Vulnerability to Elder Abuse and Neglect in Assisted Living Facilities

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Purpose: The purpose of this study was to examine the decision-making abilities of residents in assisted living regarding abuse and neglect. Design and Methods: Twenty-seven residents in assisted living facilities were recruited for this descriptive study. Participants were administered an interview to assess baseline knowledge of support services, including ombudsman programs. They were next asked to watch videotaped scenarios of common types of elder abuse (physical, verbal, fiduciary, neglect) and asked to identify abusive situations. Finally, the participants were asked to develop a plan of action if they were to experience similar situations. Results: The results suggested poor awareness of available elder support services ($M = 25\%$). Residents performed fairly well in the simple identification of the abusive situations ($54\%$), but had difficulty generating acceptable strategies for handling abusive situations. Approximately $25\%$ had no suggestion, $50\%$ reported they would consult a family member, and $25\%$ had nonspecific suggestions (e.g., talk to staff about problem). Implications: The results of this study suggest that residents of assisted living facilities are poorly informed about protective services and uncertain about options if care were not optimal. Further work with larger samples is needed to confirm these results.

Key Words: Decision making, Long-term care

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Assisted living facilities are the most rapidly growing source of residential care for the elderly. According to Hawes, Phillips, and Rose (2000) there are approximately 611,000 residents living in assisted living facilities, and no doubt this figure will continue to grow. Assisted living facilities promise a new model of long-term care, one that blurs the distinction between nursing homes and community-based care. At their best, assisted living facilities hold the promise to maximize the dignity, privacy, and independence of their residents (U.S. General Accounting Office [GAO], 1999). Facilities are designed to be home-like and are not regulated to the same extent as nursing homes, if at all (Hawes, Rose, & Phillips, 1999). The opportunity for residents to “age in place” with the availability of increased services allows for a highly variable range of residents to coexist in assisted living (Newcomer, Breuer, & Zhang, 1994). Yet, these very strengths of assisted living facilities may create an environment that places residents at increased risk for abuse and neglect. Specifically, the presence of cognitive impairment in conjunction with minimal regulations and oversight, private rooms, low staff ratios, minimal staff training, and high staff turnover may conspire to increase risk.

There has been reluctance on the part of the assisted living industry to move toward a more regulated environment for both philosophical and practical reasons. Assisted living is a consumer-driven phenomenon (Kane & Wilson, 1993). One might make the argument that market forces are all that are required to control quality in assisted living. Consumers paying a monthly fee for room and board have more options than those in nursing care and could simply leave the setting if they found the care to be substandard. A more regulated environment may become a more institutional environment, an outcome at odds with
consumers’ stated preferences (GAO, 1999). Although these arguments are certainly valid, an assumption is made regarding the competency of the consumers’ decision-making abilities in assisted living.

There is emerging evidence to suggest that market forces alone are not maintaining high standards in assisted living facilities. A report issued by the GAO (1999) reveals a pattern of deficiencies in the majority of homes sampled in four states. In this report, 622 assisted living facilities in California, Florida, Ohio, and Oregon were studied using survey methodology and interviews. According to the report, one fourth of the reviewed facilities were cited either by state licensing, ombudsman, or other agencies for five or more quality of care or consumer protection related deficiencies or violations in 1996 and 1997. The report added that 11% were cited with 10 or more similar violations. Frequently identified problems included (a) a failure to provide sufficient care to residents after an accident, (b) having unqualified or insufficient staff, (c) not providing medications or storing medications inadequately, and (d) not following admission and discharge policies required by state regulations. The report stated that the primary factors related to these problems were poor staff ratios, inadequate staff training, and high staff turnover and low pay. Only 38% of facilities surveyed were not cited for any deficiencies during the period of the study. Although this report did not frame results in terms of abuse and neglect, per se, the results describe a setting where the combination of staff issues and limited oversight set the stage for vulnerability to abuse and neglect.

There is limited research characterizing the cognitive status of the residents in assisted living. According to Hawes and colleagues (2000), cognitive status may vary based on facility type. The authors characterize two general types of facilities: those with high privacy and high services and those with low privacy and high services. According to the report, approximately 24% of residents of the high-service, high-privacy setting have severe cognitive impairment compared with approximately 36% of residents in the low-privacy, high-service facilities. Based on the GAO (1999) report, 94% of assisted living facilities reported that they would admit residents with cognitive impairment. This figure suggests that cognitive impairment is common among this population. The Institute for Health and Aging at the University of California San Francisco issued a report describing residential care for the elderly individuals in 500 California facilities (Newcomer et al., 1994). According to the report, approximately 10–34% of residents have moderate to severe cognitive impairment based upon the Mini-Mental State Examination (MMSE; Folstein, Folstein, & McHugh, 1975), consistent with the Hawes and colleagues (2000) report. These figures suggest that a substantial proportion of the population in assisted living may lack the cognitive resources necessary to act as advocates for themselves regarding quality of care.

The goal of this study was to examine the assumption that residents in assisted living facilities are well-informed consumers who could take action in the face of substandard care. We were specifically interested in gaining a better understanding of the ability of residents to protect themselves from elder abuse and neglect by examining their decision-making abilities related to abuse issues. We reasoned that there were at least three steps involved in assessing elders’ self-protection from abuse. The first step was to determine if residents could identify inappropriate care. This skill was assessed by asking the residents to watch videotaped scenarios depicting abuse, neglect, and poor care. Participants were asked to point out the incidents of concern on the videotape. The second step was to determine if the residents were aware of elder protective services and reporting laws. We reasoned that the identification of abuse without awareness of resources might affect a decision to report substandard care. Knowledge regarding reporting laws and elder services was assessed using a questionnaire. The third step was to consider what the residents would do personally if placed in a setting that had such poor care. The residents were asked to whom they would report abuse and neglect and how they would go about finding a new place to live. Our hypothesis was that the residents would have difficulty forming a plan—a finding that would be at odds with a market-driven model of quality assurance. Taken together, we believed that a better understanding of these specific skills might help in the development of intervention programs targeting residents in assisted living facilities.

Methods

Participants

Twenty-seven residents in three assisted living facilities were recruited for the study. The mean age was 87, and the majority of participants were female (23/27). Seventeen of the residents were members of continuing care facilities with 30-bed assisted living units and 10 were residents of a 75-bed, for-profit, freestanding facility. All residents were private pay. The settings would be characterized by the Hawes and colleagues (2000) criteria as high-privacy and high-service facilities. Participants’ mean MMSE score was 27/30 with a range from 13–30, indicating most were cognitively intact, but the range included those with moderate impairment. The residents were recruited with help from the administrator in each setting. The administrators chose residents that they felt would be able to watch a videotape and answer questions. Thus, this sample is highly selected and likely represents a less impaired population than is typical in comparison to published data (Newcomer et al., 1994).

Materials

In order to assess decision-making ability related to abuse and neglect, four instruments were developed: a demographic intake form, a videotape, and two written instruments. The demographic intake form was designed to capture the essential demographic charac-
Table 1. Average Percentage of Correct Responses Across Specific Domains

<table>
<thead>
<tr>
<th>Population</th>
<th>Physical Abuse</th>
<th>Verbal Abuse</th>
<th>Neglect</th>
<th>Environmental Hazards</th>
<th>Fiduciary Abuse</th>
<th>Medication Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents</td>
<td>53.26</td>
<td>67.83</td>
<td>42.39</td>
<td>19.00</td>
<td>73.91</td>
<td>91.30</td>
</tr>
<tr>
<td>Nursing staff</td>
<td>58.87</td>
<td>87.10</td>
<td>51.61</td>
<td>33.06</td>
<td>66.94</td>
<td>70.97</td>
</tr>
</tbody>
</table>

Procedure

Residents were invited to participate, and those who were interested contacted the study coordinator. During the first session, the goals and the procedures of the study were explained and the participants were given a copy of the consent documents. The participants were advised that they could stop at any time. Those that remained interested completed the forms and began the session. Residents were tested individually. Following mental status testing and intake, participants were shown the videotape. The participants were administered two practice scenarios. In the first scenario, there are several inappropriate items to note: a safety issue (loose throw rug), poor medication administration (aide throws out “extra” medication so family will be unaware of faulty compliance), and verbal abuse (aide calls resident “cranky old lady” in disrespectful tone). In the second practice scenario, an aide roughly handles a resident during a transfer. Following the practice items, 17 test scenarios were administered and participants were asked to describe any inappropriate behaviors or safety hazards displayed in each of the scenarios. After they watched the tape, participants were asked what they would do if they found themselves in a facility that provided inadequate care. They were encouraged to generate as many strategies as possible. Next they were administered the questionnaire on elder services; the questionnaire was to be read to them and completed by the research assistant. We also administered the videotaped scenarios to 27 nursing staff working in the same facilities as part of an educational intervention, and we use this group for comparison.

Results

According to the intake form, 13/27 of our sample chose an assisted living facility on their own, 8/27 did so in collaboration with their family, and 6/27 reported that their family made all arrangements. Thus, 78% of the participating residents were involved in choosing their current placement.

The results of the questionnaire regarding knowledge about elder protection indicated a poor awareness of available services ($M = 25\%$). Participants were most likely to know internal services (e.g., nurses or administrators) and least likely to know external services (e.g., ombudsman program).

Performance on the identification of abuse scenarios was variable (see Table 1). Participants demonstrated a weakness compared with staff in the identification of verbal abuse (insults, threats), neglect (isolation), and environmental hazards (filthy room, lit candles). Performance was fair compared with staff in terms of physical abuse (rough handling, slapping), and superior to staff in terms of identifying fiduciary abuse and medication issues. Overall, the participants identified approximately 54% of the inappropriate behaviors embedded in the scenarios compared with 63%
identified by nursing staff. There was a significant positive correlation between MMSE score and performance on the elder protective survey ($r^2 = 600; p < .01$) and the videotaped vignette test ($r^2 = .890; p < .05$) indicating that those with highest MMSE score performed best. These findings suggest that the residents were able to identify physical abuse, fiduciary abuse, and medication issues and articulate what was wrong but demonstrated a relative weakness in the identification of verbal abuse, neglect, and environmental hazards.

Qualitative analyses of the strategies generated by the residents revealed the following patterns. In response to the question “If you were concerned about the quality of care in this home, to whom would you voice your concerns?,” 51% of the participants responded that they would contact family members for help, 26% gave no response or were very vague (e.g., “tell girl at desk”), and the remainder mentioned a specific non-family member. In response to the question “If you wanted to leave because you were unhappy with the quality of life in this facility, what steps would you take?,” 26% of the participants stated that they would rely on family, 51% were unable to generate any plan, and 22% gave an acceptable response that did not rely on family. When asked how they would leave if family were not available to help, 78% of participants were not able to generate a plan.

Discussion

The results of this study confirm the primary hypothesis: Residents of assisted living facilities would not easily be able to make changes in their housing arrangements if they were unhappy with care. In terms of abuse issues, residents were able to identify most of the issues raised in the videotaped scenarios compared with staff. However, they were poorly informed about protective services and uncertain about options if care were not optimal. The results suggest, at least in our selected sample, that residents in assisted living facilities would have difficulty reporting elder abuse if it occurred and would have difficulty making alternate arrangements without assistance from family members.

The sample included in the study was highly selected and may not be representative of the assisted living population as a whole. The sample most likely is more cognitively intact than the population of assisted living facilities as a whole, and is likely more consistent with high privacy and high service sectors. Thus, the actual resources of the population that are required to make decisions about quality of care in assisted living or the ability to “vote with their feet” are most likely even more limited than our results suggest. However, further studies with larger, more generalizable samples are needed before conclusions can be drawn about the representativeness of our sample.

There are at least two possible interpretations regarding our results. The first is that while certain aspects of cognitive functions (perception, memory, language) that allowed for the identification of appropriate care were relatively intact in our sample, more complex executive functions required to develop and carry out a plan may have been impaired. There is considerable evidence to suggest that there is a decline in executive function in aging (see, for example, Reuter-Lorenz, 2000) and certainly such a decline would be present in individuals with early stages of dementia (LaRue, 1992). Decision-making research suggests that an ability to generate options results in optimal decision making, and a decline in executive functioning may affect the generation of options (Yates & Patalano, 1999). A second possible interpretation relates to aspects of social cognition. Older individuals in an institutional setting may rely more on powerful others such as family members to make decisions (Park, 1999; Curley, Eraker, & Yates, 1984), have a decreased sense of self-efficacy (Rodin, 1986), or have an increased external locus of control (Lachman & Leff, 1989). Any or all of these social-cognitive factors may interact with cognitive changes affecting decision-making abilities in this population. Future research should examine the cognitive and social factors that affect decision making in residents of assisted living.

The results strongly suggest that the residents could benefit from learning more about what constitutes abuse and neglect and what social services are available to assist them. Residents demonstrated weakness in identifying verbal abuse, neglect, and environmental hazards. Future studies will begin by addressing the need for educational in-services for residents. The use of videotaped scenarios could be useful to elicit residents’ experiences in a home, to assess potential vulnerability, or to augment an education intervention.

References
Appendix A

Vignette Scenarios

Scenario 1. The scene included a facility hazard of a misplaced throw rug, a verbal insult of “she’s always cranky” and concerns of medication compliance. (environmental hazards, verbal abuse, medication issue)

Scenario 2. The scene included inappropriate transfer assistance from sit to stand. (neglect)

Scenario 3. The scene included the nurse stealing the resident’s medication. (theft)

Scenario 4. The scene included a verbal insult of “you are always nagging.” (verbal abuse)

Scenario 5. The scene included inappropriate transfer assistance from sit to stand. (neglect)

Scenario 6. The scene included fiduciary abuse by a daughter and an obscured ombudsman sign. (fiduciary abuse, environmental issue)

Scenario 7. The scene included inadequate temperature control in the room and a verbal threat. (neglect, verbal abuse)

Scenario 8. The scene included unmet nutritional needs. (physical abuse)

Scenario 9. The scene portrayed a nurse using coercion in order to benefit financially. (verbal abuse, theft)

Scenario 10. The scene included physical abuse of a resident by a staff member. (physical abuse)

Scenario 11. The scene included neglect of ambulatory assistance and bedsores on the resident. (neglect)

Scenario 12. The scene included no abuse or neglect. This was a control scenario.

Scenario 13. The scene included staff taunting resident about his memory problems. (verbal abuse)

Scenario 14. The scene included staff taunting resident about his memory problems. (verbal abuse)

Scenario 15. The scene included no abuse or neglect. This was a control scenario.

Scenario 16. The scene included unmet laundering needs, rough handling, and verbal insults. (physical abuse, verbal abuse, environmental issue)

Scenario 17. The scene included stealing from a resident and unmet housekeeping needs. (theft, neglect)

Scenario 18. The scene portrayed a nurse stealing and no response to the resident’s calls for help. (theft, neglect)

Scenario 19. The scene included unmet nutritional needs. (physical abuse)

Appendix B

Knowledge of Aging Services Questionnaire

1. Are you aware of the ombudsman program? If yes, please describe the function of the program. Do you know how to contact the ombudsman program?
2. Do you know how to contact your local law enforcement agency?
3. Are you familiar with the Area Agency on Aging? If yes, please describe the function of this agency.
4. If you were concerned about the care provided, what options would be afforded to you? To whom would you report your concerns? (prompts: family, nurse, administrator, ombudsman)

Appendix C

Decision-Making Questionnaire

1. If you wanted to leave because you were unhappy with your current quality of life, what steps would you take? What would you do if your family could not help you? (prompts: logistically, what would need to happen? Who would you have to contact? How would you find alternative housing options?)