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journal homepage: [www.gnjournal.com](http://www.gnjournal.com)

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## Elder abuse

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## Introduction

Elder abuse or mistreatment includes physical, emotional, sexual abuse as well as financial exploitation, neglect and abandonment.<sup>1,2</sup> According to the National Center on Elder Abuse (NCEA), it is “an intentional act or failure to act by a caregiver or another person in a trust relationship involving an expectation of trust”.<sup>1</sup> The abuser can be family, friends, as well as staff at nursing homes, assisted living facilities and home health care agencies. Elder abuse is a worldwide public health problem.<sup>3</sup> In the United States, 1 in 10 older adults experience some form of elder abuse with estimates as high as 5 million older adults abused annually.<sup>1–3</sup> Elder abuse is associated with greater risk of death, even after adjusting for a number of potential confounders. Importantly, we know that elder abuse predicts higher rates of hospitalization, readmission to hospitals, emergency department visits, nursing home placement and hospice.<sup>4,5</sup> Thus, acute care nurses are in a pivotal role to assess, identify and report suspected cases of elder abuse or mistreatment.

## Barriers to identifying elder abuse or mistreatment

Despite the number and consequences of elder abuse, only 4% to 7% of the cases are reported.<sup>3,4</sup> Identifying elder abuse and mistreatment is complex and there are a number of barriers involving the older adult, the health care provider and the health care organization.

Older adults are often reluctant to report abuse due to fear of retaliation and further abuse, rejection by their caregiver(s), possible abandonment or fear of institutionalization.<sup>6,7</sup> Additionally, older

adults may be reluctant to report their offenders, who are often caregivers, due to a sense of security of knowing their situation. For these older adults, abusive care is regarded as better than no care. Some may have shame or self-blame for what is happening to them. Older adults may not know that help is available or how to access it, further contributing to feelings of hopelessness and belief that their situation is unchangeable.<sup>10</sup> Many older adults “normalize” their abusive situation as a part of their family dynamics and adopt general acceptance. Another barrier to reporting abuse is lack of capacity; older adults’ abilities to report may be limited due to cognitive impairment, such as dementia.

Health care providers, including nurses in acute care settings, will often encounter older adults who are victims of abuse or neglect.<sup>1,3,8</sup> Indeed, an emergency department visit or admission to the hospital may be the only time the older adult is away from his home. Nurses may not suspect presence of elder abuse because of lack of knowledge and training in detecting elder abuse and mistreatment, neutral attitudes regarding elder abuse, or fear of potential litigation.<sup>6,9,10</sup> Further, nurses may feel uncomfortable having these discussions with older adult patients. Patient interactions are brief and time does not allow for or facilitate discussions of such personal nature. Perpetrators can be menacing or threatening, either with physical harm or litigation.<sup>11</sup> Many nurses and other health care providers are uncertain of their role in screening and assessing for elder abuse and many view it as a social service issue. In addition, nurses and health care providers may be reluctant to pursue assessment or screening because of they lack knowledge of resources or processes to aid the older adult.

Acute care hospitals are an access point for case finding.<sup>12</sup> Hospitals provide a safe, structured environment which may be an escape for the older adult from an abusive home environment. There are opportunities to screen for and diagnose abuse in older adults seen in

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emergency departments as well as those treated on inpatient units. However, challenges exist.

On a systems level, many organizations lack standardized protocols and tools for detailed or focused assessment.<sup>6,8,13</sup> Assessment of elder abuse is commonly folded into family or domestic violence in one or 2 questions, such as “do you feel safe in your environment?” Abused older adults may not interpret “safety” as an indicator of abuse. Without further direct questioning, opportunities to identify specific red flags or symptoms are lost.

### Risk factors for elder abuse or mistreatment

As older adults access health care in the acute care setting, clinicians including nurses have a professional and legal obligation to assist with case finding, utilizing a comprehensive approach. Assessment includes the identification of risk factors or red flags that indicate a potential or likelihood of elder abuse or mistreatment, recognition of signs or symptoms, and the use of validated screening tools.

Many elder abuse risk factors have been identified and are helpful in the assessment of older adults.<sup>7,8,14</sup> With each additional risk factor, the likelihood of elder abuse or mistreatment increases greatly. In a systematic review of risk factors in community dwelling elders, Johannesen and LoGiudice identified thirteen risk factors that were common in a majority of the high quality studies included in the review.<sup>15</sup> Risk factors encompass the older adult, the perpetrator, the quality of the relationship between the older adult and perpetrator, and the environment (Fig. 1).

It is important to note that age, gender, race or ethnicity are not risk factors – elder abuse and mistreatment cuts across all segments of society. What is known is that older adults with cognitive impairment (e.g., dementia), behavioral problems (e.g., agitation, sleep disturbances) or psychiatric illnesses or problems (e.g., depression, anxiety) are all strong risk factors. Functional dependence on others for eating, bathing, dressing, and mobility as well as poor physical health or frailty have been shown to be strong risk factors. Last, financial dependence on others can be a red flag.

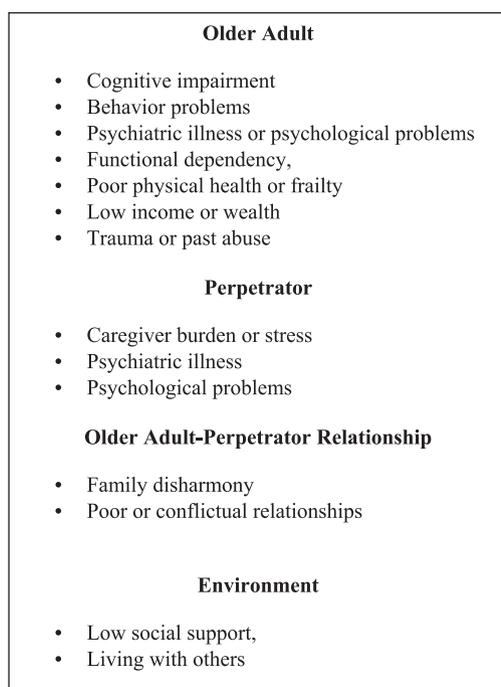


Fig. 1. Risk Factors for Elder Abuse or Mistreatment.

Among the perpetrators, common risk factors include expression of caregiver burden or stress and mental illness. Some have reported that substance abuse and financial dependency on the older adult are also potential risk factors.<sup>7,14</sup>

The relationship between the older adult and the perpetrator is an important risk factor to consider.<sup>6,7,15</sup> Family disharmony as well as poor or conflictual relationships are common. Additional red flag caregiver behaviors that raise suspicion of abuse include substance abuse, emotional outbursts, reluctance to leave the older adult alone with the health care provider, or interruption or speaking for the older adult without allowing the older adult to speak for himself.

The living environment may also raise suspicion for presence of elder abuse or mistreatment taken in combination with other risk factors. Those with low social support, i.e., few family members or friends, as well as those living with others are potential factors.

### Screening tools and hospital responsibilities

A number of screening tools exist as a first step in determining the presence of elder abuse or mistreatment.<sup>8,16</sup> No single screening tool is recommended as the gold standard.<sup>17,18</sup> Nevertheless, the usefulness of a screening tool is that it provides the nurse with a standardized approach to assessing for potential abuse or mistreatment.

Three tools highlighted in the 2013 Elder Maltreatment Symposium convened by the Centers for Medicare and Medicaid Services were recommended for use in practice by trained professionals.<sup>17</sup> (See Table 1). There are many other screening tools studied for use in specific health care settings such as primary care, dental clinics, home health settings and long-term care facilities. At this time, there are no specific screening tools designated for use in acute care hospitals.

Some have questioned the usefulness of routine screening of all older adults based on lack of resources and potential downside effects of falsely accusing caregivers of abuse or neglect.<sup>11</sup> The United States Preventative Task Force (USPTF) found that current evidence is insufficient to assess the balance of harms and benefits of screening all older adults for abuse.<sup>18</sup> In addition, the USPSTF found inadequate evidence that screening or early detection of elder abuse or abuse of vulnerable adults reduces exposure to abuse, physical or mental harms, or mortality in older or vulnerable adults.

Nevertheless, screening for abuse and mistreatment is considered by many to be a quality of care indicator and part of the Joint Commission standards for hospitals (PC.01.02.09).<sup>8,13,19</sup> As part of the Joint Commission standards, hospitals must educate staff to recognize signs of possible abuse and their role in follow-up in reporting abuse and assist with referrals of possible victims of abuse. Hospitals are to have criteria to identify patients who may be victims of abuse, use these criteria to identify potential victims, and internally reports cases of possible abuse to appropriate department(s), such as Social Service or Security departments. State laws vary in their reporting requirements; thus, hospitals designate the process within their organization for reporting the suspected abuse or mistreatment to outside agencies.

### The role of the nurse- assessment and crucial conversations

#### Physical assessment

Nurses are in a pivotal role to identify the signs and symptoms of elder abuse or mistreatment, but identification of physical signs and symptoms of abuse can be complicated. Age related changes or diseases can mimic or mask signs of abuse. For example, older adults bruise easily and it is not unusual to see bruising along forearms or shins because of bumping into objects. Many times, the older adult

**Table 1**  
Elder Abuse and Mistreatment Screening Tools.

Screening Tool	# Items	Administration	Setting
Elder Abuse Suspicion Index (EASI)	6	Completed by health care professional to assess risk, neglect, verbal, psychological, emotional, financial, physical and sexual abuse over a 12 month period; 2 min to complete	Validated in family practices and ambulatory care settings
Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST)	6	Self report or interview by a professional	Suitable in emergency or outpatient settings
Vulnerability to Abuse Screening Scale (VASS)	12	Self report of dependency, dejection, coercion and vulnerability	N/A

may not remember the source of the bruise. There are, however, certain patterns of injury and fracture that are more indicative of abuse than accidental trauma. Bruising on the head, neck, abdomen, inner aspects of the arms and thighs, posterior legs and spiral long bone fractures suggest abuse.<sup>7,20,21</sup> Healing of bruises and lacerations in various stages may be suggestive of abuse.

Observe for signs of neglect. These include unkempt or dirty appearance, pressure ulcers, malnutrition or dehydration. Assess the appropriateness of dress for the season. Assess for adherence to medication regimen.

Observe the older adult's behavior with the caregiver. Does the older adult become passive in responding to questions? Does the older adult appear anxious or tense in the presence of the caregiver, but relaxed when the caregiver is not present? What are the caregiver's behaviors? Does the caregiver interrupt or contradict the older adult's statements?

#### Crucial conversations

Many nurses do not see themselves having a participative role in elder abuse case finding and/or assessment.<sup>9,10</sup> Typically, social workers have been delegated the lead in gathering information and formally reporting if indicated. However, nurses have the most direct patient contact time which can foster a trusting relationship and confidence. Some patients will talk with their nurse about their abusive situation, concerns and vulnerabilities if they feel safe and supported.

There are verbal and nonverbal strategies that foster open communication. The nurse should consider the following:

1. Demonstrate sensitivity to the individual's cultural, spiritual beliefs and practices.
2. If present, request that family members step out of the room and use the opportunity to talk with the older adult patient alone. This can be done as a request for needing privacy to provide care to the older adult so as not to raise suspicions.
3. Set up the environment to promote ease of conversation; for instance arrange seating for face to face interaction at eye level. Minimize noise to reduce distraction. Standing at the foot or side of the bed with a computerized health entry system does little to engender relationship building. Rather, it sends the message to the older adult that the nurse is 'too busy' to speak with him.
4. Use clear and simple language and open ended questions.
5. Note inconsistencies in the older adult patient's responses and gently seek clarifications.
6. Be alert for both obvious and subtle abuse indicators such as: symptoms of injury, the manner of the older adult patient's discussion and patient-caregiver interactions.
7. Acknowledge and support the older adult's discomfort. Be attentive to emotional reactions. Pause, take time out, or stop according to the older adult's comfort levels.
8. Convey a nonjudgmental approach and attitude towards both the caregiver and the older adult.

**Table 2**  
Direct questions to identify potential elder abuse or mistreatment.

Physical Abuse	<ul style="list-style-type: none"> <li>• "Are you afraid of anyone at home?"</li> <li>• "Have you been slapped, hit, kicked or pushed around?"</li> <li>• "Have you been locked in a room or tied up?"</li> <li>• "Does anyone hurt or abuse you?"</li> </ul>
Psychological/Emotional Abuse	<ul style="list-style-type: none"> <li>• "Do you feel put down, made fun or ridiculed by your caregiver?"</li> <li>• "Have you been threatened to be put in a nursing home?"</li> <li>• "Have you been shut off from seeing or talking with people outside the home?"</li> </ul>
Financial Abuse	<ul style="list-style-type: none"> <li>• "Has anyone ever asked you to sign documents that you didn't want to sign?"</li> <li>• "Has anyone taken your money without permission?"</li> <li>• "Has anyone taken your valuables?"</li> </ul>
Neglect	<ul style="list-style-type: none"> <li>• "Are you made to stay in your room or left alone a lot?"</li> <li>• "Has anyone ever failed to help you when you needed help?"</li> <li>• "Do you have enough to eat and drink each day?"</li> </ul>
Sexual Abuse	<ul style="list-style-type: none"> <li>• "Has anyone touched you without your permission?"</li> <li>• "Has anyone forced you to have sexual relations?"</li> </ul>

Start with open ended questions or general assessment questions that can get at functional dependency. For example, 'Do you need help at home for bathing, dressing, getting in and out of the bed'? If yes, a follow up question may be, 'Do you get the help when you need it?' Similarly, questions on instrumental activities of daily living may reveal potential for financial abuse or other mistreatment, such as 'Do you need help with your banking?' 'Who helps you with getting your medicines/food/supplies?' More direct questions can be used to specifically target the type(s) of abuse the older adult may have experienced (See Table 2). As with the case of "Lucy", several red flags are apparent: falling with fractures, fearful of her granddaughter, lack of medication refill, dependency on grand-daughter to meet needs, and socially isolated. (See Case Study).

#### Mandatory reporting

Per Joint Commission, hospitals must have a plan for internal reporting of suspected abuse or mistreatment. Typically, Social Service or Case Management Departments are the departments that receive and act upon reports of suspected abuse. Trained professionals will interview the older adult as well as the caregiver to determine the level of safety concerns and urgency, assess the older adult's capacity, assess caregiving and social support, address immediate needs, such as food or transportation, arrange for supportive services as necessary, and in the event of serious risk, find a safe place, such as the home of a friend or long term care facility. Because of the complexity of older abuse cases, interprofessional teams are often needed to address the myriad health, medical, psychological and social service needs of the patient and the caregiver.<sup>6,7,13</sup> The patient may refuse the plan of care, which is often a source of frustration for the health care provider.<sup>6</sup> When possible, plans are put in place to provide the older adult and caregiver with needed resources.

**Table 3**  
Resources for the identification, prevention and management of elder abuse or mistreatment.

Resource	Services	Contact URL
National Adult Protective Services Association NAPSA	Adult Protective Service (APS) agencies conduct investigations; assess risk, capacity to make decisions, arrange for emergency shelter, care and support. The NAPSA provides current training content, latest practice methods and policy developments	<a href="https://www.napsa-now.org/">https://www.napsa-now.org/</a>
National Center on Elder Abuse NCEA	Established by the U.S. Administration on Aging in 1988, serves as a national elder abuse resource center. NCEA synthesizes research, provides technical assistance tools, informs public policy and provides training and awareness education materials.	<a href="https://ncea.acl.gov/">https://ncea.acl.gov/</a>
Eldercare Locator	A public service provided by the U.S. Administration on Aging; provides information on services for older adults and their families. Services include support, housing, elder rights, insurance and benefits, health and transportation.	<a href="https://eldercare.acl.gov">https://eldercare.acl.gov</a> 1-800-677-1116
Center for Disease Control CDC	CDC provides information on risk and protective factors, prevention strategies, articles, publications and data sources.	<a href="https://www.cdc.gov">https://www.cdc.gov</a> See Violence Prevention – Elder Abuse
National Initiative for the Care of the Elderly NICE	An international network of practitioners, students, researchers and older adults dedicated to improving care of older adults. The Elder Abuse Theme Team works on numerous tools on the detection and prevention of elder abuse on an international scale.	<a href="http://www.nicenet.ca/elder-abuse">http://www.nicenet.ca/elder-abuse</a>
National Adult Maltreatment Reporting System NAMRS	A comprehensive, national reporting system for APS programs. Goal is to provide consistent, accurate national data on the exploitation and abuse of older adults and adults with disabilities. Data reports are compiled annually and available for review.	<a href="https://namrs.acl.gov/">https://namrs.acl.gov/</a>
National Council on Aging NCOA	A national organization dedicated to improving the health and economic security of older adults. Provides a video series to 'put a face on elder abuse'. An Age for Justice: Confronting Elder Abuse in America is available on YouTube.	<a href="http://www.witness.org">http://www.witness.org</a> and <a href="http://www.ncoa.org">http://www.ncoa.org</a> An Age for Justice; Elder Abuse

Besides putting a plan in place, hospitals are required to report suspected abuse to the designated agency. States vary in the definition of elder abuse and mistreatment as well as in reporting obligations. In many states, the Adult Protective Services (APS) serves as the agency to follow up on elder abuse and mistreatment reports. Upon receipt of the report, an APS case worker will visit the home to interview the older adult and caregiver as well as to evaluate the home environment. In many states, the older adult has the right to refuse APS services and despite efforts, cases may be lost to follow-up.<sup>6,7</sup>

## Conclusion

Abuse and mistreatment are common among older adults and many of the hospitalized older adults will have been victims of abuse or mistreatment. Nurses must have heightened awareness of the potential of abuse or mistreatment in their patients. Nurses need to be knowledgeable of their hospital's policy and procedures as well as resources available in their community. Generalized screening without understanding or knowing potential resources is a disservice to not only the older adult, but to the nurse. Table 3 provides a list of credible organizations and their services that can be of help to the nurse in a deeper understanding of this pervasive problem and potential resources to address it.

## Case study

*Case: Lucy, an 81 year old widow, was admitted to the hospital last evening for complaints of abdominal pain, nausea and vomiting, and weakness for the last 2 to 3 days. She states she has had a poor appetite for the last several weeks, but in the last few days "has not been able to keep anything down." She developed a dull, intense lower abdominal pain yesterday that she has consistently rated an 8 out of 10 on the pain scale after receiving pain medication.*

*In general, Lucy describes her health as "pretty good." She lives in her own home of 53 years and has lived alone until a year ago when her*

*grand-daughter, who is attending college, moved in to help around the house. Lucy's past medical history includes mild dementia, GERD, an old MI and afib. She admits she has been in the emergency room twice in the last 6 months after falling; both falls associated with injuries including a facial fracture and fractured left wrist.*

*She reports she is taking only one pill, her blood thinner, although she hasn't had it for two weeks. Lucy reports she ran out and her grand-daughter hasn't had a chance to pick up her refill from the pharmacy.*

*The morning after admission, her nurse is helping complete the comprehensive admission assessment. Addressing the functional assessment the nurse asks "Are you able to get around at home okay and take care of your basic needs?"*

*Lucy: "Yes, I do pretty good. I sit in my chair most of the day and read or watch TV. Sometimes I just look out the window and watch the neighbor's dog. He looks so friendly, I wish I could pet him and hold him in my lap. . ."*

*Nurse: "Can you go to the bathroom on your own? Do you ever have accidents?"*

*Lucy: "Yes, I usually get up and go once during the day. I'm not allowed- or supposed to get up -my grand-daughter told me – I need to stay in the chair until she gets home from school. She has long days, and sometimes is gone from sun-up till late at night. But she's worried I might fall. I fell awhile back, you know. I hurt my shoulder pretty bad. But I had xrays and nothing was broken like the time before. Last spring I was trying to hurry up the stairs to go to bed before my grand-daughter came into the house and I fell forward and hit my face and broke my wrist. My grand-daughter was so mad at me! I stayed in my room for 3 days to let her cool down. I didn't even come out for supper!" She laughs nervously.*

*In examining Lucy, the nurse notes some bruising along the back of Lucy's right thigh. When questioned, Lucy states, "I don't remember. Maybe I bumped into my chair." The nurse also notes that Lucy has lost 10 pounds since her last admission 6 months ago. When asked about her eating and getting food, Lucy states, "I wait for my grand-daughter, but she is so busy with school and work that she has a hard time getting to the grocery store."*

*The nurse reports her suspicions of elder abuse and mistreatment to the unit Social Worker, who then completes a more detailed assessment.*

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