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Recognizing and Preventing Elder Abuse in Long-Term Care Settings: Recommendations for Families

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Elder abuse in long-term care (LTC) settings has recently been in the news. As a result, public awareness of the issue has increased; concurrently, older adults' and their families' concerns and fears about LTC placement have also increased.

So, how prevalent is elder abuse in LTC settings?

> If you are concerned that abuse might be happening at an LTC facility, or if you would like more information about elder abuse, contact the Ontario Network for the Prevention of Elder Abuse:
>
> MAIL:
> 222 College St., Suite 106,
> Toronto, Ontario M5T 3J1
>
> TELEPHONE:
> (416) 978-1716
>
> EMAIL:
> onpea.info@utoronto.ca

Unfortunately, that is difficult to say. In fact, although elder abuse has been identified as an important social problem, exact incidence and prevalence of abuse in LTC settings are not known.

This lack of understanding of the depth of this still largely hidden social problem is primarily due to differences in how abuse is reported, and because many incidents are never reported (Braun et al., 1997). Despite knowing that abuse is wrong, health care professionals often empathize with the perpetrator and do not necessarily make a formal report. As well, many staff may not be able to recognize abuse; they may fear recrimination if they do report a problem; and/or they have poor knowledge of procedures when dealing with such situations (Kitchen, Richardson, & Livingston, 2002).

For these reasons, families should become more aware and educated about the various types of abuse.

A universal definition is difficult to find, as different countries, people, and cultures define elder abuse in different ways (Hogstel & Curry, 1999). The National Research Council (2003) defines elder abuse broadly:

> (a) *intentional actions that cause harm or create a serious risk of harm (whether or not the harm was intended) to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder; or*
>
> (b) *failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm*

The National Clearinghouse on Family Violence (1999) defines abuse of older adults in LTC settings as

> *"any action that takes advantage of a relationship between the health care worker and the older adult …[where the] abuse is used to the advantage of the user and to the disadvantage of the abused" (p. 1).*

Four broad categories of elder abuse have been identified, including (see table, bottom of page 3):

- *physical abuse*
- *psychological abuse*
- *financial abuse*
- *neglect*

…"Elder Abuse" continued on page 2

INSIDE …

2 … How to Recognize Elder Abuse
3 … Nov 6 CONFERENCE: "A Changing Melody"
3 … Brenda Hounam — Sharing Experiences
3 … Four Categories of Elder Abuse
4 … How to Prevent Elder Abuse

"Elder Abuse" continued from page 1…

According to a number of studies on elder abuse in LTC, neglect and psychological and physical abuses are the more prevalent forms (Clough, 1999; Pillemer & Moore, 1989, 1990).

Older adults who live in LTC settings can be more vulnerable to abuse for a number of reasons. First, the characteristics of the LTC facility can make residents more vulnerable; for example, a shortage of registered nurses to provide supervision and role modelling, a lack of clear policies and guidelines to help staff members understand abusive behaviour and know how to respond if they witness abuse, and the inability of the facility to provide high quality of care and safe environments (Conlin Shaw, 1998; National Clearinghouse on Family Violence, 1999). In fact, Conlin Shaw (1998) suggests that the model of care adopted by the facility can greatly influence the incidence of abuse in LTC care settings. More specifically, care models that focus on efficiency and productivity generate harsh, oppressive, and overly-routinized environments, compared with those that value and support the development of person-centred care (Conlin Shaw, 1998). Abuse is much more likely to occur in these non-person-centred environments.

Second, characteristics of the staff may also contribute to increased incidence of abuse. For example, lack of knowledge about managing conflict and difficult situations, low job satisfaction, frequent thoughts of quitting, high staff burnout, low levels of education and job experience, a history of violence and stress in personal lives, and high case loads have all been associated with increased incidence of abuse among health care professionals (Braun et al., 1997; Hodge, 1998; Glendenning, 1999; National Clearinghouse on Family Violence, 1999; Pillemer & Moore, 1989, 1990).

And finally, specific characteristics of the residents may make some more vulnerable to abuse than others. Some studies, for instance, have found that residents who present more aggressive behaviours (e.g., physical and verbal assaults) and have conflict with staff tend to also experience more abuse (Glendenning, 1999; Goodridge, Johnston, & Thomson, 1996; Pillemer & Bachman-Prehn, 1991; Pillemer & Moore, 1990).

How to RECOGNIZE abuse in LTC settings

Familes need a strong understanding of the different types of elder abuse (see table on page 3), and they need to know the following signs (***adapted from Hogstel & Curry, 1999; National Clearinghouse on Family Violence, 1999***):

- injuries around mouth, face, and eyes; clumps of missing hair; haemorrhaging beneath scalp
- bedsores or bruises in unexplainable places or for unexplainable reasons
- injuries around thighs and perineum
- signs of malnourishment (e.g., weight loss, lack of energy, sleepiness) and/or dehydration (e.g., sunken eyes)
- signs of over-medication or under-medication
- lack of clean bedding or clothing
- broken or missing glasses, dentures, or hearing aids
- older adult is afraid, seems anxious and/or paranoid, is depressed and/or withdrawn, appears angry or agitated, and/or confused or disoriented
- resident's behaviour changes when the LTC staff member enters or leaves the room
- staff member cannot provide a credible account for the injury sustained by the resident
- resident's account of what happened in a specific situation varies from health care worker's account
- there is a purchase of goods, supplies or services that are not needed or wanted
- money is missing from the resident's room and the resident has no recollection of spending it
- cheques are signed by another person without legal authority and/or the resident does not remember writing large cheques for anything
- prescribed medications are not available

Most importantly, take note of any changes in your loved one's behaviour and listen carefully. Do not discredit your relative's accounts: remember, individuals living with dementia may be able to describe their experiences.

…"Elder Abuse" continued on page 3

A Changing Melody: A Learning and Sharing Forum for Persons with Dementia and Their Partners in Care

November 6, 2004 (on-site registration begins at 8:30 a.m.)

Fairmont Royal York Hotel, Toronto, Ontario

Hosted by

Murray Alzheimer Research and Education Program (University of Waterloo)
Alzheimer Society of Canada
Alzheimer Society of Ontario
Dementia Advocacy and Support Network International

Registration Forms

ONLINE:
www.marep.uwaterloo.ca

BY TELEPHONE:
(519) 888-4567, ext. 6884

Brenda Hounam: "This forum is important…"

I'm a 56-year-old mother of two, diagnosed with early-onset dementia in April, 2000. Trained as an industrial accountant and computer technician, my most devastating cognitive impairment is my inability to perform simple mathematical calculations. I have a lot of support from my family, as well as the help of a homemaker and the friendly visiting program through the local Alzheimer Society Chapter. I have developed many strategies—including having routines, asking for support, and using humour—to deal with the impact of my memory loss. This allows me to maintain a certain level of independence.

I believe the Changing Melody Forum is important for three reasons. First, persons with dementia have few opportunities to participate in forums specifically related to their experiences. Although other forums are offered, their focus is more general; attendees with dementia may feel uncomfortable. Second, education is vital. Most of the educational material in the past has been geared for caregivers, not for persons with dementia. Third, most of the material out there focusses on the negative aspects of dementia (e.g., the end stages) and is therefore not very hopeful. With its focus on the future, this conference provides a more positive outlook.

The Forum Planning Committee is fortunate to have persons living with dementia involved in the planning process. Brenda is one of these people; she is also speaking on "Living with Dementia" at the forum.

"Elder Abuse" continued from page 2 … and more on page 4

Four Major Categories of Abuse

(adapted from Hogstel & Curry, 1999; National Clearinghouse on Family Violence, 1999; White, 2000)

PHYSICAL ABUSE involves inflicting physical discomfort, pain, or injury: slapping, hitting, punching, beating, burning, sexual assault, rough handling

PSYCHOLOGICAL ABUSE diminishes the identity, dignity and self-worth of the older person: name-calling, yelling, insulting, threatening, imitating, swearing, ignoring, isolating, exclusion from meaningful events, deprivation of rights

NEGLECT is the failure of a caregiver to meet the needs of an older adult who cannot meet those needs alone: denial of food, water, medication, medical treatment, therapy, nursing services, health aids, clothing, and visitors

FINANCIAL ABUSE (also known as material or property abuse) involves the misuse of money or property: stealing money or possessions, forging signatures on pension cheques or legal documents, misusing power of attorney, forcing or tricking an older adult into selling or giving away his or her property

"Elder Abuse" continued from page 3 …

How to PREVENT abuse from occurring or reoccurring

- visit the facility regularly
- observe, observe, observe—take continual assessments of the LTC environment, and monitor the care provided by staff and how they treat other residents when the family is not around
- ask about the facility's mission statement and model of care
- visit at different times and days of the week so that staff do not anticipate your presence
- develop a collaborative relationship based on open communication with a staff member involved in the resident's care
- talk to a trusted staff member about how the resident is being cared for and treated
- be aware of the resident's rights—most facilities concerned with quality of life issues post the Resident's Bill of Rights in a common area
- become involved in the facility (e.g., member of the family council, volunteer, participant in care planning meetings)
- advocate on behalf of residents by emphasizing to the administration the need for regular in-service training on elder abuse for all staff focused on recognizing abuse, conflict resolution, and proper procedures to follow when abuse is witnessed
- ask about the investigation procedures the facility has in place to respond to a reported incidence of abuse
- if an incident does occur, thoroughly document all the details of the event so that they can be described with clarity when talking to the health care worker or reporting the incident to the administration

For a list of references for this article, please contact Jessica Luh: jluh@healthy.uwaterloo.ca

Be aware that families can get help by contacting

- local social service agencies
- a family doctor or other health care professional in the community
- organizations that advocate for seniors
- community resource centres
- legal agencies
- spiritual advisors, and
- staff at other LTC facilities

Innovations: Enhancing Ability in Dementia Care is published quarterly by MAREP, an innovative program which integrates educational and research activities in an effort to improve dementia care practices in Canada. The goal of MAREP is to enhance the ability of care providers, both formal and informal, to respond to the needs of persons with Alzheimer's disease and related dementias, and ultimately to improve the quality of life of persons with dementia and their families.

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