# Elder Abuse—A Guide to Diagnosis and Management in the Emergency Department

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**KEYWORDS**

• Elder abuse • Elder abuse neglect • Elder abuse mandatory reporting
• Elder mistreatment • Elder abuse emergency department

**KEY POINTS**

- Emergency physicians should consider elder abuse and neglect when evaluating older adults in the emergency department (ED), because these conditions are both common and dangerous.
- The utilization of elder abuse screening tools in the ED can increase the detection of elder mistreatment.
- ED clinicians are mandatory reporters of suspected elder abuse in most US states. In addition to reporting suspected mistreatment, an ED physician should ensure a patient's safety and utilize a multidisciplinary team if available to develop a treatment plan for vulnerable older adults.

## BACKGROUND

Emergency medicine clinicians are trained to identify and treat life-threatening medical conditions. Although elder abuse is difficult to diagnose and challenging to treat and prevent, physicians must be trained to address this morbid and potentially mortal condition. Elder mistreatment is defined as action or negligence against an older adult that causes harm or risk of harm committed by a person in a relationship with an expectation of trust or when an older person is targeted based on age or disability.[1] Several different types of maltreatment exist[2] (**Table 1**), and each poses different diagnostic and treatment hurdles to physicians. Approximately 10% of Americans over the age of 65 experience some form of mistreatment.[3]

Most older adults live at home, with approximately 95% of older people living either independently or with their spouses, children, or other relatives, rather than in institutions.[3] Therefore, the home is where most elder abuse occurs. As older adults age in

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**Table 1**
**Types of elder abuse**

| Type | Definition | Examples |
|---|---|---|
| Physical abuse | Intentional use of physical force that may result in bodily injury, physical pain, or impairment | • Slapping, hitting, kicking, pushing, pulling hair<br>• Use of physical restraints, force-feeding<br>• Burning, use of household objects as weapons, use of firearms and knives |
| Sexual abuse | Any type of sexual contact with an elderly person that is nonconsensual or sexual contact with any person incapable of giving consent | • Sexual assault or battery, such as rape, sodomy, coerced nudity, and sexually explicit photographing<br>• Unwanted touching, verbal sexual advances<br>• Indecent exposure |
| Neglect | Refusal or failure to fulfill any part of a person's obligations or duties to an elder, which may result in harm—may be intentional or unintentional | • Withholding of food, water, clothing, shelter, medications<br>• Failure to ensure elder's personal hygiene or to provide physical aids, including walker, cane, glasses, hearing aids, dentures<br>• Failure to ensure elder's personal safety and/or appropriate medical follow-up |
| Emotional/psychological abuse | Intentional infliction of anguish, pain, or distress through verbal or nonverbal acts | • Verbal berating, harassment, or intimidation<br>• Threats of punishment or deprivation<br>• Treating the older person like an infant<br>• Isolating the older person from others |
| Abandonment | Desertion of an elderly person by an individual who has assumed responsibility for providing care for an elder or by a person with physical custody | • The desertion of an elder at a hospital, a nursing facility, or other similar institution |

(*continued on next page*)

**Table 1**
***(continued)***

| Type | Definition | Examples |
|---|---|---|
| Financial/material exploitation | Illegal or improper use of an older adult's money, property, or assets | • Stealing money or belongings<br>• Cashing an older adult's checks without permission and/or forging his or her signature<br>• Coercing an older adult into signing contracts, changing a will, or assigning durable power of attorney against his or her wishes or when the older adult does not possess the mental capacity to do so |
| Self-neglect | Behavior of an older adult that threatens his/her own health or safety—excluding when an older adult who understands the consequences of his or her actions makes a conscious and voluntary decision to engage in acts that threaten his/her health or safety | • Refusal or failure of an older adult to provide him or herself with basic necessities, such as food, water, shelter, medications, and appropriate personal hygiene<br>• Disregard for maintenance of safe home environment and/or hoarding |

*Data from* NCEA - Types of Abuse. Available at https://ncea.acl.gov/Suspect-Abuse/Abuse-Types.aspx. Accessed Aug 24, 2020.

place, the increased dependency on others for care that occurs for some puts them at higher risk for abuse. Victims of elder abuse most commonly are female and older than age 74.[4,5] Some studies also suggest victims of abuse are more likely to have mental health disorders.[6] Cognitive impairment also increases a person's risk for abuse, with older adults diagnosed with dementia approximately 5 times as likely to experience abuse than those without this diagnosis.[7,8] Social isolation also increases risk dramatically whereas a strong social support system is protective against elder abuse.[4]

Elder abuse is perpetrated most commonly by someone close to the victim, frequently a male spouse or adult child.[3] Mental illness, substance abuse, and financial dependency on the victim make someone more likely to commit abuse.[4]

Although a small percentage (4.5%) of older adults live in nursing facilities,[9] many will at some point in their lives (35%).[10] A paucity of data exists to describe the prevalence of abuse in long-term care facilities, but experts believe and studies suggest it may be higher than in the community.[11] There are two types of abuse that exist in nursing facilities: staff-to-resident abuse and resident-to-resident abuse. In resident-to-resident abuse, two forms of mistreatment are occurring simultaneously—the abuse itself and neglect by staff members who are not supervising effectively to prevent these events.

Despite popular perception, resident-to-resident abuse actually may be more prevalent than staff-to-resident abuse at nursing facility.[12] This may be, due to the number

of nursing residents with cognitive impairments, such as dementia and related behavioral disturbances. Page and colleagues[13] report a 20.2% 1-month prevalence of resident-to-resident elder mistreatment. Although most cases of elder abuse revolve around the perpetrator's intent, in these cases, the abuser frequently is confused and both the victim and the abuser may suffer harm from the encounter.[14]

## OUTCOMES OF ABUSE

The effects of elder abuse are far-reaching. Older adults who suffer from abuse have worse outcomes from preexisting health conditions and are more likely to be placed in a long-term care facility.[15] All types of abuse increase the risk of depression and anxiety,[15] and abuse victims may have an increased risk for thoughts of suicide compared with unexposed peers. Given this fact, abuse victims use more behavioral health services than other older adults.[16] Physical abuse victims experience physical pain and may sustain injuries, including fractures, wounds, and head injuries. Most importantly, studies repeatedly have shown victims of abuse have a higher risk of mortality than older adults who have not been victimized.[17] Older people exposed to abuse are more likely to utilize an emergency department (ED) and to require hospitalization,[18] because they are less likely to have a primary care doctor and may suffer from acute injury. Therefore, the direct health care expenditures associated with this phenomenon are significant.

## IDENTIFYING ELDER ABUSE AND NEGLECT IN THE EMERGENCY DEPARTMENT

### *History*

When obtaining a history from an older adult, it is important to interview the patient both with and without the caregiver present, especially if there is concern for abuse or neglect. The patient may be less forthcoming with reports of mistreatment if the caregiver remains in the room during the history-taking. If the patient presents to the ED for evaluation of a trauma, the physician should ask the patient directly if they were hit, punched, kicked, pushed, or struck. Patients with cognitive impairment can be poor historians, but studies suggest that even patients with some cognitive deficits can report mistreatment reliably.[19] Emergency practitioners should not rely solely on their history-taking to identify signs of elder abuse and neglect. While obtaining the history, the emergency clinician should be perceptive of any signs of tension between the patient and the caregiver (**Box 1**).

### *A Critical Role for Other Health Care Team Members*

Other members of the care team also can provide valuable data. Emergency medical service (EMS) providers, including paramedics, have the unique advantage of seeing inside a patient's home and can comment on habitability and availability of resources, such as food and medication.[20] These professionals sometimes develop relationships with patients who frequently use their services and can report signs of physical decline or worsening living conditions to the care team in the ED. Physicians should utilize the EMS perspective when evaluating patients with other suggestions of abuse or neglect.

Nursing staff are likely to spend more time with patients and their caregivers in the ED. As such, they can relay their observations of the interactions between these two parties and may pick up on subtle signs of mistreatment. Nurses and patient care technicians also perform a majority of the personal care tasks for patients in the ED and may be better positioned to notice soiled clothing, poor hygiene, nonhealing wounds, or other clues of abuse.[21] By educating ED nursing and support staff about the prevalence of abuse and neglect in this population and informing them of the signs

**Box 1**
**Observations from older adult/caregiver interaction that should raise concern for elder abuse or neglect**

- Older adult and caregiver provide conflicting accounts of events
- Caregiver interrupts/answers for the older adult
- Older adult seems fearful of or hostile toward caregiver
- Caregiver seems unengaged/inattentive in caring for the older adult
- Caregiver seems frustrated, tired, angry, or burdened by the older adult
- Caregiver seems overwhelmed by the older adult
- Caregiver seems to lack knowledge of the patient's care needs
- Evidence that the caregiver and/or older adult may be abusing alcohol or illicit drugs

*Data from* Rosen, Tony, et al. Identifying and initiating intervention for elder abuse and neglect in the emergency department. Clinics in geriatric medicine 2018;34(3): 435-451.

and symptoms, physicians can encourage an open dialogue and improve the chances of detection of mistreatment in the ED. Social workers working in the ED, who are trained to assess for abuse and interpersonal violence and provide resources and referrals, should evaluate older adult patients if any concern for mistreatment exists. Their perspective can inform the level of suspicion and appropriate next steps.

### *Physical Signs*

Physical abuse may be the most amenable form of abuse to detection in the ED, but the diagnosis remains challenging because geriatric patients are prone to unintentional injuries and normal aging processes can mimic abuse. When examining an older person after a trauma, clinicians should look for signs of injury that are not typical of accidental trauma[22] (**Box 2**).

Many patients report their traumatic injuries resulted from "falling" so as not to reveal that injuries actually were caused by abuse. If a patient presents to the ED more than one day after the occurrence of injury, the clinician should consider the possibility of mistreatment.[23]

**Box 2**
**Injury patterns concerning for nonaccidental trauma**

- Injuries in the maxillofacial, dental, and neck areas and the upper extremities[5]
- Injuries to the head and neck without injury to other parts of the body—a fall usually results in other signs of injury to extremities, back, or trunk.[44]
- Neck injuries—the head and shoulders typically protect the neck from injury in a fall.[44]
- Ear injuries—ear injuries typically are not seen in falls and are very concerning for nonaccidental trauma.[44]
- Left-sided facial injuries—many abusers are right-handed and punches or hits affect the left side of the victim's face.[44]
- Ligature marks[24]
- Bruises larger than 5 cm or in the shape of objects[38]

Signs of neglect may include dehydration and foul-smelling decubitus ulcers with surrounding maceration. Poor hygiene, dirty/soiled clothing, multiple diapers, or exacerbations of chronic medical conditions that should be well-controlled also may signal neglect.[24]

Any signs of vaginal/penile/perineal/anal trauma or evidence of a sexually transmitted infection in a patient with cognitive impairment who is not sexually active should trigger consideration of an evaluation for possible sexual abuse.

This assessment is made more challenging because normal changes of aging may mimic elder abuse. Unintentional injuries are common and can cause bruising and skin tears. Vasculitis can masquerade as nonaccidental trauma. Anal fissures caused by constipation and vulvar injuries from traumatic urinary catheter placement or lichen sclerosis all can mimic signs of sexual abuse.[24]

### *Laboratory Tests and Imaging*

Abnormalities in laboratory studies can raise red flags for elder abuse and neglect. Laboratory data that may arouse suspicion include hypernatremia, an elevated blood-urea-nitrogen/creatinine ratio and yes add level after hematocrit. Rhabdomyolysis has several mistreatment-related causes in older adults. It can be caused by prolonged immobility because caregivers may be using inappropriate restraints or not repositioning the older adult frequently enough. Severe dehydration or malnutrition or exposure to high heat (ie, no access to air conditioning) also may cause rhabdomyolysis. Therefore, elevated creatine kinase or myoglobinuria should stimulate the ED provider to consider mistreatment as a diagnosis.[25] Additionally, although dehydration is common among the elderly secondary to decreased thirst reflex and dysphagia, it also can be a sign of mistreatment because some caregivers may withhold fluids to decrease urination. Patients with poorly controlled chronic medical conditions also may benefit from additional laboratory testing by the ED if close follow-up with their primary physician cannot be arranged. An elevated hemoglobin $A_{1c}$ in a diabetic patient despite reported adherence to a medication regimen or abnormally low international normalized ratio measurements in an anticoagulated patient reportedly getting scheduled warfarin could signal medication withholding or neglect to the emergency physician.[25] A urine toxicology screen or abnormal thyroid studies also could suggest medication noncompliance in the appropriate patients.[25]

Radiologists are trained to identify fracture patterns or other radiographic signs of child abuse and can do the same for elder abuse. As patterns of elder abuse become better established, emergency physicians can utilize their radiology colleagues to raise red flags for possible nonaccidental trauma. Although more research is needed, currently, radiologists can identify when an injury pattern does not match with proposed injury mechanism or when a patient has new and healed injuries identified on the same studies.[20]

## SCREENING

Although common among older adults, abuse is under-recognized; the proportion of ED visits by older adults receiving a diagnosis of elder abuse is at least 2 orders of magnitude lower than the estimated prevalence in the population.[26] Multiple screening tools have been developed to increase detection of this morbid condition.[27] Universal screening of all older patients in the ED could have adverse effects. No screening tool has 100% specificity, and false-positive tests can lead to undesirable results. Psychological distress, family tension, and, in extreme circumstances, a possible change in living situation or even loss of personal autonomy all potentially

could occur after a positive screen and report to the authorities.[28] If a caregiver is wrongly accused of abuse, they could become more reluctant to seek indicated medical care in the future. The importance of these issues with screening is poorly understood and deserves more study.[23] Despite the obvious potential to increase detection and initiate intervention, the US Preventive Services Task Force found insufficient evidence that screening for elder abuse in clinical settings reduces harm.[29] These studies also have shed doubt on the proposed benefits of universal screening for elder abuse and neglect and suggest that early detection does not decrease exposure to abuse or physical or mental harm from abuse.[11] Despite the lack of evidence for harm reduction, the American Medical Association and other professional organizations still recommend physicians assess patients for elder abuse, citing an ethical responsibility to attempt to detect this life-threatening condition. Although the data do not prove that using specific screening protocols is superior to having a generally increased threshold of suspicion, screening may help clinicians remember to consider elder abuse and neglect as part of the differential diagnosis. Tools may assist ED providers who are unsure about what questions to ask or signs for which to look. Additionally, the identification of elder abuse victims is important in order to develop and implement effective harm reduction strategies. Common screening scores are included in **Table 2**, including the ED Senior Abuse Identification tool, which was designed specifically for ED use.

Ideally, screening protocols target only the individuals at highest risk for abuse. Doing so would require fewer resources than universal screening and may improve specificity. Unfortunately, no validated protocol currently exists to identify high-risk older adult patients.[27] Research that has sought to identify risk factors for the purpose of targeting screening has not identified specific demographic risk factors that can be

**Table 2**
**A summary of available screening tools**

| Elder Abuse Screening Tool | Description | Clinical Applicability |
|---|---|---|
| Elder Abuse Suspicion Index[45] | Five yes-or-no questions directed to the patient, one question based on the physician observation of the patient's appearance and behavior | Validated but suffers from poor specificity. Lauded for its brevity, this tool could be helpful for screening in the ED. |
| Elder Assessment Instrument[42] | A nursing assessment that utilizes an interview and physical assessment of the older person | A comprehensive assessment but time intensive |
| ED Senior AID[23] | A tool designed for use in cognitively intact adults based on a questionnaire and physical assessment | Combines direct questioning with physical examination findings but is designed only for cognitively intact patients. |
| Vulnerability to Abuse Screening Scale (Schofield and Mishra, 2003) | A series of questions that assess for risks of dependence, dejection, vulnerability, and coercion. | Brief and easy to use, can be self-administered by an older adult |

*Data from* Refs.[2,45–48]

utilized reliably to design targeted screening protocols. Therefore, based on available data, any targeted screening for elder abuse in the ED is likely to miss cases of abuse.

A promising approach to ED screening currently being tested is a two-step process with a universal two-question brief screen ("Has anyone close to you harmed you?" and "Has anyone close to you failed to give you the care that you need?")[27] for all patients followed by a triggered comprehensive screen using the ED Senior Abuse Identification tool for those with a positive brief screen. This approach balances efficiency in a busy ED with not missing potential victims.

### *Emergency Medical Services Screening*

Older patients are four times more likely to use EMS services than younger adults, and EMS providers interact with these patients and their caregivers in their home.[16] Given this rate of utilization, innovative approaches to the diagnosis of elder abuse are needed to increase detection in the prehospital setting. Having EMS providers screen for elder mistreatment as part of their routine protocols may increase detection of mistreatment. The Detection of Elder Mistreatment Through Emergency Care Technicians screening tool incorporates EMS providers' observations of a patient's emotional state, living conditions, physical symptoms, and interactions with caregivers. Although additional study of this tool is required, it is promising, with feasibility of incorporating it into EMS practice already demonstrated.[30]

### *Screening and Technology*

Technology has the potential to streamline and target screening. EDs already overtaxed by clinical responsibilities and budget constraints may utilize the electronic medical record and smart technology, like tablet touchscreen devices, to incorporate elder abuse screening into an ED visit with less burden. Self-screening tools combined with a touchscreen device could be used to reduce the amount of time required of ED staff to execute screening tools. In one study, approximately half of surveyed seniors were willing to use a tablet device to input information, although most did require assistance to complete the tasks in front of them.[31] This likely will improve as technology continues to advance and as seniors continue to interact with these types of devices outside the ED.

At a minimum, the electronic medical record can remind a busy physician to perform an elder abuse screen.[32] Outside of a simple alert reminding clinicians to use a screening tool, the electronic health record may be able to process vast amounts of clinical data to look for signs of elder abuse that are not immediately apparent to clinicians, such as multiple ED visits in a short time period, frequent traumatic injuries, missed primary care doctor appointments, or lapses in refills of chronic medications.[33] This artificial intelligence has the potential to facilitate targeted screening and additional work-up in select patients.[27]

## REPORTING

Once elder abuse is suspected, ED providers should report to adult protective services (APS) or law enforcement. Physicians are mandatory reporters in nearly every US state. Unfortunately, under-reporting is rampant and only a small percentage of elder abuse victims are ever referred to external services.[34] Many ED physicians do not report suspected abuse despite mandatory reporting requirements. The barriers to reporting elder abuse are numerous. Clinicians have difficulty distinguishing between accidental injuries and intentional injuries. An assessment for abuse may be time-consuming, and frequently ED physicians may not have enough time to perform

a thorough evaluation.[21] Doctors cite a lack of familiarity with state reporting laws. Many also have doubts about the efficacy of reporting, worrying that reporting actually place may a patient at higher risk for mistreatment. They also have concerns about how reporting suspected abuse will affect the doctor-patient relationship.[35] Currently, physician training on the detection and reporting of elder abuse is limited. Available data suggest that elder abuse case simulations and active hands-on learning incorporated into physician training can result in improved knowledge and confidence in their abilities to report suspected cases of mistreatment.[36]

It is critical for ED physicians to report elder mistreatment, because most older adults, even those who are able to, seldom self-report.[37] Many victims of abuse are reliant on their abuser for care and worry about loss of support if they report their abuse. Often, the abuser is a close family member and the victim does not want to get them in trouble.[37]

## DISPOSITION

If an emergency clinician suspects elder mistreatment, the treatment plan must include several critical actions. The emergent medical issues must be addressed and clinical findings and mistreatment-related suspicions reported to the appropriate authorities. The physician must also take steps to ensure the patient's safety and make a plan for either admission or safe discharge. While in the ED, severing contact between a patient and an abuser may be necessary if a patient is in immediate danger. This process can be complicated if the abuser also is the patient's medical decision maker or has power of attorney. The use of a multidisciplinary team with social work and hospital administration may be the best approach to this challenging scenario.[20]

If the patient is not at immediate risk for harm and does not require hospitalization, the ED team should develop a plan for safe discharge. A patient's primary care physician can act as a great resource to enact a care plan that includes close follow-up. Case management or social work also can help to organize community resources and offer outpatient support to the patient.

In an important difference between child abuse and elder abuse, many older adult patients may refuse the recommendations of medical providers and choose to leave the ED even if doing so may be unsafe. If a patient is refusing interventions in the ED, the clinician should assess the patient's decisional capacity. If a patient has capacity to make decisions regarding discharge, then they can refuse admission even if it will return them to an abusive situation.[20] Safety education and planning still should be offered. For patients who do not have the capacity to make these decisions, the ED provider should act in their best interest. This may involve attempting to identify non-abusive family members who can make decisions on their behalf and involving the hospital's administration and legal services.

## SPECIAL TOPICS

### *Elder Abuse and COVID-19*

The effects of the Corona virus disease- 19 (COVID-19) pandemic are far reaching for older adults and likely will increase the number of people who experience elder abuse or mistreatment. Although no event in modern history directly correlates to the COVID-19 pandemic, past experiences during natural disasters mimic some of the current conditions and likely can be extrapolated to this public health crisis. Data collection during previous disaster events show that elder abuse cases increase when people are confined to their homes and under financial and emotional stress.[38] During natural disasters and this pandemic, access to community services, senior centers, and

medical care and interactions with social support structures, family, and friends may be severely limited for victims already at high risk for abuse.[39] Home health aides, on whom many older adults rely for care, may not be able to go to older adults' homes during this pandemic. Factors that increase the risk of elder mistreatment, such as decreased income, unemployment, and increased stress for family caregivers, all are more common. During this pandemic, APS workers who investigate potential abuse cases have been limited in their ability to assess older adults in person, instead having to utilize virtual visits and other nontraditional modes of communication to reach out to at-risk elders. This increases challenges to a system that already is overburdened. Although older adults in the community are at higher risk for mistreatment during this pandemic, long-term care facility residents also are likely in increased danger. With mandatory visitor restrictions, there is a significant decrease in visibility into these facilities by family members. Family visits are very protective against abuse and neglect in these institutions. State agencies must increase inspections and ensure that facilities are staffed adequately with qualified personnel to protect these vulnerable adults from neglect, resident-to-resident abuse, and staff mistreatment.[40]

Given these increased risks, ED providers should be particularly vigilant in considering elder mistreatment in the differential diagnosis for older adults during COVID-19 outbreaks and their aftermath.

### *Elder Abuse and Cultural Considerations*

Emergency physicians care for patients from all different cultures and ethnicities, and elder mistreatment is a universal problem. One large meta-analysis suggests that globally, 16% of older adults experience some form of elder abuse.[5] The highest prevalence of elder abuse is reported in developed countries,[7] but it is difficult to assess the prevalence of elder abuse in developing countries given a lack of high-quality research on the topic.

In the United States, minority adults may be at higher risk for mistreatment and also are much less likely to report or seek assistance from available services.[34] Although research suggests that 40% of Latinx older adults have experienced elder abuse, only 2% of this mistreatment ever is reported.[41] Many factors prevent Latinx older adults from reporting abuse. Citizenship status and fear of deportation can hinder reports of abuse in undocumented Latinx immigrants, as can a lack of fluency in English. Culturally, Latinx older adults also are more likely to rely on family members for their daily care, increasing their risk of mistreatment but also decreasing their likelihood of self-reporting abuse.[41]

African Americans experience three times as much financial exploitation and four times as much psychological abuse as their white counterparts.[42,43] Possible explanations include socioeconomic factors and cultural differences in family dynamics. African Americans also have higher rates of contact with police and other law enforcement agencies, due in part to systemic racism. As a result, the number of reports to APS may be higher in this population, falsely elevating the reported incidence of elder mistreatment.[42]

## SUMMARY

Emergency physicians strive to identify all potentially life-threatening conditions patients may have and to develop comprehensive treatment plans for them to prevent morbidity and mortality. Given the high prevalence of and morbidity and mortality associated with elder abuse and neglect, emergency providers should consider this under-recognized phenomenon when assessing older adult patients. EDs should

consider adopting screening protocols. ED providers ethically and legally are obligated to report suspicion of mistreatment to the appropriate investigative agency, and EDs should develop protocols and utilize multidisciplinary teams to ensure patients' safety while in the ED and after discharge.

## CLINICS CARE POINTS

- Older adults exposed to abuse are more likely to utilize the ED and to require hospitalization. They experience higher morbidity and mortality than older adults who do not experience mistreatment.
- Validated screening tools exist to detect elder abuse, and future developments in electronic health records may help clinicians to target screening.
- Physicians are mandatory reporters of elder abuse and can utilize other members of their health care team, such as nursing staff, social workers, and paramedics, to identify signs of mistreatment, thereby increasing rates of detection.
- Factors associated with the COVID-19 pandemic, such as stay-at-home orders, likely will increase the number of older adults who experience elder abuse while straining existing investigative agencies, making detection of abuse in the ED even more important.

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## DISCLOSURE

The authors have nothing to disclose.

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