# The Complaint

As an Ombudsman, you are an advocate acting on behalf of residents. In some cases, you will be able to educate, support, and encourage residents to engage in self-advocacy—to represent themselves. In other situations, you will be representing residents. There is a basic complaint process which Ombudsmen use to analyze and resolve problems. This problem solving process and its prerequisite skills are the focus of this section.

The Ombudsman Complaint Action Form is located in the Appendix.

## OMBUDSMAN ROLE IN COMPLAINTS

Ombudsmen need to be familiar with:

- documentation requirements — what should be included in documentation; how to document a case involving one resident, versus one involving many residents.
- any time requirements to initiate investigations.
- role of paid and volunteer staff in complaint handling.
- lines of communication when referring cases, i.e., volunteer, sub-state staff, staff, state agencies.
- any specific requirements or differences in handling abuse complaints.
- confidentiality requirements.

# The Complaint Process

Responding to and resolving complaints is a primary part of an Ombudsman's job, and one that can at times be difficult. Complaint handling is really nothing more than a process you follow from receipt of a complaint through investigation and resolution. As you handle more and more complaints, you will adapt this process to your own style. Eventually it will become second nature to you.

## WHAT IS A COMPLAINT?

This basic question is a confusing one for many Ombudsmen. Are complaints only those problems you report to the state, only those you refer to a regulatory agency or anything a resident voices concern about?

In its simplest definition, a complaint is any expression of dissatisfaction or concern. This does not mean, however, that you should launch a full scale investigation every time someone says today's lunch tasted bad. Many people express dissatisfaction just to let off steam or to have some way of expressing themselves about things over which they have little control. They may not expect or want you to intervene on their behalf. Some residents may be disoriented as to time and express complaints that relate to the past. Your task is to get to know residents individually and to perfect the skills that will be discussed in this module well enough to be able to determine when such expressions are actual requests for assistance.

On the other hand, problems sometime exist in a facility about which no complaints are voiced. An absence of complaints may not mean that all the residents are receiving quality care or experiencing an acceptable quality of life. There are many reasons why residents are reluctant to voice complaints. Fear of being branded a "complainer," living in isolation, feeling hopeless, fear of retaliation, simple lack of awareness that they have

a legal right to complain or lack of knowledge of rights and benefits are factors that prevent persons in institutions from voicing grievances.

A lack of reported complaints should be taken as an indication of the need to reach out to the residents. An on-going presence within facilities will make you a familiar figure to the residents. Once you have established trust, nursing home residents and their families may begin to assert their rights and voice complaints. Your ability to detect the concerns of residents which are only hinted at and to observe situations which require action is as important as your ability to respond to a direct request for assistance.

Many people who make complaints need help focusing on the actual problem. They may contact you about a complaint which involves several problems. You will need to sort out the problems and determine which are most important. Many people will not complain until a problem has persisted for a long time. When they do complain, there may be a lengthy history of events and circumstances to consider.

Complainants may be highly emotional about a complaint. As a result, problems often are stated in sweeping terms ("the food here is terrible!"). You will need to work with the complainant to pinpoint the specifics of the problem.

## SOURCES OF COMPLAINTS

An Ombudsman may receive complaints from a variety of sources, including:

1. residents;
2. relatives or friends of residents;
3. local advocacy or friendly visitor groups;
4. facility staff;
5. social work and human service agencies;
6. hospital personnel; and
7. legislators and political leaders.

Depending upon how your local program works, most of your complaints will probably come either from visits in the facility or phone calls to your office.

During facility visits, you must be alert to observe situations which may not be voiced directly as complaints. Be sure your name and number are posted in the facility. If possible, cultivate relationships with staff members or with residents who can contact you on behalf of residents with less ability to communicate.

- Few residents will personally make a complaint unless they are visited regularly by an Ombudsman. Most residents will not feel comfortable complaining to a stranger, and therefore need to know and trust a person before talking openly about their concerns. In addition, many residents do not know that they have the right to complain or they feel that making a complaint will not do any good.
- In some facilities a resident council, or family council (composed of residents, relatives, and community people) may bring problems to you. Complaints made by such groups help to protect and support an individual resident. These organizations do, however, sometimes become mere "rubber stamps" for the facility's administration, so you will have to learn how much they really represent the interests of residents.
- One of the most common sources of complaints are the relatives of residents. They, too, may hesitate to complain for fear of retaliation to their loved ones. Families also fear that once the facility staff has labeled them as "complainers" or "guilty children," their credibility will decrease. Keep in mind that the needs and interests of families are not necessarily the same as the needs and interests of the residents.
- Staff complaints may be based on a variety of motives. On the one hand, many staff are concerned about residents and want to provide the best care possible. When conditions in a facility are poor,

they may look for outside help in trying to correct the problems. On the other hand, some staff become disgruntled with their employer due to low pay, poor working conditions or other disputes with management. A person with a grudge against a facility may not be a reliable source of information.

## CONFIDENTIALITY OF COMPLAINTS

Explain the confidentiality policy to the complainant at the outset of the complaint handling process. If residents, or complainants acting on behalf of the residents, insist their identity be kept secret, they must be told that Ombudsman are bound by law to keep their identities confidential. However, you need to explain that depending on the situation, the facility may be able to determine who made the complaint. You should also explain clearly that some complaints are virtually impossible to investigate without revealing the identity of the resident. For example, a complaint regarding a resident's finances may not be properly investigated unless financial records are reviewed, which immediately indicates who had filed a complaint.

If the use of a complainant's name is initially denied and it is needed to proceed further with a complaint investigation, you should speak with the person again to explain the situation and to request use of the name. You should discuss with the complainant the risks involved in being identified. A guarantee that retaliation will not occur should never be offered to obtain the complainant's permission to use her name.

## RESPONDING TO COMPLAINTS

Sometimes a resident will insist that nothing be done or said, despite your appeals. In such cases, you have little choice. You can do no more than what the resident gives you approval to do. There is only one exception to this rule: when you observe a condition or incident yourself, you have the right to initiate a complaint investigation on your own.

You will inevitably find yourself in a number of complaint situations which will pose ethical dilemmas or call for special handling. The key to knowing how to respond to many of these situations is to remember that **you represent the resident**.

Some specific suggestions for a few complaint situations are discussed below:

1. A family member may complain about a resident's care. When you talk to the resident, she says everything is fine and asks you not to proceed. Your primary responsibility is to the resident. If pursuing the investigation would identify the resident, you must discontinue unless the resident grants permission to proceed. As an alternative, if you feel there is a problem with the care in the facility, you may be able to pursue a more general investigation, taking care not to do anything which would reveal the resident's identity.

2. The reverse situation may also occur. The resident may complain, but a family member will urge you not to "rock the boat." This case is more clear-cut; the resident has requested assistance and you should honor the request. You should explain to the family that you are obligated to assist residents in resolving problems.

3. Some complaints will come from relatives who want you to investigate, but do not want the resident to know what you are doing. For example, two relatives may be involved in a dispute over who is to provide for the resident's expenses. Or, relatives may fear that the resident will be upset or alarmed by a problem.

   This is a particularly sensitive situation. In such cases, it may be advisable to have a general conversation with the resident to ascertain whether or not he is concerned about the same problem mentioned by the complainant. You will have to judge whether or not there is a problem concerning the resident. If the resident is being victimized, you have a responsibility to correct the prob-

lem. However, you should not become involved in family disputes which are not affecting the resident's well-being.

4. Special problems can arise when dealing with a resident who is unable to make decisions for himself, but has not been legally declared incapacitated. If you receive a complaint from a resident who appears to be extremely confused, how should you consider it? Even though the resident may be confused, you should check into the complaint. If it appears to be valid, it cannot be dismissed as invalid just because it comes from someone who is confused. The resident's condition should, however, be considered as one factor in determining whether the complaint is legitimate.

5. Other cases may involve residents for whom a Guardian has been appointed. Article 81 of the NYS Mental Hygiene Law, effective in 1993, replaced the prior law establishing conservatorship primarily intended to conserve assets of incapacitated persons. Existing conservatorships are grandfathered in Article 81 and currently must meet the same guardianship/reporting requirements. Article 81 is fairly complex, but, if followed as intended, provides a humane approach to Guardianship. It requires due process with clear and convincing evidence (a high standard of proof) as to the incapacity of the person, a complete and unbiased investigation of the condition of the incapacitated person and her circumstances. The Court is required to establish the least restrictive type of financial and/or personal control over the incapacitated person.

   The basic procedures of Article 81 are:

   - the filing of a Petition for Guardianship.
   - an independent fact-finding investigation by the Court evaluator.
   - due process for the alleged incompetent with legal representation at a Hearing on the Petition.
   - findings by the Court and Appointment or not of a Guardian.

The Court monitors appointed Guardians who have received required training and meets with them periodically regarding their Guardianship activities. Such meetings review the continued need for Guardianship. The system allows almost anyone concerned about the welfare of another to petition the Supreme or County Court, and in limited cases, the Surrogate's Court where a ward may be the beneficiary of an estate.

The petitioner may be a family member, friend, neighbor, nursing or other adult care facility, or public agency such as the local Department of Social Services.

For more information on Guardianship, see Module 1.

6. In some cases the interest of one resident will run counter to the well-being of a group of residents. For example, a complaint about a resident being denied the right to smoke may reveal that the resident has nearly set the home on fire by smoking in non-smoking areas. In such cases you should try to help the parties arrive at a solution that protects the rights of the individual and the group.

7. In some cases complainants other than residents will insist on remaining anonymous. As in the case of residents who do not wish their names used, such persons should not be forced to reveal their identity. The complaint, if specific enough, can still be investigated using some of the techniques below:

   - Use observation to look for supporting evidence during the course of your regular visits;
   - Engage in casual conversations to see how residents feel about the issue;
   - Review recent complaints or survey reports to see if similar problems have been noted; and
   - If all else fails, file the complaint for future reference in case similar problems arise.

# Preparing for the Investigation

## THE COMPLAINT

After someone has voiced a complaint, you will need to analyze it in order to determine how to investigate it effectively. Among the questions to consider are:

- What is the complaint about? In what general category does it fall (for example, residents' rights, nursing care, family problem);
- Who are the persons involved?
- What, if any, agencies are, or should be involved?
- What steps has the complainant already taken to resolve the matter?
- What, if any, law or rules may be relevant?
- What result is the complainant seeking?

Before proceeding with an investigation, you should have some idea of the answers to these questions.

*What type of complaint is it?* A complaint about general resident care, for example, may turn out to contain several very specific elements. Care complaints can be about the number of staff, the training of staff, the treatment plan, the manner in which treatment is given, the failure to provide treatment, the development of bedsores, and many other problems. You need to know specifically what the complaint is about before starting to investigate.

*Who is involved in the complaint?* Who is responsible and who has the power to do something about it? It may be important to gather names, phone numbers and addresses of all people who have some role in the situation. A complaint about resident care could include: the complainant; the resident; the facility nursing staff; the facility administrator; and the resident's physician. Another health care facility (hospital, nursing home) where the resident was recently

treated may be an important element in determining the cause of the resident's condition.

16. Are there any relevant agencies? A problem concerning Medicaid would likely involve the Department of Health. A case related to Medicare would involve Social Security and the State's Fiscal Intermediary. You will need to identify any other agencies that may play a role in the problem.

17. What has the complainant done about the situation? If the complainant has taken some action, you will need to know this so that you do not duplicate unproductive actions or retrace steps. You also need to know the results of the actions already taken. This can help you anticipate what obstacles there may be to resolving the problem. For example, has the complainant talked with the administrator, director of nursing, or charge nurse? Has the complainant contacted the physician? Have there been any meetings with staff of the nursing home? Have any other agencies been contacted? If the complainant has not taken any actions about the problem, you are then in a position to suggest possible steps he can take. Advice of this nature helps the complainant to learn self-advocacy and may also save you time for other problems.

18. Are there any applicable laws or regulations? If the complaint is about resident rights, for example, you may need to review the federal and State laws on resident rights. Likewise, if the case involves Medicaid, you may need to review the nursing home reimbursement rules which spell out what services are paid for by Medicaid.

## GATHERING INFORMATION

An investigation is, in essence, merely a search for information. You must seek to find information which will either prove or disprove the allegations made by the complainant. It is important you be objective in gathering information. You must not make assumptions about the validity of a given complaint, even though you believe there are problems in

a facility. However, being an objective investigator does not mean you lessen your efforts to improve the care and quality of life for long term care residents.

After you have received a complaint in which a resident or complainant does not want her identity revealed, you have a responsibility not to jeopardize the complainant. However, if the problem is a general one, there are techniques you can use to investigate:

1. personally observe the problem;
2. find other people to voice the same complaint;
3. have the complaint channeled through a group, such as a resident council; or
4. handle as an anonymous complaint.

Information can be gathered in many ways. Among the most common are:

1. interviewing;
2. observation; and
3. the use of documents and administrative agencies.

Interviewing is a primary component of complaint investigation. You should never go into an interview without a specific purpose in mind. In order to discover the facts of a case (the who, what, when, where, why, and how), you might interview a resident, an administrator or operator, or an employee of another agency or institution. Regardless of the position of the person being interviewed and the personal style of the interviewer, there are several principles of which you should be aware.

*Items to consider in preparing for an interview:*

- the setting — is it comfortable, quiet, private?
- the time allotted — will the interviewer be hurried?
- the timing — will there be interruptions?

- the goals of the interview — these should be listed beforehand.
- the possible biases of both yourself and the interviewee.

Many of these may be beyond your ability to control. For example, you may not be able to see an administrator at a time and place of your choosing. However, the most important item is one you can control: have your goals set beforehand. Know what questions you need answered and what specific information you are seeking.

It is important to remember that an interview is a social situation, and the relationship between you and the interviewee will affect what is said. Although you will want to direct the interview in order to achieve its goals, most of your time will be spent listening. You should be alert to more than the spoken words. Facial expressions, voice inflection, eye contact, gestures and general behavior should be noted. More may be learned from an interviewee's body language than from her comments. In many cases, more can be learned from what is not said than from what is said. Note when topics have been omitted and try to assess the reason for the omission.

As a general rule, it is best to speak first to the complainant so that you will have the information directly from him before securing additional information from other residents, nursing home personnel, family or other parties.

At the beginning of a resident interview you should inform the resident of the confidentiality policy. In addition, it is extremely important to avoid making promises to the complainant regarding the resolution of the problem. It can be tempting, in a sincere effort to comfort a resident, to assure her the problem will be solved. However, this can lead to false expectations which may eventually be turned against you.

*Guidelines to following during interviews:*

1. maintain objectivity (don't make assumptions about the validity of the information);

2. try to establish rapport before addressing the problem;
3. explain the purpose of the interview and the function of the Ombudsman;
4. use open-ended questions to encourage responses about the problem area;
5. use closed-ended question to obtain specific details and facts;
6. use language that is easy to understand;
7. explain any technical terms;
8. guide the interview toward the desired goals, yet be flexible enough to adjust the goals according to any new information received;
9. let the resident know when the interview is about to end;
10. summarize what has been accomplished;
11. explain how the information will be used and other steps anticipated in conducting the investigation and resolving the complaint;
12. secure the resident's consent to the planned action before proceeding.

## INTERVIEWING SKILLS

**Note**: *This section uses complainant, interviewee, and resident interchangeably to mean the person the Ombudsman is interviewing.*

### 1. Listening

Active listening is the act of hearing and responding both to the content and to the feeling of what is being said. When you listen, be alert to more than spoken words. Notice inflection of speech, qualities and tone of voice, facial expressions, a glint in the eye, body language, gestures, and general behavior. See if you can detect gaps or omissions in what the person is saying.

Try to determine whether the complainant is glossing over some fact because they think it "detracts from their position." Explain that you are interested in the "bad" facts as well as the "good," and that you can only be of help if you know the whole situation.

The responses of the interviewee may be designed to impress, appease, convince, or even distract you. Try to assess and take into account the interviewee's mood and possible motives. Listen for clues that the resident is unusually disoriented or confused on that particular day. If you detect a good deal of nervousness or apprehension in someone's speech, you will have to address the factors that are causing these feelings before a free flow of information will be possible.

An interviewer should never completely believe or disbelieve everything a person says. You will have to sort out the difference between the "truth" and fiction, and learn to distinguish fact from someone's opinion, hearsay, characterization, or evaluation. If someone labels a resident as "hostile," for example, find out why (i.e. specific behaviors the resident exhibits, how often, with what people, etc.).

## 2. Listening for problem identification

Try to identify and logically separate the many different problems a resident may be experiencing; sorting out those that you will be able to handle and those that you cannot. Be alert to problems that may be unintentionally revealed—the resident may have a very limited notion of what help is available to him or may not want to "burden" you with too many problems. You may want to check into these or other common problems that may have been raised further. Listen for "the problem behind the problem." There is always the possibility that what the client is complaining about is not the issue bothering them at all, but instead a reflection of a general feeling of hopelessness.

## 3. Note taking

Your notes will be part of the file which is the central reference point not only for you and the complainant, but also for any referral agencies. In many cases it is necessary for you to take notes during the interview. Rapport, however, must be maintained despite the note-taking process. Some people will clam up at the sight of a notebook. You can mitigate this reaction somewhat by explaining prior to the interview that you will be taking notes and the reasons why, or you may delay taking notes until you feel that sufficient rapport has been established.

## 4. Tips for effective note-taking

It is not possible or even desirable to make verbatim reports of all that is said. You should take an occasional note here and there of responses that are especially significant and/or which you feel are important to remember accurately.

Be open about taking notes. Generally, there is not a good reason for being secretive. Be careful to avoid writing anything which you are not prepared for the interviewee or someone else to see. Judgmental statements such as "Resident is obviously a chronic complainer" or "Administrator can't be trusted" should be avoided.

Keep your notes short, factual, and to the point. It is acceptable to include your personal observations and judgments, however, substantiate these with facts. For example, if you indicate that the floor was dirty, state that you noticed coffee and juice stains and that it felt sticky to the touch. In other words, substantiate and document your opinions and observations with as much information as possible.

## 5. The write-up

The interview should be written up as quickly as possible after it ends. Include as much verbatim as possible, as well as a description of the interviewee's behavior and the general tone of the interview. Some basic elements to include in the write-up are:

- names and positions of everyone present, whether or not they spoke;
- the date and time of the interview;
- the location of the interview;
- a narrative account of the content of the interview;
- the goals that were accomplished and those which were not achieved; and
- any new avenues to explore.

This record of the interview should be kept with the case file for any future reference.

## OBSERVATION

Observation is another important tool of complaint investigation. Many complaints can only be understood and verified by sharing in the experience of the complainant. Complaints that have to do with items such as staffing, sanitary conditions, and food often can only be fully checked out through observation. When observing conditions in a facility it is important to use all the senses to determine what conditions are like.

You should approach a situation requiring investigative observation with an open mind and an understanding of what is observed. During an investigative observation it is crucial that you be as impartial as possible. If you only look for evidence that fits a preconceived notion or theory, other evidence may be missed or much of the evidence may be misinterpreted. Recording observations as soon as possible after they are made will help to eliminate errors due to emotional bias.

Preparation for an observation is equally important. You need to have in mind what observations will help to investigate a particular case. For example, in a complaint about a resident being fed a regular meal instead of a salt-free dinner, you would be able to investigate by seeing and possibly tasting the food served. By making an unannounced visit to the

facility, you could observe a routine mealtime procedure. In addition, familiarity with applicable rules and regulations will allow you to better judge which observations are relevant to the individual case and which are extraneous.

## ROLE OF RECORDS IN COMPLAINT INVESTIGATION

Official documents and administrative agencies are also sources of information. One document which in some cases proves to be a key source of information is the resident's medical record. It contains physician orders and notes, daily nursing notes, and other information related to the resident's care. Medical records are useful because they provide legal, written documentation for the complaint investigation. Incident reports, the facility's record of accidents, such as a resident falling or someone being hit, may be useful in certain cases.

*There are two problems which may arise regarding medical records.*

1. Medical records are confidential. The resident, or the guardian, if one has been appointed, must sign a written statement authorizing release of the records to an Ombudsman. The resident may give oral consent. If the Ombudsman is unable to get written or oral consent, she still has the right to see records.

2. Medical records are often not totally complete and/or accurate. Records are sometimes filled out hurriedly or by staff who do not understand the significance of careful record-keeping. If the records are available to review, there may be portions which you do not understand. In these instances it is helpful to consult a specialist (doctor, nurse, therapist, or dietitian) about the comments that are unclear. In many cases it is critical that you seek the assistance of specialists in order to protect yourself from accusations of being uninformed or unprofessional.

There may be other documents which a complainant has that you will find useful as evidence during the investigation. If the complaint has to do with financial matters, there may be copies of bills, letters, and/or

written agreements (e.g. an admission contract) which would be of use. In matters regarding resident care, some nursing homes post a chart in the resident's room to note when items of routine daily care are performed. A complaint about personal care activities (washing, bathing, brushing hair, oral hygiene) may be checked out at least partially by looking at this chart and discussing a problem area with staff on the unit.

The official documents kept by the State Department of Health (SDOH) can also be useful to a complaint investigation. These records include inspection reports, license applications, and reports on complaints investigated by the state agency. All of these official records may be important sources of documentation. Staff at SDOH often have technical skills and resources which Ombudsmen do not. Or, in a case where immediate health and safety is at risk, an immediate referral to a local Police Department or calling 911 may be most appropriate.

Normally, you should attempt to resolve problems within the facility. If you cannot resolve a problem or if it seems to require technical expertise, etc., referral may be appropriate.

## A GUIDE TO SENSORY OBSERVATIONS IN A LONG TERM CARE FACILITY

*Sight*

- Are furnishings institutional, hard, cold? Are they homelike? Does resident have a favorite locker or dresser? Are there enough chairs for visitors?
- Are there any pictures, calendars, photographs, or art work? What colors are used for paint? Bright? Cheery? Dull or drab? Is the paint peeling? Are plants real or plastic? Does the facility make maximum use of natural light?
- Are residents clean, shaved, hair combed? Are clothes wrinkled or dirty?
- Are call lights left unattended?

- Is the staff neat? Do they smile at residents? Do they wear identifiable name tags?

*Sound*

- Is music piped through corridors which is too loud or too soft?
- Are call bells ringing often and long?
- Are there residents with noticeably labored breathing? Are all noisy residents in one area? Does the staff talk pleasantly with residents, with one another? Do they call each other by name?
- Is an intercom overused and annoying? Are residents involved in activities which promote conversation?

*Smell*

- Are urine odors strong? or disinfectant odors?
- Do residents smell of urine?
- Does the food smell inviting?
- Do residents smell of colognes, after shave, or perfume?
- Is there an odor from dead flowers, medicine, or alcohol?

*Taste*

- Are smells so strong they can be tasted?
- Is the food cooked completely?
- Is the coffee cold?
- Is the water fresh?

*Feel*

- Are sheets soft or stiff?
- Are blankets scratchy or smooth?
- Is the building too hot or too cold?
- Are the floors slippery or gritty?
- Are the resident's hands cold, skin stiff?

## IDENTIFYING AND ANALYZING THE PROBLEM

As you gather information to answer these questions, you should be able to identify the problem(s) underlying the complaint. Being conscious of our own biases and their effects is of help here. For example, the potential is high for Ombudsmen who have been educators to focus too much on staff training, or for nurses to concentrate excessively on the monitoring of nursing procedures, while minimalizing other important problems.

Once a problem has been identified, it should be analyzed in order to help you determine if the complaint is valid and choose a strategy for resolution. Questions to consider in analyzing the problem include:

1. Why did the problem occur? Some factors to consider in attempting to answer this question are:
    - Was there an oversight on the part of the facility staff?
    - Was there deliberate retaliation against the resident?
    - Is the problem related to policies/procedures of the facility?
    - Are there personality clashes between the resident/relatives and staff?
    - Is the facility habitually short-staffed?
    - Does the resident's physical/mental condition make good care extremely difficult to provide?
    - Is the quality of care related to the resident's method of payment (i.e., Medicaid vs. private pay)?
2. What evidence is available to show what happened? Evidence can include:
    - Personal observation.
    - Medical records.
    - Reports of witnesses.
    - Admission by facility representatives of wrongdoing.

- Financial statements/receipts.
- Official survey reports.
- Reports from other parties (agencies or professionals with expertise in the field).

3. What justification or explanation does the nursing home offer for the problem? Some possible positions which the facility might give include:
   - There is no problem.
   - The problem is due to a "difficult" resident or family member.
   - The facility's action is based on medical/professional judgment
   - The care is as good as it can be considering the low rate of reimbursement.
   - The facility meets the regulations and has good inspection reports.
4. Who or what is at fault regarding the problem? The cause may rest with one or more of the following:
   - Facility staff failed to perform their duties properly.
   - State/federal regulations are lax or there is confusion regarding the issue(s) raised by the complaint.
   - Third-party reimbursement programs may not pay for certain procedures.
   - Independent professionals (e.g., doctor, physical therapist) may not leave clear instructions for resident and staff to follow.
   - The resident or family may be causing or contributing to the problem.

## COMPLAINT VERIFICATION

A complaint is verified if it is shown that the alleged problem does exist or did occur. Verifying a complaint is part of the investigatory process. You have been gathering information in order to determine the facts of the case. Formal verification is a matter of reviewing those facts, ensuring that you have proper documentation, and then proceeding with resolution or with informing the complainant that you cannot substantiate the problem.

It is important that you carefully construct your own records in gathering information for the investigation. The emphasis should be on facts. The source of all information should be noted. If personal observations are included, they should be identified as such. If your notes refer to how a person behaved, you should describe the behavior, not attempt to label it. For example, if an administrator is unresponsive to your questions say that, not that he "appeared to be hiding something."

Verification is very important if a violation of regulations is alleged and you seek action by a regulatory agency. If a complaint becomes part of litigation, or becomes available to the media during the publicizing of an important issue or event, it is crucial that the complaint be verified before you act on it further. Consequently, you should obtain as much evidence as possible before deciding whether a complaint is verified, either partially or completely. For each complaint the key phrase to remember is **document your case**.

There are a variety of methods which can be used to verify or document a complaint. These include:

1. Ask the nursing home administrator. By asking the administrator directly if a certain condition exists or if a particular incident occurred, you may receive an admission of wrongdoing on the part of the facility. This approach has a great deal of credibility because your objectivity cannot be questioned.

2. Observe the situation personally. This is an excellent technique because it offers firsthand information concerning the situation. If anyone asks you how you know that the problem is real, you can reply, "I saw it."

3. Examine official written documents. State and federal survey forms, state survey agency complaint investigation reports, and license applications can provide documentation in writing. This category also includes other pieces of evidence on paper, such as letters, billings, and legal documents.

4. Review resident records. If the resident grants permission, you can look at records which deal with care, dietary matters, activities, social services, and inventories of the resident's personal property.

5. Talk with other residents. The original complainant may lead to other people experiencing the same problem. If several alert residents give information about the same problem, it very likely exists. Statements by residents, however, are often attacked and easily discredited because institutionalized people are seen as unreliable and incompetent. Although this form of verification is not as solid as those discussed above, it does provide an opportunity to bring a problem to the attention of the facility without endangering an individual resident.

6. Question facility staff. In most cases when you talk with non-supervisory level staff (aides/orderlies, housekeepers, ward clerks, dietary helpers), you will have to assure confidentiality before they will provide information. Although an admission of a problem by these staff will not carry the authority of statements by the administrator or other official representatives of the facility, their statements may provide clues of where to find stronger evidence.

Occasionally you will find that a complaint cannot be verified. There may be no corroborating statements or the facts may even contradict the complaint. Handling these situations will require tact, as the resident may still be convinced that the problem is valid. The best management of such situations is to include the resident in the process of attempting

to verify the complaint. When that is not possible and you must present the results of your work to the resident, be careful to avoid those things which might make the resident believe you think he is foolish. A factual, detailed presentation is especially important when telling the resident that nothing can be done. You should also explain that not verifying the complaint does not mean that you question the honesty or sincerity of the complainant. Finally, you should discuss any alternative steps that might be available. For example, there may be another agency better suited to deal with the complainant's concern.

In some cases, you may believe that a case has merit despite the fact that you have been unable to verify it. It is also possible that you have been unable to get access to records or materials which might verify the complaint. This problem can be addressed in the following manner:

- Help the resident or complainant to represent herself. Explain there is little you can do at this time without further proof. Show the person how to document problems as they occur. Explain, if possible, the "chain of command" in the facility so the individual will know who to talk to if the problem comes up again. Leave telephone numbers and addresses of the Ombudsman program and other appropriate agencies for future contact.
- Do whatever can be done to resolve the complaint. Complaints can be resolved without verification in many cases. If the resident complains that the facility is slow to answer her call light, you can always discuss the problem with the director of nursing (provided the resident approves). This may cause the director of nursing to initiate her own investigation, or quietly resolve the problem.

The important point is that you should never represent something as a fact without verification. At the same time, verification should never be used as a tool for limiting attempts to resolve complaints. Rather, it is a self-protective device to keep State and local Ombudsmen from too vigorously pursuing unfounded complaints.

# Complaint Resolution

## INTRODUCTION TO THE OMBUDSMAN'S ROLE

Policy Considerations: Before we begin discussing resolving complaints, a review of relevant program policy is in order. It is important to remember that the resolution process must be conducted within the limits of these policies.

1. When possible, you must encourage residents to resolve complaints themselves. You will be encouraging self-advocacy and working to empower residents.
2. Keep the resident informed during the resolution process and allow the resident (or complainant) to withdraw the complaint any time.
3. When asked to act on behalf of a resident, you should first attempt to resolve the complaint within the facility by contacting the administrator or appropriate staff. Referrals to other agencies should be made only after the resident's permission has been obtained. You are also responsible for follow-ups on referrals.
4. Residents have a right to confidential treatment of records and information. All records and information obtained during an investigation or during the resolution process shall be held in confidence. Information may only be disclosed if the resident (or complainant), or a legal representative of such, consents in writing to the release of such information and specifies to whom the information may be released. Confidential information may also be released under a court order. However, an Ombudsman may release information if such a release has a justified purpose and does not disclose the identity of the resident/complainant. If you have any doubts about whether a particular piece of information should or should not be disclosed, consult your supervisor or the State Ombudsman.

## BUILDING TRUST

You cannot help in resolving a complaint unless you are trusted by residents, staff and administrators. There are some specific things you can do to help convince people that you are trustworthy.

### Techniques for earning trust

1. Let the parties explain their problem even when you have prior knowledge. Put yourself in the position of being educated. People want to state their positions and grievances. You can learn a great deal by letting the complainant or staff person do the talking and listening attentively.

2. Listen appreciatively and with understanding. Good listening communicates your acceptance of the speaker. Try to understand the events and experiences of the other individual and appreciate her point of view. Train yourself to be alert, interested and to hear exactly what the party is saying. Encourage the speaker to elaborate. Demonstrate your attention through eye contact, leaning forward, etc.

3. Be comfortable with silence. Unless a silence is so awkward that the speaker is uncomfortable, do not rush to fill the gap. Use silence to organize what you have heard and to gather more information. The speaker will usually try to fill the gap by elaborating on what has been said.

4. Use note-taking positively. Explain that you take notes so you can remember everything that is said. You can write down key works to jog your memory and expand on your notes afterward.

5. Reduce defensive communication. Ask questions in a way that actively supports open communication and reduces defensive responses.

    - *Describe, don't evaluate.* Avoid value judgments. Be careful not to judge the person by verbal or non-verbal expressions. Be descriptive without using value-loaded words.

- *Problem resolution, not control.* If you attempt to take control, you can intimidate the resident and antagonize the staff. Be open, convincing the parties that you are there to aid them in resolving problems and do not have a hidden agenda.
- *Empathy, not neutrality.* Neutrality does not mean being disinterested. You should exhibit concern for all parties, even if you do not agree with what they say. You may understand the administrator's problems but are primarily interested in resolving the resident's complaints. Over-identification with either the resident or staff may result in ineffectiveness as an Ombudsman.

*Do:*

1. Let the individual do the explaining.
2. Listen attentively and with understanding.
3. Hear exactly what is being said.
4. Be sensitive to sensory losses, memory lapses.
5. Restate to clarify and assure understanding.
6. Encourage the speaker to elaborate.
7. Concentrate on physically demonstrating your attention -- use posture, facial expressions, eye contact, gestures, and voice quality.
8. Be comfortable with silences.
9. Use silence positively.
10. Keep conversation moving with open-ended questions.
11. Repeat what has been said without adding or changing.
12. Empathize.

*Do Not:*

1. Make the complainant feel defensive.

2. Evaluate, make value judgments, accuse, correct or indoctrinate.
3. Appear judgmental in your posture or facial expressions.
4. Take control of the conversation. If you control, intimidate, or threaten, you lose credibility.
5. Create an impression of superiority. If you do, your usefulness will end.
6. Seem detached or disinterested. Neutrality is not the same as lack of concern.

## THE RESOLUTION PROCESS

Once a complaint has been investigated and verified, the next step in the complaint handling process is resolution of the problem. This simply means coming up with a solution. Sometimes you will develop a solution which you can try to "sell" to the respective parties; at other times you may have to bring people together and help them work out the solutions that are meaningful to them. The important point is that the solution has to "fit" the problem. For example, helping a resident search for lost clothing may be a nice thing to do, but it does not provide a lasting solution to a problem of mishandling of laundry or personal possessions.

This process may require you to adopt a variety of roles, depending on the type of solution that seems appropriate. The major roles are: broker, mediator, educator, planner and advocate.

1. *Broker:* Refers the complaint to an outside agency. Referrals may be made before or after your investigation, depending on the nature of the problem.
2. *Mediator:* Works with two opposing sides to bring them together to resolve a dispute. In this position you do not take sides; but facilitate discussion and the exchange of information to settle the complaint.

3. *Educator:* Provides information about the law and applicable policies. For example, you can point out to people how the nursing home regulations relate to a specific condition.
4. *Planner:* Identifies the people (e.g., operator, facility administrator, the complainant) who will be responsible for carrying out a plan of action. You can discuss with people what steps need to be taken to accomplish a desired change.
5. *Advocate:* Works on behalf of the complainant to argue his cause. The advocate differs from the mediator in that the advocate takes a partisan stance on behalf of the resident.

It is not unusual for an Ombudsman to receive several complaints against different facilities which are related to the same problem. For example, you may discover that many residents are being illegally evicted from facilities after voicing complaints about their facilities' conditions or policies. Such cases may require action on a system wide basis and should be discussed with your Supervisor, a State Ombudsman Representative or the State Ombudsman. Resolution of such problems may require action at the state level.

Complaints may be resolved in many ways. Most are resolved by simply speaking with the staff or administrator of a facility, but there are many forums other than the home which may be used to resolve a complaint. The facility, regulatory agency, public benefit agency, local media, community, courts, legislature and network of agencies serving older people can all be used to resolve complaints. Resolution through forums outside the home will be discussed in more detail later in this module. The following section will focus on the complaints you will resolve within the facility.

It is important to recognize when a solution to a problem or an agreement has been reached. Some people get so involved in investigation or negotiation they fail to realize that they have won their point or solved the problem.

On the other hand, you should also recognize when no satisfactory solution is forthcoming within a specific time frame. Discuss with your supervisor, who in turn may wish to call the State Ombudsman Representative or the State Ombudsman to determine the next steps to be taken. You should have a set of procedures with the time frames for resolution within the facility, for intervention by the State Ombudsman, for contacting the regulatory agencies, etc., when such action is necessary. You should agree on what constitutes an emergency or life threatening situation and how to handle it if it occurs.

When the same grievance continually recurs, it is time to discuss this with your supervisor or the State Ombudsman rather than handling the same complaint repeatedly.

## COMPLAINT RESOLUTION STRATEGIES

As a person working on behalf of nursing home residents and their interests, you will need to become familiar with a variety of techniques for resolving complaints. Some of these techniques are especially suited for handling individual problems. Since resolving the complaints of individual residents is your fundamental job, you should be as familiar as possible with such techniques.

The resolution strategies discussed below are listed in order of increasing formality and difficulty. As you attempt to resolve problems at the facility level, it is generally a good idea to attempt the less formal remedies before trying the more formal ones.

- *Self-advocacy* is an important potential remedy which you should urge complainants to perform when possible. This approach fits the Ombudsman roles of educator and planner. When people are able to resolve their own problems, they become more confident and less dependent. Self-advocacy is a strategy which empower the complainant.

An excellent way to encourage self-advocacy is to help residents voice concerns and resolve problems through use of the resident council. In some nursing homes, resident councils have been very effective in relating opinions and feelings to administrators, resulting in changes in the facility. In other homes, the resident council may be little more than an alternative activity to bingo. The more independent the council is of staff involvement, the more likely it can be useful in solving problems. You will have to evaluate each council to determine whether it is an appropriate forum for resolving complaints.

- *Mediation* is a process by which you attempt to get the complainant and the appropriate facility personnel to meet together and develop a mutually agreeable compromise. This can be a difficult role, since both parties sometimes use the mediator as a target for their bad feelings. In some cases the parties may have different goals they want to achieve, while in other cases both parties may agree on the goals but disagree on how to reach them. A mediator is essentially a facilitator, trying to encourage open communication and helping both sides find as much common ground as possible.
- *Negotiation* is bargaining with another party in an effort to arrive at a binding agreement. It is a strategy you will probably use often, as you will negotiate with the facility staff.

You are likely to discover, however, that similar complaints will recur time and again. The same complaint(s) may be repeatedly voiced against a particular nursing home. For example, you may discover that over several months there may be twelve complaints registered about shortage of staff at a given nursing home. In such cases, you will be able to work more effectively by treating these complaints as a single issue. You will be able to make a better case against the nursing home by combining the complaints, and time can be saved by not dealing with each problem individually on behalf of a resident or group of residents. To many people negotiation implies an adversarial relationship. However, it need not be a tactic of confrontation. Negotiation can actually avoid confrontation with

the other party by clarifying the consequences of a continued course of action. Negotiating in a long term care facility will generally occur with the administrator or operator. In negotiations it is critical for you to know whom you are representing, what problems you want to solve, and what may be acceptable solutions. Negotiations should not be entered into without knowing what can and cannot be done by all parties to achieve the desired results.

Before a formal negotiating session, you should prepare an agenda so that you do not get sidetracked from the items you want to discuss. If the facility spokesperson promises that certain things will be done, you should ask for a timetable by which they will be carried out. If the solution to a problem involves a major change in facility policy or is dependent on promises made by the facility, you may want to ask for a written agreement. It is always a good idea to follow any formal session with a letter summarizing the results. Any actions agreed to should be monitored to determine if, in fact, the changes are made.

## A New Approach to Negotiation: Getting to Yes

A few years ago the Harvard Negotiation Project developed an alternative negotiating strategy in a book called Getting to Yes. The book is an excellent resource for Ombudsmen, since the role of negotiator is perhaps the one most often adopted in resolving complaints within the facility.

The general principle of Getting to Yes is that in order to negotiate successfully, you should not bargain over positions. The traditional method of negotiation involves each side taking a position, arguing its merits, and compromises being reached. Unfortunately, compromises are often difficult to find and may leave both parties less than satisfied.

Positional bargaining, as this type of negotiation is called, is often done from a "hard" or adversarial standpoint. In other cases, such as when the parties know they must maintain an ongoing relationship, the bargaining may be "soft." Both of these approaches cause problems, as indicated by the following chart:

## Positional Bargaining

*Soft*

1. Participants are friends. The goal is agreement.
2. Make concessions to cultivate the relationship.
3. Be soft on the people and the problem. Trust others.
4. Change your position easily. Make offers.
5. Disclose your bottom line.
6. Accept one-sided losses to reach agreement.
7. Search for the single answer: the one they will accept.
8. Insist on agreement.
9. Try to avoid a contest of will.
10. Yield to pressure.

*Hard*

1. Participants are adversaries. The goal is victory.
2. Demand concessions as a condition of the relationship.
3. Be hard on the problem and the people. Distrust others.
4. Dig in to your position.
5. Make threats.
6. Mislead as to your bottom line.
7. Demand one-sided gains as the price of agreement.
8. Search for the single answer: the one you will accept.
9. Insist on your position.
10. Try to win a contest of will.
11. Apply pressure.

Arguing over positions produces unwise agreements, is inefficient, and endangers on-going relationships. The alternative, according to the Harvard group, is a method they refer to as principled negotiation or negotiating on the merits.

## Principled Negotiation

*Negotiate on the merits*

Participants are problem solvers.
The goal is a wise outcome reached efficiently and amicably.

*Separate the people from the problem*

Be soft on the people, hard on the problem.
Proceed independent of trust.

*Focus on interests, not positions*

Explore interests.
Avoid having a bottom line.

*Invent options for mutual gain*

Develop multiple options to choose from; decide later.

*Insist on using objective criteria*

Try to reach a result based on standards independent of will.
Reason and be open to reason; yield to principle, not pressure.

The single most important concept of this negotiating method is keeping in mind that your goal is to solve the problem, not to score debate points or outsmart the other party. Separating the people from the problem is a key part of this concept. Be aware the other person probably perceives the situation differently than you do. Recognize and understand the emotions you both may feel about the situation. Do not react to emotional outbursts. Let the other side let off steam. Use active listening. Phrase your proposals in terms of what you think will solve a problem, not in terms of what they should do. These techniques should be helpful in allowing you to build a working relationship wherein you can discuss problems frankly without bringing personalities into the dispute.

Another major part of this method is focusing on interests, not positions. Try to get beyond positions to the underlying interests. Ask why or why

not? Realize each side has multiple interests. Some are likely to be compatible, others conflicting. The compatible ones can form the basis of a solution.

A third part of the process, and one that is often overlooked in problem-solving, is the invention of a wide range of options. Look for solutions which allow both sides to gain something (as opposed to compromises where both sides lose something). Do not be wedded to a single solution. Try to develop a win-win solution based on shared interests.

A final important point is the use of objective criteria. The search for a solution can begin with a search for an objective or fair standard by which to judge the problem. Written rules, laws, outside experts, etc., can form the basis for a solution.

Keeping these points in mind can help you to avoid some of the common pitfalls of negotiating when you must confront someone about a problem. As with the complaint handling process, experience will enable to you adapt these negotiating principles and to use them in the way that best suits your style.

## REPORTING ABUSE AND NEGLECT

All representatives of the State Ombudsmen Program (i.e. all designated Long Term Care Ombudsmen who are employees or certified volunteers of LTCOP at the State or Sub- state level) must report any actual or suspected fraud or resident abuse, mistreatment, or neglect that they personally witnessed or had reported to them to the sub-state program coordinator. Such reports, subject to the confidentiality requirements must be made as soon as possible by telephone and confirmed in writing as soon thereafter as possible

If the Ombudsman cannot reach the Sub-state Coordinator or his/her supervisor in the Office of the State Ombudsmen within 24 hours of the time the alleged incident occurred or was reported to them, the Ombudsman must report it directly to the appropriate regulatory agencies. The

Sub-state Coordinator must provide a written procedure for his/her Ombudsmen volunteers to follow in such a case. Note: All reports made by Ombudsmen must keep the identity of any complainant confidential unless the person consents to having his/her identity shared.

## OTHER COMPLAINT HANDLING STRATEGIES

RSDOH will often be called upon to investigate complaints. Since this agency has the power to enforce State and Federal regulations, you should become familiar with its complaint procedures. The more detailed a complaint is, the better the chance that it will be verified by the regulatory agency and eventually resolved. If there is evidence of a trend at the facility, it should be included in the complaint so the investigators can be alert to more widespread problems in the facility.

It is also useful to become acquainted with employees of these agencies in your area, so problems may be discussed in an informal manner. Creating and maintaining such a relationship offers the possibility of a three-fold benefit. First, regulators have legal authority not possessed by Ombudsmen. Second, frequent contact with the agency may serve as a form of subtle pressure which can lead to a more responsive bureaucracy and therefore to an improved regulatory system. Third, once such a relationship has been established, many problems can be solved through informal contact, such as a telephone call.

Community intervention, while not generally a tool for resolving individual complaints, can be an effective tool for resolving problems and keeping others from occurring. The community intervention strategy is based on the assumption that a nursing home, because it is a service to the community and because it is funded largely with public money, operates with the tacit approval of the community power structure. Since this approval will sometimes allow a facility to provide low quality care, the idea behind this strategy is to build a consensus within the power structure that high quality long term care facilities are a necessity.

Ombudsmen should be aware of social services agencies, area agencies on aging, city council people, the medical community, the legal community, and other community resources which can be called upon to assist with both individual complaints and with broader issues.

Litigation may also be a viable complaint resolution strategy if other attempts to resolve a problem have failed. Referral to an attorney may be especially appropriate if the case involves a violation of a resident's legal rights. You should be aware of what legal services are available to older people in your community. The legal services developer in the Office for Aging can refer you to these kinds of services. Referring a complainant to an attorney should be done only after discussion with your coordinator and should be clearly stated as an option the complainant may choose to exercise, not a recommendation that she take legal action.

Finally, there are two factors which you should keep in mind while attempting to resolve a complaint.

- Some complaints cannot be solved. This can happen in spite of a thorough investigation, unquestionable verification, and a wise and persistent course of action during the resolution process.
- Complaint resolution is not always clear-cut. In some cases a problem will go away, and then reappear. In other situations, some parts of the problem will be taken care of, but not others. In some instances the complainant will not be completely convinced that the situation is as good as it should be, while at other times the complainant will say that everything has been solved regardless of your desire to pursue the matter further. Most cases become less "black and white" the more they are examined, so it is possible that you will handle many cases which you can only call partially resolved.

# Monitoring Complaint Resolution

You should have a program to follow-up on complaint resolution. The purpose of follow-up is to:

1. verify that resolution of the complaint has occurred;
2. assure the complainant that everything possible has been done;
3. monitor the performance of the program; and
4. detect any deficiencies in long term care standards.

Complaints should be followed up at one or two regular intervals. This may range from a few days to several months after resolution, depending on the nature of the complaint. If the problem is recurring or the agreed upon solution was not put into effect, it may be necessary to reopen the case. At this point you should determine what went wrong and take further action. If the complaint resolution has been implemented and the case remains closed, you can elicit feedback from the complainant.

# Confronting Authority Figures

An authority figure could be any of the following: the head of an agency, an elected or appointed official, a nursing home administrator or owner, or anyone who is in a position to hurt or help you or your clients. You, too, may be perceived as an authority figure because of your knowledge, experience, status, training, or position.

The purpose of this section is to focus on the discomfort many people feel when they must, as part of their work as Ombudsmen, challenge an authority figure.

## PEOPLE IN AUTHORITY: THEIR FUNCTIONS

In the private sector, an authority figure may be a corporate president, a public relations office for a trade association, or (to clients) the receptionist at the telephone company who must collect a deposit before she will arrange to have your telephone installed. Such people often "speak softly" yet "carry a big stick." They wield power, money, influence, and have a great deal of arbitrary, often undefined, discretionary authority.

## PERCEIVED VERSUS ACTUAL AUTHORITY

You must choose the correct approach toward a person who is perceived by others to be an authority figure. A person may wield authority due to his status in society or the position she holds. For example, a judge has the power to levy sentence if court decorum and protocol are not followed. Deference must be paid to such authority figures as a matter of courtesy, survival, professional conduct, etc. However, an advocate has the right and obligation to challenge inappropriate, illegal, unjust, or negligent acts of any authority figure.

A person may actually be able to officially wield very little authority, yet his demeanor makes the person appear to be powerful. Posture, dress, snobbishness, elitism, the old-boy network and cliques can be part of

the "picture" which gives the illusion of authority. However, advocates would do better to be able to cite sources of facts, references, laws, or statistics that forward their case, rather than "posture."

## REACTIONS TO AUTHORITY FIGURES

Three common reactions to those who have the power to influence outcomes are avoidance, awe, and anger.

*Avoidance:*

It may take weeks or months for agencies to process complaints or for courts to process cases, yet many persons immediately seek such remedies without first confronting the person directly responsible for the problem. Why? Because they think it won't work, dread failure, and dislike face-to-face confrontation, especially on someone else's "turf."

*Awe:*

Ironically, many persons may gripe about officials and corrupt politicians in private but cannot always be counted on to put their grievances in writing or to stand up at a public hearing. Many people are easily intimidated by a gavel or even an imposing tone of voice. Ombudsmen, too, can be seduced into a "cozy" relationship with the opposition. Certain professions such as doctors have an aura about them that is difficult to dispel.

*Anger:*

It is frustrating to deal with officials or staff persons who fail to share your viewpoint. Some may even attempt to disguise their self-interest as concern for residents. Having to confront such persons on a regular basis can be quite stressful and may lead to anger or to "burnout." Creative brainstorming and problem solving sessions are a necessity in such circumstances, not a luxury.

## APPROACHES TO CONFRONTING THOSE IN AUTHORITY

The effective Ombudsman should have a repertoire of approaches to be considered ranging from the "soft sell" to "soft pedaling," from "consensus," from legal actions to simply citing the law. The most powerful approach is to encourage those in positions of responsibility to fulfill their public trust. If you can show an administrator a resident's right in black and white as stated in standards or statutes, there is a good chance that he will capitulate or be won over. The law is a very powerful tool which the Ombudsman must know and call upon.

Ombudsmen should be sensitive to people's needs for respect, understanding, patience, and good humor. A nursing home administrator has a difficult job and has had to meet certain requirements to get it. Acknowledging her expertise and responsibilities can help you to communicate. When you feel defensive and worried that you will be hassled or get the runaround, your attitude may be unconsciously demanding or curt.

*Four tips for dealing with authority figures*

1. Make an objective assessment of the individual to find out if he will be an ally or an adversary.
2. Size up the prejudices, preferences, and decision-making patterns exhibited by the authority figure and study her overt and covert influence.
3. Be aware of the appeal process and the chain of command if a person in authority renders an unfavorable decision.
4. Be aware of the policies, guidelines, rules, regulations, and laws that govern the authority figure, as well as those he is in charge of or can control.

## ASSERTIVENESS AS AN ATTITUDE

An Ombudsman must represent a resident's interests in a strong, but sensitive manner. When making inquiries on behalf of a resident it is

important that you gain the respect of those you deal with. It is also important that you express the needs and desires of the resident, without alienating others on whom the resident may depend for services.

Assertiveness is an attitude and a technique which allows a person to express views and stand up for rights without violating the rights of others.

Acting assertively will increase self respect and confidence. Some people will sometimes disapprove of assertive behavior. However, respect and admiration can be gained by being responsibly assertive, showing respect for self and others, having the courage to take stands, and dealing with conflict openly and fairly. Perhaps most importantly, assertion--more frequently than non-assertion--results in individuals getting their needs satisfied and preferences respected.

*Assertiveness* involves standing up for oneself or another person in such a way that the basic rights of another person are not violated. It involves direct, honest, and appropriate expression of one's feelings, opinions, and knowledge. Assertion involves respect, not deference, both for oneself and for the other person.

*Aggressiveness* is standing up for oneself or another person in such a way that the rights of another person are violated. It involves humiliating, degrading, belittling or overpowering other people. The goal of aggressive behavior is usually domination or winning, not simply the honest expression of your own feelings. It involves a lack of respect for or deaming the other person.

*Passiveness* is failing to stand up for oneself or another person, or standing up in such an ineffectual manner that one's rights are easily violated. The goal of passiveness is usually to avoid conflict at any cost, or to gain approval of others. It involves a lack of respect for oneself (or one's position).

What process does an advocate go through to produce an **assertive attitude?**

1. Validate the point of view of the other person. That is: acknowledge what the other person is saying -- the point they are making.
2. State your own problem, issues, or position. Be very clear and concise in this description.
3. State what you want. Clearly define the result you want to obtain. Have in mind the minimum you will settle for but do not reveal that until necessary in negotiating.

## Methods of assertion

*Simple Assertion*

- Statement of fact
- Refers to yourself or your wishes
- Appropriate, not rude

*Empathic Assertion*

- Gives recognition and appreciation of the feeling or position of the other person, without giving up your own.
- Shows respect, concern, and mutuality of goals.
- Combines sensitivity and firmness.
- Allows the speaker to understand the other person's point of view, thus keeping perspective and reducing the possibility of overreacting.

*Pointing Out Discrepancies*

- Focus on the behavior (not the motives) of the other person.
- Point out discrepancies between: what was promised, and what was done; what was said before and now; what was agreed upon, but not done.
- Pointing out a problem without accusing another.

*Escalation of Assertions*

- Starts out with the minimum force necessary to get your point of view across. If your rights are still not being respected, the firmness is increased, and the tone of voice becomes more action-oriented.

*Broken Record*

- Calmly repeat what you are after, while validating the feelings of the other.

*Sidestepping*

- Acknowledges the possibility that the other person has a valid (though irrelevant) point, while continuing to assert your point and advancing the conversation rather than stalling it. Allows the speaker to avoid becoming defensive by sidestepping criticism.

# Role Play Exercises

**Role Play #1**

## INTRODUCTION TO THE FACILITY ADMINISTRATOR

*Roles:*

Ombudsman

Local Coordinator (Supervisor)

Administrator

*Situation:* The Local Coordinator is taking a new Ombudsman to a Nursing Facility to introduce him to the Administrator. Upon greeting the administrator, his reaction is "You know we already have the State Health Department surveying us and they think we're doing a great job. Why do we have to have someone else checking up on us?"

**Role Play #2**

## INTRODUCTION TO THE NURSING STAFF

*Roles:*

Ombudsman

Nurse

*Situation:* It is the Ombudsman's first day alone on the job. Upon entering the assigned floor, the Head (Charge) Nurse greets the Ombudsman. "Hi, we knew you were coming, but could you tell us exactly what you plan to accomplish?"

**Role Play #3**

## INTRODUCTION TO THE RESIDENT

*Roles:*

Ombudsman

Resident

*Situation:* It is the Ombudsman's Introductory Visit to a resident that is 81 years old.

## Optional Role Play Exercise

*Roles:*

Ombudsman

Resident (as played by the Coordinator)

Time Keeper with a second watch

*Situation:* The Coordinator plays a Resident. Each new trainee is given ONE MINUTE to meet, interview and address the Resident's Problem. At the end of each Role Play, the class will list all the POSITIVE aspects of the interview.

The Resident is 81 years old, lived in the facility for 2 years, has one child and ONE OF THE FOLLOWING CONDITIONS:

1. Is friendly and glad to meet the Ombudsman.
2. Is overly friendly (and touchy) with an Ombudsman of the opposite gender.
3. Is Aphasic (cannot talk due to a stroke).
4. Is Antisocial (will not talk ... not one word).
5. Chases flies for a whole minute and pretty much ignores the Ombudsman.
6. Has a sore on the foot and insists the Ombudsman must examine it NOW!
7. Answers every Ombudsman question with a question.

8. Hates the food... everything is white on the plate.
9. Swears the nurses aide is stealing her clothes.
10. Wants to go home, NOW!!
11. Becomes weepy, because the child never comes to visit.
12. Is angry because the child never comes to visit.
13. Wants more activities, is tired of watching TV Game Shows.
14. Swears that the Administrator is out to get him.
15. Has not had their nails (hand or toe) cut in over a month.
16. Is wet all the time.
17. Wants to keep her monthly $50 Personal Needs Allowance in her dresser drawer.
18. Would like the Ombudsman to take her home for a Holiday Dinner.
19. Can't get transportation downtown to buy some new clothes.
20. Has a bruise on her leg, but isn't sure how it got there.

**Role Play #4**

## FOOD COMPLAINT

*Roles:*

Ombudsman

Resident

*Situation:* Food is the #1 complaint of Nursing Facility Residents. You have been called in to see Mrs. Ruttabager who states; "I pay $6000 per month to live here and can't even get a baked potato that's cooked all the way through."

**Role Play #5**

## THE DEPRESSED RESIDENT

*Roles:*

Ombudsman

Resident

*Situation:* A new resident bursts into tears when approached by the Ombudsman. The resident is "fearful" because he "can't remember anything" anymore.

**Role Play #6**

## THE SUSPICIOUS RESIDENT

*Roles:*

Ombudsman

Resident

*Situation:* As the Ombudsman knocks on the resident's door, the resident is searching the room. The resident exclaims, "Thieves, thieves! People are always stealing my things!"

**Role Play #7**

## THE MISSING CHECKS

*Roles:*

Ombudsman

Resident

Resident's Niece/Nephew

Facility Bookkeeper

*Situation:* You have called a meeting, because the resident's niece/nephew has not been depositing the resident's $50 in his Personal Needs Account. The resident has not had his hair cared for in 3 months!

**Role Play #8**

## PATIENT ABUSE

*Roles:*

Ombudsman

Resident

Resident's Daughter

Others: ie, Nurse or Administrator or Aide

*Situation:* The resident's daughter has sought your assistance at a meeting in the Facility. She states that she frequently sees bruises on her mother's (the resident's) wrists. However, the resident, who is competent, insists that "no one can be told."

**Role Play #9**

## LOVE AND MARRIAGE

*Roles:*

Ombudsman

2 Loving Residents

Administrator

*Situation:* The Administrator at the Open Arms Nursing Facility has told two marriage bound residents, "Yeah, you can get married, as long as your children give permission. And, I'm not sure you'll be able to room together"

**Role Play #10**

## CHEMICAL RESTRAINT

*Roles:*

Ombudsman

Resident

Resident's Daughter

Physician

*Situation:* You have called a meeting to explore the complaint of a resident's daughter. The resident's physician has prescribed heavy sedatives (Seconal) following Nursing Staff complaints that the resident was up late at night and wandering the halls. The physician insists the medication will make the resident "easier to care for." The resident now complains of blurred vision and walking problems during the day.

**Role Play #11**

## YOU CAN NEVER FIND A BANK WHEN YOU NEED ONE

*Roles:*

Ombudsman

Resident

Social Worker

*Situation:* While visiting a resident of an Adult Care Facility, you notice there are $20 bills attached up and down the back of the curtains, the back of a tablecloth and under the bedspread. The resident says that she "grew up in the Depression and doesn't trust banks." The resident keeps the money "spread out, so it won't get stolen all at once." You call in the Social Worker to try and convince the resident to put the money in the bank.

**Role Play #12**

## THE GROUP COMPLAINT

*Roles:*

Ombudsman

3 Residents

Dietician (Optional)

*Situation:* A group of residents has called the Ombudsman into a meeting at a Nursing Facility. Breakfast has been moved from 8 am to 7 am. The residents really don't want to get up that early.

*Follow Up Questions:*

1. Do the residents really have a say in this policy?
2. What approaches to this problem can the Ombudsman take?
3. If the facility agrees to serve breakfast in the resident's room at 7 am, would this be an acceptable solution?
4. In the completion of the Ombudsman Action Forms, would the Ombudsman complete one or three separate forms?

**Role Play #13**

## LATE NIGHT TELEVISION

*Roles:*

Ombudsman

Resident (40 years old)

Administrator

*Situation:* A 40 year old resident of an Adult Care Facility would like to watch television in the Lounge. The Administrator has stated that the Lounge must be closed at 8pm because the noise from the television keeps other residents awake.

# Nine Basic Principles in the National Ombudsman Reporting System (NORS) for Documenting Complaints and Other Inquiries

## THE THREE C'S: CASE, COMPLAINT, CONSULTATION

1. A case includes one or more complaints brought to, or initiated by, the ombudsman in which the ombudsman is actively involved and/or which the ombudsman investigates and works to resolve. (There may be complaints in which the ombudsman is actively involved which another agency investigates and also helps resolve.) The number of cases is equivalent to the number of complainants. (One or more people jointly filing a complaint count as one complainant.)

2. A complaint is a concern brought to, or initiated by, the ombudsman for investigation and action a) on behalf of one or more residents and b) relating to the health, safety, welfare or rights of a resident. One or more complaints constitute a case. You cannot have a case without a complaint.

3. A consultation is providing information and assistance to an individual or a facility. It does not involve investigating and working to resolve complaints (i.e., consultation is not a case). If the ombudsman refers someone with a concern to another agency and is not actively involved in investigating and working to resolve the problem, it is not an ombudsman case or complaint. However, it can be counted as a consultation.

## CODING COMPLAINTS

4. For each complaint (problem) there must be only one complaint code. The ombudsman must choose the one code which best fits the problem.

5. Codes 1 through 102 (groups A-M) are for complaints against the facility; codes 103-116 (groups N and O) are for complaints against the state licensing, certification and Medicaid agencies; codes 117-128 (group P) are for complaints against or involving individuals who are not managers/staff of facilities or of the state's licensing and certification agency (except for code 119); codes 129-133 (group Q) are for complaints about services in settings other than long-term care facilities or by outside providers.

6. Use categories in Group A — Abuse, Gross Neglect, Exploitation — only for a) serious complaints of willful mistreatment of residents by facility staff, management, other residents or unknown or outside individuals who have gained access to a resident through negligence or lax security on the part of the facility, or b) neglect which is so severe that it constitutes abuse. Do not use a NORS code to document an allegation of abuse or any other complaint unless it is a complaint made to the LTCOP for which ombudsman involvement and action is required.

7. Do not use the "other" categories unless there is no other category that comes close to describing the nature of the complaint.

## VERIFYING COMPLAINTS, CODING COMPLAINT DISPOSITION AND CLOSING A CASE

8. Ombudsmen always attempt to verify complaints, but they work to resolve a complaint, whether it is verified or not. Definition of verified: It is determined after work (interviews, record inspection, observation, etc.) that the circumstances described in the complaint are substantiated or generally accurate.

9. For each complaint, whether verified or not, there must be a disposition: a) policy, regulatory or legislative change required to resolve; b) not resolved; c) withdrawn by resident or complainant; d) referred to other agency for resolution and 1) report of final disposition not obtained or 2) other agency failed to act; e) no action needed or appropriate; f) partially resolved but some problem remained; g) resolved to satisfaction of resident or complainant. Note: If a complaint is referred to another agency for resolution and the other agency acts on the complaint and notifies the ombudsman program, the appropriate code would be used (i.e., resolved, partially resolved, not resolved, etc.), as it would be had it not been referred.

10. A case is closed when ombudsman activity on a case has stopped for any of the following reasons: resolution or partial resolution; by request of complainant; complaint(s) unresolvable; complaint(s) not verified; resident died and no further investigation was required; or complaint(s) referred to other agency for resolution and final disposition was not obtained and/or reported to ombudsman.

*Provided by the Administration on Aging, Office of Consumer Choice and Protection, March 2004*

# Long Term Care Ombudsman Program Complaint Codes

## A COMPLAINT IS ABOUT A PROBLEM OF COMMISSION OR OMISSION

Each case may have more than one complaint. However each problem will have only one code. These codes will be used on the Ombudsman Case Form (located in the Appendix). Use only one category for each type of problem (i.e., do not check both A.3 and D.26 for the same staff behavior - determine which category is most appropriate to the particular problem).

## RESIDENTS' RIGHTS

### A. Abuse, Gross Neglect, Exploitation

Use categories in this section only for serious complaints of willful mistreatment of residents by facility staff, management, other residents (use category 6) or unknown or outside individuals who have gained access to the resident through negligence or lax security on the part of the facility or for neglect which is so severe that it constitutes abuse. Use P.117 and P.121 for complaints of abuse, neglect, and exploitation by family members, friends and others whose actions the facility could not reasonably be expected to oversee or regulate.

For all categories in this part, use the broad definitions of abuse, neglect and exploitation in the Older Americans Act, which is almost identical to that in regulations for nursing homes participating in the Medicare and Medicaid programs (42 CFR 488.301):

The term abuse means the willful (A) infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical

harm, pain or mental anguish; or (B) Deprivation by a person, including a caregiver, of goods or services that are necessary to avoid physical harm, mental anguish, or mental illness. (Older Americans Act, Section 102 [13])

The term (financial) exploitation means the illegal or improper act or process of an individual, including a caregiver, using the resources of an older individual for monetary or personal benefit, profit or gain. (Older Americans Act, Section 102[24]) In addition to the above broad definitions, use the definitions for specific categories below from the Centers for Medicare and Medicaid Services (CMS; formerly HCFA) Interpretive Guidelines, section 483.13(b) and (c).


Use resident-to-resident physical or sexual abuse (A.6) only for willful abuse of one resident by another resident, not for unintentional harm or altercations between residents who require staff supervision, which should be coded in category I-66, "Resident conflict, including roommates." (For example, a confused resident who strikes out is categorized at I.66 and an alert resident who strikes out is A.6.)

1. *Abuse, physical*: Includes hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment.

2. *Abuse, sexual*: Includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.

3. *Abuse, verbal/psychological (including punishment, seclusion)*: Use of oral, written, or gestured language that includes disparaging and derogatory terms to residents or to their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability. (Use D.26 for less severe forms of staff rudeness or insensitivity; use M.100 if staff is unavailable, unresponsive to residents.) Psychological or mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation. Involuntary seclusion means the separation of a resident from other residents or from

his/her room against the resident's will or the will of the resident's legal representative. Emergency or short-term monitored separation is not considered involuntary seclusion if used for a limited period of time as a therapeutic intervention to reduce agitation.

4. *Financial exploitation (use categories in E. for less severe form of financial complaints)*: The illegal or improper act or process of an individual, including a caregiver, using the resources of an older individual for monetary or personal benefit, profit or gain.

5. *Gross neglect*: The willful deprivation by a person, including a caregiver, of goods or services that are necessary to avoid physical harm, mental anguish, or mental illness. (Use only for the most extreme forms of willful neglect. Use the appropriate categories under Resident Care, Quality of Life or, in some cases, Administration for less severe forms or manifestations of resident neglect.)

6. *Resident-to-resident physical or sexual abuse*: Use only for complaints of abuse by a resident against one or more other residents that meet the definitions of abuse provided above. (For unintentional harm or altercations between residents who require staff supervision, use category I-66, "Resident conflict, including roommates.")

7. *Other, specify*: Use for any other complaints regarding any type of abuse, neglect, exploitation perpetrated by an individual, including a caregiver, which would not fit under other codes in this section and meet the definitions of abuse or neglect, above.

## B. Access to Information

Use categories in this section for complaints involving access to information or assistance made by or on behalf of the resident or the resident's representative. Use B.9 if the ombudsman is denied access in response to a complaint. Categories B.14, D.29, and M.96 all involve communication/language barriers and yet are different. Use B.14 if information regarding

rights, medical condition, benefits, services, etc. is not communicated in an understandable language.

8. *Access to own records*: Use if complainant is denied or delayed access to resident's record.
9. *Access to ombudsman/visitors*: Use if ombudsman or visitors are denied access to a resident.
10. *Access to facility survey*: Use if the licensing and certifying agency's survey is not posted in a prominent place or not provided when requested.
11. *Information regarding advance directive(s)*: Use related to living will, do not resuscitate (DNR) order, and similar problems.
12. *Information regarding medical condition, treatment and any changes*: Use if information is denied, delayed.
13. Information regarding rights, benefits, services: Use related to resident rights, Medicaid information/process, social services, and similar problems.
14. *Information communicated in understandable language*: Use if information is not provided in a language which the resident or her representative can understand or is provided in a confusing manner.
15. *Other, specify*: Use if other information is denied or inaccessible.

## C. Admission, Transfer, Discharge Eviction

Use the appropriate category for complaints involving placement, whether into, within or outside of the facility. If resident requests assistance in transferring to another facility and there is no stated problem (complaint), record as information and assistance to individuals in Part III, Other Ombudsman Activities. If a resident requests assistance in moving out of the facility but there are no feasible alternative options, record as P.128 "other," since the problem is a lack of care alternatives within the long-term care system.

16. A*dmission contract and/or procedure*: Use if no contract; contract contains illegal wording requiring waiver of rights or guarantee of payment; admission procedure not followed; admission procedure does not contain required elements, and similar problems.

17. *Appeal process —absent, not followed*: Use if resident/representative not given required number of days to appeal a discharge; facility failed to follow appeal ruling; no appeal process in place; and similar problems.

18. *Bed hold—written notice, refusal to readmit*: Use if bed not held required number of days; resident/representative not advised of bed hold policy; incorrect bed hold procedure; bed held but resident not readmitted, and similar problems.

19. *Discharge/eviction-planning, notice, procedure, implementation*: Use if no discharge notice; required notice not given to resident/representative; required notice not given to the ombudsman program in required time frame; required notice lacks documentation, is incomplete, incorrect; discharge is for inappropriate reasons; discharge planned to inappropriate environment; and similar problems.

20. *Discrimination in admission due to condition, disability*: Use for refusal to admit resident due to medical condition, disability.

21. Discrimination in admission due to Medicaid status: Use if resident not admitted due to Medicaid status or pending Medicaid status.

22. *Room assignment/room change*: Use if resident wants room change or resident objects to planned room change; no notice or inadequate notice of change; excessive room changes; or similar problems.

23. *Other, specify*: Use for any other admission, transfer, or discharge complaint.

## D. Autonomy, Choice, Exercise of Rights, Privacy

Use for any complaint involving the resident's right, as stated in the category. If it is a related problem, but not one specific to this heading, use a category under another heading. For example, if the resident is permitted to choose her personal physician but that physician is unavailable, use P.125.

Note that D.29, B.14 and M.96 all involve communication/language barriers and yet are different. Use D.29 if the resident has a communication or language barrier. Use M.96 if staff has the communication or language barrier.

Use D.27 for right to smoke. Use K.77 for smoke-polluted air.

24. *Choose personal physician/pharmacy:* Use when the resident is denied the right to choose her own physician/pharmacy.

25. *Confinement of facility against will (illegally):* Use when the resident is denied the right to leave the facility or go out. (Use P.128 "other" for resident requests for assistance in moving out of the facility when feasible alternative options are not available.)

26. *Dignity, respect—staff attitudes:* Use when resident is treated with rudeness, indifference or insensitivity, including failure to knock before entering room, facility posts signs relating to individual's care and similar problems.

27. *Exercise preference, choice and/or civil/religious rights (includes right to smoke)*: Use when the resident is denied choice and exercise of rights; for example: voting; speaking freely; access to a smoking area, preference in sleeping and rising times, community activities, the outdoors, television program of choice and similar problems. (Use D. 31 for rights involving privacy.)

28. *Exercise right to refuse care/treatment*: Use if the resident is denied the right to refuse care/treatment; including resident's right to refuse eating, bathing, or taking medication.

29. *Language barrier in daily routine*: Use if resident speaks a language others cannot understand, resident cannot communicate.

30. *Participate in care planning*: Use if the resident or the resident's representative is denied access to or not informed of a care plan/care plan meeting.

31. *Privacy—telephone, visitors, couples, mail:* Use if the resident is denied access to a telephone, visitors or mail; phone calls are monitored; mail is opened by someone other than the resident or the resident's legal representative; couples denied privacy.

32. *Privacy in treatment, confidentiality*: Use if the resident is denied privacy in treatment; confidential information has been disclosed.

33. *Response to complaints*: Use if complaints are ignored or trivialized by facility staff: administrator, social worker, nurses, and other staff.

34. *Reprisal, retaliation*: Use if the resident has experienced reprisal/retaliation (threat of discharge, lack of care, requests ignored, call lights unanswered, rough handling, etc.) as a result of a complaint.

35. *Other, specify*: Use when the resident has experienced violations of dignity, independence and/or rights not listed above.

## E. Financial, Property (Except for Financial Exploitation)

Use the appropriate category for complaints involving non-criminal mismanagement or carelessness with residents' funds and property or billing problems. Use A.4 for complaints involving willful financial exploitation, including, but not limited to, criminal activity.

36. *Billing/charges—notice, approval, questionable, accounting wrong or denied (includes overcharge of private pay residents)*: Use if complainant alleges resident does not owe the amount billed; the resident never received the bill for amount owed; bill in error; supplies not provided as part of the daily rate and similar problems.

37. *Personal funds—mismanaged, access denied, deposits and other money not returned (report criminal-level misuse of personal funds under A)*: Use for problem with personal funds, for example, staff denies a resident use of her personal needs allowance; staff uses a nursing home resident's trust fund without consent, and similar problems.

38. *Personal property—lost, stolen, used by others, destroyed*: Use for property (including prostheses, dentures, hearing aid, glasses, radio, watch) missing/stolen at the facility. Use K.82 for loss of laundry.

39. *Other, specify*: Include any financial or property problem not covered above. Resident Care

## F. Care

Use the appropriate category for complaints involving negligence, lack of attention and poor quality in the care of residents. If the care situation is so poor that the resident is in a condition of overall neglect that is threatening to health and/or life, use A.5, "gross neglect."

40. *Accident, bruises or injury of unknown origin; falls; improper handling*: Use for unexplained bruises, scratches, cuts, skin tears; falls from bed, wheelchair, or when standing; when resident is handled improperly or dropped during transfer or other assistance; and similar problems.

41. *Call lights, response to requests for assistance*: Use for call lights or requests for assistance not answered, or not answered in a timely manner.

42. *Care plan/resident assessment—inadequate, lack of patient/family involvement, failure to follow plan or physician orders*: Use for problem related to care plan: plan is incomplete or not reflective of resident's condition; family is not informed of care plan process, not allowed to participate; staff has disregarded or is not informed of the plan; staff fails to respond, or responds slowly, to physician orders and similar problems.

43. *Contracture*: Use for problem related to resident's hands, arms, feet, or legs being drawn up and contorted.

44. *Medications—administration, organization*: Use for medications not given on time or not at all, medication administration not documented or incorrectly documented, medications not secured, incorrect medication or dosage; negligence, lack of attention or poor quality in care related to medication that is: run out; expired; not filled in a timely manner; incorrectly labeled, and similar problems.

45. *Personal hygiene (includes nail care and oral hygiene) and adequacy of dressing, grooming*: Use for resident: not bathed in a timely manner, not clean, not bathed at all, allowed to remain in soiled clothing, diaper, bed, chair; hands and face not washed after meals; teeth/dentures not cleaned; inadequately dressed or groomed and similar problems.

46. *Physician services, including podiatrist*: Use for failure of facility to obtain physician services upon a change in resident's condition, or if medical attention, including podiatrist service, is not obtained in a timely manner or not obtained at all.

47. *Pressure sores, not turned*: Use for pressure sore(s) that may have occurred at the facility or elsewhere. Use when facility fails to treat, document, monitor pressure sores. Use if resident is not turned per medical order or treatment standard, or when turning is undocumented.

48. *Symptoms unattended, no notice to others of changes in condition*: Use if facility fails to accommodate, notice or provide services related to a change in resident's condition.

49. *Toileting, incontinent care*: Use when resident is not toileted in a timely manner, as needed or requested, or as directed by the care plan; facility is using adult briefs or catheters rather than toileting. Use G.54 for inadequate or non-existent bowel and bladder plan/training.

50. *Tubes—neglect of catheter, gastric, NG tube (use D.28 for inappropriate, forced use)*: Use if tube is not cleaned, changed, or monitored appropriately.

51. *Wandering, failure to accommodate/monitor*: Use for resident wandering, failure to redirect wanderers.

52. *Other, specify*: Use for any other resident care compliant.

## G. Rehabilitation or Maintenance of Function

Use the appropriate category for complaints involving failure to provide needed rehabilitation or services necessary to maintain the expected level of function.

53. *Assistive devices or equipment*: Use if facility lacks, fails to maintain or has problems with: Hoyer lift, handrails/grab bars, toilet seat, elevators, ambulation aids, wheelchair (no brakes or foot rests, etc.), hearing or visual aids, and other assistive devices or equipment.

54. *Bowel and bladder training*: Use if facility fails to provide training, has no schedule, or schedule not maintained. See F.49. .

55. *Dental services*: Use if dental services not provided or arranged for resident, or if services are inadequate or improper.

56. *Mental health, psychosocial services*: Use if these services not provided, arranged for resident.

57. *Range of motion/ambulation/exercise*: Use if services not provided; resident not assisted or encouraged in ambulation as appropriate; no appropriate exercise available; exercise resident wants is unavailable.

58. *Therapies, outside*: Use for failure to provide or arrange for therapies with outside agency or provider.

59. *Vision and hearing*: Use for failure to provide or arrange for vision and hearing services or for problems with services.

60. *Other, specify*

## H. Restraints—Chemical and Physical

Use the appropriate category for any complaint involving the use of physical or chemical restraint.

61. *Physical restraint—assessment, use, monitoring*: Use for any physical restraint: lap buddy, bed rail(s), bindings, placement of furniture, resident not released from restraints for a specified time; no order in file; and similar problems.

62. *Psychoactive drugs—assessment, use, evaluation*: Use for any chemical restraint, including excessive or unnecessary medication.

63. *Other, specify*: Use for any problem with restraints not included in above categories. Quality of Life

## I. Activities and Social Services

Use categories under this heading for complaints involving social services for residents and social interaction of residents. Note that transportation is included in category I.65 because community interaction is sometimes (not always) dependent upon transportation.

64. *Activities—choice and appropriateness*: Use for lack of activities appropriate for each resident; facility fails to consider residents ability to perform certain activities/and preferences; variety limited; no activities; posted activities not conducted.

65. *Community interaction, transportation*: Use for any complaint involving the resident's need for transportation, for whatever reason, and/or when facility does not assist residents in participating in community services or activities or curtails community interaction.

66. *Resident conflict, including roommates*: Use for any complaint involving conflict between residents, including roommate conflict.

67. *Social services—availability, appropriateness (use G.56 for mental health, psychosocial counseling/service)*: Use if social services department fails to provide social services or encourage social interaction; fails to provide services if resident isolates himself or refuses to participate in activities, and similar problems.

68. *Other, specify*: Use for other complaint/problem with activities or social services. If resident requests assistance in transferring to another facility or setting and the ombudsman provides the assistance, record as "information and assistance to individuals." If such assistance is requested but the desired setting is not available, record under P.128, "other" under "System/Others" to indicate lack of alternatives in the long-term care system.

## J. Dietary

Use the appropriate category for complaints involving food and fluid intake. Use the appropriate category under A (A.1 or A.5) for willful cases of food deprivation.

69. *Assistance in eating or assistive devices*: Use for failure to provide assistance in eating; facility has not provided tools to assist resident in self-feeding.

70. *Fluid availability, hydration*: Use for complaint that resident is not reminded to drink; bedside water is not provided, not fresh or not in reach; fluids are not readily available; resident is dehydrated.

71. *Menu/food service—quantity, quality, variation, choice, condiments, utensils*: Use for posted menu not served; alternate selections not offered; servings too small; no variety; quality is poor; food has little nutritional value, nutrients out of date, condiments or utensils not provided

72. *Snacks, time span between meals*: Use for snacks not readily available or offered between meals; excessive time span between dinner and breakfast.

73. *Temperature*: Use for food or beverage not served at appropriate temperature.

74. *Therapeutic diet*: Use for complaint resident's therapeutic diet is not served as ordered; resident's dietary needs not accommodated.

75. *Weight loss due to inadequate nutrition*: Use A.1 or A.5 for willful food deprivation.

76. *Other, specify*: Use for other food or nutrition complaint.

## K. Environment/Safety

Use the appropriate category for complaints involving the physical environment of the facility and resident's space.

77. *Air/environment*: temperature and quality (heating, cooling, ventilation, water temperature, smoking): Use for complaints about building, room or water temperature too hot or cold, ventilation inadequate; indoor cigarette smoke; and similar problems.

78. *Cleanliness, pests, general housekeeping*: Use for uncleanliness or pests (insects, vermin - live or dead) in resident's room or other facility area. Also use for ant, snake, rat or mosquito bite.

79. *Equipment/Buildings—disrepair, hazard, poor lighting, fire safety, no handicapped access, not secur*e: Use for elevator malfunctioning/ not maintained; paint/wallpaper peeling; lights burned out or insufficient lights; exterior not maintained, littered; blocked entrances/exits or hallways; inadequate/non-functioning/ expired fire extinguishers; malfunctioning automatic doors; fire alarms, smoke detectors, and other emergency equipment not present, malfunctioning or inadequate; and any other building maintenance problem. Also use for premises not secured; lacking or broken window bars; unauthorized person gained entrance to facility; unauthorized weapon in facility, and similar problems

80. *Furnishings, storage for residents*: Use for furnishing in disrepair; lack of furnishings; inadequate storage space for belongings, including valuables

81. *Infection control*: Use for insufficient measures to prevent infection; spread of infection; resident at risk; infection unreported or not treated appropriately, and similar problems.

82. *Laundry—lost, condition*: Use for no clean clothes available; clothing lost, damaged.

83. *Odors*: Use for urine, feces, any other offending odor or any odor that is a detriment to the health of the resident.

84. *Space for activities, dining*: Use for: inadequate space for scheduled activity or resident's attendance/participation in activity; dining area does not promote resident interaction; inadequate space for wheelchair or other assistive devices while dining; activity, dining areas converted to other uses.

85. *Supplies and linens*: Use for no clean linens available or in poor condition; shortage of supplies, for example, soap, gloves, toilet paper, incontinence pads, and nursing supplies.

86. *Other, specify*: Use for other complaint involving the physical environment and resident's space.

## L. Administration Policies, Procedures, Attitudes, Resources

*(see A-E for policies on advance directives, due process, billing, management of residents' funds)*

Categories under this heading are for acts of commission or omission by facility managers, operators or owners in areas other than staffing or specific problems included in previous sections: policies on advance directives; fair and due process on admissions, transfers and discharges; billing, management of residents' funds.

87. *Abuse investigation/reporting*: Use for failure of facility to report suspected resident abuse/neglect or exploitation to the specified authority, no matter where alleged abuse occurred.

88. *Administrator(s) unresponsive, unavailable*: Use for failure of administrator or administrative staff to respond to or communicate with others.

89. *Grievance procedure (use C categories for transfer, discharge appeals)*: Use if there is no grievance procedure for handling complaints or if the procedure is not made known to residents or not complied with by the facility.

90. *Inappropriate or illegal policies, practices, record keeping*: Use for inappropriate or illegal policies or practices, or if records are incomplete, missing or falsified.

91. *Insufficient funds to operate*: Use if there is a substantiated complaint of shortage of staff, lack of food, utilities cut off, etc. that could indicate bankruptcy or insufficient funds. Also use if a complainant alleges the facility has insufficient funds to operate.

92. *Operator inadequately trained*: Use for complaint that owner/administrator has no documentation of administrator's license, training or updates, and other certifications required by the state.

93. *Offering inappropriate level of care (for B&Cs, ALFs, RCFs, and similar facilities)*: Use if facility admits or retains resident whose medical and/or care needs are greater than the facility can meet or arrange to have met and similar problems.

94. *Resident or family council/committee interfered with, not supported*: Use if facility interferes with or fails to support resident or family councils, attempts to organize councils and related problems.

95. *Other, specify*: Use for any other complaints about facility policies, procedures, attitudes and resources that do not fit in one of the other categories in L. Specify the problem.

## M. Staffing

Use appropriate categories under this heading for complaints involving staff unavailability, training, turnover, and supervision.

96. *Communication, language barrier*: Use for staff language or other communication barrier. Use D.29 if problem involves resident inability to communicate.

97. *Shortage of staff*: Use for insufficient staff to meet the needs of the resident(s); staffing is below the minimum standard.

98. *Staff training, lack of screening*: Use when staff has not received training sufficient to meet the needs of the resident(s), including basic care and technical training, including the use of a Hoyer lift, CPR, or first aid. Use for staff references not checked or required background screening has not been performed.

99. *Staff turnover, over-use of nursing pools*: Use when there is no continuity of care for the residents, new staff on board and pool/agency staff are regularly used.

100. *Staff unresponsive, unavailable*: Use if staff is unresponsive or unavailable. Use D.26 if staff is available but rude or otherwise disrespectful to resident. Use A.3 or other category under A if rudeness or disrespect is so severe that it qualifies as abuse.

101. *Supervision*: Use when the staff duties are not overseen or not reviewed by a supervisor. Use when there is no ALF staff monitoring residents.

102. *Other, specify*: Use for any complaint relating to staff unavailability, training, turnover and supervision that does not fit in one of the other categories in section M. Problems with Outside Agency, System, or People (Not Against the Facility)Use these categories for all complaints involving decisions, policies, actions or inactions by the state agencies that license facilities and certify them for participation in Medicaid and Medicare.

## N. Certification/Licensing Agency

103. *Access to information (including survey)*: Use if licensing agency does not provide facility information to ombudsmen, public.

104. *Complaint, response to*: Use when agency fails to respond adequately to any complaint or referral, from the ombudsmen or public.

105. *Decertification/closure*: Use for individual complaints about decertification/closure and if agency fails to decertify/close a facility when within residents' best interests.

106. *Intermediate sanction*: Use if licensing agency fails to sanction facility appropriately.

107. *Survey process*: Use if agency fails to survey facility as required by law.

108. *Survey process—Ombudsman participation*: Use if ombudsmen not notified and/or included in survey process.

109. *Transfer or eviction hearing*: Use for complaints of decisions, policies, actions or inactions by the licensing agency regarding resident discharge hearings.

110. *Other, specify*: Use for any other complaint against the state licensing agency.

## O. State Medicaid Agency

Categories in this section are for complaints about Medicaid coverage, benefits and services.

111. *Access to information, application*: Use if information is denied or delayed to resident or legal representative; caseworker is unavailable, or unresponsive to requests for information or application status.

112. *Denial of eligibility*: Use for complaint that resident is denied Medicaid.

113. *Non-covered services*: Use for complaints about services not covered by Medicaid.

114. *Personal needs allowance*: Use for complaints about the personal needs allowance.

115. *Services*: Use for complaints about the quality or quantity of services covered by Medicaid or difficulty in obtaining services. (Use 113 for non-covered services.)

116. *Other, specify*: Use for any Medicaid complaints that do not fit into another category in section O.

## P. System/Others

Use appropriate categories in this section to document the range of complaints against or involving individuals who are not managers/staff of facilities (except for 119, as specified) or of the State's licensing and certification or Medicaid agency.

117. *Abuse/neglect/abandonment by family member/friend/guardian or, while on visit out of facility, any other person*: Use for abuse/abandonment by individuals other than facility staff, when the facility could not reasonably have been expected to observe the acts. Use A.1 or other A categories when the facility should have overseen and acted.

118. *Bed shortage—placement; lack of alternative settings*: Use when resident is unable to find a facility placement, or for a bed shortage.

119. *Board and care licensing/similar facility licensing, regulation*: Use for complaints about unlicensed assisted living, board and care and similar facilities and other problems related to licensing or certification of such facilities; use for complaints against individuals for operating without a license or outside of regulatory requirements.

120. *Family conflict; interference*: Use when a family conflict interferes with resident's care. Use only if the conflict or problem affects the resident's care or well being.

121. *Financial exploitation or financial neglect by family or other not affiliated with facility*: Use for cases of financial exploitation or financial neglect of a resident by individuals whose actions the facility could not reasonably be expected to oversee or be responsible.

122. *Legal—guardianship, conservatorship, power of attorney, wills*: Use if the complaint involves any of the above legal issues.

123. *Medicare*: Use if resident has complaint related to Medicare coverage.

124. *PASARR*: Use for problem involving implementation of the Pre-Admission Screening and Annual Resident Review (PASARR) requirements of the Nursing Home Reform Act related to individuals with mental illness or mental retardation living/making application to live in a Medicaid-certified nursing home.

125. *Physician not available*: Use if the resident's physician fails to provide information, services. (Use F.46 if facility fails to arrange for physician service and P.48 if facility fails to attend to medical symptoms or notify family of change in resident's condition.)

126. *Protective service agency*: Use for complaints involving the agency in the State charged with investigating reports of adult abuse or exploitation and providing protective services for victims of abuse and exploitation.

127. *SSA, SSI, VA, other benefits*: Use for complaints about these benefits and the agencies that administer them.

128. *Other, including request for less restrictive placement*: Use for a complaint against any other agency or individual, but not facility staff or licensing agency staff. Use for resident requests for assistance in moving out of the facility and/or ombudsman initiative to help resident find less restrictive placement.

## Q. Complaints About Services in Settings Other Than Long-Term Care Facilities or By Outside Provider

Use categories in this section to document any complaints accepted and acted upon by the ombudsman involving individuals living in private residences, hospitals or in hospice care, and congregate and/or shared housing not providing personal care. Also use for services in a facility provided by an outside provider.

129. *Home care*: Use if complaint is made by or on behalf of an individual living in a private resident.

130. *Hospital or hospice*: Use for complaint involving hospital or hospice care, service, or administration.

131. *Public or other congregate housing not providing personal care*: Use for complaint made by or on behalf of individual living in public or private congregate housing unit where personal care is not included in the rental contract.

132. *Services from outside provider*: Use for services from an outside provider which are not included in other categories for which the facility makes arrangements; for example, personal and homemaking services in an assisted living facility, therapies, transportation, psychosocial service. (Use P.125 for outside physician services.)

133. *Other, specify*: Use for any complaint involving non-facility settings or services, which does not fit into one of the other categories in section Q.

# Quiz: Applying the NORS Three C's

In examining each scenario below, keep in mind that in the NORS system cases and complaints must involve these elements:

a. A case must have one or more complaints (concerns) brought to, or initiated by, the Ombudsman.

b. The complaint(s) must be made by or on behalf of one or more residents related to the health, safety, welfare or rights of a resident or residents.

c. The Ombudsman must be actively involved in work on the complaint(s).

## DIRECTIONS

Are the following scenarios cases or consultations? If a case, how many complaints are there and who are the complainants?

In each scenario, assume that the resident wants assistance and resolution from the Ombudsman. In those involving abuse, disregard any mandatory reporting requirements which your state may have and answer the question from a pure Ombudsman point of view.

1. A woman calls asking for information on care planning and how to select a nursing home for her mother.

2. You visit Mrs. Jones, who tells you they are still bringing her pureed food, even though her doctor said she could start eating regular food. You notice her call bell is broken. She indicates she would appreciate your assistance in resolving these problems. You speak to the DON about the call bell, and she promptly fixes the bell. You attempt to talk to the dietician about the pureed food, but she is not available until the next morning.

3. A CNA approaches you about a labor dispute in the facility. She asks you to intervene with management on behalf of the staff, which is threatening to strike if they don't get health coverage. In examining each scenario below, keep in mind that in the NORS system cases and complaints must involve these elements:

4. Your state requires that all allegations of abuse be reported to the Adult Protective Services agency or the police and that the Ombudsman program be notified. You receive a routine notification from APS, which is investigating the allegation.

5. Mrs. Oliver asks you to help her obtain the medical records for her mother, who recently died in a nursing home. She is planning to use the records in a private action lawsuit against the facility.

6. A nursing home staff person tells you that Mrs. Smith's son, who has power of attorney for his mother, is verbally abusing Mrs. Smith, using her income for his own purposes and has not paid her bill for three months. The staff person requests your involvement in resolving the non-payment issue.

7. Mr. Jones calls the Ombudsman program, complaining that his mother has a black eye and the facility can give no explanation for it. An Ombudsman representative visits his mother and notices light bruises on her face and arms, but cannot verify that she had a black eye.

8. Mr. Brown's daughter Alice, Mr. Brown's legal guardian, calls the Ombudsman program, concerned that her father is eating all his meals in his room, instead of in the dining room. You visit Mr. Brown, who seems despondent and is unable to express his wishes. You speak with the DON about Alice's concern; the DON says staff should be taking Mr. Brown to the dining room and that she will discuss the problem with two new aids and also put a note in Mr. Brown's chart. Two days later you call Alice, who tells you the aids are now taking her father to the dining room and he appears much happier.

9. Ms. Miller, a resident of Sunny Valley Assisted Living Facility, stops you in the hall and tells you she has a problem: her son, who lives at home, has just been terminated from the Medicaid program and she is concerned he won't be able to pay for his medication. As she wheels off in her wheelchair, you notice that the wheelchair keeps veering to the left and hitting the wall. You ask if she would like your assistance in getting it fixed, or getting a new chair. She replies, "yes."
10. A facility administrator calls you to complain that the volunteer Ombudsman assigned to his home is not doing her job. He explains that he called her about a problem the facility was having with a resident's behavior, but she refused to address the facility's concern and instead visited privately with the resident and refused to tell the administrator or the corporation's lawyer about her visit.

## BONUS QUESTION

On December 15th you go to Hilltop Haven to visit Mrs. Lee. Her daughter called you to complain that her mother would like to be bathed more often than once a week. On your way to Mrs. Lee's room you notice that there is dirty laundry on the floor in the hall and that the hall is quite dark because several lights are not working. After you visit Mrs. Lee, you stop in to see Mrs. Hall. She tells you that they stopped her physical therapy and she does not know why and she complains that the sliding track for the privacy curtain is broken, so it does not close all the way. You agree to investigate both complaints. You resolve and close the PT complaint within the week. You learn that the facility has tried to order a new track, but it's on back order. You decide to keep that complaint open until the new track is installed. You go back to visit Mrs. Hall on January 15th. She tells you that they are installing the track the next day. She also tells you that the she just received a notice from the facility saying that she will have to switch to the facility pharmacy even though it may cost more than the pharmacy she's been using for the past three years. You tell her you'll check into it for her.

How many cases do you open? (Identify them by complainant's name. Does any complainant have more than one case?) How many complaints are there for each case?

*Provided by the Administration on Aging, Office of Consumer Choice and Protection, February 2004*