



Chapter 69– Elder Abuse

Episode Overview:

- 1) List 6 types of elder abuse
- 2) List 10 risk factors for elder abuse
- 3) List 10 questions to screen for elder abuse
- 4) What are some indicators on the medical history and physical exam that may suggest ongoing elder abuse?
- 5) Discuss ethical and legal implications of elder abuse. Who needs to be reported?

Rosen's in Perspective:

- The elderly and “oldest” old population is growing.
- Because the elderly population are becoming an ever increasing proportion of ER patients we need to be aware of elder abuse and neglect
 - We need to start screening for it more often!
 - One review from 2008 identified 6% of older people living in the community experiencing abuse in the last month! (?ref#11 in Rosen's) with only 1 of 14 being reported
- The elderly are a very vulnerable group:
 - Financially
 - Due to cognitive decline
 - Physical deconditioning
 - Isolation
- Physicians may be the only person an aged individual sees outside their family - so we may be the patient's only chance to get to safety
 - Most perpetrators are family members/caregivers that live with the abused/neglected/taken advantage of

1) List 6 types of elder abuse

Six types (one study's breakdown of each):

- Physical abuse - 11%
 - Physical / bodily injury
 - Also includes over/under medication****
 - Restraints
 - Force-feeding
- Sexual abuse - 1%
 - Any non-consensual (or incapacitated) sexual activity
 - Can include physical/sexual advances, indecent exposure
- Emotional / psychological abuse - 15%
 - Intentional infliction of suffering, pain, distress on someone with verbal/non-verbal means
 - Demeaning comments, name calling, threats of deprivation/isolation/humiliation
- Neglect - 58%
 - “Failure or refusal of caregivers to fulfill any of their duties or obligations to an elderly individual which HAS or IS likely to result in serious harm”
 - Tough to prove
- Abandonment



- Financial OR material exploitation - 15%

Many people experience multiple types of abuse

Three main categories where this may occur:

- Domestic elder abuse
 - Happens in the home or caregivers home
- Institutional elder abuse
 - Occurs in a residential facility
- Self-neglect / self-abuse
 - The behaviour of the elderly person that threatens their own well being
 - They fail to provide themselves with basic necessities: food, water, shelter, medications, personal hygiene
 - ****This does not include mentally competent individuals who understand the consequences of their decisions****

2) List 10 risk factors for elder abuse

Caregiver risks - promoting abuse; risk factors placing the elders for abuse; environmental factors; institutional abuse risks

Box 69-1 Potential Risk Factors for Elder Abuse

Caregiver Risk Factors

Alcohol or drug abuse
Mental illness
Financial stress
Stress resulting from caring for the elder (e.g., a lack of resources)
Outside factors resulting in stress (e.g., unemployment)
Financial dependence on the elder
Unrealistic expectations regarding caregiver responsibilities
Lack of caregiving skills
Long duration of time as a caregiver

Elder Risk Factors

Physical or functional impairment
Financial dependence on the caregiver
Cognitive impairment or dementia
Social isolation
Low social support
History of family violence
Previous traumatic event exposure
Aggressive behavior
Female
Advanced age
Incontinence
Frequent falls

Environmental and Family Factors

Shared living situation
Overcrowded living conditions
Lack of family and community support
Socially isolated

Risk Factors for Institutional Abuse

Poor working conditions
Inadequate training, experience, and supervision of caregivers
Low wages
Low staff-to-patient ratio

3) List 10 questions to screen for elder abuse



- Very important to interview the caregiver and the patient privately!
 - Must be non-judgemental and non-threatening
 - “Caring for your mother/father must be a difficult task, do you ever feel anger or resentment toward them?”
 - “What are some of the biggest stressors facing you?”
 - Start off with basic questions including inquiry about daily care requirements, routines, medication and medication administration

Box 69-2

Questions for Use in Asking Patients about Elder Abuse

General

Do you feel safe where you live?
Are you afraid of anyone where you live?
Who assists you if you need help?
Who makes your meals?
Who helps you take your medications?
Who manages your checkbook?
Do you have frequent arguments with your family or caregiver?
What happens when you argue?

Physical Abuse

Have you been hit, slapped, or kicked?
Have you ever been locked in a room?
Have you ever been tied down?
Have you ever been forced to eat?

Sexual Abuse

Has anyone ever touched you sexually without your consent?

Psychological or Emotional Abuse

Do you feel alone?
Are you yelled at where you live?
Has your family or caregiver ever threatened to punish you or have you put in an institution?

Neglect

Are you left alone often at home?
Do you need to use hearing aids, glasses, dentures, or a walker or a cane? Are they readily accessible to you?
Does your family or caregiver ever fail to help you when you need help?

Financial or Material Abuse

Has anyone ever taken anything from you without asking?
Have you been forced to sign a will, power of attorney, or any documents that you did not understand?
Does your family or caregiver rely on you for housing or financial support?

- Do you feel safe where you live?
- Who takes care of you?
- Have you been hurt by anyone who was supposed to take care of you?
- Does anyone force or bully you into giving them financial support or your money?

4) What are some indicators on the medical history and physical exam that may suggest ongoing elder abuse?

- This is where our pre-hospital friends can help us out:
 - Identifying features of the patient’s home/family situation suggesting neglect or abuse (cleanliness, heat, water, infestations)



Box 69-3

Indicators from the Medical History of Possible Ongoing Elder Abuse

Implausible history of injury mechanism
Inconsistent history of injury mechanism between the patient and caregiver
Delay between onset of medical illness or injury and seeking of medical attention
Unexplained injuries
Elderly patient referred to as “accident prone”
Past history of frequent injuries
Noncompliance with medications, appointments, or physician directions
Caregiver not able to give details of the patient’s medical history or routine medications
Caregiver answers the questions regarding the patient
Patient or caregiver reluctant to answer questions
Strained patient-caregiver interaction
Poor living conditions according to paramedics or others

Box 69-4

Signs of Physical Abuse, Sexual Abuse, and Neglect That May Be Noticed on the Physical Examination

Physical Abuse

Contusions
Contusions on bilateral upper arms (grab marks)
Abrasions
Burns (e.g., from cigarettes, irons, immersion)
Sprains
Patterned injuries (e.g., marks consistent with the shape of a belt, fingers, electrical cord)
Traumatic alopecia
Bite marks
Restraint marks (e.g., involving wrists, ankles, and torso)
Fractures
Multiple injuries in various stages of healing
Blunt head trauma
Intra-abdominal injuries (e.g., liver, spleen)
Gag marks
Ocular injuries (e.g., hyphema, retinal detachment)

Physical Signs of Sexual Abuse

Evidence of genital, rectal, or oral trauma (e.g., contusions, lacerations, erythema)
Evidence of sexually transmitted disease

Physical Signs of Neglect

Dehydration
Evidence that the patient has been lying in urine and stool
Malnutrition
Clothing inappropriate for the climate; dirty or severely worn
Poor body hygiene
Untreated injuries and medical problems
Poor oral hygiene
Skin breakdown (e.g., decubitus ulcers, pressure sores)
Elongated toenails



Thorough investigations should be ordered based on this history and physical examination.

Again, documentation is super important:

- Key things to note:
 - Terms and descriptions used in the patient's own words
 - Include the mechanism of injury
 - The social situation (living arrangements)
 - Descriptions:
 - Fractures, lacerations, contusions.
 - Size, shape, location, colour,

5) Discuss ethical and legal implications of elder abuse. Who needs to be reported?

Again, the specific details of legal matters varies - in some states in the USA physicians are mandated to report any suspected case of elder abuse. It is very important to inform patients that you may have a requirement to report suspected cases of maltreatment before asking the screening questions.

Informing the patient that your goal is to end the abuse cycle AND help the patient and the family access resources; NOT punish the abuser.

In the great white north....

From Dr. Sampsel:

“We don't have Adult Protective Services in Canada. Only mandatory reporting is for residents of nursing or retirement residences. If the patient does not wish to have any help and is capable of making that decision, we cannot do anything further.”

In summary for those of us in BC: check out these show notes below for more information; but:

1. As a professional employee of a health agency you are generally expected to report suspected cases of abuse to your agency.
2. Know about SAIL
 - **Seniors Abuse & Information Line (for residents of BC)**
 - If you are an older adult who has been abused or mistreated call the Seniors Abuse & Information Line (SAIL) at 604-437-1940 or toll free at 1-866-437-1940, 7 days a week from 8:00 a.m. to 8:00 p.m., to get a referral to their legal advocate and other programs. For more information about their programs and resources visit [BC Centre for Elder Advocacy and Support](http://www2.gov.bc.ca/gov/content/family-social-supports/seniors/health-safety/protection-from-elder-abuse-and-neglect/where-to-get-help).
 - <http://www2.gov.bc.ca/gov/content/family-social-supports/seniors/health-safety/protection-from-elder-abuse-and-neglect/where-to-get-help>

Visit this excellent website on the topic: <http://bcceas.ca/for-professionals/>

Made by the BC Centre for Advocacy and Support

This section is copied from: <http://www.bcli.org/project/practical-guide-elder-abuse-and-neglect-law-canada>



The designated agencies include:

- Community Living BC
- Fraser Health Authority
- Interior Health Authority
- Northern Health Authority
- Vancouver Coastal Authority
- Vancouver Island Health Authority
- Providence Health Care Society.

Specific categories of people are obligated to report or investigate abuse. If the designated agency receives a report of abuse, and believes a crime has been committed,

it must file a report with the Police (s. 50). Employees of designated agencies are legally

required to respond to concerns of elder abuse and neglect.

Under the CCALA Residential Care Regulation (s. 77), licensees of community care and assisted living facilities must investigate and report incidents of abuse and neglect of their residents to:

- (a) the parent or representative, or contact person, of the person in care,
- (b) the medical or nurse practitioner responsible for the person's care,
- (c) a medical health officer, and
- (d) the funding program, if any.

Under the Health Professions Act, all health professionals, including nurses, occupational therapists and dental hygienists, are required to report to their registrar client or patient abuse of older adults by another health professional where:

- The abusive behaviour is a form of sexual misconduct, (s. 32.4) or
- The professional believes the person is a danger to the public (s. 32.2)."

According to: <https://www.cmpa-acpm.ca/-/elder-abuse-and-neglect-balancing-intervention-and-patients-right-to-confidentiality>

“There are no federal laws in Canada that make reporting of elder abuse mandatory, and the *Criminal Code* does not identify elder abuse as a specific crime. Physicians similarly do not have a duty to report a criminal offence related to elder abuse to the police. Indeed, this would generally be considered a breach of confidentiality unless there was consent from the patient or substitute decision-maker. If the police contact the physician about a patient who is suspected of being the subject of abuse, information should be provided only with the consent of the patient or substitute decision-maker, or with a court order.



Each Canadian province and territory takes a unique approach to how instances of suspected elder abuse are to be handled.² Physicians may be required to report to a designated authority if they suspect an older patient is harmed due to unlawful conduct, incompetent care or treatment, or neglect. In some jurisdictions, this obligation is triggered only when the patient is a resident of a care home or in-patient at a public hospital. In Ontario, for example, reporting abuse is mandatory when the patient lives in a long-term care home or a retirement home.³ “

The elderly patient may want to continue living in the abusive environment out of fear of being institutionalized in a care home. This is difficult for us to witness....but

How do you make the capacity assessment, when an elderly patient chooses to return to a potentially unsafe situation?

First it is crucial to include a whole team in this process: psychiatry, social work, occupational therapy, etc.

Second, “Legal capacity is a legal determination, not a medical determination. A doctor’s assessment or opinion can assist us, but it is up to the lawyer or legal advocate to determine capacity. As a legal advocate for older adults, it is important to assess whether there is incapacity, and whether it is a temporary situation (e.g. – acute medical condition, mitigating factors such as grieving, depression).” ~ copied from www.bcceas.ca

Instead, we’re trying to make a focused assessment whether the patient has “decisional capacity” or “mental competence”.

This is a long, topic. But here are a few elements to include:

1. Appreciation - tell me in your own words what you see as your medical problem?
2. Reasoning - able to compare information and consequences
 - a. How is X better than Y?
3. Expressing a choice - able to state a decision
4. Understanding - the information - risks and benefits of both options
 - a. Can you tell me in your own words what I just said about _____?

A.R.E. U able to choose?



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The decision-making abilities, their definitions, and questions to assess them

Decision-making ability	Definition	Sample questions
Understanding	The ability to state the meaning of the relevant information (eg, diagnosis, risks and benefits of a treatment or procedure, indications, and options of care).	After disclosing a piece of information, pause and ask the patient: "Can you tell me in your own words what I just said about [fill in the topic disclosed]?"
Expressing a choice	The ability to state a decision.	"Based on what we've just discussed about [insert the topic], what would you choose?"
Appreciation	The ability to explain how information applies to oneself.	To assess appreciation of diagnosis: "Can you tell me in your own words what you see as your medical problem?" To assess appreciation of benefit: "Regardless of what your choice is, do you think that it is possible the medication can benefit you?" To assess appreciation of risk: "Regardless of what your choice is, do you think it is possible the medication can harm you?"
Reasoning	The ability to compare information and infer consequences of choices.	To assess comparative reasoning: "How is X better than Y?" To assess consequential reasoning: "How could X affect your daily activities?"

Instructions: The usual flow of a capacity assessment begins with the clinician disclosing the relevant facts for a decision and an assessment of the patient's understanding of those facts. Next, the clinician asks for the person's choice, followed by an assessment of their appreciation and reasoning about the choice, and concluding with a reassessment of choice. During the reassessment of choice, pay attention to the logical consistency of the choice based on the reasoning provided.

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Regardless of the decision made, the elderly patient and their family should be given as much information about the outpatient support available in your community.