CASE REPORT

Elder Mistreatment: A Case Report

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Elder mistreatment may become increasingly apparent as the elderly population continues to grow. Due to their knowledge and skills, physicians have a unique role in the multidisciplinary teams that care for such patients. This case report examines the suspected elder mistreatment in an aphasic, septic patient under the care of family members, one of which was also his medical decision maker. The healthcare team utilized medical and community resources in the care and intervention, which exemplified characteristics of best practice. Physicians and other providers have a responsibility to better identify and intervene in suspected cases of elder mistreatment and further education must be sought in order to adequately serve the elderly community.

Keywords: Elder mistreatment; abuse; neglect; case report

INTRODUCTION

Elder abuse is a relatively newly-defined public health issue. Since the population of elderly people is growing, elder abuse may be even more apparent moving forward. Physicians make up an integral part of the multidisciplinary teams that intervene during suspected cases of abuse and are often charged with reporting such cases. There are several barriers to intervention for cases of suspected elder abuse. In particular, obtaining reliable history and performing a thorough physical examination can often be challenging in these patients. This case report discusses a case of suspected elder abuse in a patient with hemiplegia and expressive aphasia, whose Designated Power of Attorney (DPOA) is a possible abuser, all of which further complicates appropriate diagnosis and intervention.

CASE PRESENTATION

The patient is a 74-year-old gentleman with expressive aphasia and right hemiplegia following a stroke in 2014. He also has several comorbidities including urinary retention requiring suprapubic catheterization. He presents to the emergency department with septic shock and acute kidney injury secondary to urinary tract infection. Notable findings on examination included poor hygiene, multiple skin tears and scabs, multiple bruises, and an open laceration near the suprapubic catheter insertion site.

Due to his extensive comorbidities, the patient lives with his wife, step-daughter, grandson, and his grandson's fiancé who act as his primary caregivers. Due to his expressive aphasia and altered mentation secondary to urosepsis, history was taken from his step-daughter who reported that home health services also come daily to help care for the patient.

The team is challenged at many levels in this case. First, responding to the immediate life-threatening needs of a patient who cannot care for himself and may not have the safe home caregiving services necessary once those needs are met. Second, identifying and managing elder mistreatment if it exists in a patient who cannot effectively communicate. And third, balancing an investigation for possible neglect while maintaining a therapeutic relationship with both the patient and his family.

What We Know About Elder Abuse and Neglect

Elder abuse was first identified in 1975 by British gerontologists and was typically thought to exist as a social or family issue, limiting the public's recognition of responsibility for solutions (1). More recently, addressing the problem of elder abuse and neglect has fallen under the authority of the public health and criminal justice systems (2,3). As a result of this being a relatively newly-recognized public health issue, large amounts of data do not yet exist. Three large epidemiologic studies in the United States found the rate of elder abuse to be 7.6%, 9%, and 10% (4). It is likely that estimates underrepresent the true prevalence of elder mistreatment due to low rates of self-reporting, lack of healthcare worker education, limited reimbursement, uncertainties about reporting standards, and concern that patient harm may actually be perpetuated (2,4,5). The consequences of elder abuse include preventable healthcare cost (currently more than 5.3 billion dollars of U.S healthcare expenditure), increased rates of depression, anxiety, hospitalizations in the elderly, and a three-fold increase in mortality after accounting for comorbidity (4,6,7). In addition, the U.S Census Bureau estimates that by 2030, there will be 71 million older Americans (age 65 or older), or one in five Americans, indicating that elder abuse is a growing concern (6).

Elder abuse has been defined by multiple regulatory agencies resulting in unique and overlapping definitions. In 2016, the Center for Disease Control (CDC) published the first version of Elder Abuse Surveillance – the goal being to provide a more uniform definition of elder abuse. Uniform definitions are provided by the CDC in their report and five subtypes of elder abuse are currently recognized: physical, psychological/emotional, sexual, financial, and neglect. Elder abuse may be defined as "an intentional act or failure to act by a caregiver or another person in a relationship involving an expectation of trust that causes or creates a risk of harm to an older adult." The report also provides a uniform definition for each subtype. Elder neglect is defined as, "failure by a caregiver or other person in a trust relationship to protect an elder from harm or the failure to meet needs for essential medical care, nutrition, hydration, hygiene, clothing, basic activities of daily living or shelter, which results in a serious risk of compromised health and/or safety, relative to age, health status, and cultural norms (6)".

The evaluation of suspected elder abuse can be challenging. The interview of a patient with suspected abuse ideally occurs in a private setting without any suspected abusers so they can speak freely, however family or other caregivers often accompany elderly patients during clinic visits. Further,

since dementia is one of the most implicated risk factors for elder abuse, and since mood dysregulation including depression may also be present, reliable history is hard to obtain even when the elder is interviewed individually (4). Unlike child abuse, there have been no physical exam findings that are diagnostic for elder abuse. However, several findings can sensitize to abuse, such as abrasions, lacerations, bruises, fractures, decubitus ulcers, poor hygiene, malnutrition, failure to keep appointments, medication non-adherence, and others.[4,8] With regards to neglect, assessing functional status (i.e. activities of daily living) and comparing the needs of the elder and what is provided by the caregiver(s) can help elucidate underlying problems (4).

There is limited data regarding the effectiveness of intervention for elder abuse. One large systematic review identified more than 1,000 potentially relevant studies but only eight studies were quantitative and comparative. Of these, none were conclusive regarding effectiveness, applicability, or target population for intervention compared to no intervention. Further research is needed in order to more clearly discern best practices for elder abuse intervention (9). Currently, a multidisciplinary, long-term plan of care is accepted as best practice in cases of abuse which includes entities such as Adult Protective Services (APS), legal services, healthcare providers, and others. No two cases are identical, and therefore specific intervention strategies should be tailored to the elder, keeping in mind certain factors such as demographics, comorbidities, socioeconomic background, and support system (2,4,9).

In the United States, every state currently has a mandatory reporting law for elder abuse yet there are differences in state laws regarding who is mandated to report, what findings necessitate reporting, and considerations of elder capacity and residence. In Missouri, there is mandated reporting if there is "reasonable cause to suspect" elder abuse or neglect and it is to be done immediately to the Missouri Department of Health and Senior Services (DHSS) (10). The DHSS will then investigate and determine what, if any, action needs to be taken to protect the patient.

CASE DISCUSSION

This patient was at risk for elder abuse based on his history and known risk factors including recurrent hospitalizations, reliance on care due to disability, and a shared-living environment comprised of adult caregiver family members. Additionally, his physical exam had multiple findings consistent with abuse and neglect, including poor hygiene, several skin tears and scabs, multiple bruises, and an open laceration near his catheter site. Furthermore, he presented with altered mental status secondary to urosepsis and was aphasic. Both factors served as barriers to effective communication (4).

At this point, the healthcare team had several challenges to consider as next steps in management. As always, the first rule is to do no harm to the patient and his well-being was therefore the most important factor to consider. Shared decision making with the patient was deterred by his mental status changes, thus medical decisions were guided by evidence-based standards of care and treatment. However, it was also known to the healthcare team that his step-daughter was DPOA, therefore she had the authority to participate and help guide the medical decisions being made. Obtaining history directly from the patient even after stabilization was unreliable. The history from family did not suggest overt abuse or neglect, and their credibility, as yet, was not negated. Nevertheless, findings at presentation were concerning.

Confrontational accusations of family can actually lead to increased levels of subsequent abuse and/or isolation of the elderly and should be avoided. Also, proper determination of abuse may take weeks to months to complete, but the patient could not stay in the hospital for months once stabilized so the providers had to rely on a team approach that includes outpatient resources (4).

Although there were several ethical dilemmas including efficient identification, effective communication, and appropriate next steps in care, mandated reporting in Missouri removed some of the decision-making in this case. After presenting to the emergency department, the DHSS was contacted by the healthcare team due to their suspicion for abuse/neglect. A case worker from DHSS then contacted the hospital social worker assigned to the patient in order to obtain more information once the patient was clinically stable. At that visit, the patient was noted to be alert and oriented but had difficulty speaking due to his expressive aphasia. It was determined that he was able to nod "yes" and "no" appropriately to questions. Social services asked about his care at home, to which he confirmed that he gets care from his family at home. He was asked directly if he felt safe at home, to which he nodded, "yes." In addition, he was asked if he felt unsafe at home, to which he shook his head, "no." Social work then included the family at bedside where the family was visibly upset about the involvement of DHSS. After thorough education for the family caregivers regarding hygiene and wound care, the patient was discharged home. DHSS planned to make a home visit after discharge. They will continue to monitor the situation and offer additional interventions if necessary.

CONCLUSION

Elder abuse and neglect have recently been identified as public health issues with evolving definitions. Mistreatment of the elderly continues to be underdiagnosed as a result of several barriers. As the elderly population in this country continues to grow and one in five Americans are identified as elderly by 2030, it will be imperative that the growing concern of potential for abuse and neglect be addressed effectively. No two cases of elder mistreatment are the same, and comorbidities both acute and chronic must be addressed in order to deliver the best possible care. As mandated reporters, physicians should seek to improve their ability to recognize and manage cases of abuse by maintaining a low but reasonable threshold of suspicion, and work effectively within skilled, multi-disciplinary teams for best outcomes. In addition, more research is needed to foster strategies for intervention that will improve the plight of our growing elderly population.

Notes

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