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Identification of Elder Abuse at Emergency Departments: What Competencies are Required from Staff?

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ABSTRACT

The purpose of this mixed method study was to describe emergency department nursing staff's ratings and experiences of their competencies in identifying elder abuse. The target group consisted of nursing staff in emergency departments of one university hospital and four central hospitals in Finland. The staff were Registered Nurses, Paramedic Nurses and Practical Nurses. The study is part of a larger research project on the identification of abuse, carried out with staff in prehospital and emergency department care. The data was collected using an electronic Webropol survey in autumn 2022 and spring-summer 2023. The quantitative data was analyzed using IBM Statistics for Windows 28 and the qualitative data using inductive content analysis. In the experience of emergency department nursing staff, it was easier to identify physical abuse, compared to psychological or social abuse or neglect of care in their older patients. The staff were well aware of risk factors associated with elder abuse, but their detection was not easy in short care contexts. According to the study results, elder abuse identification competencies in emergency departments include detection of the signs of abuse; assessment of the seriousness of the situation; interaction skills; emotional intelligence and situational awareness, and ethical competencies. In addition, the results highlight the importance of multiprofessional expertise in ensuring the patient's safe follow-up care and coping at home. The identification of elder abuse is challenging in emergency departments and requires the development of multiple competencies and knowledge, especially regarding the detection of the signs of abuse, assessing the seriousness of the situation and interaction skills.

Keywords: elder, abuse, nursing staff, emergency department.

BACKGROUND

Elder abuse is a global problem that has continued to increase alarmingly in recent years [1, 2]. According to the World Health Organization [3], one in six (15.7 %) over 60-year-olds experiences abuse yearly. Earlier research has shown that abuse is even more common, since

older people do not always report abuse due to fear or shame [4, 5]. The identification of elder abuse and effective interventions can be seen as a matter of human dignity, which makes the development of nursing staff competencies in this area ethically important [6-8].

Elder abuse is defined as an act or lack of appropriate action in a trusting relationship, which jeopardizes the older (over 65-year-old) person's health, safety or wellbeing. The abuse can include physical or psychological violence, sexual abuse, financial abuse, neglect of care and help or limitation of rights, or other behaviour that violates human dignity or is experienced as insulting. Abuse can occur in the form domestic violence, in a couple relationship or in any close relationship, or as unethical treatment in a caring relationship [2]. Increased dependence on the help of others can increase the risk of abuse [9]. As pointed out by Tiilikallio and Säles [10], older people may also become subjected to structural abuse in society, which may involve age-based discrimination and lack or denial of appropriate services.

Women in old age experience violence in their couple relationships or other close relationships more commonly, compared to men. In Finland, there has been an increase in reported abuse experienced by under 75-year-old women in their close relationships [11]. In the Healthy Finland Survey, conducted in 2023 by the Finnish Institute for Health and Welfare [12], 6 % of 65-74-year-old women and 2.1 % of the men reported having experienced physical or psychological abuse in their close relationships during the previous 12 months. In a study conducted in Australia it was estimated that 14.8% of community-living over 65-year-old people had experienced abuse. Psychological abuse was found to be the most common form of abuse (11.7), followed by neglect (2.9%), financial abuse (2.1%), physical abuse (1.8%) and sexual abuse (1%) [13]. Similarly, Yılmaz et al. [14] found psychological abuse to be the most common form of abuse in older people. The next most common abuse subtypes were physical abuse, neglect and financial abuse. Research has shown that elders' physical and psychological vulnerability and loneliness make them more susceptible to abuse [15, 16]. In addition, poor health, lack of social contacts and social support, as well low socioeconomic status are associated with an elevated risk of abuse, especially financial, psychological and sexual abuse. The perpetrators are usually the elders' grown-up children, spouses or partners. Abuse from adult children is mostly financial, physical or psychological, whereas abuse committed by a spouse or partner is most commonly physical, psychological or sexual [13]. Abuse can lead to long-term illness and depression and increase the use of emergency services [17-19].

According to Qu et al. [13], abused older people seek help for physical, psychological and financial abuse more commonly, compared to sexual abuse or neglect. Help is mostly sought from family members and friends. Nursing professionals have a central role in the identification of elder abuse, so developing their expertise is imperative [8]. Emergency departments are frequently visited by abused elders, but the abuse often remains undetected [18, 20]. As declared by Åberg [21], elder abuse and violence in close relationships are difficult to detect; they are typically hidden crimes, not reported to authorities. Is has been estimated that only one out of twenty-four cases of abuse are reported to authorities [21, 22]. Earlier research on the identification of elder abuse in nursing has involved the perspectives of residential and nursing homes [24-29]; home care and nursing [30-34]; prehospital

emergency services [35-37], and hospital emergency departments [38-42]. Furthermore, a few studies have dealt with educational interventions designed for nurses on the identification of elder abuse [43-45], including training on screening and assessment tools [46-52].

The identification of elder abuse has been found to be hampered by the relatively short duration of the contacts at the emergency department [39]. Secondly, emergency departments focus on acute health problems and do not routinely seek to detect psychological or financial problems [53]. The assessment of the situation is further complicated by ethical and family dynamic factors [54]. As noted by Andermann [55], social risks factors underlying health problems should also be looked at when encountering suspected abuse. Some interventions have already been developed to identify, prevent and intervene with elder abuse. They involve education, multiprofessional collaboration and various counselling and support interventions [56]. It has been proposed that training arranged to help professionals detect elder abuse should be complemented by interventions that improve the safety of the elders and respect their autonomy and privacy [57]. When developing interventions, it is also important to assess in which environments they could be most useful [58, 59]. Especially creating screening tools for nursing staff at emergency department should be a priority [56, 60, 61]. Elder abuse protocols could also be developed to support nursing staff [62] and to increase nursing students' awareness of the scope of the problem [63]. Systematic screening with help of checklists has proven to be effective in the detection of abuse at emergency departments [22]. Checklists can help staff identify signs of abuse and people subjected to abuse [64]. Earlier studies have shown that health care professionals feel that they have not received adequate training on how to identify elder abuse [59, 65]. Increasing elder abuse training is justifiable, as it has been shown to promote professionals' interview skills, assessment of the situation, organization of further care and documentation [66]. The identification of elder abuse, the appropriate interventions and documentation call for ethical competencies [67]. In addition, health care professionals would benefit from cultural sensitivity [68] and training on the risk factors of abuse [55]. More information is required about the health care professionals' experiences of identifying elder abuse and neglect [1, 69]. Nurses working at emergency departments and caring for older clients in acute situations have a critical role in the detection of elder abuse [22, 23].

STUDY PURPOSE AND RESEARCH PROBLEMS

The purpose of this mixed method study was to describe emergency department nursing staff's ratings and experiences of their competencies in identifying elder abuse. The study aimed at producing information that can be used to promote emergency department staff's theoretical and practical competencies, or knowledge and skills, in the identification of elder abuse.

The research questions were:

1. How do staff at emergency departments rate their knowledge and skills in working with older abused clients?
2. What knowledge and skills do emergency department staff, in their own experience, need to identify and intervene with elder abuse?

THE STUDY

Target Group and Data Collection:

The target group consisted of Registered Nurses, Paramedic Nurses and Practical Nurses at emergency departments of one university hospital and four central hospitals in Finland. The study is part of a larger research project on the identification of abuse, carried out with staff in prehospital and emergency department services. The data was collected using an electronic Webropol survey in autumn 2022 and spring-summer 2023. The research team used a questionnaire they had developed earlier based on an integrated literature review [70], pre-tested with emergency care providers and piloted in a survey with prehospital emergency care providers, contacted through the Finnish Association of Paramedics and A & E nursing professionals.

All Registered Nurses, Paramedic Nurses and Practical Nurses at the emergency departments received a link to the questionnaire via e-mail through their respective hospitals' research coordinators. The respondents could choose between a Finnish and Swedish language version of the questionnaire. They responded anonymously. The background questions (n=7) in the questionnaire concerned respondents' age, gender, professional education, occupation, workplace and work experience in years. Second, the questionnaire included 12 Likert scale questions on respondents' knowledge of what constituted abuse, its risk factors, the affected persons' need for support and indicators of physical, psychological and social abuse in elders. A further purpose of the questions was to examine respondents' knowledge of action to be taken when encountering abused clients at the emergency department. They were asked to rate how skilled they felt in taking up the topic of abuse, in referring clients to further care and in supporting abused clients. Last, the questionnaire involved four open questions. The respondents were asked to describe situations at the emergency department, in which they had come to suspect abuse of elders, children or youth. They were also requested to describe competencies needed in the identification of abuse and to list their educational needs.

This article reports results from the viewpoint of theoretical and practical competencies, or knowledge and skills, required in the identification of elder abuse. The focus is on the identification of abuse, which is a prerequisite for any interventions. The two are often seamlessly intertwined. The same questionnaire was used to collect information on the identification of child and youth abuse. The results for this material are to be reported in another article.

Data Analysis

The quantitative data related to the first research question was analyzed using IBM Statistics for Windows 28 [71] and the qualitative data pertaining to the second research question using inductive content analysis [72]. Percentages and frequencies were used to report quantitative data. The purpose of the qualitative data was to bring out previously unknown aspects of the topic under study. Phrases, clauses and sentences representing a coherent idea as a response to the second research question constituted the unit of analysis [73]. After reading the data for several times, expressions that represented a response to the research question were picked out and reduced by removing "empty" filler words, but retaining the original core idea. The reduced expressions were then grouped based on similarities. These

categories were named using titles characteristic of the content, compared, and collapsed into a higher-level category, and named using a descriptive label [74].

Ethics and Reliability

Permission to conduct research was obtained from each hospital separately. Ethical approval was not required, since the study did not involve patients. Voluntary completion of the Webropol survey was considered consent to participation. Good scientific practice was followed throughout the study [75]. The cover letter contained detailed information about the study, participation and use of data [72]. Participation was voluntary. As the topic can be considered ethically sensitive, the voluntary nature of participation ensured that professionals could decline if they found the topic too stressful [76]. Respondents were also informed of the possibility to withdraw at any stage of the research process [75]. The research data was handled with confidentiality and stored safely, and data analysis undertaken with care.

The reliability and validity of the quantitative research questions can be considered good. The survey questions brought responses as planned [77, 78] and the questionnaire was consistent and clearly structured [78]. The reliability of the study was increased by the fact that the questionnaire had been pre-tested with both prehospital and emergency department staff and used in a survey with prehospital emergency care providers. As regards external validity, the study measures what it was intended to measure, and the results can be generalized to a larger population. Internal validity of the study is good; the results reflect the phenomenon and its potential cause-and-effect relationships [71]. Reliability is a key quality attribute in research, determining how trustworthy and consistent the results obtained are. This study can be considered reliable, as it produced similar results under similar circumstances in the various locations [79].

As regards the qualitative data, the research rigour of the analysis and report can be evaluated from the perspectives of credibility, conformability, reflexivity and transferability [72]. The credibility of the study was increased by the fact that the respondents described their personal experiences of the phenomenon under study. To enhance the conformability of the study, the analytical process was described carefully, but without compromising participants' anonymity. The researchers practiced reflexivity, or were aware of their potential preconceptions, as they had encountered abused clients in their previous work in nursing. To facilitate the evaluation of transferability, the background of the study participants was described briefly. The findings are transferable and useful in the Finnish nursing context and potentially useful internationally.

RESULTS

Quantitative Results

Demographic Respondent Data:

The respondents were 76 members of nursing staff; 69 Registered Nurses, 3 Paramedic Nurses and 4 Practical Nurses. There were 62 (81.5%) women and 14 (18.5%) men. The respondents' age range was 24-66 years, with the means of 36.8 years and median of 35 years. The majority of them (n=63; 82.9%) held a Bachelor-level degree from a University of Applied Sciences. Six respondents (7.9%) had a Master-level degree from a University of

Applied Sciences, four had a vocational qualification (5.3) and three (3.9%) a University degree. The length of the respondents' work experience varied between 2 and 40 years (means 12.8 years; median 10.5 years).

Most respondents, 92.1%, had encountered suspected cases of abuse at their work at the hospital emergency department. For 32.1% of the respondents, this occurred on a monthly basis; for 35.7% every week, and for 5.4% daily. However, 23.2% of the respondents reported that they suspected abuse of their clients 1-3 times per year; and 3.6% said they suspected abuse more often than 3 times a year.

Respondents' Self-Rated Knowledge Related to the Identification of Elder Abuse:

Table 1: Emergency department staff's self-rated theoretical and practical competencies in identifying and intervening with suspected abuse.

Theoretical or practical competency	Very poor	Rather poor	Neither poor nor good	Rather good	Very good	Means	Median
My knowledge of what kind of things constitute abuse	0 %	10 %	14 %	70 %	6 %	3.7	4.0
My knowledge of what kind of support an abused client needs	2 %	18 %	40 %	36 %	4 %	3.2	3.0
My knowledge of what signs and things indicate physical abuse	0 %	4 %	18 %	68 %	10 %	3.8	4.0
My knowledge of what signs and things indicate psychological abuse	2 %	28 %	28 %	36 %	6 %	3.2	3.0
My knowledge of what signs and things indicate social abuse	6 %	34 %	24 %	30 %	6 %	3.0	3.0
My knowledge of action to be taken when encountering an abused client at the emergency department	2 %	16 %	30 %	46 %	6 %	3.4	4.0
My knowledge of the risk factors related to abuse	4 %	24 %	20 %	46 %	6 %	3.3	4.0
My skills in taking up the topic of abuse with a client	6 %	18 %	30 %	40 %	6 %	3.2	3.0
My skills in referring an abused client to further care	6 %	34 %	24 %	30 %	6 %	3.0	3.0
My skills in supporting an abused client	2 %	22 %	36 %	32 %	8 %	3.2	3.0
My skills in attending to an abused client's family	4 %	38 %	32 %	24 %	2 %	2.8	3.0
My skills in documenting elder abuse	2 %	22 %	16 %	52 %	8 %	3.4	4.0

Table 1 shows the respondents' self-ratings for their knowledge and skills in identifying and intervening with abused clients. Although the majority (76%) of the respondents rated their knowledge of what constituted abuse as rather good or very good, there was great variation in their knowledge of different forms of abuse. Most respondents (78%) found that they had rather good or very good knowledge related to the identification of physical abuse, but they were less confident about the indicators of psychological or social abuse. For these forms of abuse, the responses were more evenly distributed across the three central options on the Likert scale (rather poor/neither poor nor good/rather good knowledge).

More than half of the respondents (52%) reported having rather good or very good knowledge of the risk factors related to abuse, and also knowing rather well or very well what action to take when encountering potentially abused clients. The respondents' ratings were lower for their knowledge of what kind of support the abused clients might need; the largest group of respondents (40%) chose the option "neither poor nor good knowledge", and the second largest group (36%) assessed their knowledge to be rather good.

Respondents' Self-Rated Intervention Skills:

As Table 1 shows, of the various intervention skills required when encountering potentially abused clients, the respondents trusted their documentation skills best. More than half of them rated their documentation skills as rather good. The respondents felt less confident about their skills in taking up the topic of abuse with clients, in supporting them or in referring them to further care. For these interventions, the responses were relatively evenly distributed across the three central options on the Likert scale (rather poor/neither poor nor good/rather good skills). Attending to the client's family seemed to be the most challenging intervention; the greatest group of respondents (38%) found that they had rather poor skills in this respect, 32% felt that their skills were neither poor, nor good and 24% reported rather good skills.

Qualitative Findings: Competencies Required and Educational Needs

Table 2: Competencies Required in Identifying and Intervening with Suspected Abuse and Educational Needs as Experienced by Respondents

Category	Reduced expression
Detection of the signs of abuse	Knowledge about typical injuries Knowledge about the mechanisms of injury Detecting injuries caused by abuse Comprehensive examination Detecting signs of violence
Assessing the seriousness of the situation	Good cognitive skills when interviewing clients Reasoning skills Comparing the narrative to injuries Detecting signs of crisis or trauma Interpretation of clients' description Assessing clients' ability to cope
Interaction skills	Listening and presence Ability to take up sensitive topics Creating an atmosphere of trust Authenticity, calm and privacy in encountering

	clients Social skills Multiprofessional collaboration
Emotional intelligence and situational awareness	Reading client's gestures Reading non-verbal behaviour Understanding client's emotions; compassion Supporting the client Assessing the client's emotional intelligence Sensitivity, courage to ask questions Confronting unpleasant emotions and situations
Ethical competencies	Ability to discuss sensitive issues Treating the client with respect Awareness of the client's rights Recognition of one's responsibility as the client's voice and advocate

The inductive content analysis of the responses to the four open questions revealed respondents' ideas of what skills and knowledge were required in the identification of elder abuse and use of interventions. As shown in Table 2, five themes emerged: detection of the signs of abuse; assessing the seriousness of the situation; interaction skills; emotional intelligence and situational awareness, and ethical competencies. The results are supported by direct quotes from the respondents, coded r1, r2, etc.

Detection of the Signs of Abuse:

According to the respondents, knowledge about typical injuries and their causes and mechanisms was necessary in the identification of abuse. They stressed the need to allocate time to examining clients comprehensively when abuse was suspected, and the ability to identify signs of psychological and social abuse or neglect of care. They mentioned, for example, "detection of bruises and fractures, linking the causes of malnutrition and cachexia with the client's situation" (r3). As the respondents observed, what was required was "skill to recognize signs of abuse in the patient's behaviour" (r35), and to assess if the "old person was anxious or depressed because of the situation" (r5).

Assessing the Seriousness of the Situation:

According to the respondents, interviewing clients to assess the seriousness of the situation called for sound cognitive skills and reasoning ability. As abused persons were likely to feel apprehensive or ashamed, nurses should compare clients' verbal descriptions to the injuries, and, as one respondent wrote, this required "experience and sensitivity, ability to read between the lines and make observations" (r4). To quote a few other respondents, "You need to have good cognitive skills. You have to dig into the background behind the reason for admission. It's like being a detective, asking without asking, and sorting out situations" (r1); "Carefully focusing on interviews. Paying attention to unconvincing or conflicting explanations (r8); "Reading the injuries, you must detect when the story does not fit the injuries" (r21). In addition, the respondents brought out the importance of objective interpretation of the situation described by the client. The work involved detecting signs of crisis and trauma, finding out the duration and severity of the abuse and assessing the client's ability to cope with the situation. As one of the respondents commented, "the abuse

experienced by old people may be so severe that the person is at risk of suicide". According to the respondents, it became important to assess the situation by asking oneself questions like "Does the abuse old person play down the severity of their situation to protect the abuser? What kind of words do they use of the abuser?" (r43).

Interaction Skills:

Interaction skills were among the competencies listed by the respondents as necessary when working with potentially abused clients. Genuine presence and concentration on the client were mentioned, as were "authentic encounters and interest in each case" (r50). According to the respondents, listening, calm and empathy were required to gain the client's trust. In the words of one respondent, professionals needed to possess "long feelers, presence, ability to build an atmosphere of trust" (r50). Another respondent wrote: "In addition, you need enough social skills, so that you can build a trusting relationship with the client and discuss sensitive issues" (r25). Further attributes mentioned involved "courage to take up the topic" (r31) and "a clinical eye. Courage to ask questions" (r45). Good interaction skills were also required in multiprofessional collaboration and in the creation of networks to support clients' coping.

Emotional Intelligence and Situational Awareness:

In the experience of the respondents, discretion and emotional intelligence were helpful in interaction with older clients, who often hesitated to report their experiences or complex family dynamics. Nurses needed to be able to read non-verbal cues, understand emotions and feel compassion. At times, genuine presence involved having to face unpleasant emotions. In addition, the respondents observed that taking up the topic of potential abuse called for situational awareness and understanding of the relationship between the client and the abuser. The professionals needed to assess in which situations, and in which words to ask about the client's background. To quote two respondents, "the skill to detect signs of abuse, like hiding emotions, playing down things" (r21); "Dealing with the feelings of transference and the emotions that arise in yourself, situational awareness, game sense" (r33). Furthermore, the respondents mentioned the assessment of the client's emotional intelligence skills. They thought it was important to explore how the older clients experienced the abuse, and what emotions and reactions the situation evoked in them.

Ethical Competencies:

The respondents pointed out that ethical competencies were needed when dealing with suspected abuse. This involved assuming responsibility and an advocacy role, and informing clients of their rights in a neutral and comprehensible manner. In the respondents' own words, "The old person's rights as a client, listing them, talking about them openly" (r45); "We must remember that as nurses, we are the voices and advocates for the old people. We must have courage to deal with the issue. We must not hide our moral competency but bring it forward with courage" (r47). Discretion and a respectful way of addressing the sensitive topic were also necessary, as clients often experienced shame, guilt, loss of dignity and feelings of inferiority. The respondents emphasized "sensitivity and courage to ask questions, giving space, from one human being to another" (r7); and "a respectful and appreciative approach to the work, no guilt-tripping" (r5).

DISCUSSION

Health care professionals working at emergency departments require theoretical competencies in order to identify elder abuse. In this study, the majority of the respondents rated their knowledge of elder abuse as rather good, but they need further knowledge about detecting the signs of abuse and about supporting their older clients. They might benefit from training on the identification of elder abuse [45] and on the use of screening checklists and assessment tools [49-52].

According to the nurses working at emergency departments, it is easier to detect physical abuse of elders, compared to psychological or social abuse or neglect. Although the professionals are well aware of the risk factors related to elder abuse, the identification of abuse is challenging in the short care context. Previous research confirms that the short duration of the contacts at emergency departments obstruct the identification of abuse and related risks [39, 53]. The fact that a visit to the emergency department may be the only time vulnerable, isolated elders ashamed of the way they have been treated leave their home to seek help, makes it all the more important that the theoretical and practical competencies of emergency department staff are developed [22, 23, 80].

A great variety of competencies is required from professionals at emergency departments in order to identify elder abuse and to take appropriate action. According to this study, these competencies include the detection of the signs of abuse; assessing the seriousness of the situation; interaction skills; emotional intelligence and situational awareness, and ethical competencies. The results are similar to earlier results [56, 60, 61]. Different from earlier research, emotional intelligence, situational awareness and ethical competencies were brought into focus more strongly in this study. Interventions to suspected abuse should be conducted with discretion, as elder abuse is frequently associated with complex family dynamics. An examination of the respondents' contributions in this study revealed that ethical skills were strongly represented in the responses to open questions, although they were not included in the quantitative questions. This indicates that the professionals working at emergency departments are well aware of the ethical challenges associated with elder abuse.

Since the identification of elder abuse and the development of nursing interventions for those experiencing abuse require solid emotional intelligence, situational awareness, interaction skills and ethical competencies, it is proposed that further education combining these themes should be offered to emergency department staff. Simulation-based education is a viable option that, according to Cunningham et al. [81], enables learning about the recognition of elder abuse and appropriate interventions in concrete terms, increasing participants' understanding of the assessment of abuse and fostering communication with the team to help provide wholistic care. Furthermore, a combination of lectures and simulation-based learning has been found effective in learning to recognize elder abuse, assess the seriousness of the situation and advocate for older clients [44].

The role of multiprofessional collaboration is another important finding in this study. The effectiveness of teamwork in helping vulnerable older clients at the emergency department and in ensuring safe further care and coping at home has also been described by Rosen et al. [82].

CONCLUSION

The identification of elder abuse and appropriate action at emergency departments call for theoretical and practical competencies. According to this study, these competencies include the detection of the signs of abuse; assessing the seriousness of the situation; interaction skills; emotional intelligence and situational awareness, and ethical competencies. It is advisable that these areas are more strongly integrated into nursing curricula. In addition, multiprofessional collaboration is recommended to ensure safety and care continuity for abused older clients.

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