A nurse developed toolkit for long-term care ombudsmen

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ARTICLE INFO

Article history:
Received 21 January 2011
Received in revised form 14 October 2013
Accepted 21 October 2013
Available online 15 November 2013

ABSTRACT

Federal regulations provide all nursing home resident access to third party advocates, known as ombudsmen. The ombudsmen are provided unrestricted access to this vulnerable population for complaint investigation and protection of their federally mandated resident’s rights. States autonomously administer their ombudsman programs, allowing latitude in hiring and training practices. The majority of state programs rely on a combination of paid and volunteer staff, with most staff lacking formal healthcare training. In an attempt to educate long-term care ombudsmen on common geriatric clinical diagnoses, a clinical toolkit was developed and ombudsmen employed by Alabama Department of Senior Services agreed to pilot test the toolkit. Results of the pilot test did not show ombudsmen with less experience would find the toolkit more useful. Results revealed that all ombudsmen regardless of length of tenure found the toolkit useful.

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The current population of older adults in long-term care (LTC) is frail and functionally dependent. The majority of the residents require assistance with 5 activities of total living; the two most common illnesses are cardiovascular disease (#1) and mental disorders (#2). Thus, LTC facilities are challenged to provide complex physical care while at the same time, addressing the psychological needs of their residents and families. LTC residents are considered a vulnerable population and have been afforded federally mandated rights, including access to third-party advocates (known as ombudsmen) in the event that resident care issues arise. Alabama Department of Senior Services (ADSS) identified the need for additional ombudsman training in clinical diagnoses encountered in this patient population. In response to this need, a clinical toolkit was developed and pilot tested. This paper will report on the development, implementation, and evaluation of the toolkit with a group of LTC ombudsmen who had no formal healthcare training.

History of the ombudsmen program

The LTC environment in the mid-20th century was problematic. Physical restraints were considered normative.3-4 Needs of older adults, especially those with dementia, were not well understood. The families of LTC residents voiced concerns about physical and mental abuse, inadequate treatment, and loss of personal or property rights in LTC.5 These problems caught the attention of President Nixon, who, in 1971 gave an address on Nursing Home Initiatives that sparked the idea of LTC ombudsmen.5 In response to President Nixon’s remarks, the U.S. Department of Health, Education, and Welfare orchestrated LTC ombudsman demonstration projects.6 The ombudsman was envisioned as being capable of establishing a program for the collection and resolution of complaints, as well as documenting any significant problems observed within the LTC industry.7 The LTC ombudsman demonstration projects served as the foundation for the Long-Term Care Ombudsman Program, which was established through the Older Americans Act 1978 Amendment.8 This statute granted the Long-Term Care Ombudsman Program the authority to respond to the needs of all residents residing in NHs, assisted living facilities, or other similar adult residential centers.9 Hence ombudsmen were given statutory authority to investigate and resolve complaints that adversely affected the health, safety and welfare of LTC residents.8 The Older Americans Act has continued to be amended in an effort to further protect the rights of LTC residents. In 1992 the Long-Term Care Ombudsman Program was incorporated into Title VII of the Older Americans Act in an effort to authorize vulnerable elder rights protection.7 The amended Act of 1992 also required the Administration of Aging to establish a permanent National Ombudsman Resource Center.7

Despite the formation of mandatory ombudsmen programs by 1978, concerns about quality of care issues in LTC facilities continued to remain high.9-10 The National Citizens’ Coalition for Nursing Home Reform was founded in 1975 by Elma L. Holder for the purpose of protecting America’s LTC residents; the coalition was
renamed The National Consumer Voice for Quality Long-Term Care in 2010. This national grassroots organization was instrumental in the passage of the Omnibus Budget Reconciliation Act (OBRA) of 1987. OBRA 1987 was the first comprehensive set of federal standards developed for the purpose of improving the lives of all LTC residents. OBRA 1987 expanded the power of ombudsmen by removing limitations on their visits and providing them access to residents’ medical records.

Currently, there are 53 state ombudsmen programs: 50 state programs plus programs in the District of Columbia, Guam and Puerto Rico. The programs are funded through the Older Americans Act, other federal sources, state funds, and nonfederal entities. Implementation of programs is determined at the state level but programs must be staffed with ombudsmen trained to protect the health, safety, and welfare of all LTC residents. Ombudsmen primarily mediate resident care issues but are also involved in education and policy issues (See Table 1).

Need for ombudsman clinical toolkit

As noted earlier, individual states are responsible for developing and implementing their training programs, with some material mandated in the Older Americans Act. Mandated material includes federal, state and local laws; regulations and policies related to LTC facilities; and investigative techniques. The length of the training programs varies by state and range from 2 days to 10 weeks. The Centers for Medicare & Medicaid Services offer no requirements for ombudsman training. William Benson, a former ombudsman, acknowledged the importance of ombudsman training and education. The type of training provided by the individual state has a direct impact on ombudsmen performance. For example, a study conducted using a randomized sample of Missouri NHs suggested that ombudsmen were more effective in the technical areas in which they had acquired specialized training i.e. resident rights and statutory regulations. The National Long-Term Care Ombudsman Resource Center, which serves as an educational resource, contains information about safety and dignity issues but does not include clinical topics, such as dehydration. In fact, basic information about medical terminology is absent. There is a need for clinicians who provide care to older adults to educate ombudsmen on LTC quality of care issues due to their shared goals of resolving resident conflicts and advancing quality care.

Alabama has a robust statewide aging department and employed 22 full-time and 4 part-time NH ombudsmen when the toolkit was tested. Typical of most state programs, the ADSS did not require their ombudsmen to possess past healthcare experience and the curriculum of the existing training program only contained regulatory (i.e. residents’ rights) and procedural (i.e. what forms to use for a complaint) content. No clinical content was evident. The primary author approached ADSS and proposed the development of a clinical toolkit. The offer was enthusiastically accepted. The hypothesis for this project was that ombudsmen with less experience would find the toolkit more useful. This study received expedited approval by the University of Alabama at Birmingham Institutional Review Board (UAB IRB).

Clinical toolkit development

The first step was an assessment of common clinical issues encountered by Alabama ombudsmen. The primary author met with the state ombudsman and selected seasoned ombudsmen to determine clinical topics that were frequently encountered. During each subsequent meeting with the ombudsmen, the list of potential topics was reviewed and new ones added. The ombudsmen identified pain management, pressure ulcers, dehydration, and urinary incontinence as the most frequent issues they encountered. The ombudsmen also struggled with medical terminology and medications.

Based on the feedback from the committee, the final 23 page toolkit contained six sections: medical abbreviations/terminology, pharmacology, pain management, dehydration, pressure ulcers, and urinary incontinence. The toolkit also contained a reference list of additional resources. The clinical sections contained content developed in accordance with evidence-based practice. The medical terminology section contained six pages of abbreviations and terms with corresponding abbreviations. The pharmacology section provided a general description of 11 drug classifications frequently prescribed to chronically ill older patients and included a list of drugs that commonly cause delirium when used in the older adult population. The section also discussed the need to always start with the lowest possible dose, the dangers of polypharmacy, and the need for systematic attempts at tapering antipsychotic medications per federal regulations governing LTC facilities. Non-pharmacological modalities, nonverbal signs of pain and copy of the Wong-Baker FACES Pain Rating Scale and Visual Analog Scale were included under pain management. Etiologies, common signs and clinical implications of dehydration were discussed in the dehydration section. The pressure ulcer section provided staging criteria according to the National Pressure Ulcer Advisory Panel. The toolkit contained photographs of each stage, basic preventive nursing care such as turning every 2 hours, and types of wound care dressings. Different types of urinary incontinence, implications and basic nursing care such as providing continent care every 2 hours as needed was provided in the urinary incontinence section.

Clinical toolkit training and implementation

The toolkit was introduced to the 26 ombudsmen employed with ADSS during an interactive 1 hour presentation. Twenty two ombudsmen participated in the project: 2 Caucasian males, 11 Caucasian females, 8 African American females, and 1 Asian female. Years of ombudsmen experience of participants who completed the post one month evaluation were: 60% 5 or more years; 6% 3–5 years; 17% 1–3 years; and 17% <1 year. Each section was explained in-depth and participants were given an opportunity to ask questions. For example, the ombudsmen were informed that the medical abbreviations section included recognized and non-recognized abbreviations commonly seen in LTC facilities.

Data collection

After the training, all participants were given a copy of the toolkit and asked to complete a short evaluation after using the toolkit for one month. The evaluation form contained a 5 point Likert-type scale to measure the usefulness of each section of the toolkit. A comment section was also included and the
participants were asked to select the number of years employed as an ombudsman. All participants were given a written copy of the evaluation and self-addressed, stamped envelope. The participants were also given the option of completing an online evaluation through Survey Monkey.

**Toolkit evaluation results**

Seventeen participants (78% response rate) returned the evaluation one month after using the toolkit. The hypothesis for this project was that ombudsmen with less experience would judge the toolkit more useful. The results revealed no difference between groups according to experience. The comments offered by the ombudsmen were congruent with these findings. One participant observed that the toolkit was “extremely useful tool for new ombudsmen as well as ‘old timers’.” Another noted, “I also believe the toolkit provides a great source of information on issues that ombudsmen are likely to come across in an average year. This would be particularly helpful for new ombudsmen as they are trying to acquaint themselves with the “big” issues that LTC residents face.” Among the participating cohort, 70% indicated all sections of the toolkit were extremely useful. Table 2 contains analysis of all toolkit topics.

The comments section was very informative. Ten ombudsmen provided comments, which were all positive: “this is the best set of materials provided in my tenure as ombudsman”, “it was really good…very helpful information, very user friendly,” and “I think this is an excellent tool for the ombudsmen to use.” One ombudsman commented that the pressure ulcer information from the toolkit was shared with a resident’s family member so that the family member would know how a pressure ulcer looked.

**Discussion**

The ombudsmen found this clinical toolkit to be informative and helpful. As noted above, the more experienced the ombudsman, the more helpful the toolkit was rated. We were surprised by this result. We surmised that seasoned ombudsmen would have acquired some of the clinical knowledge through “on-the-job” training and would provide lower ratings. One possibility for this finding is that less experienced ombudsmen focus more on procedural or dignity issues because they stay within the comfort zone of their training. More experienced ombudsmen, however, may be ready to tackle complaints and problems with clinical etiologies. These findings reinforce the need for ongoing education of all ombudsmen.

Limitations of this pilot project include small sample size, limited ombudsman demographic information, and a short evaluation phase. Larger studies are warranted before generalization to all LTC ombudsmen programs can be made. While none of the participants suggested any additional topics, consideration should be given to other commonly encountered clinical issues within the LTC population. Future studies should include volunteer ombudsmen, many of whom routinely encounter the same clinical issues as paid ombudsmen.

**Implications for geriatric practice**

Clinical practice is not solely direct care. Nurses working with older adults, especially with those in LTC, have an extensive knowledge base that can be used to benefit older adults when shared with other professionals. While the role of the LTC ombudsman is to advocate for the rights of the LTC resident, the ombudsman should be identified as part of a team of individuals responsible for advancing the care and treatment of older adults. By recognizing clinical knowledge deficits of ombudsmen, nurses can, and should, assume a leadership role in providing needed education.

**References**