JOINT TRAINING PROGRAMS FOR OMBUDSMEN AND SURVEYORS

Options and Advice for Implementation

by

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PREFACE

As its title suggests, this training resource paper has been developed to assist states to develop joint training programs for ombudsmen and surveyors. It presents detailed descriptions of two training events, held during the fall of 1992 in New Mexico and Colorado, and includes: background information on how each of the training events evolved, copies of the training agendas, and a description of the materials used as handouts for each of the training sessions (some of the handouts also are included in the appendices). To assist ombudsmen to make practical use of the experiences of these two states, the paper also identifies the "critical elements" of a joint training agenda, "potential action steps" states might take following a joint training event, and recommends a list of in-service training topics for ombudsmen.

The new OBRA requirements for Ombudsman participation in the survey process provide a new opportunity for ombudsmen and surveyors to work together. Thus, a joint training event for ombudsmen and surveyors may serve as a vehicle for clarifying roles and developing procedures to be followed in the new survey process. It is important, however, that a joint training event be designed to meet the specific needs and respond to the concerns of each state's ombudsman program and licensing and survey agency, as was the case in both New Mexico and Colorado. Possible goals for a joint training effort might include:

> to provide training for both ombudsmen and surveyors on the new ombudsman role in the survey process;
>
> to establish better communication between ombudsmen and surveyors (as in New Mexico);
>
> to improve the working relationship between ombudsmen and surveyors (as in Colorado);
>
> to develop a plan for addressing problems and frustrations that both ombudsmen and surveyors experience in their interactions with one another.

We hope this paper will encourage states to develop a joint training event, either as a new initiative or as a follow-up to earlier efforts. Whatever the circumstances in your state, we offer the following advice.

> Cultivate the interest of ombudsmen and surveyors in the joint training event by presenting it as part of a larger effort to develop a better working relationship between the two programs.
>
> Involve front-line, as well as administrative, staff of both the ombudsman program and licensing and survey agency in planning the joint training event.

Set aside funds for training over a period of time, not just a "one-shot" training event.

Talk to ombudsmen and surveyors in states that have already done joint training and use what they learned in developing your state's training event.

If possible, invite an outside facilitator to help with planning and lead the training session. The facilitator should have expertise in group problem-solving and have current knowledge about the national picture, including OBRA requirements and how other states have worked out the relationship between ombudsmen and surveyors. Using someone outside the two programs to lead the training will also help to assure a more equal partnership between ombudsmen and surveyors in the joint training event.

Make the joint training event part of the ombudsman program's and the licensing and survey agency's larger staff education efforts.

Finally, we hope you will call on the Institute for information and advice in planning your joint training event, and that you will let us know about your experiences in this arena. This is indeed an exciting time for new state experiments in forging relationships between ombudsmen and surveyors, providing new opportunities for states to learn from each other.

Joint Training Programs for Ombudsmen and Surveyors

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INTRODUCTION

Ombudsmen and surveyors have new opportunities to work together to promote quality care for nursing home residents through new federal survey procedures and guidelines published in April, 1992. Joint training programs for ombudsmen and surveyors can strengthen each program's efforts to achieve quality care in nursing homes. For ombudsmen, additional in-service training programs on the survey process and the OBRA requirements can lead to more effective participation in the survey process. (See Appendix 1 for information on requirements for ombudsman participation in the survey process.)

The Survey Procedures and Interpretive Guidelines (HCFA Transmittal No. 250) require surveyors to contact ombudsman program representatives for information about the quality of care and life at the facility and for assistance working with residents and families who wish to participate in the survey. These procedures expand on initial HCFA instructions, published in September, 1989, to request information from ombudsmen and invite ombudsmen to the exit conference.

As ombudsmen and surveyors begin to work with the new procedures, it is natural that mechanical and programmatic questions will arise. Joint training programs for surveyors and ombudsmen can provide a format to work through these issues and strengthen the working relationship between the two programs.

This training resource paper presents options for joint training, drawing on two such programs facilitated by Institute staff, Ms. Barbara Frank, Associate Director, National Citizens Coalition for Nursing Home Reform, in November, 1992 - one in Colorado, another in New Mexico. It describes how these programs evolved and how they were presented. It reviews action steps resulting from the ideas generated at the trainings. It also includes specific ideas for ombudsman in-service training programs to develop ombudsman skills and knowledge about the survey process.

This resource paper is part of a continuing series of technical assistance materials on ombudsman participation in the survey process produced by the National Eldercare Institute on Elder Abuse and State Long Term Care Ombudsman Services and its

predecessor, the National Center for State Long Term Care Ombudsman Resources. The series includes:

- "Special Role for Ombudsman Programs," Survey and Certification, An Ombudsman's Guide to the Nursing Home Reform Amendments of OBRA '87, revised February, 1992

- Supporting the Ombudsman's New Role in the Survey Process, Oct. 1991

- References to the Ombudsman Program in the Federal Survey Procedures and Interpretive Guidelines, April, 1992

- Resident Rights Survey Procedures, Forms and Probes for the Long Term Care Survey Process, April, 1992

HOW EACH STATE'S TRAINING EVENT EVOLVED

New Mexico: New Mexico's Ombudsman program initiated the day and a half session to establish better communication between surveyors and ombudsmen. State ombudsman staff had accompanied surveyors on an inspection to learn more about the survey process and determined that discussion between the programs would be mutually beneficial. After determining that national trainers would be available for such a program, the ombudsman program contacted the survey agency.

The state survey agency was interested in the event and in the opportunity for national trainers for its staff. The agency agreed to include a joint training in its schedule of in-service trainings for surveyors. The national trainers solicited ideas from both the ombudsman program and the survey program for topics to cover and then presented both groups with a proposed agenda.

The National Eldercare Institute for Elder Abuse and State Long Term Care Ombudsman Services provided funding for trainers. The state survey agency and state ombudsman program each covered the expenses for its program's attendees. Attendees included the regional supervisors from each program and several line staff, in total 20 surveyors and 15 ombudsmen.

The training was designed to provide substantive information and address practical issues affecting their working relationships. This was the first joint meeting for field staff of the two programs, so it included introductions to each program, how the programs are structured and located, and set the stage for tangible communication among ombudsmen and surveyors working in the same regional areas. Since then, there have been two regional day-long conferences, in which 110 ombudsmen, surveyors, and adult protective services staff have participated. The three programs have agreed to continue regional joint programs on an annual basis. Communication among regional program staff has improved through the personal contact.

Colorado: The program in Colorado was a continuation of on-going efforts between the ombudsman program and survey agency to work together. In May, 1991, the two agencies had co-sponsored a half day training in conjunction with the survey agency's regularly scheduled in-service training. In this initial session each agency provided introductory information about how it operated. The training program included an introduction to the new Nursing Home Reform law.

As the two agencies continued to meet regularly over the next eighteen months, they identified practical difficulties and programmatic challenges and decided to co-sponsor a second, larger event for their staff. They developed the agenda together, with Institute staff consultation, and shared the expenses of the event. The one-day session,

attended by over 100 people, included all the nursing home surveyors and directors of the local ombudsman programs.

The program was designed to provide a basic framework for thinking about the reform law, to address problems and frustrations each program was experiencing in their working relationship and to develop concrete proposals for local and state action to alleviate these problems. The two agencies continue to meet to work on the proposals generated from the joint program. An additional joint training will be held on investigation techniques and legal issues. Since the training, participants report that it was helpful to meet outside of the nursing home to discuss common concerns and exchange information. Ombudsmen report positive results from their participation in surveys and surveyors say they receive better information now that ombudsmen understand the survey process. Both groups say residents have benefitted from the improved working relationship.

CRITICAL ELEMENTS OF A JOINT TRAINING AGENDA

- **Grounding in a Common Vision:**

  Goal: For participants to understand how to apply the Nursing Home Reform law

  Trainer: Speaker familiar with both programs and the law's intent and detail

  Method: Presentation with audience participation

  Content: Review key elements of law, how "typical" care practices can lead to resident decline (violating quality of care/life requirements), review program roles

- **Overcoming Barriers - Working Better Together:**

  Goal: To identify obstacles to ombudsmen's and surveyors' work and specific changes in operation to improve cooperation

  Trainer: Skilled facilitator knowledgeable about how each program works

  Method: Small groups composed of ombudsmen and surveyors with reports from small groups for discussion by full assembly

  Content: Discussion of the following issues:
  * How do participants see their own and each other's roles?
  * What obstacles do participants face in individual and cooperative work?
  * What are possible strategies to overcome obstacles?

  Conclude with discussion of ways programs can operate before, during, after and in-between surveys; how to trust and rely on each other's efforts

- **Applying OBRA to Real Life**

  Goal: To understand how to work together

  Trainer: Skilled facilitator knowledgeable about each program and the law

  Method: Small group discussion of cases; report/discussion to assembly

  Content: Review of ombudsman case examples of poor care; discussion of what each program could do about identified problems separately and cooperatively

- **Closing: Where Do We Go From Here?**

  Goal: To develop an agenda for action

  Trainers: State Ombudsman and State Survey Agency Director

  Method: Discussion of recommendations and outline of future steps with audience participation

HAND-OUTS USED IN COLORADO AND NEW MEXICO

■ "Homelessness Among the Institutionalized Elderly" by Judith Carboni, from packet, Providing Good Care: Preventing Neglect distributed at NCCNHR's 1992 Annual Meeting (see Appendix 2)

This article compares homelessness with living in a nursing home. It describes what home means to people: connectedness, identity, safety, autonomy, privacy, a point of departure. It identifies homelessness with feelings of: powerlessness, insecurity, disconnectedness, non-personhood, and lack of privacy. These feelings are similar to losses experienced by nursing home residents, leading many to withdraw into psychic despair. The article concludes that nursing homes should modify their environments, including their management, to strengthen residents' sense of home. Used in the training, the article illustrates the connection between routine nursing home practices and avoidable psychosocial decline.

■ "Iatrogenesis in the Elderly: Factors of Immobility" by Paula Mobily and Lisa Kelley, from packet, Providing Good Care: Preventing Neglect, NCCNHR 1992 Annual Meeting (see Appendix 2)

"Iatrogenesis" comes from the Greek and means "We caused it." This article traces the consequences of immobility, including: decreased range of motion; loss of muscle strength; loss of bone mass; cardiovascular deterioration; respiratory problems; metabolic imbalances; pressure sores; decreased urinary and gastrointestinal function; and psychological decline. Used in the training program, the article illustrates how routine nursing home practices that prevent resident movement, or fail to provide restorative or maintenance therapy, can lead to avoidable physical decline.

■ References to the Ombudsman Program in the Federal Survey Procedures and Interpretive Guidelines, distributed by the National Eldercare Institute on Elder Abuse and State Long Term Care Ombudsman Services, 1992.

This resource contains references to the ombudsman program from the HCFA Survey Procedures and Guidelines (Transmittal # 250, published April, 1992). A summary of these references is found at Appendix 1. The procedures instruct surveyors to:

- review ombudsman complaints in preparation for the survey;
- contact the ombudsman at the beginning of the survey to: inquire about complaints received by the ombudsman about the facility; request recommendations of residents and family members to include in sample

and closed record review; determine ombudsman availability to participate in interviews; and invite the ombudsman to the exit conference;
- discuss observations and residents' rights/quality of care findings during the survey;
- if ombudsman services are requested, invite ombudsman to attend individual and/or resident group interviews;
- seek ombudsman assistance to contact family members and to locate a translator;

■ Case examples from Working Through Ethical Dilemmas in Ombudsman Practice by Sara Hunt, National Center for State Long Term Care Ombudsman Resources, 1989 (the resource paper and training guide are available from NASUA). Ms. Hunt currently serves as NCCNHR consultant to the Institute.

Used in training to evoke discussion about how ombudsmen and surveyors approach cases.

TRAINING AGENDAS

New Mexico:

Day 1

9:30-10:30 **Roles of Ombudsmen and Surveyors**

State Ombudsman, Tim Covell, provided an introduction to the ombudsman program, its federal and state mandate and authority, and how it is organized. He answered questions about the qualifications, availability, assignments and time commitment of volunteers and the organizational structure of the program. The State LTC Program Manager, Matthew Gervase, provided an introduction to the survey system, its federal and state mandate and organization, and answered questions about the operations, capacity and responsiveness of the survey staff. Trainer, Barbara Frank, reviewed federal survey procedures and guidelines requiring surveyor-ombudsman interaction.

10:45-12:15 **Working Together to Implement OBRA**

Ms. Frank discussed quality of care and quality of life requirements of the Nursing Home Reform law, focused on: "If decline occurred, was it avoidable?" The presenter drew on articles on homelessness and nursing homes and on the effects of immobility (see appendix for copy of articles). Both articles make the case that much of the physical and psychosocial decline experienced by residents is avoidable and oftentimes caused by actions or inactions of the nursing home.

The assembly then broke into smaller groups to discuss each program's role, obstacles each faces in performing their responsibilities and in working with the other's program, and strategies for overcoming obstacles. The groups reported their discussion ideas which set the agenda for the second day's discussion. Ideas focused on operational issues for working better together (see Appendix 4, "A Protocol for Best Practice.")

1:15-2:45 **Residents' Right to Self-Determination**

The session was facilitated by ethicist Joan Gibson, Ph.D., of the Institute of Public Law at the University of New Mexico, who began the group discussion with a case from "Working Through Ethical Dilemmas in Ombudsman Practice." Using participants' responses to the case, Dr. Gibson helped identify differences in values, perspectives and roles felt by ombudsmen and surveyors. Both programs' representatives approached

New Mexico, Day 1, continued:

the case example as investigators, with questions about the incident in order to determine a course of action. Ombudsmen saw themselves as representatives of residents' interests; surveyors saw themselves in a neutral role. Dr. Gibson then led a discussion about the elements of resident participation in decision-making and what supports need to be in place in the facility to promote this participation.

3:00-4:00 **Resident/family individual and group interviews**

Dr. Gibson and visiting trainer, Virginia Fraser, Colorado State Ombudsman, led a discussion on interviewing skills, and how to determine if a resident is "interviewable," as required by survey guidelines. Dr. Gibson discussed ways people with limited competency may communicate their needs and preferences. Ms. Fraser discussed skills for interviewing people with communication impairments. They led a discussion of ways to support resident participation in the survey.

4:00-4:30 **Resolving Ethical Dilemmas in Work**

Dr. Gibson facilitated a discussion about surveyors' reliance on information from resident interviews and ombudsman complaints. Participants voiced perceived differences between surveyor and ombudsman approaches - ombudsmen as resident advocates; surveyors as objective investigators - and how this difference can lead to miscommunication between the two programs, a key barrier to cooperation.

Day 2

9:00-10:00 **Introduction to the Survey Process**

Mr. Gervase described surveyor tasks in the survey process, while Tim Covell identified points for ombudsman involvement. Molly Munson, Assistant State Ombudsman, described her experience observing a survey. Participants asked questions about surveys; surveyors talked about the nuts and bolts of what they do.

10:30-12:00 **Working Together to Achieve Good Care for Residents**

Ms. Frank led a group discussion about a case of neglect: what questions participants should ask; what they should look for; how they would cite identified problems; and what would be an acceptable plan of correction.

New Mexico, Day 1, continued:

She then facilitated group review of the issues raised the previous morning, focusing on obstacles surveyors and ombudsmen faced in their individual responsibilities and in their efforts to work together. The group brain-stormed concrete solutions for addressing obstacles and working together, including program procedures for sharing information. The assembly was divided into small groups of ombudsmen and surveyors to review two cases of poor care that local ombudsmen had recently handled. The groups talked about what each of their programs should do separately and cooperatively to respond to the problems.

12:00-12:30 **Where Do We Go From Here?**

The State Ombudsman and State LTC Program Manager responded to suggestions and set an agenda for future meetings and action. Participants gave feed-back about what they had learned and how it would affect their work (see Appendix 4).

Colorado:

8:00-9:30 **Getting to Highest Practicable: Establishing a Common Mission**

Trainer, Barbara Frank, discussed quality of care and quality of life requirements under the Nursing Home Reform law focusing on the question: "If decline occurred, was it avoidable?" In her presentation, Ms. Frank used articles which compared living in a nursing home with homelessness and described the effects of immobility (see Appendix 2). Both articles make the case that much of the physical and psychosocial decline experienced by residents is avoidable and oftentimes caused by actions or inactions of the nursing home. Ms. Frank led a group discussion about a case example of neglect: what questions they should ask; what they should look for; how they would cite it; and what would be an acceptable plan of correction.

10:00-11:30 **Common Mission - Different Roles**

Participants met in small mixed groups of ombudsmen and surveyors to discuss their roles, barriers they face in their own work and in working with each other, possible solutions to barriers, and ways they can help each other overcome barriers. In the small groups, ombudsmen and surveyors discussed differences in the tools they have to work with, the perspective they bring to a situation, their role in relation to residents and facilities, and how they perceive each other. There was a "clear-the-air" element to some of the discussions as participants voiced some of their frustrations with how they felt treated by each other. A professional facilitator led the assembly in a report-back from the small groups. Many participants voiced similar frustrations and feelings of limitations, as well as some common solutions. The central issue was one of trust - whether each felt the trust of the other. Surveyors expressed frustration that ombudsmen did not seem to trust the reliability of their survey findings. Ombudsmen expressed the frustration that surveyors did not seem to trust the reliability of their complaint information.

1:00-4:00 **Overcoming Barriers -- Working Together Effectively**

Ms. Frank led the participants through a solution-oriented discussion of the ideas raised in the small group sessions. Ombudsmen and surveyors discussed the trust issues, and other operational issues, in more depth, presented examples of problems they had run into, or described what outcomes they hoped for from solutions. They offered concrete, specific

Colorado, continued:

recommendations for procedural and operational changes in their ownprograms and in their interactions with each other at the beginning, during and after the survey and in between surveys, especially during complaint investigations. (See Appendix 4 for more information.)

4:00-4:30 **New Directions -- Making a Difference**

State Ombudsman, Virginia Fraser, and Health Facilities Division Deputy Director, Susan Rehak, identified individual and joint action steps, underscoring the day's theme of change -- changing expectations of nursing homes, changing beliefs about aging, and changing appreciation and respect for each other's roles.

POTENTIAL ACTION STEPS AFTER JOINT TRAINING

As follow-up to the training, the Colorado Ombudsman Program and Survey Agency planned a joint training on investigative skills. The two programs have also revised some of their protocols for better ombudsman and surveyor interaction (see "Protocol for Best Practice," Appendix 4).

Following their joint training, the New Mexico Ombudsman Program and Survey Agency held two regional one day trainings for ombudsmen, surveyors and adult protective service staff. The trainings focused primarily on improved communication among program staff, and included listening exercises (see copy of agenda, Appendix 4). The programs now plan to make these meetings annual events, and have plans to be involved in each other's trainings as well.

Participants in the trainings generated the following ideas for follow-up action steps:

- **Establishment of regional relationships**
  - Meetings and training sessions at the regional level for ombudsmen and surveyors
  - Protocols for direct communication between local ombudsmen and regional survey staff
  - Meetings to share information about specific facility problems or emerging problems
  - Mechanisms for cooperation in on-going monitoring of facilities
- **Further education about each other's roles**
  - Opportunities for ombudsman coordinators to observe a survey from start to finish to learn about the process
  - Future joint statewide meetings between the two programs
  - Ombudsman attendance, as an observer and/or as a trainer at surveyor trainings, and inclusion of a presentation about the ombudsman program in training for new surveyors
  - Surveyor participation in sessions at ombudsman trainings

- Joint training sessions on topics of mutual interest, such as advanced directives or transfer, discharge and appeal procedures

- **Protocols to facilitate communication**

  - Procedures for facilitating initial contact with the ombudsman when the survey begins, including ombudsman accessibility on the morning most surveys begin

  - Regular information sharing about problems at facilities, instead of waiting for the survey

  - Procedures for information sharing about complaints that take into account information from the ombudsman who has witnessed or investigated the problem

IN-SERVICE TRAINING TOPICS FOR OMBUDSMEN

The following in-service training topics are recommended to enhance ombudsman understanding of the survey process:

- **A Basic Introduction to the Survey Process**

Explain the survey process, surveyors' tasks, the typical time-table for tasks, opportunities for ombudsman involvement at various points in the survey, and how surveyors operate as a team in developing their survey report. Include review of discrete sections of the Interpretive Guidelines, such as residents' rights requirements, to illustrate how surveyors determine whether or not there are deficiencies. One of the trainers should have direct surveyor experience. Allow 2-3 hours.

- **The Ombudsman Role in the Survey Process**

References to the Ombudsman Program in the Federal Survey Procedures and Interpretive Guidelines provides the framework for a session reviewing opportunities for ombudsman involvement before, at the beginning, during, at the end, and after the survey. The References review instructions to surveyors directing them to ask ombudsmen for information, guidance, and participation. Training sessions should discuss procedures within the program for responding to requests and guidance on how to organize and present information so that it is most likely to be useful to surveyors. Ombudsmen who have participated in the survey should share what has and has not worked, in sharing complaint information with surveyors, recommending residents or families be included in the sample, assisting with individual or group interviews, providing additional information to surveyors during the course of the survey, and using the exit conference to identify areas to monitor after the survey. Allow 2-3 hours.

- **Review of Long Term Care Facility Requirements and Interpretive Guidelines**

Requirements for quality of care, quality of life, resident assessment and residents' rights provide the basis for implementing the reform law. A course on these regulations and the surveyor interpretive guidelines is best taught through discussion of cases. Although three sample cases are provided in Appendix 3, it is preferable to use examples from trainees' current cases. The exercise should enhance ombudsman familiarity with the regulations and the survey procedures regarding particular issues raised by each case, which will enable them to refer to the regulations and guidelines when they present information to surveyors. Allow 1 1/2 hours per case.

- **Resident Assessment and Care Planning**

A resource for this session is "Using Resident Assessment and Care Planning as Advocacy Tools," developed by Sara Hunt and Sarah Burger of the National Citizens' Coalition for Nursing Home Reform (available from NCCNHR). Presentations should address the mechanics of resident assessment and how assessment and care planning can be used properly to attain or maintain residents' highest possible level of functioning. Articles on homelessness and on the hazards of immobility will be helpful (see Appendix 2). Applying resident assessment and care planning to case examples (see Appendix 3) will help ombudsmen become familiar with the instruments used by the facility. The session provides a framework for ombudsman understanding when a resident's decline is avoidable and may in fact be caused by the nursing home's failure to provide care. Allow 2-3 hours.

APPENDICES

Appendix 1: Summary of the Survey Tasks for the Long Term Care Survey Process; and References to Ombudsmen Program in the April 1992 Surveyor Guidelines

Appendix 2: Resource articles for presentation "Grounding in a Common Vision"

- "Homelessness Among the Institutionalized Elderly" by Judith Carboni
- "Iatrogenesis in the Elderly: Factors of Immobility" by Paula Mobily and Lisa Kelley

(Articles included in a packet on Providing Good Care: Preventing Neglect distributed at NCCNHR's 1992 Annual Meeting)

Appendix 3: Sample Cases for training programs

Appendix 4: Follow-up on Joint Trainings:

- Ombudsman and Surveyor Interaction and Cooperation: A Protocol for Best Practice by Virginia Fraser, Colorado State Ombudsman
- Agenda for Regional Ombudsman/Surveyor/Adult Protective Services joint training by Tim Covell and Molly Munson, New Mexico State Ombudsman Program

Appendix 1

SURVEY PROCEDURES

In September, 1989, HCFA issued new Survey Procedures and Guidelines to use beginning October 1, 1990 with the February 2, 1989 Long Term Care Facility Requirements. These were revised and published in April, 1992 as State Operations Manual Transmittal #250. (**Note:** See References to the Ombudsman Program, pages 3-4)

The April, 1992 Survey Procedures give surveyors **the following tasks:**

Task 1 Off-site Survey Preparation

Review facility files, compliance history, complaint records and any key personnel changes

Task 2 Entrance Conference/On-Site Preparation Activities

Inform staff and residents of survey process; request information about resident characteristics, facility schedules, the resident council, accidents/incidents, complaints, staffing, and facility physical layout; and **contact ombudsman program** for information.

Task 3 Orientation Tour

Identify (1) residents to interview and to include in the quality of care assessment; and (2) look for possible patterns of poor care to be investigated in depth in the survey.

Task 4 Resident Sampling

Sample includes "interviewable" and "non-interviewable" residents who are heavy care or light care, including someone recently admitted, "non-aged", a resident council officer, and a mentally ill or retarded resident. The procedures set a minimum of sampled residents to be interviewed and direct surveyors to "over sample" on the heavy care side.

Task 5 Information Gathering

Provides a systematic way of gathering information necessary to make decisions concerning facility compliance. Surveyors are to meet daily to share information. Subtasks include:

5A Environmental Quality Assessment

On each wing, review at least 2 rooms and the common areas, corridors and bath/toilet facilities; observe (1) physical plant areas that bear on residents' well-being; (2) the relationship between residents' living environment and their health, functional and psychosocial needs; (3) residents' grooming, infection control, abuse and neglect, and physical plant. Include residents who are in the quality of care assessment sample.

5B Quality of Care Assessment

Review residents' assessment and care plan for "risk factors, for deterioration in functioning, clinical condition, potential for improvement, treatment/care plans, and indicators of actual or potential malnutrition." Determine if declines occur and if they are "avoidable." Observe residents and staff at different times of day, settings and care situations; evaluate accuracy and adequacy of care plan and implementation, and resident-staff interaction. Review unnecessary drugs and inappropriate use of antipsychotic drugs.

5C Closed Record Review of Transfers and Discharges

Review at least 5 records of people who recently died or were discharged to determine adequacy of discharge planning and appropriateness of care provided by facility.

5D Resident Rights Assessment

Conduct 30-45 minute private interviews with a sample of residents and private discussion with the resident council. Interview families of up to three residents unable to be interviewed. Individual interviews focus on residents' rights, autonomy and choice in everyday life and care. Resident council interview focuses on residents' ability to influence facility policies affecting everyday life. Resident/family can request ombudsman presence.

5E Dietary Services and Systems Assessment

Review sanitation of food preparation; observe food quality, assistance to residents with eating, dining room environment, and quality of life associated with dining.

5F Medication Pass

Review preparation and administration of drugs; calculate the drug error rate based on: omissions, unauthorized drugs, wrong dose, wrong method of administering, wrong form of dosage, and wrong time of administration.

Task 6 Information Analysis and Decision-Making

Analyze observations and findings by frequency and severity; seek facility and ombudsman input and clarification throughout survey. Surveyors must call for extended surveys if poor outcomes are of sufficient severity and frequency in Residents' Rights, Resident Behavior and Facility Practices, Quality of Life, or Quality of Care.

Task 7 Exit Conference

Surveyor meeting with facility staff to discuss findings, and Plan of Correction; ombudsman and resident representative may observe. If facility disagrees with findings, the survey team attempts to resolve differences or notes why they are unresolvable. Surveyors must notify the facility if the survey is to be extended and what deficiencies will require further review.

SURVEY PROCEDURES/INTERPRETIVE GUIDELINES (HCFA Trans. 250, April, 1992):

[Pg. P-5] TASK 1 - OFFSITE SURVEY PREPARATION:

- Surveyors must review ombudsman complaint information on file:

  *"Review all files for facility-specific information ... abuse reports; complaint investigations; and information concerning the **Ombudsman**..."*

[Pg. P-7] TASK 2 - ON-SITE PREPARATORY ACTIVITIES:

- Surveyors must contact ombudsman, ask for information and invite to the exit conference:

  *"Contact the long-term care **Ombudsman** (state, local, or regional) as early as possible to inform him/her of the survey. Ask if the **Ombudsman** will be available if residents participating in individual or group interviews wish him/her to be present. Also, inquire whether complaints have been received about the facility, the nature of the complaints, whether these complaints have been validated, and whether there are complaints pending validation. Request any recommendations from the **Ombudsman** of residents and family members for possible inclusion in the sample, and for inclusion in the closed record review. Advise the **Ombudsman** of the likely time the exit conference will occur and invite him/her to observe the conference."*

[Pg. P-13] TASK 5 - INFORMATION GATHERING:

- Discuss observations with ombudsman:
  *"Throughout the survey, discuss your observations, as appropriate, with team members, facility staff, residents, family members, and **Ombudsmen**."*

  (Guidelines later tell surveyors to ask ombudsmen especially about access to residents' records; transfers; bed-holds; medicaid discrimination; admissions contracts; and abuse.)

[Pg. P-19] TASK 5B - QUALITY OF CARE ASSESSMENT

- Interview ombudsmen and let them know if residents' fear retaliation:
  *"The objectives of interviews are to: collect additional information; verify and validate information obtained from other survey procedures; allow the facility staff to explain their rationale for care activities; assist you in determining if a decline or lack of improvement was avoidable or unavoidable; and provide the opportunity for all interested parties to give you what they believe is pertinent information....Interview residents, staff, family, **Ombudsman**, visitors, and other appropriate persons."*

*"If residents appear reticent in providing you with information or express concern about retaliation: verify that resident have information on whom to contact in the event they become the objects of retaliation by the facility; Notify the **Ombudsman** of the resident's concerns, if you have the resident's permission."*

[Pp. P-23, 24, 25] TASK 5D - RESIDENT RIGHTS ASSESSMENT:

- Ombudsman may attend group interview [P-23]:
  *"Contact the officer of the organized residents group, if one exists. Provide a copy of both the individual and group interview guides to this person. Request a special meeting of this group and ask facility staff to help schedule this meeting. Inquire if residents prefer a third party (e.g., family member, **Ombudsman**) to be present at the meeting. If **Ombudsman** services are requested, and the **Ombudsman** is available, attempt to schedule the meeting accordingly. Ask permission to review minutes of the resident group meetings to determine recent issues raised and recommendations made to the facility. If the group declines permission to review the minutes, do not pursue this matter."*

- Ombudsman may intend individual resident interview [P-24]:
  *"Inform residents of their right to have a person of their choosing present during the interview (e.g., an **Ombudsman**, if available, or family member) and accommodate their wishes if you are able to arrange for their presence."*

- Ask for Ombudsman assistance to contact family members [P-24]:
  *"Interview family members or legal representatives of three residents included in sample groups C and D [Non-interviewable residents]. If you are unable to locate three family members of non-interviewable residents in the sample, interview family or legal representatives directly, through the local **Ombudsman**, or with the facility's assistance...."*

- Ask for Ombudsman assistance to locate an interpreter [P-25]:
  For Resident Rights Assessments of sampled residents: *"If you do not speak their language, arrange to have an interpreter present for interviews. Obtain an interpreter through the **Ombudsman**, churches or temples, or local schools. Be sure that the interpreter understands and agrees to maintain the confidentiality of the information provided by the resident during the interview. Ask the resident for his/her verbal consent to use the interpreter."*

- Corroborate resident rights problems with Ombudsman [P-25]:
  "If the response show problems with resident rights or quality of life requirements (e.g., unsatisfactory responses either with specific resident rights or quality of life requirements or overall care), then, if necessary corroborate this by:

  - ... Conducting additional staff, resident, and family/legal representatives, or local **Ombudsman** interviews. Also, interview residents outside the sample or group interview to gather information to confirm the problems."

[Pg. P-31] TASK 7 - EXIT CONFERENCE:

- Invite Ombudsman to observe:
  *"Invite the **Ombudsman**, and an officer of the organized residents group, if one exists, to the exit conference. There are two options for resident participation in the exit conference: 1 or 2 residents may attend the facility exit conference; or the team may provide an abbreviated Exit Conference specifically for residents after completion of the normal facility Exit Conference."*

IATROGENESIS IN THE ELDERLY

Factors of Immobility

By Paula R. Mobily, PhD, RN; and Lisa Skemp Kelley, MA, RN

INTRODUCTION

Maintenance of mobility is critical for health, well-being, and quality of life, yet immobility is one of the most common problems for the institutionalized elderly. Immobility may lead to serious physiological and psychological consequences. A multitude of factors that influence the state of clients' mobility are within nursing's realm of practice. This article discusses the iatrogenic factors associated with immobility, the consequences of immobility for the client, and what gerontological nurses can do to prevent or minimize the iatrogenic risks for the institutionalized elderly.

Teach us to live that we may dread
Unnecessary time in bed
Get people up and we may save
Our patients from an early grave[3]

There are many threats to physical mobility for the elderly. Hogue has developed a conceptual model for organizing information relative to the mobility of elderly patients in long-term care facilities.[4] Her model proposes that mobility is a consequence of the interaction between the competence of the individual and the resources within the environment. With respect to the competence of the individual, mobility is influenced by biological health, sensory-perceptual capacity, motor skills, cognitive capacity, and ego strength. Resources within the environment include the physical and architectural features, medical regimens for the treatment of disease and disability, policy factors, resident and staff characteristics, and social support availability. It is the environmental factors and resources that contribute to iatrogenic and nursing-induced complications associated with immobility.

Physical and architectural features that restrict mobility include such things as architectural barriers, slickly waxed floors, obstructions in the patient's room or hallways (ie, laundry carts), and lack of assistive devices for ambulation or mobility. Medical regimens, despite their therapeutic intent, often negatively affect mobility. Examples of this phenomenon are bedrest, surgery, physical and chemical (pharmaceutical) restraints, and other treatments that limit mobility, such as IV therapy, indwelling catheters, oxygen therapy, and suction catheters.

Policy factors are closely related to

Ten to fifteen percent of muscle strength can be lost each week that muscles are resting completely.

medical regimens. As noted by Hogue, policies determine the balance that exists between individual freedom and institutional order and continuity.[4] Policies, then, can affect the individual in terms of the relative lack of environmental choice and control and subsequently affect mobility. Other critical factors include the extent to which nursing and medical care are based on comprehensive functional assessment and on primary and secondary prevention of disability. The Omnibus Budget Reconciliation Act of 1987 (OBRA '87) is very specific with respect to policies related to comprehensive assessment, maintenance of functional abilities, use of chemical and physical restraints, and drug therapy in long-term care facilities. These factors will be addressed in more detail and interventions to prevent iatrogenically induced complications of immobility presented.

Characteristics of other residents in the facility can also influence mobility. Through modeling of the activity level and functional health of other residents, an individual's behaviors and values often change to conform to those of the majority of others within the environment.[5-7] Similarly, decreased opportunities for socialization with other residents may inadvertently contribute to the potential for loss of mobility.

Staff characteristics that influence mobility include staffing levels, care patterns, and staff knowledge and abilities. Inadequate staffing levels make it very difficult to promote mobility and institute measures to prevent or minimize the development of impaired mobility or the consequences that follow. Limited availability of physical and occupational therapists, especially in rural settings, or lack of consultation for patients prone to impaired mobility can also be detrimental because these personnel are often instrumental in developing activities and programs to promote mobility and rehabilitation.

Care patterns that promote patient dependence can also inadvertently contribute to loss of mobility and a subsequent decline in functional ability. Nursing staff may actually contribute to impaired mobility through helping activities, such as providing unnecessary assistance with transfers and bathing activities. This may ultimately promote dependence, rather than encouraging the patient to independently do as much as possible.[5,8] Finally, the knowledge and abilities of the staff with respect to understanding the hazards of impaired mobility, the iatrogenic and nursing-induced factors associated with impaired mobility, and the interventions necessary to prevent or minimize the adverse effects can be critical.

Impaired mobility, whether self- or other-imposed, can have a number of negative consequences for the older individual. Physiologically, every body system is at risk. Impaired mobility may result in decreased range of joint motion, development of contractures, loss of muscular strength and endurance, loss of bone mass and strength, deterioration of the cardiovascular and respiratory systems, metabolic imbalances, development of pressure sores, and impairment in urinary and gastrointestinal functioning. Psychologically, impaired mobility may result in depression, changes in behavior, and alterations in perceptual ability. Understanding the basic mechanisms underlying each of these consequences, the relative time frame in which they can develop, and the concomitant changes associated with aging provides the basis for interventions aimed at preventing or minimizing them.

CONSEQUENCES OF IMPAIRED MOBILITY

Decreased Joint Range of Motion

Aging produces changes in joint structure. As one ages, the collagen content of connective tissue increases progressively, resulting in an increase in the stiffness of tissue and a decrease in joint mobility.[9,10] The elderly patient with impaired mobility will face further compromise of joint function. Whenever movement is restricted, metabolic joint activity is altered. These tissues undergo a marked increase in collagen and become dense, and the fibers of the involved muscles, ligaments, and tendons shorten.[11] The result is a decrease in the overall flexibility of the joint and a subsequent decrease in joint range of motion.

These changes in joint structure may occur after as few as 5 days of immobilization, with measurable changes in range of motion within a week.[12,13] The deterioration progresses with continued immobility and contractures and permanent loss of joint mobility may result. Although all joints can be affected by immobilization, the hip, knee, and ankle are most susceptible due to the effects of gravity, the strength of the flexor muscles, and the difficulty for full extension or range of motion while sitting or in a recumbent position.[14] Contractures of the hip and knee make the patient much less stable and therefore prone to falls, which may further restrict mobility.[4,15]

Loss of Muscular Strength and Endurance

Muscular strength is maintained by frequent maximum tension contractions. Ten to fifteen percent of muscle strength can be lost each week that muscles are resting completely, and as much as 5.5% can be lost each day of rest and immobility.[16] The greatest loss of strength occurs during the initial period of immobilization. [illegible] results from deficiencies in venous functioning and stasis.[17] As muscle strength decreases, there is a concomitant decrease in endurance. When endurance is reduced, activity often becomes lim-

ited, thus initiating a cycle that can lead to further decline in strength and endurance and further reduction in mobility. The muscles most affected by immobilization are the antigravity muscles that facilitate locomotion and help maintain an upright position.[18] These include the quadriceps, glutei, erector spinae, and gastrocnemius-soleus muscles.[14]

Loss of Bone Mass and Strength

When normal weight-bearing and movement is diminished or absent, osteoclastic activity increases, greater resorption of bone occurs, calcium and phosphorous are released, and bones become thin, porous, and fragile. This is commonly termed "disuse osteoporosis." Bone loss increases rapidly from the third day to the third week of immobilization and peaks during the fifth or sixth week.[19,20] With ambulation, bone mineral has been found to restore at a rate of only 1% per month,[21] underscoring the importance of preventing the initial loss. Elderly patients are especially vulnerable because bone loss resulting from limited mobility is compounded by bone loss resulting from age-related osteoporosis. When bone density is sufficiently compromised, the elderly patient is particularly susceptible to fractures of the hip, spine, and extremities. Fractures further limit mobility and place patients at increased risk for subsequent decline in functional status and development of further complications of immobility.

Detrimental Effects on the Cardiovascular System

Cardiovascular deterioration is another adverse consequence of immobilization, particularly when the period of immobility is prolonged and the extent of limitation is severe, resulting in confinement to bed or wheelchair. When a patient is placed in the supine position, approximately 11% of the total blood volume is redistributed from the vessels of the lower extremities to the thorax. Approximately 80% of this volume enters the thoracic circulation[22] and cardiac output increases. As a result, the heart must work harder to circulate this extra volume. Cardiac workload is increased approximately 20% when the body is recumbent, and this load is doubled in individuals with pre-existing cardiovascular disease.[23]

An additional and potentially problematic effect of immobilization for the elderly results from initiation of the Valsalva maneuver. The Valsalva maneuver, an increase in intrathoracic pressure produced by forceful exhalation against a closed glottis, is commonly induced in patients with limited mobility. It can result from pushing, pulling, or straining such as occurs when turning in bed, lifting oneself with a trapeze, pushing oneself up in a wheelchair, getting on a bedpan, or straining during defecation.[24] With the sustained increase in intrathoracic pressure that results, venous blood flow is greatly inhibited, causing an increase in pulse rate and a transient increase in systemic blood pressure. Because many elderly have pre-existing cardiovascular pathology, the potentially deleterious effects of these phenomenon are increased.

Orthostatic hypotension is one of the most common cardiovascular complications of immobility. In healthy adults, movement from a supine to vertical posture causes a redistribution of blood volume as approximately 500 mL of blood pools in the large vessels of the lower half of the body.[25] Venous return is reduced, and central venous pressure, stroke volume, and systolic blood pressure decrease concomitantly.[18,26-28] Baroreceptors typically elicit sympathetic stimulation to counter these effects; however, during prolonged bedrest, position changes from supine to vertical do not occur and postural reflexes diminish, resulting in orthostatic hypotension when the person attempts to assume a vertical posture.[25]

Orthostatic hypotension can occur in persons who are immobilized for as little as 1 week, whether the immobilization is supine or sitting.[29,30] Orthostatic hypotension is common in the elderly due to age-related changes in the cardiovascular system, multiple chronic diseases, and medications that predispose to hypotension. The addition of immobility can significantly enhance the risk for orthostatic hypotension and the dangerous sequelae of falls and resulting complications. Normal men have been found to require 5 weeks to recover from the postural effects of only 3 weeks of immobility.[31] It follows that the elderly would deteriorate more quickly and would take longer to recover cardiovascular efficiency after a prolonged period of immobility.

Immobilization, whether in the supine or sitting position, also reduces the skeletal muscle pumping action and increases the gravitational pull on the vascular system. Both of these phenomena contribute to venous stasis that predisposes the patient to the development of venous thrombosis. Estimates of the incidence of thrombosis in the immobilized elderly, based on postmortem studies, are 80% to 100%.[32] Thrombosis has been found to develop within the first week of immobilization.[33] As the period of immobility increases, so does the risk of thrombosis[32] and the potentially life-threatening sequelae of emboli.

Respiratory Problems Associated with Immobility

Respiratory function can also be compromised during periods of impaired immobility. In the supine position, the vital capacity of the lungs is decreased by 4%[18]; secretions increase and expectoration decreases or becomes inadequate, causing pooling. In addition, the cilia become ineffective in propelling mucus from the respiratory tract.[34] Pneumonia is a common complication of these factors. In addition, atelectasis may occur due to restricted chest ventilation and poor oxygenation, and inadequate removal of carbon dioxide results. The elderly patient is already at increased risk for development of respiratory complications due to the anatomical changes in the respiratory system and decreased mucociliary clearance that occur with aging.[35,36] The risk escalates for elderly patients receiving sedatives or other medications that further compromise ventilatory status.

Metabolic Imbalances

Major metabolic changes resulting from immobility include loss of calcium and development of negative nitrogen balance. As bone resorption occurs during immobility, calcium is mobilized and the serum calcium level increases. If urinary function is compromised, as often occurs with aging,

Development of pressure sores can be one of the most serious consequences of immobility.

hypercalcemia can result and cause further problems, including anorexia, nausea, vomiting, abdominal cramping, constipation, and lethargy.

Normally, protein synthesis and protein breakdown within the body are in balance. During immobilization, muscle atrophy occurs, resulting in a marked increase in the excretion of urinary nitrogen, reflecting protein breakdown.[19] The result is a negative nitrogen balance. Negative nitrogen balance can develop within 5 days following immobilization[19] and is important because it represents a depletion of stores for protein synthesis essential for tissue repair. This phenomenon has important implications during immobility due to the potential for tissue injury from prolonged pressure.

Development of Pressure Sores

Development of pressure sores of the skin or muscle can be one of the most serious consequences of immobility, and the elderly are particularly susceptible. It has been estimated that two thirds of all geriatric patients in long-term care facilities have one or more diseases or conditions that create risk factors for the development of pressure sores.[37] Age-related changes in the skin and underlying tissues, combined with other factors such as the increased incidence of peripheral vascular disease, increased prevalence of nutritional deficiency and peripheral neuropathy, and the increased incidence of incontinence can quickly interact with the pressure created by immobility to produce tissue injury.

The extent and duration of immobilization are crucial factors in the development of impaired tissue integrity. Once tissue injury has occurred, the impaired body metabolism, particularly with respect to negative nitrogen balance, compounds the problem of healing. In addition, the formation of pressure sores will often result in further immobilization, initiating a spiral of negative sequelae.

Decreased Urinary Function

Urinary complications due to immobility include development of renal calculi and urinary tract infections. These complications arise primarily from impaired renal drainage and changes in urinary calcium levels and pH. Mobilization of calcium from the skeletal system increases the level of urinary calcium. During periods of immobility, especially when the patient is in a recumbent position, drainage of urine from the renal calyces is impaired, increasing the time for precipitation and aggregation of crystalloids. The result is an increased risk of renal calculi. This predisposition for calculi formation is enhanced by the increase in urinary pH, which results from the absence of acidic metabolites from muscle metabolism.[18]

The potential for development of a urinary tract infection increases during immobility because of the predisposition for urinary stasis in both the kidney and bladder, which in turn allows for bacterial growth. Elderly patients with impaired mobility, and especially those who are incontinent or have decreased cognitive or functional status, may be at even greater risk for development of urinary tract infection due to poor perineal hygiene, which favors enteric perineal bacterial growth.[38,39] Urinary tract infection further enhances the potential for development of renal calculi by providing a bacterial nuclei around which stones can form.[14]

Decreased Gastrointestinal Function

Impaired mobility affects the gastrointestinal system by altering ingestion, digestion, and elimination. Negative nitrogen balance and hypercalcemia can cause anorexia, nausea, and vomiting, which may result in inadequate intake of nutrients. Decreased protein and caloric intake, coupled with altered cardiovascular and respiratory functioning, decrease the exchange of nutrients between cells, reducing cellular metabolic activity and interfering with the body's ability to digest and use nutrients.[40]

Constipation may become a major problem for the immobilized elderly due to a decrease in intestinal motility, the inadequate ingestion of fiber and fluid associated with anorexia, development of weakness of the muscles used for defecation, the inability to respond to the urge to defecate, and the inability to assume the erect sitting position for defecation, which occurs when patients must use a bedpan. These physiological effects of immobility are often compounded by medications, particularly opiates and anticholinergics, which inhibit normal gastrointestinal function.

Psychological Effects

The patient with impaired mobility is subject to psychological as well as physiological consequences. Impaired mobility is often associated with diminished opportunities for socialization and diminished sensory input from other patients and staff. Although patient response is variable, this decrease in sensory input and socialization can cause depression; changes in behavior including hostility, belligerence, withdrawal, confusion, anxiety, apathy, and regression; decreased ability to concentrate and problem solve, altered time perception, increased dependency; and even auditory and visual hallucinations.[40-44] These psychological consequences may in turn further impair physical mobility. For example, patients who are depressed often become withdrawn and concomitantly decrease their level of mobility. Also, the deviant behaviors noted above are often less acceptable, and the patient exhibiting these may well be excluded from group activities and opportunities for social interactions that promote mobility.

In summary, the adverse conse-

ited, thus initiating a cycle that can lead to further decline in strength and endurance and further reduction in mobility. The muscles most affected by immobilization are the antigravity muscles that facilitate locomotion and help maintain an upright position.[18] These include the quadriceps, glutei, erector spinae, and gastrocnemius-soleus muscles.[14]

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quences of immobility can be devastating for the elderly client. Recognition and management of the iatrogenic factors contributing to immobility can be crucial in preventing the occurrence of these consequences.

MANAGEMENT OF IATROGENIC RISK FACTORS

Awareness of the impact of physical and architectural barriers can be instrumental in preventing the iatrogenically induced consequences of limited mobility. Attention to environmental restraints can make the resident feel more secure and more inclined to ambulate. Appropriate footwear can promote a sense of stability and security and minimize the risk of falling on waxed floors. Nursing personnel should be alert to physical barriers that restrict active mobility. Removal of obstructions in the resident's room and hallways is a simple, but often overlooked, intervention to promote ambulation. Provision of assistive devices such as handrails, walkers, and canes, as appropriate, can increase independence and the level of ambulation and mobility for many residents.

A period of bedrest can be beneficial in many circumstances. Care must be taken, however, to limit the period of bedrest to meet therapeutic objectives without prolonging the time unnecessarily. Given the speed of onset of complications associated with immobility, it is vital that interventions to prevent these complications be instituted immediately. An overbed trapeze will enable many residents confined to bed to reposition themselves independently and with greater frequency, thereby greatly diminishing the potential for development of many of the adverse consequences of bedrest.

The chief argument for the use of restraints involves patient safety. It is vital that restraints be used only when absolutely indicated and preventive interventions, including periodic removal and range of motion exercises, be instituted immediately and diligently continued. OBRA '87 regulations call for discriminant use of restraints only after alternative methods have been used and found deficient. Pharmaceutical agents, such as tranquilizers and sedatives, are also addressed in the OBRA '87 regulations. These can act as chemical restraints, and awareness of their potential in causing problems relative to mobility is important. Care must be taken to titrate the therapeutic benefits with the potential for untoward consequences with respect to mobility. Ongoing consultation with the physician and judicious use of these drugs is imperative.

Constipation may become a major problem for the immobilized elderly.

Nursing personnel must consider the degree of restraint imposed by treatments such as IV therapy, oxygen therapy, and use of indwelling and suction catheters. Residents receiving these therapies require ongoing interventions to prevent the development of problems associated with the restrictions in mobility. Ambulatory devices or units that allow for greater mobility should be available and used. Consultation with the attending physician may establish parameters for the use of these therapies that at the same time increases mobility for the resident. For example, rather than using an indwelling catheter, clean intermittent catheterization may be a feasible alternative. Similarly, a heparin lock could be used in place of an IV set-up when the IV is used only to administer medications.

As with the other factors previously discussed, institutional policies can actually contribute to impaired mobility. Good nursing practice, along with OBRA '87 mandates, should be beneficial. Long-term care facilities must provide the quality of care necessary to attain and maintain the highest possible mental and physical functional status. Comprehensive assessment on admission and periodic review no less than every 3 months are required. In addition, residents must receive necessary treatments to maintain or improve abilities, and the staff must demonstrate that a decline in abilities is unavoidable and due to the individual's clinical condition. Specifications directly relevant to the topic of impaired mobility include mandates that the client's range of motion must not decline, and that appropriate treatment and services to prevent any further reduction in range of motion, when limited, be instituted. Also, the facility is expected to prevent the development of pressure sores, institute treatment and services to promote healing when they do occur, and prevent new sores from developing. Finally, the new legislation mandates against unnecessary use of restraints and medications.

Because the characteristics of other residents in the environment can influence mobility, efforts should be made to interface, to the extent possible, residents with similar functional abilities and activity levels. Those residents with impaired mobility, but with the potential for improvement, may do better in an environment that promotes interaction with residents at higher levels of function and activity. Again, the importance of consultation with activity, occupational, and physical therapists cannot be overemphasized.

Attention to staff characteristics is critical for preventing or minimizing the effects of immobility. Adequate numbers of staff to provide the necessary care and availability of resources, such as physical, occupational, and activity therapy personnel, can significantly enhance the functional abilities and activity level of residents. Recognition of the nature of care patterns that actually promote dependence and subsequent loss of mobility, as well as knowledge of the causes and consequences of immobility and the level of

interventions necessary to prevent or minimize the effects of immobility, is critical. Inservice education programs, interdisciplinary team conferences, and comprehensive and regularly updated care plans can be important sources of information and knowledge.

This article has provided a framework for understanding the iatrogenic and nursing-induced factors associated with impaired mobility, a review of information about the physiological and psychological consequences of immobility, and interventions for preventing or minimizing immobility. The elderly patient presents a special challenge. The consequences of immobility can affect health, well-being, and quality of life, but these can be avoided with astute and vigilant nursing management.

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as a deep and intensely felt pain that cannot be endured for long. The research suggests that the elder's attempts to cope with this unendurable pain results in behaviors that are often misinterpreted by others as indicating acceptance or adjustment to the nursing home setting.

As the field research came to a close, the researcher attempted to identify through coding, any significant and consistent patterns of responses or interactions that might be indicative of the identified concepts of home and homelessness. The coding method was patterned after Glaser and Strauss' Grounded Theory Methodology.[29] In addition to identifying the categories of home and homelessness, various categories emerged that seemed to be indicative of strategies for coping with the disorganization and pain of the homeless state. The central or core variable that emerged from the data was a particular coping strategy that might be used to avoid the confusion and pain of the homeless experience. This was identified as pretending and was found to have several implementing processes that were identified as living in the past, keeping the secret, distancing, and surrendering (Figure 4).

The core variable of pretending explains how nursing home residents manage the overwhelming emotional pain of homelessness. Pretending is a maneuver or game that the elderly resident plays to avoid feeling (experiencing) the pain of homelessness. When played effectively, elders often convince themselves and others that they have accepted nursing home placement or have adjusted to institutionalization. It is a game that is played cautiously and unconsciously. If players inadvertently discover they are playing a game (for example if they are asked "How can this be your home when you say that you have no home?"), they will become disorganized and anxious until they discover how to recover the pretense.

Living in the past is a strategy that allows the individual to continue to experience the centering and comforting feeling of home. Individuals are able to transcend the current institutionalized and homeless state and return to a time when they were "home."

Keeping the secret allows homeless elderly to avoid the sure knowledge of homelessness that exists within the secret recesses of their hearts. This is accomplished when the elder can say "I have no home" and then state "this place is my home." Because individuals are keeping the secret of their homelessness locked inside of themselves, there is no contradiction in making these two opposing statements.

Distancing involves a pulling back from involvement with other residents and seems to be mutual and a perceived necessary protective maneuver. This could be because the pain of homelessness is mirrored by each resident. It is as if each is saying "If I do not see you, then I do not see (feel the pain in) me."

Surrendering entails succumbing to the fact that in coming to a nursing home, and therefore in becoming homeless, there was no choice; a kind of "what else could I do?" attitude prevails. This surrendering to the acceptance status offers protection from the experience of abandonment by family, the "I do not belong" aspect of homelessness.

The coping strategy of pretending and its implementing processes are tentatively identified at this point and need to be further investigated to be more clearly described and to further verify their validity in managing the pain and disorganization of the homeless state.

IMPLICATIONS FOR NURSING

When considering homelessness in the institutionalized elderly, a pressing issue is whether nursing homes should exist at all. If the consequence of being institutionalized is to be homeless, and if to be homeless is to lack meaning in life and to suffer intolerable pain, then can we justify providing and promoting this negative experience for the vulnerable and chronically ill elderly individual? Solutions to this dilemma might be found in the exploration and development of alternative settings, similar in structure and philosophy to half-way houses, in an attempt to move away from the total institution of the typical nursing home.

In the meantime, nurses have the primary responsibility for creating the environment of the nursing home; consequently, efforts could be directed toward modifying the environment to strengthen the relationship between it and the individual. This would involve changes in management style, policies, and attitudes to move away from such homelessness-provoking attributes of the total institution as routine, loss of autonomy, and no journey. Of significance would be recognition, on nursing's part, of the state of homelessness and the implementation of psychosocial interventions that might alleviate the pain and assist in strengthening the individual's relationship with the environment. For example, investigation of the value of group psychotherapy might provide valuable data about possible interventions to strengthen the individual's connectedness with others. Another area to investigate is the establishment of a holistic, nurturing, affirming, and healing community in the nursing home and how this might affect the homeless resident. How can nursing establish such a community, and can it reduce the degree of homelessness the individual is experiencing?

Nursing needs to address whether it is possible to adjust or accept the homeless state, and in so doing, question the use of these terms as meaningful at all. If a homeless state is intolerable, why would we ask individuals if they accepted it and why would we describe what can only be identified (from the homelessness perspective) as a state of helplessness as being adjusted? Research could be re-evaluated in this light and discoveries might be made that there is no acceptance or adjustment to homelessness; there are only coping strategies that protect the individual from the intensely consuming pain of the homeless state.[30,31]

Identifying home and homelessness on a continuum suggests that one might intervene somewhere along this continuum before the individual reaches the homeless state. Identification of elderly individuals who are at risk of becoming homeless and initiation of interventions designed to prevent further movement along the continuum might be effective in preventing homelessness. For example, elderly hospitalized individuals, who are often extremely fragile and vulnerable, need to have an advocate to

protect them from the thoughtless dismantling of their houses and a precipitous discharge to a nursing home. In addition, issues such as the inability of many hospital and nursing home nurses to deal with the pain of homelessness and their consequent need to participate in its denial need to be addressed.

This investigation of homelessness as an experience of the institutionalized elderly individual has provided a rich source of material for further exploration. The elderly individual wandering the streets is easily identified as homeless, yet there is an entire population of elders who suffer silently, enduring the painful state of homelessness within the confines of the total institution of the nursing home. To view as homeless these individuals who are, in fact, sheltered and fed seems incongruent; however, when one acknowledges these unrecognized homeless, the increased understanding can direct us in the discovery of ways in which we can alleviate or reverse the process.

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Homelessness

KEY POINTS

Carboni JT. Homelessness Among the Institutionalized Elderly. *Journal of Gerontological Nursing* 1990; 16(7):32-37.

1. Home is the experience of a dynamic relationship between the individual and the environment. It can be viewed as a lived experience that possesses deep existential meaning for the individual.

2. Homelessness is the experience of the negation of home; the relationship between the individual and the environment loses its intimacy and becomes severely damaged. This painful experience brings about deep existential despair.

3. The data supports the strong probability that the institutionalized elderly are homeless and that the elder's attempts to cope with this unendurable pain results in behaviors that are often misinterpreted as indicating acceptance or adjustment to the nursing home setting.

4. Nursing must recognize the possibility that to be institutionalized is to be homeless. This intolerable state must be alleviated either through significant modification of nursing home psychosocial environments or the identification of alternative settings for the care of chronically ill and debilitated elderly persons.

Appendix 3 -- Sample Cases for Training

Case 1

(adapted from a case handled by the Long Term Care Ombudsman Program of Dayton, OH)

A husband and wife reside in a nursing facility. When the husband becomes more frail, the nursing staff inform the husband that it wants to relocate him to another room because of his increasing needs. The staff are not certain whether the wife can accompany him to the other section of the facility because she has only limited care needs.

The couple informs the staff that they do not wish to move to another room or to be separated. The husband's refusal stems from his visual impairment and other health considerations. He has severely limited visual ability, and says he needs to be in familiar surroundings to be able to continue to function independently. He feels very comfortable and secure in his current physical environment.

The facility insists that the move must take place for a number of reasons: more staff are available in the other section to provide assistance; the rooms are equipped with adjustable beds; the bathrooms are more suitable; and rehabilitation services are available.

The man asks why he can't have all these services in his current room. The administrator explains that these services are not provided to all rooms "because of the way the facility is structured." The man is moved despite his protests, but the facility agrees to move his wife too.

Questions for Group Discussion:

- What do you question about what happened?
- What would you cite?
- What would be an acceptable plan of correction?

Trainers' Guide for Case 1:

Use article in Appendix 2, "Homelessness Among the Institutionalized Elderly" by Judith Carboni. Look at the following Requirements and Surveyor Guidelines:

Residents' Rights

- 483.10 (b)(4): "The resident has the right to refuse treatment"
- 483.10 (d)(2)and (3): Free choice
- 483.10 (f)(1) and (2): Voice Grievances; prompt efforts by facility to resolve
- 483.10 (m): Married couples right to share a room

Quality of Life

- 483.15 (a): Dignity
- 483.15 (b): Self-determination; right to make choices
- 483.15 (e): Accommodation of individual needs and preferences
- 483.15 (g): Social Services

Quality of Care

- 483.25 (a): Activities of Daily Living
- 483.25 (f): Mental and Psychosocial functioning

Case 2

(adapted from a case designed by the National Senior Citizens' Law Center)

Mrs. G is an 82 year old woman who was admitted to a nursing facility after hospitalization following a stroke. Her speech is impaired and she cannot walk; she is, however, able to use her arms and hands. While in the hospital, Mrs. G experienced periods of confusion, memory loss and apparent impaired judgement. At the time of her admission, facility staff noticed that she seemed not to recognize her daughter every now and then and was not sure where she was.

Prior to her hospitalization Mrs. G lived with her daughter in an apartment in the city. Until recently, she worked in a florist shop a mile from her apartment as a flower arranger. She and her daughter have no car and walked everywhere for the exercise and enjoyment.

Now at the facility, Mrs. G wheels her wheelchair up and down the corridors constantly, peeking into virtually everyone's room and often getting in the way of the staff. On several occasions, she has tired to stand and walk; her daughter is so concerned that she will fall and break a hip that she has asked the facility to secure her mother in the wheelchair so she cannot get up by herself. Since the facility agreed to do this, Mrs. G has had several incidents of incontinence.

Mrs. G has become increasingly agitated. The doctor ordered Mellaril p.r.n. Since taking the medication, Mrs. G is still agitated, but has been drowsy. A few times she has spit the pill out.

Mrs. G has begun refusing meals, telling the staff this is her choice; and she chooses to remain in her night clothes all day. When she was first admitted, she had actively participated in dressing herself each morning before breakfast. The facility has told Mrs. G's daughter that if she continues to refuse meals and medications, she may have to find another facility.

Questions for Group Discussion:

- What do you question about what happened?
- What would you cite?
- What would be an acceptable plan of correction?

Trainers' Guide for Case 2:

Use article in Appendix 2, "Homelessness Among the Institutionalized Elderly" by Judity Carboni. Look at the following Requirements and Surveyor Guidelines:

Residents' Rights

- 483.10 (a): Exercise of Rights
- 483.10 (d)(2)and (3): Free choice

Admission, Transfer and Discharge Rights

- 483.12 (a)(2), (4) and (5): Reasons for transfer; Notice before transfer; Timing of notice

Resident Behavior and Facility Practices

- 483.13 (a): Restraints

Quality of Life

- 483.15 (a): Dignity
- 483.15 (b): Self-determination; right to make choices
- 483.15 (d): Participation in other activities
- 483.15 (e): Accommodation of individual needs and preferences
- 483.15 (f): Activities
- 483.15 (g): Social Services

Assessment

- 483.20 (b) and (d): Comprehensive assessment and Comprehensive care plans

Quality of Care

- 483.25 (a): Activities of Daily Living
- 483.25 (d): Urinary Incontinence
- 483.25 (e): Range of Motion
- 483.25 (f): Mental and Psychosocial functioning
- 483.25 (l): Unnecessary Drugs; Antipsychotic Drugs

Case 3

(adapted from a case handled by the NCCNHR office)

Part 1

The State Survey Agency investigated a complaint of poor care. Surveyors found Mr. L bedfast, in a fetal position and catheterized. He was unresponsive, appeared to be in pain, and had been given anti-psychotic medications for his pain. He was being tube-fed and weighed 80 pounds.

The surveyors cited the facility for infection control because the catheter was improperly handled and for unnecessary drugs because the doctor's orders were not up-to-date.

Questions for group discussion:

What would you have done in this situation?

What questions would you ask?

What else would you want to know?

What would you cite?

Case 3 - Part 2

After Mr. L died a nurse reviewed the medical records for an attorney representing Mr. L's son. She found the following case history:

Mr. L entered the nursing home a robust, energetic man, weighing 180 pounds, diagnosed with dementia. During the first few weeks, he constantly headed for the door, but he was too big for the staff to handle and he became agitated when they tried to stop him. To prevent his wandering the staff restrained him. He resisted the restraints and fell several times, bringing the wheelchair down with him. He was then given an anti-psychotic medication, in a high enough dosage to make him sleepy. He soiled himself so the staff inserted a catheter, which he pulled on in an attempt to remove. The staff restrained his arms to keep him from removing the catheter.

Mr. L began to lose weight and was placed on regular tube feedings. He developed a urinary tract infection which was treated with medications. His skin started to break down and he could no longer sit up in his chair was he was placed in bed. He became unreponsive, began to develop contractures and finally went into a fetal position. Eighteen months after walking into the facility, Mr. L died.

Questions for Group Discussion:

Was Mr. L's decline avoidable or unavoidable?

What questions would you ask?

What additional information would you need?

What would you cite?

How would you support your citation?

What would be an appropriate plan of correction?

Trainers' Guide for Case 3

Use article in Appendix 2: "Iatrogenesis in the Elderly: Factors of Immobility" by Paula Mobily and Lisa Kelley. Look at the following Regulations and Surveyor Guidelines:

Residents' Rights

- 483.10 (b)(10): Notifying family of significant changes in the resident's condition or treatment
- 483.10 (d)(2) and (3): Fully informed of care; participation in planning care

Resident Behavior and Facility Practices

- 483.13 (a): Restraints

Quality of Life

- 483.15 (a): Dignity
- 483.15 (e): Accommodation of individual needs and preferences
- 483.15 (f): Activities
- 483.15 (g): Social Services

Assessment

- 483.20 (b) and (d): Comprehensive assessment and Comprehensive care plans

Quality of Care

- 483.25 (a): Activities of Daily Living
- 483.25 (c): Pressure sores
- 483.25 (d): Urinary Incontinence
- 483.25 (e): Range of Motion
- 483.25 (f): Mental and Psychosocial functioning
- 483.25 (g): Naso-gastric tubes
- 483.25 (h): Accidents
- 483.25 (i): Nutrition
- 483.25 (l): Unnecessary Drugs; Antipsychotic Drugs

Appendix 4

OMBUDSMAN AND SURVEYOR INTERACTION AND COOPERATION TO SUPPORT RESIDENT PARTICIPATION IN THE SURVEY PROCESS

A PROTOCOL FOR BEST PRACTICE

by Virginia Fraser, Colorado State Ombudsman

These are notes from joint sessions with ombudsmen and surveyors in Colorado and New Mexico facilitated by Barbara Frank, NCCNHR. They are suggestions for ombudsmen and surveyors at each step of the process. Some reflect the HCFA manual, others are best practice recommendations.

- Prior to the Survey:

Ombudsman:

1. Keep a list of issues to discuss with the survey team when they call.
2. Be as specific as possible regarding persons and issues.
3. Identify, if possible, residents who can be suggested to the team for inclusion in the sample, persons with special needs/problems or residents who are able to speak up clearly.
4. Plan to educate residents and resident council about the survey process (use "Your Role in the Survey Process").

Surveyors:

1. Check complaints and incidents which have come in during the past year, especially from ombudsmen.
2. Make sure you have a current ombudsman list. If you have questions call the state ombudsman.

- Contact at the Beginning of the Survey:

Ombudsmen:

1. Be aware of when weekly survey begins (for example, Tuesday morning). Be sure your office knows how to reach you.
2. Return surveyor's phone call or arrange to have your office let them know when you will call or be available.
3. Arrange telephone or meeting time to provide surveyor with specific information regarding persons, issues and people suggested to be part of the sample or family members to contact.

4. As appropriate, suggest closed records for review - for example, a discharge that was questionable within the last six months.
5. Be prepared to share information that pertains to bed-hold, personal needs, discharge or Medicaid discrimination.
6. Share information on quality of care issues -- in particular, information regarding residents whose abilities may have declined.

Surveyors:

1. Call the ombudsman regional office. If that office cannot be reached, call the state ombudsman on the toll-free number 1-800-288-1376 in Colorado. Leave a message as to whom you are attempting to reach. Be aware that many ombudsmen are part-time or may be in the field with conflicting time schedules.
2. Depending on how well the ombudsman knows the facility, ask for suggestions for interviewable residents and suggestions for closed record review.
3. Ask the ombudsman for information on any quality of care issues.

- Contact During the Survey:

Ombudsmen:

1. Discuss with the surveyor the time you may be available for participation in resident interviews (at resident request), resident council interviews and mid-point dialogue.
2. Let residents and families know the surveyors are there and what their role is.
3. Be with residents who want you there for the interview.
4. Attend group interviews with residents' permission.

Surveyors:

1. If the ombudsman is present in the facility, use his or her knowledge of residents.
2. Invite the ombudsman to the discussion of findings with the administration.

- Additional Suggestions:

Joint Trainings -- ombudsmen and surveyors
Information sharing between surveys
Focus on problem facilities

For more information, contact:

Virginia Fraser
Colorado State Ombudsman
455 Sherman Street, # 130
Denver, CO, 80203
(303) 722-0300

WORKING TOGETHER FOR BETTER CARE

NEW MEXICO REGIONAL CONFERENCE
FOR SURVEYORS, OMBUDSMEN AND APS
LAS CRUCES, NEW MEXICO
APRIL 15, 1993

9:00 am - 9:15 am	**Welcome and Purpose for Meeting (Molly Munson)**
	Including update on what's happened since November 1992, Joint Training for Surveyors and Ombudsmen.
9:15 am - 9:55 am	**Warm-up Exercise and Introductions (Matt Gervase)**
	MINI-BREAK
10:00 am - 10:45 am	**"Who We Are" (Gerald McBride, Matt Gervase, Tim Corvell)**
	Authority/purpose/duties of each program
	MINI-BREAK
10:50 am - 11:15 am	**"How We See Each Other" <u>listening exercise</u> in small groups**
	Group members speak without interruptions or comments from others. Each person will have about three minutes to speak. Each group will need a recorder and a timer.
11:15 am - 12:00 pm	**"How We Can Help Each Other"small groups/large group (Matt Gervase)**
	Identify the pluses and minuses of our work (interagency as well as individual); decide which interagency obstacles can be avoided or eliminated and which are beyond our control.
12:00 pm - 1:00 pm	**LUNCH**
	We will resume promptly at 1:00 p.m.

1:00 pm - 2:30 pm **"Our Interaction with Nursing Facilities" (Matt Gervase)**

A. Survey Process

Licensing and Certification Panel re: their jobs

Ombudsmen: Everyday Advocacy and special role in surveys (Molly Munson)

B. Complaint Investigation: How Are We Different?

APS (Gerald McBride), L & C (Matt Gervase) and LTCOP (Tim Corvell)

2:45 pm - 3:25 pm **"Our Interaction with Board & Care Homes" (Gerald McBride-facilitator)**

A. Survey and Licensing Process

How Board & Care Process Compares to NF (Matt Gervase with L & C Panel)

B. Unlicensed Homes and Other Concerns

Improper placements by discharge planners, level of care questions, each agency's response etc. Group discussion, (Gerald McBride-facilitator)

MINI-BREAK

3:30 pm - 3:45 pm **"Transfer and Discharge" (Tim Covell)**

Brief overview of applicable federal and state law and the appeal process for NF residents who are being involuntarily transferred or discharged.

3:45 pm - 4:00 pm **"What's Next?" (Gerald McBride, Matt Gervase, Tim Covell)**

For more information, contact:
Tim Covell & Molly Munson
State LTC Ombudsman Programs
State Agency on Aging
224 E. Palace Ave - 4th Floor
Santa Fe, New Mexico 87501
(505) 827-7640

The National Eldercare Institute on Elder Abuse and State Long Term Care Ombudsman Services is a component of the National Eldercare Campaign -- a nationwide effort spearheaded by the U.S. Administration on Aging to mobilize community action on behalf of older persons, particularly those at risk of losing their independence. The Institute strengthens local, state and national efforts to combat elder abuse in both *domestic* and *institutional* settings. It assists states in the development of effective Long Term Care Ombudsman Programs. The Institute is operated by NASUA, in collaboration with NCCNHR, and APWA.

The National Association of State Units on Aging (NASUA), founded in 1964, is a national public interest organization dedicated to providing general and specialized information, technical assistance and professional development support to State Units on Aging. The membership of the Association is comprised of the 57 state and territorial government units charged with advancing the social and economic agendas of older persons in their respective states. NASUA is the articulating force at the national level through which the State Units on Aging join together to promote social policy responsive to the needs of aging America. For more information, contact: NASUA, 1225 I Street, NW, Suite 725, Washington, D.C., 20005. (202) 898-2578.

Daniel A. Quirk, Executive Director
Sara Aravanis, Institute Director
Virginia Dize, Institute Deputy Director
Loree Cook-Daniels, Program Associate
Doreen Coates, Administrative Assistant

The National Citizens' Coalition for Nursing Home Reform (NCCNHR), founded in 1975, is a consumer-based nonprofit organization of local and state member groups and individuals, working to improve health care and quality of life for nursing home and boarding home residents. NCCNHR operates an information clearinghouse, promotes public policy responsive to the needs of nursing home residents, and promotes full implementation of the Nursing Home Reform Law. For more information, contact: NCCNHR, 1224 M Street, NW, 3rd Floor, Washington, DC 20005. (202) 393-2018.

Elma Holder, Executive Director
Barbara Frank, Associate Director
Sarah Burger, Consultant
Sara Hunt, Consultant

American Public Welfare Association (APWA), founded in 1930, is a non-profit organization representing state and local public human service agencies and individuals concerned with human services. The Association advocates for progressive social policy at the national level and provides services to meet the professional development needs of its members including state human service, local public welfare, and adult protective services administrators. Serves as the lead agency for the National Aging Resource Center on Elder Abuse (NARCEA). For further information contact: APWA, 810 First Street, NE, Suite 500, Washington, DC 20002-4205. (202) 682-0100.

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