” for residents of licensed adult care homes. KABC is a 501 (C) (3) non-profit organization, funded by members, contributors, and grants for special purposes.

For information on becoming a member of KABC, for guidance about a licensed care home issue, or to order consumer reports, call toll-free: **800-525-1782**

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