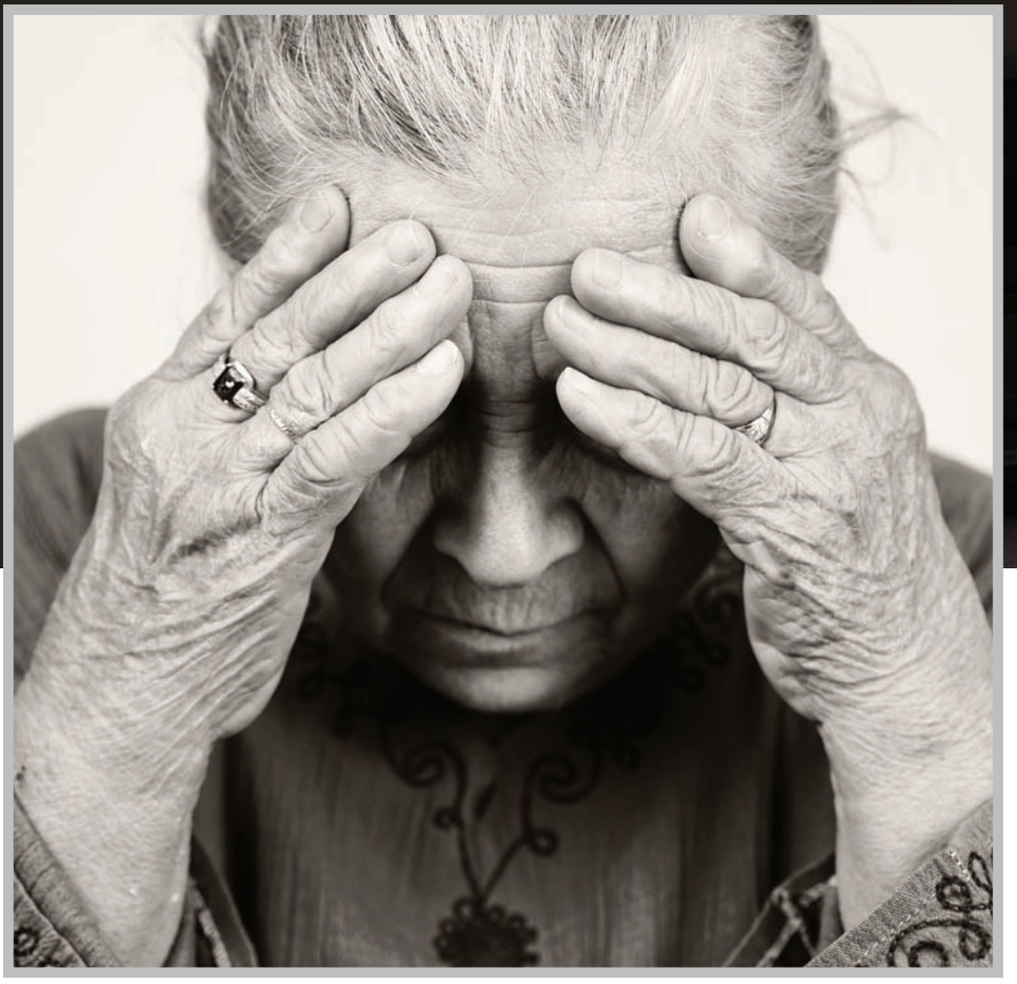
CE 2.5 contact hours

Elder Abuse: SPEAK OUT FOR JUSTICE



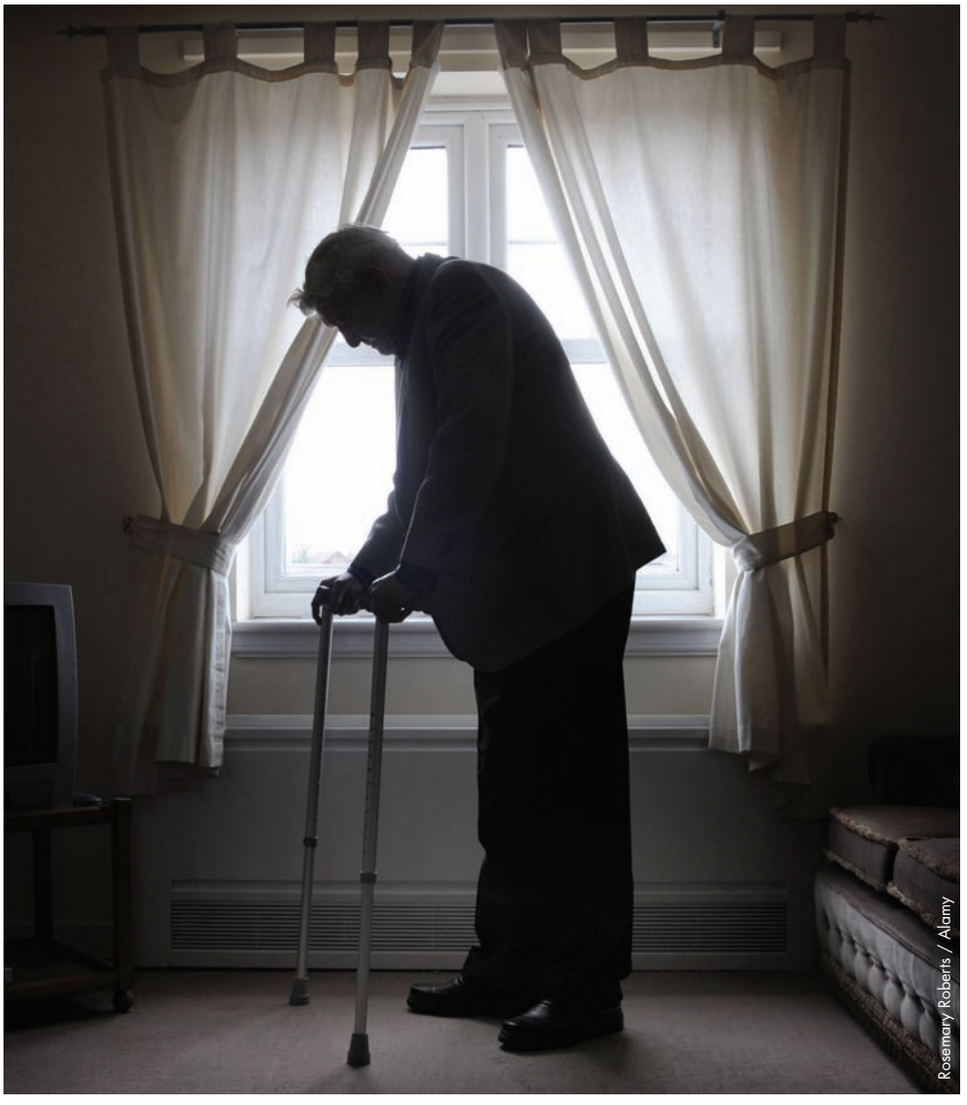
Dunca Daniel Mihai / Alamy

By Jenna M. Olson and Barbara A. Hoglund

ABSTRACT: *It is estimated that 1 in 10 older adults experience abuse, but only 1 in 5 to as little as 1 in 24 cases are reported. Elder abuse is expected to increase as the population ages. Nurses are in a prime position to identify, assess, manage, and prevent elder abuse. This article explores elder abuse and its prevalence, potential causes, and risk factors, offering case studies, assessment tools, resources, and interventions.*

VIDEO ABSTRACT: *A video abstract by author Jenna Olson is available at http://links.lww.com/NCF-JCN/A27*

KEY WORDS: *abuse prevention, elder abuse, elder mistreatment, gerontology, nursing*



Betty became a widow at age 78. A week after her husband died, the financial planner she and her husband had been working with told Betty she needed to pay him $2,500 to reorganize a Family Trust and ensure her financial resources would remain safe. She wondered why, since prior to his death her husband had paid the fee for the Trust to be executed.

Daniel, age 84, was admitted to the hospital after a hip fracture and you notice bruises on his arms and back. Daniel is talkative and friendly except when his son comes to visit and he becomes quiet and withdrawn. At one visit, he makes an attempt to say something and his son says, "Dad, BE QUIET*! Nobody wants to listen to your rambling!"*

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LACK OF JUSTICE

Sadly, abuse of elders has been prevalent worldwide for centuries (Muehlbauer & Crane, 2006); it is only within the past 30 to 40 years that serious attention has been given to elder abuse (Sellas & Krouse, 2011). Yet, elder abuse remains highly underdiagnosed and underreported by healthcare professionals (Halphen, Varas, & Sadowsky, 2009; National Center on Elder Abuse [NCEA], n.d.-a). Unfortunately, the lack of knowledge among healthcare professionals—including nurses—about elder abuse contributes to its invisibility.

Proverbs 31:8-9 (The Message) tell us, "Speak up for the people who have no voice, for the rights of all the down-and-outers. Speak out for justice! Stand up for the poor and destitute!"

Nurses are in a prime position to speak out for the elderly and to identify, assess, manage, and prevent elder abuse, as they are more likely to have regular contact with elders in and outside of healthcare facilities. Christians believe people are made in God's image (Genesis 1:27) and are deserving of love and compassion regardless of status; that every human deserves to be treated with dignity and respect, especially one's elders (Job 12:12; 1 Peter 5:5). From a Christian nursing perspective, interventions related to the prevention, early recognition, and treatment of elder abuse uphold biblical principles regarding advocating for and serving those whom some societies might not deem valuable. In doing so, the nurse fulfills the same call as Christ in Isaiah 61:1-3 (NIV): "to bind up the brokenhearted, to proclaim freedom for the captives and release from darkness for the prisoners … to comfort all who mourn." Nursing for the Christian stems from gratitude for Christ's identification with and advocacy for the world; Christ's love for the broken and wounded compels nurses to compassionately intervene in elder abuse.

As part of the interprofessional team, the role of the nurse in managing abuse is to:

- provide an accurate assessment of abuse and risk factors for abuse;
- clearly and objectively document assessment findings;
- report suspected incidents of abuse and participate in investigation as appropriate;
- provide support and referrals for clients experiencing potential or actual abuse; and
- implement strategies to prevent elder abuse.

WHAT IS ELDER ABUSE?

The terms *elder mistreatment* and *elder abuse* are often used interchangeably. However, it is more accurate to define elder mistreatment to include elder abuse along with self-neglect (Fulmer & Caceres, 2012; Mosqueda & Dong, 2011).

Each state in the United States has differing legal definitions, but in general, elder abuse is defined as the intentional or negligent treatment of a vulnerable older adult (over age 65) by a caregiver or other trusted person that results in, or may result in, psychological or physical harm (Hess, 2011; NCEA, 2012). The five most commonly recognized types of elder abuse, listed in order of most to least prevalent, are (a) financial exploitation, (b) neglect, (c) emotional or psychological abuse, (d) physical abuse, and (e) sexual abuse (See Table 1).

The most common form of elder mistreatment is self-neglect (Mosqueda & Dong, 2011). Self-neglect occurs when an older adult fails to ensure basic needs are met and perform personal care because of physical, emotional, or cognitive impairment. Although distinct from elder abuse, self-neglect is highly prevalent and should be assessed and managed in the same way as elder abuse (Fulmer & Caceres, 2012; Mosqueda & Dong, 2011).

PREVALENCE OF ELDER ABUSE

It is difficult to determine the extent of elder abuse because of lack of research and the invisibility of abuse (Acierno et al., 2010; NCEA, n.d.-a). Studies show that approximately 7.6% to 11% of older adults have experienced abuse within the past year (Acierno et al., 2010; Mosqueda & Dong, 2011; NCEA, n.d.-a). However, some researchers speculate that abuse is occurring at a much higher rate than studies reveal (Cohen, Levin, Gagin, & Friedman, 2007), especially financial abuse (NCEA, n.d.-b). The best estimates suggest that 1 in 10 or as many as 1 to 2 million older adults may be experiencing abuse; yet, 1 in 5 to as few as 1 in 24 cases are reported (Acierno et al., 2010; Halphen et al., 2009; NCEA, n.d.-b; Sellas & Krouse, 2011). Not surprisingly, the incidence of elder abuse is expected to increase as the population of older adults rises.

Some types of elder abuse are more common and an older adult may simultaneously experience more than one type of abuse at a time. According to Acierno et al. (2010), while 11% of adults 60 years and older reported having experienced abuse in the past year, these rates reflect the experience of more than one type of abuse in a given person:

- financial exploitation: 5.2%
- neglect: 5.1%
- emotional/psychological abuse: 4.6%
- physical abuse: 1.6%
- sexual abuse: 0.6%.

A large risk factor for elder abuse is dementia or other mental health issues that may render an older adult unable to report abuse (Halphen et al., 2009; NCEA, n.d.-a). The study by Acierno et al. was limited to individuals considered cognitively intact who could answer questions accurately. As well, this study did not survey individuals living in long-term care facilities; therefore, the rates of abuse listed above may be much less than reality.

There are several reasons why elder abuse remains largely unidentified and underreported. In 90% of abuse cases, the abuser is related to the victim (Muehlbauer & Crane, 2006; NCEA, n.d.-b). Therefore, the majority of abuse occurs in private homes. Abuse often places victims in a compromised position, leading to feelings of shame, guilt, and fear, which may discourage abuse reporting. Victims also may be in denial of abuse. In the case of physical, emotional, or mental impairment, the victim may be unable to report abuse. Additionally, elder abuse can remain unidentified and unreported by mandated reporters due to discomfort or denial despite legal ramifications.

Efforts have been made nationally to address elder abuse. The Older Americans Act creates and funds the Department of Health & Human

Case 1: Unsafe Living Conditions?

You are initiating home health for an 84-year-old male with chronic obstructive pulmonary disease and mild cognitive impairment who lives with his son, daughter-in-law, and grandchildren. You find him in his room smoking cigarettes with oxygen running. You turn off the oxygen and proceed with assessment. In your patient teaching, you explain he cannot smoke with oxygen and assess how well he can apply and remove his nasal cannula and turn his oxygen on/off. He says, "Oh you know how forgetful us old codgers are; I won't do it again." You speak with his family and reinforce no smoking with oxygen running. On your next three visits, he is not smoking but you notice multiple cigarette butts in an ashtray. On the fifth visit, you again find him smoking with oxygen running.

Should this be reported? This patient's problems in the domain of *perception/cognition* and *impaired gas exchange* (Herdman, 2012) make him at risk for *self-neglect* and there is potential for neglect by his family. Discuss with your supervisor and follow the policies of your agency; you or your agency should contact Adult Protective Services. Assist the family in exploring support services; offer Eldercare Locator information.

Table 1. Types and Definitions of Elder Abuse

Type of Abuse	Definition	How Abuse May Present
Financial exploitation/ abuse	Theft or misuse of money, assets or belongings including fraud	Missing money/belongings; deficient care despite ample resources; overprovision of services
Neglect	Failure of a caregiver to provide basic physical and emotional needs including abandonment (left without care)	Malnutrition, dehydration, unkempt, dirty or unsafe living conditions, untreated health issues
Psychological/ emotional abuse	Intentional social isolation or use of demeaning verbal statements or threats meant to produce mental distress or fear	Depression, withdrawal, agitation, poor interaction/ response with caregivers
Physical abuse	The threat or infliction of bodily harm by use of physical force	Unexplained injuries, bruising, burns, bumps, scrapes, etc.
Sexual abuse	Threatening or forcing participation in sexual acts or contact without consent	Injuries to genital or breast areas; unexplainable vaginal or anal bleeding

Sources: Fulmer and Caceres (2012), Hess (2011), NCEA (n.d.-a), and IAFN (2006).

Table 2. Theories Associated With the Incidence of Abuse

Theory of Abuse	Explanation
Transgenerational/ social learning theory	Abuse is described as a learned behavior: an individual who witnessed violence at a young age as a method of coping with stressful situations is more likely to utilize violence in similar situations.
Situational theory	The probability of elder abuse perpetrated by a caregiver is proportional to the perceived burden of caregiving.
Exchange theory	The incidence of abuse is classified in terms of a combination of reliance of the older adult on a caregiver (increased burden) and a history of ineffective coping methods.
Political economic theory	Abuse is more likely to occur when an older adult is forced to find a caregiver or other support after a financial loss or a decrease in the level of independence.
Risk-vulnerability model	The interplay of risks (external environmental factors) and vulnerabilities (physical, emotional, mental, social, and spiritual) increases the likelihood of abuse incidence.
Psychopathology of the caregiver	The focus for risk of abuse is on the caregiver who has emotional or mental health issues (including addiction) especially in combination with an older adult experiencing cognitive and mental health issues.

Sources: Muehlbauer and Crane (2006), Fulmer and Caceres (2012), and Sellas and Krouse (2011).

Services Administration on Aging (AoA) and programs such as the NCEA and the Long-Term Care Ombudsman Program (AoA, 2013). In 2010, a comprehensive Elder Justice Act (EJA) was passed as part of the Patient Protection and Affordable Care Act, authorizing elder abuse forensic centers, an Elder Abuse Coordinating Council, an expert public Advisory Board on Elder Abuse, Neglect and Exploitation, additional support for the Long-Term Care Ombudsman Program, and requiring the reporting of crimes in long-term care facilities to law enforcement. As of November 2013, Congress has not appropriated funding for the EJA (National Adult Protective Services Association [NAPSA], 2013; NCEA, n.d.-d).

Several theories help explain the prevalence of elder abuse. Discrimination against the elderly, ageism, and/or possibly a fear of aging in the abuser all may contribute to elder abuse. Although theories of abuse may not account for every situation, each theory can be applied to situations to facilitate understanding and intervention. Table 2 offers six theories of why elder abuse may occur.

RISK FACTORS FOR ABUSE

Elder abuse can happen to any elder, anywhere, at any time. Various factors increase the likelihood an elderly individual will experience abuse. Social isolation or low level of social support has been found to be a major component in the incidence of elder abuse (Fulmer & Caceres, 2012; NCEA, n.d.-a). According to Acierno et al. (2010), when controlling for all other factors, social isolation triples the risk of occurrence of any type of elder abuse. Demographic factors such as being female, age 80 years and older, and socioeconomic status (low income) also put an older adult at higher risk. Other common risk factors for elder abuse include dementia or other mental health issues, poor physical health, reliance on caregiver for activities of daily living (ADLs) and instrumental ADLs, and physical immobility (Fulmer & Caceres, 2012; NCEA, n.d.-a).

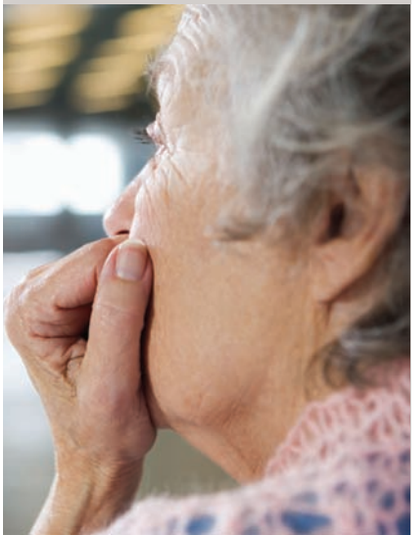
Circumstances such as caregiver strain, social isolation of the abuser, financial dependence on the older adult, and unemployment or financial strain of a caregiver, family member, or other trusted individual increase the likelihood of causing harm to an older adult (Fulmer & Caceres, 2012; Halphen et al., 2009; National Institute on Aging [NIA], 2012). The likelihood of elder abuse also increases if either/ both the elder and the trusted individual have mental health or substance abuse issues, a history of family violence, and a shared living situation (Fulmer & Caceres, 2012; NCEA, n.d.-a).

The issue of elder abuse cannot and should not be taken lightly. Abuse can lead to guilt, fear, and depression in

Case 2: Hip Fracture Complications

A previously ambulatory, home-dwelling 79-year-old female is admitted to the hospital with a hip fracture. After hip repair, she is confused and persistently yells and tries to get out of bed. Haloperidol (Haldol) is prescribed and family stay as much as possible. After weeks of hospitalization and rehabilitation, the patient is better but remains agitated at times and on Haldol. After numerous attempts to discontinue her urinary catheter, she remains catheterized. You note she is restless, grimaces constantly, and moves her arms, fingers, and legs; walking is impossible because of her persistent movement. She is discharged to a long-term care facility nonambulatory, with a urinary catheter and prescribed Haldol.

Should this be reported? This woman was healthy prior to hospitalization; now she has pseudo-Parkinsonism, possible tardive dyskinesia, akathisia, akinesia, and prolonged confusion and nervousness—all potentially caused by Haldol. She also is at high risk for urinary tract infection. Nurses need to consider treatment hazards and know medication side effects (such as extrapyramidal symptoms), and advocate for safe care. Hospital policies and procedures should be in place or developed to assess patients for treatment hazards.



the victim (Cisler, Begle, Amstadter, & Acierno, 2012; NIA, 2012). Older adults who are abused are more likely to experience permanent injury and disability (Mosqueda & Dong, 2011), as well as increased dementia and delusions (Daly & Schoenfelder, 2011). Nursing home placement for an abused older adult is four times greater than that of an older adult not experiencing abuse (NAPSA, 2011). Research also suggests that abuse leads to increased mortality, morbidity, and early death (Acierno et al., 2010; Mosqueda & Dong, 2011; NAPSA, 2011) among the elderly.

The financial cost of elder abuse also must be considered. The estimated loss from financial exploitation in 2009 for older adults was $2.9 billion (NCEA, n.d.-b). Not only is financial exploitation the most common type of elder abuse (NIA, 2012), but a significant cost arises from increased use of medical and emergency services by abused older adults (Mosqueda & Dong, 2011). According to Bond and Butler (2013), billions of dollars are spent annually on victims of elder abuse. Because the incidence of elder abuse is expected to increase with the growth of the aging population, an increase in financial cost is anticipated.

Situations of elder abuse will not resolve on their own (NIA, 2012). If abuse is already occurring, experts say it will become more frequent and severe (Fulmer & Caceres, 2012). As previously noted, one of the many risk factors for elder abuse is a family history of violence. This history of violence on the part of the abuser also puts them at risk for abuse as an older adult, thus the cycle of abuse is perpetuated. As abuse can happen to anyone, anywhere, and at any time, timely identification and intervention is critical to reduce the impact of abuse.

NURSING ASSESSMENT

Nurses have great opportunity to speak out for justice across numerous settings. When assessing for elder abuse, adhere to the policies and procedures of your facility. Procedures should include conducting three standard types of assessment: (a) violence screening; (b) physical assessment of the patient and the environment; and (c) risk assessment (Cohen et al., 2007; Fulmer & Caceres, 2012). Each assessment indicates the risk or presence of abuse at a different rate, so it is important that all three assessments are addressed for optimal identification of potential or actual abuse.

Every older client should be assessed for abuse. Develop a trusting relationship with an older adult by actively listening, demonstrating respect and concern, ensuring privacy, and providing prompt intervention and follow-up (Fulmer & Caceres, 2012). The International Association of Forensic Nurses (IAFN) (2006) suggests asking simple general questions (How is everything going for you at [location]?), then specific questions related to your observations (How did you get those bruises on your neck?) along with follow-up queries to explore what might have happened. Examples of standardized assessment tools are listed in Table 3 and many tools can be retrieved online (see Web Resources).

In a violence screening, direct questions are used to determine actual instances of neglect; emotional, physical, and sexual abuse; and financial exploitation. Topics and questions addressed during a violence screening or risk assessment are listed in Table 4. Client responses will determine the amount of risk or the type of abuse that is occurring.

A physical assessment requires head-to-toe examination for objective signs and symptoms of abuse. In addition, an objective assessment of the environment is necessary. Rather than matching signs or symptoms to a particular type of abuse, Table 5 presents general signs and symptoms of abuse according to a holistic assessment—physical, mental, emotional, social, spiritual, and environmental. Note that the social, emotional, mental, and spiritual aspects have been combined under psychosocial, as they may be difficult to differentiate. Signs of financial exploitation are included under environment.

The signs and symptoms of elder abuse can be subtle and difficult to identify. To identify abuse, mandated reporters, including healthcare professionals, must be adequately trained

(Sellas & Krouse, 2011). Moreover, signs and symptoms of elder abuse can easily be attributed to other causes such as disease pathology, mental status, or age (Cohen et al., 2007). Unfortunately, a mandated reporter may ignore the presence of elder abuse. Barriers for physicians in identifying and reporting elder abuse reported by Halphen et al. (2009) were lack of appropriate screening tools, limited time to screen clients adequately, inadequate knowledge about how and when to report abuse, and unwillingness to report. Although the majority of abuse is perpetrated by family, it may also occur in long-term care and assisted living settings.

Risk assessment focuses on identifying the level of risk (low, moderate, high) for elder abuse by examining the presence and magnitude of known risks. According to Cohen et al. (2007), it should be assumed that an older adult at high risk of abuse is currently experiencing abuse. It also is important to screen the caregiver for caregiver strain/stress, as this is a major risk factor for becoming an abuser (Fulmer & Caceres, 2012; IAFN, 2006; Sellas & Krouse, 2011).

Assessment findings should be clearly documented; diagrams and photographic evidence are valuable when available (IAFN, 2006; Sellas & Krouse, 2011). Accurate documentation is invaluable in abuse investigations. Note, a client's health record is a legal document and needs to remain objective in order to avoid potential legal issues.

NURSING INTERVENTION

Early management of elder abuse is essential. After assessing and documenting findings of actual or potential abuse, it is critical to create and implement a plan of care. Nursing diagnoses such as *powerlessness, social isolation, self-neglect, compromised human dignity,* or *dysfunctional family processes* (Herdman, 2012) can guide care planning. In addition to legal mandates, facility policies, and care designed to meet immediate physical, mental, emotional, social, and spiritual needs, there are nursing actions that can be implemented as part of a holistic plan of care to address the continuum of elder abuse.

Table 3. Standardized Elder Abuse Assessment Tools

Type of Tool	Standardized Assessment Tools
Violence screen	Actual Abuse Tool Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST) Partner Violence Screen (PVS) Questions to Elicit Elder Abuse Screen for Various Types of Abuse or Neglect
Physical assessment	Elder Assessment Instrument (EAI) Suspected Abuse Tool
Risk assessment	Brief Abuse Screen for the Elderly (BASE) Elder Abuse Suspicion Index (EASI) Elder Assessment Instrument (EAI) Health, Attitudes Toward Aging, Living Arrangements, and Finances (HALF) Indicators of Abuse (IOA, E-IOA) Risk of Abuse Tool Vulnerability to Abuse Screening Tool (VASS)
Caregiver strain	Caregiver Abuse Screen (CASE) The Modified Caregiver Strain Index (CSI)

Sources: Cohen et al. (2007), Fulmer and Caceres (2012), and University of Iowa Carver College of Medicine (n.d.).

Reporting abuse is the single most effective intervention for elder abuse (Halphen et al., 2009). As a mandated reporter by law, it is the nurse's responsibility to report any case of suspected elder abuse (Alford, 2006). The nurse is not responsible to prove that abuse has occurred—this is the responsibility of the agency to which the abuse is reported. Nor does the nurse need to determine why or how abuse occurred (Ziminski & Phillips, 2011). The nurse, however, may be called upon to be part of the investigation process (IAFN, 2006; Muehlbauer & Crane, 2006). Situations of abuse among older adults living at home should be reported to Adult Protective Services; for a long-term care setting, incidents of abuse should also be reported to the local long-term ombudsman (a position in every facility required by law). In life-threatening situations, call 911 for immediate intervention by emergency and law enforcement personnel. If abuse is suspected in a hospitalized elder, often the first step is notifying social work. Even if a client requests the nurse to not report abuse, the nurse is still legally required to report; anonymous reporting can be accomplished by calling the local Elder Abuse Hotline (Alford, 2006) or Adult Protective Services (see Web Resources). Failure to report can result in criminal charges and penalties; but a report of suspected abuse made in good faith is protected by law from liability (Halphen et al., 2009; Hess, 2011; NCEA, n.d.-a).

Table 4. Sample Violence and Risk Assessment Questions

Sample Questions
• Do you feel safe where you are living?
• Are you ever alone frequently or for long periods of time?
• Has anyone failed to assist when you needed help?
• Has anyone ever yelled at you or threatened you?
• Has anyone ever made you do something that you did not want to do?
• Has anyone hurt, or tried, to hurt you?
• Is there anybody that you afraid of?
• Does someone provide care for you regularly?
• Does your caregiver abuse drugs/alcohol?
• Was your caregiver abused as a child?
• Were you abused as a child?
• Who manages your finances?
• Have you ever signed a document that you did not understand?
• Has anyone taken away something that was yours?

Sources: Fulmer and Caceres (2012), NCEA (n.d.-a), IAFN (2006), and Ziminski and Phillips (2011).

Nurses have unique opportunities to provide immediate interventions for

older adults who may be experiencing abuse. This requires collaboration with the client's interprofessional team to obtain services such as placement into long-term care, counseling, home healthcare, and financial management. Focus on establishing a plan of safety and teaching the client actions to be taken when an abusive situation arises. For example, provide a list of phone numbers or contacts for use in an emergency as well as facilitating placement at a safer, alternative location. To help prevent financial exploitation, help the elderly reduce telemarketing calls by registering with the National Do Not Call Registry (http://www.donotcall.gov/); encourage the elderly to shred financial documents before discarding, not give out personal information, and check with trusted friend/family members before making financial decisions (NCEA, n.d.-a).

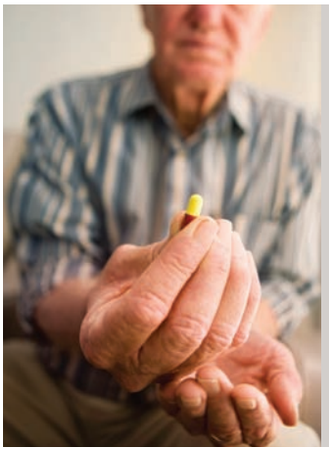
Spiritually assessing elders for their sense of meaning and purpose, hope, forgiveness, and faith background can reveal potential abuse. As elders experience *hopelessness*, *spiritual distress, impaired religiosity,* or other nursing diagnoses (Herdman, 2012), nurses can mobilize spiritual resources. Churches can play a key role in promoting the well-being of older adults, especially since the elderly are frequently connected with a faith congregation (NCEA, n.d.-c). The unique and personal network of a faith community provides the opportunity for members to act as "first responders" for elders (Rydholm et al., 2008). Faith community or parish nurses (FCNs) in particular can help elders in their role as advocates, educators, counselors, coordinators, and facilitators within faith communities. FCNs often have awareness of community resources that can help the elderly live in their homes and decrease the cost of public assistance (Rydholm et al., 2008), and they can mobilize the faith community to offer help. Furthermore, older adults tend to ask for assistance from FCNs more than other age groups. Thus, the FCNs are in an ideal position to promote and implement interventions to mitigate abuse. Church networks (i.e., members) can provide an excellent means for combating social isolation, powerlessness, and supporting elders to ameliorate abuse.

As social isolation puts the older adult at risk for abuse, strategies for preventing isolation should be implemented for elders. Strategies include maintaining contact with older adults in one's community and family, referral to a visitor or well-being check program, development of a buddy system for older adults to check in with each other, identifying community activities and transportation services for the elderly, locating caregiver

Table 5. Signs and Symptoms of Elder Abuse

Aspect of Assessment	Signs and Symptoms
Physical	• Poor hygiene and appearance • Inadequate nutrition/hydration • Suspicious bruising (especially bilateral and around breasts and genital areas) or scars • Pressure ulcers, burns, blisters, abrasions • Repeated, unusual injuries (e.g., fractures) • Untreated injuries or health issues • Unexplained sexually transmitted diseases or rectal/vaginal bleeding • Unexplained bruising/injuries to breasts
Psychosocial (mental, emotional, spiritual, social)	• Social isolation • Unusual changes in behavior or alertness • Agitation, confusion, dementia, depression, or delirium • Withdrawal from activity • Refusal to seek medical attention • Not involved in/allowed to make decisions
Environmental	• Unsafe or unsanitary living conditions • Living situation/basic needs are inadequate despite sufficient funds • Deficient medical attention • Inappropriate/long-term use of chemical or physical restraints • Witnessed threats or neglectful treatment by caregiver • Sudden or unexplained changes in finances • Misplacement or loss of assets or property • False claims, overcharges, or repeated charges for bills • Forgery of signature

Sources: Fulmer and Caceres (2012), IAFN (2006), NCEA (n.d.-a), and NIA (2012).



Case 3: Assisted Living Facility

An 86-year-old male is transferred to the emergency department from an assisted living facility with a heart rate of 50, palpitations, confusion, nausea and vomiting, and low urine output. You obtain a list of his medications from the facility: digoxin 1.25 mg PO daily, hydrochlorothiazide (HCTZ) 100 mg PO daily, and Verapamil extended release 120 mg PO daily. You call his primary care physician to verify medications and learn the patient was prescribed 0.125 mg digoxin 7 days ago.

Should this be reported? Digoxin 1.25 mg daily is not a routine dose for digoxin after titration; furthermore, toxicity can easily occur in the elderly, especially when digoxin is taken with a potassium-depleting diuretic (HCTZ) and calcium channel blocker (Verapamil). Residential facilities are accountable for accurate medication administration. Discuss the situation with your supervisor and follow hospital policy. The assisted living facility should be reported to Adult Protective Services.

respite care services and/or counseling and support groups for caregivers, and providing consistent follow-up care (Center of Excellence on Elder Abuse and Neglect, 2012; Daly & Schoenfelder, 2011; Fulmer & Caceres, 2012). The church can play a key role in preventing social isolation through visitation and phone calls to the elderly.

Speaking for justice to raise awareness is another major nursing intervention. Educating older adult clients and their caregivers and family about elder abuse before it occurs is important (Fulmer & Caceres, 2012). Providing referrals for clients to support groups and other social services can help increase awareness and ensure an established source of intervention. Advocating on local and national levels for increased awareness and enhanced policies is another arena to speak out and prevent elder abuse (Alford, 2006). June 15 is World Elder Abuse Awareness Day; nurses can participate by wearing purple and sharing about elder abuse. Community awareness about elder abuse can be facilitated through distribution of educational materials, advertisements in local newspapers, planning community awareness activities, or facilitating public service announcements via local media. Schools of nursing should include elder abuse education in undergraduate and graduate curricula.

The case study sidebars throughout this article offer cases to help you think about elder abuse and circumstances surrounding abuse. The cases can help nurses assess for abuse or potential abuse and determine when to report abuse.

CONCLUSION

Elder abuse is a complex and widespread issue that has been inadequately addressed for centuries. Nurses today can play a powerful role in identifying and managing elder abuse. With adequate knowledge of factors contributing to elder abuse and strategies for assessment and intervention, nurses will be equipped to identify and manage elder abuse safely, appropriately, and efficiently. The Christian nurse has the unique opportunity to integrate the love of Christ into interventions and provide the comfort and dignity needed by victims of elder abuse. As the elderly population continues to grow and the risk of elder abuse increases, the responsibility of addressing elder abuse in all areas of society will increase. Nurses can be ready to respond and speak out for justice on behalf of elders.

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Web Resources

- National Center on Elder Abuse—http://www.ncea.aoa.gov
- Clearinghouse on Abuse and Neglect of the Elderly—http://www.cane.udel.edu
- National Adult Protective Services Association—http://www.napsa-now.org
- Elder Rights Protection Programs—http://aoa.gov/AoARoot/AoA_Programs/Elder_Rights/index.aspx
- Eldercare Locator—http://eldercare.gov/Eldercare.NET/Public/Index.aspx (1-800-677-1116)
- Screening Tools—http://www.medicine.uiowa.edu/familymedicine/emscreeninginstruments
- State Reporting—http://www.ncea.aoa.gov/Stop_Abuse/Get_Help/State/index.aspx
- Elder Mistreatment Curriculum (free)—http://www.iafn.org/displaycommon.cfm?an=1&subarticlenbr=461
- Journal of Elder Abuse & Neglect—www.tandf.co.uk/journals/WEAN