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# Clinical Decision-Making of Nurses Regarding Elder Abuse

Diana J. Meeks-Sjostrom

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Dissertation

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## ACCEPTANCE

This dissertation, CLINICAL DECISION-MAKING OF NURSES REGARDING ELDER ABUSE by Diana Meeks-Sjostrom was prepared under the direction of the candidate's dissertation committee. It is accepted by the committee members in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Nursing in the Byrdine F. Lewis School of Nursing in the College of Health and Human Sciences, Georgia State University.

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## ABSTRACT

### CLINICAL DECISION-MAKING OF NURSES REGARDING ELDER ABUSE

By

DIANA MEEKS-SJOSTROM

A descriptive correlational design based on an adapted model of Donabedian's Structure, Process, Outcome model and Benner's Novice to Expert theory was used to examine the clinical decision-making of nurses regarding elder abuse. The relationship of the nurses applied knowledge (assessment cues) of elder abuse; demographic questions (e.g. years of experience as a Registered Nurse (RN) and their clinical level of practice status), the use of intuition in nursing practice; and clinical decision outcomes (interventions) for patients in cases of suspected elder abuse was examined.

A convenience sample of RNs who worked in the emergency department (ED) in three acute care hospitals, in southeastern United States were asked to complete questionnaires on education about elder abuse, their intuition use, demographic information, applied knowledge of elder abuse, and clinical decision outcomes for suspected elder abuse.

The majority of the nurses had participated in the clinical level of practice status program. The convenience sample of 84 RNs consisted of 68 females (81%) and 16 males (19%). The average age of the respondents was 41.43 years. The mean number of years worked as a RN was 13.87 years.

Multiple regression results indicated an overall model of two predictors (RN's applied knowledge (assessment cues) and years worked as a RN) significantly predicted

clinical decision outcomes (interventions). The model accounted for 25.1% variance in clinical decision outcomes.

The *t*-test revealed there was no difference (applied knowledge (assessment cues) of elder abuse, intuition use in nursing, years working as a RN, clinical level of practice status, and clinical decision outcomes (interventions)) between RNs who received elder abuse education at orientation and those who did not receive the education.

The study results suggest that years of working as a nurse supported elder abuse recognition and intervention. The clinical level of practice status of nurses was found not to be a sensitive indicator. Elder abuse education during orientation varied between the hospital settings. The results indicate the educational need for nurses regarding suspected elder abuse.

CLINICAL DECISION-MAKING OF NURSES REGARDING ELDER ABUSE

By

DIANA MEEKS-SJOSTROM

A DISSERTATION

Presented in Partial Fulfillment of Requirements for the  
Degree of doctor of Philosophy in Nursing in the Byrdine F. Lewis  
School of Nursing in the College of Health and Human Sciences  
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## LIST OF ABBREVIATIONS

RN	Registered Nurse
ED	Emergency Department
CDMNS	Clinical Decision-Making in Nursing Scale
GPA	Grade point Average
IRB	Institutional Review Board
SD	Standard Deviation
SJH	Saint Joseph's Hospital
SJC	Saint Joseph's Candler/Savannah

## CHAPTER I

### INTRODUCTION

#### Statement of Problem

When an older adult needs medical assistance, the emergency department (ED) is often their initial point of entry into the healthcare system. Cases of elder abuse can be identified by an alert clinician and interventions such as referral to a protective agency may be implemented (Arvanis et al., 1993). Nurses have an opportunity and a responsibility to identify potential and actual victims of elder abuse (Baker & Heitkemper, 2005). In the fast-paced, technical healthcare environment that exists today, Registered Nurses (RNs) need to be aware of the cues for elder abuse and thoroughly assess elderly patients to make clinical decisions regarding elder abuse. However, RNs may make different clinical decisions if they have not been adequately prepared to assess for elder abuse. There is a deficit of research studies that assesses the preparedness of ED RNs to assess for and intervene in cases of suspected elder abuse.

#### Purpose

The purpose of this study is to explore the relationship of the ED RN's applied knowledge (assessment cues) of elder abuse, years of experience as a RN, intuition use in nursing practice, clinical level of practice status of the RN, and the clinical decision outcomes (interventions) of the RNs regarding elder abuse.

### Specific Aims

The specific aims of the study are:

1. To determine the relationship of the RNs applied knowledge (assessment cues) of elder abuse, years of experience as a RN, intuition use in nursing practice, clinical level of practice status of the RN, and the RN's clinical decision outcomes (interventions) for elderly patients regarding elder abuse.
2. To examine the difference in applied knowledge (assessment cues) of elder abuse, years of experience in nursing, intuition use in nursing practice, clinical level of practice status of the RN, and the clinical decision outcomes (interventions) between RNs who had mandatory elder abuse training during orientation and those who did not.

### Significance of Research

Little research has been reported regarding the effectiveness of RNs in recognizing and acting on signs and symptoms of elder abuse in the ED. To date there have not been any published research studies regarding the relationship of ER RNs applied knowledge (assessment cues) of elder abuse, years of experience as a RN, intuition use in nursing practice, and clinical level of practice status in relation to the clinical decision-making (interventions) of RNs regarding elder abuse. RNs have an important role in the assessment of elder abuse. Therefore, health care organizations must ensure RNs have education and knowledge about elder abuse including what defines elder abuse, the scope of the problem, the laws and implications for practice, how to assess and intervene in a suspected case of abuse, and resources available to make the best clinical decisions possible for their elderly patients.



The results of this study have potential benefits to the local and national elderly community, their families and/or significant others and healthcare professionals by determining if a need exists for additional knowledge/training among RNs in reporting elder abuse. An intervention for RNs regarding elder abuse can then be introduced across health care systems to educate healthcare professionals regarding assessment of and interventions to be implemented in cases of elder abuse.

### Theoretical Framework

#### *Selection of Theoretical Perspective*

This section will discuss the theoretical perspective chosen for the study of clinical decision-making of nurses regarding elder abuse. The theoretical framework of this study involves combining part of Donabedian's Structure, Process, Outcome Model (1966) and Benner's Novice to Expert Theory (1984). The Clinical Decision-Making of Nurses Regarding Elder Abuse Model, adapted for this study, will be presented below. Subsequently, the rationale for the selection of the theoretical perspective will be discussed. For the purpose of clarification, the researcher acknowledges several of her own assumptions.

#### *Researcher's Assumptions*

1. Nurses have a responsibility to report suspected elder abuse.
2. Hospitals are a point of entry into the healthcare delivery system where elder abuse maybe detected.
3. The ED RN has no control over the antecedent condition.
4. The organizational structure within healthcare settings influences clinical practice related to elder abuse.

5. A thorough assessment by the RN is needed to make correct clinical decisions regarding elder abuse.

### Theoretical Perspective

This section will describe the author's adapted conceptual model derived from Donabedian's Structure Process Outcome model and Benner's Novice to Expert theory. The synthesis of these two highly valid models guided this study. The description of Donabedian's model is presented in Appendix A. Benner's assumptions are presented in Appendix B. An overview of the model will be presented followed by a more in depth look at Donabedian's Structure, Process, Outcome Model and Benner's Novice to Expert Theory.

### *Defining Clinical Decision-Making*

Decision-making is a "conscious analysis" or "rational selection of alternatives from a set of mutually exclusive possibilities; the selection is based on values associated with each possible outcome, and the probability of each outcome given the possible course of action" (Benner, Tanner, & Chesla, 1996, p. 2). Decision-making is a necessary part of nursing practice.

### Conceptual Framework

The essence of the Clinical Decision-Making of Nurses Regarding Elder Abuse conceptual framework (Figure 1) is guided by Donabedian's Structure, Process, and Outcome model. The structure process outcome model was originally developed to assess quality of care (Donabedian, 1966). An example of the original Donabedian Model can be found in Figure 2. For this study, the key element used from Donabedian's structure

section is human resource, in this case, the ED RN. Embedded within the adapted conceptual framework is Benner's Novice to Expert theory and intuition use in nursing.

Figure 1

Model of Clinical Decision-Making of Nurses Regarding Elder Abuse

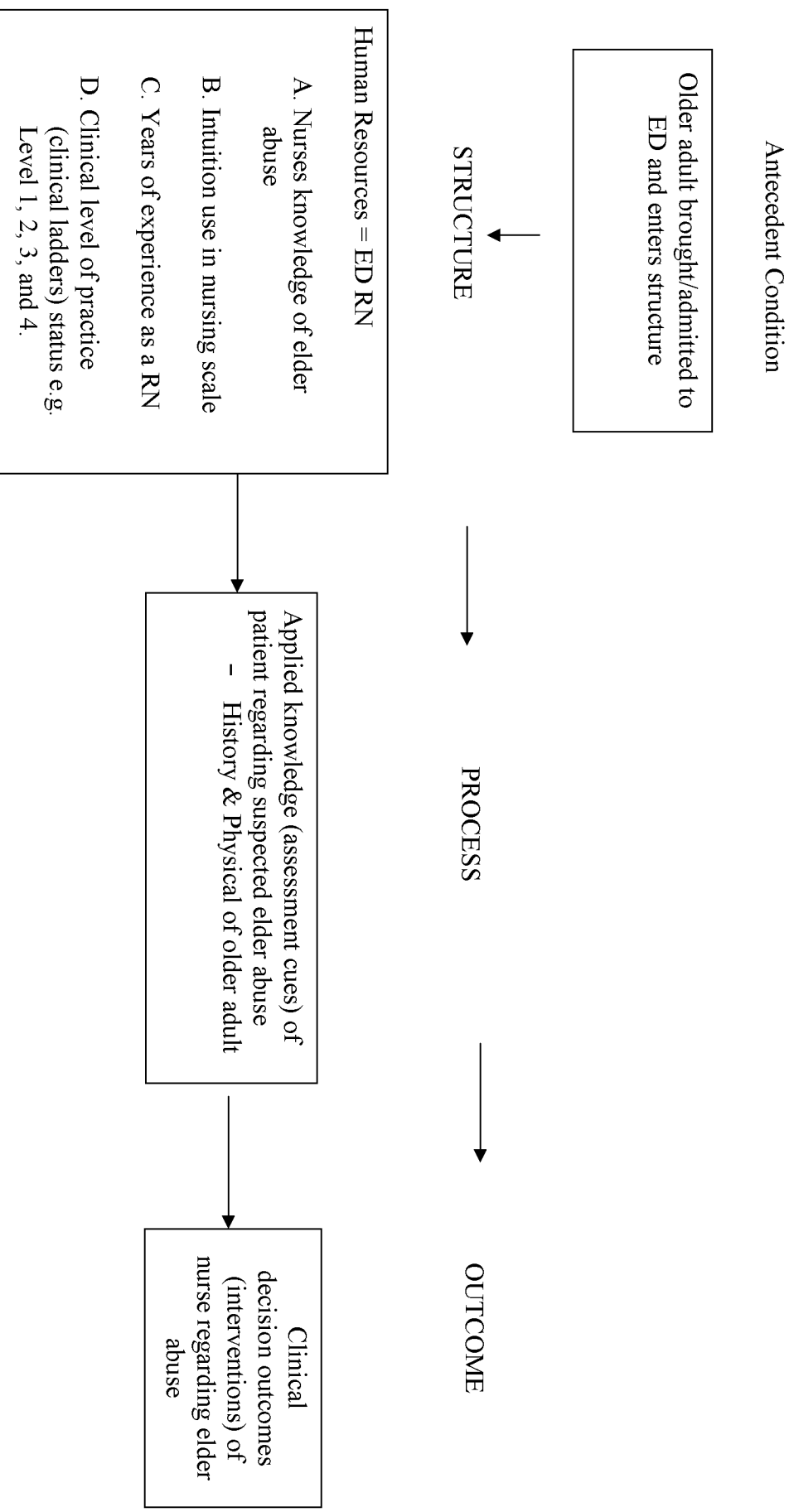
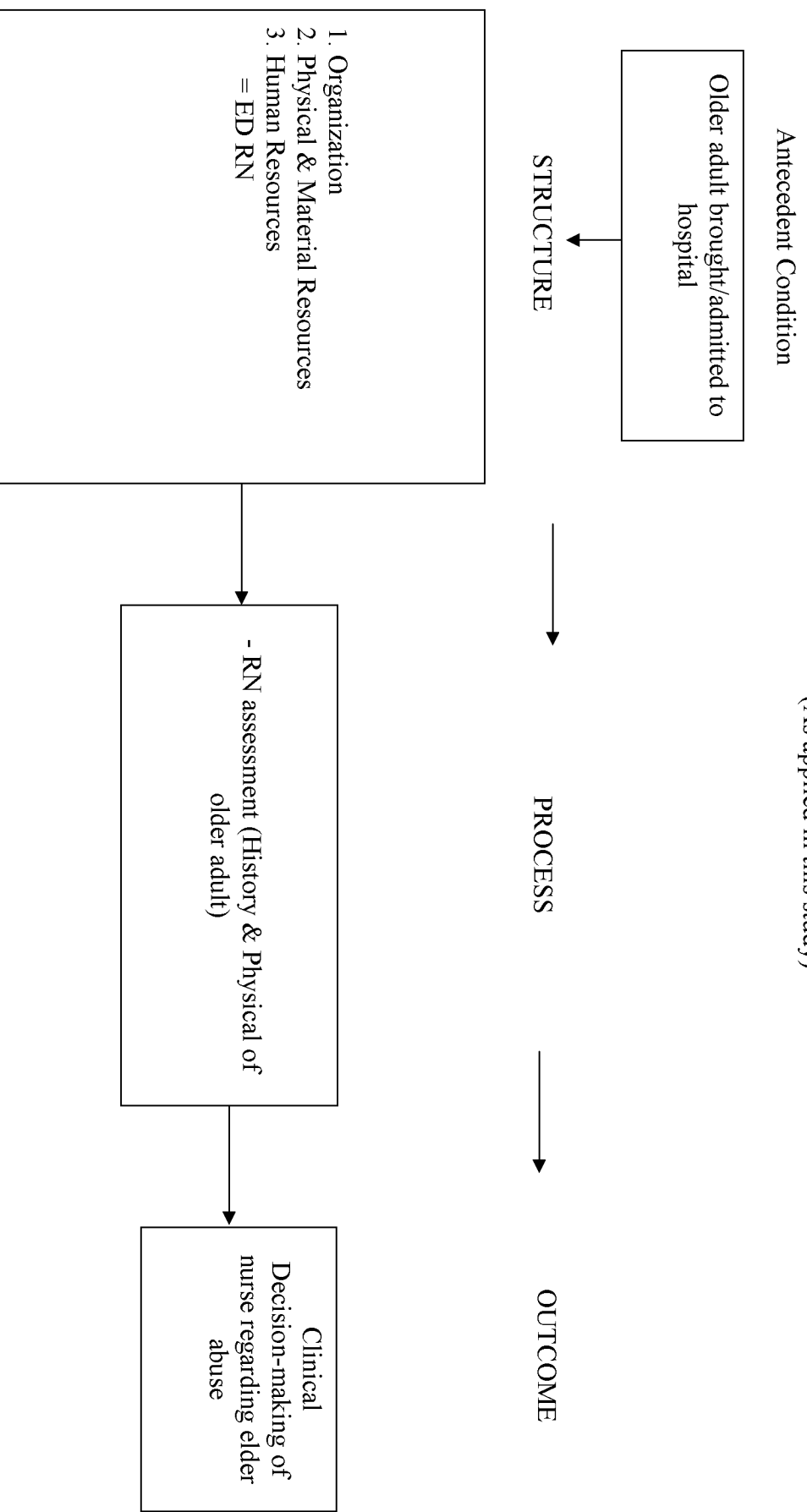


Figure 2

Donabedian's Original Structure, Process, Outcome Model  
(As applied in this study)



The Novice to Expert theory was developed to assist in evaluating competency and expertise in healthcare professionals (Benner, 1984).

#### Rationale for Selection of Theory

##### *Structure, Process, and Outcome Model*

The Donabedian Model of Structure, Process, and Outcome has been used by many researchers (Westaway, Rheeder, Vanzyl, & Seager, 2003). The assessment of quality care has been the main use of this model. The study involved exploring the relationship between the “structure” (the ED RN is a part of the structure and the characteristics of the ED RN are variables that impact the ED RN’s approach to elder abuse) and “process” (applied knowledge of elder abuse/assessment cues - how the RN assesses the patient) that enables the ED RN to make his or her clinical decision outcomes (interventions) to care for the suspected elder abuse patient.

##### Model of Clinical Decision-Making of Nurses Regarding Elder Abuse

In the adapted Model of Clinical Decision-Making of Nurses Regarding Elder Abuse, the patient first enters into the “structure” as noted in Donabedian’s model. Structure must be present in order to have the process available in which to make clinical decisions during the assessment of the patient. The main focus of structure in the adapted model is the “human resource” which, in this case, is the ED RN.

Critical aspects related to the ED RN’s response to elder abuse include the RNs applied knowledge of elder abuse (assessment cues), years of experience as a RN, intuition use in nursing practice, clinical level of practice status (clinical ladder program) of the RN, and clinical decision outcomes (interventions) the nurse performs for his or her patient.

Structure refers to the attributes of organizations delivering care and the conditions under which these organizations provide care (Donabedian, 1966). For this study, the structure is the ED in three acute care facilities with Magnet designation for nursing excellence in the southern United States. Hospital A is one hospital. Hospital B consists of two hospitals. The ED RNs are key components within the human resource structure, as these RNs have the potential to see more cases of suspected elder abuse within a health care organization than other healthcare professionals.

“Process” relates to the activities associated with the RNs applied knowledge of elder abuse (assessment cues) of the patient, and “outcome” denotes the interventions a nurse (human resource) takes to address elder abuse. In this study, process involves the RN completing a history and physical assessment of the elderly patient and determining if the signs and symptoms of elder abuse are present (Westaway et al., 2003).

#### *Novice to Expert*

Benner’s Novice to Expert theory and the use of intuition in nursing practice are also embedded within the structure of Donabedian’s model as characteristics of RNs (human resources). The clinical level of practice program (or clinical ladder program) for the ED settings participating in this study denote various levels of nursing expertise, behaviors, and expectations, as well as financial compensation for the nurse.

Benner’s Novice to Expert theory is incorporated in the conceptual model for this study. Benner’s research on expertise in nursing practice is currently one of the most referenced works in nursing literature (Buchalter, 2005). Her research applied the Dreyfus model of skill acquisition to clinical practice as reported by expert nurses and revealed that knowledge is embedded in actual nursing practice accrued over time

(Benner, 1984; Carlson et al., 1989). Benner (1984) found that nurses change their intellectual orientation, integrate and sort out knowledge, and refocus decision-making over time. The Dreyfus model posits that in skill acquisition, one passes through five levels of proficiency: novice, advanced beginner, competent, proficient, and expert (Benner, 1984; Carlson, Crawford, Contrades, 1989).

Benner (1984) defines Novice (Stage 1) as having no experience (or life experience) of the situations in which one is expected to perform. Rules taught to help performance tend to be applied universally and are limited and inflexible.

The Advanced Beginner (Stage 2) demonstrates marginally acceptable performance, experience with enough real situations, or to have situations identified out by a mentor which reinforces meaningful situational components. For recognition, these components require prior experience in actual situations. The RN formulates principles, based upon previous nursing experience, which guides nursing action.

Competent (Stage 3) is being on the job in the same or similar situations two or three years; it develops when one views his or her actions in terms of long-range goals or plans. For the competent nurse, a plan establishes a perspective, and the plan is based on conscious, abstract, analytical contemplation of the problem. The conscious, deliberate planning that is characteristic of this skill level achieves efficiency and organization, a feeling of mastery, and the ability to cope with and manage the many contingencies of clinical nursing. However, persons at this stage do not necessarily have enough years of experience as a nurse to recognize a situation in terms of the overall picture or in terms of priorities.



Proficient (Stage 4) nurses perceive situations as a whole rather than in terms of segments or aspects; and performance is guided by general truth or rules of conduct. Proficient nurses understand a situation as a whole because they perceive the meaning in terms of long-term goals and learn from experience what events to expect in a given situation and how plans need to be modified in response to these events. Proficiency can be recognized when expected normal circumstances in a situation does not occur. This holistic understanding improves decision-making; which becomes less labored because the nurse now has a perspective on which attributes and aspects of the present situation are important.

Expert (Stage 5) nurses have an enormous background of experience, allowing intuition into each situation. They no longer rely on analytical principles to connect their understanding of a situation in order to take an appropriate action. An expert focuses on the specific problem and is fluid, flexible, and highly proficient. (Benner, 1984; Carlson et al., 1989).

The Novice to Expert theoretical perspective relates intuitive knowledge or personal knowing and cognitive skills in assisting nurses to arrive at their clinical decisions. However, if one considers intuition a type of knowledge, then one must consider the nature of that knowledge and how it affects decision-making. In healthcare, the problem of using intuition as a type of knowledge is the lack of visibility to others, other than the person making the decision (Pitz & Sachs, 1984). Benner (1984) recognizes the use of intuition only with expert nurses, not in the first four stages of clinical practice.

Benner focuses on experience and defines expertise as, “the refinement of preconceived notions and theory through encounters with many actual practical situations that add nuances or shades of differences to theory” (Benner, 1984, p. 36). Benner also emphasizes the importance of education and its role in conjunction with experience, stating,

Strong educational preparation in the biological and psycho-social sciences and in nursing arts and science is the necessary base for advanced skill acquisition. . . theory and principles allow the practitioner safe and efficient access to clinical learning, provide the background knowledge that enables the clinician to ask the right questions and look for the correct problems. The person with limited background knowledge will lack the tools needed to learn from experience (p. 184).

Although improvement of skills can be gained from imitation of others and trial and error, it would be difficult to become an expert in nursing practice without a foundation of scientific knowledge (Benner, 1984).

#### *Development of a New Conceptual Framework*

Developing a new model to serve as the conceptual framework for this study has some advantages and disadvantages. One advantage is that the Donabedian’s Process, Structure, and Outcome model and the Benner’s Novice to Expert theory have been tested in many studies (Buchalter, 2005). Though important, the delivery of service by the ED RN remains only one component of the structure. The Donabedian Model provides for a description of some of the components of structure.

In this model, the ED RN is the component of interest in determining outcomes related to suspected abuse. Benner's Novice to Expert Model identifies characteristics of expert nurses; these characteristics and related skills (assessment) are essential characteristics in the determination of appropriate interventions in case of suspected elder abuse. The Model of Clinical Decision-Making of Nurses Regarding Elder Abuse was designed to be simple, clear, easy to follow and understand, and useful in practice. It recognizes that there are multiple dimensions of structure, with the ED RN being only one component of the delivery of service, although an important one. As the ED RN is the component of interest in determining outcomes related to suspected abuse, it is necessary to describe the characteristics and skills of the ED Registered Nurse. As well, the new theoretical framework fills a gap by adding to existing theories and building new theoretical insights in elder abuse research.

Using an adapted framework that has not been tested in research studies may have limitations in the research study. The clarity and the relationship of the variables used within the framework in different research areas may be lacking to the reader.

#### Linkages between the Two Frameworks

Donabedian's model provides the linear configuration for the adapted model. "Good structure increases the likelihood of good process, and good process increases the likelihood of a good outcome" (Donabedian, 1966, p. 1745). The Structure, Process, Outcome model is broad, as Donabedian does not provide detailed elements that could be used to guide a specific study (Schiff & Rucker, 2001). Therefore, Benner's Novice to Expert was embedded within the context of the adapted Donabedian Model to enhance the model and describe relevant variables.

## Summary

The Model of Clinical Decision-Making of Nurses Regarding Elder Abuse uses Donabedian's Structure, Process, Outcome model and Benner's Novice to Expert theory to evaluate the clinical decision outcomes of ED RNs regarding elder abuse. The characteristics of the ED RN (years of experience as a RN, intuition use in nursing practice, and clinical level of practice status) are part of the "human resources" within the structure of the model that influences the process (the RNs assessment skills), which may affect the clinical decisions (outcomes) regarding elder abuse. The RNs applied knowledge of elder abuse (assessment cues) include 1) the ability of the RN to use his or her clinical judgment to determine the problem, contemplate the possible causes of the problem, and gather patient information (subjective and objective), and 2) to identify a course of action. The identification of elder abuse and treatment intervention options such as notification of the patient care management department or an external agency would be examples of a clinical decision outcome (interventions) the RN may choose for their patient.

CHAPTER II  
REVIEW OF LITERATURE  
Clinical Decision-Making

This chapter will present an overview of the literature related to elder abuse and clinical decisions related to its identification.

Clinical decision-making is an essential and critical component of professional nursing and is an important factor affecting the quality of patient care. Nurses in clinical practice must make critical decisions multiple times during their shift and often under conditions of uncertainty and great complexity. In the nursing literature, the terminology associated with the concept of clinical decision-making reveals terms such as “clinical decision-making”, “clinical judgment”, “clinical inquiry” and “diagnostic reasoning”. Many of these terms have been used synonymously (Hamers, Abu-Saad, and Halfens, 1994).

Clinical decision-making is described as a “complex skill involving several cognitive phases and an integrative process” (del Bueno, 1990, p. 290). Bernard and Walsh (1990) defined clinical decision-making as a process that begins with the identification of a problem and ends with the evaluation of the choices needed to take a course of action. Lipman and Deatrck (1997) defined clinical decision-making as “the process nurses use to gather information, evaluate, and make a judgment that results in the provision of care” (p. 47).

An alternative explanation of how health-care workers make judgments and decisions has been the notion of intuition. Rew and Barrow (1987) defined intuition as knowing a fact or truth, as a whole, with immediate possession of knowledge. Schrader & Fischer (1987) defined intuition as the immediate knowing of something without the conscious use of reason. Benner (1984) examined the notion of nurse intuition, establishing that expert nurses display a judgment that is not found in novices. Benner interpreted this as the ability to make judgments intuitively which characteristically distinguishes expert nurses from novice nurses.

#### Review of Literature

A literature search was completed from several databases (CINHAL, Ovid, MEDLINE, and ProQuest databases) and revealed only one article related to clinical decision-making of nurses regarding elder abuse and no articles related to clinical decision-making of nurses regarding domestic violence. Due to the limited literature available, the following topic areas related to ED nurses clinical decision-making were included in the literature review: 1) decision-making and elder abuse (including knowledge of elder abuse); 2) factors influencing decision-making (e.g. the use of intuition in nursing practice, experience); and 3) decision-making and triage (assessment and interventions of the patient).

Decision-making and triage were included in the literature review as the author felt the majority of elder abuse emergencies would be discovered in the triage process of this setting (the subject's entry point into the healthcare system). Emergency department RNs triage or assess their patients, prioritize their patients needs and initiate appropriate interventions. The ED has been identified as a major focus area for initiating screening

and intervention of domestic abuse due to the pervasive number of domestic violence victims being seen in the healthcare setting (Walton-Moss & Campbell, 2002). The RN's applied knowledge of elder abuse (assessment cues), the use of intuition in nursing practice, the number of years experience as a RN, and the clinical level of practice status of the nurse may influence his or her clinical decision outcomes (interventions) for possible abuse of an elderly patient. The next section will present literature to support the clinical decision-making of nurses regarding elder abuse study.

#### Clinical Decision-Making of Nurses Regarding Elder Abuse

Kitchen, Richardson, & Livingston (2002) investigated whether 45 RNs working with older people would recognize elder abuse and respond appropriately to either scenario in two previously validated case scenarios; one of suspected abuse and one of definite abuse. Nurses performed significantly less well in answering the definite abuse vignette than when abuse was suspected. Nurses at a higher level (reflecting more experience) had higher scores on the definite abuse vignettes. The researchers found no significant differences in answers between nursing levels (years of experience) on the suspected abuse vignette.

In another study, Richardson et al. (2001) carried out an anonymous questionnaire survey to 380 general practitioners, 180 practice nurses, and 10 health visitors who were working in east London. The questionnaire examined attitudes and current practice with respect to domestic violence and screening, the extent of training, and reported need. The study found most practitioners do not routinely ask about domestic violence experiences and do not want to carry out routine screening. Of the 57% who responded, 80% agreed that domestic violence was a healthcare issue and over half of each group wanted further

training on this issue. Without adequate training, organizational and professional liabilities are conceivable outcomes, therefore providers (including ED RNs) need to screen for domestic violence.

Pettee (1997) surveyed 206 RNs over a one year period with RNs in both a long-term psychiatric facility and an acute care setting on medical-surgical units using a self-report questionnaire. RNs reported experience with and awareness of the problem of elder abuse, but indicated a lack of education to make them aware of the suspected incidence, of the law, and its implications. Discrepancies between observed and reported elder abuse were reported, even though differences in responses related to the study settings were not found. The researcher concluded nurse educators must provide elder abuse education which should include what constitutes elder abuse, the scope of the problem of elder abuse, the law as it pertains to reporting elder abuse, implications for RN practice, and how to assess and intervene if elder abuse is suspected. If during the nursing assessment, any reason to suspect abuse of older persons exists, the nurse is obligated to report the abuse (Capezuti, Brush, & Lawson, 1997; Greenberg, 1996; Rosenblatt, 1997). The ethical principle of beneficence is met with mandatory reporting by healthcare providers.

Inexperience and lack of knowledge in the role of a RN could result in inappropriate assessments and decision-making regarding patients which may affect their outcomes. del Bueno (1990) developed case scenarios on various medical-surgical topics to measure decision-making. A sample of 563 intensive care and medical-surgical nurses with three months or more of experience watched a video-taped clinical scenario and were asked what the priority problem was, the nursing intervention required to reduce



risk, and the rationale for the final decision. The inexperienced associate degree nurse practicing in the medical-surgical unit had the highest number of acceptable intervention responses. The inexperienced baccalaureate nurse had the highest number of acceptable rationales. The findings indicated baccalaureate nurses had adequate knowledge but lacked the experience to complete appropriate interventions. Acceptable responses were consistent among experienced medical-surgical nurses. The researcher recommended each nurse be assessed for their ability to make decisions through appropriate rationale and interventions to improve patient outcomes (del Bueno, 1990).

Expertise and intuition are variables to consider regarding the clinical decision-making of RNs. Benner (1984) conducted interviews with 16 nurses (newly employed RNs, experienced nurses, graduate nurses, and senior nursing students) in small groups. According to Benner (1984) the novice nurse had limited experience with situations and relied on rules to govern his/her actions to make decisions. As the nurse gained experience, the nurse progressed through each stage until they reached the expert (final) stage. The expert nurse had an understanding of clinical situations through the use of intuition and responded immediately due to clinical situations based on previously learned clinical information. Benner (1984) stated intuition was valid and should be recognized as being part of expert nursing practice.

Shamian (1991) studied decision-making by having 60 nursing students randomly divided into two groups and answer questions about three clinical case studies. One group received a four hour presentation on decision analysis theory and interactive problem solving. The other group received a four hour presentation but on an unrelated topic. The research found that those students who participated in the four hour decision analysis

presentation made significantly more consistent decisions than the group who did not receive that presentation. The researcher stated the decision analysis group was more aligned with how expert nurses responded to the three case studies. Further research was suggested on the use of valid questionnaires to assess clinical decision-making and the use of exclusive responses to the questions, considering the complexity of patients and nursing practice.

In addition, Ruth-Sahd and Hendy (2005) conducted a study that compared professional experiences and the use of intuition by 16 nurses. Novice nurses in 151 nursing programs were randomly selected from four regions. Measures of personal experience included age and gender. Professional experience included grade point average (GPA) and months of on-the-job experience. Results indicated that greater use of intuition by novice nurses was significantly associated with older age. As well, the results suggested that novice nurses used intuition to guide their decisions about patient care and intuition use was not related to their professional experiences either in nursing school or the workplace. Interestingly, the results indicated that earning a high GPA and having more months of on-the-job-experience was not significantly associated with novice nurses using intuition within their first year out of nursing school.

Similarly, Benner et al., (1996), conducted small group interviews with 10 nurses working in critical care areas. Each nurse was asked to tell a story about a specific patient care situation. Results suggested the advanced beginners focused on organizing and prioritizing patient care. The expert nurses had an immediate understanding of the situation and responded appropriately and quickly based upon previous observed patient patterns. These researchers found that expert nurses were confident and did not wait until

signs and symptoms were evident to implement a nursing intervention. As well, it was found that experience did not equal the number of years spent in a specific clinical setting, rather the total number of years worked as a RN.

Instruments to measure clinical decision-making of RNs regarding elder abuse are needed. Jenkins (1985) developed a 40-item Clinical Decision-Making in Nursing Scale (CDMNS) to evaluate the nursing student's perception of their own decision making skills. After pilot testing of the scale was completed, 111 nursing students from various years of their baccalaureate (BSN) program completed the CDMNS. No significant difference was noted in the mean scores of the sophomores, juniors, or seniors. The findings suggested the need to provide more clinical exposure or experience to improve their clinical decision-making.

#### Summary

The ED RNs have differences in their applied knowledge of elder abuse, their intuition use in their nursing practice, and years of experience as a nurse; these factors may influence their clinical decisions. Clinical decision-making is an essential and critical component of professional nursing and is an important factor affecting the quality of patient care. Researchers have just touched the surface of several important research areas related to clinical decision-making. The topic of clinical decision-making of ED nurses regarding elder abuse is virtually non-existent. Further research is needed regarding nurses making clinical decisions regarding elder abuse.

CHAPTER III  
METHODOLOGY  
Research Design

A descriptive, correlational design was used in this study to describe the clinical decision-making of ED RNs regarding elder abuse. The independent variables included the RNs applied knowledge (assessment cues) of elder abuse, intuition use in nursing practice, years of experience working as a RN, and clinical level of practice status. The dependent variable is the clinical decision outcomes (interventions) made by the ED RNs regarding elder abuse of the elderly patient.

*Setting*

The study was conducted in three EDs of tertiary care Magnet designated hospitals in a southeastern state in the United States. One ED was in a larger city while two EDs were located in a smaller city. The ED setting is the first point of entry into the healthcare system for elders with possible signs and symptoms of abuse (M. Thatcher, 2006, personal communication). By collecting data from RNs in similar Magnet designated hospitals and the same state, confounding variables such as policies and procedures should be controlled. However, the largest hospital does not currently conduct extensive elder abuse training during orientation for new RNs to the organization. The two smaller hospitals have extensive elder abuse training during their employment orientation. This difference allowed the researcher to see if differences in

assessment and interventions existed between those who have had the required education on elder abuse and those who have not.

The larger hospital, which is licensed for 410 beds, employs approximately 51 RNs in the ED and is a faith-based, not-for-profit health institution. Health care providers in this ED see about 170,000 patients annually serving a large metropolitan city and its surrounding areas.

Of the two hospitals located in the smaller city, one hospital is the region's only faith-based, not-for-profit health institution. Through its affiliate hospitals and health services, it is the largest and most experienced healthcare provider in the region. Together, these two anchor hospitals offer 615 licensed acute care beds serving all of the southeastern state and surrounding areas. One of the two smaller EDs employs approximately 54 nurses and serves approximately 70,000 patients annually. The second ED employs approximately 47 nurses and serves approximately 25,000 patients annually. Both EDs service pediatric and obstetrical patients. However, the larger of the two hospitals has the only admission protocols for obstetrics and pediatrics; thus, this ED tends to see a higher volume of these patients. The combined health system employs approximately 1,200 nurses.

### *Sample*

The convenience sample included all ED RNs (RN is defined as either full-time, part-time, or PRN status) employed in the three EDs totalling 152 nurses. Criterion for inclusion in this study included being English speaking, from any ethnic origin, any age and gender, and possessing a valid Georgia RN license. PRN nurses who may work few

shifts per months must also be able to recognize suspected elder abuse and know how to intervene; thus, they were included in the study.

Based upon a Power Analysis Statistical Systems (PASS) power analysis (Hintze, 2000) for multiple regression using five variables, 150 subjects was the suggested sample size for this study to assure an effect size of  $p = .80$ , with a set power of  $.80$ , and a significance level of  $0.05$  (two-tailed). Munro (2001) states that 10 subjects per variable is needed to conduct a regression analysis. Five variables of interest were identified for this analysis indicating that a sample of 50 would be acceptable. Approximately 25 subjects for each group is required for the sample based upon a power of  $.80$ , and estimated effect size of  $.50$ , and a significance level of  $0.05$  for test of difference between means using a *t*-test (Cohen, 1988). A sample size of 150 would be ideal for this study. However, it was unlikely that all ED nurses would return the surveys. It was determined that a sample of 50 would be sufficient for this study. The actual sample size was 84 ED nurses. Therefore, the study results had a power of  $.80$ , the estimated effect was  $.80$ , at a significance level of  $0.05$  (two-tailed).

#### Data Collection and Instruments

For this study, five variables of interest were measured; the ED RN's applied knowledge of elder abuse, years of experience as a RN, intuition use in nursing practice, clinical level of practice status, and the clinical decision outcomes of the RN regarding elder abuse. General information regarding knowledge of and assessment for elder abuse was measured by the Knowledge of Elder Abuse Survey. This survey was developed by the researcher from the literature and with expert input. Intuition use in nursing practice was measured by the Intuition Use in Nursing Scale developed by Lynn Rew and used

with permission (Rew, 2000). Applied knowledge (assessment cues) and clinical decision outcomes (interventions) of the ED RNs regarding elder abuse was measured by the Elder Abuse Vignette Instrument. This vignette instrument was adapted by the researcher from an abuse quiz from RN.com and used with permission (RN.com, 2006). Finally, data on years of experience as a RN and clinical level of practice status were self reported by the ED RN on the demographic information form.

### *Knowledge of Elder Abuse*

The Knowledge of Elder Abuse Survey, developed by the author, is a 25-item self-report tool used to provide an overview of screening practices, education received regarding abuse, and policies and procedures of ED RNs regarding elder abuse, child abuse, and domestic violence questions. Questions have a “yes” or “no” response, “check all that apply” format, or a likert scale with responses ranging from never to frequently. The survey takes approximately 8 to 10 minutes to complete. An open ended-question was included to allow for a wide range of responses regarding what actions the nurse would take if they suspected abuse (See Appendix C).

### *Intuition Use in Nursing*

The 7-item “Intuition Use in Nursing Scale” was developed and validated by Dr. Lynn Rew (See Appendix D). This instrument includes questions that determine intuition use by the RN during patient assessment to make clinical decisions for the patient. Permission was given via email for use of the instrument in this research study (See Appendix E). The scale takes 2 minutes to complete. The Content Validity Index was reported as .96 on responses from a panel of five experts. The Cronbach’s alpha coefficient of internal consistency of this scale was reported at .91 during its development

(Rew, 2000). In phase two of the Intuition Scale instrument development, the scale was pilot tested with a random sample of 106 psychiatric mental health nurses. In phase three, the revised scale was presented to a convenience sample of 112 nurses attending continuing education programs. The Cronbach Alpha of the Intuition Use in Nursing Scale in this study was .81.

### *Clinical Level of Practice Status*

In this study, an expert is considered as being a Level 3 (larger hospital) or Level 4 (smaller settings). The clinical level of practice status at the larger study site is defined as: Level 1 is a new graduate “novice” nurse or a nurse who has chosen not to pursue the additional criteria to advance to Level 2; Level 2 is a “competent” nurse with up to three years experience; and, Level 3 is an “expert” who has more than three years experience and certification in a specialty area (e.g. emergency nursing). The clinical levels of practice programs at the hospitals are similar except the Level 4 at the smaller hospitals is equivalent to Level 3 at the larger hospital and Level 3 at the smaller hospitals is equal to the Level 2 at the larger hospital.

The job description of a Level 1 RN and the specific behaviors required for the hospital’s Level 2 and 3 advancement programs at the larger ED can be found in Appendix F. Included are expected behaviors and criteria that must be met for each level, as well as a salary increase with each level attained. This author is defining an expert as being a Level 3 in the clinical level of practice program at the larger study site and Level 4 in the clinical level of practice program at the smaller hospitals. Behaviors for Level 2 and 3, include the Level 1 job description and the following: a) serves as a clinical advisor or mentor (CAP) for new staff as needed; b) monitors performance of new staff and



provides feedback to orientee and appropriate manager; c) serves as a resource and role model to all members of the patient care team; d) exhibits refined assessment skills by correlating all subjective and objective findings and initiating appropriate action; e) demonstrates calm and professional behavior in stressful situations; f) takes the initiative to work with the management team to develop activities to meet unit growth; g) acts as a resource/role model for documentation skills, and; h) maintains Level 2 status.

However, Benner (1984) defines a competent nurse as having three years experience and an expert as having five years experience. The levels described in this study differ from Benner's (1984) definition of an expert as Benner does not specifically require a specialty certification and states the nurse must have at least five years as a RN. Although there is some discrepancy between the level descriptions of the agencies and Benner, the agency descriptions will be used in this study as the RNs are familiar with the criterion.

### *Demographic Information*

After reviewing the literature of previous studies that collected RN characteristics data (Arvanis et al., 1993; Fulmer, 2004) the following questions were included in the demographic survey developed by the author with input from experts in instrument development: the number of years of experience as a RN, the number of years worked on their present unit, the number of years worked at their present hospital, and clinical level advancement status (See Appendix G). The general demographic data (age, gender, etc.) were similar to those collected in other previous studies related to elder abuse in nursing (Petee, 1997; Wong & Marr, 2002). Years of experience as a RN is the total number of years worked as a RN.

*Applied Knowledge (Assessment Cues) and Clinical Decision Outcomes (Interventions)*

A vignette is an appropriate method for evaluating the clinical decisions of the RN regarding elder abuse. Vignettes are simulations of real events which can be used in research to elicit the subject's knowledge, attitudes, or opinions on how one would make decisions in a hypothetical situation (Gould, 1996). According to Gould, a vignette should fulfill four basic requirements: 1) it should be easy to follow and understand; 2) it should be consistent; 3) it should be credible, and 4) it should not be too complex. The two main components of the vignette method are the introductory narrative and the reactions of the respondent. It is common to have a vignette followed by a fixed response choice. Vignettes avoid cueing of staff, while providing a practical way to assess applied knowledge (Kitchen et al., 2002). One way to determine the appropriateness of the clinical decision-making assessments is to provide a standardized patient scenario in the form of a vignette.

The elder abuse vignette instrument, developed by the author, used to collect data regarding the assessment of the patient and interventions conducted by the ED RN based on their applied knowledge (assessment cues) was adapted from a domestic violence education quiz (See Appendix H). Permission from RN.com was obtained via email (See Appendix I). Psychometrics for the original quiz were not conducted. The adapted elder abuse vignette instrument contains four different vignettes and measures the assessment cues and actions taken by the RN regarding suspected elder abuse. One vignette describes a scenario where the patient has not experienced elder abuse; the other three vignettes portray patient scenarios of different types of elder abuse. Coding of the vignettes was developed to determine the appropriateness of the assessment cues and actions taken by

the ED RN as related to elder abuse in the patient scenarios (See Appendix J). The vignette instrument takes approximately 10 minutes to complete.

Three vignettes came from the RN.com quiz and the content was adapted to reflect an ED setting (e.g. assessment cues that the RN would recognize in cases of suspected elder abuse). One vignette with no abuse cues was developed by the author for this research study to use as a baseline to evaluate whether RNs can distinguish what is and what is not elder abuse. Just enough information was provided in each scenario to allow the ED RN to use his or her knowledge and assessment skills to determine the clinical decision interventions for the patients. See Appendix K for information on the vignette testing.

### Procedure

The researcher or on-site research assistant attended all monthly unit staff meetings for each of the three EDs during a one month period to introduce the study and invite all ED RNs to participate. The monthly staff meetings were chosen to recruit the weekday and weekend shift RNs. Each RN that expressed an interest in participating in the study was informed of the following; purpose of the study, risks, benefits, confidentiality, estimated time to complete the study requirements, and instructions via a cover letter (See Appendix L) regarding completion of all questionnaires (the knowledge of elder abuse survey, the intuition use in nursing scale, the elder abuse vignettes, and the demographic information form). Informed consent was implied by returning the survey. The researcher or on-site research assistant administered all of the surveys at the monthly ED staff meetings. The surveys were either collected immediately after completion or the RN chose to mail the completed survey directly to the researcher in a self-addressed,

stamped envelope within one week. Subjects had a quiet area on their respective units to complete the surveys if they chose to complete them right away. Any RN who completed and returned all surveys was given a \$10 gift card from Panera Bread. RNs who returned the survey via mail were asked to include a separate sheet of paper with their name and mailing address so the researcher could mail them the gift card. The sheets of paper with the RNs names and address were destroyed after the researcher mailed the giftcard.

Institutional Review Board (IRB) approval was obtained from Georgia State University (GSU) (See Appendix M), and then from the participating hospitals (See Appendix N). The two smaller ED settings had the same Institutional Review Board (See Appendix O). Data are being stored at the researchers home in a locked file cabinet and will remain there for seven years after completion of the study. The researcher's personal laptop was used to analyze the data. The data are being stored on a separate jumpdrive and locked in a file cabinet at the researcher's home when not in use.

#### Data Management and Analysis

Data was entered into Statistical Package for Social Sciences (SPSS) Version 15.0 for analysis. Descriptive statistics (means, standard deviation (SD), frequency, percentages) were used to analyze the demographic data. Multiple regression was used to analyze Specific Aim 1. The independent variables were: RNs applied knowledge (assessment cues) of elder abuse; use of intuition in nursing; years of experience as a RN; and clinical level of practice status. The dependent variable is the nurse's clinical decision outcomes (interventions) for suspected elder abuse performed by the nurse. On selected variables for Specific Aim 2, an independent *t*-test was used to determine

differences between groups (ED RN group that had received mandatory elder abuse training during hospital orientation and those who had not).

### Summary

A convenience sample of ED RNs employed in three hospitals in a southeastern state were included in this study. One of the EDs is in a larger city (Hospital A) and the two remaining EDs (Hospital B are the two smaller hospitals combined) are located in a smaller city. The sample included full-time, part-time, and PRN RNs who speak English, males and females, any age or ethnicity, and with a valid Georgia Nursing License. The independent variables were: the RNs applied knowledge (assessment cues) of elder abuse; use of intuition in nursing; years of experience as a RN; and clinical level of practice status. The dependent variable is the nurse's clinical outcomes (interventions) for suspected elder abuse performed by the nurse.

## CHAPTER IV

### RESULTS

The purpose of this chapter is to present the results and interpret the analyses for this research study. The results of the two specific aims will be presented in this section.

#### Data Analysis

Descriptive statistics (means, range, frequencies, standard deviation (SD)) were used to analyze the demographic data. Multiple regression was used to analyze Specific Aim #1 and an independent t-test was used to determine differences between groups for Specific Aim #2. Data were analyzed using the SPSS version 15.0.

#### Sample

Characteristics of Hospitals: The larger hospital (referred to as Hospital A), which is licensed for 410 beds, employs approximately 51 RNs in the ED and is a faith-based, not-for-profit health institution. Health care providers in this ED see about 170,000 patients annually serving a large metropolitan city and its surrounding areas.

In the smaller city where two hospitals (collectively referred to as Hospital B) are located, the larger of the two is the region's only faith-based, not-for-profit health institution. Through its affiliate hospitals and health services, it is the largest and most experienced healthcare provider in the region. Together, its two anchor hospitals offer 615 licensed acute care beds serving all of the southeastern state and surrounding area. One of the two smaller EDs employs approximately 54 nurses and serves approximately

70,000 patients annually. The other ED employs approximately 47 nurses and serves approximately 25,000 patients annually. Both EDs service pediatric and obstetrical patients; however, the larger of the two hospitals has the only admission protocols for obstetrics and pediatrics; thus, this ED tends to see a higher volume of these patients. The combined health system employs approximately 1200 nurses.

The convenience sample of 84 RNs consisted of 68 females (81%) and 16 males (19%). Response rate to the survey was the greatest at the two smaller hospitals (75%); only 40% of the nurses at the larger hospital returned the survey. Demographic characteristics of the sample are reflected in Table 1. The average age of the respondents was 41.43 years (SD = 9.36; range = 23 - 60 years). Nurses with a bachelor's degree accounted for 42.9% (n=36) of the participants and 38.1% (n=32) were prepared at the associate degree level. The mean number of years worked as a RN at their hospital was 13.87 years (SD = 10.74; range = 1 - 35 years). The mean years worked as a RN in an ED was 8.68 years (SD = 8.24; range = 0 - 30 years). Five RNs (6%) were certified as an advanced practice nurse.

Forty-nine RNs (59%) were currently leveled in the clinical level of practice program; however, of the nurses who were leveled, 33% (n=16) were at a Level 2, 8% (n=4) were at Level 3, and 60% (n=29) were at Level four. Participants worked an average of 126.35 hours (SD = 58.57; range = 10 – 320 hours) in an ED monthly. Interestingly, 9 nurses worked hours ranging from 168 to 320 hours per month, which is over the usual 164 hours per month for a full-time employee.

When examining the differences between the two hospital groups, Hospital A had 48% (n=51) of their RNs in the 43 - 62 year category, whereas Hospital B had 51%

(n=29) in the same category. Seventy-eight percent (n=21) of the RNs in Hospital A had a bachelor's or graduate degree compared to 39% (n=22) in Hospital B. Hospital A had 45% (n=12) of their RN staff who had 21 or more years working in nursing compared to Hospital B who had 25% (n=17) of their RNs in the same category.

Table 1 Demographic Variables

Characteristics		Total n; %	Hospital A n; %	Hospital B n; %
Age	23-32	16; 19%	6; 22%	11; 20%
	33-42	25; 30%	8; 30%	17; 19%
	43-52	32; 38%	11; 41%	20; 35%
	53-62	11; 3%	2; 7%	9; 16%
Gender	Male	16; 19%	3; 11%	13; 23%
	Female	68; 81%	24; 89%	44; 77%
Highest Level of Nursing Education	Associate Degree	32; 38%	5; 19%	27; 47%
	Diploma	9; 11%	1; 4%	8; 14%
	Bachelor's Degree	36; 43%	18; 66%	18; 32%
	Graduate	7; 8%	3; 11%	4; 7%
Number of Years in Nursing	1-5 Years	30; 36%	7; 26%	23; 41%
	6-10 Years	8; 9%	3; 11%	4; 7%
	11- 15 Years	11; 13%	3; 11%	8; 14%
	16-20 Years	4; 5%	2; 4%	4; 5%
	21-25 Years	13; 15%	5; 19%	8; 9%
	26-30 Years	12; 14%	6; 22%	6; 11%
	31-35 Years	4; 5%	1; 4%	3; 5%

Thirty-six (64%) of the RNs from Hospital B worked more than usual full-time hours compared to Hospital A where 11 (41%) worked more than the usual full-time hours. Hospital B had more RNs (44%; n=25) who were at the highest clinical level of practice, Level 4 status for their hospital compared to Hospital A that had only 7 (26%)



RNs at the highest level, Level 3 of their clinical practice program. All of the RNs (n=27) at Hospital A were certified compared to Hospital B that had 53 (93%) of their RNs certified.

Given that victims of abuse often present in the ED, data were collected on the number of RNs who received education to recognize elder abuse as well as domestic violence and child abuse (See Table 2). Fifty-eight (69%) of the respondents indicated they received elder abuse education in nursing school; 65 (77%) received education regarding domestic violence in nursing school; and 63 (75%) of the respondents received education regarding child abuse in nursing school. Thirty-eight (45%) of the respondents received both elder abuse and domestic violence education in their hospital orientation and 39 (46%) received child abuse education in their hospital orientation. With respect to abuse education in schools of nursing and abuse education during hospital orientation, more nurses in Hospital B had education on the three types of abuse than Hospital A. Fifteen (18%) of the RNs at Hospital A and 43 (51%) of the RNs at Hospital B indicated they received elder abuse education in their basic school of nursing program. Eighteen (21%) of the RNs at Hospital A and 47 (56%) of the RNs at Hospital B indicated they received domestic violence education in their basic school of nursing program. Sixteen (19%) of the RNs at Hospital A and 47 (56%) of the RNs at Hospital B indicated they received child abuse education in their school of nursing. Six (7%) RNs from Hospital A and 32 (38%) RNs from Hospital B received elder abuse and domestic violence education during their hospital orientation. Two (2%) of the RNs at Hospital A and 37 (44%) of the RNs at Hospital B indicated they received child abuse education during their hospital

orientation. There is clearly a difference in the education provided during hospital orientation between the two hospital settings.

Table 3 reflects the ED RN's preparedness to assess for abuse with 43 (51%) of the respondents from both hospitals reporting they were "prepared" or "very prepared" to assess for elder abuse. Forty-seven (56%) of the respondents from both hospitals felt they were "prepared" or "very prepared" to assess for domestic violence. Similarly, 47 (56%) of the respondents from both hospitals felt they were "prepared" or "very prepared" to assess for child abuse. Fewer participants were prepared to assess for elder abuse than they were prepared to assess for domestic violence and child abuse.

Table 2

*Education to Recognize Abuse*

	Elder Abuse		Domestic Violence		Child Abuse	
	Yes	No	Yes	No	Yes	No
<i>In School Of Nursing</i>						
Total (N=84)	n: %	n: %	n: %	n: %	n: %	n: %
Hospital A	58; 69%	26; 31%	65; 77%	19; 23%	63; 75%	21; 25%
Hospital B	15; 18%	12; 14%	18; 21%	9; 11%	16; 19%	11; 13%
	43; 51%	14; 17%	47; 56%	10; 12%	47; 56%	10; 12%
<i>In Hospital Orientation</i>						
Total (N=84)	n: %	n: %	n: %	n: %	n: %	n: %
Hospital A	38; 45%	46; 55%	38; 45%	46; 55%	39; 46%	45; 54%
Hospital B	6; 7%	21; 25%	6; 7%	21; 25%	2; 2%	25; 30%
	32; 38%	25; 30%	32; 38%	25; 30%	37; 44%	20; 24%

Table 3

*Preparedness to Assess For Abuse*

Type of Abuse	Not at All	Somewhat Prepared	Prepared/Very Prepared
Elder Abuse	n: %	n: %	n: %
Total (N=84)	3; 3%	38; 45%	43; 51%
Hospital A	2; 2%	16; 19%	9; 10%
Hospital B	1; 1%	22; 26%	34; 41%
Domestic Violence			
Total (N=84)	3; 4%	34; 40%	47; 56%
Hospital A	2; 2%	17; 20%	8; 10%
Hospital B	1; 1%	17; 20%	39; 46%
Child Abuse			
Total (N=84)	8; 10%	28; 33%	47; 56%
Hospital A	6; 7%	13; 15%	7; 8%
Hospital B	2; 2%	15; 18%	40; 48%

Data regarding the RNs assessing for suspected elder abuse in the last six months revealed that 78 (97%) of the RNs assessed between 1 and 5 patients. In the last six months 71 (90%) of the RNs assessed between 1 to 5 patients for domestic violence. Finally, in the last six months 78 (97%) of the sample assessed between 1 to 5 patients for child abuse. A *t*-test revealed the RNs in Hospitals A and B were no different in the number of times they assessed patients for suspected elder abuse in the last six months. However, there was a significant difference in the number of times the nurses at Hospital A and Hospital B assessed patients for domestic violence and child abuse in the last six months. Nurses at Hospital B assessed their patients on average of 4.11 more often for domestic violence in the last six months while the RNs at Hospital A assessed their patients .56 more often over the last six months. Nurses at Hospital B assessed their patients on average of .89 more often for child abuse in the last six months while the RNs at Hospital A assessed their patients .17 more often over the last six months. See Table 4.

Table 4

*How Often RNs Assessed For Suspected Elder Abuse in Last Six Months*

Hospital	n	Mean	SD	t-test
Hospital A	25	1.04	1.485	$t(77)=-.659$
Hospital B	54	4.63	27.12	$p=.240$

*How Often RNs Assessed For Suspected Domestic Violence in Last Six Months*

Hospital	n	Mean	SD	t-test
Hospital A	25	.56	.768	$t(54.59)=-2.82$
Hospital B	54	4.11	9.19	$p=.019$

*How Often RNs Assessed For Suspected Child Abuse in Last Six Months*

Hospital	n	Mean	SD	t-test
Hospital A	24	.17	.565	$t(73.61)=-2.82$
Hospital B	55	.89	1.71	$p=.003$

Table 5

*Information Provided by Organization*

	Elder Abuse		Domestic Violence		Child Abuse		
	Yes n; %	No/DK n; %	Yes n; %	No/DK n; %	Yes n; %	No/DK n; %	
Policies/ Procedures For Screening, Referral Treatment	Total Hospital A Hospital B	58; 69% 18; 67% 40; 70%	26; 31% 9; 33 % 17; 30%	63; 75% 18; 67% 45; 79%	21; 25% 9; 33% 12; 2%	58; 69% 11; 41% 47; 82%	26; 31% 16; 59% 10; 18%
Educational Information in the ED Waiting Areas	Total Hospital A Hospital B	21; 25% 3; 11% 18; 32%	63; 75% 24; 89% 39; 68%	26; 31% 3; 11% 23; 41%	58; 69% 24; 89% 34; 60%	24; 29% 1; 4 % 23; 40%	60; 7% 26; 96% 24; 60%
Screening Questions Present on Assessment Form	Total Hospital A Hospital B	53; 63% 20; 74% 33; 58%	31; 37% 7; 26% 24; 42%	51; 61% 17; 63% 34; 60%	33; 39% 10; 33% 23; 40%	39; 46% 6; 22% 33; 58%	55; 54% 21; 78 % 24; 42%
In-service Training Conducted	Total Hospital A Hospital B	31; 37% 9; 33% 22; 39%	51; 61% 18; 67% 33; 58%	28; 33% 6; 22% 22; 39%	56; 66% 21; 78% 39; 68%	26; 3% 2; 7% 24; 42%	57; 68% 25; 93% 32; 56%
In-house Expert Available	Total Hospital A Hospital B	19; 23% 5; 19% 14; 25%	64; 76% 22; 82% 42; 74%	19; 23% 2; 7% 17; 30%	64; 86% 25; 93% 39; 68%	13; 16% 1; 4% 12; 2%	70; 83% 26; 96% 44; 68%
Referral Information For Patient Available	Total Hospital A Hospital B	27; 32% 2; 7% 25; 44%	57; 68% 25; 93% 32; 56%	37; 44% 2; 7% 35; 61%	47; 56% 25; 93% 22; 39%	28; 33% 0; 0% 28; 49%	56; 67% 27; 100% 29; 51%

Table 5a

*Available Resources for Assessment of Abuse*

	Yes	No or Don't Know
	n; %	n; %
Camera for Evidence	22; 26%	61; 73%
Body Map for Injuries	50; 60%	34; 40%

The nurses were asked if their organization had policies and procedures for screening, referral, and treatment for elder abuse, domestic violence, and child abuse; see Table 5. Fifty-eight (69%) RNs responded that their organization had policies and procedures for suspected elder abuse, while 63 (75%) RNs reported policies for domestic violence and 58 (69%) knew of policies for child abuse. More participants were aware of policies and procedures for domestic violence than for elder abuse and child abuse.

Participants were asked if their organization provided educational information in the ED or waiting areas. Twenty-one (25%) RNs responded that their organization provided educational information for elder abuse in the ED or waiting areas, while 26 (31%) RNs reported educational materials for domestic violence; 24 (29%) RNs knew of educational information for child abuse. Fewer participants were aware of educational materials in the ED or waiting areas for elder abuse than domestic violence or child abuse. More importantly, only one third of the respondents were aware of the availability of educational materials on elder abuse, domestic violence, and child abuse in the ED or waiting areas.

Participants were asked if their organization had referral information for the patients available. Twenty-seven (32%) RNs responded that their organization had referral information for elder abuse, while 37 (44%) RNs reported referrals for domestic violence and 28 (33%) RNs knew of referral information for child abuse. Less than half of the respondents were aware of the availability of referral information in the ED. More participants were aware of referral information for patients with suspected domestic violence than elder abuse or child abuse.

Participants were asked if their organization provided abuse screening questions on the assessment form. Fifty-three (63%) of the RNs responded their organization provided screening questions for elder abuse on the assessment form while 51 (61%) indicated screening items for domestic violence were on the assessment form and 39 (46%) reported screening questions for child abuse were on the assessment form. More participants were aware of screening questions on the assessment form for patients with elder abuse and domestic violence than child abuse.

Participants were asked if their organization provided in-service training on abuse. Thirty-one (37%) of the RNs responded that their organization provided in-service training on elder abuse while 28 (33%) RNs reported their organization provided in-service training for domestic violence in their agency; 26 (30%) RNs indicated that their organization provided in-service training for child abuse. Only one third of the respondents indicated that their organization had provided in-service education for elder abuse, domestic violence, and child abuse. The RNs were asked if their organization provided an in-house expert on abuse. Nineteen (32%) of the RNs responded their organization provided an in-house expert for elder abuse while 19 (23%) RNs reported an



expert for domestic violence and 13 (16%) RNs indicated they had an internal expert for child abuse. Less than one third of the respondents were aware of the in-house expertise on the three types of abuse.

To further examine the data, information about resources is presented by each hospital. To interpret the data accurately, it must be noted that Hospital A does not typically admit children, therefore, RNs in Hospital A were more familiar with elder abuse or domestic violence practices than child abuse. The RNs at Hospital B did frequently treat children in the ED, thus were more aware of policies and procedures related to child abuse. Eleven (41%) RNs from Hospital A responded that their organization provided information regarding child abuse policies and procedures in comparison to 47 (82%) of the RNs at Hospital B. The RNs were asked if their organization provided educational information in the waiting areas and ED for child abuse. One (4%) of the RNs from Hospital A responded that their organization provided educational information about child abuse in the waiting areas and ED, while 23 (40%) of the RNs at Hospital B knew there was information about child abuse available.

The RNs were asked if their organization provided screening questions on the assessment form about child abuse. Six (22%) of the RNs from Hospital A responded that their organization provided screening questions on the assessment form about child abuse while 33 (58%) of the RNs at Hospital B noted that child abuse screening questions were on the assessment form. The RNs were asked if their organization provided in-service training about child abuse. Two (7%) of the RNs from Hospital A responded that their organization provided in-service training about child abuse while 24 (42%) of the RNs from Hospital B reported in-service training about child abuse. The RNs were asked if

their organization provided an in-house expert for child abuse. One (4%) of the RNs from Hospital A responded that their organization employed an in-house expert on child abuse while 12 (20%) of the RNs of Hospital B knew that an in-house expert on child abuse was available. The RNs were asked if their organization provided referral information for the patients about child abuse. None of the RNs at Hospital A indicated that their organization provided referral information for patients about child abuse, yet 28 (49%) the RNs at Hospital B knew that referral information related to child abuse was available. Responses indicated that many nurses at both hospitals were unaware of available resources for elder abuse, domestic violence, and child abuse at their organization.

Sixty-three (73%) RNs indicated they did not know if their hospital had a camera for evidence collection; see Table 5a. However, the majority of the RNs (n=50; 60%) knew there was a body map available to document patient injuries.

These ED nurses indicated they used intuition when they sometimes “act on sudden knowledge” (74%; n=64); when “a decision just comes to me” (75%; n=63), and when there are times they just “know what to do for the patient” (68%; n=57). There was no difference in the use of intuition by nurses in Hospitals A and B (see Table 6).

Table 6

*Independent t-test for Intuition Scale*

Hospital	n	Mean	SD	t-test
Hospital A	27	4.07	2.60	t(82)=-1.193
Hospital B	57	4.75	2.36	p=.236

Nurses in this sample were very astute in picking up the assessment cues (applied knowledge of elder abuse) for elder abuse; see Table 7. Almost all of the sample (98%; n=82) responded correctly to the first vignette which suggested abuse; 93% (n=78) recognized suggested abuse in the second vignette; 91% (n=76) realized that the third vignette did not suggest abuse, and, 80% (n=67) correctly identified suggested abuse in the fourth vignette.

Table 7

*Vignette Assessment Cues of RN Sample*

Vignette	Yes n; %	No n; %
Inability to care for self or do activities of daily living	73; 94%	4; 5%
Son spends money	39; 51%	38; 49%
Does not get fed/nutritional issues	57; 74%	20; 26%
Meds not bought or given	64; 83%	13; 17%
Left Alone	54; 70%	23; 30%

Table 8

*Notification for Suspected Elder Abuse*

Vignette	Internal notification	Internal notification	External notification	External notification
	Yes n; %	No n; %	Yes n; %	No n; %
1	72; 91%	7; 9%	30; 38%	48; 62%
2	60; 79%	16; 21%	30; 40%	45; 60%
4	59; 83%	12; 17%	18; 25%	53; 75%

NOTE: Vignette 3 did not have have any abuse in the scenario

The maximum score for the elder abuse assessment cues in the vignettes was 24. Nurses identified an average of 13.06 (SD= 5.32; range 0 – 24) assessment cues on the vignettes. The majority of the nurses identified about half of the assessment cues in determining if there was or was not suspected elder abuse in the patient scenario. However, these nurses did accurately determine the presence of suspected elder abuse.

In the vignette assessment cue (applied elder abuse knowledge) results (Table 7), it is clear there was variation in the number of identified assessment cues. Higher assessment cue scores (greater than 80%) indicated the RNs were correctly assessing signs and symptoms of elder abuse: Vignette 1 - inability to care for self or do activities of daily living (94%) and meds were not bought or given (83%); and Vignette 2 - daughter screams, slaps, and punches patient (89%). Lower assessment cue scores (less than 80%) indicated that many of the RNs did not list some of the important assessment cues: Vignette 1 - son spends money (51%), does not get fed/nutritional issues (74%), and left alone (70%); Vignette 2 – left alone (64%) and does not get medications (51%); Vignette 4 – incontinence addressed (78%), and threatened to be sent to a nursing home, unable to ambulate, and left alone without help (48%).

Table 8 presents the vignette action/intervention scores of the RN sample for vignettes 1, 2, and 4. The scores for vignettes 1, 2, and 4 for internal notification about potential elder abuse (range 79%-91%) were higher than the scores for notifying an external source, such as Office of Regulatory Services or Department of Family and Children Services (DFACS). A *t*-test revealed no significant differences between the nurses at Hospital A and Hospital B regarding the internal and external notification outcomes. Elder abuse assessment is multifactorial situation and each suspected abuse

case is unique. The vignette data indicated that elder abuse was properly identified; however, it revealed that many of nurses would not report suspected elder abuse, especially outside the hospital.

At Hospital A, 30% of the RNs responded they had attained the clinical level of practice status as an “expert nurse” at their hospital compared to 81% at of the RNs at Hospital B. For this study, an expert nurse was defined as a RN who had reached the highest clinical level of practice status level within their organization. Benner defines an expert as having worked greater than 5 years as a nurse. However, a RN may have worked as a RN for 30 years, but never attained the “expert nurse” clinical level of practice status at Hospitals A and B. Likewise, a RN with less than 5 years experience could have attained the clinical level of practice status as an “expert nurse” at Hospitals A and B. The number of years worked as a RN ranged from 1 to 35 years; the range of the number of years worked in the ED was similar (0 to 31 years). The “non-experts” RNs (mean = 18.71 years; SD=10.97) had more years worked as a RN than those nurses classified as an expert (mean = 13.27 years; SD=10.66). Similarly, “non-expert” nurses had worked longer in the ED (mean 11.82 years; SD=7.93) than the “expert” nurses (mean=9.22; SD=9.41). Analysis of the data revealed there was no significance difference on assessment cues or intervention scores between the groups having attained the clinical level of practice status as an “expert nurse” and those who did not ( $t(50)=1.78$ ,  $p=.08$ ).

## Results

### *Predictors of Elder Abuse Reporting*

Bivariate correlations between the independent variables (applied knowledge (assessment cues), intuition use in nursing practice, years worked as a RN, and clinical level of practice status) and the dependent variable (clinical decision outcomes/interventions) were calculated to examine the relationship between the independent variables and the dependent variable. One of the variables under study, applied knowledge, had a moderate statistically significant relationship with the clinical decision outcomes (interventions); see Table 9.

Table 9

*Intercorrelations for Scores for Applied Knowledge, Intuition, Years worked as a RN, Clinical Level of Advancement Status, and Outcome (N=84)*

Variables	Outcome (Clinical Decisions)	Applied Knowledge	Intuition	Years Worked as a RN	Clinical Level of Advancement Status
1. Outcome (Clinical Decisions)	1 $p=-$	-	-	-	-
2. Applied Knowledge	<b>.429**</b> $p=.000$	1 $p=-$	-	-	-
3. Intuition	.133 $p=.230$	-.020 $p=.858$	1 $p=-$	-	-
4. Years Worked As a RN	.108 $p=.332$	-.224 $p=.049$	.144 $p=.198$	1 $p=-$	-
5. Clinical Level Of Advancement Practice	-.222 $p=.257$	.121 $p=.548$	-.277 $p=.153$	-.379 $p=.051$	1 $p=-$

\*\* Correlation is significant at the 0.01 level (2-tailed)

Multiple regression was conducted to determine which independent variables (applied knowledge (assessment cues), years worked as an RN, intuition use in nursing practice, and clinical level of practice status) were the predictors of clinical decision outcomes (interventions). Data screening led to the elimination of one variable, intuition. Years as an RN and current level of practice status were left in the model based on strong support from the literature. Regression results indicated an overall model of two predictors, RNs applied knowledge (assessment cues) and years worked as a RN, significantly predicted clinical decision outcomes (interventions),  $R^2=.341$ ,  $R^2_{adj}=.251$ ,  $F(3, 22)= 3.79$ ,  $p<.05$ ). The model accounted for 25.1% variance in clinical decision outcomes as summarized in Table 10. The results indicated the identification of assessment cues by the RNs (applied knowledge of elder abuse) and years of experience worked as a RN are predictors for appropriate nursing interventions to address suspected elder abuse.

Table 10

*Predictor Variables of Clinical Decision Outcomes with Applied Knowledge, Years worked as a RN, and Clinical Level of Practice Status as Independent Variables (N = 84)*

Model	Beta	SE B	$\beta$	<i>t</i>	<i>p</i>
1. Applied Knowledge (Assessment cues)	.379	.245	.527	2.152	.043
2. Years Worked As A RN	.390	.042	.087	2.081	.049
3. Clinical Level of Practice Status	-.147	1.677	-1.298	-.774	.447



*Differences Between RNs with and Without Mandatory Elder Abuse Training*

The convenience sample of the 84 ED nurses was divided into two groups based on self report of elder abuse training during orientation. An independent sample *t*-test was calculated to compare the mean scores on selected variables the two RN groups who had elder abuse education in their employment orientation and those who did not; see Table 11. There were no differences in applied knowledge (assessment cues) of elder abuse, intuition use in nursing, years working as a RN, clinical level of practice status, and clinical decision outcomes (interventions) between RNs who received elder abuse education at orientation and those who did not receive the education.

Table 11

*Group Differences for RNs Who Received Elder Abuse Education (EA Ed) at Orientation  
And Those Who Did Not*

Variables	Received Elder Mean	Abuse SD	Education at Orientation	t-test
Intuition Use in Nursing				
Had EA Ed	n=55	9.51	2.49	$t(82)=-.381$ $p=.704$
No EA Ed	n=29	9.90	2.64	
Applied Knowledge (Assessment Cues)				
Had EA Ed	n=52	13.52	2.72	$t(51)=-.207$ $p=.831$
No EA Ed	n=27	14.11	2.29	
Clinical Decision Outcomes (Interventions)				
Had EA Ed	n=55	13.89	3.50	$t(71)=-1.77$ $p=.086$
No EA Ed	n=28	14.18	3.49	
Years worked as a RN				
Had EA Ed	15 years	14.96	11.22	$t(80)=-1.42$ $p=.160$
No EA Ed	12 years	11.77	9.60	
Clinical Level of Practice Status				
Had EA Ed	1.09 Level	.29	.06	$U=3.00$ $p=.593$
No EA Ed	1.00 Level	.00	.00	

### Summary

The convenience sample of 84 RNs consisted of 68 females (81%) and 16 males (19%). The RNs at Hospital B had a 75% survey response rate, while those at Hospital A had only 40% return rate. The average age of the respondents was 41 years. The mean number of years worked as a RN at their hospital was 14 years.

Multiple regression results indicated an overall model of two variables, RNs applied knowledge (assessment cues) and years worked as a RN, significantly predicted clinical decision outcomes (interventions) in cases of suspected elder abuse, accounting for 25% of the variance.

The independent samples *t*-test revealed there were no differences in applied knowledge (assessment cues) of elder abuse, intuition use in nursing, years working as a RN, clinical level of practice status, and clinical decision outcomes (interventions) between RNs who received elder abuse education at orientation and those who did not receive the education.

## CHAPTER V

### DISCUSSION AND CONCLUSIONS

This chapter will provide discussion and conclusions of the study, including limitations, implications, and suggestions for future research. The implications for nursing practice and future research are also discussed.

#### Discussion of the Findings

Regression results indicated that nurses who identified more assessment cues (RNs applied knowledge (assessment cues) and had more years worked as a RN) were likely to act on cases of suspected elder abuse. The multiple regression model only accounted for 25% of the variance in clinical decision outcomes. Many factors could account for the unaccountable variance such as an ethical (values) phenomenon that attunes nurses to suspected elder abuse, domestic violence, and/or child abuse. A sense of justice or protection of others may make nurses sensitive to others needs and may encourage them to report suspected abuse. Future studies should explore other variables that may be associated with the identification of elder abuse.

In this study, the “non-expert” RNs had worked more years as a RN and more years in the ED. Clinical level of practice status, is an organizational indicator of expertise and was found not to be a sensitive indicator of expertise in the recognition of elder abuse. However, the more years worked in nursing, the more likely the nurse was to recognize elder abuse. By Benner’s definition, nurses with more than five years experience were “expert” nurses, yet the study sample was not classified as such based on

the criterion for achieving advanced clinical level of practice status. A RN could be considered an “expert” at the hospitals in as little as three years. Based upon the study results, clinical level of practice status should not be used as a measure of expertise in future studies.

Elder abuse education provided during hospital orientation differed between Hospital A and B. However, this orientation did not seem to affect the RNs clinical decision outcomes regarding suspected elder abuse identification. Several factors could account for the recognition of and intervention for elder abuse. Previous education in one’s basic nursing education may have provided the RNs with sufficient knowledge to recognize and act on suspected elder abuse. Also, years of experience may have offered “hands on” experiences that supported their recognition and intervention.

Results of the study found the RN sample was less prepared to assess for suspected elder abuse than for suspected domestic violence or child abuse. However, this did not make a difference in the RN’s ability to recognize suspected elder abuse. Even though many participants did not identify all relevant assessment cues, they still recognized suspected elder abuse, indicating that many have been prepared to assess for suspected elder abuse. Elder abuse is a multifactorial situation; it may be that nurses intellectually took into account relevant cues but did not include them in the survey.

The majority of the nurses correctly identified about half of the assessment cues in determining if the scenario represented a possible elder abuse case. However, greater than 80% of the participants correctly identified elder abuse regardless of their assessment cue scores and training. It may be that the respondents included all assessment cues in their decision to intervene but failed to list all of the cues.

Richardson et al., (2001) examined attitudes and current practice of health care professionals with respect to domestic violence and screening. The study found that most practitioners do not routinely ask about abuse experiences and do not want to carry out routine screening. Although the majority of nurses in this study reported screening for abuse situations, many did not indicate they would take action in cases of suspected elder abuse. Hospital orientation should assure that nurses can recognize cases of suspected abuse, know the hospital's policies regarding suspected abuse and be ready to act should these cases present themselves. In future educational programs, nurses could be guided in explaining their feelings and beliefs about reporting suspected elder abuse. With values clarification, nurses may be more ready to intervene in cases of suspected elder abuse.

Findings of the study suggest some of the elder abuse vignette scenarios may have been too easy for the subjects due to the high scores on some scenarios. Although the vignettes were evaluated by experts and tested with ED nurses, further testing may strengthen the scenarios, refine the scoring and more clearly describe the interventions.

Further testing should include interviews or focus groups with participants after completion of the survey. These RNs could share why they made their choices, giving additional insight into their decision-making process. Without further clarification, it is difficult to know if the RNs considered all the elder abuse assessment cues, even though they may not have listed them in their responses. Since they completed the survey at work in the ED, the participants may have been rushed in completing the instrument or completed it in several sittings depending upon the business of the ED during that time. This could have distracted their thought process when responding to the questions.

Qualitative data could assist in determining if there is some basic sense of preventing harm that guided the nurses in their assessment and willingness to act.

In addition, it is possible that the outcome measures for the vignette instrument should have been more related to the specific policies and procedures of the hospitals. The scoring of the instrument could have been focused on a more exact process for notification and the justification for this notification in the event of suspected elder abuse. The assessment cues could have been weighted instead of an even point distribution, giving more weight to strong cues of abuse. Although the vignette instrument provided much information for this study, the need for further refinement should be considered.

## Conclusions

### *Limitations of the Study*

One limitation of this study was that a small convenience sample of ED RNs was used. A larger sample would assist with the generalizability of the study results. The outcomes of the study were from a nonrandom sampling method and therefore, the participants may not represent the general population of nurses.

The elder abuse vignette instrument is in the early development process. A weakness of the instrument is that it is based on self-report. The nurses' views may differ from their real behavior. However, the instrument is easy to use and simple to complete. The instrument allows for the assessment of clinical decision-making regarding elder abuse scenarios by individual nurses. Further testing of the instrument is recommended with additional representative samples to enhance the generalizability of the results.

### *Implications for Nursing Practice*

Findings of the study suggest RNs need more education regarding various aspects of elder abuse recognition (assessment cues) and reporting (internal and external notification) in their organizations. An appropriate starting place for this instruction is during their basic nursing education. Nurse educators should include elder abuse education in all nursing school curriculums. In addition, since many participants indicated they did not receive education on elder abuse in their workplace, proper education of RNs regarding the prevalence of and various types of elder abuse, identification, interventions, documentation, policies and resources related to managing suspected elder abuse is essential in addressing the healthcare needs of elders.

Several of the nurses with many years in nursing practice and ED nursing were not at the clinical level of practice status level of an “expert”. However, the study found there was no difference between the “expert” and “non-expert” and the identification of suspected elder abuse. Therefore, organizations should consider exploring and adopting a different measure of expertise than their current clinical level of practice status.

### *Suggestions for Future Research*

Studies regarding clinical decision-making of ED RNs related to elder abuse are virtually non-existent. Further research on the topic of elder abuse needs to continue in the area of clinical decision-making of nurses and other health care professionals. Replication of this study is recommended with a larger random sample and with RNs from various areas of healthcare such as community health, long term care, etc. In addition, studies that examine other ways to determine if RNs are attuned to the assessment cues of suspected elder abuse would provide additional insights. For example,



RNs could write a scenario of what they believe is suspected elder abuse. Longitudinal studies may also be necessary to examine the progression of critical thinking and decision-making in ED nurses. More research is needed regarding elder abuse as healthcare prepares for the aging United States society.

Additional research using the elder abuse vignette survey needs to be conducted to assist with the sensitivity and specificity testing of this new instrument. In future research, the elder abuse vignette survey could be used by organizations to determine what response their staff may have in elder abuse situations, and then focus on the specific education needs of the staff.

#### Summary

The study results suggest that years of working as a nurse and the ability to identify numerous assessment cues related to elder abuse supported elder abuse recognition and intervention. Also, the clinical level of practice status of the nurses was found not to be a sensitive indicator of elder abuse recognition and intervention. The inclusion of elder abuse education during hospital orientation varied between the hospital settings. The results indicate that there is an educational need for RNs regarding suspected elder abuse. It is imperative that new nurses receive training to recognize suspected elder abuse and to intervene in these situations, as they do not have the years of experience to draw upon to assist them with their clinical decision-making regarding elder abuse. The multiple regression results indicated an overall model of two variables; RNs applied knowledge (assessment cues) and years worked as a RN, which significantly predicted clinical decision outcomes (interventions) in cases of suspected elder abuse. This accounted for 25% of the variance in the cases of suspected elder abuse.

This is the first study to use the knowledge of elder abuse survey, the intuition use in nursing, and elder abuse vignettes to study recognition of elder abuse. Therefore, this study contributed to understanding more about specific cues RNs used to report suspected elder abuse and it served to test the reliability of the elder abuse vignettes. Researchers have just touched the surface of several important research areas related to clinical decision-making in nursing regarding elder abuse. Lastly, the topic of clinical decision-making of ED RNs regarding elder abuse is virtually non-existent. Therefore, further research is needed in the area of clinical decision-making of RNs regarding elder abuse.

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## Appendix A



## Definitions of the Donabedian Model

Donabedian's structure-process-outcome model serves as a unifying framework for examining health services and assessing patient outcomes. Donabedian defined structure as the physical and organizational properties of the settings in which care is provided, process as the actual treatments and procedures that are done for patients, and outcomes as what is actually accomplished for patients. From the standpoint of patient safety, Donabedian's model provides a framework for examining how risks and hazards that are embedded within the structure and process of care have the potential to cause injury or harm to patients. For example, individual or team failures on the part of health care providers have been consistently cited as leading to negative patient outcomes.

Donabedian identifies two principal components composing the quality of medical care: technical aspects of care and the interpersonal relationship between the provider and the patient. Technical quality is primarily reflected in clinical outcomes. Interpersonal processes of care, such as accessibility, continuity, and personal accountability affect patient satisfaction with care.

Donabedian also asks whether the cost of care should be included as a measure of quality. In light of the movement toward health care reform, this question seems now to have been answered in the affirmative. Optimal care balances clinical outcomes, satisfaction, and costs.

Although Donabedian does not include provider satisfaction as part of his conception of the quality of care, there are several reasons to do so. No organized system of primary care will succeed without the support of its providers. Strong evidence suggests that patient satisfaction and the job satisfaction of physicians and other health

care providers are closely linked. In evaluating the quality of primary care systems, then, four principal outcomes should be considered: clinical quality, patient satisfaction with care, physician (and other provider) satisfaction with the care process, and the cost of care.

(Donabedian 1966)

## Appendix B

## Benner's Theoretical Assertions and Definitions Novice to Expert

Based on the Dreyfus Model: With Experience and Mastery the Skill

Transformed

- Theory is crucial to form the right questions to ask in clinical situations.
- Theory directs the practitioner in looking for problems and anticipating care needs.
- Skilled practice of nursing exceeds the bounds of formal theory.
- Concrete experience provides the learning about the exceptions and shades of meaning in a situation.
- Situation conveys a peopled environment. A person's interaction is subject to interpretation and bounded by the way the individual sees himself in the situation.
- Knowledge embedded in practice discovers and interprets theory, precedes and extends theory, and synthesizes and adapts theory in caring nursing practice.
- Perceptual awareness is central to good nursing judgment.
- Formal rules are limited and discretionary judgment is used in actually clinical situations.
- Knowledge accrues over time in the practice of an applied discipline.
- Expertise develops when the clinician tests and refines propositions, hypothesis and principle based expectations in actual practice situations".
- Domains and competencies of nursing practice are nonlinear, with no precise beginning and no end point.
- Clinicians develop "agency", "a sense of responsibility toward the patient".

KNOWLEDGE OF ELDER ABUSE SURVEY

Please complete these questions by checking the appropriate box or filling in the blank.

1. Have you ever received continuing education on the following topics?

- 1a. Elder abuse                       Yes       No
- 1b. Domestic abuse                 Yes       No
- 1c. Child abuse                     Yes       No

If you checked “yes” to any of these topics, please complete 1d, 1e, and 1f.

If you checked “no” please go to question #2.

Where did you receive your education on these topics? (Check all that apply).

Topic	At this Institution	On-line Resource Modules	Conference, Workshop, Etc.	Course on abuse	Other: Please indicate
1d. Elder Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
1e. Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
1f. Child Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

2. In the last six months, approximately how many times did you assess patients for suspected elder abuse in your ED? \_\_\_\_\_ times in the last six months

3. In the last six months, approximately how many times did you assess patients for suspected domestic violence in your ED? \_\_\_\_\_ times in the last six months

4. In the last six months, approximately how many times did \_\_\_\_\_ times in the last six months  
you assess children for suspected child abuse in your ED?

	Not at All	Somewhat Prepared	Prepared	Very Prepared
5. To what degree do you feel prepared to assess for elder abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. To what degree do you feel prepared to assess for domestic violence?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. To what degree do you feel prepared to assess for child abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. In your emergency department, does your organization have a policy or procedure for addressing or managing suspected cases of:

	Yes	No	Don't Know
a. elder abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. domestic violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. child abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. When you SUSPECT the presence of elder abuse, what action(s) do you take?

---



---

10. In the last year, approximately how many times have you personally initiated a referral because you suspected:

10a. elder abuse? \_\_\_\_\_ times

10b. domestic violence? \_\_\_\_\_ times

10c. child abuse? \_\_\_\_\_ times

Does your organization have the following? Please check the appropriate box for each question.

	Yes	No	Don't Know
11. Cameras for collection of abuse evidence?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. A picture of the body (body map) to document injuries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In regards to <u>Elder Abuse</u> , does your organization provide the following:	Yes	No	Don't Know
13a. Written policies and procedures for elder abuse screening, referral, and documentation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13b. Educational information in the waiting areas or within the Emergency Department depicting elder abuse as a health care issue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13c. Elder abuse screening questions written in the admission assessment form	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13d. An in-service training on elder abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13e. An in-house expert on elder abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13f. Elder abuse referral information for patients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In regards to <u>Domestic Violence</u> , does your organization provide the following:	Yes	No	Don't Know
14a. Written policies and procedures for domestic violence screening, referral, and documentation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14b. Educational information in the waiting areas or within the Emergency Department depicting domestic violence as a health care issue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14c. Domestic violence screening questions written into the admission assessment form	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14d. An in-service training on domestic violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14e. An in-house expert on domestic violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14f. Domestic violence referral information for patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In regards to <u>Child Abuse</u> , does your organization provide the following:	Yes	No	Don't Know
15a. Written policies and procedures for child abuse screening, referral, and documentation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15b. Educational information in the waiting areas or within the Emergency Department depicting child abuse as a health care issue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15c. Child abuse screening questions written into the admission assessment form	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



16. Did courses in your basic nursing education program include any of the following topics? (Check all that apply.)

Gerontology     Family/domestic violence     Policy influence in health care   
Elder abuse     Child abuse     None of the above

17. Did the orientation to your present position include any of the following topics?  
(Check all that apply.)

Gerontology     Family/domestic violence     Policy influence in health care   
Elder abuse     Child abuse     None of the above

(Meeks-Sjostrom, D. 2007)

## Appendix D

Intuition Use in Nursing Scale (by L. Rew, permission to use obtained)

Please put a check beside your response for each question.

Question	Agree	Disagree	Don't Know
1. There are times when I suddenly know what to do for a patient, but I don't know why.			
2. I am inclined to make decisions based on a sudden flash of insight.			
3. There are times when I immediately understand what to do for a patient, but I can't explain it to other people.			
4. There are times when I feel that I know what will happen to a patient, but I don't know why			
5. There are times when a decision about my patient's care just comes to me.			
6. There are some things I suddenly know to be true about some of my patients, but I am unable to support this with concrete data.			
7. Sometimes I act on a sudden knowledge about a patient to prevent a crisis from developing even when I can't explain it.			

Appendix E

[Original Message]

> From: Diana Meeks-Sjostrom <[sjomee@earthlink.net](mailto:sjomee@earthlink.net)>  
> To: Lynn Rew <[ellerew@mail.utexas.edu](mailto:ellerew@mail.utexas.edu)>  
> Date: 3/17/2007 4:09:33 AM  
> Subject: Re: 7 item intuition scale  
> Thank you Dr. Rew. I will certainly provide a copy of my findings upon  
completion. Have a great weekend.  
> Respectfully,  
> Diana Meeks-Sjostrom  
> [sjomee@earthlink.net](mailto:sjomee@earthlink.net)

>> [Original Message]

>> From: Lynn Rew <[ellerew@mail.utexas.edu](mailto:ellerew@mail.utexas.edu)>  
>> To: <[sjomee@earthlink.net](mailto:sjomee@earthlink.net)>  
>> Date: 3/16/2007 12:00:15 PM  
>> Subject: Re: 7 item intuition scale  
>> Yes, you have my permission. I would like to have a copy of your  
findings.  
>>  
>> On 3/15/07, Diana Meeks-Sjostrom <[sjomee@earthlink.net](mailto:sjomee@earthlink.net)> wrote:  
>>> Good Morning Dr. Rew,  
>>> I am a PhD nursing student at Georgia State University. My  
dissertation is clinical decision making of nurses regarding elder abuse.  
I was hoping to obtain permission to use your instrument in my  
Dissertation work.  
>>> I would appreciate any comments or feedback. Thank you.

> > > Respectfully,

> > > Diana Meeks-Sjostrom

> > > [sjomee@earthlink.net](mailto:sjomee@earthlink.net)

> > Lynn Rew, EdD, RN, AHN-BC, FAAN

> > Denton & Louise Cooley and Family Centennial Professor in Nursing

> > The University of Texas at Austin School of Nursing

> > 1700 Red River

> > Austin, TX 78701

> > Phone: 512-232-4784

## Appendix F

Saint Joseph's Health System Saint Joseph's Hospital of Atlanta Staff Position Description	
POSITION TITLE: Staff Nurse	POSITION CODE: 12701, 12702,
DEPARTMENT: Nursing	DATE PREPARED: 1/02
REPORTS TO: Unit Nursing Director, Unit Nurse Manager	DATE REVIEWED: 1/02, 8/03, 12/03, 6/04,1/05
<p><b>POSITION SUMMARY:</b> The staff nurse under the supervision of the nursing director provides patient care and/or support activities appropriate to ages served; primarily adults ages 18-65 or geriatric patient's ages over 65. May also include care for infant age 0-1 year, child ages 1-12 years or adolescent ages 13-17 years. A team member or team leader in the planning and implementing of patient care. Directs and assists in carrying out safe aseptic technique and procedures. Offers leadership and direction to nursing assistants, patient care technicians, department secretaries, and monitor technicians.</p>	
<p><b>EDUCATION REQUIREMENTS:</b> Graduate of an accredited school of nursing. Current Georgia State license. Membership in a professional organization preferred.</p>	
<p><b>EXPERIENCE REQUIREMENTS:</b> One-year experience in nursing preferred. Will accept new graduate.</p>	
<p><b>JOB KNOWLEDGE:</b> Able to assess, plan, implement and evaluate nursing care.</p>	
<p><b>PHYSICAL REQUIREMENTS:</b> See attached Working Conditions and Physical Requirements Sheet</p>	



Overall Performance Evaluation Rating (circle one):	Does Not Meet	Needs Improve ment	Meets Standards	Exceeds Standards
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Rating Guide:

DNM – Does not meet standards

NI – Needs Improvement, Inconsistently meets standards

MS – Meets standards

ES – Exceeds standards

SC – Significant Contributor/ Additional contribution to the organization (Must be documented)

Level II							N/A
Complete for Level II and Level III Staff Nurse							
	<ul style="list-style-type: none"> <li>Serves as a CAP for new staff as needed.</li> </ul>						
	<ul style="list-style-type: none"> <li>Monitors performance of new staff and provides feedback to orientee and appropriate manager.</li> </ul>						
	<ul style="list-style-type: none"> <li>Serves as a resource and role model to all members of the patient care team.</li> </ul>						
	<ul style="list-style-type: none"> <li>Exhibits refined assessment skills by correlating all subjective and objective findings and initiating appropriate action.</li> </ul>						
	<ul style="list-style-type: none"> <li>Demonstrates calm and professional behavior in stressful situations.</li> </ul>						
	<ul style="list-style-type: none"> <li>Takes the initiative to work with the management team to develop activities to meet unit growth.</li> </ul>						
	<ul style="list-style-type: none"> <li>Acts as a resource/role model for documentation skills.</li> </ul>						
	<ul style="list-style-type: none"> <li>Maintains level II status according to the Levels Advancement Panel criteria.</li> </ul>						
Level II Competency Rating							

Level III								N/A
Complete for Level III Staff Nurse								
	<ul style="list-style-type: none"> <li>Exhibits advanced assessment skills by correlating all subjective and objective findings and initiating appropriate action.</li> </ul>							
	<ul style="list-style-type: none"> <li>Mentors others in developing resource/role model behaviors.</li> </ul>							
	<ul style="list-style-type: none"> <li>Acts as a clinical resource for all patients including the most complex patients on the unit.</li> </ul>							
	<ul style="list-style-type: none"> <li>Facilitates coordination of the multidisciplinary team to provide positive patient outcomes.</li> </ul>							
	<ul style="list-style-type: none"> <li>Is recognized as an expert clinician by the multidisciplinary team.</li> </ul>							
	<ul style="list-style-type: none"> <li>Effective participation in the skills validation program.</li> </ul>							
	<ul style="list-style-type: none"> <li>Maintains level III status according to the Levels Advancement Panel guidelines.</li> </ul>							
Level III Competency Rating								

#### Saint Joseph/Candler Professional Nursing Bridge to Excellence Program

The goal of the Professional Nursing Bridge to Excellence is to reward the unit-based bedside RN with tenure. These are the RNs who are employed 24 hours per day/seven days per week, every day of the year and who may take call.

Categories of eligibility include:

FTR - 80hr/pp

PTB - 60-72hr/pp

PT - 48hr/pp (only eligible for Clinical Expert III)

Unit based per diem and Keys Plus are not eligible

Note: The first two levels- Entry Level I and Staff Nurse Level II are not included in the Nursing Bridge to Excellence. Upon completion of the requirements of these two levels, professional staff nurses may choose the option of “bridging” to the Nursing Excellence Program

(Entry) Level I

New Graduate RN

### Re-entry RN

Non-acute care RN = has never practiced in acute care environment- such as school, office or care call

### Experienced RN

Experienced RN = 1 yr or more “like” experience for area of hire

Minimum of 90 days in Entry Level I

### Core Criteria:

#### Satisfactory Completion:

- 1) Orientation (Hospital – Nursing – Department)
- 2) CPR/ACLS/PALS/NRP (as indicated by specialty)
- 3) Nursing Fellowship and/or Nursing Residency as available
- 4) Annual Competencies (skills checklist)
- 5) CQI: The Basics

All results satisfactory or above on Preceptor Evaluation

Develops Education Plan on 90 day/annual evaluation

All Key results satisfactory on 90 day/annual evaluation

Upon completion of all Entry Level requirements, automatic entry into:

Updated: 10/27/2004 2

### Staff Nurse Level II

To apply for initial Bridge Level, advised to complete following minimum time interval in

#### Level II

New graduate RN (1 year)

Non Acute Care experienced RN (6 months)

Experienced RN (3 months)

Re entry RN (1 year)

### Core Criteria

Meet job requirements according to job description, including attendance at Skills Days and unit in-services

Satisfactory Key results

Internal Certification as designated by area

Participate in peer review

CQI Course Orientation (completed or scheduled)

### Bridge Levels:

#### Clinical Expert Level III

RN with minimum of 1 year of practice at SJC

### Core Criteria:

Exceed standards greater than 75% on key results and receives overall “outstanding” on evaluation

Demonstrates exemplary attendance (no more than four occurrences per year)

Demonstrates exemplary adherence to Basic Principles

Participates in 75% of unit staff meetings. (Participation to be defined by the unit manager)

Participates in: (at least five below; one of which needs to be a committee)

#### A. Unit Performance Improvement

1. Product evaluation

2. Open chart reviews- 2 per month
3. Documentation Audits- 2 per month
4. Unit specifics
5. NDNQI nurse sensitive

Updated: 10/27/2004 3

6. Balanced score card
7. Nursing Research (literature/data collection)

Participation is demonstrated by conducting data collection through chart review, collating of performance indicator reports and Meditech reports. This participation is in collaboration with the clinical support staff and the nurse manager.

B. Council/ Committee involvement

8. Nursing Council for Excellence
9. Professional Nursing Council
10. Recruitment/Retention
11. Patient Care Policy
12. Nursing Performance Improvement
13. Nursing Research Council
14. Team Council
15. CRD
16. JCAHO task force
17. Designated nursing task force (time limited)

Participation is demonstrated via council membership, request to bring information to council or participation in council work as in a subteam

C. Other

17. Functions as Designated Preceptor – Satisfactory completion of course and required documentation- (at least 2 nurses per year/if no new nurses, serves as resource for existing staff.) Documentation includes satisfactory preceptee evaluations, preceptor evaluations and documentation of goals for preceptee.

Recognition for service excellence (Examples but not limited to the following: We Care, letter from a patient, employees, MDS, other staff, nomination for award, other)

Demonstrates measures to improve unit balanced scorecard indicators, such as staff satisfaction and length of stay. Measures include participation in unit surveys and other data collection, participation in care track activities, consultation with physicians and other team members.

Completion of CQI – Continuous Improvement Principles/tools or three modules from CIP/T.

Demonstration of critical thinking skills (Submission of Exemplar, Unit Conference presentation, develop a carepath, present a case study, other)

Performs unit specific priority technical procedures efficiently and safely. Performance demonstrated by successful credentialing and performance as instructor/resource for staff.

Demonstrates clinical knowledge and competency in skills. Performance demonstrated as above.

Facilitates incorporation of new technologies into patient care delivery systems as evidenced by involvement in unit evaluation programs and serving as technology resource for staff

Demonstrates expertise in patient/family education as evidenced by documentation of education and evaluation of provided education in Teach Patient Simple

Updated: 10/27/2004 4

Facilitates completion of complicated patient education needs by assuring appropriate disciplines have intervened with patient and family in a timely fashion

Utilizes knowledge of continuum of care in discharge planning to assure appropriate level of care for patient population. Performance demonstrated by leading or active participation in care track as well as documentation of patient specific measures to decrease length of stay or facilitate appropriate transfer.

Demonstrates accuracy and timeliness in completion of care path documentation

Manages clinical situations with advanced skills ensuring incorporation of Florence Nightingales tenets (social, physical, spiritual)

Participates in a health system sponsored Community Service activity

Clinical Expert Level IV (includes all of Level III plus:)

RN with more than 1 year Clinical Experience at SJC

Core Criteria:

National Certification in area of specialty

Assumes charge/RC roles (all didactic and clinical requirements completed to assume role)

CIP/T or seven modules completed.

Demonstrates ability to identify barriers and develop process interventions for decreasing length of stay. Performance demonstrated as above and/or may include unit specific process initiation or revision.

Integrates evidence based nursing theory research and practice knowledge in patient care delivery. Performance demonstrated by nursing case studies, exemplars and documentation evidencing the physical, spiritual and social aspects of the Nightingale theory.

Provides clinical information to staff regarding new/unusual patient diagnosis, condition or technology. Performance demonstrated by documentation on peer review, annual evaluation or anecdotal staff and clinical resource documentation.

Facilitates or co-facilitates staff meetings. At least 2 a year.

Demonstrates advanced critical thinking as evidenced by observation of performance, exemplar

Performs advanced clinical skills- including emergency and anticipatory assessments.

Functions as resource for nursing staff in assessing patients for adverse outcomes.

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Member of Professional Nursing organization

Attendance at National/State Nsg Organization (attendance at least once every 2 yrs)

- Presentation at meeting

- Presentation to SJC Nursing, of summary findings

Chair/Member of unit based/division/hospital council

Mentor:

1)New "nurse" employee

2)Assist promotion thru bridge

3)Other Staff

Performance demonstrated by evaluation by staff as exemplary preceptor focusing on

overall professional development, not only unit organization and clinical skills.  
Exceeds standards and Receives overall outstanding evaluation on 75% of areas  
evaluated on Key Results

Updated: 10/27/2004 6

Excellence Criteria for Clinical Expert Levels III and IV

In Accordance with Nightingale's theoretical tenets

For Clinical Expert III choose three criteria

For Clinical Expert IV choose six criteria

Clinical (patient)

ACLS/PALS/NRP certification

Develops proposal and/or implements innovative patient focused health  
system project (focus on patient satisfaction/customer service). Performance  
demonstrated by participation on Smart Service team or unit directed activities.

Develops/implements evidenced based cost saving/ safety initiative

- Example: Low LOS, improving pt flow through system

Formal recognition by ethics committee or other entity for excellence in clinical decision  
making

Involvement in development/implementation of evidenced-based care paths or other  
documentation for area

Demonstrated evidence of patient advocacy

Team member (investigator) of Nursing research project

Formal recognition of peer clinical excellence

Facilitates communication with physicians and other health care team members regarding  
unit outcomes

Promotes improvement in unit clinical outcomes via partnering/rounding with physicians  
and other health care team members

Community (social)

Smart Service Teams

Participates in more than one health system sponsored community service activity

Assumes Leadership role in health system sponsored community service activity

Involvement in legislative concerns regarding health-related issues

Develops proposal and/or implements innovative patient focused  
community project (focus on patient satisfaction/customer service)

Updated: 10/27/2004 7

Leadership/Education (Nurse)

Communication liaison between dept/units/areas/team members

Participation in:

1) Professional Nursing Council

2) Nursing PI

3) Patient Care Policy

1) Team Council

2) Nursing Council for Excellence

3) Recruitment and Retention

4) Nursing Research Council

National Certification in Specialty

Publications (regional/national)

- System
- Local ie: SMN
- Journal
- Magazine
- Submits abstract to Prof. Organization
- National Certification in additional health related field/area
- Instructor and/or Instructor trainer - CPR, ACLS, PALS, NRP
- Develops/incorporates conceptual framework and
- Presents/Teaches:
  - Nsg grand rounds
  - Summary of CE program attended
  - Exemplar reading
  - Nsg residency component
  - Continued education program
  - Basic Orientation Class
  - Public Forum
  - Case Study (lunch and learn)
  - Ethics presentation
  - Skills Day (department/system)
- Participates in unit staff evaluations
- \*Pursuing advanced nursing degree (BSN or MSN)
- \*Will count for three criteria
- Holds office in local/state/national professional nursing organization
- Pursuing advanced degree in related field
- Functions as a preceptor for Nursing Students

## Appendix G





## Appendix H

## ELDER ABUSE VIGNETTE INSTRUMENT

Dear Healthcare Professional:

Please read each scenario and respond to the questions following each.

### SCENARIO 1:

Margaret, an 82-year-old retired musician, lives with her 65-year-old son, Maurice. Margaret states that her son spends all of his time at the racetrack and never has any money. Margaret suffers from congestive heart failure and mild dementia. She states she is unable to dress, wash, or feed herself without assistance. Margaret states that she is left alone at home quite often, is frequently not fed or bathed, and when she given her son money for her medications, he does not purchase them. Margaret states she has also burned herself several times while trying to prepare her own meal. Consequently, Margaret presents to the emergency department with shortness of breath and chest pain. (Welfel, et al., 2000).

- 1a. Does this situation suggest abuse?  Yes  No

If you checked "yes" in question 1a, please check all types of elder abuse reflected in this scenario.

- |                                   |                                       |                                    |
|-----------------------------------|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Neglect  | <input type="checkbox"/> Self-neglect | <input type="checkbox"/> Financial |
| <input type="checkbox"/> Physical | <input type="checkbox"/> Psychosocial | <input type="checkbox"/> Isolation |

If you answered "yes" to question 1a, please complete questions 1b, 1c, and 1d.

- 1b. Assessment of Patient: Are there any assessment items related to elder abuse in the scenario that concerns you?

Please list all the items related to elder abuse that concerns you in this scenario.

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1c. Action: What actions would you take with regards to suspected elder abuse in this scenario?

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1d. Please list any additional information you would want to know about this patient regarding suspected elder abuse.

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## SCENARIO 2:

Catherine, age 93, presents to your emergency room. She states she is often forgetful. Catherine states her daughter, Myra, suffers from diabetes and depression. Catherine states her daughter has forgotten to give her the medicine. Occasionally her daughter has screamed, slapped, and punched her. Catherine states her daughter gets frustrated and sometimes leaves the house for many hours. (Welfel, et al., 2000).

2a. Does this situation suggest abuse?  Yes  No

If you checked "yes" in question 2a, please check all types of elder abuse reflected in this scenario.

Neglect  Self-neglect  Financial  
 Physical  Psychosocial  Isolation

If you answered "yes" to question 2a, please complete questions 2b, 2c, and 2d.

2b. Assessment of Patient: Are there any assessment items related to elder abuse in the scenario that concerns you?

Please list all the items related to elder abuse that concerns you in this scenario.

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2c. Action: What actions would you take with regards to suspected elder abuse in this scenario?

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2d. Please list any additional information you would want to know about this patient regarding suspected elder abuse.

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## SCENARIO 3:

Archie, age 65, presents to your emergency room. He states he lost his balance and fell down a flight of stairs, landing on his right hip. Archie screams in pain when the right leg is moved. He states he lives with his son who helps manage his financial affairs. Archie states he is otherwise healthy.

3a. Does this situation suggest abuse?  Yes  No

If you checked “yes” in question 3a, please check all types of elder abuse reflected in this scenario.

Neglect  Self-neglect  Financial  
 Physical  Psychosocial  Isolation

If you answered “yes” to question 3a, please complete questions 3b, 3c, and 3d.

3b. Assessment of Patient: Are there any assessment items related to elder abuse in the scenario that concerns you?

Please list all the items related to elder abuse that concerns you in this scenario.

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3c. Action: What actions would you take with regards to suspected elder abuse in this scenario?

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3d. Please list any additional information you would want to know about this patient regarding suspected elder abuse.

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## SCENARIO 4:

Ingrid is a 91-year-old woman who presents to your emergency department. She states she lives in the downstairs half of a two-family home which she shares with her grandniece, Monica. Ingrid states she has begun to lose control of her urine at times. She states she can't get out of her wheelchair and pays Monica to do her grocery shopping. Ingrid also stated her niece told her she felt embarrassed when she had to buy adult diapers and made fun of Ingrid when they are put on the shopping list. In fact, Ingrid stated, Monica had threatened to put her in a nursing home if she wore diapers. As a result, Ingrid states she tries not to use many diapers and saves them for outings away from home. Ingrid states she goes to the bathroom frequently and it burns when she goes to the bathroom. As well, Ingrid states her skin under her diaper area is very red and sore (Welfel, et al., 2000).

4a. Does this situation suggest abuse?  Yes  No

If you checked "yes" in question 4a, please check all types of elder abuse reflected in this scenario.

Neglect  Self-neglect  Financial  
 Physical  Psychosocial  Isolation

If you answered "yes" to question 4a, please complete questions 4b, 4c, and 4d.

4b. Assessment of Patient: Are there any assessment items related to elder abuse in the scenario that concerns you?

Please list all the items related to elder abuse that concerns you in this scenario.

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4c. Action: What actions would you take with regards to suspected elder abuse in this scenario?

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4d. Please list any additional information you would want to know about this patient regarding suspected elder abuse.

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Adapted with permission from RN.com. (2004). Domestic Violence: Elder Abuse What Healthcare Providers Need to Know. Retrieved March 12, 2007 from <http://www.rn.com/getpdf.php/599/pdf>

Appendix I

Diana, this sounds great. I am thrilled you will be using our tool. I will save this email as documentation of our conversation.

May I request the following?

1. A copy of your resume/CV (electronic is fine)
2. A brief description of your dissertation
3. Any feedback you receive or deduce from your work on this project

Thanks

Karen Siroky

1-888-890-6333

From: Diana Meeks-Sjostrom [<mailto:sjomee@earthlink.net>]

Sent: Sunday, April 01, 2007 4:04 PM

To: Karen Siroky      Subject: RE: question

Hi Karen,

This is the instrument that I will be testing for content validity (pilot testing) before initiating data collection. Parts of the scenarios are from the quiz from the domestic violence/elder abuse. I am trying to determine the knowledge and use of intuition in nursing practice of RNs regarding elder abuse. In order to evaluate how RNs assess, I was developing the attached vignette instrument.

Please advise. Thank you.

Respectfully,

Diana Meeks-Sjostrom

[sjomee@earthlink.net](mailto:sjomee@earthlink.net)

> [Original Message]

> From: Karen Siroky <[Karen.Siroky@amnhealthcare.com](mailto:Karen.Siroky@amnhealthcare.com)>

> To: <[sjomee@earthlink.net](mailto:sjomee@earthlink.net)>

> Cc: <[karen.siroky@rn.com](mailto:karen.siroky@rn.com)>; <[info@rn.com](mailto:info@rn.com)>

> Date: 4/1/2007 2:46:16 PM

> Subject: RE: question

> Ms Meeks-Sjostrom,

> We would love to share the test questions with you, but I need to know more about your dissertation and use of the questions. Can you give me a little bit of further information about this and then we can make our decision.

> Thanks

> Karen Siroky, RN, MSN

> Director of Education      RN.com      1-888-890-6333

> From: [info@rn.com](mailto:info@rn.com) [<mailto:info@rn.com>]

> Sent: Friday, March 30, 2007 2:49 PM

> To: [karen.siroky@rn.com](mailto:karen.siroky@rn.com)

> Subject: Fwd: question

> Please see below.

> Education Coordinator

> RN.com      12400 High Bluff Dr

> San Diego, CA 92130      Toll Free Phone 877-578-3975

> Date: Wed, 28 Mar 2007 20:39:26 -0400

> From: Diana Meeks-Sjostrom <[sjomee@earthlink.net](mailto:sjomee@earthlink.net)>

> Subject: question To: [info@rn.com](mailto:info@rn.com)

> Good Evening,

> I am emailing to request permission to adapt your quiz that is

> associated with the Domestic Violence contact hour package. This is will be

used in my research study for my nursing PhD dissertation. Thank you.

Respectfully,

> Diana Meeks-Sjostrom     [sjomee@earthlink.net](mailto:sjomee@earthlink.net)

Appendix J

### Coding/Scoring of the Elder Abuse Vignette Instrument

Answers to the Elder Abuse Vignette instrument were developed based on the literature, the expert ED RNs, and elder abuse experts. Individual points for the identified assessment cues and nursing intervention responses were given equal weight. There will be no negative scores. Positive or correct vignette responses will be calculated into a total score. The greater the total score, the better able the RN is regarding assessing a patient for elder abuse.

Coding of the vignettes was based upon the appropriateness of the clinical decision-making of the RN. The detailed criterion for coding was established by the researcher after discussion with the dissertation Chair.

### Elder Abuse Vignette Coding Instructions

- 1b. 1 point – inability to care for self or do activities of daily living (ADLs)
- 1 point – son spends her money
- 1 point – does not get fed/nutritional issues
- 1 point – medications not bought and given
- 1 point – left alone
- Range 0-5 points. Five points being the maximum total score for this question.
- 1c. 1 point – internal notification of suspected abuse e.g. case manager, social worker
- 1 point – external notification of suspected abuse e.g. regulatory body or 911.
- Range 0-2 points. Two points being the maximum total score for this question.
- 1d. 1 point – neglect
- 1 point – psychosocial
- 1 point – financial



Range 0-3 points. Three being the maximum total score for this question.

Total possible score for Vignette #1 = 10 points.

- 2b. 1 point – daughter screams, slaps, and punches patient (verbal and /or physical abuse)

1 point – left alone (safety risk, neglect)

1 point – doesn't get medications

Range 0-3 points. Three points being the maximum total score for this question.

- 2c. 1 point – internal notification of suspected abuse e.g. case manager, social worker

1 point – external notification of suspected abuse e.g. regulatory body or 911.

Range 0-2 points. Two points being the maximum total score for this question.

- 2d. 1 point – neglect

1 point – physical

1 point – psychosocial

1 point – isolation

1 point – financial

Range 0-5. Five points being the maximum total score for this question.

Total score possible score for Vignette #2 =10 points.

- 3b. 1 point – no abuse

Range is 0-1. One point being the maximum total score for this question.

Total possible score for Vignette #3 is 1 point.

- 4b. 1 point – incontinence not addressed (skin breakdown, urinary tract infection/UTI, hygiene issues)

1 point – threatened to be sent to a nursing home (verbal abuse, made fun of)

1 point – unable to ambulate, left alone without help (neglect, no assistance with ADLs)

Range is 0-3 points. Three points being the maximum total score for this question.

4c. 1 point – internal notification of suspected abuse e.g. case manager, social worker

1 point – external notification of suspected abuse e.g. regulatory body or 911.

Range 0-2 points. Two points being the maximum total score for this question.

4d. 1 point – neglect

1 point – psychosocial

1 point – financial

1 point – isolation

Range is 0-4 points. Four points being the maximum total score for this question.

Total possible score for Vignette #4 is 9 points.

Final total maximum score for the four Vignettes is 30 points.

## Appendix K

## Elder Abuse Vignette Instrument Development

The author's area of study for this research project is the elder abuse, which is often detected in the ED. To assist with the assessment and clinical decision outcomes information, this vignette instrument was modified. Three vignettes came from the RN.com quiz and the content was adapted to reflect an ED setting. One vignette indicating no abuse was developed by the author for this research study to use as a baseline to evaluate whether RNs can distinguish what is and what is not elder abuse. To determine the usefulness of these vignettes, psychometric testing was done.

### Reliability Testing

The vignettes describe a scenario involving an elderly patient who presents in the ED and may exhibit possible signs and symptoms of abuse. Three vignettes describe elder abuse scenarios. One vignette does not suggest an elder abuse situation. The researcher determined if the RN used the correct dynamic and critical thinking process during the assessment of the patient (applied knowledge) to determine the need for interventions to address suspected abuse (clinical decision outcomes).

### Validity Testing

The vignettes have been developed purposely to evaluate the RNs assessment skills (applied knowledge) and intended interventions (clinical decision outcomes) to address suspected elder abuse. The vignettes have been reviewed for content validity by three RNs and one other individual with expertise in elder abuse. As well, a sample of ten ED RNs employed at an independent hospital completed the vignettes to identify any needed modifications to the instrument to enhance clarity and usefulness of the instrument.

A panel of experts consisting of three ED RNs and two experts in the field of elder abuse were used to determine content validity (CV) for the abuse knowledge survey and the elder abuse vignette instrument. The experts considered if the vignettes described abusive situations clearly, without using the words “elder abuse” to cue the participants. For scenarios one (Margaret) and two (Catherine), questions one and two, 100% of the experts felt the scenario reflected elder abuse and was clear, succinct, and thorough. For scenario three (Archie), question one, 50% indicated no reflection of abuse and for question two, 75% felt the scenario was clear, succinct, and very thorough. For scenario four (Ingrid), question one, 50% felt the scenario reflected elder abuse and 75% felt the scenario was clear, succinct, and very thorough. In the general question, 50% of the experts indicated the scenarios were very understandable and easy to respond to.

#### Content Validity of Assessment and Interventions – Elder Abuse Vignette Instrument

##### 1. Assessment of Patient

For the first scenario, 100% of the elder abuse experts identified inability to perform activities of daily living, needs a care giver, hasn't taken meds, dementia, son gambles money away, chest pain and shortness of breath related to congestive heart failure (CHF) in the assessment of the patient. One expert indicated they would like to know the role of the son.

##### Interventions

All experts agreed that the signs of CHF must be addressed first, then clean her, do a thorough screen for elder abuse, call the social worker or case manager, then adult protective services (APS).

##### 2. Assessment of Patient

For the second scenario, all experts felt there was an unreliable caregiver, verbal abuse and physical abuse were evident, and the patient was left alone often. Cognitive status and the status of the medications were assessed in 75% of the experts.

## Interventions

All experts felt a social worker or a case manager, and then Adult Protective Service (APS) should be called. Half of the experts stated to call the law enforcement and perform a thorough abuse screening. As well, the discharge plans should include promoting safety in 75% of the experts.

### 3. Assessment of Patient

All experts felt there were not many concerns except the fall precaution and as to why the patient lost balance. Issues of mobility and activities of daily living and the role of the care giver were questioned in 75% of the experts.

## Interventions

Initially after lab work, x-rays, pain medication, they would talk to the son to assess the home situation. Completing an abuse screen was indicated in 50% of the experts. Determining the role of the caregiver was stated by 75% of the experts.

### 4. Assessment of Patient

All of the experts indicated they would assess the skin breakdown, incontinence and the needs of the caregiver. Seventy-five percent of the experts indicated they would explore the caregiver's role further.

## Interventions

All of the experts indicated they would clean the perineal area, assess the skin, provide a diaper or Foley catheter (if needed), do necessary lab work, start an intravenous, etc, then call the social worker or case manager and APS. As well, 100% of the experts would educate the caregiver on how to assist the patient and how to access resources to assist with the cost of purchasing diapers. Fifty percent of the experts indicated they would complete an abuse screening on the patient.

The revised developed instrument was then sent out to the same convenience sample of 10 ED RNs to actually complete the elder abuse vignette survey indicating what they would expect to see as responses for the questions. Feedback from their responses to the questions and input from the dissertation chair resulted in the final elder abuse survey intervention.

Appendix L



Georgia State University  
Byrdine F. Lewis School of Nursing

Title: Emergency Nurses' Assessment of Elder Abuse  
Principal Investigator: Diana Meeks-Sjostrom, PhD, RN  
Cecelia Gatson Grindel, PhD, RN, FAAN

**Purpose:** You are invited to participate in a research study. The purpose of the study is to have a better understanding of emergency nurses' knowledge of elder abuse. You have been invited to participate because you are either a full-time, part-time, or prn emergency department nurse who works at one of the three study sites. A total of 140 participants will be recruited for this study. Completion of the surveys takes about 30-45 minutes.

**Procedure:** You are asked to complete four surveys on nurse's knowledge about elder abuse, your use of intuition, assessment for elder abuse, and a background form. You may choose to hand the completed surveys to the principal investigator or her designee immediately upon completion or you may choose to mail the completed surveys directly to the researcher in the self-addressed, stamped envelope provided to you. If you choose to mail the survey to the researchers, you will be asked to complete and mail the survey within one week. You will have a quiet area on your unit to complete the surveys if you chose to complete them right away. When you complete and return all surveys, you will be given a \$10 gift card. If you mail the survey, you will be asked to include a separate sheet of paper with your name and mailing address for the researcher to mail the gift card.

**Risks:** In this study, you should not have any more risks that you would in a normal day of life. However, there may be some anxiety when responding to elder abuse questions if there was a previous experience related to elder abuse. If required, there are psychological and Chaplin services available on-site at your organization, free of charge.

**Benefits:** There is no direct benefit to you for participating in the study; however, participants will be contributing to the body of nursing knowledge regarding nursing assessment of elder abuse.

**Voluntary Participation and Withdrawal:** By completing and returning the surveys, informed consent will be implied. Your participation in the study is voluntary and you may discontinue your involvement at anytime without consequences to your employment. You may skip questions or stop participating at any time. Whatever you decide, you will not lose any benefits to which you are otherwise entitled.

**Confidentiality:** We will keep your records private to the extent allowed by law. Your name will not be associated with the surveys. If you mail your survey, the sheet of paper with your name and address will be destroyed once the researcher has mailed the gift card. All completed surveys will be kept by the researcher in a locked cabinet at her home and destroyed after 7 years. When we present this study or publish its results, you will not be identified personally. The results will be summarized and reported in group form.

**Contact Persons:** For any questions please contact Diana Meeks-Sjostrom (770-402-3973) or Dr. Cecelia Grindel (404-413-1167). If you have any questions or concerns about your rights as a participant, you may contact Sue Vogtner (404-413-3513) in the Office of Research Integrity.

Appendix M



INSTITUTIONAL REVIEW BOARD

Mail: P.O. Box 3999

In Person: Alumni Hall

Atlanta, Georgia 30302-3999

30 Courtland St, Suite 217

Phone: 404/463-0674

Fax: 404/654-5838

July 16, 2007

Principal Investigator: Grindel, Cecelia Marie

Student PI: Diana Meeks-Sjostrom

Protocol Department: B.F. Lewis School of Nursing

Protocol Title: Clinical Decision-Making of Nurses Regarding Elder Abuse

Submission Type: Protocol H08013

Review Type: Exempt Review

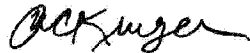
Approval Date: July 15, 2007

The Georgia State University Institutional Review Board (IRB) reviewed and approved your IRB protocol entitled Clinical Decision-Making of Nurses Regarding Elder Abuse. The approval date is listed above.

Exempt protocols do not require yearly renewal. However, if any changes occur in the protocol that would change the category of review, you must re-submit the protocol for IRB review. When the protocol is complete, a Study Closure Form must be submitted to the IRB.

Any adverse reactions or problems resulting from this investigation must be reported immediately to the University Institutional Review Board. For more information, please visit our website at [www.gsu.edu/irb](http://www.gsu.edu/irb).

Sincerely,

A handwritten signature in black ink, appearing to read "Ann C. Kruger".

Ann C. Kruger, IRB Chair

Federal Wide Assurance Number: 00000129

Appendix N



June 18, 2007

Diana Meeks-Sjostrom, PhD, MSN, RN  
5665 Peachtree Dunwoody Road  
Atlanta, GA 30342

**RE: NOTIFICATION OF PROTOCOL APPROVAL**

**027-07-1** Clinical decision-making of nurses regarding elder abuse

**Review Type: Expedited**

Items Reviewed:

Protocol (no date specified) including Knowledge of Elder Abuse Survey, Intuition Use in Nursing Scale, Demographic Information Form and Elder Abuse Vignette and Cover Letter for Elder Abuse Research Study  
Consent form dated 3/2007

Dear Dr. Meeks-Sjostrom:

As Chairman of the Institutional Review Board (IRB) I have reviewed the above-referenced protocol and granted approval in accordance with specific expedited review criteria. In compliance with Federal Regulations [21 CFR 56.109 (e); 45 CFR 46.109 (d)] this letter serves as your administrative notification of the IRB's determination.

**This approval is valid from 6/6/07 to 6/5/08.**

Federal regulations require that the IRB review each research project at least annually. Prior to the expiration date listed above, or upon completion of your research project, a report will need to be submitted to the IRB that addresses the following points:

1. The current status of the investigation (completed or continuing);
2. A description of the experience of the subjects, including adverse reactions, complications, benefits and/or withdrawals from the study;
3. A summary of the research results thus far;
4. A current assessment of the risks and benefits based on study results, including any new information that has come to light since the IRB's last review;
5. A copy of the current consent form.

Approximately four to six weeks in advance of the due date, you will receive a friendly reminder from the IRB office. Failure to receive notification from the IRB office will not alleviate you of your responsibility to ensure compliance with Federal Regulations regarding continuing review (See 21 CFR 56.109 (f) and 45 CFR 46.109 (e)). You should be aware that if the report is delinquent it is IRB policy to close the study.

Appendix O





May 29, 2007

Diana M. Meeks-Sjostrom  
3363 Preakness Court  
Marietta, GA 30062

**Study Title: Clinical Decision-Making of Nurses Regarding Elder Abuse**

**Type Review: Expedited**  
**Expiration Date: May 29, 2008**  
**Re-Approval and Progress Report Due: April 2008**

Dear Ms Meeks-Sjostrom:

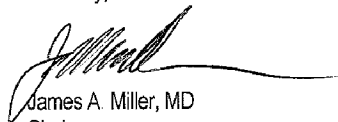
The above captioned data collection study (no date indicated), including Knowledge of Elder Abuse Survey, Intuition Use in Nursing Survey, Demographic Form, and Elder Abuse Vignettes, has been approved through expedited review for use at St. Joseph's/Candler Health System, Inc. Your study will be presented for information purposes to the full IRB at their meeting. Due to the minimal risk nature of the study and the fact that no survey identifiable data or patient identifiable data will be collected, the IRB has waived informed consent for the study.

Your study will be due for re-approval and a progress report in April 2008. If your study concludes before the above due date, please send a letter of closure, progress report, and summary of findings (if available) to the address listed below.

In the interim, please provide the IRB with any information concerning any significant adverse event, whether or not it is believed to be related to the study, within five working days of notification of the event. You may send this information to the address listed below.

**Please refer to IRB# SC-07-020 on all correspondence relating to this study.**

Sincerely,



James A. Miller, MD  
Chairman  
Institutional Review Board

**St. Joseph's Hospital**  
11705 Mercy Boulevard  
Savannah, Georgia 31419  
(912) 819-4100

**Candler Hospital**  
5353 Reynolds Street  
Savannah, Georgia 31405  
(912) 819-6000

*St. Joseph's/Candler is the recipient of the National Magnet Award for Nursing Excellence.  
[www.sjchs.org](http://www.sjchs.org)*