



The National Adult Protective Services Association's

2015 Survey of Nurses in APS



Produced by
The National Coalition of APS Nurses

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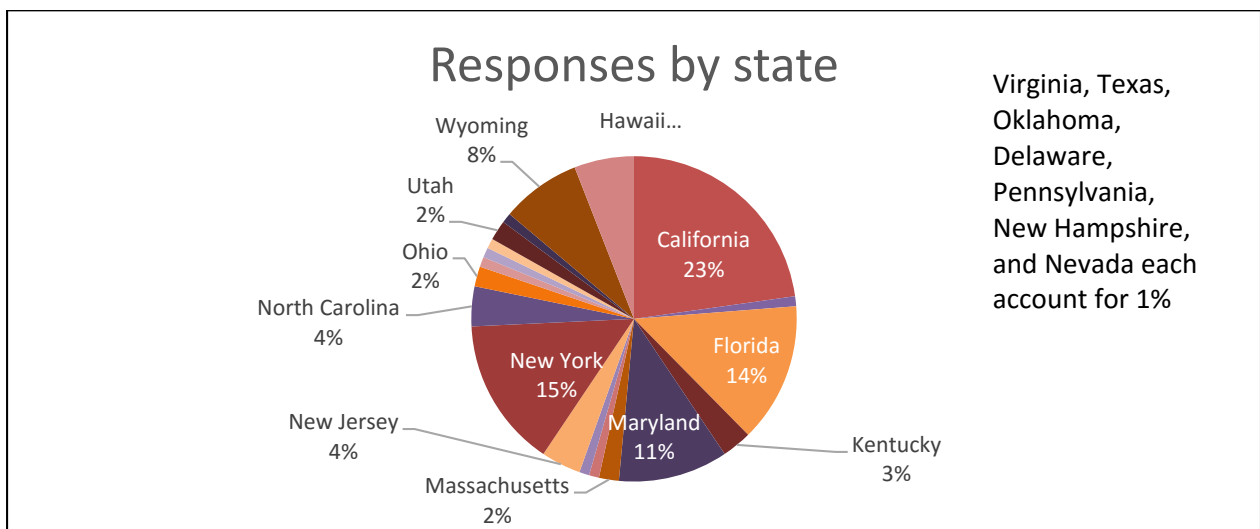
In the spring of 2014, The National Adult Protective Services Association (NAPSA), the Academy for Professional Excellence and Adult Protective Services (APS) nursing staff from San Diego County in California began to host a national monthly telephone conference call for nurses who work in/with APS in their investigations and remediation of elder and dependent adult abuse. The calls were begun because nurses were believed to be somewhat isolated within their agencies as the majority of their colleagues are social workers. The telephone calls provide an opportunity for APS nurses to discuss their work with peers.

In the course of discussions on these monthly conference calls, the nurses asked each other numerous questions about each other's job duties and situations. It became obvious that APS nursing practice differs greatly across the country and the nurses, working collectively, developed a list of survey questions to explore the parameters of the job of an APS nurse.

In October of 2014, we launched an electronic Qualtrics survey to attempt to learn more about the nurses who with/in APS. Using a snowball methodology, a link to the survey was distributed via the email distribution lists of APS contacts across the nation kept by NAPSA. Recipients were asked to forward the email link to any nurses who work for or support APS. The survey closed on November 11, 2014. However, we were contacted by states that had missed the opportunity to participate so the survey was reopened. The survey closed the second time on July 5, 2015 at which time we had 151 responses.

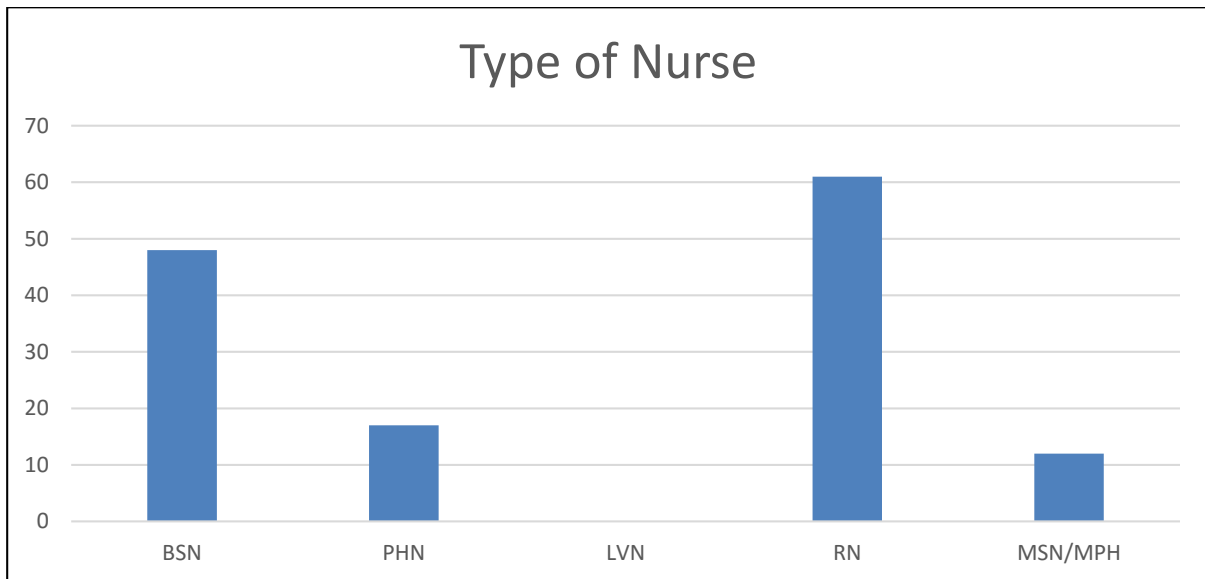
Results

We heard from 19 states. We received 23 responses from California, 15 from New York, 14 from Florida, 11 from Maryland, 8 from Wyoming, 4 from New Jersey and North Carolina, 3 from Kentucky, 2 from Ohio, Massachusetts and Utah, and one each from Delaware, Nevada, New Hampshire, Oklahoma, Pennsylvania, Texas, and Virginia.

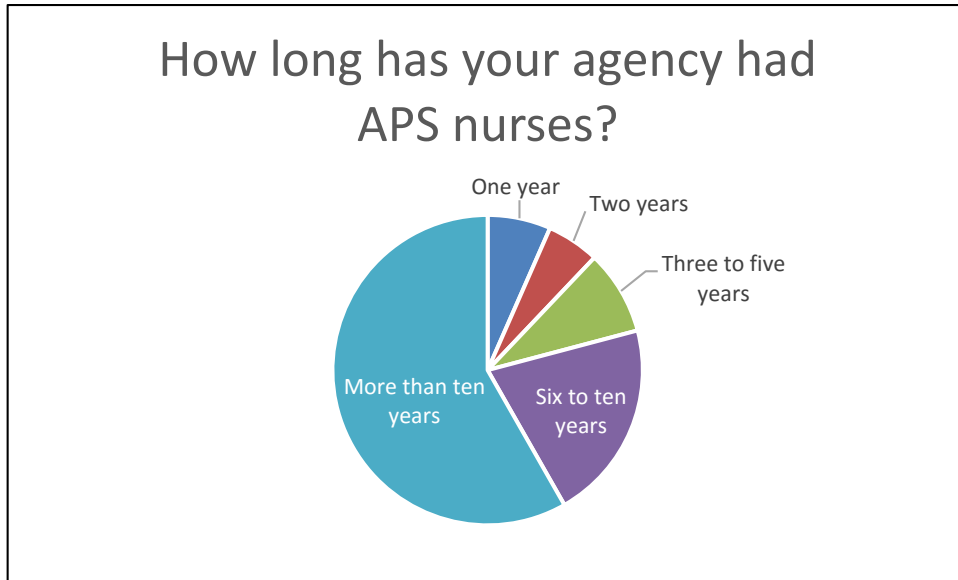


No responses were received from the following states: Alabama (they do not employ nurses), Alaska, Arizona, Arkansas, Colorado, Connecticut, District of Columbia, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Mexico, North Dakota, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Vermont, Washington, West Virginia, Wisconsin, and Puerto Rico. Lack of response may mean that that state does not employ nurses or it may mean that nurses in that state did not receive the survey.

Nurses were asked to indicate their educational status. Forty eight nurses said that they had a BSN degree, 17 had a PHN, 61 have an Associate’s degree/RN, and 12 had a MSN or MPH. Seven percent indicated that they were either completing the survey for the nurses on staff or were a CRNP or an Emergency Medical Technician. When the results of this question were reviewed, it was noted that, despite common terminology, these categories have different definitions in different states.

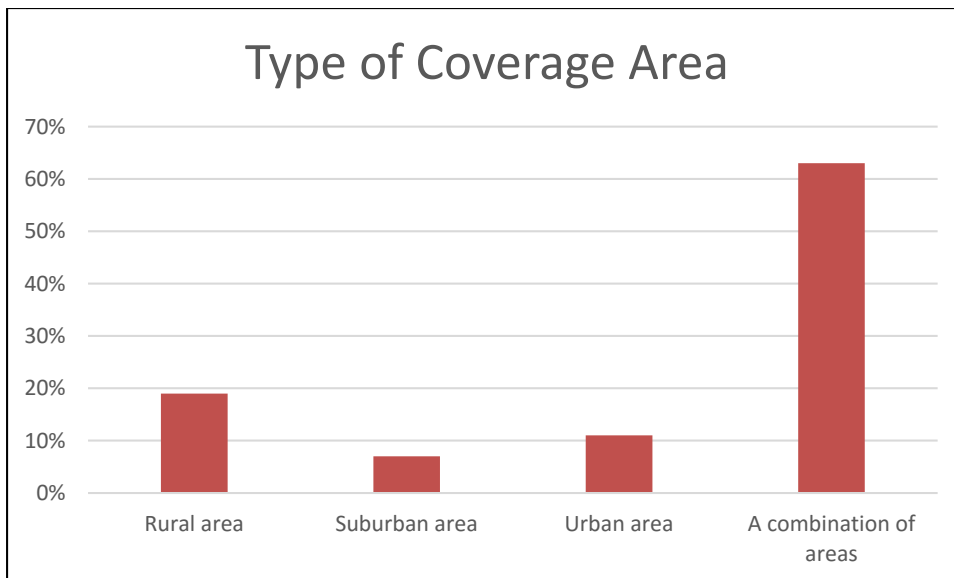


Nurses were asked how long their agency had used nurses? Fifty eight percent have had nurses on staff or supporting their staff for over ten years. Another 21% have used nurses for three to ten years.

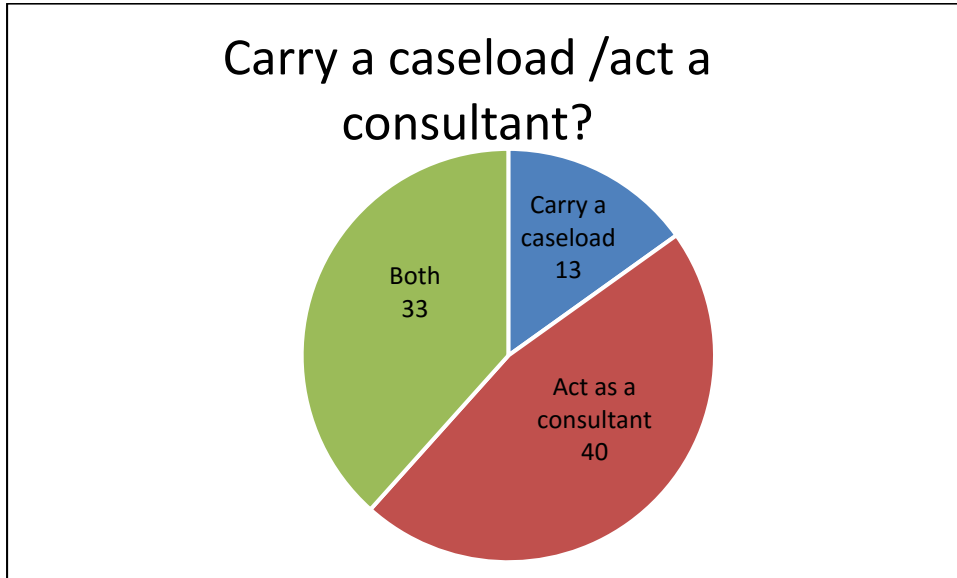


Ten responders stated that their agency had had nurses in the past and had discontinued them for reasons ranging from budget considerations or policy changes (different agency to provide the service) to loss of a key individual.

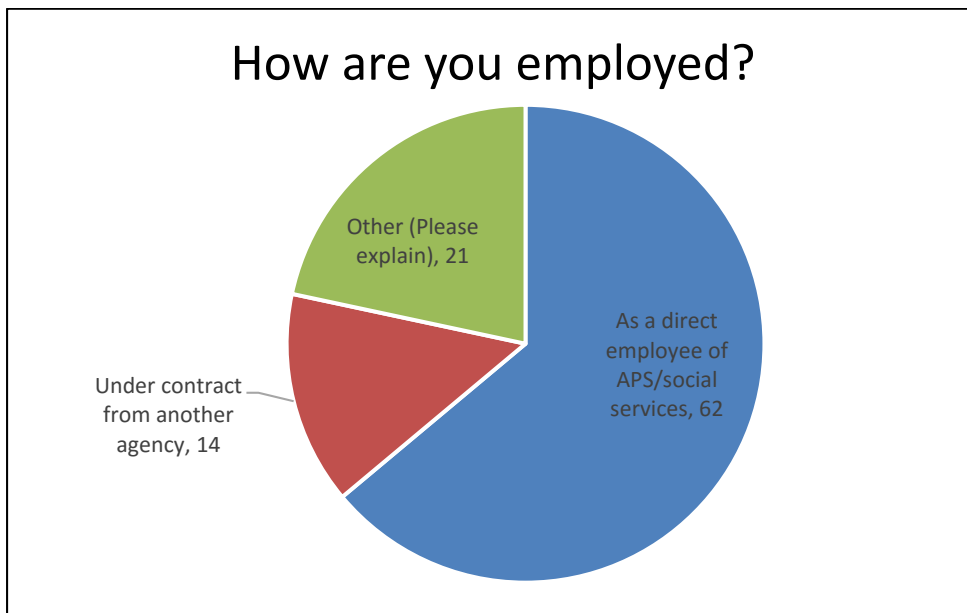
Nurses were asked about the area in which they work. Nineteen percent said that they work in a rural area, 7% work in a suburban area, 11% work in urban area, and 63% work in a combination of areas.



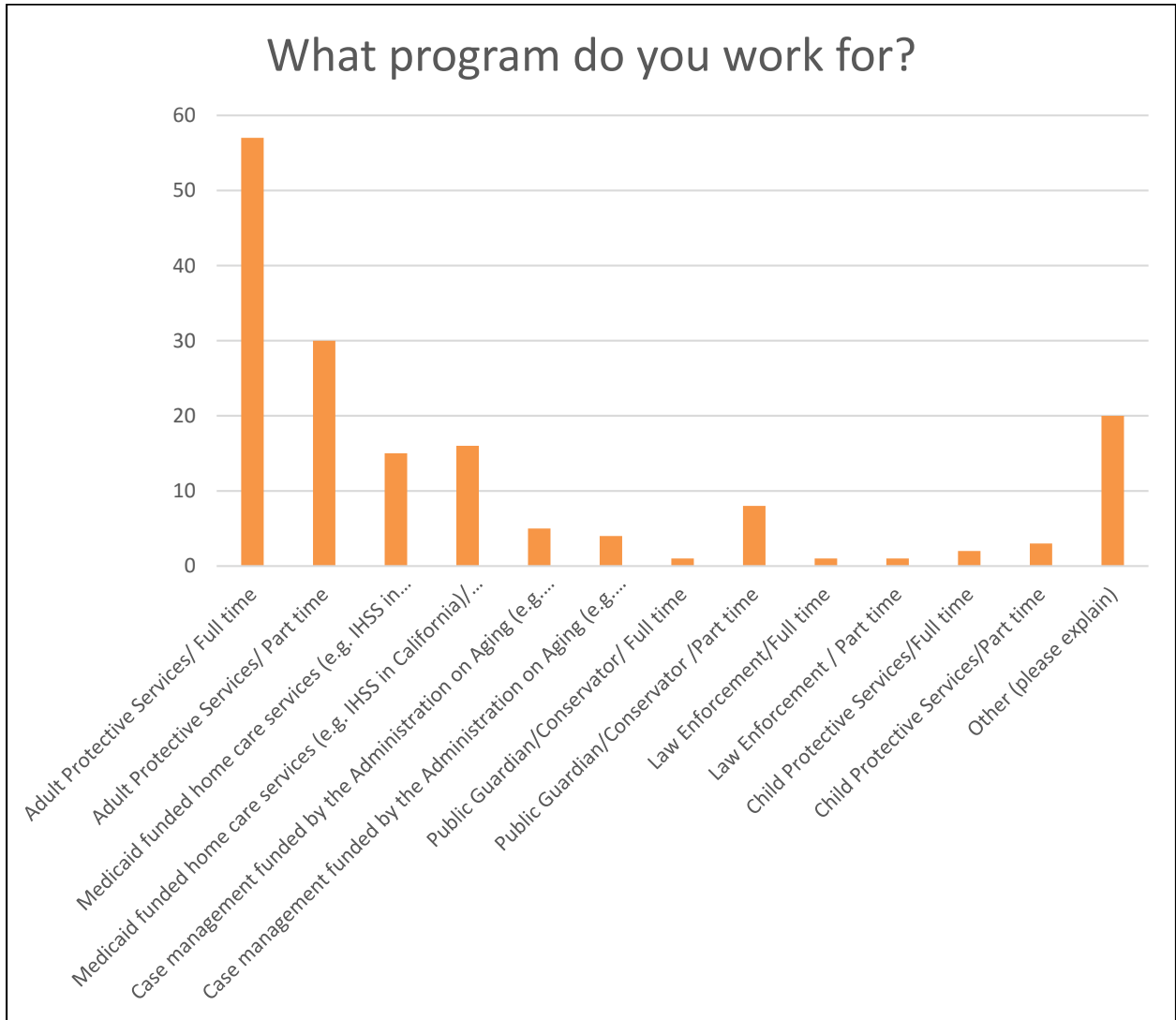
One of the major questions that nurses wanted answered was whether most nurses carry their own caseload or act as consultants. Forty-one percent of respondents indicated that they only act as a consultant. Thirteen percent carry their own caseloads and thirty-four percent do both. Eight respondents indicated that their involvement was OTHER which included administrative duties and working on an MDT. Five of those responses were moved to “act as a consultant”.



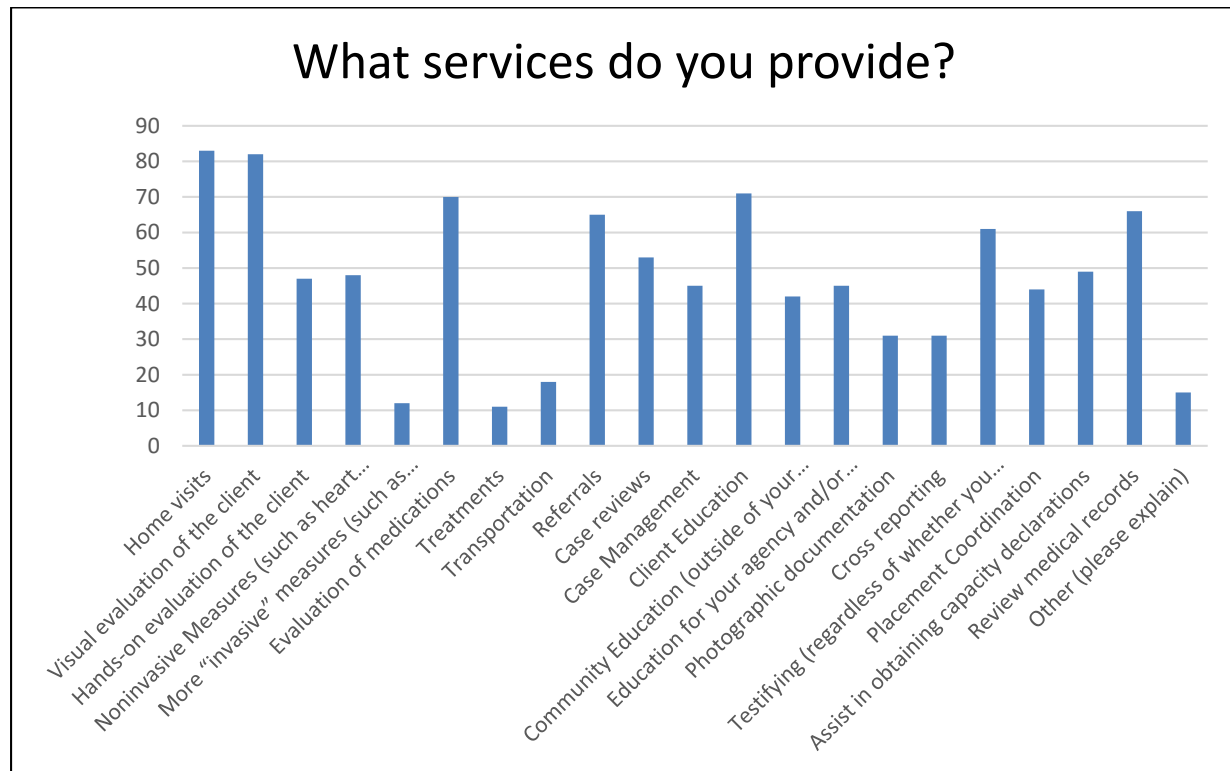
Nurses were asked whether they were a direct employee of APS/Social Services or whether they provided services under a contract. Sixty-four percent said that they were APS employees, 14% said that they work under contract. Another 22% reported “other”. The “other” included five individuals who stated they work for public health.



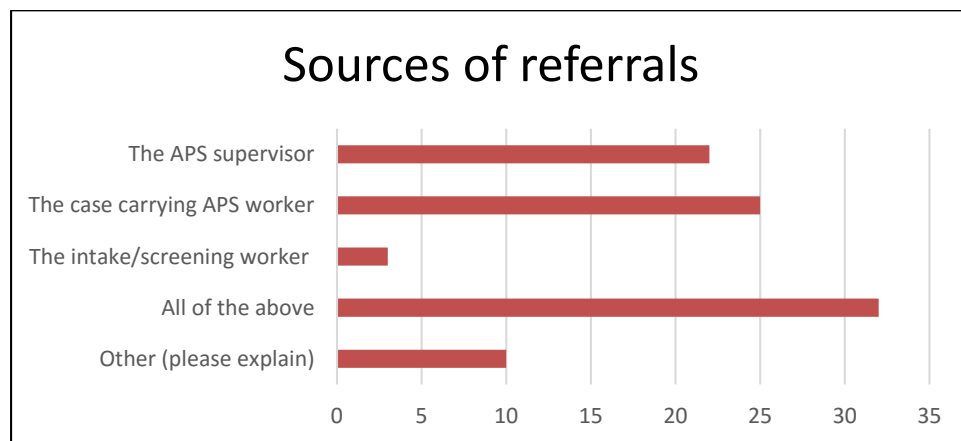
Nurses were asked about the programs for which they work. Fifty seven respondents (58%) said that they work full time for APS. Another 30 (31%) said that they work part time for APS. Many of the respondents said that they officially work full or part-time for a Medicaid funded home care service program (31%). Other respondents work for Law Enforcement, Public Guardian (Conservator), Case Management program or a Child Protective Services program. Nineteen respondents work for some other program. A good percentage of the “Other” category were public health nurses.



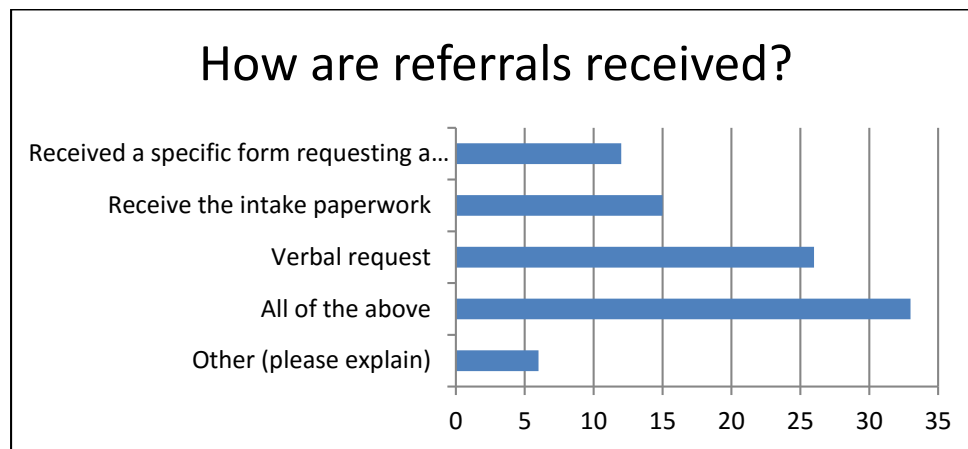
Nurses were asked what services they provide to clients. The most common services, provided by over 60 percent of nurses, are home visits, evaluations of clients and their medications, client education, and referrals. The least often provided services are “invasive” measures such as blood sugar and urine testing, treatments and transportation.



Seventy-seven percent of nurses stated that they did not have a doctor who signs off on their agency’s policy and procedure. And, only 53% of the respondents stated that their agency had a protocol stating when to assign a case to a nurse or to ask for a consultation. Sources of referrals to the nurse are fairly evenly divided between APS supervisor (24%), the case carrying APS workers (27%) and “all of the above” (35%).



Nurses receive their referrals in a number of different ways. Twenty-eight percent receive their referrals verbally, 16% received the intake paperwork asking them to see the client and 13% receive a specific form requesting a nursing investigation/consultation. However, 36% said they receive their referrals from multiple sources.

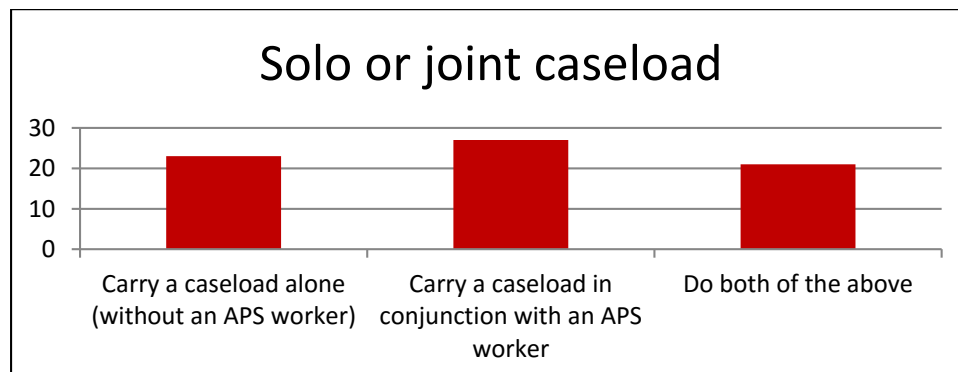


Thirty-three percent of nurses stated that they were supervised by a nurse but 67% are supervised by a non-nursing professional. And, unfortunately, 58% of respondents indicated that they did not have the option to use another nurse as a geriatric clinical resource.

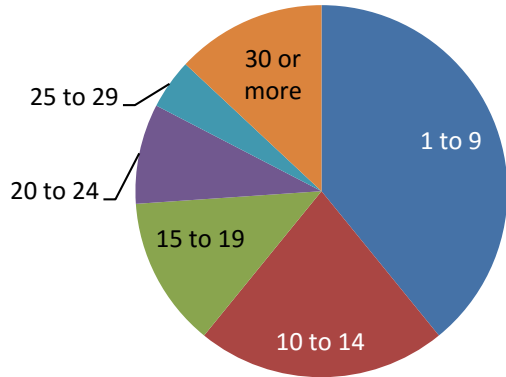
... 67% are supervised by a non-nursing professional. And ... 58% of respondents indicated that they did not have the option to use another nurse as a geriatric clinical resource.

Thirty-seven percent of nurses stated that they received orientation training for APS nurses when they were hired/contracted by APS. Conversely, 49% said that they did not receive any APS nursing orientation.

Nurses were asked whether they carried a caseload alone (32%) or in conjunction with the APS worker (38%) and both alone/with the APS social worker (30%).

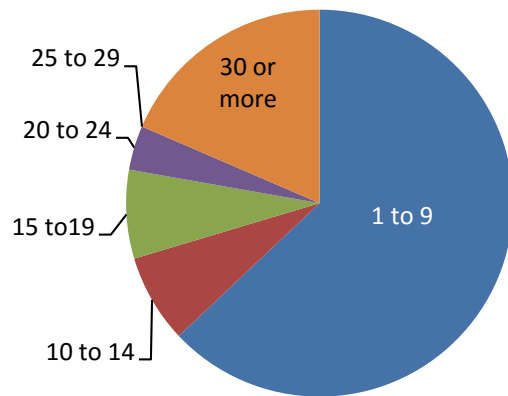


Number of clients when caseload is carried alone



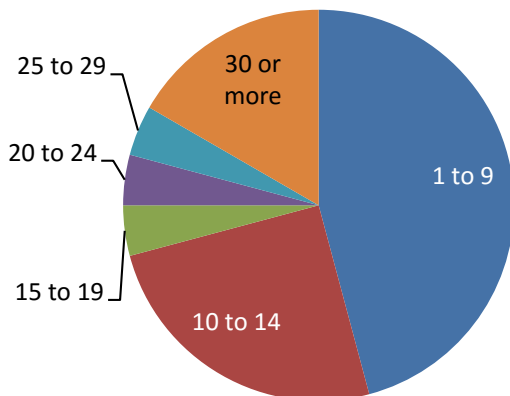
In the cases where the nurses said that they carried their own caseloads, they were asked how many clients they had (on average) at any given time. Thirty nine percent of nurses stated that they have 1-9 clients. Another 22% said that they had 10-14 clients. Thirteen percent said that they had 15-19 clients. Nine percent had 20-24 clients and four percent had 25-29 clients. But, thirteen percent of nurses have over 30 cases/clients.

Number of clients when it is a joint caseload



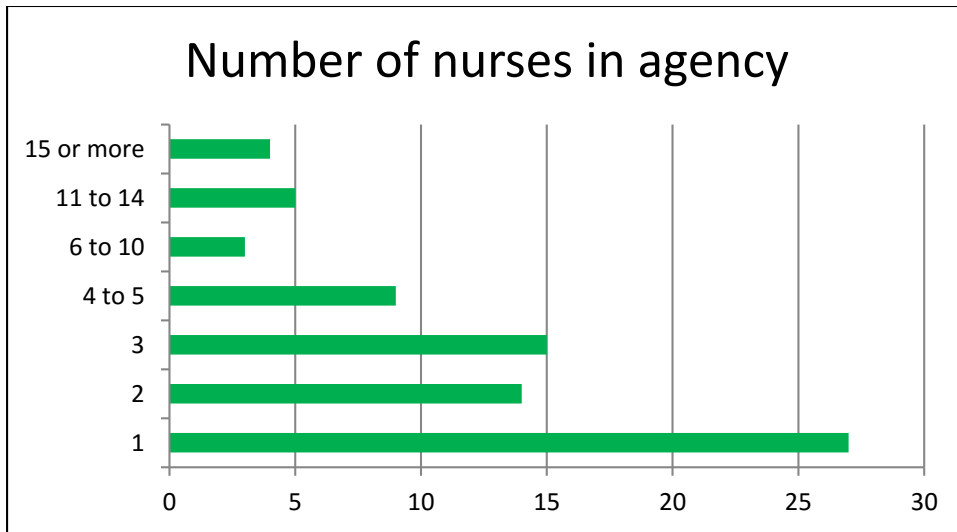
When the nurses said that they carried joint caseloads, 63% of nurses stated that they have 1-9 clients. Another 7% said that they had either 10-14 clients or 15-19 clients. Four percent had 20-24 clients. But, nineteen percent of nurses have over 30 clients.

Number of clients when nurse has both solo and joint cases

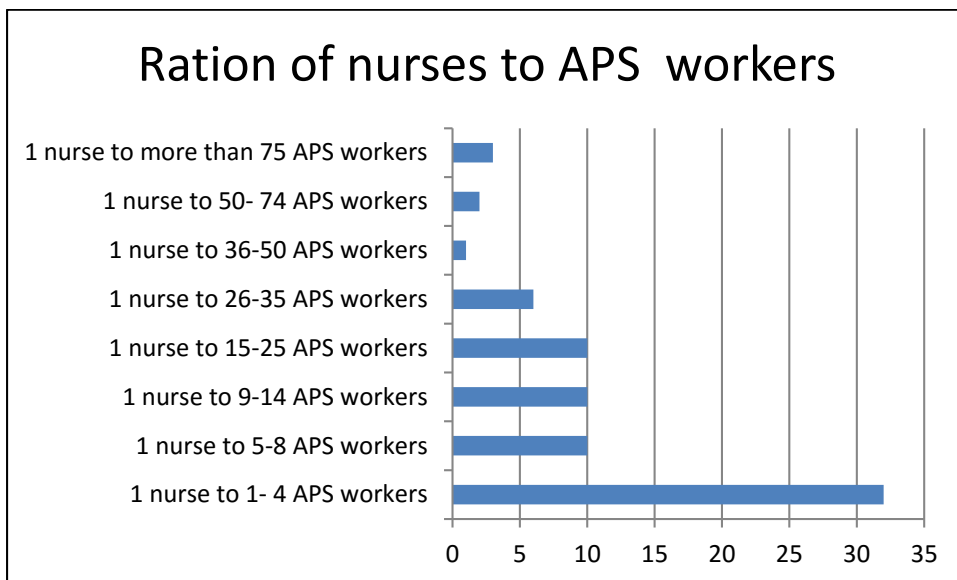


In situations where nurses have both solo and joint cases, 46% of nurses have 1-9 clients. Twenty-five percent have 10-14 clients. Four percent have either 20-24 clients or 25-29 clients. In this case, seventeen percent of nurses have more than 30 clients.

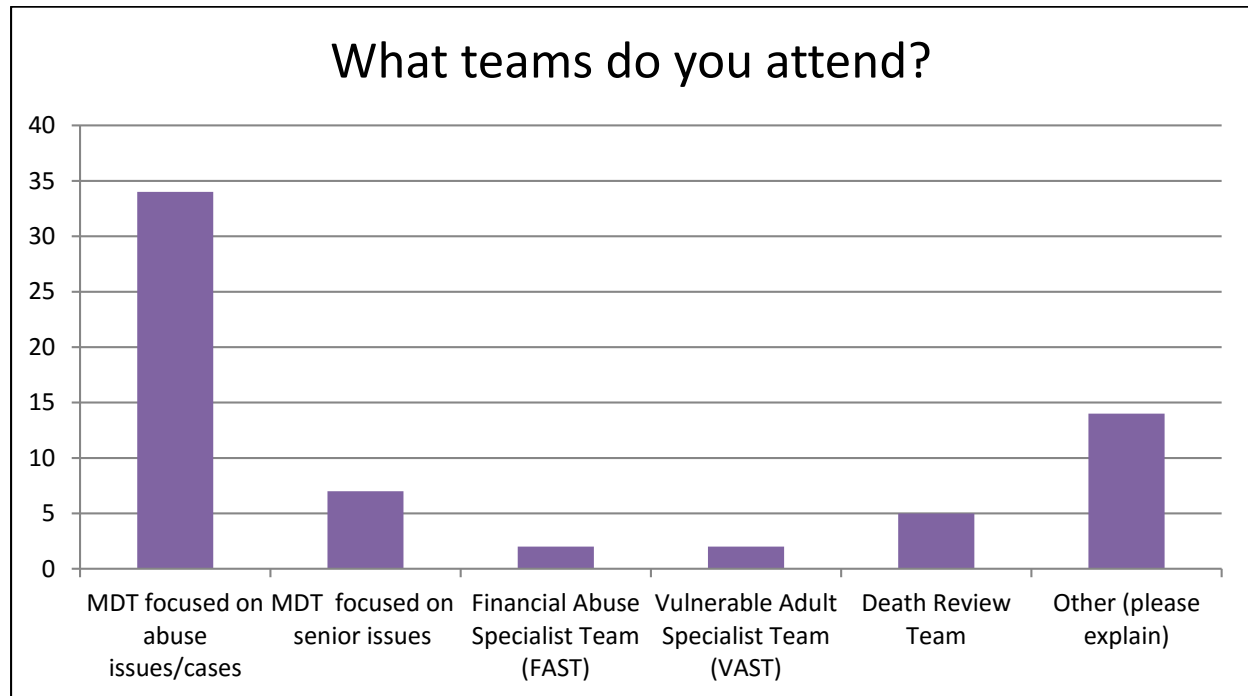
The nurses wanted to know whether most nurses were isolated so they asked respondents how many nurses are employed in your agency. Thirty-five percent stated that they were the only nurse in their agency. Another 37 percent indicated that there were only 2 or 3 nurses within the agency.



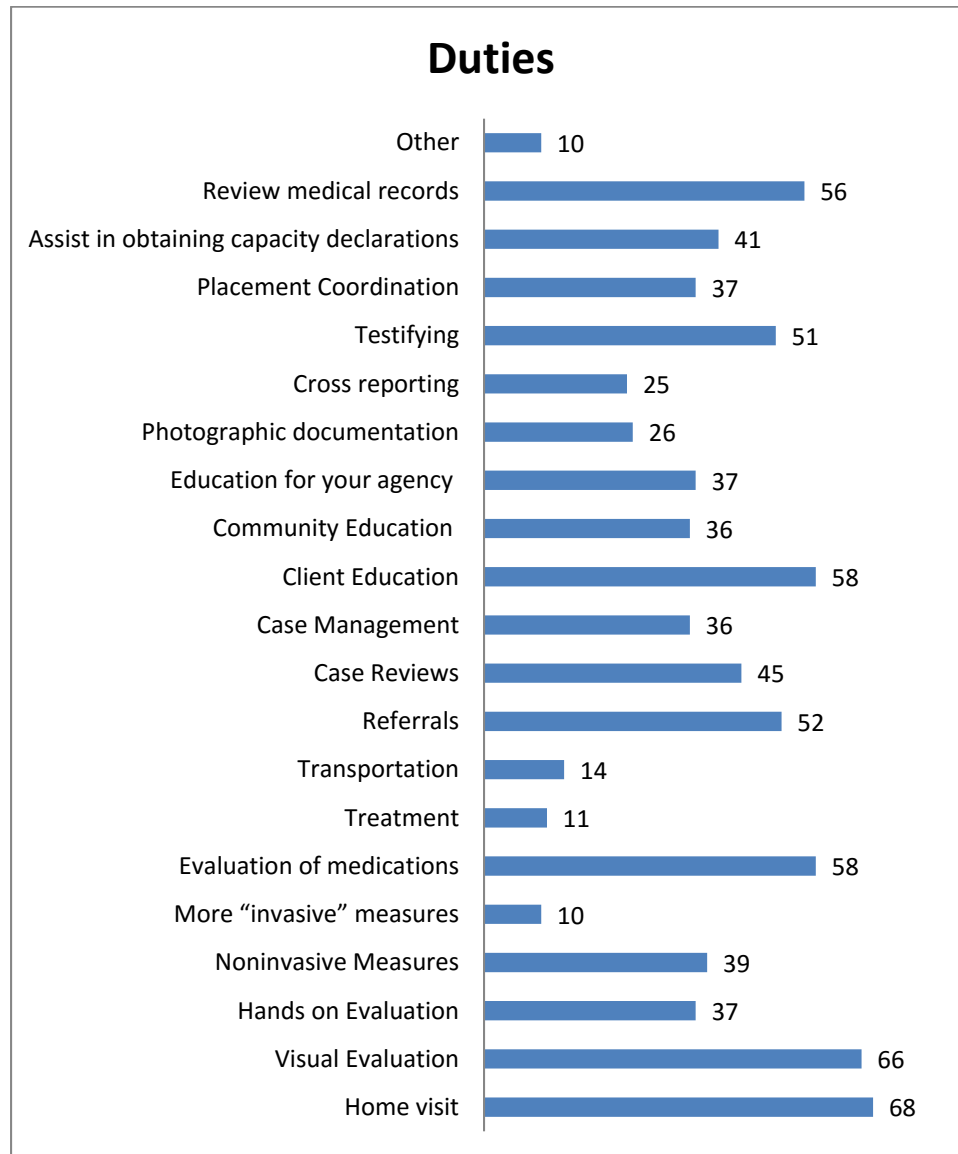
The nurses wanted to know the ratio of nurses to APS social workers within their agencies. Forty three percent of nurses work with 1-4 APS social workers. Fourteen percent work with 5-8 APS social workers, 9-14 APS social workers or 15-25 APS social workers. A smaller percentage of nurses (8%) support more than 25 APS social workers. Four percent work with more than 75 APS social workers. It is hypothesized that the higher the ratio of APS social workers to nurses/ the more likely that the nurse acts as a consultant.



Nurses were asked if they attend any elder abuse and neglect teams. Fifty three percent attend a multi-disciplinary team that focuses on abuse and neglect issues. Eleven percent attend a multi-disciplinary team that focuses on generalized senior issues. Three percent participate in a Financial Abuse Specialist Team (FAST) and 3% participate in a Vulnerable Adult Specialist Team (VAST). Twenty two percent indicated “OTHER”. In 4% of the answers, that meant that they did not attend any meetings. The other 20% of “OTHERS” attended multiple meetings.



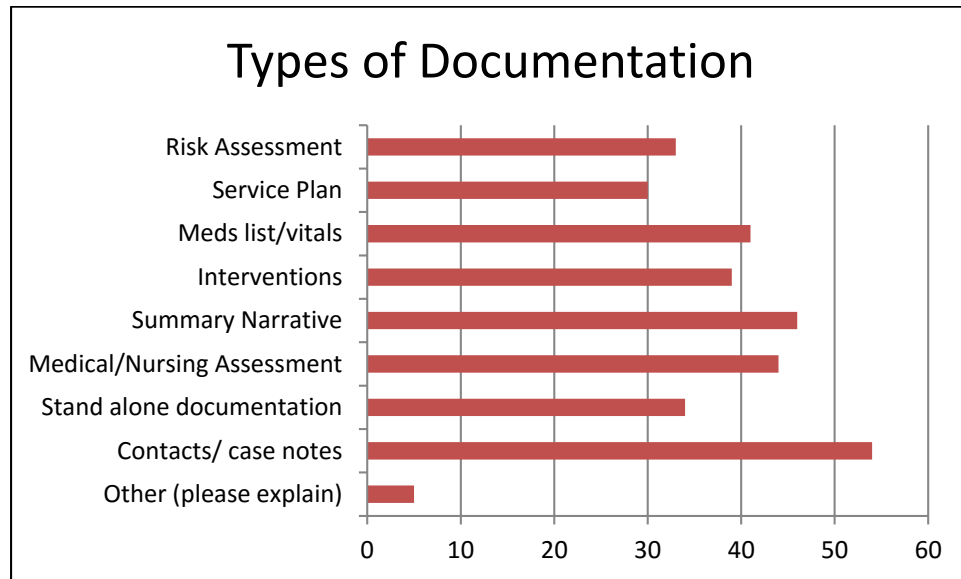
The nurses were especially interested in learning what tasks their colleagues were expected to perform within their jobs. More than 60% of respondents said that they provide home visits, review medical records, evaluate medications, provide referrals, provide client education, and are expected (when needed) to provide testimony. Forty-nine percent of nurses can take noninvasive vital measurements but 13% of nurses are able to provide “invasive” measures such as blood sugar testing and collection of urine samples. Only 14% of nurses provide treatment.



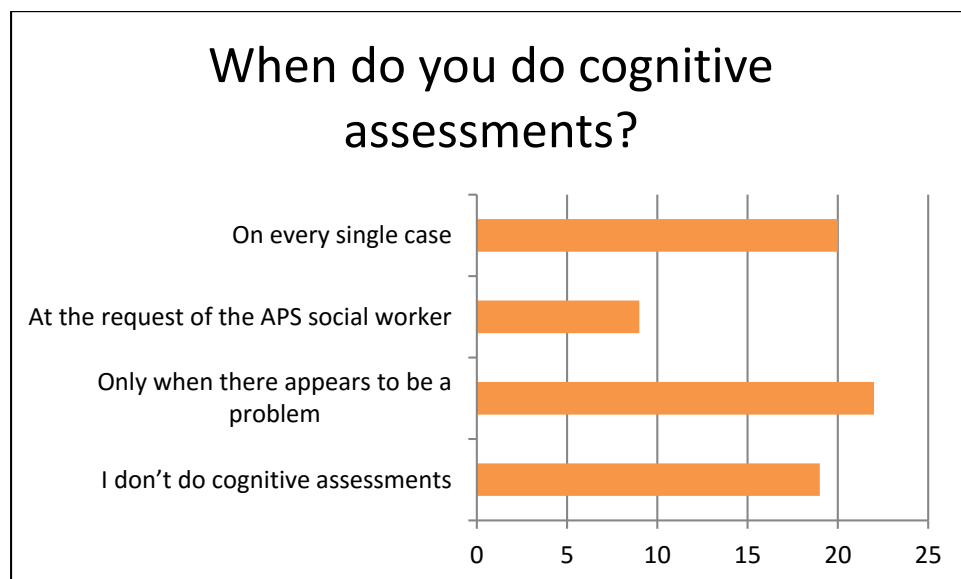
Seventy percent of nurses said that they document their cases in a database. The databases being used included:

AACTS, Florida Safe Families Network (FSFN), SAMS, Avatar, ALEX, ACCTS, CJIS, CMIPs II, ASAP, CPSS, Panoramic, AIF, Maxcess, Centraport, New York State “Adult Services Automation Project”, UAS, Care Access, Jump, SAMS and DCF. One respondent indicated Word.

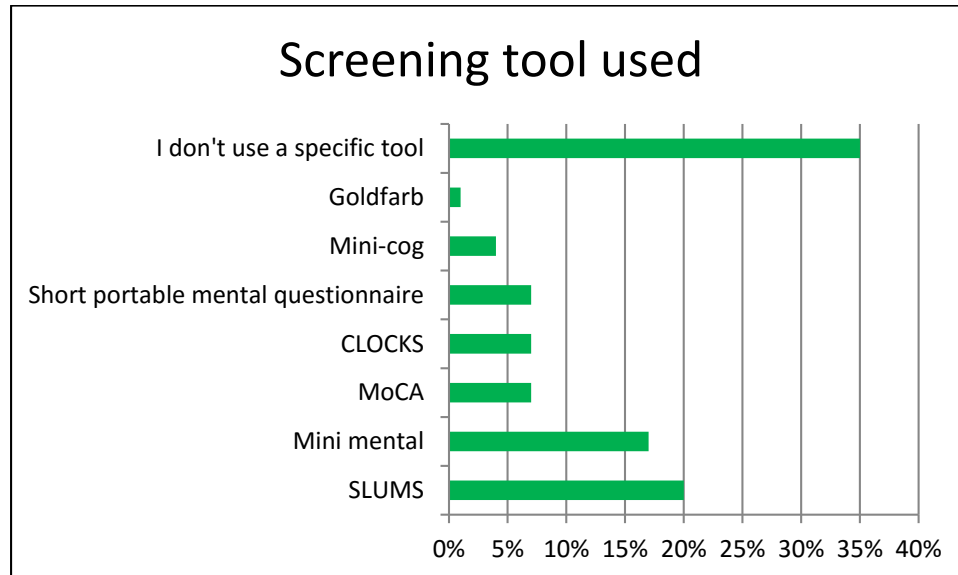
Nurses were asked what aspects of the case they normally document. Nurses could select multiple answers so percentages equal more than 100%. More than 60% of nurses said that they document the client’s medications and vitals, the interventions, the summary narrative, the nursing assessment and the contact/case notes. Fifty-six percent of nurses complete stand-alone documentation. Forty nine percent of nurses document a service plan and 54% document the risk assessment. The 8% who said “OTHER” mentioned medical opinions regarding the case findings and legal interventions.



Nurses were asked if and when they perform formal cognitive assessments. Twenty four percent of nurses stated that they did not do cognitive assessments at all. Twenty six percent said that they do a cognitive assessment on every case. Twenty eight percent stated that they only performed a cognitive assessment when there appeared to be a problem and twelve percent stated that they did them when requested to do so by an APS social worker.



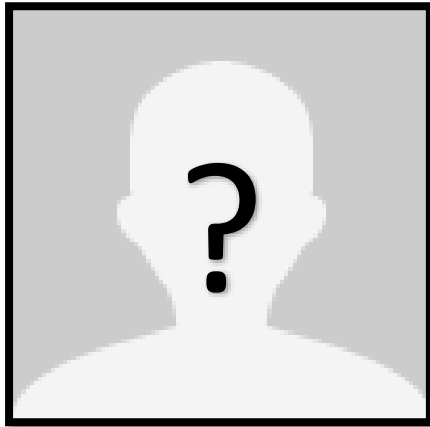
When asked which cognitive assessment screening tool they were using, the majority of nurses (35%) indicated that they did not use a specific tool. The most commonly used screening tool was Saint Luis University's tool (SLUMS), with 20% of nurses using it. Other tools used include the Mini mental (17%), the MoCA, CLOCKS and Short Portable Mental Questionnaire (all three at 7%), Mini-cog (4%) and Goldfarb (1%).



Nurses were asked what services they provide (or have provided) that are outside their normal scope of practice. Their answers included:

- Transporting clients
- Obtaining food and clothing for clients
- Setting up medisets
- Providing mental status exams
- During facility closing, transitioning residents to new placement.
- Providing training to multiple partners (Office of the Attorney General, Agency for Health Care Administration, Skilled facilities, Assisted Living facilities, Hospitals, and Law Enforcement)
- Providing community education at senior fairs
- Providing sexual assault forensic exams
- Providing consultation to attorney's and courts on cases involving vulnerable mentally ill clients facing incarceration
- Dealing with financial abuse related to Medicaid issues and benefits.
- Completing financial abuse investigations
- Acting as a domestic violence liaison
- Screening incoming APS reports
- Cleaning out hoarder homes
- Completing medical forms that would not normally be completed by a nurse
- Monitoring programs, budgeting and secretarial duties

To help agencies determine what characteristics they should seek if they decide to add nurses to their staffs, nurses were asked “What are the characteristics of a good APS nurse?”



According to their most common responses (mentioned by at least 5 respondents), an APS nurse must be compassionate and empathic. She must have excellent communication/ interviewing skills, especially listening skills. She must be non-judgmental and open-minded. She must have good analytic skills and use them decisively. She has to be a team player. In addition, she must have good assessment skills in regards to the client’s safety, functional ability and medical/environmental/social concerns. And, lastly she must be willing and able to handle unclean/unsafe client environments such as those seen in hoarding cases.

Additionally, many nurses (at least 3 respondents) indicated that an APS nurse need to have good nursing skills including having wide experience with different populations/settings. She needs to be a seasoned professional. She needs to be knowledgeable about standards of practice and understand the state statutes regulating her work. She should have good documentation skills. And, she needs to be a strong outspoken advocate for her client. Personality wise, she needs to be patient, detail oriented, emotionally stable and self-motivated.

The last question the nurses were asked was, “If you were asked to make an argument for why APS needs to have nurses on staff, what would you say? What are the benefits of having nurses on staff?” Their comments included

- Clients’ greatest vulnerability is their health status- nurses address this vulnerability
- Nurses can save lives- timely recognition of medical emergencies
- Credibility with clients- we gain easier entry into homes and better compliance with treatment plans- the public trusts and respects nurses
- Clients are willing to tell nurses very intimate details they won’t disclosure to others
- Reduced liability re: recognition of medical emergencies
- Focus is holistic: Nurses are trained to look at the whole picture and so are natural investigators
- Different perspective than provided by the social worker/ prevents social work “group think”
- Understand the full continuum of care
- Quick, credible assessments/ immediate interventions
- When on staff, immediate medical resource for social workers, esp. for clients with complex needs or diagnosis
- Provide physical and mental work-up of client
- Can work collaboratively with medical providers to reduce medical neglect
- When contacting doctors, can ask the medically appropriate questions
- Give opinions as to whether the standard of care has been met (in neglect cases)
- Assess medications and their side effects



- Provide assessments of clients who leave AMA (against medical advice) from hospital settings- their situations can quickly become life or death medical emergencies
- Set up aid services and homecare supports/ vital link to other medical services
- Good understanding of medical risks and interventions
- Immediate attention to medical needs, may reduce ER visits and hospital admits
- Accurate interpretation of medical records (able to interpret the nuances of medical records)
- Decreased recidivism due to better client education
- Provide accurate medical opinions and recommendations
- Determine the appropriate level of care for clients (e.g. is remaining in their home appropriate/safe)
- Testifying in court as a medical expert
- Provide functional/cognitive assessments
- More bang for your buck re: cognitive assessments (versus paying per assessment)
- Provide assessments in the home for clients who refuse to go to a doctor/mental health professional
- Nurses are compassionate and understanding (accept the client as he is)
- Interpret medical diagnoses and treatments to family
- Trained as patient advocates and educators, advocate for referrals to specialists when needed
- Staffing cases with nurses can streamline the investigative process for social workers
- Educate staff, community partners and the public
- Nurses can take med students and nurses on home visits to expand our pool of knowledgeable medical professionals
- Assist guardianship staff to make informed medical decisions, end of life decisions, Do Not Resuscitate orders and level of care changes
- Familiar with state and federal medical regulations
- Identify new, often unrecognized (by the social worker) health concerns
- Explain medical issues to law enforcement
- Understand the changes occurring in the health care system

Here is a very persuasive quote from one of the nurse respondents:

“Many times our nurses and their evaluations have literally saved people’s lives, e.g. client screaming when urinating, totally dismissed for several months by untrained ears, was sent to the ER immediately after RN, during investigation, heard him. He has a malignant tumor in his urethra. Another example--client complaining of pain in his feet, stopped walking a few weeks before assessment due to severe pain. He was totally dismissed by his caregiver and by his son, who just happened to be a physician himself; both stated “he is just old and has arthritis” Client was 92 y/o [years old] at the time of the examination. After nursing evaluation, it was discovered client had 3rd degree pressure sores on heels of both his feet which needed immediate medical attention. Another CI was walking without any difficulties, refusing to go to a physician due to past hx [history] of HTN [Hypertension]. During nursing examination, RN found severe, infected cellulites on both of his legs, both legs were draining and the fluid and blood were being soaked and retained by his cotton socks, unnoticed by son or the other investigator. CI was taken to ER and hospitalized for over a week due to sepsis. E.g. Client was refusing going to hospital due to SOB [shortness of breath]. Not even the EMT/fire department was able to persuade client to cooperate. During RN assessment, client also refused. After refusal, RN decided to grab mirror to show client the severity of the swelling of his face and neck and began explaining his illness. As the client was able to witness the swelling himself, RN started explaining the consequences of not seeking medical help immediately. CI agreed to go to the hospital. Lives are saved by our RNs in the field.”

Conclusion:

The 2015 APS-Nurse Survey illustrates the diverse utilization of nurses employed in social services nationally. Nurses are hired to work in social services across the United States for their unique assessment skills and trainings. While there was no consistency in the nurses’ educational background, level of practice or scope of work, one common finding was that nurses were being utilized to perform nursing assessment on complex medical cases and that nurses’ role varied from state to state. A higher percentage of nurses (67%) did not practice under a licensed nursing supervisor, and the majority (58%) did not have a medical or a nurse geriatric specialist that provided oversight on their practice policies and procedures. Additionally, 49% of nurses report receiving no formal APS-nurse orientation training, while 37% report receiving orientation training by Social Services.

The majority of nurses report that their role revolves around performing nursing assessment during home visits, medication reviews, consulting and teaching. Thirty three percent of the nurses are carrying a caseload and consulting, which include providing case management services, nursing treatments and hands-on skilled nursing services. Thirty-seven percent indicated that there were only 2 or 3 nurses

within their agency. It is hypothesized that the higher the ratio of APS social workers to nurses is the more likely it is that the nurse acts as a consultant. Nurses reported feeling isolated in their practice working for social services since they do not have the opportunity to interact and consult with peers. The nurses provided a list of duties and roles that they felt were outside their “normal scope of practice”.

As it pertains to cognitive assessment screening tools, the majority of nurses (35%) indicated that they did not use a specific tool. The most commonly used screening tool by the nurses was the Saint Luis University’s tool (SLUMS). Much consideration will be needed to determine best-practice and the efficacy of the cognitive assessments screening tools.

Future research consideration:

Future research will need to explore the APS-Nurses’ role, and address standardization of the practice. The National APS-Nurse Coalition monthly conference calls provides a great venue for the APS-Nurses to network, interact and share best practices with each other. Future research should also address the liability for the individual practicing nurse and social services, associated with employing a licensed registered nurse to practice without having a nursing supervisor. Moreover there is a need to ensure safe nursing practice by addressing what is “Normal Registered Nurse Scope of Practice”. We need to identify the specific types of nursing orientation, and the on-going trainings that a registered nurse needs to have when working for Adult Protective Services.

Recommendation:

The National Coalition of APS Nurses recommends having a registered nurse at each state level providing the oversight for all APS-nurses practice and scope of work. Additionally, we would like to see an advance practice RN at the national level providing policies and procedures addressing APS nursing practice and scope of work.

Limitations:

It is important to point out two significant limitations to the interpretation of the results of this survey. First, we were unable to get all states to participate therefore it is unclear whether this survey is an accurate portrait of APS nurses nationally. And, secondly, we still do not know how many nurses are actually working for/with Adult Protective Services.

Final Thoughts:

Nurses possess expertise and skills that make them great assets to work for Adult Protective Services in addressing the needs of abused elders and disabled adults. Nursing services in social services save lives, reduce recidivism, and provide cost-effective outcomes. To increase the efficacy of the APS-nurses’ role, nurses will need to fully understand their scope of work in relationship to their particular state nursing practice act. It is our hope that APS will begin to develop policies and procedures, standards of practice and outcome measurements regarding the significant impact of nurses in APS practice.

