

Elder Abuse in the Nursing Home Setting:  
Social Workers' Perspectives of Training and Education

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MSW Clinical Research Paper

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present their findings. This project is neither a Master's thesis nor a dissertation.

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### Abstract

The purpose of this study is to investigate the perspectives that social workers in the nursing home setting have in regard to their training and education on prevalence and prevention of elder abuse. Qualitative interviews were conducted with six nursing home social workers and one aging advocate from the St. Paul area, using convenience and snowball sampling. A demographic survey was also administered to participants. Content analysis was used to analyze the data. Findings from the nursing home social worker interviews suggest themes of: awareness of elder abuse, education on elder abuse (both in nursing homes and education settings) and its adequacy, knowledge and understanding of abuse reporting procedures, limited knowledge of federal laws, lack of trust in state Ombudsman, increased education for other nursing home staff, and brief responses and researcher observations of uncomfortable body language. Themes in the data from the aging advocate interview include: limited education on elder abuse for nursing home social workers, limited experience of nursing home social workers, limited comfort level for nursing home social workers to discuss elder abuse, and good and bad experiences in working with the Ombudsman. Thus, though nursing home social workers are aware of elder abuse and perceive their training and education on elder abuse to be comprehensive, training and education is still lacking in both nursing home and educational settings.

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The United States has had a large demographic shift in the area of life expectancy and the aging population (Kerschner & Pegues, 1998). There is an increase in proportion of the population that is over 65 years due to the aging of the baby boom generation (Berkman, Gardner, Zodikoff, & Harootyan, 2006). The group of people in the United States that are 65 and over make up 12.4% of the population. In 1990 this age group made up four percent of the population. By the year 2030, older adults are expected to make up 21% of the population (Kerchner & Pegues, 1998). In addition, those ages 85 years and older are the fastest growing segment of the population. In 2000 this group measured four million and is expected to reach 19 million by 2050 (Berkman et al., 2006).

Due to this growing population, research suggests that there will also be a growing prevalence of elder abuse (Baker, 2007). Although exact numbers of elder abuse are unknown, estimates show that in the United States, 2.16 million older persons are victims of abuse each year (Plitnick, 2008). In addition, the National Research Council Panel to Review Risk and Prevalence of Elder Abuse and Neglect reports that between one and two million older adults in the United States have been injured, exploited, or mistreated by a caregiver (as cited in National Center on Elder Abuse, 2005) and that only one in 14 incidents are brought to authority attention (Pillemer & Finkelhor, 1988 as cited in Center on Elder Abuse, 2005). Kuebelbeck (2010) estimated that in 2010, 24,000 cases of mistreatment of vulnerable adults were reported to adult protective services in



Minnesota. Additional reports made to law enforcement agencies are not included in that estimate; therefore, there are an unknown number of additional maltreatment cases.

Different types of abuse recognized by the National Center on Elder Abuse (2010) include: physical abuse, emotional abuse, sexual abuse, exploitation, neglect, abandonment, and self-neglect. According to Kuebelbeck (2010), the most common type of abuse, which comprises 40% of cases, is caregiver neglect, followed by self neglect, financial abuse, physical abuse, and emotional abuse. Payne and Fletcher (2005) state that elder abuse may occur when three different environmental condition are present: “a motivated offender...the lack of capable guardian...and a vulnerable target” (p. 121). Conner, Prokhorov, Page, Fang, Xiao, and Post (2011) found that there is a correlation between the vulnerability of a person in care and the likelihood of abuse and neglect. Risk factors include “functional disability, cognitive impairment, social isolation, age, race, income, family background, life events, dementia, and depression” (Dyer, Pavlik, Murphy, & Hyman, 2000; Lachs & Pillemar, 2004; Lachs, Williams, Obrien, Hurst, & Horwitz, 1997; Pavlik, Hyman, Festa, & Dyer, 2001; Schofield & Mishra, 2003, as cited in Conner et al., 2011, p. 21).

Most of the research that has been conducted on elder abuse has been community and family based. There is a lack of research examining elder abuse in the nursing home setting (Payne & Fletcher, 2005). The limited research that has been performed in the nursing home setting indicates the national reporting system may need revamping, for there is “no uniform reporting system” and there is no nation-wide tracking system of elder abuse (National Center on Elder Abuse, 2005, p. 1).

The state level reporting system and reporting tendencies are also problematic. According to the Minneapolis Star Tribune (2011), “Federal officials have repeatedly faulted Minnesota for how it reviews complaints of abuse and neglect [in elder care living facilities]. Twice in the past four years, federal records show, state regulators did not properly investigate 40% of reported complaints” (p. 1). This may be due to the fact that many mandated reporters may be unaware of the reporting laws of their state and facility (Bergeron, 2008). The Nursing Home Reform Act of 1987 was created to eliminate abusive, negligent, and deficient care of elders in nursing home facilities, however, this mission of the Act has fallen short (Breen, Matusitz, & Wan, 2009).

Research consistently suggests that the prevalence of elder abuse and the lack of awareness and reporting in the nursing home setting may be due to a lack of worker education and training (Payne & Fletcher, 2005; Sherr & Ellor, 2009). According to Jogerst, Daly, and Hartz (2005), half of nursing home administrators and Ombudsmen in Pennsylvania believe that 60% of elder abuse cases in the institutional setting go unreported. In 2007, an estimated 1.6 million people were in nursing homes and an additional one million in residential care facilities in the United States (Baker, 2007). Thus, those working directly with residents in nursing home facilities need to be fully trained on prevention and regulations of abuse. Education among staff in the nursing home is essential to the diminishment of elder abuse (Jogerst, Daly, & Hartz, 2005; Payne & Fletcher, 2005). This study investigated the perspectives that social workers in the nursing home setting have in regard to training and education on prevalence and prevention of elder abuse.

## Literature Review

There are many important aspects when reviewing the literature on elder abuse in the nursing home setting. This section includes definitions of elder abuse, elder abuse risk factors (caregiver, elder, and family violence), outcomes of elder abuse, community vs. institutional elder abuse, institutional preventions and regulations of elder abuse, and formal regulations and responses to elder abuse at the federal, state, and institutional level.

### Elder Abuse

The United States holds no official statistical data on the occurrence and prevalence of elder abuse (*Elder maltreatment*, 2010; *Elder abuse*, 2005); however, it is estimated that 2.16 million older persons are victims of abuse each year (Plitnick, 2008). There are many varying definitions of elder abuse which may contribute to the difficulty of developing an accurate account of prevalence. The National Center on Elder Abuse (NCEA) (2010) lists seven types of elder abuse. *Physical abuse* is described as using force to threaten or injure a vulnerable elder physically. *Emotional abuse* involves attacks and threats that are verbal as well as rejection, isolation, and belittling; these acts cause or may cause mental distress to an elder. *Sexual abuse* involves sexual contact upon an elder who is coerced or unable to allow consent; the elder may be tricked or threatened as well. *Exploitation*, sometimes referred to as financial abuse, refers to gaining an elder's money or property through theft, fraud, and misuse of authority. *Neglect* is the failure or refusal of a caregiver to provide physical, emotional, and safety needs for an elder. *Abandonment* is described as the caregiver deserting a vulnerable elder. Finally, *self-neglect* is the

inability to understand how one's actions or lack of actions may lead to harm of one's self (*Why should I care, 2010*).

The Minnesota Department of Human Services lists three types of maltreatment: *abuse, neglect, and financial exploitation*. Abuse includes physical, sexual, or emotional. Neglect encompasses caregiver neglect or self neglect (Minnesota Department of Human Services, 2011). For the purposes of the current research, when abuse is mentioned, it may reflect any of the previously listed types of abuse. In addition, the terms abuse, maltreatment and mistreatment may be used interchangeably (*Why should I care, 2010*).

Elder abuse is a world-wide problem. Overall, there lies a general lack of awareness and understanding of elder abuse in every community (Joubert & Posenelli, 2009). Because professionals do not know how great the problem of elder abuse truly is, they must become aware of the varying definitions and types of abuse as well as risk factors and interventions. Therefore, awareness and education are the first steps in taking action to reduce elder abuse.

### **Elder Abuse Risk Factors**

Another step in reducing elder abuse is by recognizing potential risk factors and predictors of abuse. It is important to note why abuse may be occurring in order to prevent and reduce the risk. Risk factors occur both on the side of the caregiver and the older adult who is victim of abuse. According to Brozowski and Hall (2010), elder abuse is a social problem. It is a symptom of "deeply entrenched ageism within a highly individualized risk oriented culture" (p. 1184). The authors go on to state that this symptom of ageism is "magnified for women and minorities and is condoned in North America" (p. 1184). There are many elder and caregiver predictors that may lead to elder

abuse, however no theory exists to relate factors to each other in a structural fashion (Conner, Prokhorov, Page, Fang, Xiao, & Post, 2011).

### **Caregiver risk factors.**

The majority of studies discuss elder risk factors; however, the Center for Disease Control and Prevention (CDC) (*Why should I care*, 2010) and an article on elder abuse in the *The Journal of the American Medical Association* (JAMA) by authors Hildreth, Burke, and Golub (2011) discuss caregiver risk factors. A caregiver risk factor is something in the caregiver's life that makes him or her more likely to be an abuser of a care receiver.

As discussed by the CDC, predictors that may cause a caregiver to hurt a vulnerable elder include factors such as: excessive drug or alcohol use, increased stress levels, minimal or limited support system, dependence on the elder for emotional or financial support, lack of training in how to take care of the elder, and finally, depressive symptoms (*Elder maltreatment*, 2010). Hildreth, Burke, and Golub (2010) recognize risk factors including: feelings of resentment and being overwhelmed, history of drug abuse, history of abuse, and dependence on elder for essential needs. Not only are caregiver risk factors important for determining elder abuse but elder risk factors are important as well.

### **Elder risk factors.**

As previously stated, most researchers discuss elder risk factors of abuse (Hildreth, Burke, & Golub, 2011; *Elder Maltreatment*, 2010). In a survey administered to members of households in Michigan composed of relatives or adults responsible for the long-term care of an elder, Conner et al. (2011) found that the more assistance and

treatment needed by a patient, the greater likelihood that they will be abused or neglected. In addition, they discuss that cognitive impairment may play a predictive role. Cognitive impairment creates the need for more assistance with activities of daily living. This dependency creates more demands on the caregiver and could also be considered a caregiver risk. Conner et al. (2011), states, “excessive demands made on caretakers results in decreased tolerance, loss of self-control, and reduced time and energy...they are more likely to feel tired, frustrated, and angry and exercise poor judgment” (p. 22). These situations increase the likelihood that a person will be abused. Joubert and Posenelli (2009) and Baker (2007) agree that elder dependency on an abuser may be an issue. However, Baker (2007) also suggests that scientific evidence to support physical dysfunction as a predictor is lacking. Baker states that “research has generally failed to find support for the view that frailty of elderly persons is in itself a risk factor for elderly maltreatment” (p. 316).

Demographics may also play a role in predicting elder abuse. Choi, Kim, and Asseff (2009) suggest that older adults with a lower income in addition to health and mental health issues are more likely to have an increased risk of self-neglect and neglect. In their study, Choi, Kim, and Asseff (2009) used the 2005 initial assessment and investigation data from Adult Protection Services cases in Texas to examine reports of elder abuse. This study found that elder victims and family caregivers who lack personal funds to pay for goods and services and had little Medicare or Medicaid coverage was a primary predictor in elder self-neglect or neglect. They also discovered that the risk of self-neglect and neglect increased when there was a lack of available services in poor and rural communities. Brozowski and Hall (2010) conducted a study in Canada with a

sample of 3,366 older adults ages 65-80 which found that women, aboriginal Canadians, and elders who were divorced, those living in urban areas, and those with low income have a higher risk of being physically and sexually abused. The limited research conducted in nursing homes suggests that there are complex relationships between higher abuse incidents and report rates in nursing homes in metro areas.

A study conducted by Jorgest, Daly, and Hartz (2005) analyzing data from the 2000 Census report also found that there is a strong association between the population over 60 years of age and financial exploitation. This study suggests that compared to the general population, those sixty and over had the strongest association to all types of abuse. Brozowski and Hall (2010) found that being a victim of sexual assault prior to age 60 was the primary risk factor for elder assault.

#### **Family violence as risk factor.**

In family situations, it may be predicted that older adult victims of one form of violence are then at an increased risk of other forms of abuse; unequal power between victim and abuser is the starting point for all types of family violence (Walsh, Ploeg, Lohfeld, MacMillan, & Lai, 2007). In Walsh et al.'s (2007) study of 77 older adults and 33 caregivers, findings support the intergenerational transmission of violence in families. There is a link between violence over a lifespan. Therefore, it is important to assess family violence as a risk factor for further elder abuse.

#### **Outcomes of Elder Abuse**

There are many negative outcomes for elders who have experienced abuse. Bergeron (2008) suggests that abuse intensifies health conditions that make it difficult for one to have the ability to make decisions. Examples of this include: "lack of sleep, lack of

food, dehydration, improper medication or medical care, or mental health issues” (p. 96). McCreadie (1996) states, “Mental and emotional problems may be both a cause and an effect of elder abuse. It would be hardly surprising if people living with abuse, some of which may be long term, displayed psychological effects” (as cited in Bergeron, 2008, p. 96).

When speaking of financial exploitation, Choi, Kim, and Asseff (2009) state that much research suggests that the negative effects of this type of abuse on elders may be just as serious, if not more serious, than the detrimental effects of physical abuse on an older adult (Fulmer et al., 2005b; Lachs, Williams, O’Brien, Pullemer, & Charlson, 1998, as cited in Choi, Kim, and Asseff, 2009). When speaking of all types of elder abuse, there is a higher mortality risk for elders who have been abused when compared to their peers who have not been abused (Baker, 2007).

Walsh et al. (2007) suggest that victims of elder abuse frequently ‘suffer in silence’ due to cultural factors and ageism that permeate elder abuse. Walsh and colleagues (2007) note that in the United States, an estimated five cases go unreported for every one case that actually is reported, indicating that those five cases that go unreported may be victims who are suffering in silence. This may be due to our individualistic society which states we must be responsible for ourselves (Brozowski & Hall, 2010). Thus, it is important to recognize this as a factor as to why some victims of elder abuse do not report the abuse.

### **Community vs. Institutional Elder Abuse**

Elder abuse may occur in community-based environments such as family settings or in institutional settings such as nursing homes.



**Elder abuse in community settings.**

Familial and community elder abuse is on the rise (Lowenstein, 2010). Many debates surround the topic of extended family and intergenerational patterns. According to Lowenstein (2010), there are growing pressures on the elder family member who needs care. The author goes on to discuss that families may be unable or unwilling to meet these needs of the family member who needs care. According to Baker (2007), findings suggest that elders are most likely mistreated in the domestic setting; this may be due to the stress that is associated with caring for older family members.

**Elder abuse in institutional settings.**

According to Payne, Brian, Fletcher, and Burke (2005), the majority of research on elder abuse is in community based settings, not institutional settings. Additionally, prevalence and incidence rates of elder maltreatment in institutions are unknown (Baker, 2007). It is known, however, that in the United States there are an estimated 1.6 million people in nursing homes and an additional one million in residential care facilities (Baker, 2007).

Jorgest, Daly, and Hartz (2005), suggest that in Pennsylvania, half of all nursing home administrators and Ombudsmen believe that 60% of institutional cases of elder abuse go unreported. An *Ombudsman* is someone at the state level who provides advocacy and assistance for elder residents in nursing homes and assisted living facilities (Neting, Huber, Paton, & Kautz, 1995; Price, 1993, as cited in Jorgest, Daly, & Hartz, 2005). Frequency of abuse seems to be on the rise; resident complaints to Ombudsmen have risen from 145,000 in the year 1996 to 186,000 in 2000 (National Long-Term Care Ombudsman, 2001 as cited in Jorgest, Daly, & Hartz, 2005). The researchers also suggest

a range from .4 to 158 incidents of abuse per 1,000 nursing home residents. In their study, Jorgest, Daly, and Hartz (2005) found that 36% of 577 nursing home employees sampled nationwide had seen a minimum of one occurrence of physical abuse, and 81% of the 577 nursing home employees had seen a minimum of one occurrence of psychological abuse over the previous ten years.

The Nursing Home Reform Act of 1987 sought to decrease elder abuse in the institutional setting; however, deficiencies in care for older adults continue today, 25 years later, in such environments. As described in the Minneapolis Star Tribune, a nursing home advocate and Ombudsman for Long-Term Care for Minnesota, Deb Holtz, receives complaints daily from nursing home residents and how they have been wronged (Schrade, 2011). Holtz visited a nursing home as a temporary resident in Roseville, Minnesota to gain insight on what living in a nursing home was really like. Holtz states that except for one person who came to offer her dinner she sat in her room “for five hours, with no admission meeting, no greeting, just nothing” (Schrade, 2011, p. 2).

Much information is still lacking on prevalence and incidence of abuse in the institutional setting, therefore, the current study will examine the institutional setting, not the community setting.

### **Institutional Preventions and Regulations**

Nursing homes and other institutions have regulations and rules set in place to prevent and respond to cases of elder abuse. In Pennsylvania, Ombudsmen provided community education sessions, conducted media interviews, and did media press releases (Jogerst, Daly, & Hartz, 2005). Findings from Jogerst, Daly, and Hartz (2005) suggest that community education sessions at the state level were significantly associated with

higher abuse rates reported, indicating that if community education sessions were conducted, people were more likely to report abuse cases. The interviews and press releases with the media did not have a significant association with abuse reporting rates and correlations were low. Reingold (2006) states that services need to be set in place such as: legal advocacy for older adults, support services, education, and public education and training.

Joubert and Posenelli (2009) suggest that hospital emergency departments have a “window of opportunity” and should be the primary opportunity for help and support since they typically have the first point of contact with the person who had been abused. The researchers suggest that education for these medical professionals is the most effective way of improving the recognition of elder abuse. In their study, 73% of the staff was familiar with elder abuse, however, only 14% had received any kind of education or training on how to detect or manage the abuse.

To prevent elder abuse in the nursing home, Payne et al., (2005) suggest that nursing homes should have educational in-services and trainings on the prevention of elder abuse and education for residents. There should also be community outreach and building security. In addition, procedures should follow a logical progression or clearer course of action. Many report that there is a slow agency response which may be due to an unclear course of action.

Bergeron (2008) states that it is a shared professional responsibility to create interventions and develop services to assist in protecting vulnerable adults. Professionals must use critical thinking to take environmental and social factors into consideration. For example, abuse may be “in the privacy of one’s home or in full view of the community”

(p. 99). Reingold (2006) adds that professionals working together can make significant progress in decreasing elder abuse. Baker (2007) suggest that to prevent elderly maltreatment it is first important to make employees aware of the prevalence and incidence elder maltreatment; it needs to be on peoples' radar. In addition, there needs to be reliable screening protocols to help identify victims. There needs to be early suspicion and effective responding (Joubert & Posenelli, 2009). For this to happen, education and professional development programs for nursing home staff need to be in place so that awareness of abuse is increased.

Research suggests that institutions do have preventative procedures and regulations in place, but there may be discrepancies due to lack of awareness and education. Payne and Fletcher (2005) found that nursing homes with an active safety committee helped to prevent injuries from occurring amongst the residents. In addition, hiring procedures, such as background checks and credential checking, must be thorough. Payne and Fletcher (2005) also discovered that nursing home administrators believe that safety among residents necessitated meetings regarding "residents' rights, privacy and dignity, facility policies, and abuse and neglect (types of, recognition of, and prevention of)" for employees, residents, and residents' family members (p. 122). The authors also discuss that staff education is an effective preventative strategy (Payne & Fletcher, 2005). Though there are effective preventative procedures, discrepancies arise from the lack of proper training. Thus, this is important to the current research study since direct care workers may be unaware and undereducated.

**Formal Regulations and Responses**

Formal regulations and responses to elder abuse are found at federal, state, and institutional/professional levels.

**Federal level.**

Bergeron (2008) suggests that social work may have oversimplified the principles of self-determination and competency in allowing abused older adults to choose to remain in abusive situations. Elder protection laws do not provide clear directions when dealing with self-determination and competency. This allows for discrepancies and variances in Adult Protection Services. According to Walsh et al. (2007), little research has been conducted regarding elder abuse in comparison to child/partner abuse. Joubert and Posenelli (2009) discuss that elder abuse holds no clear model like child abuse does. Reingold (2006), states that:

Elder abuse is, today, where child and domestic violence were 25 years ago: there are only a limited number of states with mandatory reporting of community-based elder abuse, there is no definitive conclusion on prevalence, there is ambiguity as to definition, and there is debate as to what constitutes the most effective intervention (p. 124).

Reingold (2006) discusses that the government has only started to have a policy response to elder abuse. Choi, Kim, and Asseff (2009), state that insufficient public policy responses need to be considered rather than individual and familial risk factors of abuse.

**State level.**

Joubert and Posenelli (2009), claim that “health professionals frequently lack the confidence when screening and management to respond appropriately when abuse is

suspected” (p. 702). There is a major deficit in the detection of elder abuse due to lack of staff knowledge and skills (Joubert and Posenelli, 2009). Lowenstein (2010) suggests that this lack of knowledge and skill may be due to a lack of consistent, unified definitions and understandings of elder abuse at a federal level that also impact the state policy level. Jogerest, Daly, and Hartz (2005) discuss that a region or state may have varying regulations for reporting abuse. They also state that complaints of abuse cases are more often reported from for-profit, larger nursing homes than less expensive nursing homes.

Minnesota itself lacks many of these sufficient policies and regulations. As discussed in the Star Tribune (2011), “Minnesota is one of only five states without a felony-level penalty for criminal neglect of a vulnerable adult” (Schrade & Howatt, p. 1). A nursing home in Albert Lea, Minnesota was recently exposed for tormenting an 89-year old Alzheimer’s patient and fourteen other patients. This article states that:

Federal officials have repeatedly faulted Minnesota for how it reviews complaints of abuse and neglect. Twice in the past four years, federal records show, state regulators did not properly investigate 40% of reported complaints...to meet federal guidelines, states are supposed to properly review and investigate complaints of abuse and other problems at least 90% of the time. But Minnesota’s Health Department missed that mark in each of the past four years...Minnesota is one of just three states that failed to properly review and investigate nursing home complaints in at least four of the past five years (p. 1-3).

Therefore, elders in Minnesota nursing homes may be placed at higher risk for abuse due to the lack of coherent state statutes and policies in this area (Schrade & Howatt, 2011).

**Institutional, professional level.**

Study after study discusses the inadequacy of relations and responses to elder abuse. Nerenberg (2008) states that the professional response to elder abuse is inadequate, that services are scarce, fragmented, and of varying quality. In addition, elder abuse is an idea that is poorly understood by the public. Sherr and Ellor (2009) state that:

Elder abuse often falls in the cracks between informal and formal systems as it more often reflects something that caregivers do, rather than specific acts of aggression...extended informal systems of persons outside the immediate family is uncertain as to how to address their suspicions and the formal system does not learn about it until it is a crisis (p. 14).

According to Reingold (2006), there is limited awareness of elder abuse. Nerenberg (2008) goes on to discuss that law enforcement, social service agencies, courts, and health care providers do not coordinate around elder abuse issues, very few perpetrators are brought to justice, and victims of elder abuse do not receive the compensation, services, or treatment that they need. There are limited shelters, respite services, or counseling services for those in need and inevitably, funding is limited.

In addition, many mandated reporters fail to report the abuse they see (Bergeron, 2008). Berdes and Eckert (2007) suggest that a primary problem of paid caregivers is that there is a “tension between the bureaucratic aspects of caring tasks” such as productivity and documentation and the caring aspects of compassion and relationship building (p. 341). Other cases go unreported due to the fact that elders may be afraid to inform the police, friends, or family of the abuse since they may depend on the care of their abuser (*Elder maltreatment*, 2010).

**Summary**

Elder abuse is pervasive in both the community and in institutions. Little research has been conducted on elder abuse in institutional settings and prevalence and incidence are unknown; however, elder abuse does exist and many cases go unreported (Baker, 2007). Regulations and responses to elder abuse are insufficient, particularly in Minnesota. According to Nerenberg (2008), “the professional response to elder abuse remains inadequate....services are scarce, fragmented [and] of varying quality” (p. 6).

Over and over it is repeated in research that those working with older adults need to be aware and trained in elder abuse to prevent elder abuse and reduce prevalence. Education is essential for understanding and awareness (Walsh et al., 2007). Thus, this research examines the perspectives that social workers in the nursing home setting have in regard to training and education on prevalence and prevention of elder abuse.



### **Conceptual Framework**

The conceptual framework this study uses draws on the theory of Street-Level Bureaucracy. This theory was created and coined by Michael Lipsky in the 1970s to encompass a bureaucracy in which public service providers work face-to-face with clientele. This theory impacted the development of the current study and the way the data was interpreted. Street-Level Bureaucracy illuminates and drives the current research due to the fact that the theory and the current research both deal specifically with providers who are providing direct care. The main problem that this framework focuses on is the “gap between what policy says and how policy is enacted in the day-to-day delivery of service” (Evans, 2011, p. 371).

### **Theoretical Lens**

As Finlay and Sandall (2009) present, bureaucracy is defined as “a hierarchical organizational structure designed rationally to co-ordinate the work of many individuals in the pursuit of large-scale administrative tasks and organizational goals” (Weber, 1949). *Street-Level Bureaucrats* are referred to by Lipsky (1980) as frontline workers “who interact with citizens in the course of their jobs, and who have substantial discretion in the execution of their work” (p. 3, as cited in Finlay & Sandall, 2009). Lipsky’s 1980 street-level bureaucracy study provided new perceptive analysis to the work of those who work directly with clients (Evans & Harris, 2004). This theory fits with social workers in nursing homes due to the fact that social workers work directly with clients; therefore, these are the workers who should be fully trained on the issues of elder abuse.

As discussed by Evans (2011), typically, policy implementation is either a top-down process (policy implemented by organizational bureaucracy) or a bottom-up

process (policy created by front line employees). Lipsky's theory rides the middle of these two explanations of implementation. His perspective states that to make policy work, street level workers are necessary. However, discretion within the street level workers must be utilized, therefore stating that a top-down perspective is also necessary. Evans (2011) discusses that this can be difficult for social workers due to the fact that they act in front-line positions to deliver services and act as policy initiators; this means that they not only implement services but they also act work to advocate for more suitable agency/state/federal policies for their clients. It is a balancing act between knowing when to advocate for policy change and when to deliver services. Evans and Harris (2004) state that Lipsky (1980) believes that direct care workers choose their profession because they want to help people, but they often face real-world practice that consists of day-to-day operations in 'a corrupted world of service' in which there are insufficient resources and unclear policies (p. 13). Evans and Harris (2004) go on to discuss that though managers establish rules and regulations, it may be difficult for them to control how a staff member completes his/her work. Therefore, this is where policy initiation by the front-line workers comes into play.

Finlay and Sandall (2009) state that street-level bureaucrats include workers such as: teachers, social workers, law enforcement personnel, and healthcare employees. Evans (2011) adds judges, lawyers, and court officials to the list. For the purpose of the current study, social workers in the nursing home setting, as direct-care workers, will be examined as the street-level bureaucrats.

**Advocacy**

Street-level bureaucrats must be advocates for their clients; they face the dilemma of competing demands between the client and the organizational administration. As the *Code of Ethics of the National Association of Social Workers* (2008) discusses, “social workers’ primary responsibility is to promote the well-being of clients” (p. 7) while at the same time “social workers generally should adhere to commitments made to employers and employing organizations” (p. 21). These workers must provide effective, individualized services to large numbers of clientele while attempting to meet the competing demands of the individual client and the agency (Finlay & Sandall, 2009). Lipsky (1980) defines that one who advocates must “use their knowledge, skill, and position to secure for clients the best treatment or position consistent with the constraints of the service”; this is done through discretion (p. 72 as cited in Finlay & Sandall, 2009). Managers are the regulators of discretion within street-level bureaucrats. They must make discretionary decisions while constraining their employees’ discretion (Evan, 2011). Due to the fact that managers are limited in controlling their direct care workers, discretion among direct care workers must be practiced; the practical way that policies are implemented may look different than official statements (Evans & Harris, 2011). Goals of an organization are often unclear, vague, or ambiguous, and therefore, difficult for street-level bureaucrats to implement them. It is in these cases discretion is highly valuable to street-level bureaucrats and why front-line workers create their own policies which become the policies in place in direct practice.

**Street-Level Bureaucrats and Nursing Home Social Workers**

The current study will examine nursing home social workers as street-level bureaucrats. Evans (2011) states that “social workers are classic street-level bureaucrats” (p. 368). Nursing home social workers are in the front-lines, directly with clientele. In addition, they are the policy implementers; they put the regulations and standards into action. It is important to recognize whether or not there are discrepancies between policy makers and policy implementers and who is working for the betterment of the client. Social workers use advocacy and discretion in their work with clients, but they may not be properly advised from their administration on how to deal with elderly clients who face abuse. As previously discussed, the theory of street-level bureaucracy focuses on the problematic gap that endures between stated policies and how these policies are played out on a daily basis (Evans, 2011). Are social workers trained sufficiently in the area of elder abuse to properly enact the policies? And if they are not enacting policies as they are written, who is at fault?

## **Methods**

The following section discusses the research design and sample of the study, the precautions the study took to protect human subjects, data collection procedures, data analysis techniques, and the strengths and limitations of the study.

### **Research Design**

Qualitative research using semistandardized interviews was conducted for the purposes of this study. As discussed by Berg (2009) in his text *Qualitative Research Methods for the Social Sciences*, in semistandardized interviews the wording of the questions read by the interviewer are somewhat flexible and the participant may ask clarifying questions. In addition, the interviewer can add or delete follow up questions. The semistandardized interview method was selected so that the majority of interview questions were predetermined and asked in a systematic way while at the same time allowing for probing of the participant and clarifying questions if the participant did not understand (Berg, 2009). Interviews with nursing home social workers and an aging advocate from the St. Paul area were completed using convenience and snowball sampling.

### **Sample**

Six nursing home social workers from a variety of nursing homes in the St. Paul area volunteered to participate in the study. Social workers employed at nursing homes were selected due to the fact that the researcher desired to examine social workers' perspectives on training and education on prevalence and prevention of elder abuse in the nursing home setting. An aging consultant from the St. Paul area was also added to the sample. An aging consultant was selected because the researcher desired to examine

social workers' training and education on elder abuse in the nursing home setting from a different perspective. The aging advocate was also selected to allow for a client-focused view point.

Recruitment was completed by e-mailing or phoning nursing home social workers at nursing homes in the St. Paul area asking if they would like to participate in the current study. Recruitment of the aging consultant was completed by e-mailing an aging consultant in the St. Paul area and asking if she would like to participate in the current study. This study used a convenience, snowball sample, using professional contacts as a starting point. Contacts included social workers that the researcher is acquainted with, but no reimbursement was traded between agencies.

### **Protection of Human Subjects**

To ensure confidentiality the researcher kept all participant information and data in a private, secure safe at home and it was not shared. The researcher completed the transcription; transcriptions were stored on a password protected computer in a secured location. Data will be destroyed when the study is completed in May 2012. In addition, when presenting the findings of the research data, no participant or nursing home names were used; nursing homes were renamed A, B, C, D, etc. Interview questions and a consent form were approved by the St. Thomas IRB prior to the interview. The participants signed an informed consent form prior to beginning the interview. See Appendix A for consent form.

### **Data Collection**

The data was collected through face-to-face interviews that were audio recorded. This study first used a demographic survey to gather demographic information of the

participant and nursing home. Demographic questions were typed out on a piece of paper for the participant to fill out with a pen during the interview meeting but prior to the interview questionnaire. Upon completion of the demographic survey, the interview began. The development of the interview questionnaire focused on the study's research question. There were six questions on the demographic survey and eight questions on the interview questionnaire for the nursing home social worker sample and five questions on the demographic survey and eleven questions on the interview questionnaire for the aging consultant. See Appendix B for demographic survey interview questionnaire administered to nursing home social workers.

On the demographic survey, the first question asked the participant of their gender. The second question asked what the participant's level of social work education is. The third question asked what the participant's job position is at the nursing home where he/she is employed, the fourth asked how long he/she has been employed at the nursing home, and the fifth asked whether the participant is a full-time or part-time employee. The last question asked the participant to describe the nursing home at which he/she works. This was to discover if the nursing home is rural, urban, for-profit, non-profit, large, or small.

The interview questionnaire focused on the participant's training by asking first, how much training and/or education on elder abuse the participant had in the last year and to explain the training/education and asking second, how much training or education on elder abuse the participant had in his/her social work degree program and to explain. The third question asks the participant if he/she considers the training he/she has had to be comprehensive and if not, what the participant considers to be lacking. The fourth asks

how well the participant understands the Common Entry Point (CEP), the county unity responsible for receiving oral reports of suspected maltreatment; a follow up question asks what the participant does know about the CEP. The fifth question asks the participant to speak about his/her understanding of the Federal Vulnerable Adults Act and how the participant sees it pertaining to his/her work. Question six asked about the participant's understanding of the Minnesota Department of Health and the Office of Health and Facility Complaints and how that could pertain to his/her work, and the seventh asked about the participant's understanding of the role of the state Ombudsman and how the Ombudsman pertains to the participant's work. The interview ended by asking the participant if there was anything else he/she would like to tell the researcher.

The demographic survey and interview questionnaire for the aging consultant interview are slightly different due to applicability. For this interview, questions were asked about federal and state reporting requirements, prevalence and experience with elder abuse, and experience working with nursing home social workers. See Appendix C for demographic survey and interview questionnaire administered to aging consultant.

### **Data Analysis Techniques**

The audio interviews were transcribed and put into a Word document within 72 hours after the interview. The analytic strategy that the researcher used to analyze the data was content analysis. Content analysis "is a careful, detailed, systematic examination and interpretation of a particular body of material in an effort to identify patterns, themes, biases, and meanings" (Berg & Latin, 2008; Leedy & Ormrod, 2005; Neuendorf, 2002 as cited in Berg, 2009). A grounded theory approach was used which means that the themes emerged from the data (Monette, Sullivan, & DeJong, 2011, p. 225). The researcher



carefully examined the data (the transcript) to find themes in which to code meanings in the data. The researcher hand coded the data using Microsoft Word and categorized data into major themes and subthemes. Frequency of themes and subthemes were also counted. The research Committee Chair also assisted in content analysis and coding of the data for subthemes and themes through informal consultation.

### **Strengths and Limitations**

A strength of the study is that it is qualitative and therefore “provides deeper and more insightful data” (Monette, Sullivan, & DeJong, 2011, p. 252). It allows the researcher to delve into the experiences of the participant and see the participant’s individual characteristics more in depth. Qualitative research provides insight into less researched topics such as the topic of this study. In addition, this study utilizes a Committee Chair and Committee Members which provides triangulation and oversight of the research.

A limitation of this study is that there may be researcher observer bias since the researcher is passionate about bringing nursing home elder abuse into the awareness of the general public. Another limitation when using qualitative research is that findings are not generalizable to the population, however, it does provide areas for additional research. In addition, there is a limit of sample in terms of geographical area. Due to low budget and time parameters, the geographical sample area is small.

### **Findings: Nursing Home Social Workers**

Findings from interviews with nursing home social workers suggest numerous themes throughout the data. Themes include: awareness of elder abuse, education on elder abuse (both in nursing homes and education settings) and its adequacy, knowledge and understanding of abuse reporting procedures, limited knowledge of federal laws, lack of trust in state Ombudsman, increased education for other nursing home staff, and researcher's observations of brief responses and uncomfortable body language.

For the purposes of understanding parts of the findings, *Common Entry Point (CEP)* and the *Office of Health and Facility Complaints (OHFC)* must be defined. The CEP is the county unit responsible for receiving oral reports of suspected maltreatment (*Adult protective, 2012*). OHFC falls under the Minnesota Department of Health and is:

Responsible for the receipt of all complaints and facility reported incidents; for gathering information that will assist in the appropriate review of this information; for evaluation and triage of this information and for selecting the level of investigative response. In addition, OHFC is required to notify complainants and reporters as to the outcome of the review and any subsequent investigation (*Complaint, 2005, p. 3*).

### **Demographics**

The majority of participants interviewed were educated at the bachelor's level in social work and were employed full-time at a nursing home. Half of the participants had been employed in a nursing home with employment for one year or less; the other half had been employed in a nursing home seven or more years. Of the nursing homes where the participants were employed, four were non-profit while two were for-profit and five

were large in size while one was small in size. Size of nursing home was relative to each participant's perception. The following table gives specific demographic information for each participant.

Table 1

*Demographics of Nursing Home Social Workers*

	SW 1	SW 2	SW 3	SW 4	SW 5	SW 6
Years in Facility	5 months	9 ½ years	4 months	2 months	11 ½ years	1 year
Education Level	LGSW	BSW	BSW	BSW	BSW	BSW
Gender	Female	Female	Female	Female	Female	Female
Nursing Home Type	Urban/non-profit	Urban/non-profit	Suburban/non-profit	Suburban/for-profit	Urban/non-profit	Suburban/for-profit
Nursing Home Size	150 beds	Large	Large	Large	Small	Large

*Note.* SW = Social Worker

**Awareness of Elder Abuse**

The theme of awareness of elder abuse was discovered in the data. One participant stated *on my floor, the memory care unit, there's resident to resident altercations a lot. So I see it everyday where I would have to be sending things into the cops.* Others discussed in regard to reporting elder abuse, *it's seriously an every day thing that we're going through to make sure our residents are safe and filing reports... we probably tend to over-report...the minute you don't report something, that's going to be the one they say well you should have reported.* Another responded in regard to reporting

to the Common Entry Point, *so just report report report um and between CEP and OHFC as you know, we're dual reporters so we contact them about everything.* Thus,

participants were clearly aware of elder abuse in their settings and dealt with it regularly.

### **Education on Elder Abuse, Both in Nursing Homes and Education Settings, and its Adequacy**

A major theme present throughout the data is education on elder abuse, both in nursing homes and educational settings, and its adequacy. There are three subcategories that fit within this theme. The three subcategories are: limited education on elder abuse in social work degree programs, limited education on elder abuse provided by nursing home, and comprehensive education and training

#### **Limited Education on Elder Abuse in Social Work Degree Program**

A subtheme present throughout the data is the limited or non-existence of education or training on elder abuse in the participants' social work degree programs. When asked how much education or training a participant had in the social work degree program the majority responded with little or no education on elder abuse. One participant responded with *Very little. I don't even know if we had any.* Other responses included: *It never really focused directly on elders, it was just kinda general, there was no main focus on elderly or young...I would say very minimal.* Another participants stated, *It was maybe touched on...I took a geriatrics class so that['s] where it was touched on, I don't know if we actually had a, I don't think we actually had a course specifically but we did talk about different types.*

If a participant did have education on elder abuse in the social work degree program, it was brief and touched on in a class geared toward geriatrics. As previously

stated, one participant took a course in geriatrics while another took a course that covered the topic of elderly and suicide.

### **Limited Education on Elder Abuse Provided by Nursing Home**

A second subtheme found in the data was the limited education and training on elder abuse provided by the nursing home for their social work staff. Research consistently suggests that the prevalence of elder abuse and the lack of awareness and reporting in the nursing home setting may be due to a lack of worker education and training (Payne & Fletcher, 2005; Sherr & Ellor, 2009). However, research has not shown a right amount of training that is needed for the training to be effective. When asked of the participants' amount of training in the last year it varied from a half an hour of training to 10 hours of training, however, most of the training was obtained by continuing education or outside providers. One participant discussed, *We had one day of general orientation when we first came in and they had like a little maybe half an hour segment about it.* Another stated that her three hours of education on elder abuse were completed *off-site* that she sought it out on her own. Other participants obtained elder abuse education through conferences or supervision.

### **Comprehensive Education and Training**

A third subtheme found in the data is that the majority of participants found their education and training of elder abuse to be comprehensive. When asked, "Do you consider the training you have had to be comprehensive?", participants answered with a brief *yes* or *I do* or *yeah, yeah*. And when asked, "Do you consider anything to be lacking in your training?", the majority participants answered with a brief *no*. Therefore, though participants found their training and education of elder abuse to be

comprehensive, limited education on elder abuse was provided by the nursing homes and the participants' social work degree program.

### **Knowledge and Understanding of Abuse Reporting Procedures**

The data also showed that social workers in nursing homes have knowledge and understanding of elder abuse reporting procedures. When participants were asked about their understanding and utilization of the Common Entry Point, Minnesota Department of Health, and the Office of Health and Facility Complaints, they knew who to contact about the abuse and the process that the different departments listed go through.

All participants stated they understood the previously listed resources. One participant stated, *I know it like the back of my hand...if we don't report correctly, it we don't whatever, we're up against the board. So as a social worker you absolutely have to know every single aspect. One discussed, you have to actually report it to OHFC first and then after that's completed then you have to fax it in to CEP.* Another participant discussed that the CEP:

*Gathers information on the suspected um abuse or neglect, financial exploitation, whatever you're calling in to them. They gather general information on the client/patient/resident, whomever you want to call them. Then they forward it and screen it out to see if they need to continue the process.*

The participant also discussed:

*When a CEP call is made, then the Minnesota Department of Health, online, you have to submit a like a synopsis of what happened um and then they will investigate and rule out if it needs an on site visit and if it does then the Minnesota Department of Health will come into to a nursing care slash*

*transitional care facility and um do a proper investigation to make sure all aspects of that person's care plan, that person's rights were um abided by.*

Other participants had similar responses including:

*I immediately have to notify, uh, OHFC and then I will fax report to Common Entry Point as well...then we do the investigation, we do a very brief initial investigation, very brief, and then we have five days to basically complete a more thorough investigation so then we resubmit that online as well and CEP will tell us if they want more contact or not.*

### **Limited Knowledge of Federal Laws**

It was also discovered that the social workers had limited knowledge of federal guidelines; however, the researcher was unable to get more specific due to an interview question error. The researcher asked of participants' understanding of the Federal Vulnerable Adults Act when instead the researcher should have asked what the participants' understanding is of the Elder Justice Act. When asked of federal laws participants stated, *I just follow whatever's the strictest, that's all I do, and I know basic components but I don't think I am as well educated on that aspect...we just go off our intuitions and that alone* and:

*I actually hadn't heard too much about the Elder Justice Act until today. We have to do a general orientation every year at work and I was reviewing some material on elder abuse this morning. The information that was given today was real brief, so to be honest I went online and looked it up more.*

**Lack of Trust in State Ombudsman**

Another major theme found throughout the data was lack of trust in the state Ombudsman. The data suggests that social workers in nursing homes know that the state Ombudsman acts as an advocate for the patients, however, the data suggests that social workers perceive the Ombudsman as not always being helpful for all patients or an advocate for the patient. One participant spoke of a story about a husband and wife who were roommates at a nursing home. It was known that the husband had physically abused his wife much of their lives and was continuing to abuse her in the nursing home. She discussed:

*He would barricade the doors sometimes...one time he did have a his reacher and uh someone saw him hold it over her head...there was just another incident where she was given her medications and he quickly was hitting her on the back for her to spit them out.*

She continued to tell the story that the male patient was given a 30 day notice to be discharged from the nursing home due to the inability for them to meet his needs since he was not taking medication and due to his paranoia. At that time he contacted the Ombudsman who *acting on the man's behalf is saying, ya know, the man wants to stay with his wife*. The family knew he was abusive; however *the family still wanted them to remain together even though they know that we can't stop that abusive behavior...everybody was for him and wanting them to be together*. The participant stated, *but we asked the question, should there be a second Ombudsman for her?... Because who was protecting her rights?... Shouldn't there be another Ombudsman to represent her?...It was interesting because ya know the Ombudsman is to protect the*



*resident's rights but it was a married couple but it didn't feel like both the residents' rights were being protected.*

When another participant was asked about her understanding of the role of the state Ombudsman she stated, *Mmhmm. Mmmhmmm. Ummm...I, uh, the role of the state Ombudsman is suppose to be an advocate for the patient. That's about all I have to say about that.* When asked if she wanted to elaborate she responded *No.* When asked how the state Ombudsman pertains to her work she replied, *Mmhmmm...make my life miserable.*

### **Increased Education for Other Nursing Home Staff**

Social workers in the nursing home felt that their education was sufficient, but that other nursing home staff is in need of more training; therefore the theme of the need for increased education and training on elder abuse for other nursing home staff was found. When a participant was asked about what is lacking in her elder abuse training and education she discussed:

*For me its kinda like common sense, but for other people, like the actual staff that are ya know, there, like dietary or nursing aides, who haven't had very many like trainings and school and everything. I don't think they understand it if they didn't have the background...so if they see a bruise they wouldn't be like telling us, its something we need to know.*

When another participant was asked if there was anything else she would like to say on the topic of elder abuse the participant stated:

*I believe that there should be more education on vulnerable adult with line staff or nursing staff, nursing assistants. I think sometimes it is very brushed over. Um when it comes to that topic with the aides where I think it needs to go a little more in depth.*

### **Brief Responses and Uncomfortable Body Language**

A final theme that was found throughout the data was the theme of researcher observations of brief responses and uncomfortable body language from the participants. The majority of participants gave brief *yes* or *no* answers and responses with minimal detail even when the researcher asked follow up questions. When one participant was asked of the understanding and utilization of the state Ombudsman there were many long pauses, eye widening, and deep breaths. She spoke with *mmhmms* when asked if she would like to elaborate she said *No*. In addition, participants spoke with *umms* when responding to interviewer's questions.

Participants seemed to be defensive in the fact that they reported that their education was comprehensive even if they had received limited training or education in elder abuse from their nursing home and little or no training from their social work degree program. Participants reported having half an hour to ten hours of training or education in the last year on elder abuse. Participants also seemed to talk quickly and be time crunched during the interviews. One participant had fidgety body language throughout the interview and when responding to questions she would look through the papers on her desk.

### **Findings: Aging Consultant**

An additional interview was conducted with an aging consultant in order to triangulate themes that had emerged during the interviews with the social workers. Many themes were found throughout the interview with the aging consultant. Themes include: limited education on elder abuse for nursing home social workers, limited experience of nursing home social workers, limited comfort level for nursing home social workers to discuss elder abuse, and good and bad experiences in working with the Ombudsman.

### **Demographics**

The participant who was interviewed was a female with her Master's in Social Work. She has been an Aging Consultant for ten years and has worked with the elderly population for more than 20 years. Upon getting her Bachelor's in Social Work (BSW) she worked at a nursing home social worker. Now as an Aging Consultant she also supervises BSW level graduates in which many are employed in the nursing home setting.

### **Limited Education on Elder Abuse for Nursing Home Social Workers**

A major theme that is present throughout the data is that nursing home social workers have limited education on elder abuse. When the participant was asked if she felt that social workers in nursing homes are adequately trained and educated about elder abuse she stated:

*Specific to elder abuse, um, hmm, probably not. I mean, ya know, everybody gets the training for the vulnerable adults training. Anybody that works in a nursing home gets the same training. As far as what a social worker would get beyond*

*that, well, they don't get anything beyond that...what they're not getting I think is how to recognize it.*

When asked if she sees any barriers to talking about elder abuse she discussed:

*It's more of a recognizing it and then knowing when to report it. Um 'cause I get that question a lot from my supervisees. So these are new social workers, they don't know when to report and of course I always tell them to report.*

She goes on to say:

*We don't get any kind of training or education in a BSW level. As a BSW you can go and you can work in a homeless shelter or you can go and work in a nursing home. And there are some, ya know, you don't have to learn about elder abuse necessarily if you're gonna go work at a homeless shelter or work with kids or something or go work at a community agency somewhere. So you get all of your training on the job. And like I said, if you don't have a good mentor, if you don't have somebody who is actually trained, I mean, you're thrown to the wolves as a nursing home social worker. And like I said, a lot of times there is nobody there.*

When the participant spoke of when she was a nursing home social worker she stated, *It's like the blind leading the blind.*

### **Limited Experience for Nursing Home Social Workers**

The theme of limited experience for nursing home social workers was also found in the data. When asked of her experience in working with social workers in the nursing home she responded by saying:

*It's an entry level position for social work. They typically don't have a lot of experience, although there are some that do. Um, but overall they don't have a*

*whole lot of experience. So I find that that sometimes shows as far as, in a lot of ways. I see um just lack of confidence, uhh sometimes they just don't know certain things. I usually see that they're completely overwhelmed...their not very able to stand up for themselves because of that lack of confidence. It's sometimes their first job, a lot of times it's their first job.*

She does add, *I think normally the social workers have the resident's best interest in mind...they're in the profession and in those jobs for the rights reasons for the most part.*

### **Limited Comfort Level for Nursing Home Social Workers to Discuss Elder Abuse**

Another theme discovered through the data is a limited comfort level for nursing home social workers to discuss and talk about elder abuse. The participant was asked why nursing home social workers might respond to interview questions related to elder abuse with short, brief answers with little elaboration. She responded by saying, *I think number one, they probably um aren't that comfortable talking about elder abuse. They haven't had a lot of training, it's not been a big part of...they have probably never even talked about it with anybody before.* In addition, she discussed that *this could be their first job so they don't have any experience. I mean, I think its being inexperienced and not really having a kind of comfort level surrounding elder abuse.* When asked the clarifying question by the interviewer, *they're uncomfortable because they're not experienced?* She stated, *Yeah, and the lack of training probably and lack of just education in regards to ya know you're going to be more willing to talk about something if you've been exposed to others talking about it.*

### **Good and Bad Experiences in Working with Ombudsman**

A final theme found in the data was good and bad experiences in working with the Ombudsman. When asking the participant of her experience in working with the Ombudsman she replied by saying, *I've had great experiences*. When asked if she has seen the Ombudsman used effectively or ineffectively she stated, *I've never seen them utilized inappropriately...I think they're very effective*. When speaking of giving a resident a 30 day notice to discharge from the nursing home she discusses, *those are the times I remember specifically that was successful to have them come in and they were helpful in helping resolve whatever it is*.

When the participant was asked why some nursing home social workers might not be comfortable interacting with resources such as the state Ombudsman she discussed, *Perhaps they've had a bad experience with a specific person or an adult protection worker or a ya know, somebody that maybe wasn't professional or something*.

The additional interview with the aging consultant aided in the triangulation of themes that emerged during the interviews with nursing home social workers. It allowed for a better understanding of why certain themes emerged.

## **Discussion and Implications**

This section suggests interpretations in relation to literature for why there is limited education and training in both educational and nursing home settings, discomfort in discussing elder abuse, and the lack of trust surrounding the state Ombudsman. This section also discusses the findings of the research in relation to the research question of: what perspectives do nursing home social workers hold in regard to their training and education of elder abuse on prevalence and incidence of elder abuse?

### **Interpretation and Relation to Literature**

When interpreting and relating the findings to the literature, two main areas are discussed including limited education and training in educational settings and limited education and training provided by nursing homes.

#### **Limited Education and Training in Educational Settings**

The purpose of the study was to investigate the perspectives that social workers in the nursing home setting have in regard to training and education on prevalence and prevention of elder abuse. Two main questions that the researcher wanted answered included: are nursing home social workers aware of elder abuse prevalence in nursing homes? and are nursing home social workers adequately trained and educated on elder abuse? Findings suggest that nursing home social workers are aware of elder abuse. However, nursing home social workers reported having limited training and education on elder abuse in nursing homes and educational settings.

In regard to awareness, many participants discussed that they report elder abuse to CEP and OHFC daily or weekly. Participants discussed that they tend to over-report to protect themselves and their clients. These findings contradict what is found in the

literature. Jorgest, Daly, and Hartz (2005) suggest in Pennsylvania, half of all nursing home administrators and Ombudsman believe that 60% of institutional cases of elder abuse go unreported. In addition, *Minnesota is one of just three states that failed to properly review and investigate nursing home complaints in at least four of the past five years* (Schrade & Howatt, 2011, p. 1-3). Through the literature and the findings of this study it may be suggested that nursing home social workers do report abuse and that it is at the state level where discrepancies exist. Alternately, it may be that there are different perceptions of what is or what is not reportable. It could be that social workers feel as if they report a lot, but that they do not report every case due to their limited knowledge and training.

As discussed in the findings, education specifically about elder abuse in participants' social work degree program was limited or non-existent. An implication for this lack of training and education may be the lack of general public awareness of elder abuse. Nerenberg (2008) discusses that elder abuse is an idea that is poorly understood by the public and according to Reingold (2006); there is limited awareness of elder abuse. In addition, Sherr and Ellor (2009) discuss that issues of elder abuse often fall between the cracks of informal and formal systems. This lack of understanding and awareness of elder abuse may contribute to the lack of training and education in schools of social work. If the schools of social work are unaware of elder abuse, perhaps they do not offer courses that focus on the aging population. Perhaps it is an area that professors are not well versed in and therefore they do not offer courses. In addition, this lack of awareness could explain why students may not take courses that focus on the elder population.



A final implication for the lack of training in elder abuse in social work programs may be that not all students will need this knowledge in their place of employment. As discussed in the findings, the aging consultant explained that as a BSW graduate, one may work with children, work in a homeless shelter, or work in a nursing home. Students planning to work with children or a homeless shelter do not necessarily need to be proficiently trained in elder abuse due to the fact that they may not be working with or come into contact with the elder population. Being well versed in elder abuse laws would not be pertinent for a BSW who is not working with elders. Overall, there is a lack of awareness and understanding of elder abuse which may contribute to the lack of education provided by social work programs.

#### **Limited Education and Training Provided by Nursing Homes**

The findings also indicate that participants received anywhere between a half an hour and ten hours of training in elder abuse in the past year; however, most of the training was obtained through continuing education or outside providers not offered at their place of employment. An implication for this lack of training and education may be, as discussed by the aging consultant, that nursing homes already have numerous regulations in place so it may be difficult to make more rules and regulations that employees must follow. She also discussed that it would be difficult to provide training and education in a nursing home as a requirement since nursing home employees spend all of their time just trying to meet the requirements and regulations that are already in place. Nursing home employees do not have time for additional requirements.

Another implication may be that nursing homes see elder abuse training and education as the employee's responsibility to identify and pursue their own training

needs. As discussed, most of the participants' training in the last year did come from continuing education or outside providers. Payne and colleagues (2005) suggest that nursing homes should have educational in-services and trainings on the prevention of elder abuse and education for residents. Minnesota Rule 4658.0100 (2007) states that:

A nursing home must provide in-service education. The in-service education must be sufficient to ensure the continuing competence of employees, must address areas identified by the quality assessment and assurance committee, and must address the special needs of residents as determined by the nursing home staff. A nursing home must provide an in-service training program in rehabilitation for all nursing personnel to promote ambulation; aid in activities of daily living; assist in activities, self-help, maintenance of range of motion, and proper chair and bed positioning; and in the prevention or reduction of incontinence.

This statute is general in that it does not require nursing homes to provide educational in-services on elder abuse.

Though nursing homes do provide a brief orientation on the Vulnerable Adults Act, as discussed in the findings, nursing homes should offer additional in-services provided at the nursing home. Bergeron (2006) discusses that it is a shared professional responsibility to create interventions and develop services to assist in protecting vulnerable adults. In addition, Baker (2007) suggests that to prevent elder maltreatment it is first important to make employees aware of the prevalence and incidence of elder maltreatment. Though nursing home social workers perceive that they are aware of elder abuse, it is still a shared responsibility of the nursing home administration and staff to ensure that staff is properly trained.

Despite the fact that participants had limited training and see frequent indicators of elder abuse, the majority of participants did not think they needed additional training. They saw their training as comprehensive. However, more training is needed. The aging consultant participant discussed that nursing home social workers receive the same training that other nursing home staff receive during their orientation, but nothing beyond that. Nursing home social workers are not trained on how to recognize abuse. Joubert and Posenelli (2009) suggest that education for medical professionals is the most effective way of improving recognition of elder abuse. Since education is effective for improving recognition of elder abuse, nursing home social workers need increased education.

It is to be noted, however, that though nursing home social workers received minimal training, participants appear to be competent in Minnesota elder abuse reporting procedures. This may imply that nursing homes do train their social workers on reporting procedures but not on forms of recognition.

### **Discomfort Discussing Elder Abuse**

Interviews with the nursing home social workers were very brief and many participants showed uncomfortable body language. Social workers offered little elaboration even when prompted. An implication for this unwillingness to talk about elder abuse may be that the participants were uncomfortable discussing elder abuse due to lack of knowledge or experience around it. Another concern may be the participants' fear of reprisal if they were to share too much information about their place of employment.

No literature was found to discuss why professionals might be uncomfortable discussing elder abuse, however, in the interview with the aging consultant it was

discussed that working in a nursing home is an entry level job for social work. She discussed that these social workers do not have a lot of experience or confidence around elder abuse since they have only minimally talked of it. As previously discussed, research also discusses a lack of training in elder abuse (Payne & Flectch, 2005; Sherr & Ellor, 2009). This lack of training may contribute to the lack of comfort in elaborating on elder abuse issues in the research interviews.

Another implication of brief interviews may be that the interview questions were worded in a way that was difficult for the participants to understand. Perhaps the interview questions were unclear and therefore social workers did not know how to answer; however participants did not appear to know enough, or have enough confidence in their own knowledge, to tell the interviewer that he/she did not understand the question.

### **Lack of Trust in State Ombudsman**

Participants showed uncertainty surrounding the helpfulness of the state Ombudsman. This may imply that social workers may have a lack of trust in the role of government oversight of their work. Participants were able to discuss that the purpose of an Ombudsman is to advocate for their clients, however, one participant spoke of the unfairness for one nursing home resident to be able to utilize an Ombudsman while his spouse, who was in danger, was not allotted an Ombudsman. Another participant refused to discuss the Ombudsman with the researcher when asked to. This lack of trust of state officials may be linked to the fact that Minnesota lacks sufficient policies and regulations (Shrade & Howatt, 2011). According to Schrade & Howatt (2011), “Federal officials have repeatedly faulted Minnesota for how it reviews complaints of abuse and neglect”

(p. 1). Since the Ombudsman is part of the state, perhaps the unpredictability for the way the state reviews complaints expounds to the usefulness and predictability of the state Ombudsman. Again, an additional concern for nursing home social workers may be a fear of reprisal from a state Ombudsman.

This lack of trust could also be explained by the theory of street-level bureaucracy. As Evans (2011) states, the main problem of the framework of street-level bureaucracy is the “gap between what policy says and how policy is enacted in the day-to-day delivery of service” (p. 371). This theory is a top-down perspective meaning that their work is driven by policy makers. Perhaps the policies that are in place are not clear or adequate and therefore difficult for social workers (street-level bureaucrats) to enact. Bergeron (2006) discusses the discrepancies and variances in Adult Protection Services. These discrepancies at the state or federal level could in turn create a lack of trust from the street-level bureaucrat.

Another implication of the lack of trust as discussed by the aging consultant may be that the participants have had a bad experience in working with the state Ombudsman. As observed by the researcher, people tend to remember the negative aspects of situations over the positive. Perhaps the participants had one bad experience that tainted their view.

The lack of trust in the state Ombudsman may lead to the outcome of social workers not contacting the Ombudsman when he or she should be contacted. In turn, this leads to nursing home residents not getting the best care that they should be getting. This issue could be addressed by the Ombudsman and social workers having more contact with one another. As previously discussed, as Payne and Fletcher (2005) suggest, nursing homes should have educational in-services and trainings on the prevention of elder abuse

and education for residents. Perhaps the education in-services and trainings could be conducted by staff from the state Ombudsman's office. Jorgest, Daly, and Hartz (2005) state that community education sessions at the state level were significantly associated with higher abuse rates reported, indicating that if community education sessions were conducted, people were more likely to report abuse cases. The Ombudsman could be this person at the state level to offer these educational sessions.

The research study found a lack of training and education in elder abuse for nursing home social workers; however, nursing home social workers felt their training was comprehensive. In addition, it was found that there is discomfort for nursing home social workers to discuss elder abuse and that there may be a lack of trust in state officials.

### **Implications for Social Work Practice and Policy**

As previously stated, the United States has had a large demographic shift in the area of life expectancy and the aging population (Kerschner & Pegues, 1998). Because of this growing population, research suggests that there will also be a growing incidence of elder abuse (Baker, 2007). In addition, due to the growing population, social workers will more frequently be faced with working with this clientele.

The current research provides many implications for social work practice and policy. First and foremost, as street-level bureaucrats, social workers are to enact, initiate, and implement policy. Social workers should become more familiar with the policies so that they can be enacted. If policies are unclear, perhaps the social work profession needs to speak with policy-makers so that law and regulations can be better understood. By

ensuring that policies and procedures are clear, street-level bureaucrats can better implement the policies which in turn will provide better care for the aging clientele.

In addition, social workers must become aware of the social injustice of elder abuse. As street-level bureaucrats, social workers must be advocates for their clients. As stated in the *Code of Ethics of the National Association of Social Workers* (2008), “social workers’ primary responsibility is to promote the well-being of clients” (p. 7). Without first being aware of elder abuse, one cannot fully advocate and promote the well-being of the client. Social workers, therefore, are ethically required to educate themselves if education on elder abuse is not provided or required.

Schools of social work should also be responsible to educate students on elder abuse. Education should begin at the BSW level since it is BSW level professionals that primarily practice in the nursing home setting.

In addition, social workers can assist in raising awareness for the general population. This can be done by talking about elder abuse and experiences with elder abuse with friends, co-workers, or classmates instead of avoiding the topic. If education about elder abuse cannot be sought out by the general population, social workers must provide it or advocate for others to provide it. As Reingold (2006) states, “Elder abuse is, today, where child and domestic violence was 25 years ago” (p. 124). This is a problem. Overall, conversations about elder abuse need to begin. If the conversation can get going, awareness will grow.

### **Implications for Future Social Work Research**

As previously discussed, most of the research that has been conducted on elder abuse has been community and family based and there is lack of research examining

elder abuse in the nursing home setting (Payne & Fletcher, 2005). Though the current study focuses on the nursing home setting, more research is needed.

Throughout the findings it was discovered that social workers felt that other nursing home staff, such as dietary and nursing aides, is in need of more training on elder abuse. Research should be done to determine whether all nursing home staff are adequately trained and educated on elder abuse. In addition, little is known about prevalence and incidence rates of elder abuse in the nursing home setting (Baker, 2007). More research is needed in this area so that it can be measured whether or not prevalence is rising or declining.

In addition, throughout the findings it was discovered that social workers had discomfort when speaking about elder abuse and had a lack of trust in the state Ombudsman. Research to investigate discomfort in discussing elder abuse and research to investigate interactions with Ombudsman should be done. This could be addressed by conducting further qualitative interviews with social workers.

There could also be further research as to why social work schools do not provide more education and training on elder abuse. What is actually behind the lack of education? BSW programs should provide students with opportunities to become aware of elder injustices and to be educated on elder abuse. Research should be done to investigate social work curriculum and practice education. To investigate curriculum and practice education one could directly look at syllabi and interview professors on their teaching topics.



**Strengths and Limitations of Study**

There are many strengths and limitations of the current study. A strength of the study is that it utilized qualitative interviewing which allows for “deeper and more insightful data” (Monette, Sullivan, & DeJong, 2011, p. 252). Qualitative research provides insight into less researched topics such as the topic of this study. Through the interviews, the participants were able to tell stories that could not have been told within a quantitative study.

Another strength is that this study looked at a relatively under-researched topic. As previously discussed, most of the research that has been conducted on elder abuse has been community and family based and there is a lack of research examining elder abuse in the nursing home setting (Payne & Fletcher, 2005). The current study begins to examine perspectives of elder abuse in the nursing home setting.

A final strength of the study is that participants ranged in age and years of experience in working in the nursing home setting. This allows for a broader perspective of the interview questions.

There are also limitations to the study. The participants responded to the interview with brief answers and little elaboration. This may have been due to the fact that interview questions could have been worded in a way that was difficult for the participants to understand. Perhaps the interview questions were unclear and therefore social workers did not know to answer; however, participants did not appear to know enough to tell the interviewer that he/she did not understand the question. In addition, more prompts may have been beneficial in the interview questionnaire. Another implication may be that the participants were limited in their discussion of elder abuse

due to protection of the agency. Perhaps participants thought that if they said something wrong the agency may get into trouble.

Another limitation of the study was the small sample size in terms of number of participants and geographical area. Due to low budget and time parameters, more interviews and a larger geographical area could not be included. In addition, all of the participants were female. If this study were to be replicated it could be beneficial to have more male participants so that it is more generalizable to the population.

### **Conclusion**

As the aging population grows it is expected that there will also be a growing prevalence of elder abuse (Baker, 2007). However, the issue of elder abuse in the nursing home setting has been minimally researched. The current study researched the perspectives of social workers in the nursing home setting in regard to training and education on prevalence and prevention of elder abuse. Through interviewing nursing home social workers and an aging advocate it was discovered that limited training and education is provided on elder abuse in both nursing home and educational settings for social workers. In addition, there appears to be discomfort in discussing elder abuse and a lack of trust in state officials from the standpoint of the nursing home social worker.

Social workers should become more familiar with elder abuse policies so that policies can be better enacted and understood. In addition, social workers need to become aware of the injustices of elder abuse and assist in raising awareness of elder abuse to the general population. Finally, social workers should educate themselves about elder abuse if education is not required.

In addition, nursing homes need to offer more training for non-social work staff on the recognition of elder abuse. As found in the literature, education among staff in the nursing home is essential to the diminishment of elder abuse (Jogerst, Daly, & Hartz, 2005; Payne & Fletcher, 2005).

The field of social work, in general, needs to become more aware of elder abuse. The aging population is on the rise (Kerschner & Pegues, 1998) meaning more and more social workers will come into contact with issues of elder abuse. Education and

awareness is essential so that client needs are being met to the best of the social worker's abilities.

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*Appendix A***CONSENT FORM**

Please read this form and ask any questions you may have before agreeing to participate in the study.

Please keep a copy of this form for your records.

**Project Name:**

Elder Abuse in the Nursing Home Setting: Social Workers' Perspectives of Training and Education

**General Information Statement about the Study:**

This study examines the perspectives that social workers in the nursing home setting have in regard to training and education of elder abuse.

**You are invited to participate in this research. You were selected as a possible participant for this study because:**

You are a social worker employed at a nursing home; the researcher desires to examine social workers' perspectives on training and education on the prevalence and prevention of elder abuse in the nursing home setting.

**Study is being conducted by:** Kelli Kinney, MSW Student

**Research Advisor:** Katharine Hill, PhD, MSW, MPP, LISW

**Department Affiliation:** Social Work

**Background Information**

In the United States there are an estimated 1.6 million people in nursing homes and an additional one million in residential care facilities (Baker, 2007). Jorgest, Daly, and Hartz (2005), suggest that in Pennsylvania, half of all nursing home administrators and Ombudsman believe that 60% of institutional cases of elder abuse go unreported; there is a major deficit in the detection of elder abuse due to lack of staff knowledge and skills (Joubert and Posenelli, 2009). The purpose of the current study is to investigate the perspectives that social workers in the nursing home setting have in regard to training and education on the prevalence and prevention of elder abuse.

**Procedures**

If you agree to be in the study, you will be asked to do the following:

Data will be collected through one face-to-face interview that will be audio recorded. A short pen-and-paper demographic survey will be completed at the interview meeting but prior to the interview. Interviews will take approximately 45 minutes.

**Risks and Benefits of being in the study**

The risks involved for participating in the study are: No risks.

The direct benefits you will receive from participating in the study are: No direct benefits.

**Compensation**

N/A

*Note:* In the event that this research activity results in an injury, treatment will be available, including first aid, emergency treatment and follow-up care as needed. Payment for any such treatment must be provided by you or your third party payer if any (such as health insurance, Medicare, etc.).

### **Confidentiality**

The records of this study will be kept confidential. In any sort of report published, information will not be provided that will make it possible to identify you in any way. The types of records, who will have access to records and when they will be destroyed as a result of this study include:

To ensure confidentiality the researcher will keep all participant information and data including audio recordings, consent forms, and written notes in a private, locked safe at the researcher's home. The audio interviews will be transcribed and put into a Word document within 72 hours after the interview. Audio data will be erased at that point. Transcriptions will be stored on a password protected computer in a secured location at the researcher's home. The principle investigator and a research Committee Chair will have access to the transcripts. The principle investigator is the only person who will have access to data identifying the subjects.

### **Voluntary Nature of the Study**

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with any cooperating agencies or institutions or the University of St. Thomas. If you decide to participate, you are free to withdraw at any time up to and until the date\time specified in the study. You are also free to skip any questions that may be asked unless there is an exception(s) to this rule listed below with its rationale for the exception(s).

Should you decide to withdraw, data collected about you will NOT be used in this study.

### **Contacts and Questions**

You may contact any of the resources listed below with questions or concerns about the study.

**Researcher name:** Kelli Kinney **Researcher email:** ande9079@stthomas.edu **Research Advisor name:** Katharine Hill **Research Advisor email:** kmhill1@stthomas.edu **Research Advisor phone:** 651-962-5809 **UST IRB Office:** 651.962.5341

### **Statement of Consent**

I have read the above information. My questions have been answered to my satisfaction and I am at least 18 years old. I consent to participate in the study.

\_\_\_\_\_  
**Signature of Study Participant**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name of Study Participant**

\_\_\_\_\_  
**Signature of Researcher**

\_\_\_\_\_  
**Date**

- The information provided in this form is true and accurate.
- The principal investigator will seek and obtain prior approval from the UST IRB office for any substantive modification in the proposal, including but not limited to changes in cooperating investigators/agencies as well as changes in procedures.
- Unexpected or otherwise significant adverse events in the course of this study which may affect the risks and benefits to participation will be reported in writing to the UST IRB office and to the subjects.
- The research will not be initiated and subjects cannot be recruited until final approval is granted.

*Appendix B*

## Demographic Survey for Nursing Home Social Workers

1. What is your gender?
2. What is your level of social work education?
3. What is your job position at nursing home which you are employed at?
4. How long have you been employed at the nursing home?
5. Are you a full-time or part-time employee?
6. How would you describe the nursing home at which you work?

Is it rural/urban/suburban? For-profit/non-profit? Large/small?

## Qualitative Interview Questions for Nursing Home Social Workers

1. How much training and/or education on elder abuse have you had in the last year?

Explain.

2. How much training and/or education on elder abuse have you had in your social work degree program?

Explain.

3. Do you consider the training that you have had to be comprehensive?

If not, what do you consider to be lacking?

4. How well do you understand the Common Entry Point (CEP), the county unit responsible for receiving oral reports of suspected maltreatment?

What do you know about the CEP?

5. Can you tell me about your understanding of the Federal Vulnerable Adults Act?

How do you see it pertaining to your work?

6. Can you tell me about your understanding of the role of the Minnesota Department of Health and the Office of Health and Facility Complaints?

How do you see this pertaining to your work?

7. Can you tell me about your understanding of the role of the state Ombudsman?

How do you see the state Ombudsman as pertaining to your work?

8. Is there anything else you would like to tell me?

*Appendix C*

## Demographic Survey for Aging Consultant

1. What is your gender?
2. What is your level and field of education?
3. What is your profession/job title?
4. How long have you been employed at your place of work?
5. How long have you worked with the elder population?

## Qualitative Interview Questions for Aging Consultant

1. Are you aware of the issue of elder abuse in the nursing home setting?

Explain.

2. Do you know of the Common Entry Point (CEP), the county unit responsible for receiving oral reports of suspected maltreatment?

What do you know of the CEP?

Do you utilize the CEP?

Have you seen it utilized effectively in your work with nursing homes?

Have you seen it not used or used inappropriately?

3. Do you know of the Federal laws regarding elder abuse??

How do federal laws pertain to your work?

4. Do you know of the Minnesota Department of Health and the Office of Health and

Facility Complaints?

What do you know of it?

Do you utilize it?

5. What is your understanding of the role of the State Ombudsman?

What is your experience in working with the State Ombudsman?

Have you seen the Ombudsman to be utilized effectively in your work with nursing homes?

Have you seen the Ombudsman not utilized how it should be or utilized inappropriately?

6. Are you comfortable interacting with the previously discussed resources?

Why might some social workers not be comfortable interacting with them?

7. What has been your experience when working with the previously discussed resources?

8. What is your experience in working with social workers in nursing homes?

How are social workers particularly helpful and/or particularly not?

Do you feel that social workers are adequately trained and educated about elder abuse?

9. In my interviews with nursing home social workers, I received many brief answers with little elaboration. Why do you think this is?

10. What barriers are there to talking about elder abuse and the reporting of elder abuse?

11. Is there anything else you would like to tell me?