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Case Report: Elder Mistreatment

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Abstract

Elder maltreatment is a widespread and growing healthcare problem in the United States. The National Center on Elder Abuse (NCEA) defines elder mistreatment as "intentional actions that cause harm or create a serious risk of harm to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder. This includes failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm". This paper is going to examine a case report highlighting the difficulties that healthcare providers must overcome in order to diagnose elder maltreatment as well as the assessment tools and tests needed to diagnose and screen for injury. A literature review looking at the growing problem of elder abuse; including the risk factors for elder maltreatment, difficulties diagnosing elder maltreatment, and why patients and physicians often do not report maltreatment will be presented. Having a greater understanding of what elder mistreatment is, who is at risk, and who to screen for elder maltreatment will help improve the primary care providers' ability to diagnose and manage these delicate situations.

Background

The case study in this report involves a 62 year old female who comes into the clinic with her daughter with the complaint of a "cough". Throughout the visit, the patient's daughter becomes obtrusive to the physical exam and the patient exhibits a very flat and quiet affect. The healthcare provider notices abnormal bruising on the patient's arms and neck and needs to further investigate how these injuries came about. The case will show how the provider was able to get the patients family member to leave the exam room so that he could perform a complete physical assessment privately with the patient. Once the provider was one on one with the patient and able to complete a physical exam the patient was very hesitant to say how the bruises happened to her. After a few minutes of comforting and talking to the patient about her injuries, the patient went on to say that her daughter had caused the bruises.

This report will look in depth at the risk for elder maltreatment and determine what populations should be screened for elder maltreatment. Elder maltreatment is an important issue for healthcare providers to know how to handle, as it is currently estimated that there are between one and two million Americans age 65 and older who are suffering from some form of elder mistreatment (Halphen et al, 2009). Diagnosing this healthcare concern is often difficult, as in many cases the people causing the abuse are often loved ones who the patient does not want to get in legal trouble by reporting. Also, abuse isn't always easy to spot as it is not always physical abuse that can be visually diagnosed. Often the abuse is verbal or financial abuse which are very difficult diagnose as patients often are reluctant to confide in their providers that this form of maltreatment may be occurring.

Case Report

History of Present Illness: LJ is a pleasant 62 year old woman who comes into the clinic today with her daughter SJ whom the patient currently lives with. The patient informed the provider that her son had made the appointment for her today because when they spoke on the phone last Sunday, he felt she sounded weak and had a bad cough. She states that he had told his sister (SJ), who lives with and cares for his mother, that she needed to take her into the clinic. He also told his mother that if his sister did not bring her in, he would call her pastor and have him bring her in for the appointment. At first LJ appeared to be very quiet/withdrawn and was not making very much eye contact. LJ did state that she has recently developed a cough a few days ago that she describes to be a "dry" cough, and states her daughter did not think it was serious enough to be seen in the clinic for. LJ states her cough is not very severe and that she notices it most at night. She denies any sputum production or shortness of breath. She denies knowing of anything that seems to make the cough better or worse. The patient's daughter SJ was quite intrusive throughout the subjective part of the interview, often interrupting and answering questions for the patient.

While starting the assessment, many bruises were noted to patients' arms bilaterally and to the upper back and neck areas. When asked about these, the patient states she doesn't know how they happened and that she thinks she may have fell. The appearance and location of these bruises did not seem to correlate with a fall injury. Because of the significance of these bruises the patient was asked to undress and put on a gown while her daughter and the provider stepped out of the room. The patient's daughter was saying this was un-necessary and that she was going to stay in the room. She was adamant that her mother should stay in her own clothing. The provider explained patients heavy winter clothing on it is necessary for her to wear a gown to allow and perform a more accurate physical assessment. After a few minutes of talking with the

daughter she hesitantly agreed to step out of the room while her mother changed. The daughter was then instructed to sit in the waiting room until her mother was done with the assessment.

Past Medical History: 1. Depression 2. Constipation

Allergies: Denies any environmental, food, latex, or medication allergies.

Medication: Patient had a list of her medications with her; however it did not list the current doses of the medications.

1) Prozac 1 tab daily
2) Seroqil 1 tab daily
3) Colace PRN constipation
4) Tylenol PRN mild pain
5) Hydrocodone PRN moderate pain.

Family History: Patient denies knowledge of family history. States everyone was healthy.

Personal/Social History: Patient is currently living with her daughter in her house. Patient states her husband passed away a few years ago from a heart attack. Patient has 1 son who lives in Colorado. Patient is retired.

Review of Systems

General: Denies fever, chills, malaise, fatigue, and night sweats. Has occasional episodes back pain and takes Tylenol for this.

HEENT: Denies blurred vision or visual changes. Denies pain in the throat or neck. Denies hoarseness or sore throat. Denies any ear pain or runny nose.

Skin: Denies any rashes, changes in mole size or color, or problems with hair loss. Patient denies knowing about bruises that are on her upper arms bilaterally or her upper back.

Neurologic: Denies numbness, tingling, seizures, or headaches.

Eyes: Denies blurred vision or visual changes.

Throat/Neck: Denies pain in the throat or neck. Denies hoarseness or sore throat.

Chest/Lungs: Does not have feelings of shortness of breath. Complains of dry cough.

Heart and Blood Vessels: Denies chest pressure, back pain or pain to neck or between shoulder blades. Denies palpitations, bounding pulses, or increased heart rate.

Psychological: Denies feeling depressed, mood changes, and difficulty concentrating, stress or sleep disturbances.

Physical Examination:

Vital Signs: Temp: n/a; BP: 132/82; Pulse: 81; Resp: 18; O2: n/a

General: A pleasant 62 year old female who appears very quiet and timid. She is well groomed, well nourished, but does not make good eye contact throughout the communication process.

Skin: Patient has significant bruising to her upper extremities bilaterally. Bruises to right upper arm/deltoid area are estimated to be around 3.5 inches in diameter. Bruises to left upper bicep/deltoid area are estimated to be around 3.5 inches in diameter as well. Patient has bruising to her upper back/lower neck in the C2-C6 region midline of the patients back. Bruises on back appear to be estimated at 3 inches in diameter. All bruises appear dark purple in nature and are

very tender to palpation. There are no lesions noted. Patient has significant discomfort and exhibits guarding when palpating affected areas.

Musculoskeletal: Full range of motion to upper extremities bilaterally. Patient has no pain with internal/external rotation, flexion, and extension of her upper extremities bilaterally.

Respiratory: Lungs clear bilaterally with good air movement to bases. Respirations are non-labored. Respiratory expansion is symmetric. No CVA tenderness noted with indirect percussion. Respiratory rate of 18/minute.

Cardiovascular: Apical pulse regular at 73/minute. No S3/S4 or murmur noted upon auscultation. Regular S1 and S2 sounds.

Assessment: ICD-9: 995.85 - Adult Abuse and Neglect

Upon reentering the room, the patient was very quiet and withdrawn. The provider did a head to toe skin assessment and noted significant bruising to bilateral upper arms and to her posterior neck/cervical spine area. The exam was then stopped and the provider spent some time discussing the injuries with the patient and questioned how they came about. The provider had to spend time comforting the patient and expressing concern over her safety and empathy to her current condition. After some time comforting and talking with the patient she stated "I don't want to get anyone in trouble over something like this." The patient was informed that healthcare providers are mandated reporters and that even if we suspect possible abuse we need to report it to social services. After a few more minutes of comforting and talking with the patient she states "I sometimes forget to do things around the house and my daughter gets very upset with me. It's my fault though." She then admitted that her daughter was the one who sometimes hits and pushes her and this is where the bruises had come from.

At this point the provider informed the patient that social services and law enforcement would be notified about these findings. The provider also felt that it would be beneficial to obtain some lab work and screening tests including: CBC, complete metabolic panel, PHQ-9 depression screening tool, photographs of the injured areas, as well as x-rays of bilateral upper arms, chest, and neck to screen for any fractured bones/injuries. The patient was also offered a referral to a counselor in which she refused at this time. LJ was encouraged to follow up in one week's time for a reevaluation and follow up appointment to see how she is doing at home.

Literature Review

It is estimated that between one and two million Americans over the age of 65 have been abused or mistreated by someone they depend on for care (Halphen, Varas, & Sadowsky, 2009). Primary care providers are responsible for reporting such abuse or mistreatment as they are "mandatory reporters." It is a primary care provider's legal responsibility to screen for and report suspected elder mistreatment, yet it is estimated that only two percent of all elder mistreatment cases are reported to government agencies (Halphen et al., 2009). For primary providers, knowing if it would be beneficial to e importance of routinely screening for elder maltreatment, the population at highest risk for maltreatment, and the difficulties in diagnosing elder maltreatment could really benefit their practice by allowing them to better screen, diagnose, and handle a patient suffering from elder maltreatment.

With all the new literature and studies being developed, there have been many different grading systems developed to help give the reader a greater understanding of the level of evidence involved in the research. This, in turn, gives the reader better insight as to the quality of evidence and the validity of the information from various articles. With all the different evidence grading scales, this author chose to use the "ABC" scale from the American Academy

of Family Physicians (AAFP) for its straight forward approach at grading the evidence. With the "ABC" rating system, randomized controlled trials/meta-analysis is given the highest evidence grade of "A" (AAFP, 2013). A grade of "B" is given to studies such as nonrandomized clinical trials, non-quantitative systematic reviews, and lower quality RCT's (AAFP, 2013). The lowest grade of a "C" is given to articles that are based on consensus viewpoint or expert opinion (AAFP, 2013). The articles in this literature review have been reviewed using this grading system and a table outlining each article's grade is included in the Appendix.

Importance of Screening

The current USPSTF guidelines give an "I" recommendation to routine screening for elder maltreatment stating: "evidence is insufficient to assess the balance of the benefits and harms of screening all elderly or vulnerable adults for abuse and neglect" (USPSTF, 2014). However, four studies reviewed recommend routine screening for elder maltreatment (Perel-Levin, 2005; Halphen et al., 2009; Laumann et al., 2008; and Dong, 2013).

Perel-Levin (2008) investigated the benefits and risks associated with screening for elder maltreatment in the primary care setting. The author gathered literature for review from qualitative and quantitative studies, scientific and professional journal editorials, opinion articles, policy reports, and specialized books. Perel-Levin recommends routine screening for elder maltreatment as long as it is done with appropriate sensitivity by the provider. Halphen et al. (2009) reviewed multiple studies in order to determine reasons why elder abuse often was not screened for and why it was not reported when it was suspected by the primary care provider. The authors were able to conclude that in all settings, elders should be screened for

maltreatment. They found that the most beneficial intervention a primary care provider can provide is to report suspected elder abuse (Halphen et al., 2009).

Highest Risk

Sellas (2013), published an article that reviewed different factors that place an elderly individual at highest risk for maltreatment. Sellas was able to conclude that the biggest factors increasing the likelihood of elder abuse are: "shared living situation with the abuser, dementia, social isolation, and pathologic characteristics of perpetrators such as mental illness and alcohol abuse (Sellas, 2013, pg. 2)." Sellas also recommends that healthcare providers keep their questions direct and simple and to ensure questions asked are done so in a non-judgmental and non-threatening way. If both the patient and caregiver are present, it is recommended that the primary care provider interview them separately in order to identify disparities – especially if abuse is suspected. This finding is consistent with the presented case study. The patient was not willing to discuss how her injuries happened until she was separated from her caregiver. The patient also had two of the largest risk factors in that she suffered from dementia and was living with the abuser. Paying attention to these major red flags can help primary care providers screen and diagnose elder maltreatment more appropriately.

Dong, Simon, and Evans (2012), used a prospective population based study to investigate what factors put elderly patients at risk for elder maltreatment. The study reviewed 143 participants in the Chicago are from 1993 to 2010 that had reported elder abuse. The authors were able to conclude that a decline in physical function plays a significant role in the increased risk of elder abuse. "For every one point decline in functional ability there is a 10% increase of risk for elder abuse" (Dong et al., 2012, pg. 1927). This information can directly be applied to

the case study above. The patient had a history of dementia and depression which increases her risk for elder maltreatment. The article goes on to recommend further studies that look into racial and ethnic differences regarding decline in physical function and risk of elder abuse to further target the most at risk populations for elder abuse.

Jackson and Hafemestier (2011), performed a literature review focusing on the importance of differentiating the different types of elder maltreatment in order to more appropriately screen in the primary care setting. They looked at the risk factors of the victim as well as the abuser. For this study, they interviewed 71 victims of elder maltreatment and gathered information on another 40 patients from the Adult Protective Services Database. The article was able to conclude that widowed individuals are at a higher risk of both financial and physical abuse (Jackson & Hafemestier, 2011, pg. 743). There was also a two time increase in risk for financial abuse ($P<0.001$) if the victim is cohabitating with their abuser (Jackson & Hafemestier, 2011, pg. 743). The authors stress the importance of gathering accurate patient background and histories in order to better help determine if they are at a higher risk for different types of abuse. Once again, it is easy to see a direct correlation with the information this study finds and the case study discussed earlier. Our patient in the study was cohabitating with the abuser and she was widowed. Both of these factors increased her risk for elder maltreatment.

Dong (2013), focused on factors that put individuals at an increased risk for elder maltreatment, as well as how the primary care provider should screen and report suspected elder maltreatment. This article concluded that lower cognitive functioning leads to an increased risk for both physical abuse and self-neglect (Dong, 2013, pg. 3). Dong goes on to show that patients dealing with psychological issues such as depression and anxiety are also at a much higher risk for elder abuse (Dong, 2013, pg. 3). Reasons for lack of reporting also are discussed in this

article and the author concludes that "systematic training and education are needed" in order to increase the likelihood of primary care provider's accurately diagnosing and reporting elder maltreatment cases (Dong, 2013, pg. 9). Another similar study by Lachs et al. (1997), performed a nine year cohort study looking at the greatest risk factors for elder maltreatment. This article was also able to conclude that worsening cognitive impairment and functional disability are two of the biggest risk factors for elder maltreatment (Lachs et al., 1997, pg. 474). Lachs et al., also found that poverty level and minority status played a significant role in elder maltreatment with those living below the poverty line and non-white ethnic groups being at higher risk for elder maltreatment ($P<0.001$) (Lachs et al., 1997, pg. 471).

The National Center on Elder Abuse (2014) released a report that looks into who is at the highest risk for elder maltreatment, why it is often not diagnosed, as well as the impact elder abuse has on the affected individuals. The NCEA states there are multiple reasons elder abuse may not be easily diagnosed by healthcare professionals. Reasons the NCEA (2014) feels elder maltreatment is not diagnosed are:

> Healthcare professionals may have a lack of training on detecting abuse; often the elderly may be reluctant to report abuse themselves because of fear of retaliation by the abuser; lack of physical and/or cognitive ability to report; or because they don't want to get the abuser (90% of whom are family members) in trouble (NCEA, 2014, pg. 2).

The NCEA also found that patients suffering from dementia were up to 50% more likely to be exposed to some form of abuse (NCEA, 2014). This is a staggering number and healthcare providers need to be especially aware of this when they have patients diagnosed with dementia.

It is interesting how well the NCEA report correlates with the case study discussed in this paper. The case patient was afraid to report her physical maltreatment due to fears of getting her daughter in trouble. The abuser was a family member (NCEA states 90% of maltreatment is from a family member). The case patient also suffers from mild dementia which increased her risk.

Murphy et al. (2013), performed a literature review to find the most common type of injuries that occur in physical elder abuse. The authors were able to conclude from this study that two thirds of the injuries that occur in elder abuse are to the upper extremities and the maxillofacial region (Murphy et al., 2013). The authors point out that the social context in which the injuries take place such as: "a culture of violence in the family, a demented, debilitated, or depressed and socially isolated victim, and a perpetrator profile of mental illness, alcohol or drug abuse, or emotional/financial dependence on the victim," are crucial to accurate identification of elder abuse (Murphy et al., 2013, pg 14).

Laumann et al. (2008), performed a study to find estimates of elder mistreatment by family members and examined the association of elder mistreatment with demographic and health characteristics. This study found verbal maltreatment to be the most common form of maltreatment. It did point out that most of the mistreatment reported was done by someone other than a member of the respondent's immediate family. In the study, they found 57% of respondents reporting verbal abuse said that someone other than a member of their immediate family, such as a spouse or child, was responsible (Laumann et al., 2008). Compare this to the NCEA report discussed previously and you will see completely different results. The NCEA found that in any abuse type, the vast majority of abusers are family members (approximately 90%), most often children, spouses, and partners (NCEA, 2014). The results of the study by

Laumann et al., (2008) showed that 9% of elder adults reported verbal mistreatment, 3.5% financial mistreatment, and 0.2% reported physical mistreatment by a family member. This study is a prime example on why it is so important to talk to patients about possible elder maltreatment as physical abuse tends to occur at much lower rates than verbal and financial abuse.

Diagnostic Challenges

A variety of studies were reviewed that addressed the difficulties of diagnosing elder abuse. While there were some variations between them; most of the articles did address the same principle barriers such as: lack of accurate screening tools, lack of time for the primary care provider to screen and intervene, lack of training on how to report, and patients not reporting maltreatment due to fear of retaliation by the abuser (Perel-Levin, 2005; Halphen et al., 2009; Laumann et al., 2008; and Dong, 2013).

Perel-Levin (2008) points out that some of the biggest barriers to screening for elder maltreatment are the healthcare provider's fears of offending their patients as well as the thought of ineffective interventions if they do report elder abuse. Providers are also afraid of retaliation from those who get reported (Perel-Levin, 2008, pg. 20). Trust and communication are listed as the most important things a provider can have with their patients; if the patient trusts their provider they will be more likely to discuss possible maltreatment issues knowing that their provider will have the patients' best interests in mind when dealing with these issues (Perel-Levin, 2008, pg. 22). In the case study it was very clear that the patient was not going to notify the provider about the abuse until she trusted the provider and understood that they were there to help her. Once that trust was built, the patient was able to open up and discuss her physical maltreatment with the provider.

The idea that providers do not have the time or resources to investigate suspicions of abuse or neglect is completely refuted by Halphen et al (2009). "The clinician does not have to spend much of their own time on the investigation because government agencies are available to help with this task" (p. 16).

Summary

Routine screening for elder maltreatment could play a significant role in accurately diagnosing elder maltreatment and providing help and support to the patients who are being mistreated. Providers should be aware that patients who live with a caregiver, who have depression, have a learning disability, and who suffer from dementia are at significantly higher risk for all forms of elder maltreatment. When elder maltreatment is suspected, providers should interview patients and caregivers separately to screen for disparities and to allow for confidential and trusting communication with their patients. Evidence reviewed supports the recommendation that when physical abuse is suspected, providers perform a full head to toe assessment to screen for injuries. After reviewing the literature, there are three simple recommendations that can allow primary providers to more accurately screen and diagnose elder maltreatment, as well as provide better outcomes for their patients.

Learning Points

As a result of this literature review, there are three different practice recommendations. The AAFP uses the Strength of Recommendation Taxonomy (SORT) system for a tool to determine the strength of recommendation (Ebell et al., 2004). The system takes a basic and straight forward approach towards grading the strength of recommendation. SORT gives letter grades A, B, and C with the emphasis of this system being on the key elements of: "quality, quantity, and consistency of evidence" (Ebell et al., 2004). The SORT grade of "A" is given if

there is "consistent and high quality patient-oriented evidence; a SORT grade of "B" is given if there is inconsistent or limited quality patient-oriented evidence; where a SORT grade of "C" is given when recommendations are based "consensus, unusual practice, opinion, disease-oriented evidence, or case series for studies of diagnosis, treatment, prevention, or screening" (Ebell et al., 2004, pg. 548).

First, primary care providers should consider screening all patients for elder maltreatment. This is a grade B recommendation using the SORT grading system. Studies reviewed all showed significant evidence showing the benefit of routine screening and that screening for elder maltreatment with no harm caused to the patient with screening. Although the USPSTF gives a "I" recommendation in routine screening of elder maltreatment, it is important that providers put special focus on patients who suffer from dementia, functional decline, who are socially isolated, and/or are living along with a caregiver as these are clearly the population at the highest risk for elder maltreatment (Perel-Levin, 2005; Halphen et al., 2009; Laumann et al., 2008; and Dong, 2013). Articles reviewed that focused on who is at highest risk for elder maltreatment all had these traits listed as criteria that put elders at a significantly higher risk for elder maltreatment.

Second, when elder maltreatment is suspected, the patient should be interviewed alone to allow the healthcare provider to obtain accurate information. If the patient is accompanied by a caregiver, the primary provider should interview both the caregiver and patient separately to screen for disparities in statements. Comforting the patient and building a trusting relationship, as well as conducting the interview in a non-judgmental fashion will likely aid in the patient confiding in the primary care provider and allow for a more accurate diagnosis of elder maltreatment. Sellas (2013), was able to conclude that providers who interview caregivers and

patients separately have a much higher likelihood of accurately screening for and diagnosing elder maltreatment in high risk populations. This, in turn, can provide a much better outcome of the patient and allow for better patient care. This recommendation has been given a SORT grade of "C" as the recommendation is based on expert opinion and case studies focusing on screening for elder maltreatment.

The final recommendation is that when physical abuse is suspected a full head to toe assessment should be performed by the primary care provider. It has been found that two thirds of all injuries that occur in elder abuse are found on the upper extremities and maxillofacial region, but there have been reported injuries to almost all parts of the human body (Murphy et al., 2013). Providers should pay close attention to patients suffering from dementia, who have a family history of violence, and who are depressed as this puts them at a higher risk for physical elder maltreatment (Murphy et al., 2013). This recommendation has can be categorized as a SORT grade "B" recommendation as there is limited amount of quality patient-oriented evidence suggesting the benefit of a head to toe assessment when physical abuse is suspected.

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Appendix A

Authors	Title	AAFP Level of Evidence
Dong, X. (2013).	Research, Practice, and health policy	C
Dong, X.,Simon, M., & Evans, D. (2012).	Decline in physical function and risk of elder abuse reported to social services in a community-dwelling population of older adults.	B
Halphen, J., Varas, G., & Sadowsky, J. (2009).	Recognizing and reporting elder abuse and neglect.	C
Jackson, S. & Hafemeister, T. (2011).	Risk factors associated with elder abuse: the importance of differentiating by type of elder maltreatment.	B
Lachs, M., Williams, C., O'Brein, S., Hurst, L., Horwitz, R. (1997).	Risk factors for reported elder abuse and neglect: a nine year observational cohort study.	B
Laumann, E., Leitsch, S., & Waite, L. (2008).	Elder mistreatment in the United States.	C
Murphy, K., Waa, S., Jaffer, H., Sauter, A., & Chan, A. (2013).	A literature review of findings in physical elder abuse.	B
National Center on Elder Abuse. (2014).	Americas growing elderly population: statistics and data.	C
Perel-Levin, S. (2008).	Discussing screening for elder abuse at primary health care level.	C
Sellas, M. (2013).	Elder Abuse Clinical Presentation.	C

PERMISSION

Title

Department Nursing

Degree Master of Science

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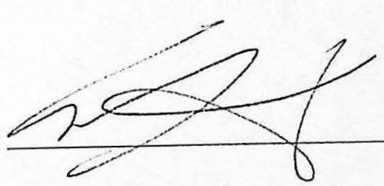
Signature 

Date 4/10/14