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Critical Care Nurses' Perspectives on Elder Abuse

Jeanette M. Daly, RN, PhD [Associate Research Scientist],

Department of Family Medicine, University of Iowa, 01290-F PFP, 200 Hawkins Drive, Iowa City, IA 52242, Office: 319-384-8995, Home: 319-351-7800, Fax: 319-384-7822

Amy N. Schmeidel Klein, BA [Medical Student (M4)], and
Carver College of Medicine, University of Iowa, Iowa City, IA 52242

Gerald J. Jogerst, MD [Professor/Associate Head]

Department of Family Medicine, University of Iowa, Iowa City, IA 52242

Jeanette M. Daly: jeanette-daly@uiowa.edu

Abstract

Aims—to explore through interviews of critical care nurses their perspectives on elder abuse to achieve a better understanding of the problems of reporting and generate ideas for improving the process.

Background—In 44 states and the District of Columbia healthcare providers are required by law to report elder abuse but the patient, patient's family, and healthcare providers all have barriers to reporting allegations of elder abuse.

Design—This study design is qualitative.

Method—Through a mailed survey, critical care nurses were invited to participate in a taped in-depth qualitative interview.

Results—Ten nurses were interviewed. A thematic analysis was used to describe the following core themes: types of elder abuse, suspicions of elder abuse, reporting of elder abuse, barriers to reporting elder abuse, legislation, and improvement in practice.

Conclusions—Critical care nurses are aware of elder abuse and somewhat systematically evaluate for abuse at admission to their unit. They recognize signs and symptoms of abuse and are suspicious when it is warranted. They are aware of why an older person does not want to report abuse and take this into consideration when soliciting information. Facts, values, and experience influence personally defining abuse, suspicion, and dependence for each individual healthcare professional.

Relevance to Clinical Practice—Critical care unit protocols and/or policies and procedure for reporting elder abuse are needed in critical care settings and are warranted for providing quality of care.

Keywords

Elder abuse; qualitative study; mandatory reporting; critical care

Healthcare Professionals' Perspectives on Elder Abuse

A recent national study found one in ten of 5777 respondents, persons 60 years and older, reported emotional, physical, or sexual mistreatment or potential neglect in the past year (Acierno, et al., 2010). It is difficult for persons who are older to report mistreatment. Victims have many reasons for not reporting elder mistreatment, including fear of retaliation, being afraid of institutionalization, being ashamed, lack of information on who to contact for reporting, and thinking no one can help (National Research Council of the National Academies, 2003).

In the critical care setting, patients are treated for brief but severe episodes of illness, and the intensity of the situation may not allow for exploration or thoughts of elder abuse. Barriers for healthcare providers in the critical care setting for reporting elder abuse are varied and include the patient as potential victim, patient's family/significant others, and the healthcare provider. High patient acuity and lack of consciousness are important factors that hinder reporting of abuse by the patient and when alert and responsive, the typical barriers exist, i.e., fear of retaliation, fear of being placed in a nursing home, powerlessness, and wanting to protect their family (Beaulaurier, Seff, and Newman, 2008). Family members may know or actually be the perpetrators and they deny the abuse (Krueger and Patterson, 1997). For the healthcare provider, reporting barriers may be lack of knowledge about the law, not wanting to be involved in court cases, and not routinely screening for abuse (Clark-Daniels, Daniels, and Baumhover, 1990; Tayloe, Bachuwa, Evans, and Jackson-Johnson, 2006).

In some states, healthcare professionals are not obligated to report elder abuse to adult protective services, but in 44 states and the District of Columbia they are required by law to report elder abuse (Daly, Jogerst, Brinig, and Dawson, 2003). Guidelines from the American Medical Association note that a physician may be the only person outside the family whom an elder sees regularly, and is therefore in a key position to report elder abuse (Aravanis, et al., 1993). Healthcare professionals attest to viewing cases of suspected elder abuse but fail to report those cases (Daly and Jogerst, 2005). In a retrospective medical record review of 28 thermally injured patients 60 years and older, findings indicated that the patients were poorly screened for elder abuse and 7 persons were victims of abuse, neglect, or self-neglect; but only 2 cases had intervention by Adult Protective Services (Bird, et al., 1998). In another study, physicians were found to report only 2% of all suspected cases (Rosenblatt, Cho, and Durance, 1996). In the same study, a substantially larger number of cases were reported by social workers (18%) and nurses (26%).

From 2010 to 2050, the U.S. population is expected to grow from 310 million to 439 million, and by 2030 one in five persons will be 65 years and older. Healthcare professionals in all settings will need to become increasingly aware of elder abuse and reporting mechanisms (Vincent and Velkoff, 2010). From 2010 to 2030, the dependency ratio (number of persons 65 years and older to every 100 persons of traditional working age) will increase from 22 to 35 persons. The higher the dependency ratio, the greater the potential burden on health care (U.S. Census Bureau, 2011).

Reasons for lack of reporting are understudied. While laws require reporting regardless of mitigating circumstances, most healthcare professionals consider the broader context of the patient before reporting, including patient autonomy and rights, patient-physician confidentiality, quality of life, and future patient-healthcare professional relationships (Daly, Jogerst, Brinig, and Dawson, 2003). Rodriguez and colleagues (2006) interviewed a convenience sample of 20 family and general internal medicine physicians to identify their perspectives on mandated reporting of elder abuse. They reported that physicians worry about future physician-patient rapport and trust, patient quality of life, and physician control

when deciding to make an elder abuse report (Rodriguez, Wallace, Woolf, and Mangione, 2006). Schmeidel and colleagues expanded that study and interviewed nurses and physicians in primary care settings with a main conclusion that pragmatic elder abuse education is necessary and the reporting system may need reorganization (Schmeidel, et al., 2011).

This study continues the author's earlier work and examines the perspectives of other healthcare professionals, critical care nurses. It has been noted that there is sparse research regarding critical care nurses and their perceptions of elder abuse (Burgess, Watt, Brown, and Petrozzi, 2006; Daly, Merchant and Jogerst, 2011). The purpose of this study was to explore through interviews of critical nurses their perspectives on elder abuse, to achieve a better understanding of the problems of reporting and to generate ideas for improving the process. This qualitative approach using in-depth interviews is appropriate for exploring a complex domain that is not fully understood--in this case, perspectives on and barriers to mandatory reporting of elder abuse--and is meant to be hypothesis-generating rather than hypothesis testing.

Methods

The methods for this project were approved by the Institutional Review Board of the University of Iowa. Methods are described for subject recruitment, instrument, interviews, and qualitative analyses.

Subject Recruitment

A list of critical care nurses was obtained from the Iowa Board of Nursing. All nurses employed in critical care settings were selected from three counties in Iowa. A cover letter with the list of interview questions was sent to all 396 nurses. Also included in the envelope was a form to complete and return in a postage-paid envelope indicating the respondent would participate in the study. Contact information was provided on the form. After receipt of agreement to participate, a researcher contacted the respondent and set up a time and place for interview. Thirty-eight envelopes from nurses were returned as undeliverable. No further attempts were made to engage non-responders after the initial invitation letter.

Instrument and Interviews

An interview guide developed by Rodriguez and colleagues (2006) was used for this study. The guide had 13 open-ended interview questions (see Table 1) and was developed from literature review and expert input. The questions were developed for physicians and were modified for the critical care nurses. No demographic information was collected because of the sensitivity of the topic. Anonymity was protected because a respondent could indicate they were aware of an elder abuse incident and had not reported it, which would be in violation of Iowa laws.

One interviewer (AS) was trained in ethnographic techniques, and she has conducted similar research. The interviews were conducted in the respondent's or interviewer's office. At the beginning of the interview, respondents were reminded not to indicate who they were or the names of any of the abuse victims. Interviews lasted from 20 to 50 minutes, were all tape-recorded, and transcribed verbatim.

Qualitative Analysis

A multi-step process of thematic analysis was used to identify the core themes that represent the perceptions of nurses and physicians about elder abuse (Rice and Ezzy, 1999; Crabtree and Miller, 1999). All transcriptions were entered in N'Vivo (QSR International, Victoria, Australia), a qualitative software program that allows for coding and systematic searching of

interview data. After development of a preliminary codebook, initial coding was conducted by the interviewer (AS) to identify general themes in the responses of all persons interviewed. A second coding step entailed members of the research team representing each profession (MD and RN) interactively reading through interview transcripts. All members of the research team concurred on themes identified during the transcript review.

Results

Twelve nurses who worked in intensive care units agreed to participate in the interviews. During the project 10 nurses were interviewed, for an overall interview rate of 83% and 2.7% of those initially contacted to participate. The nurses all worked in hospital-based critical care units in three Iowa counties. Interview responses are provided within the concepts of types of elder abuse, suspicions of elder abuse, reporting of elder abuse, barriers to reporting elder abuse, legislation, and improvement in practice.

Types of Elder Abuse

Nurses reported the kinds of abuse they may encounter as emotional abuse, financial exploitation, neglect, and physical abuse. None of the nurses reported sexual abuse, and one nurse stated: "I'm trying to think...I don't think we've ever seen sexual...not to my knowledge." Another nurse stated, "I've worked in the surgical intensive care unit for over 20 years and I haven't seen any signs of any physical abuse, partly because as a nurse in the ICU, you're usually so busy you don't have time to scratch your nose."

Neglect issues were frequently mentioned and described as the patient having many sores on the body, bruises, needing hygiene care, and looking malnourished. One nurse reported, "They will be very filthy. They'll have sores. It's obvious they haven't been bathed or shampooed for a long time. So we see a lot of that type of thing."

An example of financial exploitation was provided. "The patient was on a ventilator, controlled life support, and the family wanted us to wake him up to sign his social security check. And that was kind of like a red flag right there. And the patient was in for 3 months, and the only time we saw the family was the first of the month when the check came in."

A report of actual abuse occurring in the intensive care unit was depicted by a nurse. "I had one case where the wife would come in every day and sat for 3 hours next to her husband's bed, and shortly after she left the ventilator alarm would always go off, and we could never figure out why, and we always ended up changing the tubing. Well, we sat and watched her one day, and she sat there with her sewing needles and was poking all these holes in the ventilator tubing. And she'd called in later, asking, "Oh, is he still alive?" So, that was something we did report."

Suspicious of Elder Abuse

Nurses report being suspicious of elder abuse if the patient 1) depicts being malnourished and unkempt; 2) has bruising or other marks on the body with no reasonable explanation, 3) has burn marks in places where the patient can't reach, 4) can't provide a clear explanation/reluctance to answer questions, or 5) if a family member hovers or appears uncomfortable with health care professionals present. Many reported suspicions because of evidence such as sores on their body and the patient being hungry.

Two nurses reported their admission questionnaire asks about their care at home and if they are safe. One reported, "The joint commission standards have mandated that we ask people, you know, have you been sexually abused, have you ever been physically abused, and that sort of thing. So, my particular situation, it's rare...we ask those questions to an awake and

oriented person. Well, most of our people come to us completely anesthetized from the operating room, and by the time they do wake up they're pretty disoriented."

A nurse described one situation as, "an elderly gentleman came in with cigarette burns on his back, and he did not smoke, and a step-son who was a primary care giver did. We just kind of figured that had to be the son. There was no logical explanation for it [other] than that. And it wasn't a single burn; it was multiple burns on his back."

An example of establishing rapport to confirm suspicions was provided. "Ultimately my goal is to be able to have time alone with that patient. If we have a good rapport going on, the family will leave. If we force them to leave, a lot of times that really frightens the patient and that puts up more defenses because then they really think they are going to get in trouble." Thus, suspicions of elder abuse lead to the reporting of an allegation of abuse.

Reporting of Elder Abuse

Similar themes were found from all the nurses where reporting of abuse is conducted in the hospital setting according to hospital policy. In most instances, the nurses reported suspected abuse to the patient's physician or the unit's social worker. And in a VA hospital, one nurse reported, "I know in the hospital I work in right now that we aren't supposed to report it directly to the Department of Human Services. We are supposed to go to the federal before we go to state, as this is a federal hospital. We have to report it to the manager and then the social worker, and then she takes it further."

One nurse said, "I would report, because there's not a penalty to reporting, unless you are doing it to be malicious. There's no penalty and there's no harm to the patient by me saying, something doesn't seem right here." Stressing the importance of physical injuries, one nurse would "find the physician probably first, so that the physical conditions can be dealt with, and then we have our nurse managers, and the nurse managers' then are required to notify appropriate people."

Nurses generally seemed to let someone else do the actual reporting to the state's adult protective services agency. "No, I've never reported the abuse. I've told them what I've noticed, and then the social worker does the report." And another similar response, "We've got the chain of command: our charge nurses, or supervisor, and so on. It's always worked. We have an excellent social worker."

Another similar theme to reporting was that the nurses didn't know what happens after the allegation is reported to the social worker. A nurse described, "I'm not sure how the system works as far as reporting up past the social worker...where it's supposed to go, but I'd always go to the social worker." Similarly, nurses did not know the end result of the case, if it was founded or not. A nurse conveyed, "I don't really know whatever happens afterwards. It goes to the manager, it goes to the social worker, and then it goes to...I don't know, like a safety officer or something and then it goes...I don't know where it goes. It goes to some federal officer and then state gets notified. So, it's like, where does it go? It's like out there in virtual space or something." Another nurse said, "We never find out a result."

In emergency situations, a nurse reported, "If it was severe enough you would have to call the authorities. Absolutely, call the police and make sure whoever the perpetrator was had no access to the patient." And because of the shift changes and staffing, another nurse conveyed, "...because we do 12-hour shifts, but there are a lot of nurses that take care of these patients, so you always want to make sure to give your thoughts and your feedback to give it to the next nurse to be sure it doesn't fall through the cracks. Because you're not

going to come back a week later and be like, Well you know I thought there could potentially be... You don't want that."

Barriers to Reporting Elder Abuse

Reasons provided by the nurses why patients are reluctant to report being abused include being scared, feeling they deserve the abuse, it may get worse when they get home, fear of being relocated to a nursing home or different institution, fear of abandonment, or they don't want to get their children in trouble. One nurse stated, "You have an inverse ratio of power in that relationship, whether it's with a spouse, or a neighbor, or a child, or whoever the perpetrator is. These people are older. They are dependent on who ever or at least their perception is that they are dependent on that person for whatever, shelter, food, clothing, care, money, or whatever. I think they are afraid to disrupt it." Another nurse reiterated the same thought, "people that are co-dependent on other people tend to need that other person and tend to justify [the abuse]."

A similar thread across interviews was that the perpetrator was a relative and they didn't want to get them in trouble. The nurse felt the patient thinks, "Oh, I brought this child up, this is how I brought them up to be. They get real touchy when it's their kid."

Legislation

Nurses provided mixed responses about the state's legislation, including the following: we don't need a law, the law should be better enforced, and healthcare professionals' education should be more frequent and content expanded. A nurse responded about Iowa legislation that, "I don't really think we even need the law, because we do it anyway." And another nurse provided a different opinion, "Oh, I think it definitely needs to be there, because, you know, without that, some people when they notice it, well, that's too bad, but it's not me."

Healthcare professionals in Iowa are required to report allegations of elder abuse. A nurse's perception about this reporting was, "I think that if people feel like its mandatory, they have to, they are more likely to do it than if they think, Oh, I don't really have to do it. I know it's wrong, but I don't really want to get involved." Whereas, another said, "the nurses that I know anyway take that seriously and realize that they have made an oath, so that if they feel that something is going on with someone that it is their moral and ethical duty to step up and say, This isn't right and I'm not going to let it continue."

Completion of a dependent adult abuse curriculum is required for healthcare professionals, beginning when they enter a healthcare profession and every five years thereafter. Additional content to this curriculum was suggested, as "more education about it [reporting abuse], what we can and cannot do. And our legal liability, are we putting ourselves up for a lawsuit." Another complaint about the law was "the law doesn't lay out the signs and symptoms [of abuse], doesn't tell you when you see it. It doesn't give you that way of noticing the abuse. It just gives you a way of contacting the law enforcement. It doesn't give you a way of recognizing the abuse or...how to recognize the symptoms." I think it's adequate, but like I said I'd like to have something on elderly abuse and just abuse in general annually. Because I don't think every three years is enough."

In response to the law needing to be better enforced, one nurse stated, "we don't have investigators out there," Indicating that the law should provide for additional investigators for conducting investigations of alleged abuse. Another final thought on the law was, "in the best of all worlds, we wouldn't have abuse [and then wouldn't need the law]."

Improvement in Practice

Various ideas were suggested for improving nursing practice for elder abuse in critical care. Suggestions included the following: conduct health history in private, ask safety questions on admission assessment, readdress the issue of elder abuse at discharge from the unit, establish the reporting of elder abuse as a priority for the unit, and offer elder abuse education in addition to that required by law.

One nurse reports, "On admissions, we ask questions like, Are you in a relationship where you feel unsafe? Are you in a relationship where you are being harmed by someone? Do you want to harm yourself?" Those kinds of things. We ask those questions, and that gives them an opportunity to say, Yes." Emphasizing the need for admission assessment, another nurse responded, "You know, I think probably..., you have to identify that there is truly a problem, and for example, a problem there. Epidemiology comes up, documents transmission of one bacteria from one patient to another that can be stopped by washing your hands. And they show that there is a problem. And if there is problem that it can be changed by doing this. So, I think that if you could document that there is some type of abuse going on, then I think there is more motivation, and maybe that's how to change."

Additional education was suggested by providing information about the seriousness of elder abuse. A nurse suggested, "I think it should almost be like an annual thing that they cover in the hospital. Because, I don't know, I think with the way the economic situation is out there....I just think things are going to get worse instead of better and I think we need to be more aware of that." Another nurse stated, "Just keeping the education going."

In conclusion to the interviews, one nurse stated, "I just really think we're on top of it. Not to toot our own horn, but I really do, I really think that we're on top of it... any admission, I mean, we're really looking at those things whether you realize it or not."

Discussion

The purpose of this study was to explore the perspectives of critical care nurses on elder abuse to achieve a better understanding of the problems of reporting and generate ideas for improving the process. A variety of responses emerged, some responses similar for a particular concept and dissimilar for other concepts.

Intensive care nurses are aware of the different types of elder abuse. They described different scenarios regarding emotional abuse, financial exploitation, neglect, and physical abuse and noted that none were aware of sexual abuse. Being aware of abuse is the first step in caring for persons who are at-risk or are victims of abuse. Burgess and colleagues (2006) emphasize the importance for critical care nurses of having protocols in place to detect and manage elder sexual abuse. Protocols would allow nurses to detect abusive instances but also identify risk factors that may contribute to abuse and establish a mechanism for reporting the suspicion or allegation of abuse.

These nurses want to do the right thing: that is, to ensure that victims of elder abuse are identified and properly cared for during their ICU stay and after discharge. ICU policies and procedures must be an integral part of the standards of care. Hoyt provides a compliance checklist for forensic issues in the ICU that includes the following: 1) staff orientation for use of abuse and neglect screening tools with appropriate documentation, 2) forensic case management criteria, 3) management of sentinel events (such as death from neglect), 4) equipment and supplies for evidentiary specimens available in a dedicated, locked storage area, 5) references and resources available to all staff members, and 6) procedures that

include collection of specimens, photo documentation, chain-of-custody, and reporting/referral (Hoyt, 2006)¹⁶

These nurses did have the intuition for being suspicious of abuse. Winfrey and Smith describe a phenomenon called the “suspiciousness factor” which is an intuitive sense of heightened alertness based on knowledge and experience that compels a nurse to take action in response to a given circumstance or series of events (Winfrey and Smith, 1999). Nurses described reasons for being suspicious, and in one instance the suspicion became real when the nurse realized the ventilator tubing was being damaged. Nurses need to continually be aware, to act on their suspicious feelings, and to obtain additional information from the patients or respective family members/significant others who can provide needed information. This extra intense probing must continue until their curiosity is satisfied. As noted by one of the interviewees, the opportunity for obtaining information is sometimes short-lived in the intensive care setting.

The nurses indicated the process for reporting elder abuse in the critical care setting is vague and unknown. They collect some of the information, or enough information to raise concern, and pass that information on to the patient’s physician or the unit’s social worker. The actual mechanism of calling adult protective services has not been done by this group of nurses, as they are following hospital protocol. As a result, they never know the results of the report. No feedback is provided to them about further investigation by the state’s adult protective services unit. This lack of feedback may be a reason why one nurse thought there were not enough investigators in the state. Hospital social services could implement a protocol that provides feedback to reporters when they are notified of the decision by adult protective services to accept the report and provide an outcome of the investigation. Having such a mechanism in place would raise awareness of elder abuse and provide the reporter with more confidence that the extra work of investigating was worth the effort.

No new information was gleaned from the nurses’ perceptions regarding the older person’s rationale for not reporting elder abuse. The nurses described the law for dependent elder abuse on a continuum, from not being necessary to the need for it to be in place. As healthcare professionals in Iowa, nurses are required by law to be mandatory reporters. A suggestion from nurses in critical care units is that they be notified when the abuse they have reported to hospital employees is actually reported to adult protective services. Hospital employees who report the allegation of abuse receive the results of adult protective services investigations and should report those results to the healthcare professionals involved in the collection of relevant information.

While Iowa is currently the only state with mandatory training on dependent adult abuse, confusion still persists as to the actual law surrounding both abuse and mandatory reporting, especially by nurses (Jogerst, et al., 2003). Differing institutional requirements and chains of command may contribute to this confusion. However, when asked what changes or improvements could be made, many people from all groups suggested more frequent and more practical education. While currently mandated for every five years in Iowa, participants requested refreshers to be given as often as yearly. They also desired content to focus on specific cases, how to identify elder abuse, as well as how to best respond.

Some novel and useful suggestions were offered for improving critical care practice in relation to elder abuse. Assessment for abuse or risk factors of abuse is acknowledged on admission to a unit; however, one nurse thought this assessment should also occur at discharge from the unit. Persons admitted to critical care are in critical condition and usually not of sound mind to answer questions or provide relevant information, but at discharge their health has improved and useful information may be obtained.

Even though Iowa law requires dependent adult abuse education, the numbers of elder abuse investigations and substantiations have not changed since 1988, when this law was implemented (Jogerst, et al., 2003). These nurses believe education is valuable and indicated they want more education than that which is required every five years.

While this sample size was small, it was appropriate in order to fulfill our study purpose which was to identify the range and complexity of issues and barriers perceived by critical care nurses in relation to elder abuse and within the sample size range for similar exploratory qualitative studies (Rice and Ezzy, 1999). Our sample was limited to three counties in Iowa which report to the Iowa Department of Human Services, whose elder abuse legislation is different from other states (Jogerst, et al., 2003; Daly and Jogerst, 2001). Nurses who agreed to participate may have particular interest in elder abuse from prior experience, and responses may be different from those who did not participate.

Conclusion

Critical care nurses are aware of elder abuse and somewhat systematically evaluate for abuse at admission to their unit. They recognize signs and symptoms of abuse and are suspicious when it is warranted. They are aware of why an older person does not want to report abuse and take this into consideration when soliciting information. Facts, values, and experience impact personal approaches to defining abuse, suspicion, and dependence for each individual healthcare professional. Promoting the inclusion of elder abuse reporting and investigations in unit protocol and/or policies and procedures is warranted for providing quality of care.

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References

- Acierno R, Hernandez MA, Amstadter AB, Resnick HS, Steve K, Muzzy W, Kilpatrick DG. Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: The national elder mistreatment study. *American Journal of Public Health*. 2010; 100(2):292–297. [PubMed: 20019303]
- Aravanis SC, Adelman RD, Breckman R, Fulmer TT, Holder E, Lachs M, O'Brien JG, Sanders AB. Diagnostic and treatment guidelines on elder abuse and neglect. *Archives of Family Medicine*. 1993; 2(4):371–388. [PubMed: 8130916]
- Beaulaurier RL, Seff LR, Newman FL. Barriers to help-seeking for older women who experience intimate partner violence: A descriptive model. *Journal of Women & Aging*. 2008; 20(3/4):231–248. [PubMed: 18983109]
- Bird PE, Harrington DT, Barillo DJ, McSweeney A, Shirani KZ, Goodwin CW. Elder abuse: A call to action. *Journal of Burn Care & Rehabilitation*. 1998; 19(6):522–7. [PubMed: 9848043]
- Burgess AW, Watt ME, Brown KM, Petrozzi D. Management of elder sexual abuse cases in critical care settings. *Critical Care Nursing Clinics of North America*. 2006; 18:313–319. [PubMed: 16962453]
- Clark-Daniels CL, Daniels RS, Baumhover LA. Physicians' and nurses' responses to abuse of the elderly: A comparative study of two surveys in Alabama. *Journal of Elder Abuse & Neglect*. 1990; 1(4):57–72.
- Crabtree, B.; Miller, W. *Doing qualitative research*. 2. Thousand Oaks, CA: Sage Publications Inc; 1999.

- Daly JM, Jogerst GJ. Association of knowledge of adult protective services legislation with rates of reporting of abuse in Iowa nursing homes. *Journal of the American Medical Directors Association*. 2005; 6(2):113–120. [PubMed: 15871886]
- Daly JM, Jogerst GJ. Statute Definitions of Elder Abuse. *Journal of Elder Abuse & Neglect*. 2001; 13(4):39–57.
- Daly JM, Jogerst GJ, Brinig M, Dawson J. Mandatory reporting: Relationship of APS statute language on state reported elder abuse. *Journal of Elder Abuse & Neglect*. 2003; 15(2):1–21.
- Daly JM, Merchant ML, Jogerst GJ. Elder abuse research: A systematic review. *Journal of Elder Abuse & Neglect*. 2011; 23(4):348–65. [PubMed: 21978292]
- Hoyt CA. Integrating forensic science into nursing processes in the ICU. *Critical Care Nursing Quarterly*. 2006; 29(3):259–270. [PubMed: 16862029]
- Jogerst GJ, Daly JM, Dawson J, Brinig M, Schmuck G. Required Education for Iowa Mandatory Reporters of Elder Abuse. *Journal of Elder Abuse & Neglect*. 2003; 15(1):59–73.
- Krueger P, Patterson C. Detecting and managing elder abuse: Challenges in primary care. *Canadian Medical Association Journal*. 1997; 157(8):1095–1100. [PubMed: 9347780]
- Bonnie, RJ.; Wallace, RB., editors. National Research Council of the National Academies. Elder mistreatment: Abuse, neglect, and exploitation in an aging America. Washington, DC: The National Academies Press; 2003.
- Rice, P.; Ezzy, D. Qualitative research methods: A health focus. Oxford, England: Oxford University Press; 1999.
- Rodriguez MA, Wallace SP, Woolf NH, Mangione CM. Mandatory Reporting of Elder Abuse: Between a Rock and a Hard Place. *Annals of Family Medicine*. 2006; 4:403–409. [PubMed: 17003139]
- Rosenblatt DE, Cho KH, Durance PW. Reporting mistreatment of older adults: The role of physicians. *Journal of the American Geriatrics Society*. 1996; 44:65–70. [PubMed: 8537593]
- Schmeidel AN, Daly JM, Rosenbaum ME, Schmuck GA, Jogerst GJ. Healthcare professionals' perspectives on barriers to elder abuse detection and reporting in primary care settings. *Journal of Elder Abuse & Neglect*. 2012; 24(1):17–36. [PubMed: 22206510]
- U.S. Census Bureau. [Accessed July 25, 2011] Aging boomers will increase dependency ratio, census bureau projects: Older American population to become more diverse. 2011. Available at http://www.census.gov/newsroom/releases/archives/aging_population/cb10-72.html
- Vincent, GK.; Velkoff, VA. [Accessed July 25, 2011] The next four decades: The older population in the United States: 2010 to 2050. 2010. Available at <http://www.census.gov/prod/2010pubs/p25-1138.pdf>
- Winfrey M, Smith A. The suspiciousness factor: Critical care nursing and forensics. *Critical Care Nursing Quarterly*. 1999; 22(1):1–7. [PubMed: 10646458]
- Taylor DK, Bachuwa G, Evans J, Jackson-Johnson V. Assessing barriers to the identification of elder abuse and neglect: a communitywide survey of primary care physicians. *Journal of the National Medical Association*. 2006; 98:403–404. [PubMed: 16573305]

What Is Known About This Topic

- Elder abuse presents in any health care setting, including critical care
- In Iowa, health care providers are required to report suspicions of elder abuse

What this Paper Adds

- Protocols for reporting elder abuse are needed in critical care settings
- Barriers for older patients in critical care not reporting abuse are similar to other settings, including fear of retaliation, perpetrator is a relative, and physical injury.

Table 1**Open-Ended Interview Questions**

Instructions: Remember, during the interview, I will be taping our conversation. Please provide no information that would identify yourself or any of your patients. We are interested in understanding nurse's thoughts on addressing elder abuse in the outpatient clinical setting.

- 1 Please tell me about the kinds of elder abuse that an ICU/CCU nurse might encounter in the inpatient setting?
 - 2 Please tell me about any patient situations (provide no names or patient identifiers) in which, for whatever reason, made you think that there may be risk of or probable elder abuse?
 - 3 What might make you suspicious that a patient of yours was experiencing elder abuse?
 - 4 What would you do if you become suspicious?
 - 5 Is there anything else that a nurse might consider doing once there is suspicion of elder abuse?
 - 6 Under what conditions if any would you report abuse?
 - 7 Under what circumstances if any would you consider only monitoring?
 - 8 Why do you think that patients who have been victims of elder abuse might be reluctant to bring this up with their nurse?
 - 9 Why do you think nurses may not address the topic of elder abuse, even if suspected?
 - 10 How do you feel about the law that requires nurses to report suspected elder abuse?
 - 11 What do you think could be done in your practice to help improve the effectiveness of nurse efforts to address elder abuse?
 - 12 What changes can be made to the clinic (inpatient) setting or environment that will help improve the effectiveness of nurse efforts to address elder abuse?
 - 13 Is there anything else that we haven't talked about that you would like to say about improving nurse effectiveness in addressing elder abuse?
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