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Look for signs of abuse

Growing old shouldn't mean becoming a victim. But for too many of this country's senior citizens, it does. Here's how you can help.

It's estimated that one million Americans age 60 or older are abused in domestic settings each year.[1] No one knows the full scope of the problem, because most cases never come to the attention of authorities. Some experts believe that only one case in 14 is ever reported.[2,3]

The reasons for underreporting are numerous. Many victims do not want the abuse reported—out of fear, shame, or a sense of loyalty to the abuser—and often deny that they are being mistreated. But all too often, clinicians do not even consider the possibility of abuse, and overlook its telltale signs.

Part of the difficulty is that certain signs of abuse may be easily attributable to the normal process of aging. Recurrent fractures, for instance, may be automatically ascribed to the brittle bones of osteoporosis. Malnourishment may be attributed to the nutritional problems and poor appetite that often accompany old age.

One key to combating elder abuse, then, is being open to its possibility every time you care for an older patient. Here we'll discuss the risk factors and red flags, how to probe for abuse, and what you can do to stop it.

Profiling victims and abusers

The words "elder abuse" encompass a variety of forms of mistreatment, most notably neglect, emotional/psychological abuse, financial exploitation, and physical abuse. (Self-neglect may also be considered a form of elder abuse, but we'll limit our focus here to abuse or neglect perpetrated by others.) Often, victims experience more than one form of mistreatment.

What do many victims have in common? They're vulnerable.[4] They may be physically or cognitively impaired, socially isolated, and dependent on a caregiver—who is often the abuser and often a family member with whom they live.[4,5,6] In 1996, adult children were the perpetrators in 37% of reported cases of domestic elder abuse, making them the most frequent abusers.[1]

Abusers typically have a family history of violence. Stress, par-

ticularly stress related to the demands of caregiving, increases the likelihood of abuse. So do problems such as mental illness, drug abuse, or alcoholism. Many abusers are also overly dependent on the elderly person—say, for financial assistance or living accommodations.[4,5,6]

When to suspect mistreatment

Certain things, quite apart from any clinical signs and symptoms, may point to abuse right off the bat. In many cases, they're the same sort of things that tip you off to child abuse.

Explanations of the injury that are vague or overly specific, implausible, or inconsistent with the medical findings should raise a red flag.[5,7] So should disparities between the patient's account of the injury and the explanation given by the caregiver.

Other tipoffs include an unexplained delay in getting medical attention and a pattern of doctor or hospital "hopping."[7] Frequent visits to the ED with a similar illness or injury—despite a prescribed care plan and the resources to carry it out—is also suggestive of abuse.[5]

When doing your physical assessment, check the patient's overall appearance for signs of neglect. For example, is he (or she) dirty and unkempt? Is he missing his glasses, dentures, or hearing aid? Is he poorly nourished or dehydrated?

Since abuse or neglect manifests itself in behavior, too, note the patient's demeanor and mental state. Does he appear unduly fearful, withdrawn, nervous, passive, or depressed? How does he interact with his caregiver?

During the physical exam, check for such things as alopecia, pressure ulcers, welts, scars, abrasions, burns, lacerations, fractures, and bruising. Be alert to signs of sexual abuse.

Note the size, shape, and location of injuries, all of which can be telling. Bruises located on both upper arms, for instance, may indicate that the person was held tightly and shaken. Those on the wrists may suggest the use of restraints.

Be especially suspicious if you find multiple injuries in various stages of healing. Follow up on any unusual findings, physical or otherwise. Alert your colleagues to your suspicions, so they can observe interactions between the patient and visitors for indications of a problem.

If your patient lives in a residential facility, or if you work in long-term care, you'll need to be attuned to the possibility of insti-

Ferreting out elder abuse: Sample interview questions

When screening for elder abuse, start with general questions, such as the following:

- Do you feel safe where you live?
- Are you alone a lot?
- Do you know someone you can turn to in a crisis?
- Do you support anyone?
- Do you make your own decisions about your life, such as where you live?
- Do you need help taking care of yourself?
- Do you take your own medicines?
- Who prepares your meals?
- Who handles your checkbook?
- Does anyone in your family drink too much alcohol or take drugs?

If you suspect a problem based on the answers, move on to more direct questions, along these lines:

- When you disagree with a family member, what happens?
- Are you yelled at or punished in any way?
- Does anyone at home make you uncomfortable or afraid?
- Has anyone ever threatened or hurt you?
- Have you ever been forced to do something?
- Has anyone ever made you stay in your home or room?
- Has anyone ever taken anything of yours without your permission?
- Has anyone ever failed to take care of you when you needed help?
- Has anyone ever withheld food or medications from you?
- Have you ever signed a document that you did not understand?

SOURCES: 1. O'Brien, J. G. (1996). Screening: A primary care clinician's perspective. In L. A. Baumhover & S. C. Beall, *Abuse, neglect, and exploitation of older persons* (pp. 51- 64). Baltimore: Health Professions Press. 2. Lachs, M. S., & Pillemer, K. (1995). Abuse and neglect of elderly persons. *N. Engl. J. Med., 332*(7), 437. 3. Rosenblatt, D. E. (1996). Elder Abuse: What Can Physicians Do? *Arch. Fam. Med., 5*(2), 88.

tutional abuse. Patients in these settings are particularly vulnerable to abuse or neglect at the hands of professional caregivers.

Asking questions to uncover some answers

If you suspect your patient is being mistreated, interview him in private—away from the suspected abuser. In an acute care setting, you'll of course zero in on an account of the presenting injury or illness and any pertinent medical history.

In a setting like the home or a doctor's office, nurses have the opportunity to investigate the possibility of abuse even in the absence of suspicious signs. That's something members of the healthcare community have called upon primary care practitioners to do routinely, with all older patients.[2,8]

Nurses can screen for abuse by asking general questions about the patient's home and family. For example: Are you happy with your living situation? What is a typical day like? Then move on to queries about who is responsible for taking care of the patient. For example: Who gives you your medications? Who bathes you? Who manages your finances?[8]

If the answers lead you to suspect a problem, ask specifically about mistreatment.[8] The box at left lists sample interview questions.

An in-depth interview of the suspected abuser is often best left to someone from the social services department or another professional with training in this area. If you do question the suspected abuser, maintain a nonaccusatory and nonjudgmental tone. Watch for indications that he or she feels antipathy toward the patient or is overwhelmed by his or her role as caregiver, particularly if the patient can't perform basic activities of daily living.

To find out more ...

Contact the National Center on Elder Abuse (NCEA), in care of the American Public Welfare Association, 810 First Street, NE, Washington, DC 20002; (202) 682-2470. Their Web site on the Internet is http://www.gwjapan.com/NCEA.

How to intervene to protect the patient

If you suspect abuse, you'll need to follow the reporting policy set down by your state and your facility; the article beginning on page 52 discusses these and other legal aspects of elder abuse. In many states, interventions for victims are coordinated by Adult Protective Services (APS).

Assuming the patient acknowledges the mistreatment and is willing to accept assistance, discuss the options for ensuring his safety. These include temporary admission to the hospital, placement in a safe home, and a court order of protection. Refer the patient to hospital and community social services and home healthcare, as appropriate.

If the patient refuses assistance—and is competent to do so—educate him about available support services. These include APS, the department of social services, public legal services, the local victim services agency, and the local unit on aging. Provide him with emergency contact numbers; many states have 24-hour elder abuse hotlines. If the patient is not competent to make his own decisions, guardianship arrangements will need to be made.

Interventions aimed at the abuser can also help stop mistreatment—or even prevent it—especially if the abuser is an overburdened caregiver. Respite care such as homemaker or home health services, counseling, drug or alcohol rehab, and legal assistance are among the options.

Nurses can also help prevent abuse by encouraging older patients to maintain social contacts, receive visitors, and remain active in their community.[9] Church activities, for example, may be a good option.

Getting at the root causes of elder abuse is beyond the ability of any single nurse. But intervening on an individual basis *can* change things for the better, one family at a time. □

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Elder abuse:

What the law requires

As in the case of child abuse, the mistreatment of older people has prompted a legislative response to the problem. All states have enacted so-called elder abuse laws, designed to protect older or vulnerable adults from abuse, neglect, and financial exploitation.

These laws generally define a vulnerable adult as a person with a physical or mental condition—such as Alzheimer's disease or an infirmity related to aging—that substantially impairs his ability to care for himself. Some statutes specifically cover adults over a certain age—for instance, anyone older than 60.

Nurses who suspect that an older patient is being mistreated are obligated to take action.

To uphold your legal and ethical obligations to help stop elder abuse, you need to be familiar with what constitutes abuse and what the reporting requirements for nurses are.

The many forms of victimization

Although state definitions vary, the term abuse generally includes both physical and psychological abuse. Physical abuse typically means intentionally inflicting, or allowing someone else to intentionally inflict, bodily injury or pain. It includes such things as slapping, kicking, biting, pinching, and burning, as well as sexual abuse. It may also include the inappropriate use of drugs and physical restraints.

Psychological abuse includes verbal harassment, intimidation, denigration, and isolation. It may include repeated threats of abandonment or of physical harm.

Neglect means the failure of a caretaker to provide the goods, services, or care necessary to maintain the health or safety of a vulnerable adult. Neglect may be repeated conduct or a single incident that endangers the person's physical or psychological well-being.

Financial exploitation usually occurs when family members, friends, or paid caretakers "help out" a confused or disabled adult, in the process cleaning out bank accounts, selling possessions, and taking Social Security checks. It includes the improper or unauthorized use of funds, property, powers of attorney, and guardianships. Exploitation may also include forcing a vulnerable adult to work against his wishes.

Your duty to report

The vast majority of states require nurses and other healthcare providers to report cases of suspected elder abuse. Those states that don't mandate reporting encourage it.[1] The standard for reporting is usually a "reasonable belief" that a vulnerable adult has been, or is likely to be, abused, neglected, or exploited.[2]

That means you don't have to be *certain* that someone is being mistreated or exploited, you only need a legitimate basis for suspecting this to be the case. You might have reasonable grounds to be suspicious if, say, a patient has multiple bruises in different stages of healing and the caretaker is evasive when answering your questions or provides an explanation that makes no sense.

As long as you report the suspected abuse in good faith, most states provide immunity from civil

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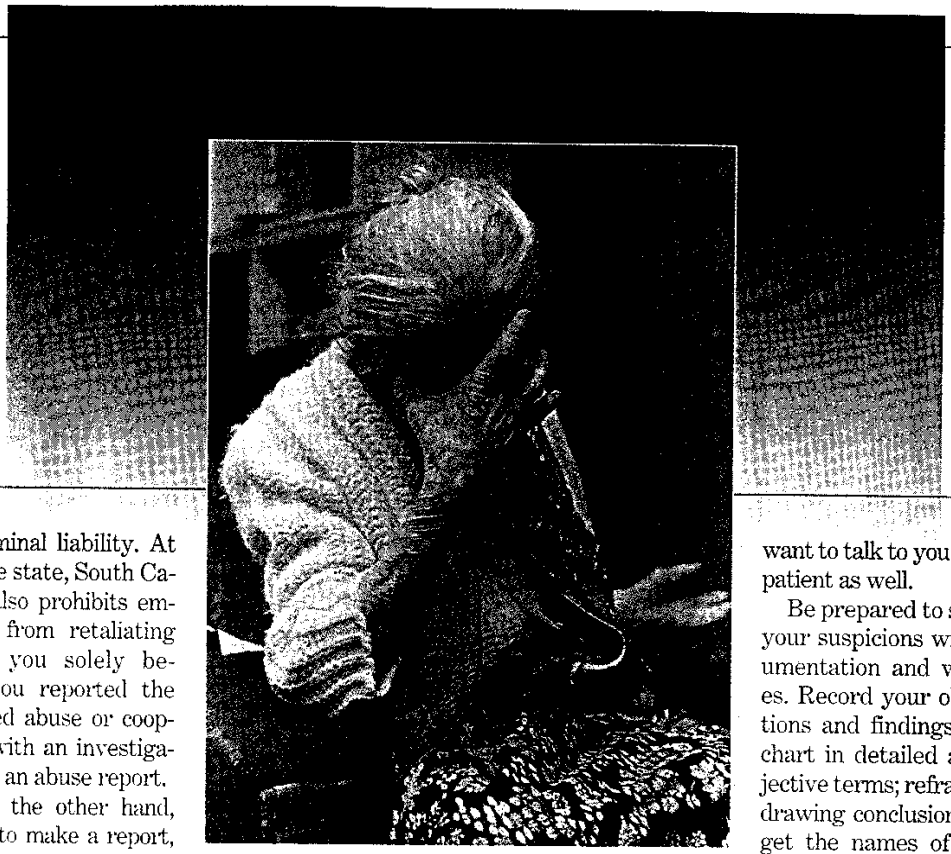

and criminal liability. At least one state, South Carolina, also prohibits employers from retaliating against you solely because you reported the suspected abuse or cooperated with an investigation into an abuse report.

If, on the other hand, you fail to make a report, you could be found guilty of a misdemeanor.[2] In some states, you'll also be reported to your licensing agency for disciplinary action.

Setting the process in motion

Each state has its own process for reporting abuse, so check your own state statute and your employer's policy. Some policies require you to contact a particular individual within your facility, who is then responsible for reporting the abuse to the designated agency or person—such as Adult Protective Services (APS) or the long term care ombudsman—and possibly to the police as well. Other policies require the nurse or doctor to make the report.

If the suspected abuser is a healthcare provider, many states also require that the incident be reported to the occupational body that licenses that professional.

The report to APS or its equivalent agency may be done either orally or in writing, and many states have a reporting time frame—such as within 24 hours of an incident or the next business day. Usually, the agency receiving your report is obligated to conduct an investigation shortly after a report is made. The investigation may include face-to-face interviews with the at-risk adult and the person making the report. The police may want to talk to you and the patient as well.

Be prepared to support your suspicions with documentation and witnesses. Record your observations and findings in the chart in detailed and objective terms; refrain from drawing conclusions. Also get the names of family members, caretakers, and other people you observed having contact with the vulnerable adult. Quote the patient or caretaker in the chart whenever possible.

Some states allow you to take pictures of injuries believed to be the result of abuse. If your state does and the patient is competent, you should ask for, and document, his permission before shooting the photos.

Be aware that once a report is made, many states will not share the results of the investigation with the person who makes the report. In some states, you may be able to find out the results—and the subsequent care plan—if you get the consent of the patient or his legal representative.

Elder abuse is an ugly crime. When confronted with it or the possibility that it's occurring, it may be easier to dismiss your concerns or let someone else take care of the problem. But from a legal perspective—and a moral one—looking the other way simply isn't an option. □

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