EAO Webinar

The information and opinions expressed here today are not necessarily those of the Government of Ontario

Ethical Considerations in Responding to Elder Abuse

March 30th 2017

Presented by: Blair Henry, MTS, D. Bioethics
Senior Ethicist, Ethics Centre, Sunnybrook Health Sciences
Assistant Professor, DFCM, University of Toronto

Elder Abuse Ontario
Stop Abuse - Restore Respect

Ontario

Welcome to EAO's Webinar!

All attendees will be muted during the webinar.

If you are experiencing issues, please type into the CHAT/QUESTION BOX and send message to Mary Mead/Raeann Rideout.

There will be 15-20 minutes allocated at the end presentation for QUESTIONS AND ANSWERS.

You will be prompted to fill out an EVALUATION FORM once the session has ended. Please fill out the form as your feedback will guide us for our future webinars. You will also receive an email link to the evaluation after the session.

Speaker CONTACT INFORMATION will be provided at the end of the presentation to connect directly if you have further questions.

Elder Abuse Ontario
Stop Abuse - Restore Respect

Elder Abuse Ontario (EAO)

- ✓ Not-for-profit charitable organization
- ✓ Established in 1990
- ✓ Funded by the Province of Ontario, under the Ministry of Seniors Affairs

Mission: Create an Ontario where all seniors are free from abuse through awareness, education, training, collaboration, service co-ordination and advocacy.

EAO oversees the Implementation of Ontario's Strategy to Combat Elder Abuse

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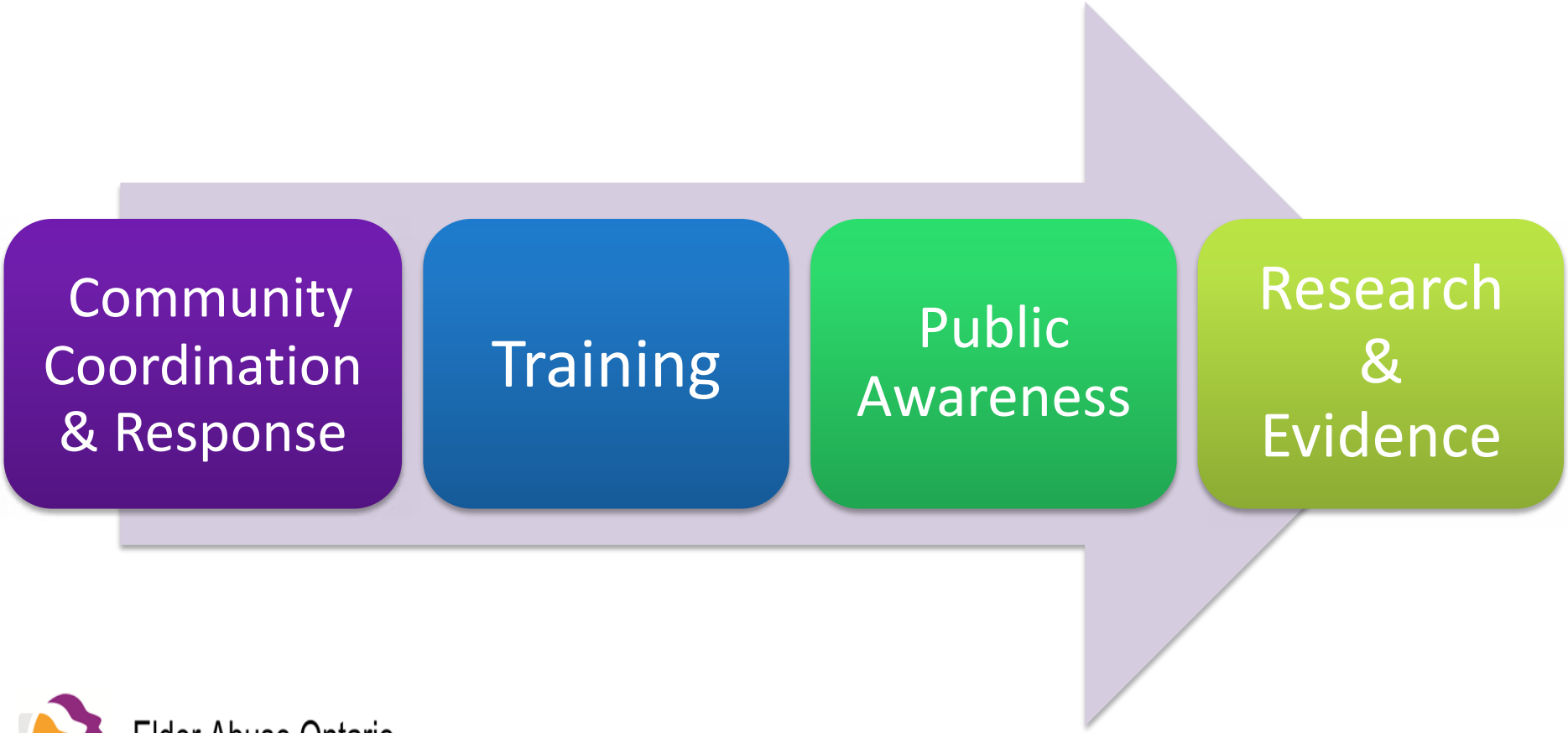
Elder Abuse Ontario
Stop Abuse - Restore Respect

Ontario's Strategy to Combat Elder Abuse

Comprised of 3 Major Priorities



Elder Abuse Ontario
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Elder Abuse Ontario (EAO)

- ✓ **7 Regional Consultants in Ontario** (Thunder Bay, Sudbury, Woodstock, Mississauga, Toronto, Peterborough, and Ottawa)
- ✓ Francophone
- ✓ Key resources for providing consultation on elder abuse cases to review options and resources for intervention.
- ✓ Consultants DO NOT act as case managers for cases of abuse.

- ✓ Support over 50 local Elder Abuse Committees/Networks
- ✓ Strengthen partnerships between these committees and other health/social service agencies to enhance the response to elder abuse.
- ✓ Develop and implement training materials, tools and resources for elder abuse prevention and intervention.

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Community Coordination

Elder Abuse Ontario (EAO) continues to offer webinars to elder abuse networks and community stakeholders to support knowledge sharing opportunities and to build capacity to respond and intervene in cases of elder abuse.

EAO partners and supports many organizations in the prevention and intervention of Elder Abuse. EAO has leveraged partnerships between agencies and hospitals to develop policies and procedures to assist older adults as well as consult on complex cases, in which ethical decisions are encountered.

We thank Blair Henry for providing his expertise in this field of ethics, to further our understanding of these ethical considerations.

Presenter: Blair Henry

Blair Henry, holds a Doctor of Bioethics from Loyola University and is a senior ethicist with the Ethics Centre at Sunnybrook Health Sciences. He also holds an academic appointment as Assistant Professor for the Department of Family and Community Medicine at the University of Toronto.

Following the completion of a Fellowship and Senior Fellowship in Clinical, Organizational and Research Ethics through the Joint Center for Bioethics at the University of Toronto (2005- 2007), he has been working at Sunnybrook since 2007. Prior to working in the field of ethics, he worked as a case manager for a hospice organization for 10 years.

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Learning Objectives

- To use ethical decision making principles when providing intervention in elder abuse situations.
- Balancing an older adult's rights to safety and health care when living in an abusive situation.
- Understanding the ethical dilemmas of an older adults decision making when capacity and competency fluctuates due to health or illness.
- Understanding the ethical principles of reporting elder abuse situations in community, given the obligations of mandatory reporting are only required in Care Facilities.

Ethical Considerations in Responding to Elder Abuse Part 2

Blair Henry D. Bioethics
Senior Ethicist
NYGH & SHSC

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March 30, 2017 Webinar Series

But first things first!

I have got no conflict of interest to declare.

Statistics Reporting Caveat

Whose on the line?

- ❑ Profession
- ❑ Location

Road Map for this session

- ✓ Elder abuse tools
- ✓ Elder abuse cases
- ✓ Ethics…..
- ✓ “Lets talk about it…”

Assisted Living Facility

An 86-year-old male is transferred to the emergency department from an assisted living facility with a heart rate of 50, palpitations, confusion, nausea and vomiting, and low urine output. You obtain a list of his medications from the facility: digoxin 1.25 mg PO daily, hydrochlorothiazide (HCTZ) 100 mg PO daily, and Verapamil extended release 120 mg PO daily.

You call his primary care physician to verify medications and learn the patient was prescribed 0.125 mg digoxin 7 days ago.

How should we proceed?

It is estimated that 1 in 10 older adults experience abuse, but only 1 in 5 to as little as 1 in 24 cases are reported. Elder abuse is expected to increase as the population ages. Nurses are in a prime position to identify, assess, manage, and prevent elder abuse.

Elder Abuse: Speak out for justice.
JCN/Volume 31, Number 1

Caution: Politically sensitive information forthcoming

These represent the views of the writer only.

Public Abuse of Seniors

The inequitable distribution of funds for aged care and the onerous responsibility thrust onto families, who generally receive insufficient support in the caring role. This raises a number of potential ethical dilemmas in caring for seniors, and the perpetuation these inequalities is a major form of elder abuse which must be recognized and addressed if we are ever going to be able to tackle the more private domestic issues of the abuse of seniors.

Many older caregivers are themselves victims of the public abuse of seniors. Community care appears to be a euphemism for family care and family care is usually care by women who most often reduce themselves to a dependent state in order to provide it.

Its been said that 94 per cent of the aged who live in the community receive only 10 per cent of the funds.

Social Abuse of Seniors

We live in a society where one in five people condones violence of some degree toward women; it appears only natural that there should be an acceptance of violence toward older people, the great majority of whom are female.

This is the same society which considers violence within the domestic sphere to be a private family matter. Parents who "had to be cruel to be kind". As unacceptable childhood behavior is often controlled by physical means, many seniors accept the moral rightness of physical force.

To this end, the acceptance of force can become so internalized by elderly victims, they feel the punishment must have been deserved and is therefore warranted.

Family Abuse of Seniors

A majority of the abuse of seniors occurs within the private sphere of the family home. In many cases, the abuser is both a relative and a co-resident of the older person for whom they have some caregiving responsibility.

Abuse is most prevalent in cases where the senior at risk lives with their primary carer, where more than one generation live together, and where the senior is dependent on the carer for physical care, emotional support or financial security.

Dealing with elder abuse within the family relationship can become very complex, especially in cases where the abuse is a continuation of domestic violence, where it is the it may well be that is is the frail relative who abuses their carer or where they abuse one another. Just because they are "family" does not guarantee efficient or compassionate care.

Types and Definitions of Elder Abuse

Type of Abuse	Definition	How Abuse May Present
Financial exploitation/abuse	Theft or misuse of money, assets or belongings including fraud	Missing money/belongings; deficient care despite ample resources; overprovision of services
Neglect	Failure of a caregiver to provide basic physical and emotional needs including abandonment (left without care)	Malnutrition, dehydration, unkempt, dirty or unsafe living conditions, untreated health issues
Psychological/ emotional abuse	Intentional social isolation or use of demeaning verbal statements or threats meant to produce mental distress or fear	Depression, withdrawal, agitation, poor interaction/ response with caregivers
Physical abuse	The threat or infliction of bodily harm by use of physical force	Unexplained injuries, bruising, burns, bumps, scrapes, etc.
Sexual abuse	Threatening or forcing participation in sexual acts or contact without consent	Injuries to genital or breast areas; unexplainable vaginal or anal bleeding

Sources: Fulmer and Caceres (2012), Hess (2011), NCEA (n.d.-a), and IAFN (2006).

Theories Associated with the Incidence of Abuse	
Theory of Abuse	Explanation
Trans generational/ social learning theory	Abuse is described as a learned behavior: an individual who witnessed violence at a young age as a method of coping with stressful situations is more likely to utilize violence in similar situations.
Situational Theory	The probability of elder abuse perpetrated by a caregiver is proportional to the perceived burden of caregiving.
Exchange theory	The incidence of abuse is classified in terms of a combination of reliance of the older adult on a caregiver (increased burden) and a history of ineffective coping methods.
Political economic theory	Abuse is more likely to occur when an older adult is forced to find a caregiver or other support after a financial loss or a decrease in the level of independence.
Risk-vulnerability model	The interplay of risks (external environmental factors) and vulnerabilities (physical, emotional, mental, social, and spiritual) increases the likelihood of abuse incidence.
Psychopathology of the caregiver	The focus for risk of abuse is on the caregiver who has emotional or mental health issues (including addiction) especially in combination with an older adult experiencing cognitive and mental health issues.

Sources: Muehlbauer and Crane (2006), Fulmer and Caceres (2012), and Sellas and Krouse (2011).

Standardized Elder Abuse Assessment Tools	
Type	**Standardized Assessments**
Violence Screen	Actual Abuse Tool Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST) Partner Violence Screen (PVS) Questions to Elicit Elder Abuse Screen for Various Types of Abuse or Neglect
Physical Assessment	Elder Assessment Instrument (EAI) Suspected Abuse Tool
Risk Assessment	Brief Abuse Screen for the Elderly (BASE) Elder Abuse Suspicion Index (EASI) Elder Assessment Instrument (EAI) Health, Attitudes Toward Aging, Living Arrangements, and Finances (HALF) Indicators of Abuse (IOA, E-IOA) Risk of Abuse Tool Vulnerability to Abuse Screening Tool (VASS)
Caregiver Strain	Caregiver Abuse Screen (CASE) The Modified Caregiver Strain Index (CSI)

Sources: Cohen et al. (2007), Fulmer and Caceres (2012), and University of Iowa Carver College of Medicine (n.d.).

Sample Violence and Risk Assessment Questions

- Do you feel safe where you are living?
- Are you ever alone frequently or for long periods of time?
- Has anyone failed to assist when you needed help?
- Has anyone ever yelled at you or threatened you?
- Has anyone ever made you do something that you did not want to do?
- Has anyone hurt, or tried, to hurt you?
- Is there anybody that you afraid of?
- Does someone provide care for you regularly?
- Does your caregiver abuse drugs/alcohol?
- Was your caregiver abused as a child?
- Were you abused as a child?
- Who manages your finances?
- Have you ever signed a document that you did not understand?
- Has anyone taken away something that was yours?

Sources: Fulmer and Caceres (2012), NCEA (n.d.-a), IAFN (2006), and Ziminski and Phillips (2011).

Epidemiological data on Elder Abuse

Median age of the victim 76.5 yr
Elders over 80 are abuse 2-3 times more often
50% were physically dependent on others
Females are abused more than males
90% of abusers were family members

Hospitals reported 17% and community workers only 8-10%

Mortality Rates

Elder Abuse results in unnecessary suffering, injury, pain, decreased quality of life, and loss or violation of human rights.

A longitudinal study showed that in the 13th year following the initiation of the study, 40% of the non-reported, that is, the non-abused or non-neglected, group was still alive, versus 17% of those seen for self-neglect, while only 9% of those seen for elder mistreatment were still living.

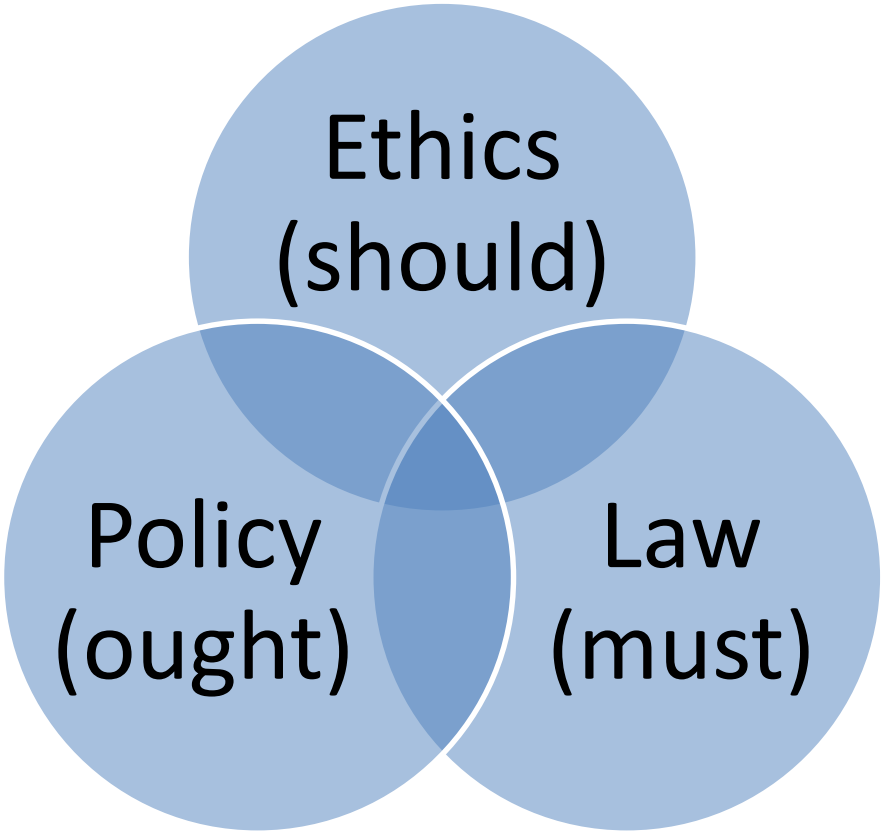
These figures were adjusted to account for all possible factors that might affect mortality including age, gender, income, functional status, cognitive status, diagnosis, and social support.

Three major causes generic to the problem of low reporting of any form of family violence:

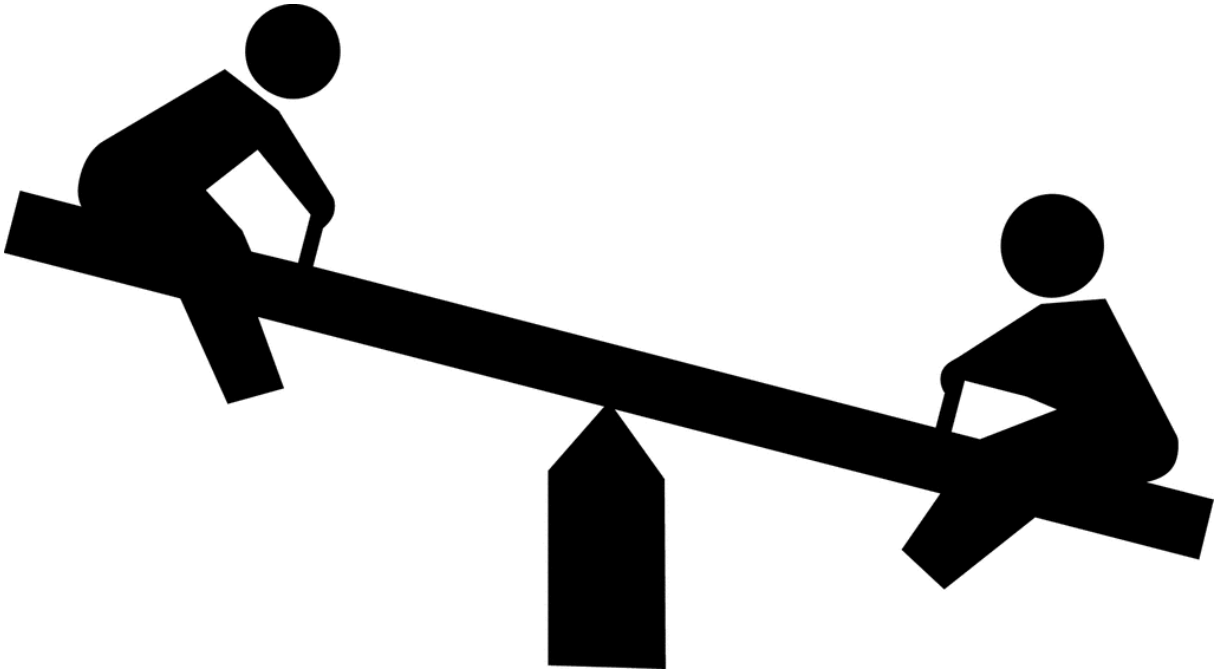
- clinical and academic discomfort
- time and reimbursement constraints,
- perceived impotence

Did you participate in the Part 1 of this webinar?

- ❑ Yes
- ❑ No


Ethics
(should)
Policy
(ought)
Law
(must)

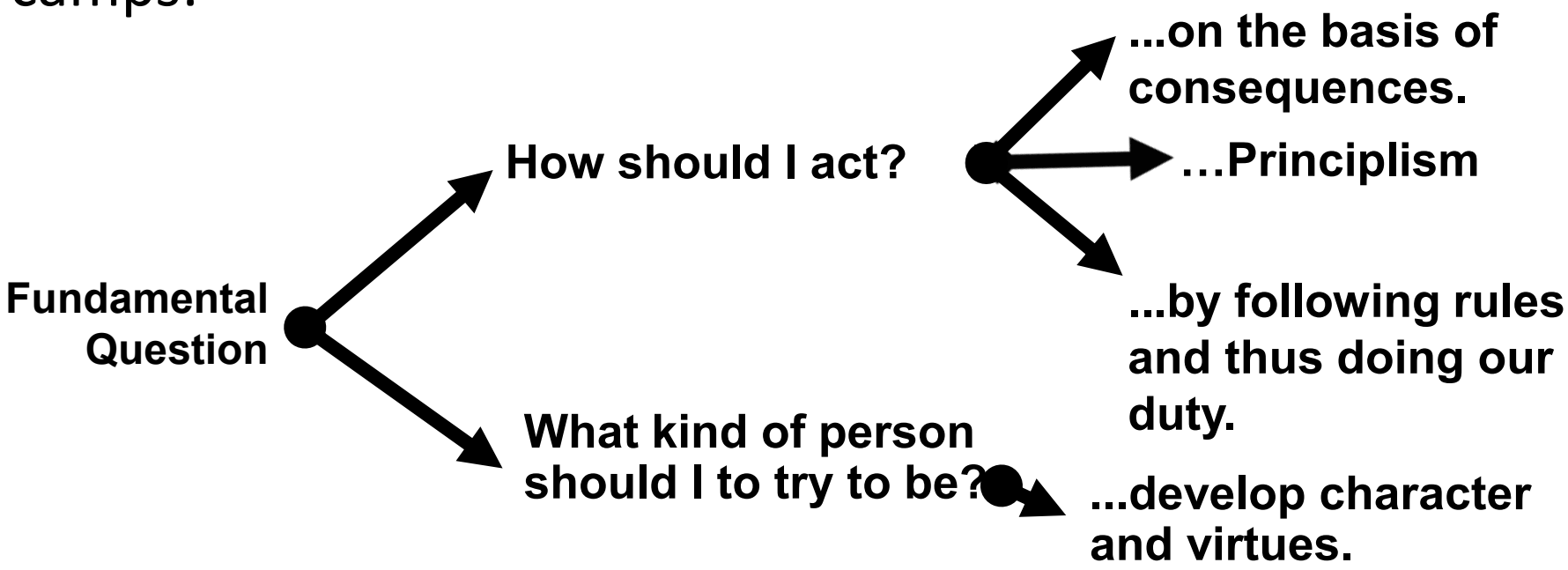
Values Clash



The challenge for health care professionals is to balance the duty to protect the safety of the vulnerable elder with the elder's right to self-determination

The Basic Question of Ethics

- Historically, philosophers have disagreed about what the basic question of ethics is. They fall into two camps:



There are four main approaches to ethics:

- ❑ **Consequence-based approaches**
- ❑ **Principle Based ethics**
- ❑ **Rule-based approaches**
- ❑ **Character-based approaches**

The first two approaches address the question of how we ought to act, the third approach responds to the question of what kind of person we should be.

Ethical Theories: A Very Brief Overview. Phil. 334-04: Ethics @ the Frontiers of Science & Technology. Spring, 2012 Lawrence M. Hinman, Professor of Philosophy University of San Diego

How/Who should we be in the world?

virtue (noun)

a beneficial quality, feature or trait leading to excellence; advantage or goodness

What would you say are the necessary virtue needed for you to do the job that you do?
Or think about writing a reference letter to a trusted friend applying for the job GEM Nurse- what would you say about that person in your letter?

VIRTUES: THE GIFTS OF CHARACTER

Acceptance
Accountability
Appreciation
Assertiveness
Awe
Beauty
Caring
Certitude
Charity
Cheerfulness
Cleanliness
Commitment
Compassion
Confidence
Consideration
Contentment
Cooperation
Courage
Courtesy
Creativity
Decisiveness
Detachment
Determination
Devotion
Dignity
Diligence
Discernment
Empathy
Endurance
Enthusiasm
Excellence
Fairness
Faith
Faithfulness
Fidelity
Flexibility
Forbearance
Forgiveness
Fortitude
Friendliness
Generosity
Gentleness
Grace
Gratitude
Helpfulness
Honesty
Honor
Hope
Humanity
Humility
Idealism
Independence
Initiative
Integrity
Joyfulness
Justice
Kindness
Love
Loyalty
Mercy
Mindfulness
Moderation
Modesty
Nobility
Openness
Optimism
Orderliness
Patience
Peacefulness
Perceptiveness
Perseverance
Prayerfulness
Purity
Purposefulness
Reliability
Resilience
Respect
Responsibility
Reverence
Righteousness
Sacrifice
Self-discipline
Serenity
Service
Simplicity
Sincerity
Steadfastness
Strength
Tact
Thankfulness
Thoughtfulness
Tolerance
Trust
Trustworthiness
Truthfulness
Understanding
Unity
Wisdom
Wonder
Zeal


virtue ethics
courage
theorizing
contrast
disagreement
conception
concept
postmodern
theorists
theory
deal
morally
notion
turn
utilitarianism
moral
polis
abstain
appears
anarchism
hermeneutical
servile
lie
means
purpose
prominent
human
proper
humanistic
objection
consequences
postulating
ascendancy
normative
thought
society
duty
notably
fortitude
action
ethos
wisdom
rightness
proposed
virtuous
origins
ethics
vice
exponent
words
teleology
emphasize
intellectual
jurisprudence
desirable
term
ancient
abolitionist
phenomenology
distinction
morality
contention
tradition
respond
rashness
blessedness
murder
epistemology
ethical
character
modern
ethicists
beings
emphasis
behavior
adhere
seminal
important
wrongness
moralistic
impermissible
classical
political
happiness
interrelation
constitutional
good
embodies
paralleled
temperance
philosophical
racehorse
philosophy
conflated
republicans
virtue
predominant
relativism

Virtue Based (Character-based) Ethics

- **Fundamental Question:** What kind of person do I want to be?
- **Emphasizes strengths of character necessary to human flourishing**
  - Example: courage
- Emphasizes flexibility of rules for new situations

Detail from facing page: Plato the teacher, in the likeness of Leonardo da Vinci and holding his *Timaeus*, strides alongside Aristotle, his greatest pupil, on our right and holding his great work: *The Ethics*.

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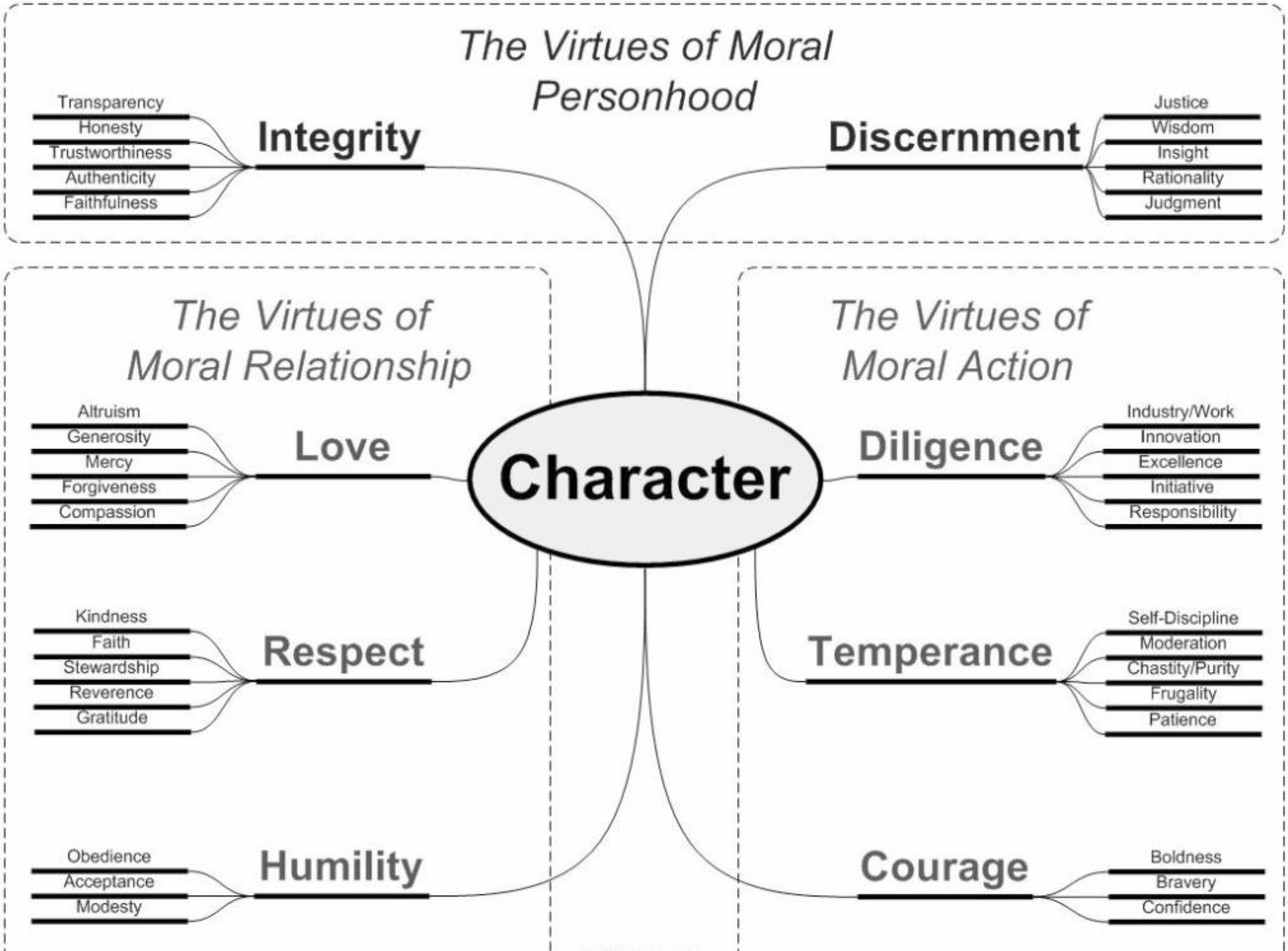
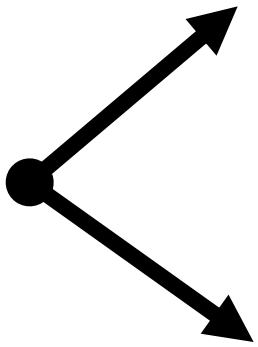

The Virtues of Moral Personhood
Integrity
Transparency
Honesty
Trustworthiness
Authenticity
Faithfulness
Discernment
Justice
Wisdom
Insight
Rationality
Judgment
The Virtues of Moral Relationship
Love
Altruism
Generosity
Mercy
Forgiveness
Compassion
Respect
Kindness
Faith
Stewardship
Reverence
Gratitude
Humility
Obedience
Acceptance
Modesty
Character
The Virtues of Moral Action
Diligence
Industry/Work
Innovation
Excellence
Initiative
Responsibility
Temperance
Self-Discipline
Moderation
Chastity/Purity
Frugality
Patience
Courage
Boldness
Bravery
Confidence

Act-oriented Approaches

- **There are two basic ways of answer the question, "How should I act?"**

Act-oriented approaches



Consequentialism:

- **Look at the consequences and choose the action that has the best consequences**

Deontology:

- **Look at the rules and follow the rules (ten commandments, duty, human rights, justice).**

Rule-oriented Approaches

- Numerous approaches have one thing in common: **rules trump consequences**.
- No matter how much good might be accomplished, you cannot break the rules
- **Examples of rule-oriented approaches:**
- **The Golden Rule**
- **Human Rights**
- **Justice**
- **Kant & Deontology**
- **Ten Commandments**

Consequences for whom?

For whom?	Name of Position
Just for me	Egoism
Just for my group •Family •Country •Religion	Group consequentialism
For everyone •All human beings •All sentient beings	Utilitarianism

What Are Ethical Principles, and How Do They Help With Decision Making?

Ethical Principles

Conflict is inevitable. Ethical principles provide the framework/ tools which may facilitate individuals and society to resolve conflict in a fair, just and moral manner.

Autonomy

Autonomy is vital to seniors, if they are to retain their dignity and enjoy the freedom, rights and choices they are entitled to as first-class citizens. Included is the assumption that no community worker will deal with a senior without their full involvement and informed consent. Autonomy also requires community workers to treat clients with respect, to honor their rights and freedom of choice, and to ensure that seniors are in full control of all decisions which affect their health and well-being.

William ME. The Ethical Challenges of Elder Abuse. Medscape Published March 23, 2017Accessed at: http://www.medscape.org/viewarticle/532943

Nonmaleficence

No harm means that no action should cause any hurt to a senior. This maxim requires that all interventions be carefully considered to ensure no harm occurs to any of the parties involved, especially to the elderly victim of abuse. Because the actions of community workers have the potential to harm a client, these workers have an added responsibility to ensure their actions do not contravene the client's wishes or best interests. This ideal, which is also known as "non maleficence", is closely tied to Justice is an essential component of dealings with any client, regardless of their age or the nature of their problem.

William ME. The Ethical Challenges of Elder Abuse. Medscape Published March 23, 2017Accessed at: http://www.medscape.org/viewarticle/532943

Beneficence

The ideal of "beneficence“ which states that not only should actions not cause harm, they should also be directed toward doing good. Although there are difficulties in defining what is meant by the term "doing good", if workers carefully consider what benefit their client will receive from interventions, their actions will tend to enhance rather than harm client well-being.

William ME. The Ethical Challenges of Elder Abuse. Medscape Published March 23, 2017Accessed at: http://www.medscape.org/viewarticle/532943

Justice

In elder abuse cases, justice demands that actions are fair and equitable, whether they be between a victim, and a perpetrator or the family or between the family unit and the bureaucracy.

William ME. The Ethical Challenges of Elder Abuse. Medscape Published March 23, 2017Accessed at: http://www.medscape.org/viewarticle/532943

Hip Fracture Complications

A previously ambulatory, home-dwelling 79-year-old female is admitted to the hospital with a hip fracture. After hip repair, she is confused and persistently yells and tries to get out of bed. Haloperidol (Haldol) is prescribed and family stay as much as possible. After weeks of hospitalization and rehabilitation, the patient is better but remains agitated at times and on Haldol. After numerous attempts to discontinue her urinary catheter, she remains catheterized. You note she is restless, grimaces constantly, and moves her arms, fingers, and legs; walking is impossible because of her persistent movement. She is discharged to a long-term care facility non-ambulatory, with a urinary catheter and prescribed Haldol.

How should we proceed?

Olsen JM, Hoglund B. Elder Abuse: Speak out for Justice. 2014, JCN; 31(1): 14-21

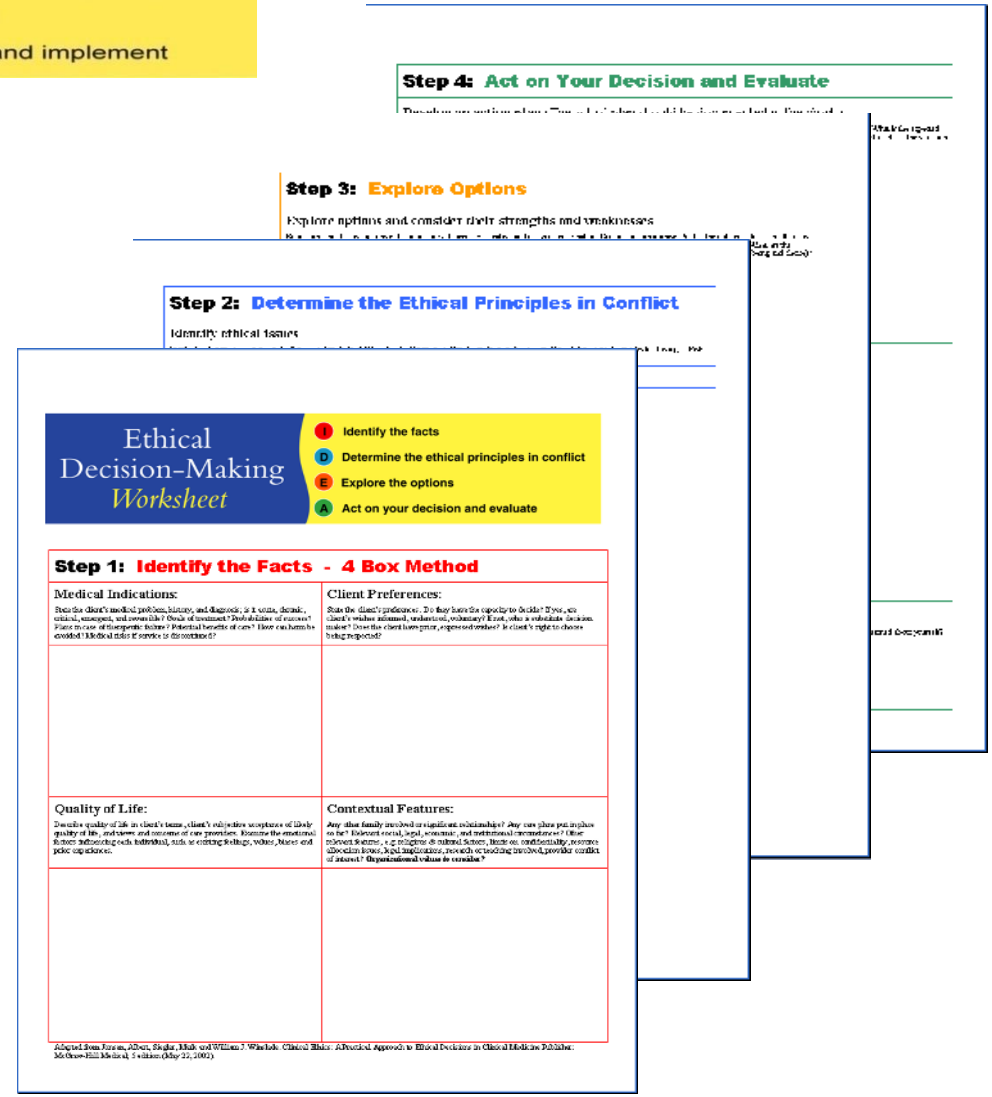
When and how to use principlism?

"IDEA" Framework

Ethics Worksheet

- I — Identify the facts
- D — Determine relevant ethical principles
- E — Explore the options
- A — Act - Recommend and implement

- Step-by-step tool
- Common language
- Assists in deciding what we should do, why & how we should do it
- Facilitates systematic discussion of ethical issues
- Focuses discussion



Illustrative Case :

- After recovering from a hip fracture suffered from a fall at home , a resident in his late 70’s is ready for discharge and adamantly wants to go home.
- Patient has a long history of obsessive compulsive behaviors and has hoarding issues that pose safety and mobility challenges for patient and home health workers
- However, prior to his fall he was living at home independently
- Patient has symptoms of early onset vascular dementia.
- Patient has two adult children but their relationship is strained as of late as they are “fed up” of dealing with him and do not have the time or resources to help him at home.
- The children want their father to go to a long-term care home and the team is not confident that the patient is capable

Step 1: Identify the Relevant Facts:

- *What is the presenting ethical issue(s)?*
- *What are the relevant medical indications?*
- *What are the patient(s) preferences?*
- *What is the evidence?*
- *What are the contextual features?*
- *What is the ethical issue?*

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- *What is the evidence?*
- *What are the contextual features?*
- *What is the ethical issue?*

- Is the patient capable? Team effectuating a safe d/c
- OCD/hoarding issues and early vascular dementia
- Patient wants to go home
- Capacity assessment?
- Family does not want him to go home. How much did family help previously when living independently?
- Is patient capable?

Step 2: Determine the Ethical Principles:

- *Who are the stakeholders (relevant parties)?*
- *What values/principles does each (stakeholder) believe are relevant to the issue?*
- *Which values/principles do stakeholders agree are most important in the current context?*
- *Are there any other factors that need to be considered?*
- *Have perspectives of relevant groups or individuals been sought?*

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- Patient, family/children, HCT, CCAC
- Autonomy (patient); harm, fatigue (family) liability, welfare, do no harm (HCT)
- Supporting patient autonomy
- CCAC supports, patient/family's ability for private pay, etc.
- Typically would be done in a team-family mtg.

Step 3: Explore the Options:

- *Identify ALL options (even options that might have limitations or seem unfeasible)*
- *What are the strengths/benefits of each option?*
- *What are the limitations/harm of each option?*
- *What is the most ethically justifiable option?*

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- *Identify ALL options (even options that might have limitations or seem unfeasible)*
- *What are the strengths/benefits of each option?*
- *What are the limitations/harm of each option?*
- *What is the most ethically justifiable option?*

- Option 1: Determining that patient is capable; d/c home with supports
  - Patient is capable to me own decision but will not likely have family support
- Option 2: Patient is incapable; children consent to LTCH placement
  - Patient is in safe environment and needs will be met
  - Risk of depression
- Option 3: patient is incapable but are able to facilitate safe discharge home
  - Still respecting patient's wishes
  - Not enough support so could be risky or unsafe
- Most ethically justifiable option: depends on patient's capacity

Step 4: Act:

- *Documentation/Communication of Decision (who, what, where, how)*
- *Implementation Plan*
- *Evaluation Plan*
- *Are we (am I) comfortable with this decision?*

- Identify who would relay along decision to patient & family and document
- Clearly identify implementation plan, e.g. connecting with CCAC or placement coordinator
- How do you/team/patient feel about the decision?

The role of the nurse in managing abuse is to:

- **provide an accurate assessment of abuse and risk factors for abuse;**
- **clearly and objectively document assessment findings;**
- **report suspected incidents of abuse**

and participate in investigation as appropriate;

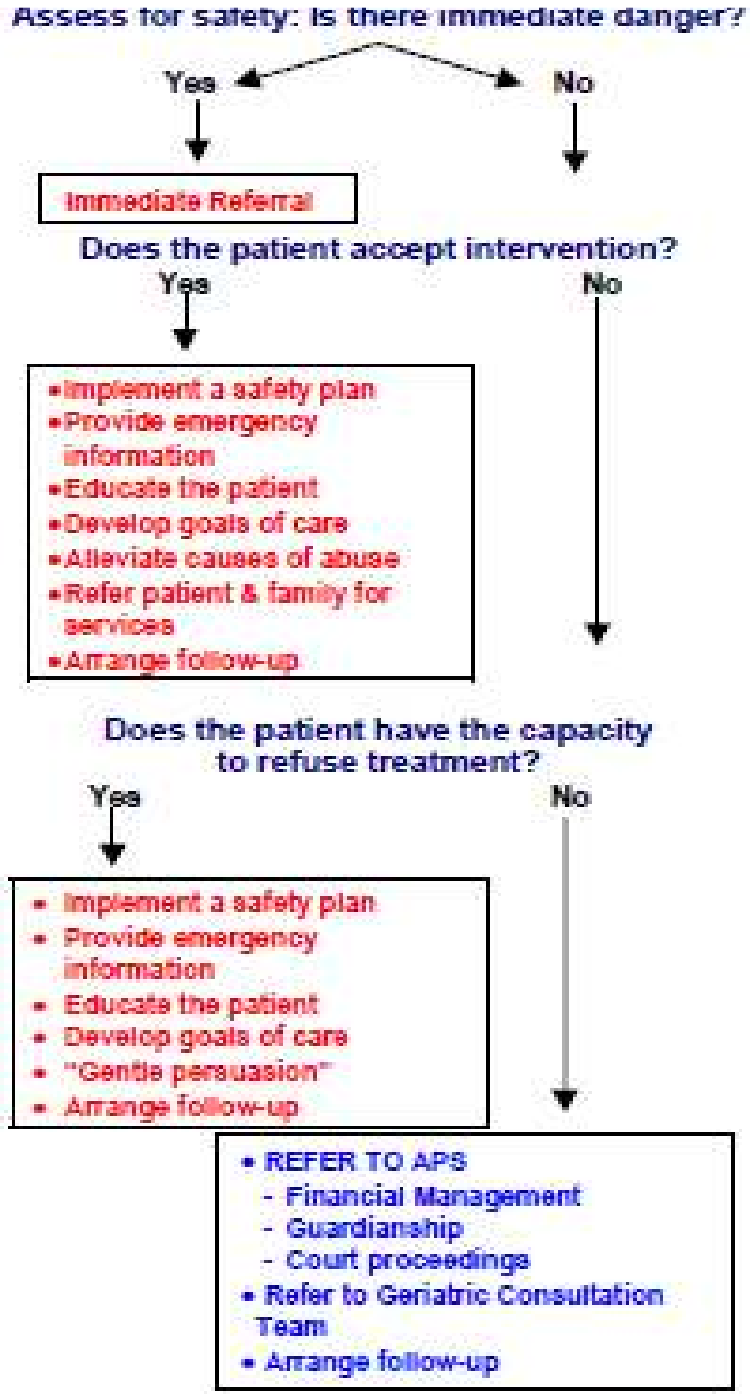
- **provide support and referrals for clients experiencing potential or actual abuse; and implement strategies to prevent elder abuse.**

Bomba PA. Use of a single page elder abuse assessment and management tool: a practical clinician's approach to identifying elder mistreatment. J Gerontol Soc Work. 2006;46(3-4):103-22.

The principles are based on the right of older adults and include

- The right to be safe
- The right to retain civil and constitutional rights, unless restricted by the courts
- The right to make decisions th do not conform to social norms no harm is brought to others
- The assumption that decision-making capacity is present, unle the courts decide otherwise and
- The older adult may accept or refuse services.

Bomba PA. Use of a single page elder abuse assessment and management tool: a practical clinician's approach to identifying elder mistreatment. J Gerontol Soc Work. 2006;46(3-4):103-22.



Principles of Assessment and Management of Elder Abuse

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* Should be the basic structure of most Elder Abuse Policies

Bomba PA. Use of a single page elder abuse assessment and management tool: a practical clinician's approach to identifying elder mistreatment. J Gerontol Soc Work. 2006;46(3-4):103-22.

Best Practice

- First, DO NO HARM
- The interest of the senior is the priority
- Avoid imposing your personal values
- Respect diversity
- Involve the senior in the plan of care
- Establish short-term and long-term goals of care
- Recognize the senior's right to make choices
- Use family and informal support
- Recommend community-based services before institutional-based services, whenever possible
- In the absence of known wishes, act in the best interest and use substituted judgment.

Bomba PA. Use of a single page elder abuse assessment and management tool: a practical clinician's approach to identifying elder mistreatment. J Gerontol Soc Work. 2006;46(3-4):103-22.

There are three essential questions to consider when one suspects elder mistreatment:

1. Is the patient safe?
2. Does the patient accept intervention?
3. Does the patient have the capacity to refuse treatment?

Bomba PA. Use of a single page elder abuse assessment and management tool: a practical clinician's approach to identifying elder mistreatment. J Gerontol Soc Work. 2006;46(3-4):103-22.

Basic Values for HCP's

treating elders with honesty, compassion, and respect and recognizing that goals of care should focus on improving quality of life and reducing suffering.

Bomba PA. Use of a single page elder abuse assessment and management tool: a practical clinician's approach to identifying elder mistreatment. J Gerontol Soc Work. 2006;46(3-4):103-22.

Case 1

Clive Peterson is 79 years old and lives in his own home. Clive has limited mobility, and as such needs someone to accompany him to walk more than a short distance. He also suffers from chronic arthritis, and has reoccuring chest infections, meaning that he is a known service user. Because Clive has difficulty moving around, and with some aspects of his daily care, his next door neighbour Jane, has adopted an informal caring role, and visits him on a daily basis to cook for him and help out around the house. This arrangement has been going on for a number of years. Clive has recently been discharged from hospital following a bout of bronchitis, and whilst on a home visit to see how he is progressing when Jane is out of the room making a cup of tea, he quickly tells you that he thinks some money has gone missing, and that she won't give him access to his bank books. Clive is quite anxious about the situation as doesn't feel he has any way to check what is going on. He doesn't want to accuse Jane though, so is initially unwilling to speak to her about it.

Elder Financial Abuse Research and Training. Brunel University, West London. Updated 2012. Accessed at: http://www.elderfinancialabuse.co.uk/case-examples.html

In this instance the Occupational Therapist began by gathering more information

It is clear that Clive is very dependent on Jane in order to remain living at home independently, and it seemed that he was worried that she might not want to continue helping him if he was to accuse her of something. He was therefore torn between wanting to know if his money was going missing, versus not wanting to jepordise the help Jane provided.

Because the neighbor is known to you, you are surprised to hear Clive's concerns, but arrange to visit again when Jane won't be there so that you can talk to him alone about what he thinks has happened and what he wants to do about it. In the meantime you speak to the social worker on your multidisciplinary team to check the procedure that should be followed in such cases. She offers to visit Clive with you so that you can make sure the bank books haven't just been mislaid before any formal action is taken.

A number of attempts are made to visit Clive over the next few days, but it becomes clear that Jane is aware that you will be visiting and so it is hard to get a time to see Clive on his own. After a few attempts you do manage to visit Clive at home alone, and no evidence of the bank books can be found.

Questions

Have you thoughts about the case changed?

What would you do next?

Elder Financial Abuse Research and Training. Brunel University, West London. Updated 2012. Accessed at: http://www.elderfinancialabuse.co.uk/case-examples.html

In this instance Clive is provided with advice about keeping his money safe You remind Clive that if he has any similar concerns in the future he can always phone the bank to ask for a statement to be posted to him. Jane is still visiting Clive on a daily basis to help him, and on one occasion when you visit she says to you directly that she has been worried Clive thinks she is stealing from him. Even though she is happy to be helping, she doesn't want to be put in a situation where she is accused of taking money.

She then suggests that someone else should have formal responsible for Clive's finances, because she wanted to be above suspicion. You have a conversation with both Clive and Jane, and they both agree that it would be sensible for someone else to manage Clive's finances to avoid any problems in the future.

Question

What issues does this case highlight in relation to financial management by someone in an informal caring role?

Elder Financial Abuse Research and Training. Brunel University, West London. Updated 2012. Accessed at: http://www.elderfinancialabuse.co.uk/case-examples.html

Case 2

Daniel is 84 years old, he was admitted to hospital after a hip fracture and you notice bruises on his arms and back. Daniel is very talkative and friendly except when his son comes to visit, and he becomes quiet and withdrawn.

At one visit, he attempts to say something and his son says: “Dad, BE QUIET! Nobody wants to listen to your rambling!”

How should we proceed?

Olsen JM, Hoglund B. Elder Abuse: Speak out for Justice. 2014, JCN; 31(1): 14-21

Case 3: Unsafe Living Conditions?

You are initiating home health for an 84-year-old male with chronic obstructive pulmonary disease and mild cognitive impairment who lives with his son, daughter-in-law, and grandchildren. You find him in his room smoking cigarettes with oxygen running. You turn off the oxygen and proceed with assessment. In your patient teaching, you explain he cannot smoke with oxygen and assess how well he can apply and remove his nasal cannula and turn his oxygen on/off. He says, “Oh you know how forgetful us old codgers are; I won’t do it again.” You speak with his family and reinforce no smoking with oxygen running. On your next three visits, he is not smoking but you notice multiple cigarette butts in an ashtray. On the fifth visit, you again find him smoking with oxygen running. Should this be reported?

How should we proceed?

Olsen JM, Hoglund B. Elder Abuse: Speak out for Justice. 2014, JCN; 31(1): 14-21

Preventive Ethics

Another value consideration for health professionals is preventive ethics. Examples of preventive ethics include regular visits to the home to gain insight into family interactions, the living environment, and adaptive patterns. Observations over time in a non emergent atmosphere can allow an objective relationship to develop and a therapeutic dialogue to be established and strengthened.

William ME. The Ethical Challenges of Elder Abuse. Medscape Published March 23, 2017Accessed at: http://www.medscape.org/viewarticle/532943

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- Elder Financial Abuse Research and Training. Brunel University, West London. Updated 2012. Accessed at: http://www.elderfinancialabuse.co.uk/case-examples.html
- William ME. The Ethical Challenges of Elder Abuse. Medscape Published March 23, 2017
  Accessed at: http://www.medscape.org/viewarticle/532943

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EAO Resources and Tools

Sampling of Tools :

- Tea & Talk Toolkit
- Empowering Bereaved Seniors
- Sexual Harm Module and Brochure
- Elder Abuse in our LGBTQ Community
- Financial Abuse Module
- Emotional Abuse Module
- Physical Abuse Module
- Re: Act Manual - Ontario Addendum

Elder Abuse Ontario
Stop Abuse - Restore Respect

Ontario

Provincial Information and Support

Provincial Information and Support

Advocacy Centre for the Elderly
www.advocacycentreelderly.org
1-855-598-2656

Alzheimer Society of Ontario
www.alzheimer.ca/en/on
1-800-879-4226

Assaulted Women's Helpline
www.awhl.org
1-866-863-0511

Community Care Access Centre
http://healthcareathome.ca
310-2222 (CCAC)

Consent and Capacity Board
www.ccboard.on.ca
1-866-777-7391

Elder Abuse Ontario
www.elderabuseontario.com/
(416) 916-6728

Fem'aide
www.femaide.ca/
1-877-336-2433

Law Society Referral Service
www.lsuc.on.ca/lsrs/
1-855-947-5255

Provincial Information and Support

Ministry of Health LTC-Action Line
www.ontario.ca/page/long-term-care-home-complaint-process

Office of the Public Guardian and Trustee
www.attorneygeneral.jus.gov.on.ca
1-800-366-0335

Ontario Coalition of Rape Crisis Centres
www.sexualassaultsupport.ca/

Ontario Provincial Police
www.opp.ca
1-800-310-1122

Ontario Network of Sexual Assault/ Domestic Violence Treatment Centres
www.satcontario.com/en/home.php
(416) 323-7518

Retirement Homes Regulatory Authority
www.rhra.ca/en/
1-855-275-7472
1866-434-0144

Rainbow Health Ontario
www.rainbowhealthontario.ca/
(416) 324-4262

Provincial Information and Support

Senior's Safety Line
1-866-299-1011

Senior Crime Stoppers
http://ontariocrimestoppers.ca
1-800-222-TIPS (8477)

Support Services for Male Survivors of Sexual Abuse
http://www.attorneygeneral.jus.gov.on.ca/english/ovss/male_support_services/
1-866-887-0015

TALK4HEALING
http://www.talk4healing.com/
1-855-554-HEAL (4325)

Victim Support Line
www.attorneygeneral.jus.gov.on.ca/english/about/vw/vsl.asp
1-888-579-2888

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