Mediation in Long-Term Care Facilities: A Pilot Project

Diane Persson, PhD, and Carmen Castro, MS

Objective: To describe the development and implementation of a mediation model appropriate for long-term care facilities.

Methods: The recruitment and training of mediators; the role of the ombudsman; and approaches to educating facility staff, families, and residents are described. Disputes identified as suitable for mediation include care disputes, resident-to-resident issues, and family matters.

Results: Pilot project results indicate cases that reach mediation generally come to a mutual agreement that is upheld over time. Only a small number of cases referred for mediation are actually mediated. A main barrier to using mediation as an option is lack of knowledge of its availability and potential benefits. Intensive outreach within facilities is essential if residents, families, and staff are to recognize and refer cases.

Conclusion: Mediation must be considered broadly as an approach, not as a single process. Mediation can help to involve residents and families in constructive decision making that improves care, and could be a part of the overall dispute resolution system in long-term care. (J Am Med Dir Assoc 2008; 9: 332–336)

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There is a spectrum for resolving conflict in the long-term care (LTC) environment. At one end, solutions are imposed by an outside arbiter through litigation or arbitration. At the other end, solutions are designed by the parties themselves through negotiation or mediation. There are many common approaches to conflict: using a collaborative versus competitive approach; resolving conflict formally versus informally; and ignoring versus addressing conflict.\(^1\) Perhaps the most common response to conflict is to do nothing and hope that in time it will disappear. The purpose of this article is to describe the development and implementation of a mediation model as an option to resolving disputes in nursing and assisted living facilities.

Before describing the mediation pilot project, let us examine the 2 most recognized forms of alternative dispute resolution in health care settings: arbitration and mediation.\(^2\) In arbitration, a sole arbitrator or a panel of 3 listens to all sides of the case and render a decision, usually termed an award.\(^3\) An advantage to arbitration is that it attempts to address disputes as a less costly and time-consuming alternative to litigation. The use of arbitration, either mandatory or voluntary, is increasing in long-term care settings.\(^4,5\) However, the future of arbitration is uncertain given a recent Oklahoma Supreme Court ruling that the arbitration clause in nursing facility admission forms is not enforceable.\(^6\)

In contrast, mediation is a voluntary, nonbinding process in which all parties reach a negotiated agreement.\(^7\) Mediation is a facilitated, confidential, and voluntary negotiation whereby a third neutral party, the mediator, facilitates a process for disputing parties to reach a mutually satisfactory resolution.\(^8\) Mediation acknowledges that the responsibility for making decisions belongs to the parties involved in the conflict. The process is outlined in Table 1 and consists of several stages in which participants have an opportunity to express concerns, expectations, and goals.\(^7\)

Mediation has long been used in labor-management disputes and is gaining prominence as a process for the resolution of conflicts by health care professionals, institutional ethics committees, and claimants under the Americans with Disabilities Act.\(^9-14\) In the aging network, mediation is used by the elderly in conflicts related to housing, consumer, and neighbor disputes;\(^15\) by professionals and families as an alternative to adult guardianship;\(^16\) and by Medicare beneficiaries as an option to resolve quality of care complaints.\(^17\) Mediation has also been suggested as an approach for the promotion of sexual rights for nursing facility residents with cognitive impairments.\(^18\) The advantages of mediation in LTC settings are that it can be quick, flexible, inexpensive, and empowering. However, the informality of mediation can be a disadvantage for disenfranchised groups such as the elderly in that it is not open to public scrutiny, and it may hinder reform.\(^1\)

Mediation in LTC settings has received little attention, in part due to the setting of nursing and assisted living facilities,
Stage 1 – Introduction and Opening Statements
- Mediator makes introductions, describes the process, and sets out ground rules for the mediation.
- Participants make an uninterrupted presentation of their views of the case or dispute; ventilation of emotions may occur.

Stage 2 – Gathering Information and Exploring the Issues
- Mediator asks open-ended questions to get a clear and complete picture of the dispute.
- Mediator may call for private meetings (caucuses) to explore issues more fully, thereby reducing participant’s vulnerability.

Stage 3 – Generating Options and Negotiating
- Participants are assisted by mediator to explore options and common areas of interest.
- Mediator may engage in reality testing by checking out with each side the realistic possibility of attaining what they are hoping for.
- Mediator assists the parties in the give and take part of mediation to reach an agreement.

Stage 4 – Agreement and Closure
- If an agreement is reached, the mediator will restate the agreement and draft an agreement or memorandum of settlement.
- If no agreement is reached, the mediator will restate where the parties are, noting any progress made in the process.
- Mediator thanks parties for their participation in the process.

Identifying Cases for Mediation
A significant amount of time was spent identifying cases suitable for mediation. The project excludes staff-to-staff conflicts, abuse allegations that are more appropriately referred to Regulatory Services or Adult Protective Services, conflicts concerning life-sustaining treatment, and any issue currently under arbitration or part of a legal dispute. The project is designed to mediate care disputes, resident-to-resident issues, and family concerns. Care disputes may include dietary, medication, and rehabilitation issues; access to physicians; use of restraints; transfer and discharge; bathing; and the development and implementation of care plans. For example, in one care dispute a family member was concerned that her mother and aunt were not being toileted as needed. In another, the family council stated the administrator did not have sufficient staff as evidenced by unanswered call lights. Resident-to-resident issues include areas such as roommate disputes, accommodation of personal preferences in congregate living arrangements, and inappropriate sexual behavior. A variety of family matters such as expectations regarding care and problematic communication with any responsible party may be referred for mediation.
Since mediation is premised on the notion that the disputing parties understand the issue and the process for resolution, can parties with dementia participate and how is the capacity to mediate determined? For this project, capacity for the purposes of resident rights issues is not global but decision specific. Capacity is not a criterion for mediation but is always a factor in the mediation process. The determination of resident capacity was made by the project coordinator after consultation with family and facility staff, an interview with the resident, and a review of the medical record. If it is not possible to include the resident in the mediation process, it may be possible to include the resident’s preferences through family members, staff, and volunteers. Other types of support or accommodations might include modifying the location and scheduling of the session, having shorter sessions, allowing frequent breaks, and using caucuses and special communication techniques such as paraphrasing, simplifying technical language, repetition, illustrations, or step-by-step explanations. The question is less “can the party mediate” but “can the party mediate with support?”

### Education and Outreach

The project uses co-mediation, which pairs 2 mediators to serve as facilitators. A volunteer community mediator is partnered with another community mediator or a volunteer ombudsman who is not associated with the facility in which the dispute is taking place. Twenty-five experienced community mediators with a background mediating complex family matters with the Dispute Resolution Center had additional 1-day training in resident rights and regulatory issues and 1-day advanced elder mediation training. Ombudsman mediators are volunteers who completed the 40-hour basic mediation training required for state certification as well as advanced 1-day training in elder mediation. Ten volunteer ombudsman completed training and became long-term care mediators.

The long-term care ombudsman has been a catalyst for this project. While ombudsmen primarily act as advocates for residents, their role as visitors in facilities and mediators in conflict is recognized as essential to this program. The ombudsman role is multifaceted: ombudsmen refer issues to mediation that they are unable to resolve; they educate residents and families about the mediation option; and, at the resident’s request, they attend the mediation session. Ombudsmen do not mediate issues arising in their assigned facility and because of their varied roles in the mediation process, they must clearly separate their roles of investigation and advocacy from that of mediation.22

A part-time coordinator is integral to the project. This individual handles the intake process for each referral, identifies and contacts the necessary participants, explains how mediation works, and makes the arrangements regarding scheduling location and volunteer mediators. The role of the coordinator also includes determining the appropriateness of the problem, dispute, or issue for mediation and the resident’s ability to participate in mediation. The coordinator provides presentations for facility staff and family councils on mediation, and conducts a follow-up of mediated cases. The project has had 2 coordinators: the first person was a lawyer and the current individual is a health educator. Coordinators have a background in mediation and are also staff ombudsmen.

Initial outreach included in-service presentations on mediation to facility staff. The presentation, about an hour in length, provided an overview of mediation, examples of the types of cases suitable for mediation, and a general discussion on mechanisms of dispute resolution in facilities. This training was provided at all pilot sites and participants included department heads and direct-care staff. In addition, a brochure was developed and a Web site created. Direct mailings were sent annually to all pilot-site residents, families, medical directors, and nurse practitioners and the program was presented at resident and family council meetings. An educational video/DVD is now part of training and a listserv provides regular updates. Given the turnover rate in pilot facilities, comparable to the state average of 86% for nursing assistants, ongoing staff education is essential.23

### RESULTS

In this pilot program, most mediated disputes have dealt with issues related to resident care. Other cases focus on resident-to-resident disputes, family issues, or a combination of care and family concerns. One noticeable characteristic of the referrals is that disputes referred by the facility staff regarding resident or family behavior tend to actually be about dissatisfaction on the part of the family member or resident with regard to care provided by the facility.

Since the pilot project was launched 3 years ago, 44 conflicts have been referred for mediation. The mediation framework and results are shown in Figure 1. Referrals came primarily from facility staff, ombudsmen, and family members including a family council. No clear differences were noted among the facilities making referrals to the program although most were Medicaid certified. Seven of the 10 pilot facilities made a referral, with 1 accounting for 7 (16%) of all referrals. While 44 cases were referred for mediation, only 12 (27%) were actually mediated. An unexpected result was the number of referred cases that resolved without mediation. From the period between referral and intake, 43% were resolved by more traditional means of increasing communication and ombudsman intervention. Follow-up for mediated cases conducted at 3- and 6-month intervals reveals that of the 10 disputes reaching agreement, 8 were upheld and in 2 cases the resident had died.

Considerable effort was spent in the pilot development stage addressing the capacity of residents to participate. Of the 12 mediated cases, 3 residents were unable to participate and had surrogates (primarily family members) representing them. Those residents who had the capacity to participate were assisted by the ombudsman for their facility or they had family who could support them. Capacity was not an issue in the majority of referrals resolved without mediation or in cases where not all parties agreed to participate. It may be that capacity was less of an issue than originally thought since most of the disputes were between family and staff or between family members.

A formative evaluation conducted by area local law students made several observations. First, most cases referred to
Mediation were referred by facility staff or ombudsmen. It is suggested that the lack of referrals from residents could be based on several issues including fear of retaliation, a lack of understanding about mediation, or simply a lack of knowing the program is available. A second observation is that few family members know about the mediation option and information sent to families needs to be periodically repeated. Since less than half of all nursing facilities, including those in the pilot, have active family councils, education needs to be broad-based from information in admission packages to flyers posted in the facility. A third observation is that specific staff administrators and social workers should be selected as the go-to people for issues that may be appropriate for mediation. Initial efforts of introducing mediation at staff inservices were not especially effective, and given the high rate of turnover among direct-care staff, a more selective approach may be productive. A final observation is that increasing state regulatory service awareness of the program could serve as a source of referrals.

The results of this project are supported by other studies. One of the lessons learned by Karp and Wood was that while mediation can work, if you build it they might not come. In spite of early and broad outreach, the number of referrals has not been great and only about 1 in 4 referred cases is actually mediated. While mediation is successful when used, getting people to use it remains a challenge.

CONCLUSION

This pilot project identified several challenges to mediation in LTC facilities. One is the culture of institutional care, where conflicts occur among all the primary constituents: staff, residents, and families. Some of these are expressed and dealt with, others may fester for a variety of reasons including fear, justified or not, of retaliation. Another is the conflict resolution culture of LTC facilities and the need to see mediation as supplementing, not supplanting, the ways disputes are traditionally resolved. While this project had a large number of referred cases that were resolved without medi-
tion, it may be that the approach of mediation facilitates resolution. A third challenge is to support residents who are on an uneven playing field to ensure greater accessibility. Finally, intensifying outreach within facilities is essential if residents, families, and staff are to recognize and refer cases, as is outreach beyond facilities, for example regulators, provider associations, and community groups.

Providers have a role to play including education and involvement in the quality assurance process. The role of the physician, including the medical director, is vital as nursing staff carry out physician’s orders in attending to resident needs. As such, medical directors can potentially play an important role in addressing and resolving disputes through mediation. There are several ways in which physicians can work with staff, residents, and their family members to resolve disputes. Medical directors can ensure facility policies and procedures allow for various approaches to dispute resolution including mediation. Second, they can work with staff to identify issues that are frequent sources of disputes and develop practices that target these concerns, such as nonpharmacological behavior management for cognitively impaired residents. Third, medical directors can encourage staff to work with family members to engage in constructive decision making that improves the care of residents. Another role for the medical director is to identify and refer family situations that may benefit from mediation, such as concerns about falls, weight loss, and staffing issues. Finally, the medical director is in a unique position to motivate noncompliant residents and family members to comply with care instructions.

Mediation is one aspect on the continuum of dispute resolution. In order to have a healthy future in long-term care, mediation must be considered broadly as an approach, not as a single process with specific techniques. While the hope for systemic impact is a more elusive goal, this project offers evidence that mediation can open the door to new ways of thinking about how to make LTC facilities more cooperative places both for the residents and the staff who care for them.

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REFERENCES