Elder Mistreatment: Self-Learning Module

The Geriatric Resource Nurse Model is used at the University of Virginia to improve the competency of staff in caring for older adults. Eight self-learning educational modules were developed to address common concerns in hospitalized elders. The Elder Mistreatment: Geriatric Self-Learning Module is published here, along with a post-test. This is the fourth in a four-part publication of self-learning modules.

The Geriatric Resource Nurses at the University of Virginia developed the Self-Learning Modules in Geriatric Care. The SPPICEES pneumonic addresses the eight distinct modules, each targeting a commonly encountered area of health concern of older adults across health care settings. These include:

- S: Sleep
- P: Problems with eating and nutrition
- P: Pain
- I: Immobility
- C: Confusion
- E: Elimination
- E: Elder mistreatment
- S: Skin

The modules were designed using a case study approach in order to encourage the learner to gain new knowledge as well as apply this knowledge. Each module includes two case studies, one applicable to the care of an older adult in the inpatient setting and the other applicable to an older adult in the outpatient setting. Each module will take approximately 20 to 30 minutes to complete.

The completion of these self-study modules alone does not ensure the staff member is age-specific competent; this is determined through the observation and demonstration of behaviors while working directly with older adults. However, these modules will enhance the staff member’s knowledge as a foundational step in developing competent behaviors.

Purpose

The purpose of this module is to provide age-specific educational information related to elder abuse for the patient care staff.

Target Audience

This self-study module was developed for use by a target audience of health care professionals who care for inpatient and outpatient older adults.

Objectives

At the end of the module the clinician will be able to:
1. Define and explain the dynamics of elder mistreatment.
2. Discuss the clinician’s responsibility in regard to assessing, intervening, and reporting suspected mistreatment.

Overview

Elder mistreatment is the most recent domestic violence issue to gain the attention of the public and the medical community. Elder abuse was first described in 1975. A 5-year review of the literature revealed 26 articles on elder abuse, compared to 248 articles on child abuse. A random survey of emergency departments showed that 27% had protocols for elder abuse and 75% had protocols for child abuse. Older adults use emergency medical services at twice the rate of other age groups. The geriatric population is the fastest growing age group in the United States, composing 13% of the population in 1990; older adults are expected to reach 18% of the population in 2020, and 25% in 2050. The population of people older than 85 years will more than double during the same time. With a decline in the population under 18, in the year 2020 older adults will outnumber children.

Inpatient Case Study

Mrs. M. is an 80-year-old widow with arthritis and CHF who lives in the home she and her husband bought 50 years ago. Her granddaughter moved in with her after her parents died. A few months later, a neighbor came to visit and noticed there was little food and no medications in the house, and that Mrs. M. was very short of breath. The neighbor was concerned and called the ambulance. In the hospital, the granddaughter was very cold and demanding of all, and would not come to a discharge planning meeting. Mrs. M. was presented with the option of returning home with home health care, have the granddaughter move out and get someone to live with her, or sell her home and move to assisted living. She decided to return home with home health assistance.

• How would you discuss the situation with Mrs. M. before discharge?
• What observations will the home health nurse make?
• What activity would she report and to whom would she report it?
• What factors would make Mrs. M. cover up abuse/neglect?
• What can be done to help make the situation more workable for all?

Outpatient Case Study

Mrs. R. is an 80-year-old woman who moved in with her sister, Mrs. L., because of Mrs. R.’s problems with diabetes and memory. Mrs. L. requests medication for Mrs. R. “to make her sleep at night and control her kidneys.” Mrs. R. appears disheveled and smells of urine. Her gait appears unsteady. Her weight is 130 pounds, a 30 pound weight loss since the last visit. Mrs. R. complains about being left alone for long periods of time, and Mrs. L. interrupts and claims that Mrs. R. is very demanding and needs constant attention.

• What aspects of this case cause suspicion of mistreatment?
• How would you assess this situation further?
• What actions would you take?

Definitions

There are seven generally accepted categories of elder mistreatment:

1. Physical abuse includes hitting, grabbing, slapping, pushing, or causing bodily injury. This definition also can include sexual abuse.
2. Psychologic or emotional abuse includes verbal or non-
verbal insults, humiliation, infantilization, or threats (for example, to institutionalize or abandon the patient).

3. **Financial or material abuse** includes theft (social security checks, pensions), misappropriation of funds, and coercion (changing a will or deed).

4. **Neglect** is the failure of a caregiver to provide basic care to a patient, typically involving assistance with the activities of daily living (ADLs). **Active neglect** is willful failure to provide care, and **passive neglect** is the nonwillful failure due to caregiver’s ignorance or lack of skills.

5. **Self-neglect** is conduct by a patient that threatens his or her own health or safety. Competent older adults who have difficulty performing ADLs may refuse assistance despite the resulting problems. Such a situation presents health care providers with the ethical dilemma of patient autonomy versus beneficence.

6. **Sexual abuse** is nonconsensual intimate contact. Some definitions include this under the elder abuse category of “exploitation.” Older people are at risk because they may be too weak to resist advances, reside in poorly supervised institutions, and may not recognize or report the abuse as a result of cognitive deficits.

7. The **Other** category encompasses all other types, including a violation of rights in decision making and abandonment.

### Prevalence

It is very difficult to get an actual picture of the prevalence of elder abuse because of the differences in definitions used, methods used for reporting, inadequate data systems, and the fact that much abuse is not reported. A survey showed that only 1 case in 14 is actually reported to authorities. It is estimated that 1 to 2 million older adults are abused each year (see Figure 1 & Table 1).

The National Center for Elder Abuse reported the following about older adult victims of abuse in 1996:

- Median age: 77.9 years
- Race: 66.4% white, 18.7% black, 10.4% Hispanic
- Sex of victims: 67.3% female
- Sex of perpetrators: 48.9% female
- Relationship of perpetrator to victim: 36.7% adult children, 10.8% other family, 12.6% spouse

### Recognition of Possible Abuse (see Table 2)

- Acknowledge the possibility of abuse.
- Build trusting relationship with older adults.
- Ensure privacy/confidentiality during interview.
- Remember cultural influences on caregiver roles and responsibilities that may cause conflicts between the generations.
- Routinely ask, “Has anyone at home ever hurt you, scolded
or threatened? Are you alone frequently? Are you afraid of anyone?”

Ethics and the Law

All states have statutes or adult protective service laws addressing elder abuse. Mandatory reporting of elder abuse raises ethical concerns about infringing on competent adults’ autonomy and privacy, and it may discourage patients from seeking care because they may fear investigations and possible institutionalization. An ethical dilemma may arise when a victim who is competent to make a decision exercises the right to refuse intervention. If there is no evidence of coercion, the victim has the right to decide to stay in an abusive situation.

Mandatory Reporting

The goals of interventions are to stop the abuse of older adults and hold the perpetrators accountable. An important consideration is if the elder is in immediate danger. What can be done now to increase safety? What are the barriers to and resources for intervening? The law requires that clinicians report cases of elder abuse. This can be done by calling the police if there is immediate danger; contacting local Adult Protective Services to alert them to investigate; calling the appropriate hospital social worker to report the problem and manage the case; and/or calling the elder abuse hotline or long-term-care ombudsman listed in the front of the telephone book for advice and assistance. A written report should include careful observation of the patient and caregiver, interactions between them, and a detailed history of both a typical day as well as instances of possible abuse, neglect, or exploitation. This provides accurate, complete documentation of the situation (see Figure 2).

In Virginia, the following are required to report suspected abuse, neglect, and/or exploitation of adults over 60, and adults who are over 18 and incapacitated:

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**Elder Mistreatment: Geriatric Self-Learning Module Post-Test**

1. All of the following statements about elder abuse are true except a. People who abuse others often were abused themselves. b. Substance abuse is associated with elder abuse. c. Most elderly victims know their abuser. d. Child abuse is reported less than elder abuse.

2. Definitions of abuse include: a. physical and psychological abuse and neglect. b. financial abuse. c. self-neglect. d. all of the above.

3. All of the following statements about elder abuse are true except a. Elder abuse is seldom reported by the victim. b. Bruises on the arms usually indicate abuse. c. Neglect is the most frequent type of abuse seen. d. Abuse tends to escalate over time.

4. The only true statement about mistreatment of older men and women is: a. it occurs across all socioeconomic, racial, and religious lines. b. it occurs only in homes where the income is below the poverty line. c. clinicians do not have to be aware of their responsibilities to report. d. it occurs only in home settings.

5. Clinician preventive interventions include all except a. Educating professionals and the general public about potential abuse. b. Helping families develop and nurture support systems. c. Informing families of possible resources. d. Not reporting suspected cases of abuse because of fear.

**Post-Test Answers**

1. d
2. d
3. b
4. a
5. d
• Any person licensed to practice medicine.
• Any person employed in the nursing profession.
• Any person employed by a public or private agency/facility working with adults.
• Any person providing care to adults for pay on a regular basis.
• Any person employed as a social worker or mental health professional.
• Any law enforcement officer in his professional or official capacity.
• Any person required to file a report and found guilty of failure to do so shall be fined.

Report-Receiving Agencies

State laws addressing elder abuse designate various agencies to receive and to investigate reports of elder abuse, neglect, and exploitation. In 1996, there were 67 state laws (of a possible 71 laws) that designated report-receiving agencies: state human service agencies; local adult protective service (APS); social service agencies; law enforcement agencies; local police departments; and sheriff’s offices. In Virginia, a report should be made immediately to the city or county Department of Social Services where the incident is believed to have occurred.

Prevention

Abuse may occur because of psychopathologic and learned behavior factors of the victim and caregivers as well as an accumulation of stress. Preventive interventions include:
• Educating professionals about potentially abusive situations.
• Educating the public about normal aging processes.
• Helping families develop and nurture informal support systems.
• Linking families with support groups.
• Teaching families stress-management techniques.
• Arranging comprehensive care resources.
• Providing counseling for troubled families.
• Encouraging the use of respite care and day care.
• Informing families about resources for meals, transportation, in-home care.
• Utilizing the long-term-care ombudsman program to address quality of life issues in long-term care.
• Encouraging caregivers to pursue individual interest for self-care.

Conclusion

The two case studies have provided the framework for understanding problems related to mistreatment of older adults. Elder mistreatment is overlooked frequently but exists in many forms: physical, emotional, financial, and sexual abuse; neglect; and self-neglect. As many as 2.5 million older people are abused each year, and the number of cases will likely increase as this population grows. Clinicians must be alert to signs of abuse and neglect of an elder and report known cases to appropriate agencies as required by law.

Resources

Elder Mistreatment
National Center on Elder Abuse (202-898-2586) www.elderabusecenter.org

General Aging