

**Long Term Care Ombudsman Volunteers:  
Making a Measurable Difference for Nursing Home Residents**

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**Abstract**

*This study investigates the roles and participation of volunteers in a Long Term Care Ombudsman Program (LTCOP) and assesses if differences exist between nursing homes with and without volunteer ombudsmen. Volunteers are found to favorably influence the environment in nursing homes by encouraging a supportive climate in which residents and their representatives can voice complaints. Furthermore, the working relationships between unpaid advocates and regulators are viewed as beneficial in illuminating and addressing problems. The study evaluates Connecticut's operating facilities (N=261) with 180 volunteers, and finds those with increased volunteer presence also have significant higher sanctioning activity. The study promotes volunteer advocacy and serves as a step toward improving the status of nursing home care through volunteer presence. The power of the volunteer in the LTCOP in enhancing both the program and mission may provide insight to other volunteer organizations, particularly those serving members of our aging society.*

**Key Words:**

volunteer ombudsmen, nursing homes, advocacy, long-term care

**Introduction**

Volunteerism is a critical ingredient in the effectiveness of the Long Term Care Ombudsman Program (LTCOP), a nursing home advocacy/watchdog agency that has been widely credited as advancing pro-resident efforts in nursing homes and other long-stay settings since the late 1970s (Estes, Zulman, Goldberg, & Ogawa, 2004). Unpaid workers provide the great majority of ombudsman advocacy nationwide. In 2000, there were more than 12,000 volunteers in contrast to the 1,000 paid staff. Paid and unpaid workers combined handled 231,889 concerns by 137,165 individual complainants of ombudsman personnel

nationwide (NORS, 2006). This study views one state's operating nursing facilities, comparing those with and without volunteer presence to deficiencies issued by the Department of Public Health. It also looks into the role and relationship between volunteer and surveyor in terms of strengthening the efficacy of the program in identifying real problems, and remedying poor care and deficient quality in the nursing home setting. Implications to utilize effective volunteers in other venues are explored.

**Do Volunteers Increase or Decrease Complaints?**

Discussion as to whether ombudsman program volunteers raise complaints or ward off problems has been debated from the program's beginning. There are at least two schools of thought as to whether volunteers increase or decrease complaints and deficiencies. Earlier research indicated that grass roots ombudsmen provided a "sentinel effect" (Litwin & Monk, 1987, p. 102) warding off problems by their regular advocacy presence (Arcus, 1993; Cherry, 1991). But the power of the role exceeds mere presence, and realities such as volunteers conferring with regulators ahead of the survey add teeth to the volunteer's role. Recent literature speaks to volunteers increasing deficiencies, through education, empowerment, and whistle-blowing, given that they tip off the surveyors prior to inspections (Nelson, Huber & Walter, 1995). Those facilities with volunteer presence raise official investigation of concerns, which may allow facilities to be more accountable to citing deficiencies. Therefore, the roles may be synergistic. Others have attributed the presence of ombudsmen to higher complaint reporting in general, and to more vigorous regulatory activity in particular (Nelson, Huber et al., 1995) both believed to provide short and long-term benefits to nursing home care (Cherry, 1991).

Nelson, Huber and Walter (1995) found that nursing homes with assigned volunteers had more substantiated abuse complaints; a finding also confirmed by Allen, Gruman and Kellet (2003). Allen, Klein and Gruman measured volunteer presence against complaint types and found the longer an ombudsman volunteer was in a facility, the more likely care and resident rights complaints surfaced, while administration and quality of life complaints diminished.

Nelson, Huber and Walter (1995) expanded on Litwin and Monk's original question posed in 1987: Do ombudsmen

make a difference? Overall, volunteer ombudsmen felt they were making a difference in the lives of their residents, but often voiced ambivalence about the extent of their contribution. Consistent with this study, Nelson, Huber and Walter found that volunteers' presence increased overall complaints and deficiencies. This paper suggests that the presence is not necessarily an "either or" situation, but rather both. Volunteers ward off problems through their presence with heightened accountability of workers, and illuminate problems needing sanctioning activity for those issues that require a higher level of intervention, each favorable to the health of the residents occupying nursing facilities.

### **Managing Volunteers**

The volunteer's working relationship with the paid ombudsman manager is essential in promoting change in nursing facilities. Overall, ombudsman managers see the volunteer role aiding their efficiency. There is no question that an investment of a manager's time and energy pays off with a skillful volunteer advocate. Given the huge numbers of nursing home residents paid ombudsmen are expected to advocate for, having an in-house, ongoing presence fulfills the original intent of the ombudsman program. Overseeing volunteers is an added level of managerial responsibility, and the difference between a good and bad working relationship might make all the difference between retention and resignation. Managers can favorably influence quality in the volunteer's role, from providing guidance on documentation, to the level of advocacy embraced. Perhaps most important, paid workers can illuminate and recognize the volunteers' efforts. Managers also conduct monthly meetings to allow for regular contact with the site office, and for ongoing education and troubleshooting. Meetings also provide socialization and connection to

other advocates, both of which have been found to be beneficial to volunteers' morale (Nelson, Hooker, DeHart, Edwards, & Lanning, 2004).

### **Volunteer Ombudsman Role Orientation**

Ombudsman volunteers have been categorized in a variety of roles, including mediators, educators, collaborators, advocates, friendly visitors, counselors and watchdogs (Harris-Wehling, Feasley & Estes, 1995; Keith, 2001a; Monk, Kaye & Litwin, 1984). Pioneering LTCOP researchers, Monk, Kaye and Litwin (1984) set the trend in exploring ombudsmen role orientations. Three primary roles have persisted in the literature (Nelson, Pratt, Carpenter & Walter 1995): advocate, collaborator, and counselor. Advocates are identified as watchdogs who use a contest-oriented "win-lose" approach, forcing change by arguing the resident's cause from getting a warm meal to changing policies at the macro political level. Collaborators use a "win-win" approach to problem-solving, while the counselor orientation is a non-conflict patient support model sometimes linked to the ombudsman's education and resource brokering roles (Monk & Kaye, 1982; Nelson, 1995). The majority of ombudsman volunteers in Monk and Kaye's study self-identified as counselors (Monk & Kaye, 1982, p. 198), while those in Nelson's study a decade later (1995), found that those using the contest strategies were more numerous and generally, more effective. It may be that we are advancing to more of an advocacy-based model of training due to the increased recognition that nursing home residents require a strong presence of fearless advocates.

### **Volunteer Presence**

The Department of Health and Human Services (DHHS) in 1991 assessed the national LTCOP. One defining characteristic of effective programs was the use of volunteers (Nelson, 1995). Regular presence and consistency, as well as timely follow-up to concerns, distinguish successful ombudsman programs from unsuccessful programs (Nelson, 1995). Volunteers were not always well received by the nursing home industry and are occasionally strong-armed out of facilities. However, legislation under the 1987 Older Americans Act (OAA) bolstered the strength of volunteers, giving them parallel power to paid ombudsstaff. The Act secured volunteers the right to make unannounced visits, to access any appropriate party relevant to the concern, to proceed on complaint investigation with the permission of the resident or the legal responsible party when the resident is deemed legally/medically incapacitated, and to communicate concerns to the regulating agency prior to an inspection. The OAA specifies that facilities interfering or not cooperating with ombudsman program personnel, including volunteers, can be sanctioned. Given the heft of the role, the position undoubtedly has its challenges.

### **Role Perceptions**

Keith (2005) studied perceptions of ombudsman volunteers before and after they spent time in their assigned volunteer role and noted that the majority changed perceptions of what nursing homes were like. Largely, perceptions were changed for the better. Volunteers felt more of a sympathetic stance toward primary workers and found that facilities were not always as bad as they originally feared. Authors in the area of volunteer practices highlight the favorable exchange between volunteer role and agency/provider. For example, Nagel, Cimboric and Newlin (1988) suggest the

positive return volunteers have on the provider. Pillemer (1988) likewise describes volunteerism as mutually beneficial to those who participate and to those served (Estes, Zulman, Goldberg, & Ogawa, 2004).

### **Communication with Officials**

As noted, some of the ombudsman program's power lies in the ability to report wrongdoings to government officials (Kahana, 1994). A requirement of LTCOP is that ombudsmen are kept apprised of times and dates of health department inspections. If a volunteer is assigned to a facility, that volunteer has the responsibility to communicate any concerns to inspectors prior to the time of inspection or upon the survey team's entrance. The ombudsman raising a concern for official investigation, therefore, may add accountability to the survey team to investigate issues. Ombudsmen personnel are also invited to attend the exit conference where findings are presented. Inspectors reviewing facilities without volunteers rely on regional or local ombudsmen to communicate concerns. Hence, the better the worker's ability to align with other agencies, the more effective they will be in producing positive change within the nursing home, and in ensuring that residents' complaints are carried to the powerful regulators (Zischka & Jones, 1984).

### **Program Implementation**

Connecticut meets the OAA mandate to provide advocacy for some 30,000 nursing home residents by training and placing ombudsmen volunteers in its 261 nursing homes. Volunteer ombudsmen are trained by regional (local) staff managers and appointed by the state ombudsman. Measures are taken to screen and appropriately match ombudsmen volunteers with nursing homes. Given the reality that volunteers work with vulnerable populations

with close access to resources and information related to residents' lives, prospective ombudsmen are required to disclose any criminal history. Motivations for entering the volunteering role are reviewed, such as whether there is a past history with the facility, if there is an ax to grind of sorts, or if there is a more general willingness to volunteer where the advocate is needed. Furthermore, current work placement and other demographic information are identified. Efforts are made to assure that no conflict of interest exists under the OAA. For example, volunteer ombudsmen may not receive any remuneration from the nursing home industry while serving as a volunteer.

In addition to thirty hours of classroom training, ombudsmen volunteers visit a minimum of two nursing facilities with an experienced volunteer or paid staff member. Placement is prioritized for facilities lacking ombudsman representation. Other considerations are made, such as proximity to the volunteer's home. Once certified, volunteers provide a minimum of five hours per week to their assigned facility. Many work far beyond the minimum requirement. Barriers to

### **Barriers to Volunteering and Retention**

Volunteers handle resident concerns spanning the gamut from cold food to rape in a conflict-riddled environment, deeming ombudsman volunteerism one of the most difficult in the entire volunteer arena (Keith, 2001b; Monk, Kaye & Litwin, 1984; Nelson, 1995). Furthermore, nursing homes are plagued with bad press and are places people would rather avoid (Keith, 2005). LTCOP volunteers, facing daunting realities, take on challenges in these stigmatized places. The role of nursing home advocate, important as it is, does not boast a long waiting list. The work requires a serious

investment of time and energy in a venue many wish to avoid.

Contrary to her study expectations, Keith (2005) did not find time constraints a major barrier to effective advocacy. The majority of the unpaid staff had simultaneous roles as caregivers, paid employees, and volunteers in other capacities. It seems to echo the old adage: To get something done, you've got to ask a busy person. Volunteers are largely busy, productive people who wish to improve society through the effort of advocacy (Keith, 2005). In terms of retention, those who stay in the program longer feel they are making more of a difference, receive regular feedback from the paid staff, and have a favorable working relationship with the facility and manager. Alternatively, those who drop out feel that supervision is lacking, their work is unappreciated, and/or they are met with resistance from nursing facilities and paid workers in the ombudsman program (Nelson, Netting, Huber, & Borders, 2004). Educating volunteers on effective strategies of problem-solving may prove beneficial in breaking through barriers that may undermine the capacity of the workers' efforts (Nelson, et al).

### **Motivation**

Most often, volunteers enter the arena of volunteer resident advocacy after personal experiences with family members or friends in the long-term care system. Scholars investigating motivations behind volunteerism find that older volunteers have longer tenure rates and higher alignment to the ombudsman program's mission than their younger counterparts (Nelson, 1995). The majority of LTCOP volunteers are at or above retirement age, yet variations of ages exist, as do motivations. Younger volunteer advocates are found to have more selfish motives than altruistic ones, such as resume-

building (Nelson, Hooker, DeHart, Edwards, & Lanning, 2004). Nelson et al. also reported that male volunteers feel less effective than female volunteers. In Keith's article (2005), males were found to be more likely to volunteer to put their professional and technical skills to work, whereas women were more likely to feel motivated to help others with more personal problems.

It is becoming known that volunteers are needed in nursing homes and volunteers themselves find the work rewarding. In short, the power of the volunteer role is gaining momentum as a high impact, necessary effort. With an aging society, there may be more interest in working to promote advocacy in areas that baby boomers and their older cohorts might have to utilize in the future. With this added buy-in and recognition that the work done by today's volunteers may influence the future conditions for the volunteers themselves, a synergy of increased numbers and increased dedication seems to exist. Volunteers lacking a so-called professional role may be a strength rather than a weakness. Using indigenous/volunteer workers can prove successful in human service delivery as it reduces stigma of clients seeking assistance on a more formal level (Gilbert & Terrell, 2005).

### **Methods**

The exploratory nature of the study posed whether facilities with and without volunteers would vary in deficiencies imposed by the health department. There was an expectation that the longer tenure of a volunteer's presence, the more the deficiencies received. The findings speak to the level of investment of volunteers in bringing serious issues to the forefront of regulatory reviews. The sample included a retrospective account of deficiencies from the 261 operating facilities received over a two-year period in the Connecticut LTCOP.

The study reports whether the facility had volunteer ombudsman presence during the reporting period. To evaluate whether these differences existed, chi-square tests were used.

### Health Department Deficiencies

All Medicaid and Medicare certified nursing facilities must undergo yearly inspections and meet basic federal requirements (USDHHS, 2005). Each state has a designated unit charged with providing unannounced surveys to long-term care providers who monitor such issues as decubitus ulcers, weight loss, restraints, end of life care, and proper staffing levels. Typically, inspection teams choose a core sample of residents with various “triggered” or high-risk conditions. Ombudsmen personnel receive survey schedules in advance to inspections to facilitate communication between the advocates and the inspectors. Volunteer advocates, partnering with the licensing agencies, favorably change the nursing home environment through advocates dialoguing with inspectors, instead of the historic cold war between the two factions (Nelson, Huber & Walter, 1995; Sadden, Deaton & Gonzales, 2004).

The deficiency variable reflects the number of deficiencies over the two-year time period. In order to collect data covering the National Ombudsman Reporting System (NORS) time period, the researcher entered data from the reports of 1998 - 1999 and 1999 - 2000 into SPSS (Statistical Package for the Social Sciences)12.0, adding the number of deficiencies each facility received over the reporting years. The variable refers to the total number of deficiencies (A & B) received from the Department of Public Health. As stated in the Public Health and Well-Being section of the Connecticut General Statutes (1999), deficiencies are classified Class A or B:

1. Class A violations are conditions which the Commissioner of Public Health and Addiction Services determines present an immediate danger of death or serious harm to any patient in the nursing facility. The penalty for Class A violations cannot exceed \$5,000.
2. Class B violations are conditions which the Commissioner of Public Health and Addiction Services determines present a probability of death or serious harm in the reasonably foreseeable future to any patient in the nursing home facility, but which does not find constitute a Class A violation. Fines for Class B violations do not exceed \$3,000.

### Findings

There were 180 volunteers trained and placed by the Ombudsman Program in Connecticut during the reporting period. In terms of facility coverage, 30% of the facilities had a volunteer placed only one of the two years, and 66% had a VRA formally assigned to them during both reporting years, which showed an increase in volunteer presence in Connecticut’s facilities.

Facilities with volunteers at least one of the reporting years were significantly more likely to have one or more survey deficiencies than those without volunteer coverage ( $\chi^2 = 4.42, 1 df, p = .035$ ). In terms of increased deficiencies in relation to increased volunteer presence, 39 facilities with no volunteer coverage received one or more deficiencies, but the number of facilities with at least one or more deficiencies jumped to 99 with a volunteer placed for at least one year. As advocacy presence increased, deficiencies followed. Nineteen percent of all facilities received zero deficiencies. Deficiencies (Type A & B) ranged from zero to three in the reporting

period almost three quarters receiving one or more. Taken separately, Type A deficiencies are the less common, and reflect the more injurious of the types. Twenty-four facilities (9.2%) had one Type A deficiency in the reporting period, with only one facility receiving two Type A deficiencies. Fifty-two percent of the facilities had one Type B in the reporting period, 23 had two Type B deficiencies, and five facilities received three Type B deficiencies. Connecticut is a low ranking state in regard to receiving deficiencies. A related study revealed that Connecticut ranks fourth nationally in the lowest deficiencies received (IOM, 2001).

### **Conclusions and Implications**

Fewer, if any, avenues exist in providing such an intimate exposure to nursing facilities from a resident's perspective as ombudsman volunteers (Nelson, Huber & Walter, 1995). Huber, Borders, Netting and Nelson (2001) suggest that ombudsman data give a clearer picture than lone survey reports from health departments about actual problems seen on a daily basis by nursing home residents. Using both in tandem may illuminate what is really happening inside of the facility. Such findings are suggested by the increased numbers of substantiated deficient practices sanctioned by the health department in facilities with volunteers. It appears that the dual-arm approach of volunteer advocate and surveyor stands as a stronger ally to the resident. The power of an advocate lies in the ability to empower the client and to suggest change. That power is enhanced when regulators heed advocates' input regarding problems within nursing homes, which is implied in this study.

There are several areas of volunteerism worthy of exploring. Why is it that volunteerism in general is declining, but volunteerism within the LTCOP is increasing? Might it be that people investing

in human capital wish to do meaningful work despite the challenges? How can states with lower volunteer rates and shorter retention increase the participation of the valuable workers? And who are these workers? Are they representative of the general public? What are the most salient reasons for keeping them volunteering? Further, studies on the surveyor's reaction to the volunteer may reveal interesting findings. Only through continued research and investigation can we discover more valuable information pertaining to the precious, unpaid workers' roles. Given the increased numbers of baby boomers soon to retire, issues of volunteerism may prove more and more important to the health of our society. These workers may prove the most robust given their historical inclination to advocate for change.

The volunteer represents a true change agent toward the vision of social change and reduction of problems within the nursing home. The partnership between volunteers, ombudsmen, residents, families, nursing home staff, and inspectors is a favorable one. It is critical for the ombudsman program to recognize the contribution of these members on a regional, state, and national level. Proper resources targeted to effective running of the ombudsman program, such as training resources and recognition remain a top priority of advocates and researchers (Huber, Borders et al., 2001; Keith, 2005; Nelson, Hooker et al., 2004). By encouraging nursing home residents and their representatives to voice concerns, the fundamental right of dignified care -- free from abuse, maltreatment, corporal punishment, retaliation, and fear of expressing the speech that belongs to them -- is upheld. The potential to encourage unpaid workers to do such important work as to strengthen quality of care within the nation's facilities is hopeful and has implications in other areas.

There are countless opportunities in other venues for unpaid workers to add strength in numbers and power to the service delivery system. With proper training and identifying passionate individuals, volunteers may be champions to provide other levels of work, breathing energy and participation in the profit and nonprofit sectors. Nonprofit organizations taking a proactive approach in recruiting, training, and utilizing volunteers in advocacy roles would support a win-win situation for both the organization, the workers, and the clients/consumers served. Volunteerism is a powerful bridge to effective advocacy and investment in quality of life (IOM, 1995). We often hear of broken systems in our educational, political, and health care arenas, and volunteers, invested in making a difference, may be a key to address the enormity of problems that seem intractable. They certainly have made a difference in our nation's nursing homes.

Given the timing with so many vital social services being cut, human service organizations may profit from recruiting and training volunteers. Of course challenges exist, and some may fear that a volunteer's role may undermine a professional's. However, there is more than enough room for paid and unpaid workers to fulfill common missions in working to improve the conditions of humanity, particularly where social injustices are involved. Also, with a growing retired force, several trained professionals may find a logical, rewarding role in programs such as the LTCOP. It may be time for society to recognize the true spirit of people who willingly work for benefits other than pay.

The relationship found between unpaid workers and regulatory officials in a time of human service contraction gives hope to protecting resident rights. Rather than succumbing to the reality of the power of the nursing home industry, pairing unpaid

workers in the profit and nonprofit health care sector bridges an arena that often as viewed as impossible. The ombudsman program provides a model for upholding the rights of historically vulnerable people and may indeed be a model necessary for the overall health and well being of our aging society.

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