

**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**

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Good morning Chairman Baucus, Senator Grassley and members of the Committee. Thank you for the opportunity to be here and, with other panel members, to address the critical issue of how to prevent abuse and neglect of the elderly. I am grateful to this Committee and the Senate Special Committee on Aging for bringing this topic to the national agenda.

My name is Catherine Hawes. I am a Professor and Director of the Southwest Rural Health Research Center at the School of Rural Public Health, Texas A&M University System Health Science Center.

In my testimony today, I will be focusing on residential long-term care settings, such as nursing homes, assisted living facilities, and residential care homes. This testimony is basically a summary of information provided in greater detail in a paper prepared for the National Academy of Sciences report on elder abuse that was just released.

I intend to make four basic arguments:

1. The elderly in residential long-term care settings are particularly vulnerable to abuse and neglect, and the scant evidence available suggests abuse and neglect are serious and widespread.
2. The most significant preventable causes of abuse and neglect are low staffing levels and inadequate staff training.
3. There are exemplary regulatory policies, facility practices, and training programs that appear to be successful in minimizing abuse and neglect in nursing homes.
4. Little attention has been directed toward these issues in residential care.

1. RESIDENTS AT RISK FOR ABUSE AND NEGLECT

On any given day, approximately 1.6 million people live in approximately 17,000 licensed nursing homes, and an estimated 900,000 to one million persons live in approximately 45,000 residential care facilities, variously known as personal care homes, adult congregate living facilities, domiciliary care homes, homes for the aged, and assisted living facilities.¹

These residents are at particular risk for abuse and neglect. Most suffer from several chronic diseases that lead to limitations in physical functioning and are thus dependent on others for assistance in the most basic daily activities, such as bathing, dressing, eating and using the toilet. Further, two-thirds of nursing home residents and an

¹ Sources: Strahan, 1997; Hawes, Rose & Phillips, 1999; Hawes et al., 1995. While only 2.5 million persons live in a residential long-term care facility on any given day, over their lives many elderly will be at risk during a period of long-term care facility use. Research suggests that more than two-fifths (43%) of all persons who turned 65 in 1990 or later will enter a nursing home at some time before they die, a figure that rises to 60 percent for persons who live to be 85 or older (Kemper & Murtaugh, 1991; Murtaugh, Kemper & Spillman, 1991).

estimated 40 percent of residential care facility residents have significant cognitive impairment, many from diseases such as Alzheimer's.² These resident characteristics, particularly a diagnosis of Alzheimer's or other dementias, or challenging behaviors, have been found to place residents at greater risk of both physical and sexual abuse. Finally, only 12 to 13 percent of the residents are married, and many of the others lack a close family member who lives within an hour of the facility. Thus, these individuals are extremely vulnerable, largely unable to protect themselves, and dependent for their care on the kindness of strangers.

"I saw a nurse hit and yell at the lady across the hall because the nurse told the lady she didn't have all day to wait on her. The lady made some remark. The nurse hit the lady and said 'shut up.'"
Georgia Nursing Home Resident (Atlanta, 2000)

Estimates of Prevalence of Abuse³ and Neglect⁴

There are no reliable data on the prevalence of abuse or neglect in nursing homes or residential long-term care facilities. However, the piecemeal evidence we do have suggests the problem is serious and widespread.

Abuse in Nursing Homes.

"Have I seen abuse? No, not directly. But I've come in and found my mom battered and bruised. I mean, her whole face was bruised and swollen, the backs of her hands and arms were bruised, as if she tried to protect herself."
Daughter of a Texas Resident
(Hawes, Blevins & Shanley, 2000)

For decades, nursing homes have been plagued with reports suggesting widespread and serious maltreatment of residents, including abuse, neglect, and theft of personal property. In addition, a number of case studies, participant-observation studies, interviews with nursing home staff, and

interviews with residents and ombudsmen provided some evidence of abuse. However, there has never been a systematic study of the prevalence of abuse in nursing homes. Much of what we know is based on individual stories or focus group interviews with residents and families. These do not provide reliable estimates of the prevalence of

² Sources: Hing, 1995; Hawes et al., 1995

³ The Administration on Aging (AoA, 1998, 13) in its instructions to long-term care ombudsmen, defines abuse as "the willful infliction of injury, unreasonable confinement, intimidation or cruel punishment with resulting physical harm, pain, or mental anguish or deprivation by a person, including a caregiver, of goods or services that are necessary to avoid physical harm, mental anguish, or mental illness."

Physical abuse is generally thought to include hitting, slapping, pushing, or striking with objects. In nursing homes, other types of actions have been included, such as improper use of physical or chemical restraints. Physical abuse also typically includes **sexual abuse** or nonconsensual sexual involvement of any kind, from rape to unwanted touching or indecent exposure. In residential LTC settings, it also includes **verbal** or **psychosocial abuse**. This is generally thought of as "intentional infliction of anguish, pain, or distress through verbal or nonverbal acts" and includes threats, harassment, and attempts to humiliate or intimidate the older person (Clarke & Pierson, 1999, 632).

⁴ Neglect is thought of as including "the refusal or failure of a caregiver to fulfill his or her obligations or duties to an older person, including...providing any food, clothing, medicine, shelter, supervision, and medical care and services that a prudent person would deem essential for the well-being of another" (Clarke and Pierson, 1999, 632).

abuse. However, there are a few studies that suggest the problem is both serious and widespread.

Reports from Residents. The Atlanta Long Term Care (LTC) Ombudsman Program (Atlanta, 2000) conducted the most recent study of abuse in nursing homes under a grant funded by the National Ombudsman Resource Center. In this study, ombudsmen interviewed 80 residents in 23 nursing homes in Georgia.⁵ This survey found that 44 percent of the residents reported that they had been abused, while 48 percent reported that they had been treated roughly. For example, one resident noted:

"They throw me like a sack of feed...[and] that leaves marks on my breast."

Georgia Nursing Home Resident (Atlanta, 2000)

In addition, 38 percent of the residents reported that they had seen other residents being abused, and 44 percent said they had seen other residents being treated roughly. For example, as one resident reported:

"My roommate – they throw him in the bed. They handle him any kind of way.

He can't take up for himself." Georgia Nursing Home Resident (Atlanta, 2000)

Reports from Facility Staff. A 1987 survey of 577 nursing home staff members from 31 facilities found that more than one-third (36%) had witnessed at least one incident of physical abuse during the preceding 12 months.⁶ Such incidents included excessive use of physical restraints (21%), pushing, shoving, grabbing or pinching a resident

"Oh, yeah. I've seen abuse. Things like rough handling, pinching, pulling too hard on a resident to make them do what you want. Slapping, that too. People get so tired, working mandatory overtime, short-staffed. It's not an excuse, but it makes it so hard for them to respond right."

CNA from South Carolina
Hawes, Blevins & Shanley, 2001

(17%), slapping or hitting (13%), throwing something at a resident (3%), kicking or hitting with a fist or object (2%). Ten percent of the staff members surveyed reported they had committed such acts themselves. A total of 81 percent of the staff reported that they had observed and 40

percent had committed at least one incident of verbal or psychological abuse during the same 12-month time period.

Subsequent surveys of nursing home CNAs have shown similar results. For example, a 1993 survey found that 17 percent of CNAs reported they had pushed, grabbed or

⁵ The ombudsmen initially identified what they considered 10 problem facilities and recruited residents from those nursing homes. The process was subsequently expanded to a total of 23 facilities, based on local ombudsman identification of residents willing to speak with the interviewers about issues of abuse and neglect. The authors reported, "Almost all those approached agreed to be interviewed." Those who declined cited fear of retaliation. Finally, the ombudsmen used CMS Survey protocols to identify "interviewable" residents in long-term care facilities (Atlanta, 2000).

⁶ Source: Pillemer & Moore, 1989. 31 of a potential sample of 77 facilities in one state met the facility size criteria, agreed to participate in the study, and provided complete lists of staff.

shoved a resident. More than half (51%) reported they had yelled at a resident in anger during the last year, while one-quarter (23%) had insulted or sworn at a resident.⁷

In a training project designed to reduce abuse and neglect in nursing homes, 77 CNAs from 31 different nursing facilities were interviewed (MacDonald, 2000). More than half (58%) of the CNAs said they had seen a staff member yell at a resident in anger; 36% had seen staff insult or swear at a resident; 11% had witnessed staff threatening to hit or throw something at a resident (MacDonald, 2000). They also reported witnessing incidents of rough treatment and physical abuse of residents by other staff.

Twenty-five percent of the CNAs witnessed staff isolating a resident beyond what was needed to manage his/her behavior; 21 percent witnessed restraint of a resident beyond what was needed; 11 percent saw a resident being denied food as punishment. CNAs also reported witnessing more explicit instances of abuse. For example, 21 percent saw a resident pushed, grabbed, shoved or pinched in anger; 12 percent witnessed staff slapping a resident; seven percent saw a resident being kicked or hit with a fist; three percent saw staff throw something at a resident; and one percent saw a resident being hit with an object (MacDonald, 2000).

Reports from Ombudsmen. An estimated ten percent of the complaints or about 20,000 complaints received by ombudsmen during FY 98 involved allegations of abuse, gross neglect, or exploitation (AoA, 2000). However, it is well-known that formal complaints provide an underestimate of the actual instances of abuse or neglect, since residents and families are often unwilling to file a formal complaint. Residents and family members report fear of retaliation and a belief that complaining would be futile as common reasons for not reporting incidents (Atlanta LTC Ombudsman, 2000; Haley et al., 1996; Hawes, Blevins & Shanley, 2001).

Analysis of Deficiency Data by the Office of the DHHS Inspector General. The OIG reviewed data from the CMS Online Survey Certification and Reporting System (OSCAR) for one full survey cycle (1997-98) in ten States. The OIG found 4,707 abuse complaints, involving nearly one-third of the facilities certified to participate in the Medicare or Medicaid programs in those states, although most were not substantiated.⁸

U.S. House of Representatives, Committee on Government Reform. Recently, the Minority Staff of the Special Investigations Division of the House Committee on Government Reform issued a report asserting that abuse of residents "is a major problem in U.S. nursing homes (US House, 2001). This report analyzed data from the OSCAR system and the nursing home complaint database covering all surveys and complaint investigations during a two-year period (i.e., January 1999 – January 2000) and included four deficiency codes related to abuse (F223, 224, 225 and 226). The report concluded:

⁷ Pillemer and Hudson, 1993

⁸ The vast majority of complaints (e.g., about 2/3rds) were not substantiated, an issue discussed at greater length in the body of this report.

- During the two-year period, nearly one-third of all certified facilities had been cited for some type of abuse violation that had the potential to cause harm or had actually caused harm to a nursing home resident.
- Ten percent of the nursing homes in the U.S. were cited for abuse violations that caused actual harm to residents or placed them in immediate jeopardy of death or serious injury.
- The percentage of homes with abuse violations has been increasing, probably as a result, at least in part, as a result of more stringent reporting requirements and increased vulnerability among residents.
- The cases involving abuse included physical and sexual abuse as well as verbal abuse involving threats and humiliation.

Reports from the Nurse Aide Registries. One potential source of data on abuse in nursing homes is the Nurse Aide Registries. Under federal law, states are required to establish a nurse aide registry and investigate any complaints of abuse, neglect, and misappropriation of resident property by any nurse aide in a nursing home that participates in the Medicare or Medicaid program.⁹ In a recent study for CMS, researchers surveyed the state agencies administering the Nurse Aide Registries (Hawes, Blevins & Shanley, 2001). Forty of the 51 agencies responded, but those agencies varied widely in their ability to provide data and in the operation of their systems, from intake to investigation and resolution. Most states could not provide a breakdown of the complaints by type. However, among the 14 states that could provide data, most complaints were about abuse. If these states were representative, there were between 17,000 and 34,000 allegations of abuse, neglect or misappropriation in 1999, with an estimated 11,900 to 23,900 formal complaints of abuse. This is probably a severe underestimate of incidents, since residents and families were reluctant to file a formal complaint and since most states did not have extensive outreach practices.

Neglect in Nursing Homes. The daily misery, indignity, preventable decline, and premature death caused by neglect in nursing homes is truly a national tragedy. Moreover, it is probably more widespread than abuse.

Resident and CNA Reports of Neglect. Ninety-five percent of the residents who were interviewed as part of the Atlanta Long-Term Care Ombudsman study reported that they had experienced neglect or witnessed other residents being neglected (Atlanta, 2000). Similarly, in one study, 37 percent of the CNAs reported they had seen neglect of a resident's care needs (MacDonald, 2000). The kinds of things residents and CNAs identified and reported as neglect included residents being left wet or soiled with feces; residents not being turned and positioned, which can lead to pressure ulcers; staff shutting off call lights without helping the resident seeking assistance; residents not receiving enough help at mealtimes; staff failing to perform prescribed range of motion

⁹ Sections 1819 (e) (2) (A) or 1919 (e) (2) (A) of the Social Security Act.

exercises to prevent residents from developing contractures; and staff failure to respond to residents' requests or need for something to drink.

Ombudsman Reports. The 1998 compilation of complaints received by the State Long-Term Care Ombudsman program reported that 27 percent of the complaints ombudsmen received had to do with the types of inadequate care that are typically thought of as neglect (e.g., improper handling, accidents, neglected personal hygiene, and unheeded requests for assistance) (Administration on Aging [AOA], 2000).

Deficiency Citations and Research. It is sometimes difficult to distinguish neglect from what might be termed poor quality of care in nursing homes. However, some areas can be classified as neglect. For example, the OIG (1999) found an increase in the frequency with which deficiencies were cited for neglect and poor quality of care. In recent years, deficiency citations increased in 13 of 25 quality of care areas, including such problems as improper care for pressure ulcers, inadequate care to maximize physical functioning in activities of daily living (ADLs), and lack of adequate supervision to prevent accidents. Other research studies have raised similar concerns. For example, in California facilities, the GAO found unacceptable care, including lack of appropriate attention to dramatic, unplanned weight loss, failure to properly treat pressure ulcers, and failure to manage pain. In another study, a review of records and care practices in 14 facilities in 11 States documented inadequate treatment in one-third of the facilities in the areas of nutritional support, pressure ulcer care, prevention of contractures, pain management, and personal assistance (Johnson & Kramer, 1998). Other studies and hearings by the U.S. Senate Special Committee on Aging have documented similar problems.¹⁰ For example, one study found that a major predictor of unintended weight loss and low body-mass index among nursing home residents was that the residents needed help with eating. Similarly, Kayser-Jones and Schell (1997) found that many facilities were so understaffed that even though trays were taken into rooms, residents who needed help were not fed.

Abuse and Neglect in Residential Care Facilities. There are no federal standards that govern residential care facilities, which are known by more than 30 different names across the country.¹¹ As a result, there are no national databases containing information on deficiencies, no uniform mechanism for reporting allegations of abuse or neglect, and no uniform role for ombudsmen in residential care and assisted living. Thus, it is even more difficult than with nursing homes to generate anything approaching reliable estimates of the prevalence or nature of abuse or neglect.

Staff Reports. In one ten-state study of board and care homes, funded by the US Department of Health and Human Services, 15 percent of a random sample of staff reported witnessing other staff engage in verbal abuse (e.g., threats, cursing, yelling) or

¹⁰ Bernabei et al., 1998; Blaum, Fries & Fiatarone, 1995; Fries et al., 1997; Hawes et al., 1997; Hawes, 1997; Kayser-Jones, 1997; Phillips et al., 1997.

¹¹ Those names include personal care homes, adult care homes, adult congregate living facilities, residential care homes for the elderly, shelter care homes, homes for the aged, domiciliary care homes, board and care homes, and assisted living facilities.

forms of punishment, such as withholding food, excessive use of physical restraints, or isolating difficult residents (Hawes et al., 1995b).

Ombudsman Reports. The ombudsman presence in residential care facilities is much more limited than in nursing homes (Phillips et al. 1994). For example, ombudsmen handled 121,686 cases in FY '98, but only 17 percent were about residents in residential care facilities. However, of the cases handled by ombudsmen in residential care facilities and reported in NORS, physical abuse was one of the five most common complaints registered with the ombudsman program (AoA 2000).

Neglect. Because there is no federal reporting system and state systems are highly variable, it is impossible to generate useful estimates of neglect in residential care. The only available evidence is from scattered studies of care in these facilities. As a result, it is difficult to separate estimates of neglect from reports of quality problems. These problems included medication errors, high rates of psychotropic drug use, poor management of behavioral symptoms among residents with Alzheimer's disease or other dementias, including inappropriate use of physical restraints, and poorer functional outcomes for RCF residents compared to nursing home residents, which suggested neglect of care needs.¹² In addition one study asked a national probability sample of assisted living residents who could respond about whether they had unmet care needs (Hawes, Phillips and Rose, 2000). A few residents reported needing more help with dressing (12%) and locomotion (walking or using a wheelchair) (12%); however, slightly more than one-quarter (26%) of residents who were receiving some assistance with toilet use reported they had unmet needs for assistance in toileting.

Limitations of the Estimates. Several factors make it difficult to rely on these estimates. First, there are multiple reporting agencies, and they use different definitions of abuse and neglect. Second, there is widespread underreporting, particularly of abuse, among residents and families, regulatory agencies, ombudsmen, and health professionals.

2. PREVENTING ABUSE AND NEGLECT: THE ROLE OF STAFFING AND STAFF TRAINING

Although there has been only minimal research on the causes of abuse and neglect in residential long-term care settings, there is remarkable consensus across diverse studies and surveys of stakeholders. Three factors are generally viewed as causing or significantly contributing to abuse and neglect in nursing homes. They are:

- Staffing shortages that cause neglect and create stressful working conditions in which abuse is more likely to occur.
- Staff burn-out, often a product of staffing shortages, mandatory overtime, and the fact that many staff must work two jobs to survive financially; and

¹² Baldwin, 1992; Bates, 1997; Spore, Mor, Hiris, Larrat, & Hawes, 1995; Spore, Mor, Larrat, Hiris & Hawes, 1996; Spore, Mor, Larrat, Hiris & Hawes, 1997a and 1997b; Stark, Kane, Kane & Finch, 1995; U.S., GAO, 1992.

- Poor staff training, particularly about the impact of dementia and how to interpret and manage challenging behaviors among residents.

I should note that if I were going to do only one thing to reduce abuse and neglect, it would be to increase staffing in the nation's nursing homes.

As part of several studies, including two funded by CMS as part of their initiatives to improve nursing home quality, my colleagues and I interviewed state survey agency directors, the managers of the state nurse aide registries, residents, family members, ombudsmen, and CNAs working in nursing homes. There was universal agreement that inadequate staffing was the major preventable cause of abuse and neglect.

"A male nurse grabbed me, slung me on the floor and threw me into the bed. He was in a bad mood because we were short-staffed, and he had to work two floors."
 Georgia Nursing Home Resident (Atlanta, 2000)

- 85 percent of the nurse aide registry directors argued that staffing shortages, too few staff, and poor staff to resident ratios were the main cause of abuse and neglect.
- 71 percent of these managers asserted that staffing shortages & difficulty hiring qualified staff were major causes of abuse and neglect.
- 78 percent of the aide registry directors argued that low wages paid to CNAs made it difficult or impossible to hire and retain good staff, thus exacerbating staffing shortages and turnover.
- 92 percent of 43 state LTC ombudsmen identified staffing shortages as the major cause of neglect and poor quality in nursing homes.

"The best [thing about the job of CNA] is doing something for residents. You can see they appreciate it. The worst is working short [staffed] and you can't provide quality of care."
 CNA from Illinois

Several other studies have reached the same conclusion. For example, in 10 States surveyed by the OIG (1999), survey and certification staff, State and local ombudsmen, and directors of State Units on Aging identified inadequate staffing levels as one of the

"The worst [thing about being a CNA] is the sense of powerlessness. To see residents suffering, but you've got 15 on your hands, and can't get to a resident. You tell charge nurse what's going on; she just looks at you like you're a fool, says nothing she can do. Yeah, it's that hopelessness of not being able to make a difference."
 CNA from Florida
 (Hawes, Blevins & Shanley, 2001)

major problems in nursing homes. The OIG report concluded that the type of deficiencies commonly cited "suggest that nursing home staffing levels are inadequate" (OIG, 1999). More recently, the CMS staffing study concluded that most facilities were understaffed, with a significant number dangerously

understaffed.

In focus group interviews, CNAs explained why staffing shortages caused or contributed to abuse and neglect. First, the CNAs noted that when they were working short-staffed, there was no way to meet all of the residents' needs. There was strong agreement among the CNAs that the first things to be neglected were range of motion exercises and other types of restorative nursing care, keeping residents hydrated, and giving residents enough time and assistance with eating. Each of these has dire long-term consequences for residents.

The CNAs made it clear that they found such a situation profoundly demoralizing, particularly if it persisted over time. They also noted that this inability to meet resident needs was a major cause of staff turnover among good staff, since they could not tolerate the guilt they felt when neglecting residents.

CNAs also described the way in which the stress associated with short-staffing made abuse more likely to occur. Sometimes, short-staffing meant that a CNA would be asked or "required" to work all or part of a second shift, leading to exhaustion and frayed tempers. Other times, short-staffing meant that a CNA might have more than 20 residents to care for on the day shift, the shift that is busiest in terms of the care to be provided. During night shifts, a single CNA might have 30 or more residents to care for, which might involve waking residents as early as 4:30 am to get them dressed and in the breakfast room. As several state survey agency staff noted, such situations make abuse and neglect nearly inevitable.

"Facilities place CNAs in situations where abuse is bound to happen."
Aide Registry Director
(Hawes, Blevins & Shanley, 2001)

Finally, it became clear that inadequate training of staff was a major factor in abuse. The current federal requirement for CNA training is only 75 hours. This is inadequate in the view of key stakeholders, including state agency staff, LTC ombudsmen, and CNAs.

- 61 percent of the aide registry directors argued that poor training was a significant factor causing abuse;
- 58 percent of the ombudsmen identified inadequate training of CNAs as a major obstacle to quality of care in nursing homes.

CNAs listed inadequate training as one of the top three problems they encountered. Moreover, this became obvious in their discussions of how to handle residents who

"We hear, if they have Alzheimer's, they don't know what they're doing. But I mean it, if our husbands hit us like some residents do, he would be in jail. Somebody sneaks up and hits you or pinches. You jump; you might hit someone. It's automatic."

CNA from Oregon (Hawes, Blevins & Shanley, 2001)

exhibited challenging behaviors, such as resisting nursing care or ADL assistance or physically aggressive behaviors. The current "best practice" model for managing behaviors involves viewing behaviors as

a mode of communication for residents with dementia who have difficulty making

themselves understood through verbal communication. Moreover, behaviors should be understood in the context of the neurological changes associated with dementia. In general, this leads to a non-confrontational and accommodating approach to dealing with resident behaviors.

Despite this, many staff viewed resident behaviors as purposive, intentional. Thus, a resident who resisted care or struck out at staff was often viewed as intending to harm the staff or as deliberately “being difficult.” Given these views, some staff believed that treating such residents “roughly” was acceptable, particularly if the staff member had been “startled” by the

resident or if, in their view, the resident might hurt the staff member. Addressing this situation is clearly

“Individuals come in who are not adequately trained, and then they have a heavy workload, [are] frustrated, under-oriented, under-supervised, under-paid, under-trained.”
Aide Registry Director (Hawes, Blevins & Shanley, 2001)

complex and must involve vastly improved basic training and continuing education for CNAs. It may also involve steps designed to improve management and oversight in nursing homes.

3. WHAT CAN BE DONE: STATE AND FACILITY-BASED INITIATIVES

It is important to note that there are a number of state policies and facility initiatives that appear to be quite promising in terms of preventing abuse and neglect in nursing homes. Some of these may also apply to residential care facilities.

“As a society, we need to respect our disabled elderly enough to want to care for them and, in addition, to care enough to foster caring in the staff, for example, with career ladders, proper pay, decent work loads.”
Aide Registry Director

First, some states have instituted a number of policies and practices designed to make the complaint system more responsive to resident and families and to address cases of abuse and neglect more effectively. For example:

- Some states have extensive outreach programs to inform the public about what abuse and neglect are and how to report them.
- A few states have toll-free abuse hotlines that are manned 24-hours a day, 7 days a week.
- One state routinely communicates all complaints about abuse and neglect – as soon as they are received – to the ombudsman, the Medicaid Fraud Unit, and, as appropriate, to local law enforcement, inviting them to participate in the on-site investigation.
- A few states have developed more sophisticated investigative protocols for abuse and neglect complaints, particularly for how to handle incidents in which the alleged perpetrator of abuse was not identified by the facility or in which there was not an “independent” third-party witness.

- A few states analyze data on the types of complaints they receive about abuse and neglect and develop training programs for providers around the most common problems, with a particular focus on preventing abuse.
- One state has developed an investigative protocol that requires an examination of the care received by residents who did not complain but who have similar conditions to those of the resident whose care generated a complaint of abuse or neglect.

Many long-term care facilities have also developed and implemented policies and practices that seem promising in terms of preventing abuse and neglect. These are important practices to examine in terms of their effectiveness and exportability.

- Many facilities provide training that goes well beyond the required 75 hours for CNAs. For example, one facility in the greater Cleveland, Ohio area provides three additional weeks of training for CNAs at the start of their employment, as well as substantial continuing education.
- Many facilities, particularly non-profits and some Alzheimer's Special Care Units, have staffing ratios of one CNA for every six to eight residents and have more staffing and supervision by registered nurses than is found in the average facility.
- Some facilities have been active with ombudsmen and consumer advocates in sponsoring or participating in special training programs designed to prevent abuse. Examples include facilities in Pennsylvania that have worked with the advocates at CARIE, and facilities working with ombudsman programs in Georgia and Massachusetts.
- Many facilities are participating in quality improvement initiatives that may well have positive effects in terms of preventing abuse or neglect. The Wellspring Initiative, started in Wisconsin and spread to Texas and Illinois, is one example. It involves both empowerment of CNAs and enhanced clinical training for all staff from a Geriatric Nurse Practitioner as well as peer facilities. An early evaluation found reduced staff turnover and reduced deficiencies among the participating facilities. Other facilities, such as the Pioneers, those participating in the Eden Alternative, and innovators such as Kendall-Crossland in Pennsylvania and Benedictine in Oregon may also shed light on how to prevent abuse and neglect.

4. PAUCITY OF INFORMATION ABOUT RESIDENTIAL CARE

Unfortunately, we do not have the same kind of information about residential long-term care outside nursing homes. While information on the nature and extent of abuse and on ways to prevent abuse and neglect in nursing homes is scant, similar knowledge is non-existent with respect to board and care homes. This is true despite the fact that between 900,000 to 1 million people live in these settings. Moreover, they are a much more complex mix of persons in terms of their care needs. People who live in these facilities include the frail elderly, persons with significant cognitive impairment, including

Alzheimer's disease, persons with developmental disabilities, and persons with persistent and severe mental illness. In addition, considerable tax dollars are spent on these facilities, including payments from SSI and Medicaid. Further, significant Medicare dollars are spent on the fairly high rate of hospital, emergency room, and home health use by these residents.

Despite these factors, we know next to nothing about the prevalence of abuse and neglect, what types of regulatory systems states have in place to address abuse and neglect if they arise, and whether there are institutional or environmental factors that are associated with different levels of abuse or neglect in board and care homes and assisted living facilities. The last federally-funded study of regulation took place nearly a decade ago, except for summaries of legislation aimed at assisted living. Analyses of different regulatory models, staffing models, and quality improvement initiatives are largely absent. Indeed, we do not even know whether abuse and neglect are significant problems in these settings, only that the residents are particularly vulnerable.