Confronting Elder Mistreatment in Long-Term Care

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Elder mistreatment has a devastating impact on its victims and is associated with increased mortality rates. Elderly persons residing in residential care facilities are vulnerable due to decreased ability for self-care and medical illnesses affecting cognitive and physical function. Markers for neglect such as pressure ulcers, malnutrition, and dehydration may be falsely attributed to "natural" consequences of declining health. Research and education regarding markers of mistreatment are needed for early recognition and intervention. In addition, effective communication between care providers and residents with dementia helps to avert aggressive behaviors that precipitate physical and verbal abuse. Long-term care providers must be vigilant in looking for markers of mistreatment and must report suspected cases so that elderly persons are protected, abusers are identified, and facility care is improved. (*Annals of Long-Term Care: Clinical Care and Aging* 2004;12[4]:30-35)

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METHODS

There are few research publications regarding elder mistreatment in long-term care settings. Material for this review was gathered by various methods. These include a Pub Med review of search terms that include: "elder abuse and risk factors," "elder abuse and long-term care," "elder abuse and institution," "elder abuse and assisted living facility," and "elder abuse and board and care." Inclusion criteria included all original research publications with a focus on elder abuse and long-term care. A recent publication, "Elder Mistreatment by the National Research Council," was reviewed as an expert report.[1] Given the paucity of literature, unpublished material from professional experience and communication was also utilized.

BACKGROUND

Federal legislation against nursing home abuse was included in the Omnibus Budget Reconciliation Act of 1987 (OBRA '87). Types of elder mistreatment in nursing homes, residential care facilities (RCF), and assisted living facilities include neglect, and physical, psychological, financial, and sexual abuse. Elder abuse is associated with increased morbidity and mortality rates.[2] Some researchers believe that elder abuse in institutional care is "a common part of institutional life," rather than isolated, noteworthy events.[3] Elder abuse is estimated to affect at least 3-4%[4] of our nation's seniors and 13% of community-dwelling persons referred to health and social service agencies.[5] Determining the true incidence and prevalence of elder abuse is difficult due to underreporting, varying definitions, and lack of uniform processes among reporting agencies. In addition, various states have different reporting methods and requirements. Administration on Aging (AoA) data from 2001 show that there are 63,433 licensed long-term care facilities with 2.8 million beds. This includes nursing and board-and-care facilities. Over the past five years, the number of nursing facilities has declined by 3% to 17,710, while the number of board-and-care

facilities has risen by 17.5% to 45,723. Nationally, there were 90 complaints per 1,000 long-term care beds. Of these, there were 9.3 complaints of abuse, gross neglect, or exploitation per 1000 nursing home beds, and 4.3 complaints per 1,000 board-and-care beds.[6] It should be noted that these numbers represent complaints, not substantiated cases of mistreatment. These numbers do not include complaints related to chemical and physical restraints or pressure sores. The Waxman report revealed that one out of every three nursing homes was cited for physical, sexual, or verbal abuse throughout a two-year period. Over 9% of U. S. nursing homes were cited for abuse that caused actual harm, placed residents in serious danger, or resulted in significant injury or death.[7]

Definitive incidence and prevalence data are lacking. Regulatory agencies that oversee nursing homes have annual survey data, but no such data from other long-term care facilities are collected.[8] Elder mistreatment remains both underreported and underrecognized, particularly by healthcare providers[9] such as physicians and nurses. In addition, long-term care residents and their families are underreporters.[8] In one survey, 95% of the residents interviewed noted that they have either been a victim of neglect or witnessed someone else being neglected.[10]

Surveys of nursing facility staff reveal that abuse is common. One study noted that 36% of the staff had witnessed an episode of physical abuse and 81% had witnessed psychological abuse over a one-year period.[3] Physical abuse was defined as excessive use of restraints as well as multiple types of physical aggression. Psychological abuse included isolating, insulting, swearing at, yelling, and threatening a patient. Denying food privileges to a patient was also included. Self-reported abusive behaviors were also high. Fifty-one percent of the staff had "yelled at a resident in anger" and 17% had "pushed, grabbed or shoved" a resident during a one-month period.[11]

INCREASED VULNERABILITY IN LONG-TERM CARE

The characteristics of those who live in long-term care facilities put residents at risk for mistreatment. Vulnerability results from dependency on caregivers due to chronic medical illnesses, especially those that affect cognition. A 1999 national survey revealed that 32% of the residents living in nursing facilities required assistance with four activities of daily living (ADLs), and 75% required assistance with at least three ADLs.[12] Moreover, since Adult Protective Service use is an independent risk factor for placement into a nursing facility,[13] many residents in nursing homes may have already experienced elder abuse prior to placement and continue to be at risk.

Studies continue to provide evidence that persons with dementia carry a high risk for mistreatment. One study surveyed persons calling a dementia helpline and found that 12% of the caregivers had physically abused the demented persons in their care.[14] A nine-year observational cohort study of community-dwelling seniors found that cognitive impairment, and specifically, the onset of a new cognitive impairment was an associated risk factor for elder mistreatment.[9] The prevalence of cognitive problems among nursing home residents is very high: 42-66% of the elderly population living in facilities have a significant cognitive impairment.[15] In addition, many may experience adverse effects from polypharmacy, infections, and dehydration; all of these may contribute to delirium. These numbers leave no doubt that long-term care facilities harbor a group of seniors who are particularly vulnerable to mistreatment.

Multiple authors have shown that persons with behavioral problems are at higher risk for abuse. One study of nursing home staff revealed that aggressive behavior was associated with higher rates of psychological and physical abuse by staff.[16] In addition, a survey of community-dwelling caregivers revealed that 26% of those who suffered abuse from persons with dementia returned abusive behavior.[14] Hawes found similar reports in a qualitative study of nursing assistants.[8]

Victimization often continues because residents and family members do not report abuse. Reasons for this include fear of retaliation by staff members, a belief that reporting is futile, and the desire to find other solutions by working with the facility.[8] A recent

Government Accounting Office (GAO) survey reports that fear of retribution and lack of knowledge regarding reporting procedures affects many cases.[17] Delayed reporting is another pervasive problem. A study of sexual abuse in nursing homes also found that a preexisting cognitive deficit delayed information processing and effective communication.[18.] Delayed reporting also reduces the chances of finding forensic evidence. A recent analysis of 158 physical and sexual abuse allegations found that 50% were submitted at least two days after the alleged abuse was known.[17] Allegations may be easily delayed or even discounted if a person is thought to "fantasize" or has a cognitive impairment.[18]

PERPETRATORS OF ABUSE

The abusers may be those who work in the long-term care setting (direct care providers or other employees), family members, or even other residents of the long-term care facility. There are few studies addressing these groups, and long-term care workers have received the most attention. Studies of long-term care abusers are largely based on surveys.[3,16]

As noted above, caregivers who are abused by persons with dementia are more likely to return the abusive behavior.[14,16] Perpetrators of abuse may not perceive certain behaviors as abusive. For instance, "slapping" may not be considered a form of abuse in certain families.[8] Sixty-three percent of self-reported abusers viewed nursing home patients "like children."[3] Many abusers believed that combative behaviors by residents were intentional and that "rough handling" by staff was justified as self-defense and not considered abusive.[8]

Other factors strongly associated with abusive behavior include an unwilling or inexperienced caregiver, the presence of a relationship conflict, high strain, isolation, substance abuse, mental illness, and a personal history of transgenerational violence.[19] Although these factors may apply to caregivers in long-term care, no formal studies have been conducted in this setting. Personal qualities previously shown to be associated with poorer quality of care in nursing homes were not necessarily predictors of abusive behaviors.[3] These personal qualities included younger age, less education, fewer years of nursing home experience, and care by nursing aides rather than nurses.[20] However, several other variables were associated with abusive behavior, including job satisfaction, personal stress, and burnout rates as measured by the Maslach Burnout Inventory. The perception of residents as "childlike," and the high levels of conflict measured by arguments with residents also proved to be significant. Negative attitudes towards the elderly are also implicated.[3] Furthermore, staffing shortages in nursing homes are implicated as one of the major factors contributing to abuse and neglect.[8,21]

A recent investigation concluded that employment background checks do not provide adequate protection against elder mistreatment. For instance, the Centers for Medicare and Medicaid Services (CMS) prohibit nursing homes from hiring persons with a prior history of committing abuse in a nursing home setting; however, those who have been convicted of child abuse may be hired. Some states require a criminal background check, while others do not. Even so, these checks usually do not uncover convictions in another state. Furthermore, in some states, other staff such as maintenance workers and others without a direct patient care role do not undergo criminal checks.[17]

TYPES OF ABUSE IN LONG-TERM CARE

Categories of abuse in nursing homes include physical, psychological, sexual, financial, and neglect. While definitions may vary between states and between organizations within those states, definitions from a recent national incidence study are comprehensive[22] (Table).

The issue of neglect is particularly difficult to characterize. There is no obvious line that demarcates the point at which good care transitions to acceptable care or where poor care transitions to neglect. The spectrum of care occurs along a continuum; there is often a judgment call involved in labeling a situation as "neglect." There are different types of neglect. One type of neglect is the failure to provide needed assis-

Table: Elder Abuse Definitions: National Elder Abuse Incidence Study (NEAIS), 1998.

Physical abuse is the use of physical force that may result in bodily injury, physical pain, or impairment. Physical abuse may include but is not limited to such acts of violence as striking (with or without an object), hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, and burning. The unwarranted administration of drugs and physical restraints, force-feeding, and physical punishment of any kind also are examples of physical abuse.

Psychological abuse is the infliction of anguish, emotional pain, or distress. Emotional or psychological abuse includes but is not limited to verbal assaults, insults, threats, intimidation, humiliation, and harassment. In addition, treating an older person like an infant; isolating an elderly person from family, friends, or regular activities; giving an older person the "silent treatment"; and enforced social isolation also are examples of emotional or psychological abuse.

Neglect is the refusal or failure to fulfill any part of a person's obligations or duties to an elder. Neglect may also include a refusal or failure by a person who has fiduciary responsibilities to provide care for an elder. Neglect typically means the refusal or failure to provide an elderly person with such life necessities as food, water, clothing, shelter, personal hygiene, medicine, comfort, personal safety, and other essentials included as a responsibility or an agreement.

Sexual abuse is nonconsensual sexual contact of any kind with an elderly person. Sexual contact with any person incapable of giving consent also is considered sexual abuse; it includes but is not limited to unwanted touching, all types of sexual assault or battery such as rape, sodomy, coerced nudity, and sexually explicit photographing.

Financial or material exploitation is the illegal or improper use of an elder's funds, property, or assets. Examples include but are not limited to cashing checks without authorization or permission; forging an older person's signature; misusing or stealing an older person's money or possessions; coercing or deceiving an older person into signing a document; and the improper use of conservatorship, guardianship, or power of attorney.

tance and services. Another type of neglect involves performing a task, but knowingly placing the resident at unnecessary risk for harm during that task. An example of this is performing a two-person transfer with only one person, knowing that two people are required to be present.[8] The development of malnourishment, dehydration, and pressure sores may qualify as neglect if surveillance and interventions have not been instituted to prevent or treat these conditions. Nursing aides reported that the failure to turn and reposition a resident, perform range of motion exercises, remind cognitively impaired residents to drink, and withholding feeding assistance were the most common areas of neglect.[8] Failure to treat pain may also be considered a form of neglect in some circumstances.

Many physical signs may be indicators of abuse and neglect but are mistakenly attributed to the aging process or to inevitable complications of chronic illness. For instance, a person with dementia may begin to have difficulties with eating and swallowing. If one is forced to eat despite signs of choking, they are at high risk for aspiration and pneumonia. Pneumonia is a very common cause of death among the elderly, and there may be little indication that a person's death was actually a result of physical abuse. Pressure sores may be attributed to a debilitated state, when in fact the resident was not repositioned according to the standards of care or was tied with physical restraints to prevent freedom of movement. Skin tears and bruises may be the result of rough handling or outright physical violence rather than the result of thin, friable skin.

While the incidence of sexual abuse appears to be low, it is more likely to occur in a nursing home rather than in the community setting. A small survey of sexual abuse revealed that 40 out of 42 cases occurred in facilities.[23] Sexual abuse made up 4.6%

of all cases of nursing home abuse and 5.6% of other long-term care facility abuse in 2001.[6] A case series of 20 cases revealed that 75% of the abused persons were nonambulatory and all suffered from cognitive and neurological disorders.[18] Perpetrators are usually gerophiles who seek out elderly victims, or are male residents of the facility.[24] The sexual aggressor may be a patient's own family member.

CASE EXAMPLES OF MISTREATMENT

Case 1

Dr P was a 78-year-old retired physician who had moderately advanced vascular dementia. He was able to communicate at a basic level, feed himself, and walk slowly but independently with a walker. He had been living in a nursing home for many years where he received excellent care. For several days the CNAs and nurses noted that he was "not his usual self"; he seemed a little more tired and a little less hungry. In the middle of the night he developed abdominal pain and was sent to the emergency room for evaluation. While there he had several episodes of hematochezia and was diagnosed with a large bleeding duodenal ulcer. During this three-day hospital stay he was kept at bedrest, and given IV fluids, a blood transfusion, bowel preparations, and a variety of medications for both the ulcer and his "agitated behavior." He became significantly more confused than he had been at the nursing home and was unable to walk independently. He was readmitted to his original nursing home after a two-week stay in a subacute unit. When the nurses examined him for readmission, they were surprised to see multiple pressure sores on his back, buttocks, and heels. These included one stage IV sore, five stage III sores, and eleven stage II sores. They were also saddened to see the transformation of this man from his prior state (interactive, enjoyed participating in activities, walked in the hallways and outside) to his current state (totally dependent in all ADLs, unable to communicate).

Discussion

After careful review of the notes from the hospital and subacute facilities it was difficult to determine when these sores developed. He clearly had multiple risk factors. Regardless of the facility where these began, careful surveillance of pressure points is indicated in patients who are bedbound for even short periods of time. Patients suffering from acute delirium are at high risk for developing pressure sores. No notes from nurses or physicians made any reference to the fact that he was having skin breakdown.

Questions: Do you think this was neglectful care? If so, should anybody be held accountable? If so, whom?

Case 2

Mrs H, a 90-year-old woman, suffered from advanced Alzheimer's disease and resided in a skilled nursing facility for two years. Monthly weights revealed a loss from 125 pounds to 120 pounds in one month. She was evaluated both by the facility and her physician. Her family agreed to the use of an appetite stimulant. Weekly weights were ordered. She began to improve; however three weeks later, the physician was notified that she was sleeping constantly and had not eaten well for three days. Upon questioning, the staff said that she had been "acting strangely" for two days, yet no one contacted her physician regarding the likely delirium. She was transferred to the emergency room according to the family's wishes. There she was diagnosed with dehydration and a urinary tract infection. By that time, her sodium was 160.

Discussion

Passive neglect may occur if caregivers do not recognize a potentially life-threatening situation. Severely impaired persons have difficulty communicating; subtle changes in personality, alertness, and appetite are extremely important signs of illness. Educating long-term care staff to look for these signs can decrease the incidence of passive neglect. If a physiologic decline is recognized as an inevitable part of an end-stage disease, then comfort care can be given.

CONCLUSION

Interventions should address the modifiable risk factors for neglect. Experts agree that increasing nursing home staff ratios is one of the most effective ways to

decrease neglect and abuse. Qualitative studies reveal that a majority of the staff in nursing homes have caring attitudes and good intentions, but they are simply too overworked to adequately care for residents.[21] This leads to burnout, loss of compassion, and high turnover rates. The minority who have criminal records ought to be restricted from nursing home employment by identification through a national database.

Targeted educational programs may significantly reduce mistreatment. Specific training for nurses and nursing aides must include strategies to recognize abuse and neglect. While physical abuse is often unmistakable, the nature of psychological abuse and neglect may not be as clear. In addition, long-term care facility staff must be educated to use communication strategies and coping mechanisms. Behavior of elderly persons with dementia should be interpreted in the context of their illnesses.

Primary healthcare providers can serve as models for care and guide facility staff in meeting quality of care standards. For instance, discussing a resident's care plan with long-term care staff imparts expectations for care. Guidelines to ensure standards of care can be utilized. Reviewing the risks for pressure sores, malnutrition and contractures is an integral part of caring for nursing home patients.

Training programs within medical schools, residencies, and geriatric fellowships can be developed to educate future long-term care providers about elder mistreatment. Education about mechanisms of injury and chronic illness progression improves providers' confidence and reduces barriers for reporting. Most important, this knowledge and skill will lead to the prevention of elder abuse in long-term care settings. ✧

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