Staff perceptions of elder abuse

Joan Daly and Alice Coffey present findings from a study in Ireland that revealed a high level of uncertainty among staff about what constitutes abuse of residents in long-term care.

Abstract

Aims The aims of this study were to ascertain perceptions of elder abuse among nurses and care assistants who worked in long-term care settings and whether staff had been educated on elder abuse.

Method A quantitative descriptive co-relational design was used. Questionnaires were completed by 66 nurses and 48 care assistants in three long-term care settings in southern Ireland.

Results Thirty nine (59 per cent) nurses and 25 (52 per cent) care assistants were confident about recognising elder abuse. Nevertheless, there was a high level of uncertainty about what constituted elder abuse.

Conclusion Uncertainty about what constitutes elder abuse may be a barrier to its detection and management. Nurses and care staff working with older people must be able to identify abusive situations and be confident that managers will support them to address the uncertainty surrounding this complex phenomenon.

Keywords Abuse, care homes, long-term care

Literature review

In one of the first studies on elder abuse in long-term care, Pillemer and Moore (1989) found that more than one third of 577 nursing home staff in the United States had witnessed elder abuse, with psychological abuse cited as the most prevalent type. The authors concluded that abuse of residents in nursing homes was sufficiently extensive to merit public concern.

O’Loughlin and Duggan (1998) verified the presence of elder abuse in the Irish community. Although the prevalence of elder abuse in Ireland is not known, it is likely to occur in 3 to 5 per cent of the older population, as it does in other developed countries (Department of Health and Children 2007). Much of the responsibility for detecting and managing cases of suspected elder abuse in the Irish context lies with health and social care workers. Healthcare professionals’ knowledge and understanding of elder abuse are therefore important areas for enquiry. However, awareness of elder abuse among health and social care workers has not been evaluated (Kennelly et al 2007).

Research on elder abuse was first explored by Pettee (1997), who recommended education on assessment, legal implications and available interventions. Pettee (1997) also suggested that nurses should examine their attitude towards older patients.

More recent research has recommended education to help practitioners identify and manage elder abuse. McCreadie et al’s (2000) research with GPs in the UK indicated that the strongest factor predicting diagnosis of abuse was knowledge of risk situations; GPs who read articles on elder abuse were four times more likely to diagnose abuse than those who did not.

In long-term care situations, residents’ need for assistance with their activities of daily living, along with caregiver workload, can be strongly
associated with abusive situations (Isaksson et al 2008). However, the identification of elder abuse has proved difficult for healthcare workers (Erlingsson et al 2006, Conry 2009, Lo et al 2009, McGarry and Simpson 2009a, Phelan 2009). Healthcare professionals have also expressed a lack of confidence in reporting abuse (Buchwald et al 2000, Wong and Marr 2002). These difficulties have been attributed to lack of awareness and different perceptions of elder abuse (Meeks-Sjostrom 2004).

In Ireland, Kennelly et al (2007) explored understanding of the term ‘elder abuse’ with hospital doctors and social workers, and found that all participants felt uncomfortable using the label ‘elder abuse’. In addition, social workers were shown to have substantially more knowledge and familiarity with the terminology of elder abuse than doctors, which the researchers attributed to the formal education received by social workers at undergraduate level.

Education and training focused on adult protection have been shown to be significant in the prevention of elder abuse (Richardson et al 2002, Sturdy and Heath 2007, Buzgová and Ivanová 2009, Shiman-Altman and Cohen 2009, Wang et al 2009). In the context of long-term care, Hirst (2002) found that resident abuse often stemmed from lack of awareness among staff that certain behaviours were abusive. Despite initiatives to improve awareness about elder abuse it is likely that older people residing in long-term care may be more vulnerable. Little research has been conducted to examine the knowledge and perceptions of staff working in long-term care about what constitutes elder abuse.

**Aims**

The aims of this study were to ascertain perceptions of elder abuse among nurses and care assistants who worked in long-term care settings and whether staff had been educated on elder abuse.

**Method**

The study design was quantitative descriptive co-relational. A researcher-developed questionnaire was used to record level of education, how knowledge was gained on elder abuse, confidence about recognising elder abuse and desire to obtain further education on elder abuse.

Staff perceptions of elder abuse were measured using the perception of elder abuse questionnaire (Kottwitz and Bowling 2003), a 25-item instrument consisting of five subscales of abuse: physical, psychological, developmental, sociocultural and spiritual. Questions on the instrument were formulated on the basis that it is the right of a person to refuse care, however, if care is not performed the caregiver may be cited for neglect (Kottwitz and Bowling 2003). With this contradiction in mind, rather than requiring right or wrong answers, the questionnaire was set out to measure consistency in and between staff responses (Kottwitz and Bowling 2003).

To test usability of the research instruments, a pilot study was conducted with 16 staff before the main study. The perception of elder abuse questionnaire was reported by Kottwitz and Bowling (2003) to be reliable in statistical tests (reliability index Cronbach’s alpha coefficient 0.67). Cronbach’s alpha is a reliability index that estimates the internal consistency or homogeneity of a measure composed of several items or subparts (Polit and Beck 2004).

The Statistical Package for Social Sciences version 12 was used to analyse the data using descriptive and inferential statistics. The total number of nurses and care assistants (n=163) in three long-term care settings for older people in southern Ireland were invited to take part. Eligible respondents were staff who had worked in the care setting for at least six months.

**Ethical considerations** Ethical approval was given for the study by the clinical research ethics committee of the local teaching hospitals before the study began and access to the sample group was gained through the directors of nursing in each hospital. Identifiable details were not requested on the questionnaire; therefore anonymity of the respondents was assured. Consent was implied by completion and return of questionnaires. Respondents were aware that their involvement was voluntary and they could withdraw at any time. Data were kept on password-protected computers and shredded electronically after analysis.

**Results**

The overall response rate was 70 per cent (n=114), which consisted of 55 (48 per cent) staff nurses, 48 (42 per cent) care assistants, eight (7 per cent) clinical nurse managers and three (3 per cent) clinical nurse specialists (CNSs). Years of employment in long-term care ranged from one to 40 with a mean of 11.9 years. All respondents were female.

**Level of education** Of the 66 nurse respondents, the majority (n=54, 82 per cent) were educated only at general certificate level. Six (9 per cent) had a bachelor’s degree and a further six (9 per cent) had a postgraduate diploma in gerontological nursing. Seventeen (35 per cent) of the 48 care assistants had a recognised national certificate qualification for their role.
How knowledge was gained on elder abuse Forty (60 per cent) nurses stated that they had attended at least one training session on elder abuse compared with eight (17 per cent) care assistants.

Confidence about recognising elder abuse Thirty nine (59 per cent) nurses were confident about recognising elder abuse, while 20 (30 per cent) said they were not confident, and seven (11 per cent) were uncertain. Twenty five (52 per cent) care assistants said that they were confident about recognising abuse, 17 (35 per cent) stated they were not confident, while six (13 per cent) were uncertain. Further analysis revealed that care assistants who were formally educated for their role and nurses who had a postgraduate qualification were more likely to express a lack of confidence about their ability to recognise elder abuse.

Desire to obtain further education on elder abuse Fifty two (79 per cent) nurses and 36 (75 per cent) care assistants expressed a strong interest in receiving formal training on elder abuse.

Staff perceptions of elder abuse Findings from the perception of elder abuse questionnaire (Kottwitz and Bowling 2003) are presented with examples from each subscale.

Perceptions of physical abuse Statements included in the physical subscale were related to activities of daily living and safety. Results showed variability in agreement and disagreement among respondents and a considerable level of uncertainty. For example, 86/114 (75 per cent) agreed with the statement that ‘forced bathing twice a week’ was abusive, however, 67 (59 per cent) disagreed with the statement that ‘insisting on daily oral hygiene’ was abusive and 12 (11 per cent) were undecided.

Responses to the statement ‘using chemical restraints for the protection of the elder’s safety’ was abusive also demonstrated the uncertainty among many respondents about what constituted abuse: 68 (60 per cent) agreed, 11 (10 per cent) disagreed and the remainder were undecided.

Perceptions of psychological abuse The psychological subscale contained statements about patient dignity and respondents’ reactions to cognitive impairment in the older person. Sixty one (54 per cent) respondents agreed with the statement ‘forcing elders to participate in activities’ was abusive and ‘enforced bedtimes’ were deemed abusive by 80 (70 per cent) respondents, with similar results for nurses and care assistants.

However, considerable uncertainty existed in response to the following statement: ‘admitting elders with the diagnosis of dementia and elders without the diagnosis of dementia to the same long-term facility is abusive to elders without the diagnosis of dementia’. Although half of the respondents agreed with this statement, 32 (28 per cent) disagreed and 24 (21 per cent) were undecided (one did not reply). Some respondents commented that the stage of dementia would determine their views, which may have accounted for the high level of undecided responses.

Perceptions of developmental abuse The developmental subscale statements related to the behaviour of older people and their judgement. While 57 (50 per cent) respondents agreed that ‘excluding disruptive older patients from activities’ was abusive, there was also a high level of disagreement (n=35, 31 per cent) and indecision (n=19, 17 per cent) (three respondents did not reply to this statement). Seventy two (63 per cent) respondents agreed that a ‘requirement for yearly driving tests for those aged over 75 whether the older person agreed or not’ was not abusive. In addition, ‘reality testing’, that is, asking older people questions about date, day, time, month and year to test their orientation to external reality, was not deemed abusive by 78 (68 per cent) respondents.

Perceptions of sociocultural abuse The sociocultural subscale statements related to cultural integration. There was greater agreement among all respondents in their perceptions of what was abuse in this subscale. For example, 98 (86 per cent) agreed that ‘the practice of ignoring an older person’ was abusive and 103 (90 per cent) agreed that ‘ignoring an elder’s cultural beliefs’ was abusive.

Perceptions of spiritual abuse Statements on spiritual abuse were related to church activities and beliefs. Results from this subscale showed greater consensus and certainty in responses. For example, 89 (78 per cent) respondents agreed that it was abusive ‘not to honour holidays of all faiths’ and 106 (93 per cent) agreed with the statement that ‘insisting elders are involved in church activities against their beliefs is abusive’.

Overall, the results of the staff perceptions of elder abuse questionnaire revealed high levels of uncertainty about what constituted abuse.

Discussion The study was restricted to a limited population and geographical area, therefore results may not be
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generalisable to a larger population. The perception of elder abuse questionnaire (Kottwitz and Bowling 2003) asked staff to determine their perceptions of abuse on the basis of a series of single statements, which may not have taken into account the complexity of issues involved. Although the anonymity afforded by the questionnaire may have assisted in responses other than those that were socially acceptable, the language of the questionnaire may need to be more culturally appropriate.

Few respondents had received any formal post-registration education or training about elder abuse. Results suggested that the educational standard of respondents affected their level of confidence in recognising abuse. Those who were knowledgeable about elder abuse were more likely to voice their concerns about recognising elder abuse.

This finding is similar to McLaughlin and Lavery's (2000) study, which found that only 25 per cent of specialists in elder care believed they were competent in identifying elder abuse. It could be argued that staff who are provided with even a little knowledge about elder abuse issues are more likely to diagnose abuse (McCreadie et al 2000). However, more specific and focused education about elder abuse is necessary to provide staff with the confidence to recognise all forms of abuse.

The perceptions of elder abuse indicated that there was a high level of uncertainty about what constituted elder abuse. This uncertainty was shared almost equally between nurses and care assistants. These findings concur with research where uncertainty of what constituted abuse was cited as a reason for not reporting incidents of abuse (Meeks-Sjostrom 2004, Erlingsson et al 2006, Kennelly et al 2007).

Meeks-Sjostrom (2004) suggested that low identification rates of elder abuse were due to lack of alertness and the difficulty in distinguishing symptoms of abuse and neglect from symptoms relating to physical and mental illness.

Pillemer and Moore (1989) suggested that staff who had negative attitudes towards older people and who tended to view patients as childlike appeared to be more likely to behave inappropriately towards them. In this study a high level of uncertainty was identified, particularly in the developmental subscale. This may be indicative of the recognition among staff that some of the examples given may not always be construed as negative in the context of care. For example, the segregation of a person with challenging behaviour could be construed as positive, if the patient's family and multidisciplinary team identified that personal space was more appropriate for a specific care intervention.

The uncertainty of responses may also have been derived from unhappiness with use of the term 'abuse', which is consistent with previous research (Ayres and Wooddli 2001, Kennelly et al 2007). Uncertainty may also be a response to the complexities surrounding the detection of abuse, particularly the subtle forms (Buka and Sookhoo 2006, Lo et al 2009, McGarry et al 2009b, Phelan 2009). However, it can also be assumed that respondents' uncertainty reflected a lack of awareness of circumstances that can potentially lead to abuse in long-term care (Hirst 2002). Uncertainty, whatever the cause, may lead to conflicting work practices among staff and lack of appropriate action (Department of Health and Children 2002).

These findings highlight a need to promote awareness of and reflection on the complexities of elder abuse among all staff working with older people. Focused education and training for staff on elder abuse are necessary to address uncertainty and clarify protocols for reporting abuse, which concurs with previous research (Kennelly et al 2007, Lo et al 2009, McGarry and Simpson 2009b, Rinker 2009, Saarnio et al 2009, Wang et al 2009). Educational programmes should therefore be tailored to participants' initial knowledge (Richardson et al 2002) and also the context of care (Phelan 2009).

Further research on knowledge and perceptions of elder abuse is required on a larger scale in Ireland and elsewhere to identify problems in perception of elder abuse and to promote awareness among care providers. A qualitative enquiry into staff attitudes to elder abuse which were not explored in this study would be of value. Providers of formal education programmes for nurses and care staff should examine the content of educational programmes on elder abuse to ensure that the topic and its complexities are addressed in curricula.

**Implications for practice**

The findings reinforce the need for nurses and other healthcare staff working with older people to understand the multiple dimensions of what constitutes abuse (Phelan 2009). The importance of including context-specific education on elder abuse in nursing curricula is also highlighted, so that nurse-patient interactions in different care settings can be explored to highlight situations where abuse could take place.

*More specific education on elder abuse is necessary to provide staff with the confidence to recognise all forms of abuse*
Respondents who were more educated felt less confident about recognising abuse. This finding suggests that all staff, even those who were aware of elder abuse, require clearly written protocols and guidelines to assist them in the identification and management of elder abuse. When assessing an older person, nurses should always keep abuse in the realm of possibility (Phelan 2009).

Due to the complex nature of elder abuse it is important that all staff feel confident and supported to express concerns, and seek clarity on delicate care issues, thereby alleviating possible abusive situations. It is vital that nurses and care staff working with older people are able to identify abusive situations and are confident that management will support them in reflection and discussion to address the uncertainty surrounding this complex phenomenon.

Information sharing and multidisciplinary approaches to care are important in providing a safe environment for older people (Buka and Sookhoo 2006, McGarry and Simpson 2009a) and should be encouraged in long-term care settings. This would also allow for context-specific discussion on elder abuse. Nurse managers of long-term care facilities need to be vigilant and aware of the safety and dignity of older people through regular review of staff knowledge, perceptions and guidelines for practice. They should strive to create a culture conducive to safe reporting of abuse and a working environment where critical reflection is encouraged.

Conclusion
Abuse of older people is an important issue to address, particularly in care settings where older people are dependent and may be more vulnerable. This study aimed to ascertain the perceptions of elder abuse among nurses and care assistants who worked in long-term care settings for older people in Ireland. Most staff had not received specific education about elder abuse and there was considerable uncertainty about what constituted abuse. Staff who had been educated about elder abuse were less confident in recognising abuse. This may indicate either an awareness of the complexities of its detection or lack of awareness of circumstances that could potentially lead to abuse. Findings highlight a need to promote awareness of and reflection on the complexities of elder abuse among all staff working with older people. The researchers concur with previous research calling for focused education and training for staff tailored to participants’ initial knowledge (Richardson et al 2002) and applicable to the context of care (Phelan 2009).

References


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