1994

Abuse and neglect: As defined by registered nurses/case managers

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ABUSE AND NEGLECT:
AS DEFINED BY REGISTERED NURSES/CASE MANAGERS

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

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ABSTRACT

This research project was designed to determine the ability of Registered Nurses/Case Managers in the field of Home Health Care to correctly identify potential cases of elder and dependent adult abuse and neglect. Currently, medical social work services are frequently being offered to the patient and family receiving home health care services after the situation reaches a crisis. This post-positivist study, identified through the use of survey questionnaires, reasons that Registered Nurses/Case Managers do not identify and refer potentially problematic cases to the Medical Social Worker in a more timely manner. Qualitative data was analyzed from interviews of the Home Health Care professionals in Visiting Nurses Association of Inland Counties and the Ramona Visiting Nurses Association and Hospice. The results of the study will serve as a basis for training medical professionals of the two agencies regarding abuse/neglect issues.

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INTRODUCTION

Problem Statement

The majority of patients served by the Ramona Visiting Nurses Association and Hospice and the Visiting Nurses Association of Inland Counties are elderly. Ruben (1990) projects that by the year 2000, the number of people over 65 years of age will be 31,000,000, or approximately 12% of this country's total population. He further projects that by the year 2020, 17% of our population of 46,000,000 will be over age 65. Due to Medicare's regulations regarding Diagnostic Related Groupings (DRG's), patients are leaving the hospital earlier and requiring more assistance in the home after hospital discharge. In addition, Medi-Cal's new Managed Care approach provides for agencies to contract with the State to deliver care to patients who have Medi-Cal coverage only. Given that part of the rationale is cost containment, it is even more important for agencies that provide care to have a clear understanding of the need for preventative social work intervention.

The combination of Medicare regulations, the new Medi-Cal Managed Care Program, and the increasing number of elderly in the community will result in a far greater demand for Home Health Care Agencies to meet the medical and psychosocial needs of homebound patients in the

future. In her study of the Ramona Visiting Nurses Association and Hospice in Southern Riverside County, which is a Home Health Care Agency, Jacobs (1993) found Medical Social Work to be any underutilized component of Home Health Care Services. By definition, Home Health Care Agencies serve homebound patient who need skilled nursing or adjunctive therapies. Jacobs (1993) points out that during 1991, while two offices of the Ramona Visiting Nurses Association and Hospice had approximately 4,000 patients, only 970 were referred to a Medical Social Worker for intervention. Of those referred to a Medical Social Worker, 500 were for crisis intervention and 200 of the crisis referrals required APS (Adult Protective Services) reports due to suspected abuse or neglect.

The Registered Nurse, as Case Manager, makes the initial decision regarding when to make a referral to a Medical Social Worker. If the Registered Nurse/Case Manager does not make a referral until a patient and family reach a crisis situation, the Medical Social Worker will always be practicing crisis intervention, rather than providing preventative case management. The daily unmet needs of patients exacerbate the potential for abuse/neglect.

Problem Focus

This post-positivist research project is a follow-up study on Jacobs' 1993 project "Medical Social Work: Why is it Underutilized in Home Health Care?". Jacobs suggested that an area needing further research is the issue of elder and dependent adult abuse/neglect and how it is defined by Registered Nurses/Case Managers. It is in the best interest of the patient, the family, the agency, and the County's Adult Protective Services Unit for a referral to the Medical Social Worker to be made by the Registered Nurse/Case Manager before the patient has actually become a victim of abuse/neglect.

It appears to these researchers that the majority of patients of these agencies are not being referred to the Medical Social Worker until the patient's situation becomes a crisis. Patients and families are not being given needed resources and referral information early enough to prevent caregivers from becoming overwhelmed by the patients' needs, thus reducing abuse/neglect.

LITERATURE REVIEW

Although there is not a considerable amount of literature dealing with Social Work within a Home Health Care Agency, there is an indication that more and more research is being done in the area of elder and dependent adult abuse/neglect issues.

History of Elder/Dependent Adult Abuse Reporting

Elder abuse reporting has a short history (Steinmetz, 1988; Pillemer and Wolf, 1986; and Staudt, 1985). Pillemer and Finkelhor (1988) were the first researchers to conduct a large-scale random sample survey of elder abuse and neglect. In this study, the overall prevalence rate of maltreatment was 32 elderly persons per 1000.

Since Roman times to the 19th Century, the primary focus was on the care of a person's property rather than on the care of the elder or on assisting the elder in returning to self-sufficiency. In the early 1950's, the Social Security Administration (SSA) and the Veterans Administration (VA) developed procedures for protective payee. A protective payee is a person appointed by the SSA or the VA to receive payments and handle the finances of an individual who is not mentally capable of managing his own financial affairs. In 1961, the White House Conference on Aging recognized the need for protective services. In the mid 1960's, several demonstration projects were funded. In 1975, after passage of Title XX, adult protective services were to be provided without regard to eligibility. In the late 1970's and throughout the 1980's, elder abuse emerged as a social issue of concern (Staudt, 1985).

Adult abuse reporting statutes were developed using the historical developments of child abuse as a model. Two major differences between CPS (Children's Protective Services) and APS are the right of the elder to call off an investigation of abuse about him/herself and the possibility of appropriate professionals completing a 5150 to show the elder is incompetent (Averbuck, 1984).

Definition and Legislation

Several researchers have noted that a lack of consensus on a uniform, comprehensive definition of elder and dependent adult abuse is part of the overall problem of abuse (Steinmetz, 1988; Pillemer and Finkelhor, 1988; Daniels, Baumhover, and Clark-Daniels, 1989; Kosberg, 1988; Giordano and Giordano, 1984; King, 1983; Staudt, 1985; Pillemer and Wolf, 1986; Callahan, 1988). These social researchers indicate that there is a clear need for definition and teaching to health care professionals and caregivers. Steinmetz (1988) states, "Until we can adopt a standard definition of elder abuse, causal theory cannot be explored. Theory building relies on clearly defined, measurable proposition with a consistent definition."

Examples of problems with definition are given by Pillemer and Wolf (1886 and Steinmetz, 1988). The act of withholding personal care can be classified as physical

abuse, active neglect, physical neglect or psychological neglect. Categories of behavior that include several forms of abuse and neglect are physical, psychological, verbal; active and passive behaviors; self-inflicted or inflicted by another; financial or material exploitation; and violation of basic rights. Research regarding the definitions of elder and dependent adult abuse/neglect supports the position that there is no single, theoretical explanation for all behaviors which are currently broadly classified as elder abuse/neglect. Giordano and Giordano (1984) assert that elder abuse/neglect includes mental anguish, denial of medicines or medical care, exploitation, psychological mistreatment, physical abuse, and self-inflicted injurious behaviors. The Select Committee on Aging, in hearings before the Subcommittee on Human Services, House of Representatives in Washington, D.C., on April 21, 1980, listed the following categories of elder abuse: 1) Physical abuse; 2) Negligence; 3) Financial exploitation; 4) Psychological abuse; 5) Violation of rights; 6) Self-neglect.

These researchers agree with Giordano and Giordano (1984) that as long as definitions of abuse are inconsistent, comparability and corroboration among researchers will be inaccurate. When mandated reporters are not able to clearly articulate a definition of abuse, they are not able to adequately report abuse.

Daniels, Baumhover, and Clark-Daniels (1989), suggest looking at current legislation regarding abuse: 1) Make explicit the population that the law seeks to protect; 2) Provide effective definitions of the behaviors prohibited to make determinations of incidence possible; 3) Define clearly the reporting population covered under the provision; 4) Justify the selected population and the mandated reporting requirement; 5) Guarantee immunity from prosecution for the reporting individual; 6) Protect confidential information.

A primary concern is the need to make explicit the population that the law seeks to protect (Daniels, Baumhover, and Clark-Daniels, 1989). In California Statutes (Chapter 769, AB 3988, Section 972 of the Evidence Code, and Section 368 of the Penal Code), mandated reporting legislation protects "elders" and "dependent adults".

> (d) As used in this section, "elder" means any person who is 65 years of age or older.
>
> (e) As used in this section, "dependent adult" means any person who is between the ages of 18 and 64, who has physical or mental limitations which restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age. "Dependent adult" includes any person between the ages of 18 and 64 who

> is admitted as an inpatient to a twenty-four hour health facility as defined in Sections 1250, 1250.2, 1250.3, of the Health and Safety Code.

The second concern expressed by Daniels, Baumhover, and Clark-Daniels (1989) is the need for clear definitions of abusive behaviors. While California Statutes (Chapter 967, Section 15610 of the Welfare and Institutions Code) do define abuse, there appears to be questions and lack of clarity regarding the definition among health care professionals.

Section 15610 of the Welfare and Institutions Code states:

> (c) "Physical abuse" means all of the following:
>
> (1) Assault, as defined in Section 240 of the Penal Code.
>
> (2) Battery, as defined in Section 242 of the Penal Code.
>
> (3) Assault with a deadly weapon or force likely to produce great bodily injury, as defined in Section 2345 of the Penal Code.
>
> (4) Unreasonable physical constraint, or prolonged or continual deprivation of food or water.
>
> (5) Sexual assault, which means any of the following:
>
> (A) Sexual battery, as defined in Section 243 of the Penal Code.
>
> (B) Rape, as defined in Section 261 of the Penal Code.

(C) Rape in concert, as described in Section 264.1 of the Penal Code.

(D) Incest, as defined in Section 285 of the Penal Code.

(E) Sodomy, as defined in Section 285 of the Penal Code.

(F) Oral copulation, as defined in Section 288a of the Penal Code.

(G) Penetration of a genital or anal opening by a foreign object, as defined in Section 189 of the Penal Code.

(d) (1) "Neglect" means the negligent failure of any persons having the care or custody of an elder or a dependent adult to exercise that degree of care which a reasonable person in a like position would exercise. Neglect includes, but is not limited to all of the following:

(1) Failure to assist in personal hygiene, or in the provision of food, clothing, or shelter.

(2) Failure to provide medical care for physical and mental health needs. No person shall be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment by spiritual means through prayer alone in lieu of medical treatment.

(3) Failure to protect from health and safety hazards.

(4) Failure to prevent malnutrition.

(e) "Abandonment" means the desertion or willful forsaking of an elder or dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody.

(f) "Fiduciary abuse" means a situation in which any person who has the care or custody of, or who stands in a position

> of trust to, an elder or a dependent adult, takes, secretes, or appropriates their money or property, to any use or purpose not in the due and lawful execution of his or her trust.
>
> (g) "Abuse of an elder or a dependent adult" means physical abuse, neglect, intimidation, cruel punishment, fiduciary abuse, abandonment, or other treatment with resulting physical harm or pain or mental suffering.

Daniels, Baumhover, and Clark-Daniels (1989) follow with a discussion of the need for a precise definition of the mandated reporting population covered Adult Abuse Reporting legislation. According to California Statutes (Chapter 769):

> PROFESSIONAL WHO ARE REQUIRED TO REPORT PHYSICAL ABUSE OF ELDERS AND DEPENDENT ADULTS:
>
> (A) Care custodians, as defined by Welfare and Institutions Code Section 16510 (h):
>
> "Care custodian" means an administrator or an employee, except persons who do not work directly with elders as part of their official duties, including members of support staff and maintenance staff, or any of the following public or private facilities:
>
> (1) Twenty-four hour health facilities, as defined in Section 1250, 1250.2, or 1250.3 of the Health and Safety Code.
>
> (2) Clinics.
>
> (3) Home health agencies.
>
> (4) Adult day health care centers.
>
> (5) Secondary schools which serve 18 to 22 year old dependent adults and post-secondary education institutions which serve dependent adults or elders.

(6) Sheltered workshops.

(7) Camps.

(8) Community care facilities, as defined in Section 1502 of the Health and Safety Code and residential care facilities for the elderly, as defined by Section 1569.2 of the Health and Safety Code.

(9) Respite care facilities.

(10) Foster homes.

(11) Regional centers for persons with developmental disabilities.

(12) State Department of Social Services and State Department of Health Services licensing division.

(13) County welfare departments.

(14) Offices of patients' right advocates.

(15) Office of the long-term care ombudsman.

(16) Offices of public conservators and public guardians.

(17) Any other protective or public assistance agency which provides medical services or social services to elders or dependent adults.

(b) Health practitioners, as defined by Welfare and Institutions Code Section 15610 (i):

"Health practitioner" means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, licensed clinical social worker, marriage, family and child counselor or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professional Code, any emergency medical technician I or II,

> paramedic, a person certified pursuant to Division 2.5 (commencing with Section 1979) of the Health and Safety Code, a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code, a marriage, family and child counselor trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, or an unlicensed marriage, family and child counselor intern registered under Section 4980.44 of the Business and Professions Code, a state or county public health employee who treats an elder or a dependent adult for any condition, a coroner, or a religions practitioner who diagnoses, examines, or treats elder or dependent adults.
>
> (c) Employees of adult protective service agencies, as defined by: Welfare and Institutions Code Section 15610 (j):
>
> "Adult protective services agency" means a county welfare department except persons who do no work directly with elders or dependent adults as part of their official duties, including members of support staff and maintenance staff.
>
> (d) Employees of local law enforcement agencies, as defined by Welfare and Institutions Code 16510 (g):
>
> "Local law enforcement agency" means a city police or county sheriff's department, or a county probation department except persons who do not work directly with elders or dependent adults as part of their official duties, including members of support staff and maintenance staff.

A need stipulated by Daniels, Baumhover, and Clark-Daniels (1989), is for justification for the selected population covered under reporting laws. California Statutes do not address the rationale for the decision to protect "dependent adults" and "elders". Battered wives,

for example, are not covered by this legislation unless they are over 65 years of age or are "dependent adults". It seems questionable that a woman who did not see herself as dependent upon her mate physically, financially, or emotionally, would remain in a battering relationship.

Daniels, Baumhover, and Clark-Daniels (1989), expect that a mandated elder and dependent adult abuse/neglect report should be guaranteed immunity from prosecution regarding the report of abuse. California Statutes state (Chapter 769):

> Section 14, 15634 (b). Any care custodian health practitioner or employee of an adult protective services agency who reports a known or suspected instance of elder or dependent adult abuse shall not be civilly or criminally liable for any report required or authorized by this article. Any other person reporting a known or suspected instance of elder or dependent adult abuse shall not incur civil or criminal liability as a result of any report authorized by this article, unless it can be proven that a false report was made and the person knew that the report was false.

California Statutes (Chapter 769) also address the issue of confidentiality of reporters: "Reports made under this law are confidential and may be disclosed only to the agencies specified."

At first glance, it appears that five of the six requirements suggested by Daniels, Baumhover, and Clark-Daniels (1989) to assist mandated reporters are adequately legislated in California. However, upon

closer examination, there are problems. Firstly, in order to have a complete understanding of this legislation, it is not only necessary to have a copy of the California Statutes, Chapter 769, but also necessary to refer to Welfare and Institution Codes, Health and Safety Codes, Penal Codes, and Business and Professional Codes. Secondarily, there are problematic ambiguities in the definition of abuse, e.g., who is a "reasonable person", what is "unreasonable physical restraint", how long is "prolonged or continual deprivation", and what defines "mental suffering"?

Abuse Victims

Distinguishing characteristics of elder abuse victims were identified in a study by Pillemer and Finkelhor (1988): "Abused elders are more likely to be living with someone else and are more likely to be those in poor health. Neglected elders are most likely to have no one to turn to for support." This profile may be helpful for teaching interventions with Registered Nurses/Case Managers as well as offering insightful information to the Medical Social Worker.

Block and Sinnott (1979) found some common characteristics of abuse victims, which support the findings of Pillemer and Finkelhor cited above. Eighty-one percent of the victims identified in Block and Sinnott's

study were female and most victims were over the age of 75 years--the mean age of these victims was 84 years. The majority of victims were physically or mentally impaired. Most of the victims lived with the abuser, were dependent upon the abuser for physical, emotional and/or financial support, and were fearful of existing or perceived alternatives. Eighty-four percent of the victims were abused by family members. Some victims fear retaliation and are therefore reluctant to report abuse or deny maltreatment when evidence of abuse exists. A critical factor in the victim's ability to report is his/her feelings of responsibility for the abuser and responsibility for his/her own behavior. One in twenty-five older Americans become a victim of abuse each year (Steinmetz, 1933; and Pillemer and Wolf, 1986).

King (1983) further points out that violence is a learned and potentially cyclical pattern of inter-generational abuse throughout life. According to Steinmetz (1980), adult children who were not treated violently in childhood, later abuse parents at a ratio of one time in four hundred cases, while those who were abused as children abuse their aging parents by a ratio of one to two.

The most serious self-inflicted abuse is suicide. The elderly remain clearly at risk for suicide. The highest rates of suicide by age (17.7%) are for those

over 65 (McIntosh, 1985). It is imperative for mandated reporters to be aware that elders are at risk for suicide and to learn warning signs that can alert them to implement crisis intervention.

Factors Which Cause Abuse

Kosberg (1988) offers suggestions regarding how to avoid placing the elderly in potentially abusive environments by defining characteristics of both high risk elders and high risk caregivers. This information is more pertinent to hospital social workers doing discharge planning, but use of the High Risk Placement Worksheet (see Appendix H) can also indicate that social work intervention is imperative in situations where the elder is already residing in a high risk situation and receiving home health care.

O'Rourke (1981) posits that there are seven theories regarding factors that lead to elder abuse: 1) family dynamics, 2) dependence, 3) personality traits of the abuser, 4) filial crisis, 5) internal stress, 6) external stress, and 7) negative attitudes. These factors agree with those suggested by Kosberg (1988) and are targeted in the latter's High Risk Placement Worksheet.

Bookin and Dunkle (1985) suggest that the five most prominent causes of abuse are: 1) vulnerability/ dependency of the elder, 2) learned patterns of violence

and unresolved family conflict, 3) stress of caregiving, 4) lack of family support, and 5) psychological symptoms such as mental illness, alcoholism, or drug abuse.

The Abuser

Hooyman and Lustbader (1985) note that:

> Most instances of abuse are not intentional, but results from the accumulation of stress and limited resources for providing care. In many cases, caregivers do not recognize their abusiveness; those who acknowledge it often are at a loss as to how to stop their harmful behavior.

Lau and Kosberg (1978), in their study of elder abuse, found that ninety percent of the abusers were relatives: Daughters were the perpetrators twice as often as any other relative (31%), followed by sons, grand-daughters, husbands and siblings. Block and Sinnott (1979) found that the majority of abusers were relatives (81%), primarily children of the victim (42%), female (57%), white (88%), and middle class (65%).

Several studies point to stress and alcohol or substance abuse as indicators which make a caregiver more vulnerable to becoming an abuser (King, 1983; Block and Sinnott, 1979; Kosberg, 1988; Bookin and Dunkle, 1985).

Barriers to Reporting

An article in The Gerontologist (Daniels, Baumhover, and Clark-Daniels, 1989) discusses physicians' mandatory reporting responsibilities, reasons why physicians fail

to report, inability of an outside observer to identify abuse, lack of a clear definition of abuse, and inadequate training on abuse issues for physicians. This article targets case discovery as a problem for physicians; the same problem exists for nurses in Home Health Care.

Jackson (1990) suggests questions which may assist the Home Health Care mandated reporter in determining whether abuse/neglect exists. Has the patient lost weight? Has the patient lost condition? Is there general deterioration of physical condition? Is there an exacerbation of medical problems? Does the patient have high blood pressure? Is there any unexplained physical injury?

Home Health Care Agencies' Role in Abuse Reporting

Past research does not directly speak to professionals of Home Health Care Agencies and how to identify and prevent elder and dependent adult abuse/neglect. There is a need to identify the deficiencies in Registered Nurses/Case Managers' ability to recognize potentially abusive home environments before the patient becomes a victim.

Elder abuse is not as visible as child abuse because elders are not seen in the community as frequently as are children (King, 1983). This observation establishes the

necessity of home health care staff to be able to correctly identify and report elder and dependent adult abuse and neglect.

RESEARCH DESIGN AND METHOD

Purpose of the Study

Home Health care professionals have the opportunity to see the patient in his/her home environment and to make early identification of potentially abusive/ neglectful situations. If referrals to the Medical Social Worker are made early in the Registered Nurse/Case Manager's assessment process, some elder/dependent adult abuse may be avoided. The intent of this study is to explore the nurses' understanding of abuse/neglect and to examine whether nurses are hesitant to make both Medical Social Worker referrals and mandated Adult Protective Service referrals.

Research Question

This is a post-positivist study in which respondents were asked to answer open-ended questions. This paradigm allows the participants to voice their opinions and ideas without limiting their choices.

The question to be explored was: Are Home Health Care professionals able to identify and report abusive/ neglectful family situations? The post-positivist

paradigm allowed the question to evolve through exploration and the resulting question at the end of the study is: What can these researchers contribute to enhance the ability of Registered Nurses/Case Managers to identify and intervene appropriately where abuse/neglect or the potential for either exists?

Sampling

Since this was an exploratory study, qualitative data were collected. A purposeful sample of key informants was used. The sample consisted of administrators of Ramona Visiting Nurses Association and Visiting Nurses Association of Inland Counties. Administrators for this study were defined as Executive Directors, Directors of Clinical Services, Branch Managers, Assistant Branch Managers, Rehabilitation Managers, and Managers of Education. In addition, a random sample of Registered Nurses/Case Managers, other Registered Nurses, and Licensed Vocational Nurses were surveyed. All Medical Social Workers, except researchers, in both agencies were invited to participate. The researchers decided to use a stratified purposeful sample in order to survey all administrators in both agencies, since it appears that values of the administrators are passed on to the field employees. A random sample of 20% of other professionals in the agency was utilized in order to limit the size

of the total number of respondents, while still obtaining a wide range of opinions.

The sample was designed to be large and covered a total of nine different offices (two offices of Ramona Visiting Nurses Association and seven offices of Visiting Nurses Association of Inland Counties). These offices include Riverside and San Bernardino Counties. The study was limited to employees of the Ramona Visiting Nurses Association and the Visiting Nurses Association of Inland Counties. The total sample consisted of 50% of the 300 employees of the Ramona Visiting Nurses Association and Hospice and the Visiting Nurses Association of Inland Counties. Both agencies are private non-profit.

Of the 70 surveys distributed, only 50 were returned, for a survey completion rate of 71%.

Data Collection and Instruments

There were two parts to the questionnaire. The first part contained demographic information and was used to identify the backgrounds of the informants who participated (see Appendix D). This information was also used to determine what role the informant plays in the Home Health Care Industry.

The second part of the questionnaire includes six open-ended questions (see Appendix E). Some respondents were given the opportunity to give additional

information as questions were revised or new questions developed in order to expound on and clarify information.

The initial survey instrument (Appendix E) includes the following six questions:

1) How do you define adult abuse?

2) How do you define neglect?

3) Who is protected under Adult Protective Services legislation?

4a) Who are mandated reporters of elder and dependent adult abuse and neglect?

4b) Is there any legal protection for mandated reporters?

5) At what point does the Registered Nurse/Case Manager feel that Medical Social Work intervention is necessary?

6) How do you <u>feel</u> that others (agency, APS workers, co-workers, patient's family, patient's caregiver, etc.) <u>perceive</u> you when you make an APS referral?

One additional question was asked of selected respondents after the first group of responses was reviewed. This additional question was added to gain further information about training and education which can be provided to Home Health Care professionals to enhance their ability to discover and report adult abuse and neglect.

The additional question was: What opportunities have you had in the past to learn about adult abuse and neglect reporting?

Procedure

Informants were initially contacted by a letter requesting their participation. The letter to Administrators (see Appendix A) included a request to advise researchers of a convenient time to complete the survey instrument. The letter to the randomly selected informants (see Appendix B) explained the random selection process and requested that the informants complete the survey instrument at the end of the pre-scheduled monthly staff meeting in each office. The respondents were asked to write their answers on the instrument at the time the survey was administered. The data were collected between June and September, 1993.

The administration of the survey instrument and the coding of the responses was divided between the two researchers.

Ramona Visiting Nurses Association and Visiting Nurses Association of Inland Counties both have the same personnel department. Randomly selected informants were selected from the agencies' personnel master alphabetical list. Selection included every fifth employee in the chosen professional categories.

Randomly selected informants completed the survey instrument in writing at the time of the pre-scheduled monthly staff meeting. Surveys were completed in each of the offices of the Ramona Visiting Nurses Association and the Visiting Nurses Association of Inland Counties because the survey encompasses a large geographical area.

Researchers met individually with administrators of both agencies to explain the research project and to go over the Informed Consent and the Debriefing Statement. Administrators also completed the surveys in writing.

Protection of Human Subjects

Before the surveys were distributed, an Informed Consent (see Appendix C) was given to each respondent. The Informed Consent explained the nature of the study.

The Informed Consent, after being signed by the participant, was removed from the remainder of the survey, so respondents remain anonymous.

A Debriefing Statement was given at the end of the survey administration (see Appendix G). The Debriefing Statement included information for the informants to know how to obtain additional information about the results of the survey.

Data Analysis

Qualitative data were gathered and continually analyzed throughout the post-positivist study. As new

information was reported by respondents, it was possible for the focus or direction of the study to be adjusted.

The data were broken down and open-coded into concepts. These concepts were then categorized through the technique of axial coding. As a final step, the selective coding process was used to link categories of concepts together by validating their relationships to make final statements regarding the outcome of the study (Strauss and Corbin, 1990).

The data, after coding and categorizing, indicate the ability of Home Health Care professionals (specifically Registered Nurses/Case Managers) to correctly assess potentially abusive/neglectful family situations. It is hoped that this study will assist Registered Nurses/Case Managers in correctly identifying potentially abusive/ neglectful family situations; utilizing the Medical Social Worker before a situation becomes a crisis; and understanding both the responsibilities of and the protection of mandated abuse reporters.

The open coding process of Strauss and Corbin was used in this study with the Glaser and Strauss Constant Comparative Method. Sentences from the questionnaires were copied onto 5" x 7" index cares and open-coded according to responses. The cards were then separated by categories (Strauss and Corbin, 1990). A data

incident, after being coded for a category, was compared to other data incidents in that category to justify assignment and to correlate it with other incidents in that category. In this way, the researchers have been able to build a full range of data to explain each category (Lincoln and Guba, 1985).

The four stages of the Glaser and Strauss Constant Comparative Method are: 1) comparing incidents applicable to each category; 2) integrating categories and their properties; 3) delimiting the theory; and 4) writing the theory (Lincoln and Guba, 1985).

The process of integrating categories and their properties was completed by determining relationships within each category and identifying properties of the description for each. The next step was that of limiting and reducing categories. This step encompassed formulating the final theories and explanations for the hesitancy of Registered Nurses/Case Managers to identify and report potentially abusive/neglectful family situations (Lincoln and Guba, 1985).

The analysis is an on-going process in a post-positivist study. Using this approach allowed the researchers to accommodate shifts the data made to the original questions.

FINDINGS

Demographics

There were 50 subjects who participated in this study. Demographic data includes occupation, gender, age, ethnicity, educational degrees, professional licenses, training in abuse reporting, years employed in the Home Health Care field, and whether employed by a large (over 25 employees) or small (less than 25 employees) agency (see Appendix D).

Occupations of Respondents:

Registered Nurses/Case Managers	21
Licensed Vocational Nurses	8
Other Registered Nurses	2
Medical Social Workers	7
Administrators	12

The mode of the occupations is Registered Nurses/ Case Managers. The Registered Nurses/Case Managers are responsible for the majority of referrals to the Medical Social Worker.

The gender of the respondents was primarily female with only 1 of the 50 respondents male. The majority of the employees of the Ramona Visiting Nurses Association and Hospice and the Visiting Nurses Association of Inland Counties are female. The ages of respondents range from 24 to 64. The largest number of respondents are aged 38 to 47; the mean age is 43.

Ethnicity of Respondents:

Caucasian	44
Hispanic	1
African American	4
Native American	1
Asians	0

The majority of the respondents are Caucasian and this is representative of the agencies' personnel.

Degrees Listed by Respondents:

AA Level	16
BA Level	21
MA Level	6

Respondents, except for some of the Licensed Vocational Nurses, all have Associate or higher level degrees.

Forty-three of the fifty respondents have a professional license. The majority of respondents, including administrators, have an RN license (30). Other licenses are: LVN (8), PHN (3), ET (1), RNC (1). The respondents who are not licensed are the Medical Social Workers (7).

Training in abuse reporting varied. Nine respondents stated they had received no training, while one reported having attended a five-hour in-service. The most common response was an in-service of one to four hours.

Years of Employment in Home Health Care:

Less than 5 years	30
5 to 10 years	8
More than 10 years	12

Years of employment in the Home Health Care field spanned from one month to 30 years, with a mean of 7-1/2 years.

All respondents listed that they worked for an agency with more than 25 employees. Researchers had expected employees of Visiting Nurses Association of Inland Counties to identify themselves from large versus small branches. When questioned about this response, subjects stated they considered themselves employees of Visiting Nurses Association of Inland Counties, a large agency which includes seven offices, several of which have less than 25 employees.

Definition of Adult Abuse/Neglect

Round One:

The first round of questionnaires included only the first six questions. The answers to these questions supported the findings of the researchers' literature survey that abuse and neglect are not well-defined concepts.

The responses also suggested that employees of these agencies do not have a clear understanding of their

reporting responsibilities or the authority of Adult Protective Services (APS) Social Service Workers.

Question #1.

How did Home Health Workers and Administrators define adult abuse?

The major thread in the definition of abuse was concern for the physical welfare of the patient. In fact, physical harm was listed in 39 of the 50 responses to define abuse; 14 of the 39 responses also indicated hitting or beating as a determinant of the existence of physical abuse. Neglect was listed as abuse by only 18 of the respondents.

One nurse indicated a broad definition of abuse and a willingness to be safe rather than sorry, "I like to leave my definitions very general and open because this allows for each situation to be evaluated. This way no case gets ruled out prior to evaluation based on a strict definition of terms. I would rather evaluate a case that may not require further treatment than to miss one which may need help."

Final groupings of definitions of abuse fell into four major categories. These categories were physical abuse, fiduciary abuse, psychosocial abuse, and characteristics of perpetrators. Each of these categories was made up of smaller categories. For example, the

category "psychosocial abuse" was conceptualized from categories of social isolation, verbal abuse, emotional abuse, violation of rights, and abandonment.

"Physical abuse" includes groupings of physical harm, beatings, failure to provide for basic needs, suicide attempts, medication mismanagement, and physical and chemical restraints.

"Fiduciary abuse" includes groupings related to monetary exploitation, withholding finances, and defrauding another of possessions.

The responses which were grouped as "characteristics of the perpetrator" included concepts that abuse is only perpetrated by others, can be self or others, can be knowingly and unknowingly performed, and can be a deliberate or an unintentional act.

Registered Nurses/Case Managers were particularly aware of the need to evaluate safety issues, such as patients' access to food and nutrition, access to hydration, provision of adequate care, and medication management.

One Registered Nurse requested an in-service "to recognize significant signs of adult abuse".

Only one respondent (a Medical Social Worker with a Master of Social Work) identified a suicide attempt as a component in the definition of adult abuse.

Question #2.

How did Home Health Employees define neglect?

The majority of respondents focused on the physical and more tangible aspects of neglect. The most common definitions of neglect included withholding of basic needs (29), nutrition (25), clean and safe shelter or ade-quate and appropriate housing (17), hydration (11), and hygiene (11). It would appear that the disparity between the 25 responses listing nutrition and the 11 who listed both nutrition and hydration is that some considered hydration as a part of adequate nutrition. The researchers' experience with Registered Nurses/Case Managers, in these agencies, is that they consistently evaluate for both adequate nutrition and hydration.

Final groupings of categories fell into three major areas. These were physical neglect, psychosocial neglect, and intentional neglect.

In the category of intentional neglect, 4 of the 50 respondents stated that neglect is a deliberate and intentional act of failing to meet patient needs. Surprisingly, one of the 4 who defined neglect as a deliberate act was a Medical Social Worker. Only 6 respondents defined neglect as being either with intent or unintentional (due to lack of education or training). One Registered Nurse/Case Manager defined neglect as the result of a caregiver being "unwilling or unable to

provide effective safe care" to meet patient needs. Self-abuse was reported by 2 respondents as a cause of neglect. It was a Registered Nurse/Case Manager who stated that neglect "may be inflicted by the caretaker/ family or actually self inflicted."

An administrator expressed the concern of several respondents who felt "Neglect is a difficult area to define in reporting potential abuse. There are many cases where neglect is not a malicious attack but rather a result of lack of training and understanding... Neglect is subtle where I find that more information is required."

A member of the field nursing staff vividly defined neglect as "A form of abuse allowing a helpless person to needlessly suffer the loss of adequate physical, emotional, or spiritual nourishment. Maybe a feeling projected onto a helpless person that he/she is not loved or wanted -- projection can come from body language, tone of voice, or refusing to acknowledge a person by not speaking to or looking at them." Although some respondents did not describe neglect in such touching yet concrete terms, responses to this question consistently referred to the respondents' awareness of patients' psychosocial needs. These identified needs included spiritual needs, need for personal contact, need for social interaction, as well as emotional and mental needs.

Question #3.

How did Home Health Professionals identify protected populations?

Many of the respondents expressed frustration at the interventions (or lack of) by Adult Protective Services workers after referrals have been made. "The reality of this situation is that when a report is made to APS there is often little action taken except in extreme cases" captures what many respondents consider to be inaction, lack of authority, inability, or lack of concern on the part of the APS workers. Perhaps some of the frustration expressed in these responses is a direct result of the respondents' lack of knowledge of who is protected by APS legislation and lack of understanding of the legal limitations imposed on APS workers in an effort to protect victims' rights.

Responses to this question support researchers quoted previously in this paper who have noted that a lack of consensus on a uniform, comprehensive definition of elder and dependent adult abuse is part of the overall problem of abuse.

The three final groupings resulting from responses to this question are age/physical condition, psychosocial, and miscellaneous. The miscellaneous category consists of responses which indicate inadequate level of knowledge about who is protected by APS legislation.

Responses which fall into the final grouping, age/physical condition, have a wide range of responses from over 18 (7) to consenting age (1) and elderly (4). A dependent adult (18-64) was listed by 7 respondents, 5 of whom failed to list those over 65 as also protected. Physical conditions delineated by respondents were patients (2), handicapped (5), mentally retarded (3), and unable to provide self-care (3).

A Medical Social Worker effectively answered this question, "Any dependent adult (between 18 and 64) who has physical or mental limitations which restrict their ability to provide for own essential needs and ability to carry out normal activities or to protect own right. Also, any older person (over 65) residing in this state." At the other end of the scale, one Medical Social Worker stated only "Any individual 18 years and older" and another "All adults". The remaining responses by the Medical Social Workers fell on a continuum between the most accurate and least descriptive responses quoted herein.

In the psychosocial grouping, one respondent identified alcohol or drug dependent individuals, two identified anyone at risk as protected, and one described "Any adult not able to care for self -- for whatever reason -- anyone who is under a negative type of control by another and, for some reason, cannot get out of the situation."

The miscellaneous grouping included the following responses: All adults (16), no idea (1), not sure (2), and "Every adult living in our country even if an undocumented person" (1) further illustrates the lack of knowledge of all categories of respondents.

Who are Mandated Reporters

Question #4.

Mandated reporters identified by Home Health Professionals:

Professionals Identified as Mandated Reporters:

All Medical Professionals	28
Law Enforcement Employees	22
Medical Social Workers	17
Registered Nurses	15
Doctors	12
Teachers	8
Ministers	4
Home Health Aides	4
Psychologists	4
Psychiatrists	1
MFCC	1
Coroner	1
Ombudsman	1

Agencies Identified as Mandated Reporters

Social Services Agencies	10
Skilled Nursing Facilities	4
Public Health Agencies	4
Home Health Agencies	2
Foster Homes	2
Board and Care Facilities	1
Probation	1

Others Identified as Mandated Reporters:

Anyone	12
Caregiver	2
Friends	1
Family	1
Neighbors	1

Again, the most comprehensive response to this two-part question came from a Medical Social Worker. In response to who are mandated reporters, she wrote, "Elder care custodians including SNF's, social workers, home health agencies, public assistance workers, probation, ombudsman, foster homes, medical or nonmedical personnel, law enforcement, public health employees." In response to legal protection for the mandated reporter, she replied, "Identify will be kept confidential without liability." Another Medical Social Worker listed "doctors, nurses, neighbors, social workers, teachers and policemen" as mandated reporters and replied only "Yes" to whether there is legal protection for mandated reporters.

The final three groupings for this question were professionals, agencies, and others. The majority of responses feel into the professionals grouping and included medical occupations, mental health professionals, law enforcement employees, and other professionals. The vast majority (47%) of the mandated reporters were medical professionals with social service agencies (71%) as the most often reported agency. It is worth noting,

however, that 12 (20+%) of the respondents thought that everyone is mandated to report.

When to Refer to the Medical Social Worker

Question #5.

At what point does the Registered Nurse/Case Manager feel that Medical Social Work intervention is necessary?

The majority of responses focused on safety and protection duties grouping. Almost half of the respondents stated that they make a referral to the Medical Social Worker "at the first suspicion of abuse or neglect." Reasons for referrals in the category of safety and protection duties include the following.

Safety and Protection Referrals:

Safety issues	7
Rule out suicidal ideation	3
Neglect or abuse observed	3
History of falls	2
Marks on the patient's body	1
Gut reaction that something is wrong	1
Education for family/caregiver to prevent abuse	1

From the wide range of responses, three final groupings were formulated. These final categories are: Safety and protection duties, clinical duties, and task oriented duties.

In the clinical duties grouping, referrals were defined as being made to the Medical Social Worker for:

Clinical Duties Grouping

Emotional problems	6
Family problems	6
Illness	5
Counseling for terminal illness	4
Crisis intervention	4
Long term planning	3
Counseling	3
Psychosocial problems	3
Changes	3
Potential stress	2
Resolve conflicts	2
Grief and bereavement issues	2
Change in environment	2
Depression	1

Reasons for referral to the Medical Social Worker in the task oriented duties grouping include:

Task Oriented Duties Grouping

Community referrals	13
Financial assistance	8
Beginning of service	6
Placement	3
Referral to support groups	1
Advance directives	1
Non-compliance to medical treatment plan	1
Social work problem	1
Untrained/non-professional caregiver	1

One Medical Social Worker responded, "Within this office there has been an increased utilization of MSW intervention... My feeling is to involve the MSW at the first indication of a problem to set a perspective of the situation and build team interaction." A Registered Nurse/Case Manager suggests that a Medical Social Worker is "someone trained in problem solving. The nurse may

be able to handle the situation but if it is complex, I feel that it is best to refer to the MSW." Another Registered Nurse/Case Manager stated, "I never hesitate to include social worker into any plan. I recognize that social worker may identify problem areas, stressors, and difficulties that may not be recognized by myself... I recently experienced an HHA (Home Health Aide) who noticed questionable behavior, but did not report family for two weeks -- the MSW was called and went in the next day." This last quote perhaps points to an oversight by these researchers. Although the researchers continually educate HHA's on a regular one-to-one basis and seek information about patients from the HHA's, the researchers neglected to involve the HHA's in this survey. It is not unusual for an HHA to come to the MSW to discuss a patient and suggest an MSW visit.

Many Registered Nurses/Case Managers indicated the importance of Medical Social Workers in the Home Health Care Industry by comments similar to "Most are very aware of need for Social Worker and refer consistently in this office."

One administrator stated, "Usually they look to the social worker when intervention is critical -- immediate need. Should look for social worker input for education and prevention." The researchers find that they receive strong support for Social Work interventions from the

administrators or both agencies. The reasons the nurses gave for reporting to the social worker covered a wide range of problems; however, less than half said they made a referral to the social worker "at the first suspicion of abuse or neglect." This may be a factor relating to why the social worker is referred when there is a crisis situation.

Feelings About Making an APS Report

Question #6.

How do Home Health Care Professionals feel that others perceive them when they make an APS referral?

Due to the structure of this question, the four final groupings were established easily into agency, APS workers, co-workers, and patient's family/caregivers.

The majority of respondents did not break their responses down into the four major categories. Some respondents made one general statement, while others responded to any combination of two to three groupings.

In the agency grouping, responses were as follows.

Agency Grouping of Responses:

Supportive	5
Very supportive	1
See me as protecting the rights of patients	1
As patient's advocate	1
Positive	2
Approve	2
Not sure	1

The "APS worker" grouping responses included expressions of frustration at both the workers and the system. Respondents described APS workers as follows.

APS Worker Grouping Responses:

Think I exaggerated	4
Are annoyed or irritated by referrals	4
Think a report is a waste of time	3
Overworked	3
Frustrated	2
Skeptical	1
They have a negative attitude in general	1
Do nothing anyway	1
APS has no authority	1
Obligated to investigate	1

Responses which indicate a more positive response from APS workers to Home Health Care employees were fewer. They included:

Positive Responses from APS Workers:

Thinks I'm protecting the rights of my patient	1
Approves	1
Thinks I should report	1
Supportive	2

In the grouping of co-workers, the majority of respondents have had positive experiences.

Co-Worker Grouping Responses:

Supportive	15
Caring and concerned	4
Good call	1
Impartial	1
Approving	1
Respectful	1
Positive	1

Three respondents (including one administrator) stated that what others think about their APS referrals is not of concern to them. One respondent stated that co-workers have viewed her as over-reacting.

In the patient's family/caregiver grouping, respondents indicated that they usually were aware of negative feelings of patients, families or caregivers, depending upon the situation and whether or not the abuse or neglect was intentional. Some of the negative feedback that respondents have received from patient, family, or caregiver include the following:

Negative Feedback from Patient, Family, or Caregiver	
Anger	12
Resentment	7
Threatening	7
Trouble-maker	6
Interfering	5
Outsider	2
A "bad guy"	2
Punitive	1
Over-reacting	1

Respondents view the accused as reacting in a variety of ways which include the following:

Reactions of Accused	
Defensively	4
Grateful	3
Relieved	2
Betrayed by reporter	2
Upset	1

An example of a general statement is a Registered Nurse/Case Manager's statement, "I always ask the MSW to make an emergency visit to evaluate and make the APS referral." Another Registered Nurse/Case Manager stated, "I don't make APS referrals without first speaking to my supervisor." Two respondents stated they had never made an APS referral and one respondent declined to respond to this question (although she had answered the other five questions).

A Registered Nurse/Case Manager stated, "My main concern is APS itself. The reporting to APS is cumbersome and difficult... Education of how to streamline the interaction between all parties needs to be done." The majority of perceived negative reactions were those of APS (24%) and family members.

Round Two

With the exception of Questions 3 and 4, the researchers found that responses were complete and adequately supplied the information the researchers were seeking.

In an attempt to clarify with respondents the needs for employee education, the researchers asked an additional question of seven respondents who did not know who was protected under Adult Protective Services legislation

and who mandated reporters are and what protection mandated reporters have.

Past Opportunities to Learn about APS

Question #7.

What opportunities have you had in the past to learn about adult abuse and neglect reporting?

Of the seven respondents we contacted for clarification, none had been a Registered Nurse for longer than three years. All seven of the respondents had given vague answers to Questions 3 and 4; for example, "I have no idea." The second round respondent had one year or less experience in a Home Health Care Agency.

All respondents stated they had had no training in APS reporting, except a one-hour in-service (5) and brief coverage in a class while in nurses' training (2).

Six of the respondents in the second round expressed a strong desire to learn more about abuse/neglect in general. Requests for education included understanding their role in preventing abuse/neglect (7), learning how to make a referral (5), and knowing what to look for (3).

One of the seven respondents was ambivalent about learning more about Adult Protective Services. This Registered Nurse/Case Manager simply stated, "That's what you're here for." It is interesting to note that, although she declined to respond further, this nurse

has made a Medical Social Work referral on more than 90% of the patients on her caseload.

In summation the responses of these nurses exemplifies the high caliber of professionalism the Visiting Nurses have. When they realized their lack of knowledge, they requested training in order to provide their patients with the best care possible.

DISCUSSION

Interpretations:

Throughout the survey, respondents expressed confusion regarding the definitions of abuse and neglect; who is required to report; how to report; the agencies' role in reporting; and the Medical Social Workers' role in reporting. The results obtained from this research support the literature quoted earlier in this paper. Of the respondents, only two Medical Social Workers had an adequate definition of abuse/neglect. For the most part, the Registered Nurses/Case Managers left both defining and reporting abuse and neglect to the Medical Social Worker. Even the Medical Social Workers themselves do not have clear definitions of abuse and neglect; do not know who is protected under APS legislation; and do not know what protection mandated reporters have. While the majority of respondents were unclear as to the definitions of abuse and neglect, there was no question that

the respondents' overwhelming response was concern for patients and their safety. The psychological neglect issues addressed by respondents gives the reader a sense of the strong commitment and sincere level of concern that the agencies' employees have for the patients they care for.

Responses indicate that Registered Nurses/Case Managers effectively and consistently evaluate patients' safety issues related to access to food, water, adequate care, and medication management. The Registered Nurse/ Case Manager's conscientiousness to assess patients' access to nutrition, hydration, care, and medication ties in with their focus on the physical and more tangible aspects of abuse/neglect. Even though the respondents frequently indicated an awareness of patients' psychosocial needs, failure to meet these needs was not consistently identified as abuse/neglect, although 28 respondents did list psychosocial stressors as indicators of abuse/neglect.

Since less than half of the survey respondents stated they make a referral to the Medical Social Worker "at the first suspicion of abuse or neglect", a high percentage of patients are overlooked. Prevention of abuse requires early social work interventions. Janz (1990) points out that it is critical for nurses to identify and alleviate caregiver stress before it leads to

abuse/neglect. She adds that caregiver counseling is needed throughout long-term care, especially when stress is present. Families should be referred to community resources and given the opportunity to enhance caregiving skills. By early intervention, abuse/neglect can be prevented.

While some respondents identified abuse/neglect as being either intentional or non-intentional, the majority did not remark on intentional versus non-intentional. This may indicate that some Registered Nurses/Case Managers in this survey overlook the importance of education, training, and resource referrals as measures to prevent abuse/neglect, especially in cases of non-intentional abuse/neglect. However, this finding is unclear since researchers failed to ask the subjects a question regarding intent.

The respondents' negative descriptions of APS workers, together with responses identifying who is protected by APS legislation, imply that Registered Nurses/Case Managers do not know or understand the legal limitations imposed on APS Social Services Workers in an effort to protect client rights. Therefore, Registered Nurses have an expectation that if a patient is at risk, the patient should be forced to do whatever is "best" for him. This leads to a negative impression of APS workers based on the nurses' perception that the workers do not

do enough to change the patient's life situation immediately.

Responses to the survey instrument also indicated a lack of knowledge regarding who is protected under APS legislation. Because of the nature of Home Health Care, the majority of our patients are protected; however, not all meet the criteria for protection.

Responses were examined to determine possible trends according to gender, age, ethnicity, years of experience, and years of education. No trends were identified within any of these demographic domains.

Limitations

Although these researchers continually educate HHA's on an individual basis regarding social work interventions and APS issues and elicit patient information from them, the HHA's were not selected and invited to participate in this survey. Since the HHA is an integral part of the treatment team and frequently has the most intimate contact with a patient, this oversight may have forfeited valuable information for the study. Since the Home Health Aides bathe and provide personal care to patients, patients often have privacy to talk and are more willing to talk openly because of the attachment which develops between patient and HHA through such close contact. In addition, leaving the HHA's out of

the study minimizes their importance to the patient and on the team.

The survey sample size may have limited the range of responses received. Only 71% of those invited to participate completed and returned the survey instrument. It would appear that those who took the time to complete the questionnaire are those who are most interested in APS issues and in providing excellent care to the patient. At the onset, the researchers anticipated a participation rate in the 93-97% range.

The structure of Question 6 did not elicit as much information from most respondents as researchers had initially hoped. Some respondents themselves broke the question down into four separate items and thus provided the most complete and concise information. If the researchers had constructed the question more effectively, more complete information would have been given by most instead of a few respondents.

The actual process of making a legally correct mandated APS report was not addressed by the survey instrument. It is uncertain whether Registered Nurses/Case Managers know the steps involved in making an APS report which meets reporting requirements.

Recommendations

Formalized education of new employees in abuse

legislation, detection, and reporting procedures needs to be implemented. The majority of respondents inaccurately defined neglect and abuse; incorrectly identified who is protected under APS legislation; and were unable to adequately list who are mandated reporters. A packet for new employees can be developed which includes abbreviated APS legislation, suggestions for detection, and an outline of the steps required to make a report. In addition, regular in-services to remind staff of APS issues is needed. APS in-services should provide the opportunity for staff to discuss difficult cases in a safe and supportive environment.

Researchers were disappointed to find that the Medical Social Workers as a whole have a limited understanding of APS legislation. One Medical Social Worker invited to participate did not complete the survey instrument. Of the seven Medical Social Workers who did participate in the research, only two were able to give correct and complete answers to all six survey questions. Medical Social Workers should be the first to receive complete and thorough training in APS issues. It is recommended that the Medical Social Workers are trained separately from the Registered Nurses/Case Managers because they should have a more in-depth understanding of issues and increased ability to intervene

appropriately to prevent abuse/neglect as possible and report as necessary.

Ramona Visiting Nurses Association and Hospice and Visiting Nurses Association of Inland Counties need to establish agency policy/protocol in writing to clearly define the role of the mandated reporter with the agency, specify how reports are to be made, delineate documentation requirements for medical charts, and identify who within the agency needs to know when a report is filed. Positive responses from administrators who participated in the survey regarding the need for and acceptance of social work intervention indicate that management will openly receive and accept suggestions for in-service training and policy/procedure implementation.

In the Hemet Office of the Ramona Visiting Nurses Association and Hospice, new Registered Nurses spend one eight-hour day with the Medical Social Worker. This procedure has proven beneficial to team member in this office because of the increased opportunity for relationship building between the Medical Social Worker and the Registered Nurses, increased knowledge by team members of what the Medical Social Worker actually does, and an increase in social work referrals since implementation. Because of the positive outcome of this component of orientation in Hemet, it is recommended that the other

offices of Ramona Visiting Nurses Association and Hospice and the Visiting Nurses Association of Inland Counties also implement this practice.

Team conference meetings have been and continue to be an integral part of treatment planning. Team conference offers the opportunity for members of different disciplines to discuss the patient and to better evaluate and plan to meet patient needs. The more invested the team members are in contributing to the team conference, the more the patients will benefit. In discussing the patient as a team, the Medical Social Worker has greater opportunity to identify and point out potential for abuse/neglect so that early intervention may prevent abuse/neglect from occurring. Administration needs to continue to support and enforce team conference attendance and participation.

Further Research Suggestions

A research project to study the effectiveness of the Medical Social Worker as Case Manager may open new avenues of responsibility for the Medical Social Worker. This study would address whether the Medical Social Worker can facilitate treatment planning as effectively as the Registered Nurse/Case Manager.

Case management offers patients who do not have a need for daily to weekly Skilled Nursing Visits (SNV)

to receive limited services from Ramona Visiting Nurses Association and Hospice and the Visiting Nurses Association of Inland Counties. A case can be deemed to be high risk by the Registered Nurse/Case Manager who assigns medical personnel to the patient as needed. As Case Manager, the nurse sees the patient once monthly. An example of this type of case is a 98-year-old female patient, without serious ongoing medical problems, who lives alone and experiences periods of forgetfulness and confusion.

In addition, this early and continued intervention by the Medical Social Worker may result in decreased hospitalizations. When the Medical Social Worker is involved in a case from the beginning with continued contact and intervention with the patient, the patient will have access to needed community resources and support which may prevent hospitalization.

In the Hemet Office, since implementation of the procedure for Registered Nurses to spend one day of orientation with the Medical Social Worker, social work referrals have increased significantly, from an average of 47 per month prior to implementation to more than 150 per month since. As referrals have increased, the percentage of APS reports has decreased. In an attempt to identify prevention strategies, a research project

can be designed to determine whether increased Medical Social Worker utilization has decreased incidents of abuse/neglect in the patient population through prevention.

APPENDIX A

SAMPLE LETTER TO ADMINISTRATORS

Date

Address (Paula's or Carol's depending on which administrator)

Dear _____, (Each letter will be personalized)

We, Carol Davis and Paula Spencer, are third year part-time students in the Graduate Program in Social Work at California State University, San Bernardino. One of the requirements for receiving the Master of Social Work Degree (M.S.W.) is the completion of a research project.

For our project, we are conducting an exploratory survey to determine how Registered Nurses/Case Managers in the Ramona Visiting Nurses Association and Hospice and in the Visiting Nurses Association of Inland Counties define dependent adult and elder abuse and neglect. As an administrator of Ramona Visiting Nurses Association and Hospice (or Visiting Nurses Association of Inland Counties), you have been selected to participate in the survey because we believe that values held by the administrators of the agency are passed on to the Case Managers.

Your involvement in this professional endeavor is greatly appreciated. Please be assured that no harm can result from your participation in this survey and you are under no obligation to complete it should you decide to stop. The success of this study depends upon the professional concern and involvement I know you will give your request.

Please contact Paula (for Ramona Visiting Nurses Association and Hospice) (or Carol for Visiting Nurses Association of Inland Counties) to schedule an appointment to complete the survey at your earliest convenience.

If you are interested in obtaining results of this survey, California State University, San Bernardino, will have an event in June 1994 at which the research project will be present for review.

Thank you for your cooperation and assistance.

Sincerely,

Carol Davis MSW Student	Paula Spencer MSW Student

*** Information in parenthesis was not used in actual letters. ***

APPENDIX B

SAMPLE LETTER TO RANDOM SAMPLE PARTICIPANTS

Date

Address (Paula's or Carol's depending on which office)

Dear _____, (Each letter will be personalized)

We, Carol Davis and Paula Spencer, are third year part-time students in the Graduate Program in Social Work at California State University, San Bernardino. One of the requirements for receiving the Master of Social Work Degree (M.S.W.) is the completion of a research project.

For our project, we are conducting an exploratory survey to determine how Registered Nurses/Case Managers in the Ramona Visiting Nurses Association and Hospice and in the Visiting Nurses Association of Inland Counties define dependent adult and elder abuse and neglect. As an employee of Ramona Visiting Nurses Association and Hospice (or Visiting Nurses Association of Inland Counties), you have been randomly selected to participate in the survey.

Your involvement in this professional endeavor is greatly appreciated. Please be assured that no harm can result from your participation in this survey and you are under no obligation to complete it should you decide to stop. The success of this study depends upon the professional concern and involvement I know you will give your request.

The survey will be administered to those of you who were randomly selected at the close of your office's next scheduled staff meeting.

If you are interested in obtaining results of this survey, California State University, San Bernardino, will have an event in June 1994 at which the research project will be present for review.

Thank you for your cooperation and assistance.

Sincerely,

Carol Davis MSW Student	Paula Spencer MSW Student

*** Information in parenthesis was not used in actual letters. ***

APPENDIX C

INFORMED CONSENT

I consent to serve as a participant in the research investigation entitled "Abuse and Neglect: As Defined by Registered Nurses/Case Managers", developed and conducted by Carol Davis and Paula Spencer. I understand that the general purpose of this study is to determine the role of Home Health Care professionals in detecting and reporting instances of Elder and Dependent Adult Abuse and Neglect. This has been explained to me by Carol Davis and/or Paula Spencer from the Graduate Program of Social Work at California States University in San Bernardino.

I understand the research procedures involve answering questions requesting my opinions and feelings. These questions can be asked of me verbally or in writing. There are no identified potential risks to participants. The desired benefit of this research is a better understanding of the role that Home Health Care professionals have in addressing abuse/neglect of patients.

I understand that my participation is voluntary, that all information is confidential, and that my identity will not be revealed. I am free to withdraw my consent and discontinue participation at any time.

Any questions that I have will be answered by the researchers named below or by an authorized representative. Results of the study will be made available to me at my request.

California State University, San Bernardino, and the researchers named below have responsibility for insuring that participants in research projects conducted under University auspices are safeguarded from injury or harm resulting from participation.

On the basis of the information contained within this Informed Consent, I agree to participate in this project.

_____ _____

Participant's Signature Researcher's Signature

_____

Date

APPENDIX D - DEMOGRAPHICS

HOW DO REGISTERED NURSES/CASE MANAGERS DEFINE

ABUSE AND NEGLECT?

1) What is your occupation?
_____Registered Nurse/Case Manager
_____Licensed Vocational Nurse
_____Other Nurse
_____Medical Social Worker
_____Administrator (Executive Director, Branch Manager, Assistant Branch Manager, Clinical Director, Rehab Manager)

2) What is your gender? _____Male _____Female

3) What is your age?_____

4) What is your ethnicity?
_____Caucasian _____Hispanic
_____Asian _____African American
_____Other _____

5) What degree(s) do you have?_____

_____

6) What license(s) do you have?_____

_____

7) Have you had any training in abuse reporting? If so, please check any of the following that apply:

_____Formal course (2-4 units) _____CEU's
_____Brief coverage in a course _____In-service
_____Seminar (If Seminar or In-service, indicate number of hours _____) Other_____

8) How many years have you been employed in the Home Health Care field? _____

9) Does your agency have _____less than 25 employees or _____more than 25 employees?

APPENDIX E - INITIAL SURVEY INSTRUMENT

QUESTION #1

SURVEY QUESTIONS

How do you define adult abuse?

QUESTION #2

SURVEY QUESTIONS

How do you define neglect?

QUESTION #3

SURVEY QUESTIONS

Who is protected under Adult Protective Services legislation?

QUESTION #4

SURVEY QUESTIONS

Who are mandated reporters of elder and dependent adult abuse and neglect?

Is there any legal protection for mandated reporters?

QUESTION #5

SURVEY QUESTIONS

At what point does the Registered Nurse/Case Manager feel that Medical Social Work intervention is necessary?

QUESTION #6

SURVEY QUESTIONS

How do you feel that others (agency, APS workers, co-workers, patient's family, patient's caregiver, etc.) perceive you when you make an APS referral?

APPENDIX F - ROUND TWO SURVEY INSTRUMENT

QUESTION #7

SURVEY QUESTIONS

What opportunities have you had in the past to learn about adult abuse and neglect reporting?

APPENDIX G

DEBRIEFING STATEMENT

Thank you for your participation in this research project. Any questions you have in reference to this project, the methodology used, or the outcome of the data collection may be obtained by contacting the researchers named below, the advisor named below, or by an authorized representative. They may be reached by the telephone numbers listed.

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APPENDIX H

KOSBERG'S HIGH RISK PLACEMENT WORKSHEET

A.	Characteristics of Older Person	Existence of Risk
1.	Female	_____
2.	Advanced Age	_____
3.	Dependent	_____
4.	Problem Drinker	_____
5.	Intergenerational Conflict	_____
6.	Internalizer	_____
7.	Excessive Loyalty	_____
8.	Past Abuse	_____
9.	Stoicism	_____
10.	Isolation	_____
11.	Impairment	_____
12.	Provocative Behavior	_____

B.	Characteristics of Caregiver	Existence of Risk
1.	Problem Drinker	_____
2.	Medication/Drug Abuser	_____
3.	Senile Dementia/Confusion	_____
4.	Mental/Emotional Illness	_____
5.	Caregiving Inexperience	_____
6.	Economically Troubled	_____
7.	Abused as Child	_____
8.	Stressed	_____
9.	Unengaged Outside the Home	_____
10.	Blamer	_____
11.	Unsympathetic	_____
12.	Lacks Understanding	_____
13.	Unrealistic Expectations	_____
14.	Economically Dependent	_____
15.	Hypercritical	_____

C.	Characteristics of Family System	Existence of Risk
1.	Lack of Family Support	_____
2.	Caregiving Reluctance	_____
3.	Overcrowding	_____
4.	Isolation	_____
5.	Marital Conflict	_____
6.	Economic Pressures	_____

7. Intra-Family Problems _____
8. Desire for Institutionalization _____
9. Disharmony in Shared Responsibility _____

D. Congruity of Perceptions Between Older Person and (Potential Caregiver) — Existence of Risk

1. Quality of Past Relationship _____
   a. Perception of Older Person
      _____
   b. Perception of Caregiver
      _____

2. Quality of Present Relationship _____
   a. Perception of Older Person
      _____
   b. Perception of Caregiver
      _____

3. Preferred Placement Location _____
   a. Perception of Older Person
      _____
   b. Perception of Caregiver
      _____

4. Ideal Placement Location _____
   a. Perception of Older Person
      _____
   b. Perception of Caregiver
      _____

"It is not the purpose of the worksheet to arrive at a cumulative high-risk rating but, rather, to signal potential problems resulting from the characteristics of the older person, caregiver, or family system... These questions are asked independently of both individuals and, in cases where incongruities in responses between respondents are noted, further exploration by the professional should take place prior to placement decision." (Kosberg, 1988)

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