

The role of the nurse in detecting elder abuse and neglect: current perspectives

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Abstract: As global populations age, it is imperative that nurses have a knowledge base on the topic of elder abuse. Elder abuse can occur in any environment, but is most prevalent in the community setting. Older people may experience either a single type of abuse or several forms of abuse concurrently. It is also important that abuse at an institutional and societal level is recognized and addressed. Nurses have a responsibility to identify when abuse may be perpetrated and to assess the context, ensuring appropriate responses are undertaken. A knowledge of barriers to disclosure is also essential, as well as ensuring that the voice of the older person is prioritized in case management. In doing so, nurses have the ability to both prevent and provide early intervention to safeguard older people.

Keywords: elder abuse, ageism, human rights, screening, nurse's role

Introduction

Within adult care nursing, a major population group is that of older people. Current projected demographic trends demonstrate an increasing proportion of the population will be aged over 65 years. The World Health Organization (WHO)¹ states that within the period 2000–2050, the global population of people over 60 years will increase from 11% to 22%. While this represents a major success story within human longevity, it also points to the imperative of ensuring systems of care can provide adequately for the demands of a changing demographic, thus matching quantity of years to quality of life. Such requirements transcend health, but are intrinsically interwoven in the context of the social determinants of health. For example, health is impacted by issues such as adequate housing, adequate income, combatting social isolation, gender, access to health services, climate change, education, employment status and a safe environment.^{2,3} Within global populations, there is a need to ensure older people are safeguarded from maltreatment, and nurses are key professionals to detect suspected cases of abuse and trigger appropriate interventions.^{4,5} This paper critically examines issues related to elder abuse and also nurses' roles in detection and intervention. Firstly, it is important to understand the topic and also to be able to contextualize it within issues such as ageism and human rights.

Elder abuse

To detect elder abuse, it is essential to understand the phenomena. Formal recognition of elder abuse can be traced back to publications in medical journals^{6,7} and centered

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on the dyadic relationship between the older person and the perpetrator(s). However, formal responses have progressed at a relatively slower rate. For example, it was only in the early 2000s that England and Ireland formulated a policy response to elder abuse,^{8,9} while the WHO¹⁰ observes that out of 133 countries reviewed, only 40% had formal action plans to combat the issue. While definitions can vary in different jurisdictions, the Toronto Declaration on elder abuse¹¹ defines it as “a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person”. Elder abuse can further be categorized into physical abuse, psychological/emotional abuse, financial/material abuse, sexual abuse and neglect. Self-neglect is recognized as elder abuse in some jurisdictions and not included in others.¹² The WHO¹¹ definition cited above also has limitations with its scope; for example, it specifies that elder abuse involves the older person being in a relationship, implying the necessity of a perpetrator who is in a relationship of trust. Thus, abuse is defined by the relationship, rather than the actual act.

Prevalence studies globally have attempted to enumerate elder abuse and have predominantly focused in the community setting. The WHO¹⁰ states that 1:6 people over 60 years were abused within the previous year, based on examining studies from 28 countries which indicated a pooled prevalence of 15.7%.¹³ Yet, an Irish prevalence study indicated that the prevalence in community-dwelling older people in the previous 12 months was 2.2%.¹⁴ Consequently, comparisons of elder abuse studies should be treated with caution. Firstly, figures can differ according to the definition, empirical rigor, methodological approach and methods applied. Equally, issues such as culture, ethnicity and gender can impact findings.^{12,15} It is also recognized that such studies represent the iceberg theory,¹⁶ which argues that although cases are being picked up, it is probable that there are many more which are not identified. This is further validated by a New York State study,¹⁷ which found an incidence rate of almost 24 times greater than cases known by formal services such as social services, police or legal authorities. Within studies of elder abuse, the main setting it occurs in is the community and the main perpetrator is a family member with the highest perpetrations in the areas of psychological abuse and financial abuse.¹³ Risk factors for elder abuse have been identified by Pillemer et al,¹⁸ who examined ranges from a strong evidence base to a contested evidence base (ie, requiring more empirical support) as detailed in the following (strength of evidence key: ^astrong, ^bpotential, ^ccontested):

- Older person: functional dependence/physical disability^a, poor physical health^a, cognitive impairment^a, poor mental health^a, low income^a, gender^b, age^b, financial dependence^b and race/ethnicity^b
- Perpetrator: mental illness^a, substance abuser^a, abuser dependency^a
- Relationship: victim–perpetrator relationship^b, marital status^b
- Community: geographical location^b
- Societal: negative stereotypes^c of aging, cultural norms.^c

Some theories have been opined, such as the social learning theory/trans-generational theory, symbolic interaction theory, the exchange theory, the ecological theory, the domestic violence theory, the psychopathology of the abuser theory, caregiver stress theory and the revenge theory. Yet, none have been shown to provide a concrete explanation of elder abuse due to its multifaceted complex contributing factors.^{12,15} However, understanding possible causative reasons enables nurses to examine the individual older person’s conditions of abuse perpetration and, consequently, address the inherent risks and causes. In this way, nurses can apply both a preventative and an intervention approach to protect older people.

The prevalence of elder abuse is much higher in studies which have focused on older people with capacity challenges, with the WHO¹⁰ suggesting that two out of three people living with dementia have suffered abuse. Some studies have examined abuse in residential care and found that three factors could impact on abuse perpetration: facility factors, resident factors and staff factors,¹⁹ while gender was also identified as a risk.¹⁵ In the US, Page et al²⁰ found the most common form of abuse in nursing homes was neglect (9.8%) and caretaking abuse (17.4%), while Castle²¹ found 36% of nurses’ aides observed argumentative behavior toward residents and 28% reported resident intimidation. In Norway, Malmedal et al²² identified that 91% of staff had observed a colleague engaging in some form of inadequate care, while 87% were found to have themselves perpetrated inadequate care. In a German study,²³ 79% of staff indicated they had abused or neglected a resident to at least once during the previous two months, while 66% witnessed victimizations of residents by colleagues. Comparatively, Drennan et al¹⁹ found rates of elder abuse in residential care in Ireland to be lower with 57.5% reporting that they had observed one or more abusive behaviors by colleagues in the previous 12 months. Influencing factors were found to be high levels of staff burnout, frequency of resident-related stressors, staff’s experience of mistreat-

ment by residents and staff's experiences of psychological distress.¹⁹ Both Goergen²³ and Drennan et al¹⁹ commented on the difficulties of working in nursing homes. Fifty-nine percent of staff respondents in the German study reported physical or verbal aggression by residents during the previous 2 months,²³ while Drennan et al¹⁹ reported 85% of staff experiencing a physical assault by a resident in the previous year; 88.6% having residents psychologically abuse staff, with approximately a quarter of staff reporting some form of inappropriate sexual behavior by a resident in the previous 12 months. In more recent literature, the issue of resident to resident abuse has been explored, identifying risk factors such as resident depression, delusions, hallucinations, invasion of personal space and environmental challenges.^{24,25} Pillemer et al²⁶ advocate a socio-ecological model to address resident to resident abuse, which responds to examining interactions between individuals and the social and physical environment as well as examining the antecedents and consequences for both residents involved.

A professional requirement

The International Council of Nurses²⁷ offers some understanding of the role of the nurse in terms of safeguarding. The provision of a safe environment translates, not only to the physical environment, but also to the social, psychological contexts and financial security in terms of protecting from abuse. It is stated the role of nurses involves:

Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.²⁷

As a profession, nurses are regulated, and a major function of regulation is protection of the public and protection of the profession. This means following codes of professional practice which are underpinned by respect and dignity of each person and nurses are mandated to engage in responsible and accountable practice.²⁸ Many regulatory bodies and professional organizations have specific guidance on older person care^{29,30} or have integrated such guidance into codes of conduct.³¹ Such codes need to be understood by nurses from a number of perspectives, both on a personal level and as a member of a health care service. Firstly, nurses need to self-regulate care interactions to ensure dignity and respect are central components of all contacts and promote care delivery underpinned by a human rights approach, thus safeguarding the individual. Secondly, there is an obligation

to address restrictive or negative systems of care that are abusive at an organizational level. Nurses' responsibilities are not confined to their own practice, but include reporting and whistleblowing to alert appropriate authorities of suspected poor care practices or incidents. Harrow Council³² defines institutional abuse as the:

[...]mistreatment of people brought about by poor or inadequate care or support, or systematic poor practice that affects the whole care setting. It occurs when the individual's wishes and needs are sacrificed for the smooth running of a group, service or organization.³²

In this regard, much work has been done within the area of practice development underpinned by person-centered care;^{33,34} however, it is important that a number of measures are consistently applied to promote a positive organizational culture. Firstly, an audit of the practices of and general context in the care environment is needed to ensure human flourishing. This should center on issues such as how older people's autonomy is exercised, how decision making and choices are supported and enabled, how staff are orientated to getting to know each person as an individual, staff training on areas such as necessary skills, knowledge, competencies and communication generally, but with particular relevance to older person care. Equally, a knowledge of a rights-based approach, advocacy and empowerment, leadership, and how care processes are delivered in the care environment are imperative. It is essential to examine if policies are person centered, how the physical environment and processes promote this, having robust audits for the older person's personal finances, and ensure undue influence or other abuse perpetrations are addressed (eg, from family members). Closely linked is the need to ensure nurses promote integrated care as older people transition through different settings. It is imperative that safeguarding is a paramount concern and potential threats, such as specific information gaps within care coordination and communicating individual risk factors, are acknowledged and addressed.

Other important areas are ensuring adequate mentoring and supervision of student nurses and other staff, having a safe environment for whistleblowing, having robust clinical governance systems for reporting and addressing elder abuse, encouraging feedback and evaluation on care and ensuring transparency and accountability for actions. Institutional evaluation also needs to be contextualized within a national basis so that care facilities can benchmark themselves against similar settings and identify any emerging comparative

discrepancies. Most importantly, strong transformational leadership is essential and a management culture to address evolving concerns. For example, in the context of the Francis report,³⁵ there were many organizational red flags indicating poor practice which impacted negatively on people receiving care in the Mid Staffordshire NHS Foundation Trust. While an institution can meet adequate care standards by acknowledging and addressing some care deficits, the number of concerns and lack of appropriate responses in Mid Staffordshire culminated in a perfect storm for serious and negative outcomes for patients.

The conditions for detection

Detecting elder abuse demands a number of fundamental assumptions. Consequently, nurses must be conscious of the conditions of possibility of detection. Firstly, older people need to be positioned as equal human beings, who have equal rights and entitlements. Although on the surface this may seem self-evident, there is an abundance of literature demonstrating ageism within individual relationships, society and within institutions such as health care.³⁶ Ageism is a method of discrimination and is described as the systematic stereotyping of older people, denying any individual, heterogeneous qualities and ascribing universal traits to older people.³⁷ In addition, as suggested by the stereotype embodiment theory,³⁸ older people may internalize ageist assumptions and act out stereotypical assumptions.³⁹ Thus, if nurses work in an environment where ageism is enabled through, for example, systems of care, language used and attitudes, then abuse and neglect can be ingrained at various levels within care delivery.⁴⁰ Equally, the physical environment can be abusive, for example, the use of restraints (physical and chemical), the restriction of mobility and the over “clinicalization” of areas such as nursing homes, which may be run with a priority of tasks being done and profit, at the expense of person centeredness.

Closely linked to ageism is the concept of human rights. Individualist-centered human rights can be traced back to the Magna Carta in 1215,⁴¹ but following the Second World War, the United Nations (UN) published the Declaration on Human Rights,⁴² which articulated standards each individual, regardless of age, ethnicity or ability, was entitled to. However, recognizing that some marginalized groups required additional emphasis to promote rights, in 2007, the UN signed the Convention on the Rights of People with Disabilities⁴³ to overcome barriers to participation in society. Acknowledging the impact of the UN Convention on the Rights of People with Disabilities,⁴³ since 2010, the UN has hosted an Open

Ended Working Group on Aging which has lobbied to have a separate Convention on the Rights of Older People; however, this has received poor support in some European countries.⁴⁴ The use of a rights-based lens to understand and benchmark elder abuse has increased in recent years with rights being included into definitions in formal policy^{8,9,45} and advocacy standards.⁴⁶ Nurses’ responsibility in relation to human rights has also been articulated in international statements⁴⁷ and underpins care delivery in many settings where older people receive care.⁴⁸

Using an epidemiological approach: screening

Recognizing and detecting elder abuse can be difficult. In terms of cultural norms within organizations, the family and society, abuse may not be recognized due to the perpetuation of existing values, practices and power relations. Consequently, external reviews, independent and objective audits are useful mechanisms to identify care challenges within abusive environments.

As most elder abuse occurs in the home environment at a dyadic level, there have been efforts to develop epidemiologically based instruments to assess for elder abuse. However, as screening is generally based on an identifiable disease trajectory (such as breast or cervical cancer screening), there have been concerns⁴⁹ regarding screening in elder abuse. Elder abuse is a multifaceted issue which has many diverse influences from the macro-perspective of society to the micro-perspective of the older person’s immediate environment; therefore, there is not a normal trajectory which can be “screened”, and this has resulted in contested evidence regarding the efficacy of screening.^{50,51}

Despite this, a number of assessment tools have been used in practice and have targeted both caregivers and the older person (see Cohen,⁵² Phelan and Treacy,⁵³ and Gallione et al,⁵⁴ with Gallione et al recommending routine screening for elder abuse). Moreover, the American Medical Association⁵⁵ recommends that questions on abuse be integrated into the full assessment of an older person. In a review of the literature, two screening tools⁵³ were recommended for piloting in Ireland, namely, the Elder Abuse Suspicion Index (EASI),⁵⁶ and because the Irish prevalence study identified financial abuse as the most common form of elder abuse, the Older Adult Financial Exploitation Measure.⁵⁷ The EASI comprises six questions with yes, no or did not answer responses. Five questions are directed at the older person and are based on the types of elder abuse perpetration. The final question is based on the subjective assessment of the clinician. Initially

piloted in Canada by physicians with 953 older people, the EASI demonstrated strong psychometric properties with the sensitivity of each question ranging from 0.03 to 0.23 and specificity ranging from 0.72 to 0.99.⁵⁶ The EASI has engendered support from the WHO⁵⁸ and has been translated into many languages. In Ireland, the EASI was piloted by multidisciplinary health care professionals with over 700 older people and did demonstrate evidence for its implementation in practice.⁵⁹ Phelan et al's⁵⁹ study also found that the simple action of asking the questions could instigate a conversation wherein abuse would have been unacknowledged by the older person but disclosed when they probed the meaning of the questions, thus enhancing a suspicion of abuse perpetration.

Recognizing the complexity of elder abuse, specific tools based on elder abuse categories have also been developed, such as tools based on psychological abuse^{60–62} and financial abuse.⁶³ One abuse area of particular note is financial abuse, especially when decision-making capacity is a challenge, for example, in the case of dementia. Financial management draws on abstract thinking and the higher-order executive functioning in the brain; therefore, experiencing difficulties in managing financial affairs should trigger a financial capacity assessment. There are several assessments for financial capacity in the literature,^{63,64} which draw on areas such as monetary skills and monetary concepts, cash and check book management, understanding financial statements, bill payments and insight into financial balances and accounts.⁶⁴ The advantage of early assessment of financial capacity is the empowerment of older people to arrange financial affairs and, in particular, power of attorney arrangements in advance of potential capacity deterioration.

Understanding the challenges in disclosing

One of the most important areas for any health care professional is communication, and building up trust and therapeutic relationships can enable disclosure of abuse by the older person. Older people may report abuse because they want a behavior change in the perpetrator's actions and to ensure their personal safety.⁶⁵ However, in some cases, older people justify the abuse as deserving due to a perceived "burden" on a caregiver, so do not report its occurrence.⁶⁶ In a study on older people's experiences of elder abuse, participants described a lack of knowledge of the presence of or how to access helping agencies as well as feeling they would not be believed.⁶⁷ Feelings such as shame, feeling worthless or a minimizing of the impact of the abuse can also be reasons for not disclosing.⁶⁶ In addition, the context of remaining

stoic may be a lifelong experience that is continued during the abuse. There can be an irrational loyalty to the perpetrator and a belief that family life is private.⁶⁶ There may also be a reluctance to disclose if the perpetrator was dependent on the older person⁶⁸ or a perception that removing a caregiver who is a perpetrator may lead to admission to a long-term care facility.⁶⁹ Relationship dynamics between the perpetrator and the older person may also influence disclosure.⁷⁰ In addition, in cases where older people have communication or cognition challenges, the ability to disclose may be difficult. Fear of repercussions from the perpetrator may also present a barrier to seeking help (as perpetrators may be gatekeeping contacts, both physical and telephone etc).¹² Through understanding these issues, nurses can support the older person and work to overcome reporting barriers. Suspicions of abuse may be a feature of the nurse–older person interaction, but disclosure gives additional impetus to the ability to take action to intervene.

Action

Following detection of a suspicion of abuse, the nurse has a responsibility to assess and take action.⁷¹ Many countries have adult protective services that accept referrals; however, a careful assessment may avoid formal referral. For example, abuse and neglect may be due to caregiver stress or a lack of knowledge or education to provide appropriate care, so addressing such factors may address the root cause of the abuse. Unlike responsibilities in child protection, which in many countries nurses are mandated to act on suspicions of abuse, in elder abuse, nurses may feel futile as the older person who has decision-making capacity may wish to retain the status quo and be reluctant to take things further. Continued support is needed and nurses, particularly in the community setting, must also continue to engage with the perpetrator, who may ultimately be a gatekeeper to continued access to the older person. In the community setting, it can involve a delicate negotiation by nurses as there may be no legal support to independently enter the house to engage with the older person if there is a suspicion of maltreatment. The lack of such supportive systems points to tangible practice limitations where there is a need to address the legislative, institutional and siloed approaches which are experienced by health care professionals in various countries.^{72,73}

Careful deliberation of the context of suspected abuse should include evaluation on the need to refer to protective services, and judgment also involves an assessment of the immediacy of intervention. In addition, many instances of elder abuse may also represent a legal trespass, so referral

to police should be considered. In all cases, the voice of the older person is paramount and case management needs to take into account the impact on the older person. In the UK, one judge's legal commentary is important as it stresses that safeguarding is not about ensuring the total absence of risk, but a balancing of risk through careful case deliberation. Lord Justice James Munby in the case of "Local Authority X v MM & Anor (No. 1) (2007)"⁷⁴ observes:

The emphasis must be on sensible risk appraisal, not striving to avoid all risk, ... in particular to achieve the vital good of the elderly or vulnerable person's happiness. What good is it making someone safer if it merely makes them miserable.⁷⁴

Thus, care is about "doing the right thing and doing the thing right" and fundamentally delivering care that is empathetic and advocating for the older person's voice, acknowledging that human life involves some risk, which each person mediates daily.

In some countries, there are independent advocacy services for older people (see Sage Advocacy and Support for Older People⁴⁶). Independent advocacy is an important resource as nurses are embroiled in complying with institutions' policy and culture, while families have particular perspectives; thus, having an independent advocate facilitates rights representation that has no conflict of interest.⁷⁵

Conclusion

Elder abuse is a complex issue which occurs in all environmental settings and requires nurses caring for older people to be able to detect its occurrence and initiate appropriate responses. As the world faces a global demographic transition, a fundamental right for all human beings is to live in a safe environment. For older people, abuse differs in many ways than abuse from other age groups. Older people do not have time on their side, may experience communication challenges and may not recognize the abuse or be able to access helping agencies. Furthermore, issues of declining health and decreasing independence may change the fundamental relationship in families, and increased dependence may change both power and relationship dynamics and lead to abuse. On a macro level, the way society views older people can be imbued within ageist frames of reference leading to a tacit minimization or blinkered perspective of abuse. Consequently, there may be a sympathetic view of the "burden" of caregiving, blurring recognition of abuse or reducing the impetus to take ameliorative action. Nurses have both a duty of care and a duty to care about older people experiencing abuse, and taking action means recognizing responsibility in

several domains, including awareness raising, dyadic abuse, institutional abuse, sexism, ageism and lobbying for a separate UN convention for older person rights. Firstly, nurses need to have a clear understanding of what is elder abuse and what action is needed. Secondly, there is a whistleblowing responsibility when systems of care are seen as non-person centered, for example, care being task rather than people oriented. From an organizational culture level, whistleblowing should be viewed as a positive activity and located within risk management, clinical governance and quality assurance mechanisms. Systems of care need to be accountable for their care delivery. Finally, from a public health perspective, nurses, as a community, have a responsibility to address ageism and to lobby to improve policy, legislation and practice to ensure older people's safety, autonomy, equality and equity. In taking this multilevel approach, nurses are not only safeguarding older people now, but are safeguarding their own and all our futures.

Disclosure

The author reports no conflicts of interest in this work.

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