Earn 4.8 Contact Hours

ABSTRACT

Elder abuse and neglect is a critical health care issue that must be brought to the attention of health care providers and older adults' family members. Adults older than 65 who live at home or in long-term care facilities may be at risk for abuse. Nurses should be aware of the causes, screening questions, symptoms of abuse, and resources in the community. Armed with information and a better understanding about the issue, nurses can minimize the devastating effects of abuse on older adults and their families.

Elder Abuse and Neglect

Every man, woman, and child deserves to be treated with respect and caring. Individuals of all ages deserve to be protected from harm by caregivers (American Psychological Association, 2006). Significant policy developments during the past 20 years have focused on eliminating abuse. However, a deficit in health care providers' knowledge and clinical skill application remains. The purpose of this article is to define and describe the kinds of abuse, their potential clinical presentations, and theoretical explanations for abuse to enhance nurses' knowledge and understanding of their role in its assessment and management in older adults.

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TABLE 1

KINDS OF ELDER ABUSE AND THEIR DEFINITIONS

Kind of Abuse	*Definition*
Physical	Use of force that causes unnecessary pain or injury, even if the reason is to help, can be regarded as abusive behavior. Physical abuse can include deliberate or inadvertent hitting, beating, pushing, kicking, pinching, burning, biting, overmedicating, undermedicating, or force-feeding; improper use of physical or chemical restraints; and exposure to severe weather.
Emotional or psychological	Behavior that causes an older adult to have fear, mental anguish, or emotional pain or distress can be considered abusive. This kind of abuse can include name-calling, intimidation, insults, and threats; treating the older adult like a child; and isolating the older adult from family, friends, and social contact by force, threats, or manipulation.
Neglect	Neglect can range from withholding appropriate attention from the individual to intentionally failing to meet the older adults' physical, social, or emotional needs. It can include failure to provide food, water, clothing, medication, or assistance with activities of daily living or personal hygiene. In addition, failure to manage older adults' money responsibly and withholding necessary health care can be considered neglect.
Sexual	Any nonconsensual intimate contact, such as inappropriate touching, photographing the individual in suggestive poses, forcing the individual to look at pornography, forcing sexual contact with a third party, or any unwanted sexual behavior can be considered sexual abuse. This kind of abuse may also include acts such as sexual exhibition, rape, sodomy, or coerced nudity. Sexual abuse is not often reported as a kind of elder abuse.
Financial	Financial exploitation includes fraud, taking money under false pretenses, forgery, forced property transfers, purchasing expensive items without permission, or denying older adults access to their own funds or home. It includes the improper use of legal guardianship arrangements, powers of attorney, or conservatorships, as well as a variety of scams by salespeople, health-related services, mortgage companies, or friends.

Adapted from Kleinschmidt (1997).

BACKGROUND

Abuse is defined as the infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain, or mental anguish (**Table 1**). It can also be the willful deprivation by a caregiver of goods or services that are necessary to maintain physical or mental health (American Psychological Association, 2006). Elder abuse and neglect has plagued society for centuries but only recently has the issue come to the attention of health care providers, law enforcement agencies, and protective services. Fewer research studies exist about the maltreatment of older adults than about other forms of family violence, including child abuse, rape, and intimate partner violence. The earliest reports of elder abuse and neglect in the United Kingdom in the 1970s dramatized case reports of the phenomenon, termed "Granny battering." The health care community and the public were shocked and appalled. A decade later, studies confirmed that the problem was common in the United States as well.

In the late 1970s, the U.S. Senate Special Committee on Aging issued a series of reports on abuse and neglect occurring in nursing homes. In 1981, the U.S. House of Representatives Select Committee on Aging conducted hearings in which victimized older adults gave firsthand testimony of their experiences with abuse. In 1986, the Institute of Medicine published recommendations for preventing the maltreatment of older adults in institutions, and several years later, the Elder Abuse Task Force was created by the Secretary of the U.S. Department of Health and Human Services. The task force developed an action plan for the identification and prevention of maltreatment of older adults in their own homes, health care facilities, and communities. The action plan included data collection, research, technical assistance, training, and public education. The National Center on Elder Abuse was established as part of the Administration on Aging's Elder Care Campaign. Adult Protective Services

programs now exist in every state to serve vulnerable adults, particularly older adults, who may be at risk for abuse and neglect. Many law enforcement agencies and Offices of the District Attorney have investigative staff specifically trained to address abuse of older adults and other vulnerable populations, in collaboration with health care and protective service professionals.

Such actions have led to increased public and health care provider awareness about elder abuse and neglect. Researchers have also sought to grasp the full scope and causes of maltreatment among older adults. Laws that require health care providers to report suspected cases have been instituted in nearly every state. The Joint Commission on Accreditation of Healthcare Organizations' (2006) standards for emergency departments and ambulatory care centers call for improved identification and management of elder abuse, in addition to intimate partner violence and child abuse.

As the U.S. population ages, demands placed on health care systems to care for older adults are increasing. More than 36 million people who live in the United States are older than age 65, and 600,000 older adults will require assisted living (U.S. Department of Health and Human Services, Administration on Aging, 2006). Currently, there are approximately 17,000 nursing homes in the United States, with 1.6 million residents (U.S. Department of Health and Human Services, Administration on Aging, 2004). Unfortunately, older adults are becoming victims of intentional abuse and neglect within their own homes, as well as in assisted living and long-term care facilities.

Each year in the United States, 1 to 2 million adults older than age 65 are injured, exploited, or mistreated by their caregivers (National Research Council Panel to Review Risk and Prevalence of Elder Abuse and Neglect, 2003). One community-based, cross-sectional survey reported that 32 of every 1,000 older adults reported that they had experienced some form of maltreatment at least once since reaching age 65 (Pillemer & Finkelhor, 1988). Underreporting is typical with all kinds of abuse, and it is estimated that only 1 in 14 elder maltreatment cases are reported. Health care providers can expect to see a steady increase in the number of cases of elder maltreatment as the older adult population rapidly increases.

THEORIES OF ELDER ABUSE

Elder abuse is a complex problem with multiple risks and causes. Dysfunctional family lives, cultural issues, and caregiver inadequacies have been implicated as contributing factors. Awareness of such factors may help nurses understand and anticipate situations where maltreatment may be preventable.

Several theories attempt to explain the existence and increasing occurrence of elder abuse. The transgenerational, or social learning, theory asserts that violence is a learned behavior. Individuals who have witnessed or been victims of family violence are more likely to try to resolve challenging and difficult life situations with violent tactics they learned in their formative growth. Although 90% of perpetrators of elder abuse are reported to be family members, this cannot account for all cases (Fulmer, Guadagno, Bitondo, Dyer, & Connolly, 2004).

Situational theory supports the idea that the greater the burden on caregivers, the more likely caregivers are to abuse. Exchange theory addresses the dependence of older adults on their caregivers as a risk of abuse, along with inadequate methods of problem solving as an established pattern of family behavior. Political economic theory addresses the changing roles of older adults. Their loss of independence and income may cause them to look to others for care and support (Fulmer et al., 2004).

Psychopathology of the caregiver theory studies caregivers with severe emotional or mental health problems or addictions that put the older adults for whom they care at risk of being abused. For example, a caregiver with a mental health problem who cares for a frail older adult with cognitive impairment is a dangerous combination and may lead to resistant behavior and maltreatment. Although theoretical frameworks cannot explain all cases of elder maltreatment, they can provide a foundation for nurses to begin to understand the combination of factors responsible for the occurrence of elder abuse and initiate a holistic plan of care.

NURSING ASSESSMENT & INTERVENTIONS

Nurses are in an ideal position to play a significant role in the detection, management, and prevention of elder maltreatment and may be the only individuals outside of the family who have regular contact with an older adult. Nurses are uniquely qualified to perform physical and psychological assessments, order confirmatory diagnostic tests (e.g., blood tests, x-rays), and collaborate with physicians and protective services. They may authorize services, such as home health care, or recommend hospital admission as they initiate further investigation by the appropriate local agencies.

Opportunities for abuse detection and intervention occur

TABLE 2

SIGNS AND SYMPTOMS OF ELDER ABUSE

Kind of Abuse	*Sign or Symptom*
Physical	• Bruises or grip marks around the arms or neck • Rope marks or welts on the wrists or ankles • Repeated unexplained injuries • Dismissive attitude or statements about injuries • Refusal to go to the same emergency department for repeated injuries
Emotional or psychological	• Uncommunicative and unresponsive attitude • Unreasonably fearful or suspicious behavior • Lack of interest in social contacts • Chronic physical or psychiatric health problems • Evasiveness
Sexual	• Unexplained vaginal or anal bleeding • Torn or bloody underwear • Bruised breasts • Venereal diseases or vaginal infections
Financial	• Life circumstances that do not match the size of the estate • Large withdrawals from bank accounts, switching accounts, or unusual automated teller machine activity • Signatures on checks that do not match the older adult's signature
Neglect	• Sunken eyes or loss of weight • Extreme thirst • Bed sores

daily in health care settings. In institutional settings, nurses may monitor patient health and perform health history interviews and physical, psychological, sexual, and financial abuse assessments that may be crucial to elicit reports, expose or prevent abuse, and intervene for patients' safety (Wieland, 2000). Nurses and other health care providers are part of an interprofessional team collaborating to ensure appropriate, sensitive, and safe outcomes for older adult patients.

Institutional maltreatment occurs in long-term care facilities, board-and-care homes, and other assisted-living facilities. Institutional medical directors, private practitioners, nurses, and all health care workers in daily contact with older adults have a responsibility to identify, treat, and prevent abuse.

Abuse may be perpetrated by a staff member, another patient, an intruder or a visitor, or a family caregiver. Abuse may include failure to implement a plan of care or provide treatment, unauthorized use of physical or chemical restraints, and use of medication or isolation for punishment or staff convenience. Nurses must be aware of patient diagnoses, medical orders for care, and medications and their side effects to recognize what is suspicious and needs further evaluation or warrants a report to supervisors. However, most elder maltreatment does not occur in institutions but in the home at the hands of a caregiver, often a family member.

Unless nurses are educated about abuse and how to observe suspicious injuries, elder abuse may be difficult to detect. Definitions of the kinds of abuse and their signs and symptoms should be included in the training and education of family members and health care workers who care for older adults. Older adults experiencing abuse may be unable to communicate clearly, their bruises may be attributed to the aging process, or they may be fearful and hesitant to report abuse (Wieland, 2000). Indications of physical abuse should signal health care providers to evaluate for other kinds of abuse, such as sexual abuse.

In addition to inadequate information, training, and the caregiver's experience of caring for older adults, older adults are at risk for maltreatment due to other vulnerabilities. Older adult residents in institutions are typically dependent and chronically ill and may have cognitive, visual, and auditory impairments. They are usually more frail than are younger patients and may not have regular visitors who monitor their mental status, physical condition, or health care. In older adults, each vulnerability increases their mortality risk (Fulmer et al., 2004).

Co-existing conditions and medical diagnoses may lead to worse outcomes for older adults who are abused. They may have a decreased ability to heal after injury and may experience greater trauma from physical injuries than do younger people. Their bones are more brittle and tissue more easily bruised, abraded, and lacerated with minimal trauma. Injured older adults differ from the younger population in terms of cause of injury, physical and psychological responses to abuse and injury, and outcomes.

Dementia is common in 50% of residents of long-term care facilities (National Center for Health Statistics, 1985), and cognitive impairments often cause older adults to behave in a more resistant manner toward caregivers. Impaired cognition, along with insufficient resources, staff shortages, high staff turnover, and inadequate supervision and training, may increase the risk of elder maltreatment. In addition, societal ignorance about required standards for quality care and victimized older adults' acceptance of abusive or neglectful behavior can lead to exacerbation of elder abuse in institutions.

Routine questions related to elder abuse and neglect can be incorporated into daily nursing practice. Diminished cognitive capacity does not necessarily negate older adults' ability to describe maltreatment. It is always reasonable for nurses to ask about abuse or neglect. A brief mental status examination can be helpful in evaluating patients' cognitive status.

Assessment for elder abuse should include caregiver, as well as victim, evaluation. Nurses should conduct interviews and examinations with the patient first, in a private setting separate from the caregiver.

Clinical settings should have a protocol for the detection and assessment of elder maltreatment. Protocols should consist of a narrative, checklist, or standardized forms that enable rapid screening for elder abuse and provide guidelines for sound documentation that may help disclose patterns of abuse over time and will withstand scrutiny in court. Basic demographic questions should be included and should allow the interviewer to determine the family composition and socioeconomic status. Interviews should proceed from general questions that assess the patient's sense of well-being to those focusing on specific kinds of abuse. Common signs and symptoms of maltreatment should be evaluated (**Table 2**).

Elder abuse screening instruments are summarized by Fulmer et al. (2004). Questions recommended by Wieland (2000) for general abuse screening and assessment include:

No matter how minor or severe the abuse, nurses have a duty to assess elderly patients according to recommended protocols and report suspected abuse to designated authorities.

- Do you feel safe where you are living?
- Who is responsible for your care?
- Do you often disagree with your caregiver(s)? If so, what happens?
- Does anyone scold or shout at you, slap or hit you, or leave you alone and make you wait for care or food?

After general screening questions, more specific questions about kinds of abuse may follow:

- Has anyone ever touched you without your consent?
- Has anyone ever made you do things you did not want to do?
- Has anyone ever taken something that was yours without asking?
- Have you ever signed any documents that you did not understand?

Health care providers do not have to prove that elder maltreatment has occurred. They need to screen and document suspicious verbal and physical findings, which may be as simple as stating that the patient seems to have health or personal problems and needs assistance. Sound documentation may include drawings of injuries on body diagrams or photographs to support written reports. Suspicious claims for abuse and neglect may be difficult to quantify. Diagnosis of elder maltreatment depends on education about abuse and application of that knowledge by the multidisciplinary team of health care providers, law enforcement agencies, advocates, and patients. Protocols for elder abuse screening, assessment of risk factors, and documentation should be posted in all health care facilities.

ABUSE AND THE LAW

National standards for care in nursing homes are based on the Nursing Home Reform Act of 1987. The law is part of the Consolidated Omnibus Budget Reconciliation Act of 1987, often referred to as OBRA 87. The intent of the law is to promote high-quality care and prevent substandard care. The law also seeks to ensure that the rights of nursing home residents are respected. These include:

KEY POINTS

1. Abuse is defined as the infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain, or mental anguish. It can also be the willful deprivation by a caregiver of needed goods or services.
2. Ninety percent of perpetrators in reported elder abuse cases are family members.
3. Nurses can effectively intervene with accurate assessments and documentation of findings prior to reporting suspicious findings.

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- The right of protection against Medicaid discrimination.
- The right to participate in health care decisions and to give or withhold informed consent for particular interventions.
- The right to safeguards to reduce inappropriate use of physical and chemical restraints.
- The right for provisions to ensure proper transfers or discharges.
- The right to full access to a personal physician, long-term care ombudsman, and other advocates.
- The right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion.
- The right to be free from physical restraints or psychoactive drugs administered for the purpose of discipline or convenience.

Nearly all states have mandatory reporting laws that require health care professionals and paraprofessionals to report suspected elder abuse and neglect to a designated authority. Some state laws specify that after authorities have been alerted to suspected elder abuse or neglect, an agent of the state must make an onsite investigation in an attempt to corroborate the report. Uniform reporting systems are established, and cases are assigned and investigated by protective services in a timely fashion. Cases are assigned and investigated by protective services in a timely fashion. Nurses may play an important role in preventing and identifying elder abuse, as well as in the subsequent investigation.

CONCLUSION

Elder abuse is a significant problem in the United States and often goes unreported and unrecognized. Elder abuse may be physical, emotional, psychological, sexual, or financial. Immediate care, overnight housing, and care in a safe location, in addition to long-term care and home-delivered food, may be necessary. Elder abuse may be a minor issue that can be easily resolved or it can result in severe and life-threatening debilitation.

The more knowledge health care providers have, the more likely they are to institute strategies for abuse prevention and management. No matter how minor or severe the abuse, nurses have a duty to assess elderly patients according to recommended protocols and report suspected abuse to designated authorities. The multidisciplinary team then works together to help resolve the issue. The application of knowledge about elder abuse includes screening, assessment, and sound documentation in an attempt to enhance the quality of life and maximize the functional ability of older adults.

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