

Public Health Nurses' Perceptions of Assessing, Identifying, and Addressing Elder Abuse: A  
Descriptive Qualitative Study

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### **Abstract**

This descriptive qualitative study explores public health nurses' perceptions of assessing, identifying, and addressing elder abuse. Ten public health nurses from four public health units were interviewed for the study. Questions were categorized under perceptions of elder abuse, assessment and identification, and addressing elder abuse. A descriptive framework was developed, and findings revealed that the influence of ageism on public health nurses' knowledge of elder abuse determined how elder abuse is perceived. Despite general awareness, there is limited knowledge of elder abuse; nurses utilized alternative strategies to assess and identify elder abuse due to absence of screening tools, limited knowledge of interventions, professional obligations and organizational policies and guidelines. This research brings attention to the knowledge gap on elder abuse in nursing scholarship and public health nursing. It highlights the importance of education to advance understanding and promote screening of elder abuse in community nursing. Practice implications and suggestions for future research are provided to aid intervention and advocacy.

*Keywords:* elder abuse, elder abuse and neglect, abuse or mistreat, public health nursing/nurses, community health nursing/nurses, community health or home health nursing/nurses and public health.

## **Dedication**

The writing of this thesis has been an odyssey! Conducting this research has been a personal and an intellectual journey for me. This thesis is dedicated to those who made this journey possible. Foremost, to the memory of my late father, Olufemi Olukayode Otasanya, who loved me deeply and unconditionally, believed in me and was my rock. To Abila Otasanya, my mother, who began my journey of empathy, you love unassumingly and taught me to love. To Oluwatosin, Modupeoluwa, Anjolaoluwa, and Olugbenga my ever-loving and selfless children, your sacrifice of time and your understanding is highly appreciated. Thank you for letting me do this, I love you to pieces. You travelled this part of my journey with me, and now for you, your journey has begun.

I dedicate this study to victims of elder abuse, alive and demised, your experiences are real and acknowledged, your stories have touched me personally and professionally, as they have and will touch the lives and practice of other health care professionals who advocate for change. To nurses who directly and indirectly care for victims of elder abuse, may your advocacy help others understand the heinous crime of elder abuse and may it advance support for this vulnerable population.

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**List of Abbreviations**

ACE	Advocacy Centre for the Elderly
CCEL	Canadian Centre for Elder Law
CHNIG	Community Health Nursing Interest Group
CAN	Canadian Nurses Association
CNO	College of Nurses of Ontario
FEAI	Federal Elder Abuse Initiative
IFA	International Federation on Ageing
IPV	Intimate Partner Violence
LTC	Long Term Care
NICE	National Initiative for the Care of the Elderly
OHRC	Ontario Human Rights Commission
ONPEA	Ontario Network for the Prevention of Elder Abuse
OPGT	Office of the Public Guardian and Trustee
PEACE	Prevention of Elder Abuse Centres of Excellence
PHAC	Public Health Agency of Canada
POA	Power of Attorney
RNAO	Registered Nurses' Association of Ontario
SDOH	Social Determinants of Health
WEAAD	World Elder Abuse Awareness Day
WHO	World Health Organization

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## Chapter 1: Introduction

Proverbs and stories from the older generations in my family and community were the vehicle of language for my non-formal education as a child growing up in Nigeria. One of such proverbs that still resonates with me until today says: “the old woman looks after the child to grow his teeth and the young one in turn looks after the old woman when she loses her teeth”. I grew up in southern Nigeria being taught that the older generation is to be revered and cared for regardless of past differences or animosities because they are both the literal and symbolic figure of seasoned wisdom and that there is blessing in turn from doing so. As an adult and a nurse, I see how normal ageing in the presence of declining health or cognition can make an older adult prone to abuse. I have heard about, and I have also encountered and attempted to address multiple elder abuse situations, and they have all been disheartening to me. They have affected me so much that I have little tolerance for perpetrators of abuse and/or support networks of victims of neglect or elder abuse who have let such situations slide by not making ample efforts to address them. I view elder abuse as an injustice against the older generation who has cared for and served the younger generations, directly and indirectly. I believe that society owes it to the older adult to ensure they do not fear being abused or neglected. My experiences in caring for the vulnerable geriatric population in the community prompted my interest in this study on elder abuse.

Despite global recognition as an escalating public health problem and a violation of human rights, elder abuse is still under-identified, under-reported and under-researched (Butchart & Mikton, 2014). Elder abuse is not a new problem; “granny bashing” had been documented by Burston (1975) and Baker (1975) over 40 years ago in medical journals. What is new is that elder abuse is now recognized, not only as a public health issue, but as a problem of epidemic

proportion (Butchart & Mikton, 2014; Dong, 2015; Ploeg, Lohfeld & Walsh, 2013; Yon, Mikton, Gassoumis & Wilber, 2017).

Elder abuse and elder mistreatment are used interchangeably in the literature. Elder mistreatment encompasses elder abuse, neglect and exploitation (Falk, Baigis & Kopac, 2012; Fearing, Sheppard, McDonald, Beaulieu & Hitzig, 2017; National Initiative for the Care of the Elderly (NICE), 2012). The definition by the World Health Organization (WHO) is widely used in the literature, and states that elder abuse is “a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person” (WHO, 2002, p. 126). The major types of elder abuse are psychological (humiliating, threatening, treating like a child), physical (slapping, pushing, inappropriate use of restraints), financial (stealing, selling personal belongings without consent, misusing power of attorney), sexual (unwanted sexual activity), and neglect (abandonment, failing to provide basic necessities of life, health or medical needs) (Dong, 2015; Perel-Levin, 2008; Registered Nurses’ Association of Ontario (RNAO), 2014; WHO, 2017). Abuse of the elderly could be intentional or unintentional (Sandmoe, Kirkevold & Ballantyne, 2011). As per the Ontario Human Rights Commission (OHRC) (2001), submissions received by the commission show that elder abuse occurs in all contexts: homes, hospitals, long term care facilities, and in retirement homes. Elder abuse exists in both developed and developing countries, and as such, demands a global response (Podnieks, Anetzberger, Wilson, Teaster & Wangmo, 2010).

It is predicted that elder abuse will increase as the ageing population rises globally (Butchart & Mikton, 2014; WHO, 2017). It is also predicted that the number of older adults aged 60 years and over will double to reach 2 billion by the year 2050 globally (WHO, 2017).

Contrary to previous prevalence estimates of between 4-10% of older adult victims of abuse worldwide by the WHO, a recent study by Yon et al. (2017) showed that 15.7% of older persons aged 60 years and over, 1 in 6 older adults, are experiencing some form of elder mistreatment. In 1989, the prevalence of elder abuse in Canada was rated at 4%, but a recent study finding discovered it has more than doubled its rate (Fearing et al., 2017). In 2014, the aggregate rate for elder mistreatment in Canada was 8.2%, of which elder abuse alone constituted 7.5% (McDonald, 2015). Rates in the United States and also outside of North America were equally alarming due to the significant increases in occurrence and prevalence (Fearing et al., 2017). Like the 'iceberg theory' the troubling challenge is the fact that very few incidences are addressed or reported to authorities despite the high prevalence rates (Fearing et al., 2017). Only about 1 in 24 cases are reported due to multifactorial reasons, a major one being fear on the part of the older adult victims (Hirst, Penney, McNeill, Boscart, Podnieks & Sinha, 2016; WHO, 2017). In 2015, 8% of older Canadians reported experiencing abuse or neglect (Public Health Agency of Canada (PHAC), 2016).

The proportion of the Canadian population who are seniors is increasing because people are living longer, and life expectancy has increased dramatically (Statistics Canada, 2016). Currently, the population of Canadian adults over 64 years is 16.5%, exceeding that of children below age 15 which is 16.1%, due to the ageing of baby boomers and migration (Statistics Canada, 2016). This gap is expected to widen with significant implications on the economy, health care system, caregiving and intergenerational relations (PHAC, 2014). Statistics Canada's projection is that the proportion of older adults will increase in the future, representing 23% to 25% of the population by 2036 (Statistics Canada, 2016). This is a somber indication of the likelihood of significant elder mistreatment in the future and causes concerns for the well-being

and healthcare needs of seniors in relation to their social, physical and mental vulnerabilities (PHAC, 2014).

### **1.1 Scope of the Problem**

Canada has played a significant role in positioning the issue of elder abuse in a policy context globally; the current definition of elder abuse, the Toronto Declaration, was developed and adopted at the Global Prevention of Elder Abuse in Canada (International Federation on Ageing (IFA), 2012). Elder abuse is not a new phenomenon in Canada, but policy and practice responses are described to be in their infancy stage (IFA, 2012). In the past few decades, there has been a significant increase brought to the awareness and understanding of the prevalence, personal and societal costs related to the abuse of older adults in Canadian society (Fearing et al., 2017; Hirst et al., 2016; McDonald, 2015). The Canadian government invested significant funding on research and programs to combat elder abuse, most of which were focused on education, awareness, and legal remedies (IFA, 2012). Federal, provincial, and territorial legislations were enacted and numerous clauses in the criminal courts were made to protect older Canadians from mistreatment by stopping the abuse or reducing the consequences for the older adult once abuse has occurred (Podnieks, 2008). Also, systematic studies brought clarity to the nature, extent, causes and consequences of elder abuse (IFA, 2012). Despite these efforts, there is still very limited research on policy responses and interventions to address elder abuse in the community (IFA, 2012). Health care professionals in the community still lack awareness of tools and steps to address the issue and elder abuse has not achieved the same public health priority as other forms of violence such as child abuse or intimate partner violence (Perel-Levin, 2008; Yon et al., 2017).

Approximately 95% of older adults are community dwellers, living on their own or with spouses, children or other relatives (Gallione, Dal Molin, Crisitina, Ferns, Mattioli & Suardi, 2017). With a lack of national policy on mandated reporting, community dwelling older adults are subject to different regulation standards and are at a higher risk of abuse than those residing in institutions because there are initiatives in institutions to monitor abuse such as staff monitoring, ombudsman programs and mandatory reporting policies (RNAO, 2014; Summers & Hoffman, 2006).

However, the regulations in long term care (LTC) facilities are subject to questioning because older adults in residential facilities are not exempt from the negative and sometimes fatal outcomes of elder abuse despite LTC facilities being responsible for providing safe and quality care. A classic example is the case of former nurse, Elizabeth Wettlaufer, found guilty of multiple charges of murder, attempted murder and aggravated assault of residents under her care in a LTC setting (College of Nurses on Ontario, 2017). The atrocities against the elderly in LTC settings make one ponder on what priorities exist in the caregiving standards in LTC settings. It makes one to deliberate if clinical practice checkmarks overrides individualized quality care. One ponders if the priority of geriatric nursing care in the LTC setting is merely that of task completion to show that care or an intervention has been provided rather than providing care based on individual needs of the older adult. Rules implemented at government levels or in LTC facilities that inadvertently cause harm, repeated patterns of providing substandard care, and failure of administration to properly address incidents of abuse are examples of systemic abuse that can cause residents to become and remain vulnerable to elder abuse (RNAO, 2014).

The vision of the PHAC is “healthy Canadians and communities in a healthier world” (PHAC, 2016). Its mandate is to promote and protect the health of Canadians through leadership,



partnership, innovation and action in public health (PHAC, 2016). In keeping with this mandate, the Division of Aging and Seniors was initiated to address elder abuse through the Federal Elder Abuse Initiative (FEAI) launched in June 2008. Its focus includes: initiating collaborations with expert and key stakeholders in the field; compiling and assessing promising public health interventions that aid effectiveness in addressing abuse of the older adult; developing and providing access to effective up-to-date tools for effective elder abuse prevention and intervention to public health practitioners; and examining the issue of elder abuse from a gender perspective, so that public health practitioners can appropriately screen, detect and responding to elder abuse (PHAC, 2012).

Despite elder abuse becoming a domain of increasing scrutiny, with more research, awareness and education globally, there is a dearth of research on elder abuse in Canada, particularly in community health nursing practice. Majority of the older adults reside in the community, not in long term care settings. As a public health nurse practicing in the community, I have seen the far-reaching health consequences of elder abuse. I have also observed that there is a general lack of awareness, unpreparedness and rationalization for abuse from community health care providers. Most of all, elder abuse is simply missed by health care providers who are in a position to help, but who did not know what to look for or how to intervene. Since elder abuse is a public health issue that everyone including the PHAC is passionate about addressing, this study explored public health nurses' perceptions of assessing, identifying, and addressing elder abuse.

## **1.2 Research Question**

What are the perceptions of public health nurses in assessing, identifying, and addressing elder abuse in their nursing practice?

### **1.3 Research Objectives**

This study had three objectives: (1) to explore public health nurses' perceptions of elder abuse; (2) to explore how public health nurses assess and identify elder abuse in their nursing practice; and (3) to explore how public health nurses address elder abuse in their nursing practice.

The first chapter includes an introduction to the focus of my study, the scope of the problem of elder abuse in Canada, the research question, and research objectives. The second chapter will present the literature review conducted to examine research on relevant topics in this study including the definition, prevalence, risk factors, consequences, and barriers to addressing elder abuse. In chapter three, I will discuss my chosen methodology, Descriptive Qualitative method, and describe participant recruitment, data gathering and data analysis methodology. In chapter four, I will present the findings from the study. In chapter five, I will provide a discussion and an interpretation of my findings, describe their significance and implications to nursing practice, and include a summary and conclusion of the study conducted.

## Chapter Two: Literature Review

### 2.1 Search Strategy

In conducting this literature review, I reviewed published articles on the issue of elder abuse to identify studies conducted on the subject, allow for consolidation, identify gaps, and to avoid duplication (Grant & Booth, 2009). I presented the findings from the search in narrative form through themes and a conceptual framework. I conducted the literature review using electronic databases of Medline, PubMed, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and ProQuest. The following keywords were used individually and in combination with each other: 'elder abuse', 'elder abuse and neglect', 'abuse or mistreat', 'public health nursing/nurses' or 'community health nursing/nurses', 'community health or home health nursing/nurses' and 'public health'. Due to paucity of research data on elder abuse and public health nursing or community nursing in search terms or titles, the initial search for the literature review was done with a librarian. A second search was done again with support from the librarian to refine the findings. I conducted snowball search in PubMed and Scholars Portal to identify articles that speak on the topic, and I also selected studies from the Journal of Elder Abuse and Neglect.

The literature review consisted of published articles from scholarly journals and reviews that were 20 years or less, peer reviewed, both national and international, and both qualitative and quantitative studies. Limiters used to select articles were age (65+ years), subject (elder abuse, elder mistreat\*, community nursing, public health, mandatory reporting, nurses' attitudes, and nursing practice). Further search was done on community nursing as a subject; search terms included holistic, parish, rural and forensic nursing. To get a clear understanding of the concept of elder abuse in Canada, I searched through grey literature for data due to paucity of Canadian

research on the phenomenon. Additional references were obtained from reference lists of previously selected publications.

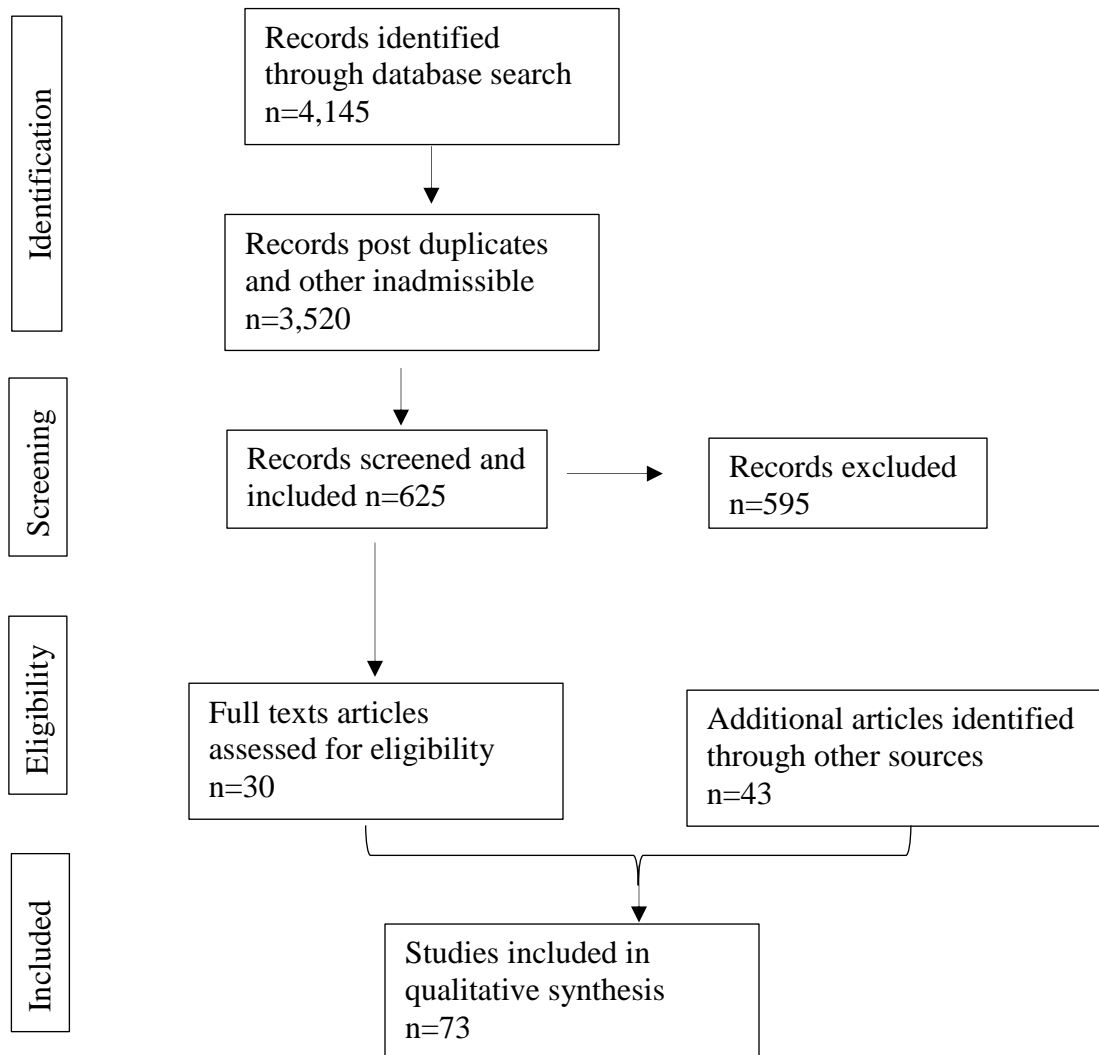


Figure 2. 1 Prisma Flow Diagram

Sum total of all records identified from all search engines were 4,145. Records considered to be duplicates or inadmissible were 3, 520. Of the 625 articles reviewed, 595 were excluded from the literature review after applying filters and limiters and also reviewing for relevance to the research objectives. With very limited outcome of about 30 articles, manual searches were done

directly from geriatrics journals and from the reference lists of previously selected publications so as to identify papers and studies that may have been missed inadvertently. Forty three additional articles were obtained using this means.

Previous studies and reviews on elder abuse have focused mostly on prevalence (Dong, Simon, Mosqueda & Evans, 2012; McDonald, 2015; Yon et al., 2017), views of older adults (Killick, Taylor, Begley, Carter-Anand & O'Brien, 2015; Mysyuk, Westendorp & Lindenberg, 2016(a); Mysyuk, Westendorp & Lindenberg, 2016(b); Ploeg et al., 2013), perceptions of physicians, nurses and social workers in primary care, emergency departments, long term care institutions (Beach, Carpenter, Rosen, Sharps & Gelles, 2016; Caceres, Bub, Negrete, Giraldo Rodriguez, & Squires, 2018; Daly, Schmeidel, & Jogerst, 2012; Erlingsson, Carlson & Saveman, 2006; Sandmoe & Kirkevold, 2011; Schmeidel, Daly, Rosenbaum, Schmuck & Jogerst, 2012; Winterstein, 2012), elder abuse assessment knowledge and screening (Almogue, Weiss, Marcus & Beloosesky, 2010; Lacher, Wettstein, Senn, Rosemann & Hasler, 2016; Fulmer, Paveza, Abraham, & Fairchild, 2000), interventions including education (Andrews, 2017; Fearing et al., 2017; Teresi et al., 2016; Teresi et al., 2013), and recognition and interventions in institutions, acute care and sub-acute care settings and faith communities (Alon & Berg Warman, 2014; Brossoie & Roberto, 2015; McCool, Jogerst, Daly & Xu, 2009; Podnieks & Wilson, 2005; Rudnick & Teaster, 2013).

The studies and reviews selected for my research were beneficial in providing clarity on the concept of elder abuse; they revealed the way elder abuse is perceived and addressed in society by individuals and healthcare providers. Previous studies found on elder abuse in healthcare were mostly conducted in long term care and acute care settings. There were very few studies identified from the literature search on elder abuse in community nursing and none was

found in public health nursing. While searching the literature, to the best of my knowledge, I did not find any Canadian study addressing elder abuse related matters in public health nursing practice. This literature review guided my research in exploring the perceptions of public health nurses in assessing, identifying and addressing of elder. My qualitative descriptive study provides a preliminary appraisal of public health nurses' perceptions and practices of assessing, identifying and addressing elder abuse. The first theme to be addressed in providing this appraisal is to ascertain how elder abuse is defined.

## **2.2 Variations in Elder Abuse Definitions**

There are debates in the literature on what elder abuse is and what it constitutes. There are therefore diverse definitions of elder abuse across jurisdictions in Canada and they reflect the differences in agenda and purpose of the various stakeholders (NICE, 2012; Wang, Brisbin, Loo & Straus, 2015). However, they all conclude that there is harm or risk of harm to an older adult. The Public Health Agency of Canada defines elder abuse as “any action by someone in a relationship of trust that results in harm or distress to an older person” (PHAC, 2012, p. 1); and neglect as “a lack of action by that person in a relationship of trust with the same result” (PHAC, 2012, p. 1). NICE (2012) states that abuse and neglect fall under maltreatment of older adults and refers to it as actions and/or behaviours, and lack of actions and/or behaviours that cause harm or risk of harm within a trusting relationship. The Canadian definition of elder abuse differs in the legal context because it clearly does not limit abuse to situations in a relationship where there is an expectation of trust (NICE, 2012). Rather, the scope of elder abuse in Canadian common law is very broad and includes systemic issues, directed exploitative marketing, “grooming” of an older adult victim, and stranger-targeted elder abuse (NICE, 2012).

The variation in the definitions of elder abuse is reflected in the differences in the interpretation of what elder abuse means in the literature. This in turn can affect the reporting of elder abuse which in turn can cause disparities in reported prevalence. The crucial first step in the public health approach to addressing elder abuse is to understand the magnitude of elder abuse (Yon, et al., 2017).

### **2.3 Prevalence of Elder abuse**

Geographical location and gender are relevant factors in elder abuse prevalence. Abuse can happen to anyone, in any family or relationship. It occurs to people of all race, cultures, ethnicities, religions, backgrounds and ages (PHAC, 2014). Globally, elder abuse has higher prevalence in low-income and middle-income countries because they have the vast majority of older adults, but there are currently limited research studies and data from those geographical areas (WHO, 2017). Wang et al. (2015) argue that there are inconsistencies in the possible association between elder abuse and ethnicity. In an American study by Dong et al. (2012) on prevalence of elder self-neglect in community-dwelling older adults, elder neglect was prevalent mostly among black older adults and among those with lower levels of education and income. On the other hand, another study done in the United States by Alexandra Hernandez-Tejada, Amstadter, Muzzy, & Acierno (2013) on race and ethnicity in a national elder mistreatment study found that race- and ethnicity-based differences in the risk of elder abuse were absent after controlling for health status, social support and income.

In comparison to the United States of America (USA), Canada has minuscule data on prevalence and incidence of elder abuse (Hirst et al., 2016; McDonald, 2015). Prevalence estimates for elder abuse in Canada were highest for psychological (11.6%) and financial abuse (6.8%), followed by neglect (4.2%), physical (2.6%), and then sexual abuse (0.9%) (WHO,

2017; Yon et al., 2017). Between 2009-2017, the rate of police-reported family violence against seniors increased by 6% (Statistics Canada, 2017).

According to the Canadian study by McDonald (2015), which estimated the prevalence and risk factors of elder abuse and neglect in Canada, a perpetrator of physical abuse was most often a spouse or ex-spouse at 34%, followed by a child or grandchild at 27%. For financial abuse, 37% of incidents were committed by adult children, 22% by spouses/ex-spouses, 15% by siblings, 10% by strangers, and 16% by others. In sexual abuse situations, the perpetrator was a friend 50% of the time, followed by a spouse at 19% of the time. In psychological abuse situations, the perpetrator was a spouse/ex-spouse 41% of the time and an adult child/grandchild 25% of the time. In cases of neglect, the perpetrator was a spouse at 31% of the time, and adult child/grandchild 25% of the time.

From police-reported data that examined the extent to which Canadian older adults were victims of family violence, Statistics Canada (2014) reported that common assault was the most typical form of violence against the elderly; weapons were rarely present in family violence against the elderly. Four in ten persons accused of police-reported violence against seniors were family members (Statistics Canada, 2017). Family violence against the elderly was highest in Nunavut and the Northwest territories (Statistics Canada, 2017). Older adults living in the rural areas, smaller towns and cities were at higher risk of abuse than those living in metropolitan areas (Statistics Canada, 2017). The overall rate of police-reported family violence among the elderly was 65 victims per 100,000 population in 2017 (Statistics Canada, 2017).

When analyzed by gender, men were at less risk of elder abuse compared to their female counterparts (Frazao, Correia, Norton & Magalhaes, 2015; Roberto, 2016; Statistics Canada, 2017); female seniors were considered 70% more likely to be victimized by their spouses than



male seniors (Statistics Canada, 2017). Physical abuse victims were commonly women with minimal cognitive impairment or psychological diagnosis and the major reason given for the injuries that ensue was accidental falls (Rosen, Bloemen, Lofaso, Clark, Flomenbaum & Lachs, 2016). However, Kosberg (2014) argues that there is a gender bias against men; older men have been deemed invisible because they do not acknowledge or report abuse. The study by Amstadter, Cisler, McCauley, Hernandez, Muzzy & Acierno (2011) found no difference in the likelihood of abuse between genders. However, gender differences were found between types of abuse and characteristics of perpetrators (Amstadter et al., 2011).

Approximately 95% of community dwelling older adults live independently or with their spouses, children or relatives (Gallione et al., 2017). In a Slovenian study attempting to ascertain if elder abuse is more prevalent in institutions or community settings, Habjanic & Lahe (2012) found no difference between settings as predictors of the occurrence of psychological abuse but being in a nursing home was a strong predictor of a significant reduction in both physical and financial abuse. On the other hand, WHO (2016) estimates that 1 in 10 older adults experience abuse each month, and rates of abuse may be higher for older adults living in institutions when compared to those living in the community. Irrespective of the setting, elder abuse needs to be addressed to ensure that older adults are protected.

Findings from the literature showed differences in the prevalence of elder abuse in relation to geographical location, ethnicity and gender. This could be attributed to the delicate nature of the subject of elder abuse and its ethical implications. Collecting sensitive data on abuse could have negative emotional, social, legal or financial outcomes for multiple parties, thereby causing both the victim and perpetrator to actively hide the abuse (Wang et al., 2015). However, McDonald (2015) state that it is imperative that elder abuse incidence and prevalence

be well documented in Canada so that this information can lead to further investigation and inform interventions.

## **2.4 Perpetrators of Elder Abuse**

Perpetrators of abuse are most often in a relationship of trust with the victims (Andrews, 2017; PHAC, 2014; WHO, 2002). Perpetrators of abuse could include a family member, friend, someone at work, a healthcare provider in institutional settings, or a care provider (PHAC, 2014; NICE, 2015). In Canada, a third of those accused of violent crimes against the elderly are family members (Statistics Canada, 2017). Lai (2011), who conducted a study examining the incidence of abuse and neglect among aging Chinese in seven Canadian cities, identified spouses and sons as those maltreating older Chinese adults. The victim's grown children were commonly the perpetrators of abuse (Statistics Canada, 2014). This is because in most cases, the perpetrator is dependent on the victim for food, money and shelter or the victim is dependent on the perpetrator for care and supports (PHAC, 2014). Some older adult victims of abuse are independent with care and decision making for themselves (PHAC, 2014), but still undergo elder abuse. This implies that elder abuse victims are not limited to older adults with limited physical or mental incapacities.

## **2.5 Gender and Elder Abuse**

While any older adult can be a victim of elder abuse, findings from studies show that gender can exacerbate a victim's experience of violence. Based on prevalence findings from the literature, majority of elder abuse victims are female, making gender a significant factor that should be considered when exploring elder abuse. Domestic violence as a social problem has its roots relating to violence against women, and it is rooted in unequal power relationships between genders (PHAC, 2012). Where elder abuse was considered a longstanding pattern of emotional

and physical abuse occurring in a family, spouses and adult children were identified as the most common perpetrators of family violence against women, while adult children were the most common perpetrators of family violence against senior men (Statistics Canada, 2017).

The PHAC (2012) recognizes gender as a determinant of health in its own right, in light of other social determinants of health such as socio-economic status and education. Gender inequality and its expression in society in both overt and covert ways, signals messages which imply that it is natural for men to have more social power than women, and this creates an underlying social condition for violence (Canadian Women's Foundation, 2016). Violence against women occurs at every age, income group, and in all cultures, religions, ethnic and racial settings (Canadian Women's Foundation, 2016). In some cultures, women have inferior status, and may have to place their trust in a male relative who cannot be challenged (Andrews, 2017). In some traditional societies, widows are subject to cruel practices such as abandonment, confiscation of property, and ejection from homes (Andrews, 2017; Perel-Levin, 2008; Pillemer, Burnes, Riffin & Lachs, 2016). Cultural or generational cohorts' attitudes to a longstanding pattern of emotional and physical abuse against women can normalize abuse and create conditions where victims do not bother to seek help. Acts of violence that are embedded in customs are also embedded in the social structure and must be considered in the broad context of human rights (Perel-Levin, 2008).

Domestic violence is not only manifest as long-standing wife abuse, it can also be violence that starts at an older age or violence that ensues from a new relationship in older age (PHAC, 2012). A significant factor to consider at this point is intimate partner violence during old age.

### **2.5.1 Intimate partner violence and gender.**

Intimate partner violence (IPV) is not normally associated with older persons, so most healthcare professionals are not aware that IPV against older women is a problem in their communities (Brossoie & Roberto, 2015). Beach et al. (2016) describe existing intimate partner abuse that continues into late adulthood as ‘IPV grown old’ and abuse that begins in late adulthood as ‘late onset IPV’. Though ‘IPV grown old’ and ‘late onset IPV’ decrease with age, IPV itself should be distinguished from other types of violence against the elderly (Beach et al., 2016). In 2017, females accounted for 58% of senior victims of family violence, and 32% of the female victims were most often victimized by a spouse (Statistics Canada, 2017). Due to non-reporting and minuscule studies on IPV in old age, there is minimal education available to health care providers for screening and intervention for this invisible group (Beach et al., 2016). A perpetrator of abuse could be male or female. While men were more likely to initiate violence, women were found to use violence in self-defense (Canadian Women’s Foundation, 2016). From these findings, power imbalance is an underlying factor in gender related elder abuse situations. Reasons given for elder abuse acts is discussed next.

## **2.6 Rationale for Elder Abuse**

Many factors contribute to elder abuse, and each case is unique. Mutual dependency between the victims and perpetrators of abuse, loneliness, power and control imbalances, and marginalized social positions of older persons in the society are causes of elder abuse identified by victims (Mysyuk et al., 2016(a); Mysyuk et al., 2016(b)). Killick et al. (2015) identified failure of the family and/or society to value and respect the elderly (ageism) as the reason for elder abuse. In a study on how older urban and rural American Indians conceptualize elder mistreatment, culture loss and substance abuse were identified as root causes for much of the mistreatment (Jervis, Sconzert-Hall & The Shielding American Indian Elders Project Team,

2017). Chinese Canadians identified high level of identification with Chinese cultural values, poor health and lower education as reasons for abuse and neglect (Lai, 2011). From the Chief Public Health Officer's Report focusing on family violence in Canada, over one-third of family-related homicide of seniors were motivated by frustration, anger or despair, a range of emotions typical of offenders who exert control over victims (Statistics Canada, 2017). A Swedish study examining the perceptions of elder abuse by agencies that are potential sources of support for elder abuse victims, uncovered the theme of 'older generation's responsibility for elder abuse', older persons' behaviours were discussed as provoking abuse. For instance, certain behaviours were seen as provoking abuse such as the older adult refusing help or making excessive requests for help and older women remaining in abusive relationships (Erlingsson et al., 2006). From these findings from the literature, power imbalances, emotions, ageism, and cultural values were reasons given for elder abuse. The risk factors for elder abuse is discussed in the next section.

## **2.7 Risk Factors for Elder Abuse**

Based on findings from the literature, I categorized the risk factors for elder abuse under individual (micro), community (meso) and systems (macro) levels. At the individual level, abuse occurs because of the abuser's power and control over the victim (Hirst et al., 2016; Mysyuk et al., 2016(a); Perel-Levin, 2008; Pillemer et al., 2016). Other individual risk factors for elder abuse include changing economic and social structures, loneliness, isolation, cognitive or functional impairment, shared living environments, intergenerational conflicts, substance misuse, inadequate knowledge of laws and services (Hirst et al., 2016; Mysyuk et al., 2016(b)) and the exacerbation of care giver stress due to lack of available information and resources about caring for an aging person (RNAO, 2014; Schiamberg, Barboza, Oehmke, Zhang, Griffore & Weatherill, Heydrich, & Post, 2011).

At the community level, social/cultural norms, societal views on ageing, and geographic location determine the availability of social benefits in the community such as affordable accessible housing, available long-term care beds, and emergency shelters for the elderly (Pillemer et al., 2016; RNAO, 2014; Schiamberg et al., 2011). System issues that increase vulnerabilities to abuse include the structure of the healthcare system, care delivery models, funding structures, and public policies (RNAO, 2014; Schiamberg et al., 2011). The interplay of these factors has far-reaching consequences for the health and well-being of the vulnerable older population. These consequences are discussed under the consequences of elder abuse section.

The risk factors for elder abuse could be viewed in the context of the **social determinants of health (SDOH)** and **ageism**. At each phase of an individual's life, health is determined by the complex interactions between economic and social factors, individual behaviours and the physical environment (PHAC, 2010). These factors are influenced by resources, wealth and status, which in turn, influence policies and choices leading to varying health status of individuals and the population at large (PHAC, 2010). The social determinants of health (SDOH) are socioeconomic factors that cause, impact or influence health outcomes (PHAC, 2010). The longer people live in stressed economic and social conditions, the greater the negative impact on their health outcome (PHAC, 2010). Socioeconomic status, gender, culture and social support network are major social determinants of health that can compound the vulnerability of an older adult and will typically determine if an older adult is at risk of being a victim of elder abuse (RNAO, 2014).

As identified by the OHRC (2001), a major contributor to elder abuse in Canada is ageism. Ageism, a prejudicial view of older adults, is one of the major reasons for elder abuse because there is ignorance surrounding the aging process and the needs of elderly people.

Ageism is a negative social attitude and a systematic discrimination of the elderly that is based on negative beliefs about ageing and assumptions that older adults are invisible, frail, senile, a burden or incapable (Band-Winterstein, 2015; Canadian Centre for Elder Law (CCEL), 2011; RNAO, 2014). The negative stereotypes of older adults having no useful role, in combination with non-acceptance of the increasing dependency that can accompany old age, contribute to elder abuse. In the Danish study by Mysyuk et al., (2016)(a), which explored how older adults explained why they became victims of abuse, the elderly participants identified that the negative image of 'being old' influenced their own perceptions of themselves which led them to conclude that abuse is a current norm in society and therefore permitted. The social determinants of health and ageism can be seen as underlying factors that are present at each category of individual, community and systems levels of the elder abuse risk factors.

## **2.8 Consequences of Elder Abuse**

All types of abuse can influence the health and well-being of victims (WHO, 2017). Consequences of physical elder abuse are particularly precarious for older adult victims because their bones are brittle, and convalescence is usually longer such that minor injuries can lead to lasting disabilities or death (Butchart & Mikton, 2014; Dong, Simon, de Leon, Fulmer, Beck, Hebert ... Evans, 2009). Other consequences of elder abuse include physical injuries ranging from minor scratches and fractures to head injuries that can cause lasting disabilities, poor quality of life, multiple health problems, psychological distress, premature hospitalization, early institutionalization, economic costs due to law enforcement and health care interventions, lost productivity and hastened death (Butchart & Mikton, 2014; Dong & Simon, 2013; Dong, 2015; Dong, Chen, Wu, Zhang, Mui & Chi, 2016; Hirst et al., 2016; Perel-Levin, 2008; RNAO, 2014; Roberto, 2016; Wong & Waite, 2017).

## **2.9 Perceptions of Elder Abuse**

The perceptions of elder abuse will be presented under the categories of assessing and identifying elder abuse and addressing elder abuse. For the purpose of this study, to assess is to gauge, evaluate or estimate an elder abuse situation or incidence, while to identify is to establish the form of abuse. There were mostly overlaps in the literature on assessing and identifying elder abuse, so it was not quite feasible to completely separate the two categories.

### **2.9.1 Assessing and identifying elder abuse.**

The lens with which older adults are seen by others and themselves influence the responses to elder abuse incidence. In the following sections, I will address assessment and identification of elder abuse under the knowledge of abuse views from victims, others (society), and healthcare professionals. I will also address the assessment and identification strategies of healthcare professionals relating to elder abuse.

#### ***2.9.1.1 Views of victims.***

Older persons' knowledge and perceptions are important to help understand how they define and identify abuse, and what interventions they are aware of to address abuse. From the systematic review done by Killick et al. (2015), on how older people conceptualized abuse, older people appeared to recognize the concept of abuse or mistreatment, but variations existed across population and geographical locations. Definitions and typologies used by older people were similar to those of professionals, but older people in minority populations emphasized different aspects of the abuse interaction (Killick et al., 2015). For instance, the systematic review compared the perceptions of older African American, Caucasian American and Korean American women. From studies included in the systematic review, Chang and Moon (1997) identified that older Koreans' individual understanding of elder abuse was based on Korean



cultural norms relating to family relationships, and that older Korean American women were less likely to perceive scenarios as abusive than their older African American or Caucasian American counterparts. Shibusawa & Yick (2007) identified that Chinese Americans were more likely to tolerate physical violence toward women. Sexual and emotional abuse were often absent from older people's definition of elder abuse and they perceived ageism and disempowerment as factors that lead to the failure of families or the society to value and respect older people (Killick et al., 2015). This shows that older adults perceived that the society in general is less caring.

In a study done in the United Kingdom by Naughton, Drennan and Lafferty (2014), which examined how older adults understood the term "elder abuse", the meanings older adults attached to elder abuse were at odds with the definition of elder abuse found in policy and public information. Despite public information campaigns, about 40% of community-dwelling older adults in the United Kingdom and Ireland were unaware of or had limited insight into elder abuse matters (Naughton et al., 2014). In the study by Mysyuk et al. (2016)(b), which examined how older adults defined and explained elder abuse in the Netherlands, Dutch participants defined elder abuse as intentional physical violence. Psychological, financial abuse and neglect, though more common than physical abuse, were less often identified as abuse (Mysyuk et al., 2016)(b). Indigenous Americans described elder mistreatment as being treated badly, providing examples of mistreatment as financial exploitation and neglect (Jervis et al., 2017). Lack of respect, psychological and physical abuse were less often identified as abuse (Jervis et al., 2017). Findings from a study by the WHO/International Network for the Prevention of Elder Abuse (2002) showed the definition of abuse was categorized into three groups by older persons: (1) neglect including isolation and abandonment, (2) deprivation of choices, status, respect, finances, and (3) violation of human, legal, and medical rights. From these studies, there were variations in

the way older adults perceived and defined elder abuse and what it constituted. It appeared that older adults did not fully understand elder abuse, and this affected the way they defined and viewed elder abuse. Furthermore, culture and societal norms (including ageism) appeared to determine how older adults viewed elder abuse.

#### *2.9.1.2 Views of others (society).*

The study by Erlingsson et al. (2006) examined perceptions of elder abuse from groups that were considered as potential sources of support for victims, namely police, primary care, church, municipal elder care and caregiver support organizations. Findings showed that despite participants viewing elder abuse from the position of their respective groups, there was a preponderance of shared perceptions among groups. One perception was that the basic cause of elder abuse was a lack of respect for older persons, which was described as an abuse itself and as sanctioned abuse, such as budget cut backs that reduces services to older persons (Erlingsson, 2006). Also identified in the study was the perception that actions grounded in good intentions could be considered as abusive; for instance, participants considered abusive actions as acceptable when providing care for the good of the older adult. Another perception identified was that older persons are sometimes responsible for elder abuse by contributing to the start of abusive situations, remaining in abusive relationships, refusing help, or making excessive requests for help. Study participants expressed frustrations with the hesitancy of victims and witnesses to report elder abuse. Findings from Erlingsson et al. (2006) also revealed that all groups tended towards ageism in describing older adults as a group with specific attributes rather than as individuals. Findings from the study by Rudnick and Teaster (2013) on clergy awareness and responsibilities relating to issues of elder abuse showed that 56% of clergy respondents in Kentucky lacked knowledge on elder abuse matters. A Canadian study by Podnieks and Wilson

(2005) about raising awareness of elder abuse in faith communities, showed that only two-thirds of faith-based leader participants were aware of elder abuse within their communities. From the literature, it appeared that the views of the society also showed that there exists poor knowledge and understanding of elder abuse. Overall findings also show that societal views of the elderly are skewed by ageism. Ageism, as an underlying factor, is evident in the way the older adults were perceived and treated in the society, thereby predisposing them to the risk of being abused.

### *2.9.1.3 Views of healthcare professionals.*

Variations in the definition and perception of elder abuse have an influence on healthcare professionals' knowledge of elder abuse issues. In a Norwegian study by Sandmoe and Kirkevold (2011) that explored how nurse managers and their staff identified and handled victims of elder abuse, community nurses struggled with defining abuse in cases they encountered and were reluctant to consider unintentional neglect as a form of abuse. However, study participants acknowledged having encountered abuse after an outline on the study's definition of abuse was discussed. In an American study by Schmeidel et al. (2012) that explored health care professional's perspective on elder abuse, nurses from the United States described rather than labelled elder abuse, physicians succinctly labelled the types of abuse, while social workers focused on self-neglect. A Malaysian study by Ahmed et al. (2016) which examined healthcare professionals' understanding of elder abuse, showed both doctors and nurses were deficient in their knowledge of elder abuse. Doctors and nurses demonstrated poor understanding of the signs of elder abuse and neglect and exhibited misperceptions regarding procedures of reporting and interventions (Ahmed et al., 2016).

In the study by Daly et al. (2012) exploring critical care nurses' perspectives on elder abuse in the United States, nurse participants described scenarios for emotional abuse, physical

abuse, financial exploitation, and neglect, but no reference was made to sexual abuse. Another study by Daly and Coffey (2010) which attempted to ascertain the perceptions of elder abuse among nurses and care assistants who worked in long term care settings, assessed participants' level of education and how knowledge was gained on elder abuse. The majority of nurse participants were educated at the general certificate level, and they had attended at least one training session on elder abuse. Despite over half of study participants being confident about recognizing abuse, there was a high level of uncertainty about what elder abuse constituted. In addition, attitudes towards the older adult also affected assessment of elder abuse (Daly & Coffey, 2010).

In the study by Caceres et al. (2018) which described Mexican healthcare professionals' perceptions of neglect of the elderly, participants perceived that factors contributing to elder neglect were independent of hospital services. Family caregivers of older adults lacked education, social support and resources to provide appropriate care to the elder family member (Caceres et al., 2018). Healthcare participants in the study also expressed a need for education on how to address neglect of the older adult (Caceres et al., 2018). They recognized that a lot of neglect cases are unintentional and are influenced by family and socioeconomic concerns. Therefore, participants reported significant distress and hopelessness related to perceived neglect (Caceres et al., 2018). Findings from the study by O'Connell (2015) which determined how home healthcare nurses perceived elder self-neglect revealed that seventy-five percent of participants reported that elder self-neglect was not taught in their nursing education programs, and seventy five percent additionally reported having no agency protocols for self-neglect. Despite these barriers, study participants were able to identify behaviours that constituted self-neglect. However, the absence of specific guidelines on elder self-neglect coupled with other

barriers left nurse participants feeling frustrated about their inability to effectively intervene to help their clients (O'Connell, 2015). Similar results were found in the study by Cairns and Vreugdenhil (2014) which explored frontline health and welfare practitioners' experiences working with older adults experiencing abuse. The study identified the work as complex, difficult, and sometimes dangerous. The cumulative effect of intimidating work contexts, the lack of support and practice dilemmas amounted to stress and frustrations for practitioner participants (Cairns & Vreugdenhil, 2014).

The views of healthcare professionals were similar to both individual and societal views on assessing and identifying elder abuse. Findings from the studies reviewed showed that there exists poor knowledge and understanding of what elder abuse is and what it constitutes. This was attributed to lack of addressing elder abuse in nursing curricula/ education. The interplay of ageism and the social determinants of health were underlying factors identified from the literature that could determine elder abuse, and they were presented in the forms of limited finances, limited funding and support of resources for the elderly, and a lack of agency protocols or guidelines relating to elder abuse. The next subsection is an overview of healthcare professionals' strategies of assessing and identifying elder abuse.

#### ***2.9.1.4 Assessment and identification strategies of healthcare professionals.***

Screening and detection play precursory roles for meaningful intervention in addressing elder abuse (Beach et al., 2016; Perel-Levin, 2008). A range of methods have been used to screen for and detect elder abuse in both the community and institutional settings (Beach et al., 2016). For cognitively intact older adults in the community, victim surveys are applicable. For the cognitively impaired older adult, indirect methods such as caregiver surveys, health care provider screenings, reports from those in frequent contact with the older adult, forensic analysis or other

validated clinical algorithms in emergency care settings are applicable (Beach et al., 2016).

Validated screening tools used in elder abuse include, but are not limited to, Brief Abuse Screen (BASE); Caregiver Abuse Screen (CASE); Elder Abuse Suspicion Index (EASI); Elder Assessment Instrument (EAI); Hwalek-Sengstock Elder Abuse Screening Test-Revised (H-S/EAST); Expanded Indicators of Abuse Inventory (E-IOA); and Elders Psychological Abuse Scale (EPAS) (Gallione et al., 2017; RNAO, 2014). The most common method of screening for both cognitively intact and cognitively impaired residents in institutions include staff and family member surveys (Beach et al., 2016).

The detection of elder abuse through screening is a fundamental challenge for healthcare providers and researchers who aim to intervene or prevent the abuse (Beach et al., 2016). Elder abuse takes place within a context, therefore screening or assessment instruments that do not put the bio-psycho-social context of the older adult and the type of abuse into context will encounter significant limitations (Perel-Levin, 2008). According to Beach et al. (2016), major challenges confront clinicians and researchers who attempt to screen for elder abuse. The first challenge is the differing definitions and conceptions of elder abuse. The second challenge is ascertaining whose perspectives are to be screened or assessed; those of the older adult victims (cognitive or non-cognitive), clinicians, or proxy informants. A third challenge is ascertaining what screening tool will be suitable for the assessment and how sensitive subjects such as self neglect, financial exploitation or wider cultural context will be approached (Beach et al., 2016).

Investment in the development of guidelines and screening tools to address elder abuse must be a public health priority to reduce the global rate of elder abuse (Yon et al., 2017). Some professional nursing bodies have published guidelines for nurses with regards to the prevention, identification and management of elder abuse in practice setting such as Nursing and Midwifery

Council, United Kingdom in 2015, Canadian Nurses Association in 2011, and the Registered Nurses' Association of Ontario in 2014. In order to address elder abuse, the RNAO developed a guideline aimed at preventing and addressing abuse and neglect of older adults throughout various health-care institutions and community settings in Canada. The guideline is titled "Preventing and Addressing Abuse and Neglect of Older Adults: Person-Centred, Collaborative, System-Wide Approaches". The guideline, though geared towards long-term care settings, contains resources to guide and support its uptake at various practice levels, education, policy and systems levels (RNAO, 2014).

Though screening tools used in assessing elder abuse have the ability to provide a multidisciplinary objective assessment to detect actual or potential elder abuse, they need to be further tested to refine their validity and reliability because some particular categories of elder abuse have been omitted or gone undetected (Gallione et al., 2017). Flow charts or algorithms have also been considered as a priority for elder abuse detection and management because they can allow a simple and clear pathway for decision making (Gallione et al., 2017). No single tool is designated as the gold standard, because abuse has to be evaluated in relation to the situation and in combination with the assessment of all aspects of the violence (Gallione et al., 2017). As per the recommendation of the American Medical Association, every clinical setting should adopt a protocol for the assessment and detection of elder mistreatment and follow a routine pattern for each case encountered with the following areas for assessment: safety, access, cognitive and emotional status, health and functional status, social and financial resources, frequency, severity and intent (Gallione et al., 2017).

Healthcare professionals who work with the older adult must possess significant knowledge and skills in recognizing victims of abuse and be aware of intervention strategies

including relevant protection of the older adult and referral agencies (Loh et al., 2015). Findings from the study by Almogue et al. (2010) which assessed and compared the knowledge and attitudes of physicians and nurses toward elder abuse in Israel, showed that responders who had a good knowledge of elder abuse matters also had a good knowledge of relevant laws and protocols relating to elder abuse. The systematic review by Cooper, Selwood and Livingston (2009) examined health and social care professionals' knowledge of elder abuse, their ability to detect it and their willingness to report it. The ability to detect abuse was most frequently evaluated by asking professionals whether they had encountered any cases of abuse in a certain time period. This implies that those who were not encountering elder abuse while working with older adults might not detect it. Few U.S. physicians routinely asked older people about abuse but those who did were more likely to detect and report it (Cooper et al., 2009). In addition, healthcare professionals who received training on elder abuse were no more likely to detect abuse than those who had no training, but they were more likely to report abuse if detected (Cooper et al., 2009). This implies that routinely asking older adults about abuse will promote the rate of detection. In addition, educating professionals appears to be beneficial to both detecting of and intervening in elder abuse cases.

According to Sandmoe and Kirkevold (2011), the Norwegian nursing curriculum did not have elder abuse as a mandatory course and only very few universities incorporated elder abuse as a topic in an elective course. Since the nurses were not taught how to identify abuse, their approach to such encounters was based on clinical experiences (Sandmoe & Kirkevold, 2011). A study by Leddy, Farrow and Schulkin (2014) aimed to determine how knowledgeable obstetrician-gynecologists were about elder abuse, its consequences, screening, reporting laws and the extent to which they screened for and reported elder abuse. Ninety-five percent of



obstetrician-gynecologists were unaware of existing validated tools for assessing elder abuse, less than 5% have heard of any screening tools. In addition, a study by Sugita and Garrett (2012) which attempted to ascertain if a symposium on elder abuse would raise the knowledge and likelihood of oral healthcare providers to report elder abuse, 91% of respondents of oral health care providers stated they had not received any formal training on elder abuse and neglect despite half of them having been in practice for over 20 years. Community care nurses reported that elder abuse encounters were often minimized and seen as a taboo because either the nurses had limited knowledge of the issue or they did not know what to do regarding the situation (Sandmoe & Kirkevold, 2011). Community care nurses in the study by Sandmoe and Kirkevold (2011) also reported that supporting factors in the work environment coupled with manager's active and supportive role had a heavy influence on nurses' ability to identify elder abuse.

Fearing et al. (2017) identified the need for more studies on community-based interventions due to the scarcity of studies on interventions for community-dwelling older adults in Canada. From the findings in literature, it is evident that screening is a preliminary activity in evaluating elder abuse. Knowledge of healthcare professionals on elder abuse matters and the applicable laws and protocols are the determinants on elder abuse intervention strategies.

### **2.9.2. Addressing elder abuse.**

The literature search showed the existence of efforts to address elder abuse. Types of interventions that have been utilized in addressing elder mistreatment included psycho-education for older adults and professionals, multidisciplinary case management programs, legal interventions by police departments, and therapeutic interventions (Fearing et al., 2017; Ploeg, Fear, Hutchison, MacMillan & Bolan, 2009). The Canadian Nurses Association (CNA) (2011) specified that a comprehensive strategy to prevent elder abuse should be addressed within a

public health framework from a population health perspective by addressing the determinants of health. This can take the form of supportive housing, social support and health support for older Canadians in their homes (CNA, 2011).

Most interventions aim at increasing awareness and knowledge of the issue of elder abuse with an overall objective of increasing elder abuse reporting. From a Swedish study by Wangmo, Nordstrom and Kressig (2017) which explored how and why abuse and neglect occurs in geriatric institutions and presented practical prevention measures, participants identified continuing education and targeted training as means to sensitize both the less experienced and qualified personnel on the nuances that afflict their clients and the ethical issues involved. The systematic review by Alt and Nguyen (2011) showed that face-to-face didactic sessions with opportunities for discussion and feedback were significantly more effective at meeting learning objectives than printed materials alone. Teresi et al. (2013) evaluated the impact of a new training intervention on nursing staff's knowledge, recognition and reporting of resident to resident elder mistreatment in nursing homes in the United States. Teresi et al. (2013) reported that post-educational intervention brought about an increase in nursing staff's recognition, reporting and intention to document elder abuse.

In the Cochrane review done by Baker, Francis, Hairi, Othman and Choo (2016), the authors argued that it was uncertain if targeted educational interventions improved the knowledge of healthcare providers and caregivers about elder abuse. It was also unclear if improved knowledge led to changes in behavior or reduction in elder abuse incidences. They stated that supporting and educating elderly victims led to more reporting of abuse. However, the authors were uncertain if the increase in reporting was related to an increase in elder abuse

incidences or if it is due to a greater willingness to report the abuse as it occurred (Baker et al., 2016).

Multidisciplinary teams engage multiple professional disciplines and perspectives in elder abuse prevention and intervention (Roberto, 2016). Alon and Berg-Warman (2014) evaluated a multisystem model for elder abuse intervention in Israel. From the evaluation study, multidisciplinary interventions on elder abuse cases included individual and group counselling and legal interventions. Individual counselling was used 79% of the time, mostly for violation of rights and psychological abuse, and this included counselling for both victim and abuser. On the other hand, legal interventions were used in 39% of the cases, mostly for violation of rights, financial exploitation and physical abuse (Alon & Berg-Warman, 2014). The systematic review by Ploeg et al. (2009) identified that therapeutic interventions were utilized as post-abuse treatments and they included individual counselling, psycho-educational support groups, volunteer victim assistance services and case management. Other interventions also included the use of the faith communities and systems change (Malks et al., 2010; Podnieks & Wilson, 2005; Rudnick & Teaster, 2013).

In the United States, in most states and territories, the Adult Protective Services (APS) is the principal public agency responsible for investigating and managing elder abuse situations in the community (Pickering, Ridenour & Salaysay, 2016; Roberto, 2016). Aside from a legal mandate to report elder abuse, healthcare professionals have an ethical and moral obligation to report elder abuse (Liao & Mosqueda, 2006). The threshold for reporting elder abuse in areas where there is mandated reporting is one of 'reasonable suspicion', and failure to make a report carries significant risks both criminally and civilly for healthcare providers and the agencies they work for (Liao & Mosqueda, 2006). The decision to file an elder abuse report is not based on

legal or administrative concerns but on clinical judgment (Liao & Mosqueda, 2006). After receiving a report of elder abuse, APS investigates and, if needed, takes action to ameliorate the situations with medical, psychological, social and legal services. An immediate response to abusive situations might involve the removal of the older victim or the abuser from the home and securing medical care and supportive services, including mental health services (Roberto, 2016). In Canada, each province determines its own approach to addressing elder abuse matters. Elder abuse law in Canada is addressed in the next subsection.

#### *2.9.2.1 Mandated reporting of elder abuse.*

The study by Roger and Ursel (2009), on investigating public views on mandatory reporting of elder abuse in Manitoba, Canada, revealed that mandatory reporting was not always preferable, except in situations of a diagnosis of incompetency. Older adults and those with regular contact with older adults did not favour mandatory reporting because it was seen as restrictive to the rights of the older person as an adult (Roger & Ursel, 2009). The autonomy and independence of the older adult who might be considered vulnerable, is protected (CCEL, 2011). This is a non-paternalizing /non-infantilizing approach to addressing elder abuse matters, such that the older adult is not treated in a child-like manner. Professionals must get consent from an older adult before disclosing personal or health information (CCEL, 2011). Disclosure without consent is permitted by hospital, government agencies, regulated health care providers if there are reasonable grounds to believe that such disclosure is necessary to eliminate or reduce significant risk to a person or group (CCEL, 2011). In the study by Killick et al. (2015), ageism and disempowerment were seen as impacting the older adult in the attempt to protect them from abuse. Critics of protective services contend that it promotes ageist attitudes, which infantilize older adults and focus on their deficits (Killick et al., 2015). Consequently, Killick et al. (2015)

argue for a human rights approach which recognizes the significance of respect, equality and dignity. Therefore, processes aimed at protecting the victims of elder abuse should focus on their needs and wishes so as to empower them.

### ***2.9.2.2 Elder abuse law in Canada.***

Compared to the United States, Canada has no specific “elder abuse” code provision. The Canadian definition of elder abuse differs in the legal context because it clearly does not limit abuse only to situations involving a relationship where there is an expectation of trust (NICE, 2012). Rather, the scope of elder abuse in Canadian common law is very broad and includes systemic issues, directed exploitative marketing, “grooming” of an older adult victim, and stranger-targeted elder abuse (NICE, 2012).

There is no elder abuse law in Canada and, therefore, no federal mandatory reporting of elder abuse (CCEL, 2011). Rather, there was an amendment to the criminal code in Bill C-36 to incorporate elder abuse as a criminal offence (Echenberg & Kirkby, 2012; Wang et al., 2015). Each province and territory take its own unique position on the issue (CCEL, 2011). There is no specific crime of elder abuse, the criminal code applies to all adults regardless of the age of the victims, and charges are laid based on the criminal act (CCEL, 2011). The Canadian Charter of Rights and Freedoms (1982), protects the rights of all Canadians. All Canadians, including the elderly have the fundamental freedom of thought, belief, opinion and expression (Justice Laws, 2018). Therefore, no one, including service providers, should force a client/victim to report elder abuse to the authority. Reporting abuse might be mandated by work obligation or professional code of ethics (Elder Abuse Ontario, 2018). RNAO (2014) recommends that nurses respond to alleged or suspected abuse and neglect situations according to legal requirements and organizational policies or procedures.

Alberta and Nova Scotia are the only provinces in Canada with mandatory reporting laws on elder abuse both in institutions and community dwellings (CCEL, 2011; Family Law Nova Scotia, 2017). Nova Scotia has two laws that relate directly to preventing and responding to abuse of older adults. The first one is the Adult Protection Act and Protection for Persons in Care Act. Under this law, suspected or known cases of abuse, neglect or self-neglect of vulnerable adults must be reported (Family Law Nova Scotia, 2017). The Adult Protection Act does not address financial abuse in Nova Scotia. The second one is the Protection of Persons in Care Act which applies to patients or residents over the age of 16 in health care facilities. It creates a duty for administrators and service providers in those facilities to report abuse or situations that would likely lead to abuse (Family Law Nova Scotia, 2017). In Newfoundland, there is mandatory reporting for only neglected adults (CCEL, 2011). In British Columbia, Manitoba and Ontario, it is mandatory to report abuse when it occurs in institutional settings (CCEL, 2011). Additionally, in Ontario, older persons with developmental disabilities are protected with mandatory reporting legislation (Elder Abuse Ontario, 2018).

### **2.10 Barriers to Seeking Help or Reporting Elder Abuse**

Most elderly victims of abuse do not seek help or report it for multifactorial reasons and each reason is contextual (Hirst et al. 2016; Pickering & Rempusheski, 2014). Barriers to seeking help include stigma, literacy, language, lack of mobility, lack of funding and culture (Hirst et al., 2016). Victims of abuse share a fear of retaliation, stigmatization, and emotional distress (Hirst et al., 2016; Ko & Koh, 2012; Perel-Levin, 2008; Sugita & Garrett, 2012). The desire to protect the abuser (if the perpetrator is an adult child dependent on the victim for support), a desire not to leave home, absence of alternative caregiver, and threat of being placed in LTC facilities are

additional reasons for the elderly not reporting abuse (Perel-Levin, 2008; Pickering & Rempusheski, 2014).

Studies show that health professionals find elder mistreatment situations complex and difficult to handle (Hirst et al., 2016). Nurses in Israel and Korea identified elder abuse as a private family matter and were neutral, unwilling, or fearful about getting legally involved (Almogue et al., 2010; Ko & Koh, 2012; Winterstein, 2012). Attitudes of uncertainty about occurrence due to lack of knowledge about signs of abuse or clinical findings, fear of misdiagnosis and perceived ineffectiveness of mandatory reporting contribute to non-reporting (Cooper et al., 2009; Daly et al., 2012; Sugita & Garrett, 2012). Time constraint was a common problem identified by both nurses and physicians in Iowa, United States, on elder abuse screening because they felt inundated with other demanding tasks (Schmeidel et al., 2012).

Some health professionals and faith-based communities were mostly unaware about the issue of elder mistreatment and of the appropriate course of action to pursue when mistreatment is suspected (Falk et al., 2012; Rudnick & Teaster, 2013; Winterstein, 2012). Inadequate knowledge of protective services laws, mandatory reporting of abuse and organizational policies contribute to under-reporting (Daly et al., 2012; Hirst et al., 2016). Nurses and physicians in the United States cited fear of damaging existing therapeutic relationships as a major reason for not reporting abuse (Cooper et al., 2009). From the literature, it is evident that the major barrier to addressing and reporting elder abuse is knowledge gap. This presents in the form of uncertainty of occurrence due to a lack of knowledge about signs of abuse, lack of knowledge on appropriate course of action to pursue or protective service laws, fear of misdiagnosis, fear of legal involvement and fear of the relationship breakdowns. The knowledge gap and the forms it takes has significant implications for victims, healthcare providers and the society.

## **2.11 Elder Abuse: Implications for Nursing Practice**

Since there is no existing national standard for defining, identifying, reporting, or investigating elder abuse, adequately addressing elder abuse matters poses a challenge in Canadian society. Nurses however do have a responsibility to care for their clients.

### **2.11.1 Professional requirement.**

Nursing is a regulated profession, and a major function of regulation is to protect both the public and the profession by adhering to the professional codes which are primarily underpinned by dignity and respect for the other (Phelan, 2018). Nurses are therefore mandated to engage in responsible and accountable practice. From both a professional and personal perspective, nurses need to have a good knowledge of elder abuse and understand the codes of their regulatory bodies and professional organizations relating to elder abuse (Andrews, 2017; Phelan, 2018). Care interactions with clients should be self-regulated to ensure that dignity and respect are central in care delivery and based on a human rights approach (Phelan, 2018). In addition, nursing obligations includes addressing restrictive or negative systems of care that can be identified as abusive at an organizational level by reporting and whistleblowing, to alert authorities about poor and unsafe care practices (Andrews, 2017; Phelan, 2018).

### **2.11.2 Assessing, identifying and addressing elder abuse.**

At the core of abuse are the fundamental loss of respect and deprivation of basic human rights as set out in the 1948 Universal Declaration of Human Rights (Perel-Levin, 2008). The recognition of abuse as a human rights issue places an onus on the government to prevent and address elder abuse as part of the its responsibility to care for all people in society (Perel-Levin, 2008). The domains of public health and human rights overlap. The recognition of risk factors and indicators of abuse by public health nurses (PHN) or other health care professionals is



critical to achieving the goal of a “healthy community”. Elder abuse will continue to be underdiagnosed and overlooked in society unless both primary health care and social services are well equipped to address the issue (IFA, 2012). The social determinants of health provide a broad and inclusive outline with which elder abuse can be prevented, identified early, and effective interventions can be provided to older adult victims (IFA, 2012).

A basic but fundamental assumption that must be made by nurses and healthcare providers is that older adults should be positioned as equal human beings with equal rights and entitlements. Stereotyping and ageist assumptions can impede the detection of elder abuse particularly when nurses work in an environment where ageism is enabled causing abuse to be ingrained at various levels of care delivery (Phelan, 2018).

For elder abuse interventions to be effective there must be a cohesive integration of human rights principles in primary health care. Healthcare, social services and legal frameworks need to be applied with a strong sense of equity to reinforce the civil and human rights of all people irrespective of ethnicity, gender, socioeconomic status and age (Perel-Levin, 2008). Home health care professionals, doctors, nurses, therapists, and personal support workers, all play key roles in assessing, addressing and preventing elder abuse through timely interventions and assistance (Summers & Hoffman, 2006). Similar to institutional settings, through routine examinations, information sharing and interactions with clients, family members, caregivers and public health professionals can contribute to safeguarding older adults in the community (Summers & Hoffman, 2006).

## **2.12 Gaps**

Pertinent gaps were identified while conducting this literature review. With an increase in the population of the elderly in Canada and the paucity of data on incidence, prevalence, and

intervention strategies, in comparison to other family violence, current research on elder abuse is important. Identifying elder abuse requires screening tools and research is needed to ascertain the use and effectiveness of the validated elder abuse screening tools and best practice guidelines for various healthcare settings. Reviews on the effectiveness of educational interventions to increase knowledge, assessment skills and reporting of elder abuse showed mixed results. The communication gap between victims and healthcare providers, whereby neither party reports nor assesses elder abuse is a big challenge to intervention. There is no specific system identified to bridge the communication gap between victims and healthcare providers. Intimate partner violence in old age is unique from other types of elder abuse and should be brought to light through research to ascertain its incidence, prevalence, screening and interventions.

Differences in the effectiveness of various modes of interventions require the need for more studies to be conducted to establish outcome measures on various types of interventions in various settings. With no federal mandatory reporting strategy, and Canadian provinces and regions addressing issues of elder abuse independently, targeted research would uncover the strategies being utilized for assessing and responding to elder abuse matters. For example, research that examines the practice of the APS in the province of Nova Scotia would measure the outcome, effectiveness, success and/or challenge of this strategy to address elder abuse. Moving from local to national levels, data are needed to identify interventions that have been implemented and their effectiveness for community dwelling older adults.

Due to variations in definitions and perceptions of the meaning of elder abuse, there is a need for research to ascertain the meanings healthcare professionals and the general public ascribe to elder abuse, and to know how these meanings influence their responses to elder abuse cases. This is the gap that my study will address with a focus on public health nurses.

### **2.13 Summary of Literature Review**

A summary of the literature review shows that the perceptions with respect to assessing, identifying, and addressing elder abuse are dependent on the knowledge of elder abuse. It revealed that an understanding of the concept of elder abuse, its prevalence, perpetrators of abuse, the rationale given for why it happens, risk factors, consequences, will determine what and how to assess and identify elder abuse, and ultimately how to address elder abuse. Uncertainty or limited knowledge of elder abuse coupled with ageism as an overshadowing factor has an effect on the assessment, identification and ultimately solution for combatting elder abuse.

Findings from the literature showed that elder abuse occurs in bio-psycho-social context. Views of victims, society, healthcare professionals, laws and protocols, organizational guidelines (if any), influence how elder abuse is assessed and addressed. Ageism also plays a significant role in the perceptions of elder abuse. Laws, protocols, and organizational guidelines determine what actions to take if elder abuse is encountered. Organizational guidelines on elder abuse will help ascertain if a work environment enables ageism. There is also the debate on mandated reporting versus non-mandated reporting with regards to respecting and maintaining the rights of the older adult as an independent, autonomous adult. Figure 2.2 below provides a summary of the literature review.

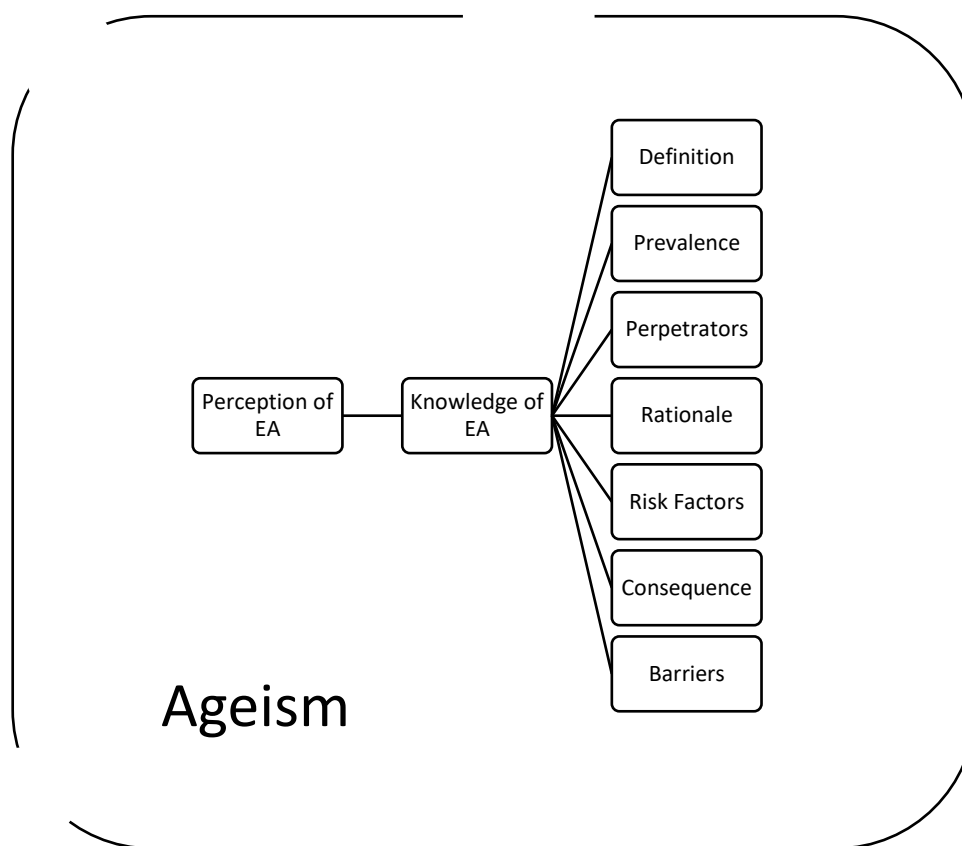


Figure 2. 2 Summary of Elder Abuse Perceptions from Literature Review

### 2.14 Study Rationale

For multifaceted reasons identified in the literature review, inadequate decisions and actions are taken with elder abuse related issues. To stop abuse from recurring, someone other than the victim needs to assess and report it. Pillemer et al. (2016) identified that the best prevention strategy is for interventions that have the potential to prevent elder abuse. Being an upstream approach to healthcare, public health nurses, as frontline healthcare professionals can positively contribute to preventing and addressing elder mistreatment. Public health nurses are ideally positioned in terms of education and authority to bear the responsibility of identifying potential and actual victims of elder mistreatment (CNA, 2011). The professional duties of a

nurse mandate the duty of disclosure on matters relating to abuse of the vulnerable elderly (CNA, 2011). Unfortunately, nurses are not always aware of their obligation to identify and address elder abuse (Winterstein, 2012).

An initiative being focused on by the public health component of the FEAI is "... to develop and provide public health practitioners with up-to-date tools, so they are better equipped in elder abuse prevention and intervention" (PHAC, 2012, p.1). What is the level of awareness of elder abuse in public health nursing? Do public health nurses assess/ screen and address elder abuse? How is elder abuse awareness translated into public health nursing practice?

Public health supports an upstream approach and particularly promotes prevention. However, to the best of my knowledge to date, I could not find studies in the Canadian context on assessing, identifying or addressing the issue of elder abuse in public health settings. In searching the literature, very limited studies were found regarding elder abuse experienced by community dwelling older adults, particularly in the Canadian context. The dearth of information on public health nursing practices and policies relating to identifying and addressing elder abuse raised the need for this study.

This study builds on previous studies that presented findings on the knowledge and perceptions of critical care nurses, emergency department nurses, long term care nurses, physicians, nurse managers, and social workers. While there is a gradual growth in the body of research on elder abuse globally, this study is unique because it will shed light on an area that is very vital yet is still in the shadows concerning elder abuse in the community. Given the potential importance of more research on elder abuse to community dwellers, findings from this study can provide valuable insights into the level of knowledge of elder abuse, existing tools for screening elder abuse, measuring and monitoring elder abuse interventions in the community and

in particular the contribution of public health units. The perceptions of public health nurses will provide the lens through which elder abuse is being assessed and ultimately addressed in public health nursing. An important implication for this study is that it can contribute to future practice and policy reviews concerning vulnerable older adults and the public health nurses they encounter.

### **Chapter Three: Methodology**

Descriptive qualitative approach, as described by Sandelowski (2000 & 2010) was utilized for this study. Descriptive qualitative approach draws from the general principles of naturalistic inquiry, which are ways of studying something in its natural state (Sandelowski, 2000). In naturalistic inquiry, the target phenomenon is allowed to present itself as it would be if it were not being studied (Sandelowski, 2000). Descriptive qualitative research seeks to discover and understand a phenomenon, the perspective and worldview of the people involved, and its use is relevant particularly when information is required directly from those experiencing the phenomenon (Bradshaw, Atkinson & Doody, 2017). A descriptive qualitative approach aids in producing findings that are closer to the given data (Sandelowski, 2010). Sandelowski (2000, pg. 337) described it as a method "... amenable to obtaining straight and largely unadorned (i.e., minimally theorized or otherwise transformed or spun) answers to questions of special relevance to practitioners and policy makers".

Descriptive qualitative approach allowed for a comprehensive summary of findings of the participants' knowledge and practice relating to elder abuse to be presented in a coherent and logical manner (Polit & Beck, 2017; Sandelowski, 2000). It is an approach that is particularly useful in examining healthcare and nursing related phenomena (Kim, Sefcik & Bradway, 2017). This approach was selected because it offered me the opportunity to present a summarized description of public health nursing practices relating to elder abuse matters. I chose it to arrive at first-hand data on public health nurses' knowledge and behavioural responses to elder abuse related issues (Sandelowski, 2000). This approach allows the researcher to borrow design elements from other methodologies depending on the research context (Sandelowski, 2000). The use of the descriptive qualitative approach in this study has a grounded theory overtone, no

theory was produced but the constant comparison technique was utilized to interpret the data (Sandelowski, 2000). Corbin and Strauss (2008) stated that description, though basic to theory is clearly not theory, and if it is not the researcher's goal, description may not lead to a theory. Collins and Stockton (2018) identified that sometimes for highly exploratory studies, such as grounded theory and the various types of ethnography, it may be better suited for them to be 'unhinged' from strong theoretical frameworks. Any dogmatic or rigid application of theoretical frameworks in these designs may result in limitations to such studies (Collins & Stockton, 2018). The end goal of using the descriptive qualitative method was to present participants' viewpoints clearly and as close to the data as much as possible. An example of a study where descriptive qualitative approach was utilized for an elder abuse research is a Norwegian study titled "Identifying and Handling Abused Older Clients in Community Care: The Perspectives of Nurse Managers" by Sandmoe and Kirkevold (2011). A second example is by Erlingsson et al. (2006), who developed a descriptive framework for their study titled "Perceptions of Elder Abuse: Voices of Professionals and Volunteers in Sweden - An Exploratory Study".

### **3.1 Sampling Strategy**

Both purposive and snowball sampling were utilized for this study. Purposive sampling is used in research to subjectively select participants based on who is thought to be representative of the population (Polit & Beck, 2017) and whose qualities and/or experiences are required for the study (Bradshaw et al., 2017). Participants were selected to describe their nursing experiences with the intent that they will provide a greater understanding of public health nurses' practice of assessing and responding to elder abuse. Sandelowski (2000) stated that the ultimate goal of purposeful sampling is to obtain participants that can provide rich information for the purpose of the study. I recruited eight participants through purposive sampling. I wanted a rich



and dense description of the phenomenon to aid transferability. I also wanted views from specific program areas from participants with diverse practice experiences, so I resorted to snowball sampling as well (Streubert & Carpenter, 2011). Snowball sampling entails recruiting participants through referral from other participants or informants with whom contact has been made already (Polit & Beck, 2017). Basically, snowball sampling uses one informant to find another (Streubert & Carpenter, 2011). Two additional participants were selected through the contacts already made from the initial selection. Public health nurses with varied demographics and practice experiences were purposively selected to gather a rich perspective on elder abuse.

A sample size of 10-12 participants was considered, with a minimum number of nurses to be selected as key informants to be 8 participants. I conducted 8 interviews and the transcription and analysis of the data started after each interview was done. The first three transcripts were analyzed independently and later in conjunction with my research supervisor. Streubert and Carpenter (2011), stated that the concept of saturation should guide an appropriate sample size in qualitative studies. Bradshaw et al. (2017) stated that data saturation has become an acceptable standard to ascertain sample size for qualitative studies. As transcribing and the preliminary analysis progressed, the emerging data was not adding anything new to the overall story from the data already collected, I conducted interviews with participants recruited through snowballing. By the tenth interview, there was no new information emerging from the interviews, so data collection was wrapped up. Strauss and Corbin (1998) stated that there will always be a potential for something new to emerge during data collection. Consequently, they suggested that data saturation should be considered as the point where the 'new' does not necessarily add anything to the overall story.

### **3.2 Participant Recruitment**

The accessible population for this study was comprised of public health nurse members of the Ontario Network for the Prevention of Elder Abuse (ONPEA) and the Community Health Nursing Interest Group (CHNIG) of the RNAO. A 'Letter of Inquiry to Gain Access to Recruit Research Participants' (Appendix I), was sent by email to both ONPEA and CHNIG requesting linkage to public health nursing members in the group to become study participants. Flyers (Appendix II) were distributed through emails and print copies to public health nurses to forward to their contacts. I intended to recruit participants from Toronto, the Greater Toronto Area (GTA) and remote public health units. Recruiting participants through these channels was done to get the knowledge of public health nurses working in various programs and with the diverse population in Ontario. Recruiting participants through ONPEA and CHNIG was surprisingly not successful because there was minimal response to the call for participation in the study. Due to this outcome, I relied more on the flyers that were distributed to nursing colleagues to forward to their nursing contacts and networks in various public health units. Telephone calls were made to provide additional information describing and clarifying the study to interested persons. Through this approach, there was positive outcome with responses from prospective participants. A consent form was sent to those interested in participating in the study (see Appendix III).

The criteria for inclusion in this study were registered nurses who practice in public health, who have come in contact with the elderly, and/or have provided public health nursing services to the elderly, and may or may not have suspected, confirmed or witnessed abuse of the elderly. Recruited nurses did not have to have worked or be working with the geriatric population or an elder abuse team. It is the knowledge level of the nurses regarding elder abuse and its translation in public health nursing care relations that was under study. Of particular

interest to this study were public health nurses with diverse backgrounds and perspectives and with minimal to full knowledge of elder abuse. I deliberately included public health nurses from a variety of practice areas in public health nursing for data collection. The goal of using this method was to gain greater insights into the issue of elder abuse from as many angles as possible so that common themes can then be identified across the sample (Polit & Beck, 2017).

Demographics that were considered in the course of selecting participants for recruitment included age, gender, years of nursing practice, and previous experience of elder abuse (see Appendix IV).

### **3.3 Research Setting**

A research setting is the actual place and conditions or circumstances where and within which the research study takes place (Polit & Beck, 2017). After receipt of agreement to participate in the study, appointments were set up through emails and by telephone to schedule dates, times, and venues to conduct face-to-face interviews. Physical distance was an issue because some interested participants in rural Ontario volunteered to participate in the study. They were 5 to 7 hours away and the feasibility of driving out to conduct face-to-face interviews during the peak of winter season was slim. I submitted an amendment to the Research and Ethics Board (REB) to request that interviews could also be conducted through video avenues (Skype and Face Time). The amendment was later withdrawn because there were enough participants for the remainder of the interview and no new data was emerging from the interviews conducted.

In order to minimize bias and influences, I opted for the participants to decide the venue most suitable for them, so they could have a neutral setting. A neutral setting is associated with comfort, accessibility, feeling at ease and without any expected behaviours (Polit & Beck, 2017). The settings were in the natural environment of the participants such as their homes, coffee shop,

and places of work. The settings were carefully reviewed with participants to allow for ease of collecting the data, to promote neutrality and to allow for privacy and confidentiality. Dates and times were adjusted to suit participants. The participants were informed that they will not be paid to participate in the study as all were service providers, and therefore were not offered participation honorarium.

### **3.4 Ethical Consideration**

Research ethics committee approval was requested and received from York University's Office of Research Ethics and the Faculty of Graduate Studies. The Written Informed Consent Document and the Human Participants Research Protocol Form (Appendix III) were submitted. The Toronto Public Health research office was notified about the study, and I provided further explanation on the study to its research office. Ethics approval was obtained from Toronto Public Health's Research Ethics Review ex post facto. Being a sensitive topic and the study on nursing practice in relation to a vulnerable group, in order to ensure participants' rights to self-determination and autonomy, detailed information on the study was provided to participants in order to meet the requirements of informed consent (Polit & Beck, 2017). As presented in Appendix III, the informed consent document provided details about the nature and purpose of the study, what participants are asked to do in the research and the potential benefits and risks/discomforts of the study. The consent form included a withdrawal clause stating that participants were undertaking to partake in the study voluntarily and may withdraw from the study at any time should they choose to. No physical risks were foreseen for participants. However, it was anticipated that participants might experience moral distress which may cause potential psychological implications after reflection on past practice(s) relating to response on previous encounters with elder abuse. Every participant was advised to seek assistance and

support for debriefing with a counselor through the Employee Assistant Program in their place of work if needed. I had a list of mental health support programs and services readily available.

Participants were also advised to contact me for additional resources to be explored that could be beneficial to them. No one contacted me regarding this. Contact details of the researcher and the supervisor were included in the information document provided to participants.

All participants were informed that confidentiality will be provided to the fullest extent possible by law. Individual participants and public health units were to be protected from being identified. Comments made while answering questions during the interviews that could potentially identify individuals, healthcare professionals or names of organizations were removed from the data. Pseudonyms were used to maintain anonymity. Initially, identification numbers were used during interview, transcribing, and data analysis, and later the pseudonyms were applied to each participant's identifier. Demographic sheets, consent forms, hard copies of transcribed interviews and field notes are stored in a locked file cabinet that can only be accessed by me. Electronic copies of the transcribed interviews are to be made available to my thesis committee if requested. All hard copies of data will be shredded after three years of concluding this study. Electronic data will also be permanently deleted.

### **3.5 Data Collection**

Ethics approval was received in December 2017 and interviews were conducted between January and February 2018. Individual face-to-face interviews were conducted with all participants. I conducted all interviews and they ranged between 20 minutes to an hour. Semi-structured interviews were utilized in order to gather data that allowed me to further explore any new ideas that emerged from participants' responses. An interview guide was developed for this study, referencing a previous interview guide developed by Rodriguez, Wallace, Woolf and

Mangione (2006). The interview guide by Rodriguez and colleagues has 13 open-ended questions and was developed from a literature review and expert input. The questions were developed by physicians and have been used by nursing studies such as Daly et al. (2012). I customized the interview guide into 10 open-ended questions that addressed areas I was interested in exploring, namely perceptions, assessment, identification and addressing of elder abuse (Appendix V). To test usability of the interview guide, I conducted 3 mock interviews with public health nursing colleagues. This aided me in restructuring the questions in such a way that guided the responses to address the questions being asked.

The interviews were audio recorded and I took notes as a form of reflective practice and also field notes to document observations, behaviours and contextual aspects of the interview. Data from the audio recordings were transcribed into text files after the interviews took place. Both field notes and interview notes were expanded into narratives.

### **3.6 My Positionality as a Researcher and Nurse**

The act of examining the research process through the context of my positionality can be described as reflexivity. Finlay (2002) defined reflexivity as a thoughtful and conscious self-awareness. Berger (2015) described it as a process that entails continuous internal dialogue and a critical self-evaluation of a researcher's positionality, and an acknowledgement and recognition that this position may influence the research process and outcome. This implies that as the researcher, I am to self-appraise myself, to recognize and take responsibility of my position within the research and the effect it may have on the participants being studied, the questions being asked, and data being collected and interpreted (Berger, 2015). Personal characteristics relevant to me as a researcher in this study include my professional experience, gender, beliefs, political and ideological stance and emotional responses to the elderly population being

discussed in the study. The way my position as a researcher might have influenced the study may be through my worldview and nursing experience with the geriatric population, and this might have been reflected through the way questions were posed, use of language, the lens for filtering and analyzing the information gathered, and the findings and conclusion of the study.

Being a qualitative study, my identity as a researcher in relation to a research topic from my nursing practice background had the potential to impact the research process. I understood that the personal preconceptions and attachments I have on the issue of elder abuse present as both strengths and weaknesses for the study I was undertaking. I currently practice as a public health nurse in Toronto Public Health on the Vulnerable Adults and Seniors (VAS) program, a program whose goal is to improve access and equity to health services for adults, mostly seniors with social determinants of health vulnerabilities and inequities. My role is to address the emerging and urgent health needs of community dwelling adults through the lens of the social determinants of health, assessment and providing linkages to appropriate support services for clients living at risk. My clientele is comprised of isolated and or reclusive adults without any identifiable support, of low social economic status, with underlying medical and or mental illness, with diminished capacity of managing activities of daily living independently, and with poor insight into their living situation. Due to these vulnerabilities, the older adult clients I provide care to are prone to elder abuse.

I did not fully comprehend the phrase 'elder abuse' until I joined the VAS program. That was where I saw how normal ageing in the presence of declining health and or cognition can make an older adult prone to abuse. Elder abuse encounters are not uncommon in my practice in public health nursing. It presents in various forms, from family or non-family member perpetrators committing abusive acts against elderly clients to care providers who sometimes are

perpetrators themselves or who ignore or are unaware of the issue. Attempts are always made by the VAS program to address elder abuse cases when encountered. As a VAS program nurse, elder abuse assessment is embedded in my routine practice. Therefore, I have been able to identify elder abuse, either suspected or confirmed, and have addressed or attempted to address it in my nursing practice. However, what I see as abuse of the elderly might not be viewed as same by another colleague. Nurses have different capacities in identifying elder abuse. The major challenge in my nursing practice on elder abuse matters is actually addressing the issue effectively. When elder abuse is suspected or confirmed, nurses hit a roadblock for various reasons in their attempts to address the issue. I see the combination of the absence of mandatory reporting, lack of adult protective services and lack of knowledge on appropriate guidelines and resources as major hurdles in addressing elder abuse for community dwelling older adults across Canada. My view of seeing elder abuse as an injustice makes me realize that I am predisposed to feel a certain way in the course of this study, and I acknowledge the tension.

To address this, I am explaining my positionality here on my experience and views regarding elder abuse. In the course of data collections and analysis, I documented my observations and feelings about the research and participants' responses in my reflective notes for the purpose of bracketing. Bracketing is a process in which the researcher suspends or holds in abeyance his or her own presuppositions, biases, assumptions, theories, or previous experiences to see and describe the phenomenon (Tufford & Newman, 2012). Reflexive practices and bracketing at the beginning and continuously in the study help the researcher to remain self-aware (Streubert & Carpenter, 2011). Prior to the commencement of the interview phase, I made a note to remind myself to be mindful of my facial expression and also not to engage in conversations that appear to approve or criticize participants' responses or their



organizations during the interview. I referred to this note before each interview. I also reviewed the research question and objectives prior to each interview. After each interview, I documented my thoughts and reactions of the interview. Reflexivity is an important aspect of qualitative research because it helps researchers understand the implications of their role in data collection, analysis and the discussion of findings (Finlay, 2002).

### **3.7 Data Analysis**

Data analysis started at the end of each interview. The initial step into data analysis was transcribing all audio responses from the interview into words. Transcription started immediately after the interviews. I connected with my supervisor after the third interview and transcription were concluded. My supervisor identified two interview questions that provided a list of options to participants as leading and limiting and did not give room for participants to provide their subjective experience. So, the questions were revised to single, open-ended questions. The revised questions were used for the rest of the interviews. Qualitative content analysis was utilized to analyze data.

Qualitative content analysis is the analysis strategy of choice in descriptive qualitative studies (Sandelowski, 2000). Hsieh and Shannon (2005) defined qualitative content analysis as a method used in subjectively interpreting the content of text data through the systematic classification process of coding and identifying themes or patterns. It is an analysis of both visual and verbal data into a summary of the content that is informative (Sandelowski, 2010). A goal of qualitative content analysis is to condense a voluminous number of words of text into smaller content categories (Polit & Beck, 2017). The data are then organized so meanings can be elicited to draw realistic conclusions from it (Bengtsson, 2016).

A conventional (inductive) content analysis was used to analyze this study. The conventional content analysis is used in study designs whose aim is to describe a phenomenon where existing theory or research literature are limited (Colorafi & Evans, 2016; Hsieh & Shannon, 2005). The conventional content analysis approach fits with the study because the outcome from the literature review showed very limited research data on elder abuse assessment and interventions in community nursing; in particular, none was found in public health nursing. This approach was chosen because I considered it would be helpful to achieve the aim of the study which was to describe the perceptions of public health nurses on elder abuse related issues (Hsieh & Shannon, 2005).

In this approach, data were derived from open-ended questions, read word for word and coded (Colorafi & Evans, 2016). The conventional content analysis allowed for codes and names of categories to flow from the data (Hsieh & Shannon, 2005; Sandelowski, 2000). The inductive way of reasoning allows for new insights to be developed as the researcher immerses self in the data to find meanings in the responses to the research question (Bengtsson, 2016; Hsieh & Shannon, 2005). Graneheim and Lundman (2004) identified that a basic issue when conducting qualitative content analysis is deciding if the analysis should be manifest or latent. I chose the manifest analysis of the conventional (inductive) content analysis, and to a lesser degree latent analysis. In manifest (explicitly stated) analysis, the visible, obvious components of the content of the text is described and interpreted (Graneheim & Lundman, 2004). The interpretation, however, is not as in depth as would be if it was latent (hidden meaning) content analysis. There will always be multiple meanings to a text. However, the duration and structure of the interviews conducted did not allow for in-depth exploration of respondents' experiences. To fully provide

an accurate latent interpretation, further questions and clarifications would need to be asked from participants.

I utilized the four stages identified by Bengtsson (2016) in data analysis process; decontextualisation, recontextualisation, categorisation and the compilation. I performed each stage a minimum of 5 times to maintain quality and trustworthiness of the analysis (Bengtsson, 2016). To ensure the quality of the analysis, a table was created to show the process of analysis from raw data to results for transparency as seen on Table 3.1 and Table 3.2. As rightly stated by Bengtsson (2016), there is the possibility of human mistakes in the analysis process due to fatigue, interpretation error and personal bias. I constantly had to refer back to the research question, research objectives and my notes on reflexivity as each interview question was being addressed.

### **3.7.1 Decontextualisation stage.**

The research questions were probing in nature, and therefore, open-ended questions were used in the interviews. In the decontextualisation stage, data from participants' responses were read repeatedly so as to achieve immersion and to obtain a sense of the words (Bengtsson, 2016; Hsieh & Shannon, 2005). Streubert and Carpenter (2011) stated that researchers must fully immerse themselves in the data and be attuned to what they hear, see and experience in the data in order to construct meaning. After this, the words were broken down into meaning units. A meaning unit is the smallest unit that contains some of the insights that are needed to answer the research question (Bengtsson, 2016). Meaning units are collections of sentences or paragraphs that contain aspects related to each other through their content and context, which answer the questions set out in the aim of the study (Bengtsson, 2016; Graneheim & Lundham, 2004). Each identified meaning unit was further condensed into a condensed meaning unit. The condensation

of the meaning unit is a process of shortening the words while still preserving the core of the meaning (Graneheim & Lundham, 2004), as indicated through an example in Table 3.1 below. Labels were then assigned to the condensed meaning unit, which became the codes that emerged from the data (Graneheim & Lundham, 2004). The label/codes were tags given to the recurring words or concepts within the data (Polit & Beck, 2017). These codes were heuristic; they enabled me to think about the data in different ways in relation to the context of the question and the research aim (Graneheim & Lundham, 2004).

Table 3. 1 Decontextualisation Stage Sample

Question 1	Meaning Unit	Condensed Meaning Unit	Code	Sub-Category	Category	Theme
What does elder abuse mean for you?	A6 being abusive to the elderly ... taking them for granted ... because they are usually old and frail, ... and taking advantage of them as being old and frail some of them have dementia, taking them for granted, cheating them ... manhandling them ... stealing from them because you	Being abusive to the elderly by taking them for granted because they are old and frail Dementia, frailty make them prone to cheating, manhandling, stealing, misusing of their stuff				

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know they  
can't do  
much  
because they  
don't have  
the strength  
and energy  
anymore ...  
misusing  
their stuff

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Since I utilized the inductive approach, I generated the codes as data became available as the study progressed. The coding unit was done repeatedly for consistency because at the initial phase of the analysis, the meaning units were clear, but obscurity occurred from time to time. So, for each participant's response to a question, I referred back to the research question, objectives, and reflexivity notes from time to time.

### **3.7.2 Recontextualisation stage.**

After identifying all meaning units, I went back to the original text and re-read it, referring to my meaning units. On very few occasions, I found some information redundant because they did not answer the research question, and I therefore distanced myself from such data by disregarding them. Bengtsson (2016) described such data as “dross” and stated they can be excluded. Data that was considered dross were not often encountered. Information that disclosed names or work places/organizations in the course of the interview were excluded during the analysis.

### **3.7.3 Categorization stage.**

For the next stage, based on how the codes are related and linked, they were classified into sub-categories and categories, as presented through an example in Table 3.2 below.

Categories are groups of contents that share commonality, a descriptive level of content

(Graneheim & Lundham, 2004). Initially, I had lots of categories from moving back and forth within the meaning and condensed meaning units, but they were later reduced.

Table 3. 2 Categorisation Stage Sample

Question 1	Meaning Unit	Condensed Meaning Unit	Code	Sub-Category	Category	Theme
What does elder abuse mean for you?	A6 being abusive to the elderly ... taking them for granted ... because they are usually old and frail, ... and taking advantage of them as being old and frail some of them have dementia, taking them for granted, cheating them ... manhandling them ... stealing from them because you know they can't do much because they don't have the strength and energy anymore ... misusing their stuff	Being abusive to the elderly by taking them for granted because they are old and frail Dementia, frailty make them prone to cheating, manhandling, stealing, misusing of their stuff	Taking advantage: exploit  Vulnerability to being exploited	Take advantage of  Forms of abuse (financial, physical) (2)	Vulnerability for abuse  Forms of abuse	

### **3.7.4 Compilation stage.**

After the categories and themes were established, I started writing out the findings of the study and later did a synthesis of the findings. Sandelowski (2000) stated that in qualitative content analysis, there is an effort made to understand both the manifest and latent content of the data. The findings chapter utilized more of the manifest findings because I stayed close to the meanings of the text. I used the participants' words and often referred to the text to ensure the meaning and my writing aligned with the categories developed (Bengtsson, 2016). I went further to synthesize and interpret my findings as close to the content of the text as much as possible. For each category used in the manifest analysis, I supported my writing with quotations from appropriate meaning units that aligned with the category. For the synthesis, I utilized the constant comparison procedure affiliated with the Glaser and Strauss' (2017) method of grounded theory. The constant comparison strategy involves taking one piece of data, category or theme, at a time and comparing it with others that may be similar or different so as to identify the commonalities and the variations (Polit & Beck, 2017). While conducting the constant comparison, categories from my findings were compared with the literature to identify commonalities and variations. Doing the constant comparison aided in my confirming if the results were reasonable and logical.

After compilation was concluded, member checking was done with study participants to share the findings of my interpretation of their responses to the study questions and for them to reflect and provide feedback on the extent to which it aligns with their practice and experiences. Member checking is the process of giving study participants the final report or description of study findings and interpretation so as to give them the opportunity to provide context and or alternative interpretation (Loh, 2013; Streubert & Carpenter, 2011). Polit and Beck (2017) describe member checking as providing feedback on emerging interpretations to participants so

as to clarify their responses and to get participants' reactions (Polit & Beck, 2017). Member checks served as a way of checking the truth value of my interpretations, participants had the opportunity to determine whether or not they find the interpretations accurate (Streubert & Carpenter, 2011).

Due to time constraints for the length of the study, proximity concerns and limiting logistics of coordinating another set of interviews, follow up interviews were not conducted. Rather, I sent out a compressed version of the findings and interpretation to all study participants through email (Appendix VI). I received four responses. Two participants were from the same public health units while the remaining two were from different public health units, and they all affirmed that the findings were representative of their practice experiences.

### **3.8 Rigour and Trustworthiness**

Lincoln and Guba's four criteria for developing the trustworthiness of a qualitative inquiry were utilized for this study (Lincoln & Guba, 1985). The four criteria are credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985; Loh, 2013; Streubert & Carpenter, 2011). The aim of trustworthiness in qualitative inquiry is to ascertain that the findings can be trusted (Korstjens & Moser, 2018). To accurately represent the experiences of participants is the goal of rigour in a qualitative research (Streubert & Carpenter, 2011). Streubert and Carpenter (2011) described credibility as activities in a study that increase the likelihood of the study to produce credible findings. Polit and Beck (2017) described it as confidence in the truth of the data and their interpretations. Graneheim and Lundman (2004) went further by describing credibility as focusing on how well the data and the process of analysis address the intended objectives of the study. Strategies utilized to ensure credibility in this study include prolonged engagement (such as initial contact, telephone calls, interview, and



follow-up emails) and member checking. Graneheim and Lundman (2004) identified selection of participants, context and approach to data gathering as vital to credibility. For this study, I chose participants from various ages, gender, practice areas and experiences in public health nursing. This was to aid in increasing the possibility of shedding light on the research question from a variety of views (Graneheim & Lundman, 2004). Strategies suggested by Kostjens and Moser (2018) include investing time to become familiar with the participant and to build trust, to have a lasting presence during the interview, to engage the respondent, and to get to know the data so as to get a rich information for the study and to test for misinformation. I developed an early relationship with participants in order to foster familiarity and trust. I connected with them through emails and telephone calls and established relationship with them prior to conducting the interviews. Participants were allowed to determine the location to be used and all the interviews were conducted at the venues of their choice. During the interview, the participants were allowed to speak to the topic at their pace. There was no manipulation or pressure from others. During the interviews, I asked further questions to get clarification of the responses from participants. Participants were encouraged to provide examples to support their statements. In addition to this, I studied the raw data from the beginning of data collection to analysis, and I provided the participants with the findings that emerged from the phenomenon under study.

Transcribed data were carefully examined and compared to the audio recording several times to ensure no content was missed. I read through the data several times to get a full understanding. I read and re-read the data while developing the codes and categories and I revised them accordingly by going back to the questions and the aim of the study many times. This entailed re-coding and re-categorizing of the data until the intended depth of insight was attained. A member check was also done after the results were compiled and data interpreted to

test for misinformation. The compressed interpreted findings were sent out to all research participants for their perusal, to enable them to challenge or correct the interpretations if they perceive them to be wrong. It was a challenge getting participants to read and provide feedback on the findings. Several reminders were sent, and 4 participants responded, and affirmed the interpretations were true to their experiences.

Dependability relates to the aspect of consistency (Kostjens & Moser, 2018). Loh (2013) described it as examining the process of inquiry. Lincoln and Guba (1985) described it as considering the factors of instability or design/phenomenon induced changes that can alter or change the data during the analysis process. To the best of my ability, I tried to ensure dependability by providing a detailed description of the research design, participant recruitment, data collection method, how data was kept, the use of a reflective journal and the data analysis process to show that it is in line with the standard stipulated in literature for the design. The descriptions can enable another researcher to replicate with the same participants in the same context and get similar findings (Polit & Beck, 2017).

Confirmability relates to neutrality in order to secure the inter-subjectivity of the data (Kostjens & Moser, 2018). Loh (2013) described it examining the findings, interpretations and recommendation to ensure they are supported by data. To ensure that the interpretation was grounded in the data from the study and was not just based on my own particular viewpoints and preferences, reflexivity was used to limit the influence of my biases and previous thoughts during the data analysis and interpretation process. Since data analysis was initiated as soon as data were collected and transcribed, the analysis of the first three transcripts were initially coded independently by both my supervisor and I. We then compared our analysis, discussed further on

the coding strategies, and then I did the rest of the coding. Polit and Beck (2017) described triangulation as the use of multiple referents to draw conclusions as to what constitutes truth. My supervisor guided me on the analytic approach. I met with my supervisor several times to discuss, review, and confirm my findings as they emerged during the study. Furthermore, I had the opportunity and privilege of presenting my data analysis steps in an advanced level research course.

Transferability, the extent to which research findings can be transferred to other settings (Lincoln & Guba, 1985) can be achieved by providing a thick description of the study (Loh, 2013). Graneheim and Lundman (2004) identified giving a clear and distinct description of the context, selection and characteristics of research participants, data collection and analysis process. Findings from this study are specific to a small group of public health nurses. However, to establish transferability of this study to a similar or other population, I provided a detailed description of the sampling strategy, inclusion and exclusion criteria and the number of participants, demographic, data collection method, time frame in which data were collected, interview procedure, changes made to interview questions based on feedback from the initial ones conducted. This information can be found in sub-sections 3.1-3.5 of this chapter.

## Chapter Four: Findings

The core findings derived from the analyzed data are presented without interpretation in this section. First, participant's demographics are presented. Afterward, the findings that are derived from the methods and data analysis are broken down into sentences and figures that are significant to the research questions and objectives.

### 4.1 Demographic Information

The study participants were a total of ten public health nurses between the ages of 20 to over 50 years of age. Three nurses were above 50 years old. Of the ten, four identified as male and six as female. Six nurses were born in Canada and originated from various ethnicities; four were from European descent: English, Scottish, Italian/Czechoslovakian and two were from West Africa. Of the remaining four participants born outside Canada, two were from East Africa, one from Central Africa and one participant is South Asian. The demographic profile of participants is presented in Table 4.1.

Public health nursing requires a university degree as minimum education. All nurses who participated in the study had a baccalaureate degree in nursing while three nurses had a master's degree. All nurses except one had over 6 years of nursing experience. One nurse was a new graduate with less than one year of nursing experience including public health nursing. Another nurse had over 5 years of nursing experience but less than 5 years in public health nursing practice. The remaining eight had more than 5 years of experience in public health nursing practice. Participants were asked to indicate their knowledge of elder abuse in the following category: novice, competent, proficient or expert. I did not intend to neither did I provide any meaning to nor impose a definition of these four categories to participants. The meaning of each category was explicit, and I wanted participants to indicate the category they fall on based on the

knowledge they have of elder abuse. I wanted to know participants' understanding about the issue. One nurse selected the proficient category. Three rated themselves as novice while the remaining six considered themselves competent on elder abuse issues. No participant selected the expert category. Appendix IV provides the study's demographic form. A profile of participants' education, nursing experience and knowledge of elder abuse is presented in Table 4.2.

Table 4. 1 Demographic Profile of Participants

	N=10	%
<u>Gender</u>		
Female	6	60
Male	4	40
<u>Age</u>		
21-50	7	70
51-Over	3	30
<u>Ethnicity</u>		
Central African	1	10
East African	2	20
European	4	40
West African	2	20
South Asian	1	10

Table 4. 2 Profile of Participants' Education, Nursing Experience and Knowledge of Elder Abuse

	N=10	%
<u>Highest Level of Nursing</u>		
<u>Education</u>		
Bachelors	7	70
Masters	3	30
<u>Years of Nursing Experience</u>		
0-5	1	10
6-Over	9	90
<u>Years of Public Health Nurse Experience</u>		
0-5	2	20
6-Over	8	80
<u>Self-Rating on Knowledge of Elder Abuse</u>		
Novice	3	30
Competent	6	60
Proficient	1	10

In the following sections, I present a descriptive summary of the findings from the interviews. Participants' names have been changed to protect their identities. The findings are organized mostly according to the categories of the research questions that I sought to answer in this study and also by themes.

## 4.2 Knowledge of Elder Abuse

### 4.2.1. Defining elder abuse: critical view.

Variations existed in the definitions and meanings ascribed to elder abuse. No participant described or defined elder abuse by the collective definition from the World Health Organization or any other local definition. Elder abuse was described based on the understanding and in the context of public health nurses' experiences and practice. However, all participants in their definition or description, held a critical view towards the act of elder abuse. Ben (novice) described elder abuse as,

I guess it is essentially anytime you know you are not treating an older person with dignity and respect. Em, so it could be psychological, it could be financial, it could be physical abuse it could be just neglecting to provide them with what they need em to flourish and to thrive. Em, yeah, so I guess like the definition of elder abuse, it would be a crime where somebody is suffering and somebody else is actively doing something to cause that person hardship.

Ben was the only participant that described elder abuse as a criminal act. Chloe (competent) described it as elder mistreatment and a violation of rights. Dan (competent) described elder abuse as an abuse of power; "... using your power in a relationship to coerce an older adult into doing something that they would not do otherwise".

Felix (competent) and Harper (competent) identified it as taking advantage of the elderly. In addition, Harper described the older person as being vulnerable to abuse while Felix described the attributes of the older person as "old and frail" that makes them vulnerable to elder abuse. Ian (competent) identified it as "harm to the elderly person" and also deprivation. Alfa (proficient) mentioned that it is subtle, hard to assess and intervene. On the other hand, Eric (competent)

mentioned elder abuse as intentional abuse. I wondered if unintentional abuse was not considered as abuse. Dan (competent) identified that there is an existence of a relationship for elder abuse to occur, which can result in a break in trust;

an older adult in a relationship with either a family member or caregiver, it can be anybody... it is a situation where you use your power to exercise some type of control over that individual and it ... results in break in trust in that relationship.

#### **4.2.2. Forms of elder abuse.**

In attempting to define elder abuse, participants mostly described the forms of elder abuse. In describing abuse, among five participants, each mentioned three to four forms of the types of abuse: financial, physical, sexual, psychological and neglect. Ben (novice) Eric (competent) and Jerome (novice) were the only participants that mentioned neglect as a form of abuse. Two participants implied the forms of abuse in the descriptions they gave to explain what elder abuse is. Felix (competent) described it as,

taking advantage of them as being old and frail. And some of them have dementia, so like yeah, taking them for granted, cheating them, and em manhandling them, and em stealing from them because you know they can't do much because they don't have the strength and energy anymore. And em like misusing their stuff.

Here, Felix described physical, financial and psychological abuse. Jerome (novice) presented a scenario of concealing information and exploitation in explaining elder abuse;

When an elder is neglected, it is a form of abuse. When information are not shared properly with an elder, ...hiding ... details that may be helpful to them .... The telemarketer company, would be calling elder in the home you know, selling stuff and



telling them stuff and uh telling them that uh, it's free but uh it's not really free, uh and they end up you know uh taking money in their account. I think if it is a form of abuse because they may not have support uh you know how people who can clarify this to them and they just um buy into that.

Here, Jerome described neglect, psychological and financial abuse. Three participants did not mention nor describe the forms of abuse.

#### **4.2.3. Awareness/knowledge of elder abuse.**

In inquiring about what knowledge participants had on elder abuse, five options were provided making question 2 a leading question with an expected response as opposed to a semi-structured question that will give participants room to provide their own original answers. For the first 4 participants that were interviewed for the study, the questions were leading. After feedback from my supervisor, I covered up the options to allow participants to provide their own original responses and then the options were uncovered for them to see if there were additional inputs to be provided. Categories for how knowledge was acquired on elder abuse were: professional training, continuing education, academic curricula, public awareness campaign and informal such as personal knowledge, self-study and others.

Seven nurses identified professional training including in-house training, continuing education and conference attendance as the knowledge source for elder abuse. Eight nurses identified public awareness campaigns as a knowledge source. Public awareness campaigns mentioned included World Elder Abuse Awareness Day (WEAAD), government websites, and television infomercials.

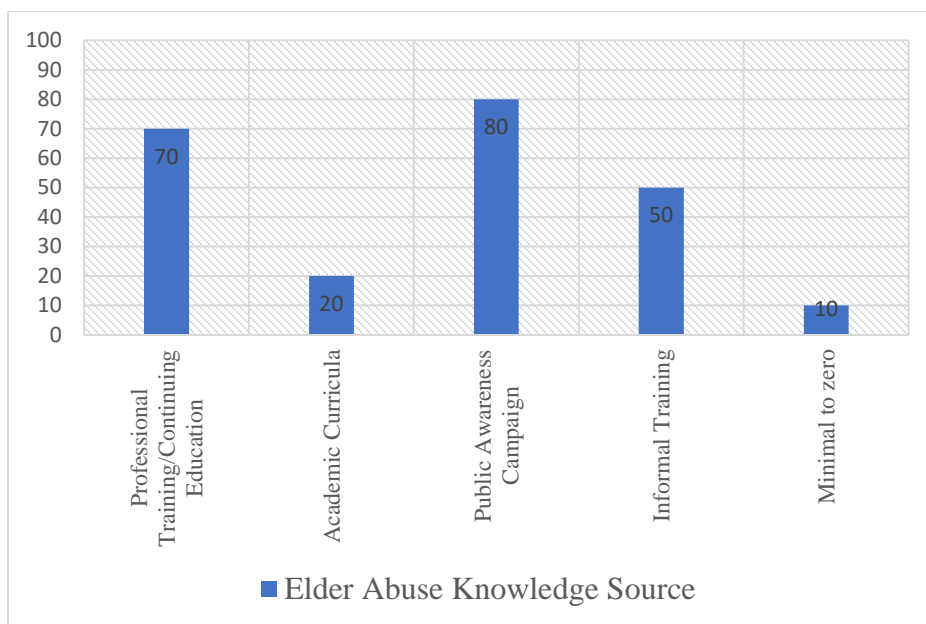


Figure 4. 1 Source of Knowledge on Elder Abuse

Four nurses had elder abuse knowledge from academia. Alfa's (proficient) knowledge on elder abuse was from graduate nursing program, while Chloe (competent) had the knowledge from both undergraduate and graduate schools which were obtained from overseas, foreign degrees. Ben (novice) and Dan's (competent) elder abuse knowledge experience in academia was acquired while doing their consolidation (nursing practicum experience) in undergraduate nursing school on geriatrics and end of life care.

Five of the nurses interviewed have all had professional experiences of directly working with victims of elder abuse. Alfa (proficient) and Dan (competent) had interdisciplinary case management in collaboration with the police. Harper (competent) sits on a situation table in his region to address elder abuse matters. Felix (competent) referred to stories victims as clients told him about their experiences of elder abuse. Ian (competent) related his professional experience;

I participated in the ... community crisis response team ... and, through that when things happen to a family ... you kind of realize how the umm elders are not that really connected to their families, and when you dig deep into whys then you realize that there

has been some sort of accusation made by the elders that someone was taking advantage of them, and that they cut them off.

Dan (competent) and Harper (competent) had pre-nursing experiences on elder abuse. Harper stated "... I definitely saw a lot of things that made me feel very uncomfortable that I would regard later as types of abuse." Dan stated,

my first exposure really to it was seeing these older adults end up in the shelter, and as you got to know them and hear their story, you would hear stories around individuals where their money had been taken by family members, there had been physical and emotional abuse, er, er, so just, it led them to leave the home environment to come into the shelter because they wanted to escape attacks on their body and just being put down and being treated as if they were slow.

Five nurses identified informal knowledge such as hearing stories, self-study, newspaper articles, television infomercials, stories of lived experiences of victims and their families, as sources of knowledge for elder abuse.

Two nurses, Greg (novice) and Jerome (novice), both stated they don't have knowledge or have limited knowledge of elder abuse. Greg stated he had no prior knowledge of elder abuse until taking continuing education courses or training at work,

I have to tell you for me it was very interesting to learn about elder abuse and what it really meant. Like my idea when we talk about elder abuse I'm thinking about physical, I'm thinking about emotion, but I never really thought about taking advantage of another person and abuse can be that as well, so I never thought about it in that sense.

Jerome (novice) also stated he does not have a lot of knowledge on elder abuse. However, he acknowledges its existence "... I would say I don't have uh a lot of knowledge but its things that we may see."

#### **4.2.4. Masking of elder abuse.**

Five participants identified elder abuse as hidden or concealed. Alfa (proficient) and Dan (competent) identified elder abuse as concealed. Alfa stated "... it is very subtle ... and so, during or post assessments, despite abuse being suspected, the victims' reluctance to expose abuse poses as a challenge to actually confirming it". Alfa further stated,

like my very first case that I had of elder abuse was a 94-year-old female ... so they were financially abusing her. So, when I looked at her, she had bruises, and it was physical as well ... she had bruises, she is very apprehensive ... when we are talking about anything financial, she just says I don't remember, but she was cognitively intact, but she didn't say specifically what happened, so she will just avoid. She would use a lot of avoidance tactics. There was the eye contact with the abuser and the abuser will actually try and intervene.

As per Alfa (proficient), there is reluctance from victims to expose abuse, and there is non-disclosure by victims by avoiding to respond to questions that may be asked. Dan (competent) stated,

... elder abuse is really really hidden so people don't want to talk about it; there is a lot of shame and guilt, so if you don't dig far enough and ask the right question often times that elder abuse could be hidden.

Chloe (competent) stated she did not encounter elder abuse specifically, but in responding to another question inquiring if elder abuse has been suspected or confirmed and how was it identified, Chloe mentioned the concealing of elder abuse stating,

I didn't encounter any kind of, that kind of elder abuse, specifically, but I was, I could not be aware, sometimes, because it is not easy to identify. Because if you try to go into the like, er, go deeper and deeper to get more information, sometimes it is like confidentiality issue, and they don't want to speak.

In addition, Dan (competent) again in response to question 5 stated in his interactions with clients, no one had out rightly said someone is abusing me. In response to same question, Felix stated that culturally some women do not disclose abuse.

#### **4.2.5. Perpetrators of elder abuse.**

Ben (novice) identified family members as the biggest perpetrators of abuse. Greg (novice) identified older adults living with children as a risk factor based on stories of the lived experiences of others because some children have taken advantage of their elderly parents. Harper (competent) identified it is limited love for parents. Ben also stated that perpetrators of abuse are valued because victims depend on them for resources and support; this reduces the chances of victims pressing charges. Children and relatives are not the only perpetrators of elder abuse. Dan mentioned having read and heard stories from professional magazines and colleagues, on professional misconduct by healthcare professionals, of which inappropriate sexual behaviour and theft are most prevalent.

#### **4.2.6. Reasons for hiding elder abuse.**

Despite that there is no specific question on reasons for hiding abuse in the interview questions, multiple reasons were identified from participants' responses. Dan (competent) stated,

elder abuse is really really hidden so people don't want to talk about it, there is a lot of shame and guilt ... so if you don't dig far enough and ask the right question often times that elder abuse could be hidden.

Dan (competent) and Ian (competent) also identified fear of less support as a reason for not disclosing elder abuse by victims. Ian stated some victims do not indicate to those around them that they are thinking of moving out of an abusive situation "... for the fear of if I don't get housing and I tell them I'm going to move out where am I going to end up?" Dan and Eric (competent) identified lack of trust as an impediment to disclosing abuse, Eric stated; "... is also like that whole idea of trust, who can they trust? ...". Felix (competent) identified culture as a reason some women do not disclose abuse, particularly spousal abuse. Ian (competent) stated that abuse or neglect are terms that are rarely talked about. Ian also inquired if individual victims of abuse consider minimizing of elder abuse as a norm. Fear that abusive events may be repeated and get worse was another reason identified by Dan.

#### **4.2.7. Lack of professional experience on elder abuse.**

Despite all participants being connected to the elderly in the course of their public health nursing practice, only 5 participants reported to have had direct professional experience dealing with elder abuse in their public health nursing practice. Ben (novice), a new graduate nurse, is yet to encounter a victim of elder abuse but stated "I haven't encountered anyone yet who I suspect is a victim of elder abuse but again just through colleagues and through the nature of the work that we do working with older adults I feel like it's probably a topic I will encounter quite a bit." Felix (competent), who has had no direct professional experience with elder abuse stated, "I am in immunization, we don't really see it, but I have worked with them like when we have, em, like flu clinics and we had to go to the nursing homes, em I haven't seen elder abuse ." Greg

(novice) and Harper (competent) also interacted with the elderly in the course of their public health nursing practice but stated they do not to have professional elder abuse experiences. Greg, who acknowledged that older people sometimes call in, stated, “sometimes they call us because they just need someone to speak to or they are calling us because they are having issues, or they might talk about family member .” Harper (competent) seats on the elder abuse network situation table in his jurisdiction where elder abuse cases are discussed. However, he stated he is rarely around the older senior population but provides services, such as falls prevention, to younger well seniors from various groups. Jerome (novice) acknowledged coming in contact with the elderly during client home visits but stated,

I see grandparents, and in that, uh, situation, the grandparents are in very good care because they live with their family who are taking care of them. So, we don’t see a lot of those things in there because they are in family who are taking care of them.

#### **4.2.8. Consequences of elder abuse.**

Most participants identified insufficient funds, being displaced from home, isolation, family conflict/estrangement, and inadequate care as outcomes of elder abuse. For instance, Dan (competent) stated, “... manipulation of the client...getting them to sign documents, sometimes they are incoherent, so it is essentially signing away life savings.” Dan further mentioned that “... seeing these older adults end up in the shelter, and as you got to know them and hear their story, you would hear stories around individuals where their money had been taken by family members.”

Ian (competent), on family estrangement due to exploitation of the older adult stated,

when things happen to a family ... you kind of realize how the ... elders are not that really connected to their families, and when you dig deep into whys then you realize that

there has been some sort of accusation made by the elders that someone was taking advantage of them, and that they cut them off.

Ian (competent) went further to provide a detailed account of an elder abuse incidence that led to homelessness;

To the point now that the grandmother that was raising these children that lived with this family almost 15 years now in senior age ... she was from Poland, did not have any money because she didn't have any social assistance, wasn't taking social services because she lived with them she didn't qualify for housing, but she didn't request, but they wanted her to move out, they wanted her to go, so she became homeless, because she was kind of used.

Another example from Ian also addressed inadequate care based on cultural practice,

In my community, we come from a place where we don't take our elders to senior homes, where you are looked on like you have horns in your head if you think about that. But what that is resulting in is elders being left at home for the sake of being home, but they can't take care of themselves leading to some sort of abuse ... and sometimes they might not have had breakfast since morning, and you come at five o' clock, because they can't do it, cause they might set fire into the house or they might burn.

In addition to this, Chloe (competent) mentioned that sometimes with family members as caregivers, older adults are sometimes kept in the basement, not getting enough food or needed care or attention, and medication not being administered on time.

Furthermore, Alfa (proficient) stated consequences of elder abuse might be physical, such as bruises, and psychological, such as apprehension. Dan (competent) mentioned fear,



anxiety and depression as outcomes of elder abuse. Alfa also mentioned apprehension of the health care system.

#### **4.2.9. Risk factors for elder abuse.**

In responding to the question on how elder abuse presents in public health nursing practice and what experiences participants have on elder abuse, participants identified susceptible factors leading to elder abuse. Some participants had no direct professional experience dealing with elder abuse in their practice, but still identified susceptible factors and outcomes. Most participants identified clients' attributes of being socially isolated, insufficient funds and inadequate care as risk factors for elder abuse. In addition to these, Alfa (proficient) further identified apprehension of the healthcare system and being marginalized as susceptible factors. Ben (novice) identified limited public health programs for the elderly. Eric (competent) mentioned the lack of resources (support) other than a victim's child who may be abusing the victim. Felix (competent) identified the reduction in financial income and health coverage, such as dental care, as susceptible factors leading to abuse on the part of the government. Greg (novice) identified a gap in screening for elder abuse stating that there is no screening for abuse, thereby making potential and actual victims to remain susceptible to elder abuse despite phoning in to make inquiries. Jerome (novice) mentioned limited mobility may keep individuals prone to neglect, thereby making them susceptible to elder abuse.

In responding to the question on what risk factors contribute to the elderly being vulnerable to abuse at the individual, community and system's level, the following were identified:

#### ***4.2.9.1 Individual (micro) level.***

A complex medical history was identified by 6 participants as a risk factor. Complex medical history resulting from mobility issues, mental illnesses and cognitive impairment all contribute to elder abuse. These factors lead to isolation of older adults making them vulnerable to abuse. Eric (competent) related medical condition to level of independence, because the more dependent an individual is on others due to illness, the higher the risk of elder abuse. Greg (novice) identified disability as a factor that may lead to susceptibility of being abused. Finance at the individual level was a big factor that 8 participants mentioned, but with differing views. Alfa (proficient) stated the more money there is, the better access to services and less chances of isolation. Ben (novice) on the other hand stated the more access to income or limited financial means, either way increase the chance of elder abuse. Chloe (competent) stated that the chances of older adults getting abused are high if there are no financial resources, because if there are no sustainable financial resources, their family can see them as burden. Dan (competent) associated retirement with reduced income, and with the rising cost of utilities, especially if the home is yet to be paid off, money spreads thin which can lead to vulnerability to abuse. On the other hand, Greg (novice) stated that having money could lead to someone taking advantage of the older adult. Harper (competent) identified financial abuse to the elderly as fairly common and perpetrator is a family member or designated person. Financial disposition leads to theft, as per Felix (competent), family and neighbours "... want to take from them..." particularly in situations where there is ill health and the elderly has money. In addition, Felix identified the frail elderly as easy targets for assault based on incidences seen on television. Ian (competent) talked about the working poor, lots of seniors who are poor before retirement still remain poor

after it. This makes them vulnerable to abuse if they are unable to provide for themselves or if others are unable to provide for them.

Chloe (competent), Ian (competent) and Jerome (novice) identified the lack of knowledge/awareness of available resources in the community as a risk factor that contributes to elder abuse. Ian stated "... if there was something that was visible in the community, this is where seniors receive help, then they would have been okay". Alfa (proficient) and Chloe identified the comprehension or understanding of what elder abuse constitutes. Ian identified educational knowledge in relation to self-advocacy, the ability to speak up and reach out for help. "... are they minimizing, do they think this is the norm? Do they know what abuse is, having it being defined for them, do they know?"

Ben (novice) on identifying family as the biggest perpetrator of abuse also stated that estrangement from family and/or incapacity to provide care to the elderly are risk factors contributing to elder abuse. Greg (novice) identified older adults living with children as a risk factor based on stories of the lived experiences of others because some children have taken advantage of their elderly parents. Harper (competent) identified it as limited love for parents. Ben also stated that perpetrators of abuse are significant because victims depend on them for resources and support; this reduces the chances of victims pressing charges. Eric (competent) identified the level of independence as a factor, particularly for the elderly to have "... connections other than not just their children, but may be neighbours, someone looking out for them."

Isolation was identified by 3 participants as a risk factor. Ben (novice) identified social isolation due to general health and limited mobility as a factor. Ben also identified estrangement from family as another factor that can lead to isolation. Dan (competent) mentioned that due to

isolation and the longing for human relations, older adults are vulnerable and susceptible to ill-intentioned people. Greg (novice) stated that from personal stories shared by others, children may at times knowingly isolate their parents. Ian (competent) described isolation based on being new to the country as an elderly, not speaking the language, living in an isolated community and not leaving for a different community.

#### *4.2.9.2 Community (meso) level.*

Ian (competent) related knowledge/awareness not only to individuals but to the community as well, asking what the collective knowledge of abuse is. Availability, knowledge and location of community resources, were also identified as significant factors. Limited community resources and/or support for the elderly contribute to risk factors for elder abuse as per Alfa (proficient), Chloe (competent), Felix (competent) and Greg (novice). Chloe stated,

like in developing countries, there are very few resources available for help in the community. Em, but in Canada, there are many resources available, like, yet still people are not aware. The family, the person himself or herself, is not aware...sometimes even the health professional, we are not aware what's available in the community.

Alfa and Greg identified the location of community resources as a risk factor to elder abuse. As per Alfa, geographical location in terms of neighborhoods is a criterion for the provision of certain community resources and programs.

#### *4.2.9.3 Systems (macro) level.*

Dan (competent) identified that there is inequitable funding and disbursement of funds which can help alleviate isolation. Alfa (proficient) stated that the disbursement of funds does not always reach the end user. Other issues identified at the systems level is a lack of response from government and the government having a different priority. Ben (novice) stated, "...there is

more political pressure they have to resolve, whereas elder abuse, I don't know, there just doesn't seem like there is much political will to address it". Dan stated,

I feel like governments have a lot of money and they care, but the way it is filtered down

I think often times it does not meet the end user... I feel there is not enough monies

actually going into creating systems where isolation is either prevented or minimized.

In addition, Dan stated, "I just recently saw a commercial for older aging but they show very competent active older adults and so I think the elephant in the room is not looking at elder abuse." Eric identified limited availability of support to enable discharged patients to be independent in the community. Ian identified the housing challenge being faced by individuals, therefore making the elderly quite vulnerable when in need of immediate housing support.

A significant risk that was identified by 2 participants to elder abuse in public health was the social determinants of health dynamics. Ben (novice) stated that the social determinants of health as a whole, such as family (social support network), income, and general health are factors that can determine vulnerability to elder abuse. Ben also identified the lack of advocacy for the elderly at the community/systems level as a risk factor. Greg (novice) on the other hand stated he is not aware of any policy relating to the social determinants of health that addresses elder abuse issues or public policy that might put the older adult at risk of abuse.

Furthermore, at the systems level, Ben stated the police have no time for elder abuse because the prosecution process is complex. Ben stated "... from a systematic level, it is like any abuse, it is very very complex, and it is very very complicated in terms of prosecuting somebody for it because first you have to prove it." Similarly, Harper (competent) stated it is a very complicated process that is not easily resolved but requires monitoring, providing education and

support on the various steps involved. Relaying his experience with legal matters on the situation table, Harper stated;

the things that really are hard to listen to is financial abuse, and I know that that is fairly common – where a family member or designated person is taking advantage and that in one way or another is one of the hardest ones and the most common one that gets discussed in our group. And it, as you know, it gets so complicated, it's not anything that can be dealt with in many cases very quickly – so it's a matter of monitoring and trying to give support and trying to give the education for the different steps in the legal process and having someone in there that can actually do that.

#### *4.2.9.4 Ageism and elder abuse.*

Ageism was identified at all levels. Three participants identified ageism as a risk factor for elder abuse. One participant expressly stated it while 2 implied it. Ben (novice) implied ageism by stating that the idea that the old have wisdom is lacking in the culture (north American culture), “...there is maybe not that idea that someone who is old has wisdom, it is more of ... you are old, you have kind of had your time, go retire maybe go to a nursing home.” Greg (novice) expressly stated there are misperceptions about the elderly, negative stereotypes that could play as factors. Greg further stated that if everyone has this perception, the community is not embracing older people, which could lead to abuse of the elderly. Harper (competent) identified discounting of the wisdom of the elderly as a loss to the society. Harper also identified being too familiar and addressing or admonishing the elderly as if they were a child as elder abuse. Both Greg and Harper identified the society as not being age-friendly. Ben (novice), Harper (competent) and Ian (competent) addressed culture in their interviews. Ben, Canadian, stated,

our relation with the elderly is a lot different than other cultures where elder people are not part of the family, the whole family doesn't live together ... it is more of you know you are old, you have kind of had your time, go retire maybe go to a nursing home.

Harper, of European (Scottish) descent, admires the reverence of the older adult in other cultures; "well, again I can't help but think the reverence that I see in other cultures, which I admire so much ... why don't we have that here?" Ian of African (Somali) descent identified the benefit of ethnic groups living closely, saying it allows for checks and balances for the elders living within the community. Ian (competent) further stated when the elderly live separately outside the community, they become isolated which makes them vulnerable to abuse. Ian stated in his Somali community, individuals who take care of their aged parents are praised, but no one is actually assessing what the actual care looks like. Ian further mentioned that elder abuse is rarely discussed, and community complacency might make elder abuse hidden and keep the elderly vulnerable and at risk. A summary of the perceptions of participants on the risk factors for elder abuse is presented in Figure 4.2.

Participants' perceptions of elder abuse risk factors were determined by the interplay of their knowledge of elder abuse and the social determinants of health factors shrouded by ageism at the micro, meso and macro levels. Drawing from the summary of elder abuse perceptions from the literature review, knowledge of elder abuse was based on participants' responses on their understanding of the concepts of elder abuse. Definition, constituents (forms), perpetrators, reasons for hiding elder abuse, barriers, consequences, and risk factors for elder abuse were concepts of elder abuse addressed from participants' responses. The social determinants identified from participants' responses were income (funding), family (social support, coping), health (access to health, healthy behaviour, biology and genetic endowment),

knowledge/awareness (education and literacy), community services and support (physical environment).

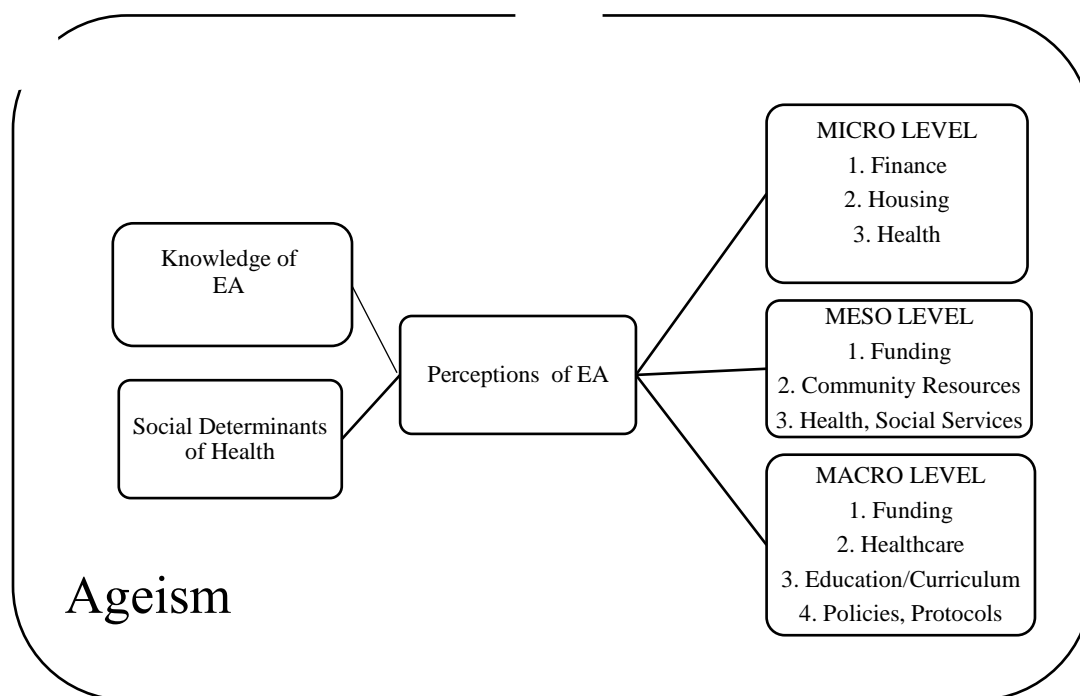


Figure 4. 2 Perceptions of Elder Abuse Risk Factors

Figure 4.2 depicts that the perceptions of elder abuse risk factors by participants is determined by their knowledge of elder abuse and the social determinants of health, which in turn is influenced by ageism. Therefore, ageism is like a lens, which, to whatever degree it is flawed, determines how elder abuse is perceived.

### 4.3 Assessment and Identification of Elder Abuse

There was variation in participants' responses when asked if they had suspected or confirmed elder abuse in their practice, and how was elder abuse identified. Responses were based on nursing assessments. Six participants had suspected and/or confirmed elder abuse; Alfa (proficient), Dan (competent), Eric (competent), Felix (competent), Harper (competent) and Ian



(competent). Felix initially suspected abuse and later through collegial validation confirmed that the incidence encountered was elder abuse.

#### **4.3.1. Assessment strategies used in identifying elder abuse.**

Ben (novice) stated in order to identify elder abuse; **initial nursing assessment** is needed to gain an understanding of the person and the situation; "...just getting a sense of what is going on". As per Ben, assessing by exploring their situation and finances, living condition, unmet needs to identify area of neglect, care support, and looking for signs of physical abuse such as bruising. Dan (competent) on the other hand stated eliminating issues might lead to suspicion of elder abuse, which can aid in discerning if there is actual abuse;

I guess it's putting the pieces together as you build the relationship, it's just the hunch that something is not right so what is it? And then you eliminate issues and not that they are always eliminated, but the big ones would be if there isn't a mental health or substance misuse going on, then there is got to be something else.

Harper (competent) who sits on the situation table in his jurisdiction stated he assesses for vulnerability in older persons having difficulties.

A significant theme that emerged in assessing abuse is the use of **intuition** in nursing assessment. Dan (competent) described it as putting the pieces together; "I guess is putting the pieces together as you build the relationship, it's just the idea, the hunch that something is not right so what is it?" Ben (novice) described it as "... just kind of trusting the gut." Ian (competent) stated "... I guess my initial gut feeling was right, I should have called ..." In addition, Felix stated "... I am sure it is complicated, but you can't really really say and report and say this is abuse, but we sensed that he wasn't being nice to his wife." These were words

used by participants to describe the significant role intuition played in nursing assessment of elder abuse.

*4.3.1.1. Visible and invisible signs of elder abuse.*

From participants' responses to how elder abuse was identified, findings showed both **visible** and **invisible** presentations of elder abuse. Visible signs of elder abuse include **appearance, manifest behaviours, finance, and narratives** to assess for psychological/emotional/verbal abuse. Alfa (proficient) and Ian (competent) identified **appearance** as a pointer to suspecting or confirming abuse. Alfa's description of appearance included disheveled appearance and poor grooming. Ian mentioned an "unkept" appearance, including hair and teeth which he later identified to be self neglect. Chloe (competent) identified **manifest behaviours** present during home visits or assessments; "...what kind of behaviour you see in front of you when you go for home visit or assessment, sometimes, you can see the like verbal abuse, from the family member, service provider ..." Dan (competent) confirmed physical and **financial** abuse but stated he did not do the assessment. Rather, police investigation revealed both physical and financial abuse; "...and so as the police case progressed, the police were able to elicit sort of information that there was physical abuse going on which led to financial..." Eric (competent) also encountered elder abuse due to neglect in his practice and described it as; "... I noticed it because I didn't feel she was feeding well, or the house was in disrepair... and I don't think she had any other resources other than her children."

Dan (competent) suspected abuse in his practice stating, "... you have an individual they are in subsidized housing conceivably have a source of income but have nothing to show for it." In addition, Dan identified older adults who being hospitalized, and in spite of having power of attorneys in place, their money was disappearing to family members and caregivers. Eric

(competent) experienced confirmed cases of financial elder abuse, but not physical abuse.

Jerome (novice) described a scenario which during the interview was identified as the vulnerability of the elderly to financial abuse,

and I was working for this company and we would be calling people on who have credit card of ... stores, and we would be calling elderly people but the explanations that were given, I know that some of the persons on the phone will not understand clearly what we're explaining to them. They would get the mail, the mail is very thick a lot of writing, information. Some of them can't read properly but by the time you are reading the mail you have, uh, you have one month free but by the time the mail get to you, and you don't understand what's in the mail, the one month is gone and they start taking money from you, your credit card because you gave information on the phone, so that we can send you package. For me I felt uncomfortable with that, um, like okay. I can read, I can take time but a person you know, uh, lost ability to, uh, see and, uh, and is at that age you know elder person may not take the time to understand, may not understand what is this about, and the money will be withdrawn from the account, uh, I was reflecting on that. I was wondering if that would that would was really, um, good thing to do for those persons.

Felix (competent) suspected abuse in his practice, and gave context to it as;

he was blind, but every time is like before he comes into the room, his voice is kind of harsh towards the wife, you will know something is going on. And one of my colleagues even did like a home visit and she does not quite understand their language, but she understands a bit, and that she feels like this man is very verbally abusive to the wife.

Chloe (competent) described how psychological abuse presents saying; "... could be like crying, that kind of panic situation ... they are afraid of talking ... they suppress their like intentions of talking." Chloe went further to say sometimes there is verbal abuse (**narratives**) from family member or service provider and that if somebody is visiting from outside, victims keep quiet.

Invisible signs of elder abuse identified by participants include **inconsistent narrative**, silence or **concealing abuse**, **lack of evidence of care** and **inhibition of service**. Alfa (proficient) identified inconsistent narrative as a sign of abuse. Alfa stated when the story of the abuser and the victim are not corroborating (**inconsistent narratives**), it is definitely a reason to suspect abuse. On the other hand, Ian assessed the narrative of others to identify abuse,

But even in speaking to the husband and son afterwards also, I kind of learned, and from the neighbours, the lady was really stubborn. And no matter what they would have done, the father and the son, she wouldn't have listened to them ... She was a really strong person in her ways.

A variation in own assessment and the narrative of others posed as a challenge to Ian in determining abuse; "...and because of that I don't know if it was her, her end, or if it was actually an abuse from the family, so it can get tricky".

A sign stated by Chloe (competent) was silence. Chloe stated that there may be **silence (concealing)** but with persistent observation, elder abuse can be identified from body language of the victims.

So, but most of the time if somebody from outside is visiting, they probably keep quiet. You don't hear that. But sometimes, if the person is very like firm, then you can see that happening, so in front of you, right. ... But most of the time, could be silent, kind of like you can see the body language, like very kind of afraid of his speaking and so neglected,

and lonely, feeling lonely ...Because if someone has been abused for a long time, the person will not like to explain anything and depressed.

Chloe (competent) further stated that even with good rapport, victims do not reveal what is going on and the reason victims may conceal abuse; victims do not talk to anyone due to fear of previous event and depression from prolonged abuse. Dan (competent) talked further on non-disclosure of abuse. Dan stated,

... I have never had someone outright say to me you know someone is abusing me physically, emotionally. So, it has to be a relationship. They have to trust you and that trust is hard to earn because they already don't trust the person that is abusing them.

In addition, Felix (competent) stated due to culture, some women in certain cultures do not disclose abuse, in particular, spousal abuse. Felix stated;

And culturally, some women, when they are facing abuse, and this one is spousal. So, when they are facing abuse, culturally because of where they come from, they want, they don't want it out. ... And the wife will be quiet so, but you can't really pinpoint. I am pretty sure if you ask the woman, she will not own up to anything.

Other pointers which was only identified by Alfa (proficient) were **inhibition of service and lack of evidence of care**. This could present as the elderly clearly in need of a service and the abuser denying the need for such service, or claiming it was or will be taken care of, but there is no evidence that the service was or will be provided. Alfa stated,

although she clearly needed services, they did not want to admit to the services, they were like, no no we got it, we are taking care of it, we are doing this we are doing that.

So, all the stuff that they said they were doing did not show in the client.

A figure illustrating how public health nurse participants identified elder abuse in their practice is presented in Figure 4.3.

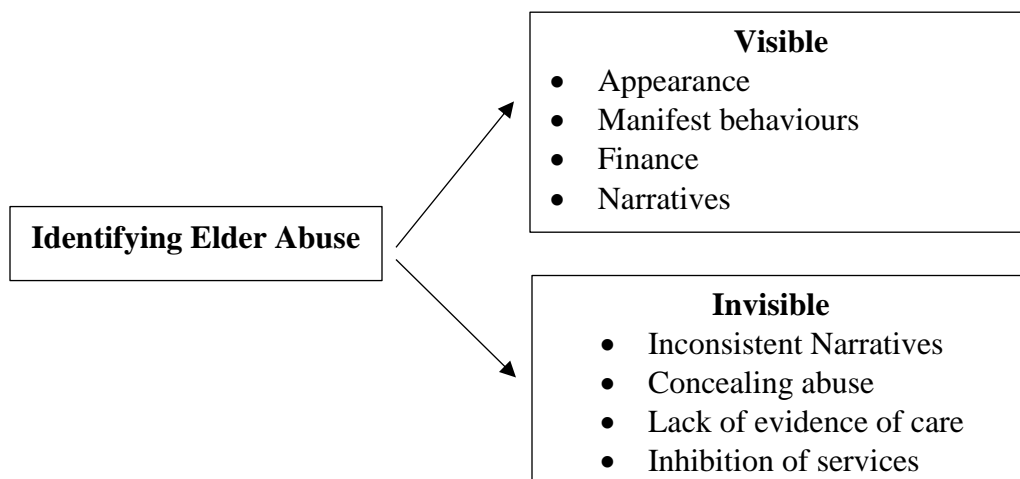


Figure 4. 3 Identification of Elder Abuse by Public Health Nurses

Figure 4.3 depicts the strategies mentioned by participants that they have utilized to identify elder abuse in their nursing practice. Signs of elder abuse were categorized under visible or invisible. Visible signs identified were appearance (grooming, neglect), manifest behaviours (verbal, physical), finance (housing, feeding), and narratives (verbal). Invisible signs of elder abuse identified were inconsistent narratives, concealing of abuse, lack of evidence of care and inhibition of services.

#### **4.3.2. No elder abuse encounters.**

Three participants reported not to have specifically encountered elder abuse in their public health practice. However, Chloe (competent) stated she might not have encountered any kind of elder abuse but acknowledged lack of identification might have occurred due to lack of further assessment,

I didn't encounter any kind of that kind of elder abuse specifically, but I was, I could not be aware sometimes, because it is not easy to identify. Because if you go deeper and

deeper to get more information, sometimes it is kind of confidential issue, and they don't want to speak.

However, Chloe stated with persistent observation, abuse becomes evident; "but sometime, if the person is very like kind of firm, then you can see that happening, so in front of you, right..." Ben (novice) being a new nurse stated he has not specifically seen elder abuse. Greg (novice) also reported not to have encountered elder abuse in his practice. Similar to what Chloe said about the possibility of lack of awareness, Dan (competent) who had encountered abuse stated,

So, I would suspect too that I, you know, have probably missed elder abuse in some situations with clients just because they are not in a position or place to actually tell you and what I would say is that we can become better at looking for signs of elder abuse.

#### **4.3.3. Barriers to identifying elder abuse.**

A significant theme that emerged in response to the interview questions was the challenges participants identified as barriers to identifying abuse. These same barriers also pertain to the challenges addressing elder abuse. Both Chloe (competent) and Dan (competent) identified a **lack of awareness/oversight (knowledge gap)** of service provider and the **need to conceal** abuse by victims as a challenge. Dan said organizations are hesitant in taking action regarding elder abuse and that victims don't talk about it because of shame and fear. Greg (novice) had reported not encountering elder abuse in practice, but in the course of the interview realized there might have been some oversight. Greg identified this knowledge gap and said because he does not have the knowledge or skill, he might suspect it but do not know how to address it. Both Ian (competent) and Jerome (novice) identified the challenge of discerning if abuse occurred or not in some particular situations. Chloe acknowledged that there might be oversight due to not assessing further. Dan (competent) had suspected that he might have

probably missed identifying elder abuse incidences due to client not being able to disclose it and suggested that care providers should be proactive in looking for signs of elder abuse. Jerome (novice) stated the issue was never focused on in his practice. Jerome further stated that "... you can see a situation but not like to come to a conclusion like that, that an elder was being abused". So elder abuse is not a priority focus in his practice and therefore not assessed. Felix (competent) stated he was unable to pinpoint abuse due to language barrier and the need to conceal due to culture.

Lack of knowledge about organizational protocols or policies on elder abuse also contributed to a knowledge gap. Harper (competent) mentioned being a villain for being the one reporting that a colleague abused a client. Harper also stated he felt he lacked the position then to address, and also did not know the process of addressing elder abuse back then. Harper stated,

like I was I became the villain for reporting her, and I actually did... I wanted it in the chart ... but I didn't know the process back then. But years later, it's still the first thing that comes in my mind because justice wasn't done, the abuser was never held accountable. And this man's family was never informed. No action was taken, I mean formal action.

Dan (competent) and Eric (competent) both identified **trust** issues as a challenge. Barriers to identifying and addressing elder abuse is presented in Figure 4.4.



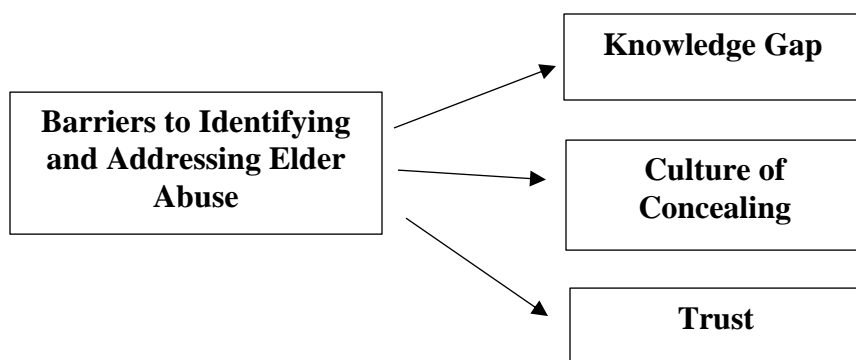


Figure 4. 4 Barriers to Identifying and Addressing Elder Abuse

#### 4.3.4. Lack of elder abuse screening in public health nursing.

When asked what screening tool, if any, was used to assess elder abuse, though the general response was mostly none, the question still generated a wide range of responses from participants as well. Basically, no screening tool is used as per 9 of the 10 participants. All participants except for Harper (competent) stated no specific tool is being used. Harper identified the ‘Elder Abuse of Ontario’s Safety Planning Toolkit for Older Adults Keeping Safe in Unhealthy Relationships’ (EAO, 2017) as the screening tool used. Harper also mentioned that on the local elder abuse network group, there are other short screens used which he has not utilized himself. Jerome (novice) said he has no idea of a screening tool for elder abuse.

##### 4.3.4.1 Strategies for screening for elder abuse in public health nursing.

Since 9 participants did not use a screening tool, alternative strategies for elder abuse were identified. Alfa (proficient) stated there is no formal tool used in her practice, but she asks 2-3 questions in assessing for physical, financial or any other type of abuse (**nursing assessment**). Ben (novice) stated he feels like there are screening tools out there but has never used a specific tool. But in assessing for abuse, he does routine **nursing assessment**, assessing clients’ situations including finances, he looks for things that don’t seem right such as relying on

gut feeling and **intuition** and then **consulting** with co-workers. Chloe (competent) stated since she does not encounter the situation in her practice, there is no specific tool used. However, if there is an occurrence, **help is sourced** (consultation) from other programs. Dan (competent) stated he is not aware of any screening tool developed to assess elder abuse and has not used one in his practice. However, Dan stated he based his assessment on his familiarity with the social determinants of health. Dan stated it is best to learn the signs of elder abuse and advocated for it. Eric (competent) was also unaware of any screening tool, but stated if it comes to his knowledge, he will use his professional judgment and awareness of community resources to source for support e.g. consult with other programs, service agency. Felix (competent) stated no tool is used in his practice. However, in ascertaining abuse, encountering similar experiences with a colleague from different encounters with the same clients, helped him to identify abuse. Greg (novice) also affirmed being unaware of a tool but stated that awareness has been raised in his organization, but he is not aware of any tool that has been created. Greg stated that the public health department he works in has a different focus currently, such as falls prevention, youth and substance misuse. Both Ian (competent) and Jerome (novice) also stated they have no knowledge of a screening tool.

Harper (competent), who presented a copy of an elder abuse safety toolkit that was provided by the provincial representative of Elder Abuse Ontario in his jurisdiction, is yet to use the safety toolkit himself. Harper was also aware of a short screen utilized by members of the elder abuse network in his jurisdiction in which he is a part of. Harper advocates for routine screening by physicians and other care providers. The assessment strategies identified by study participants is presented in Figure 4.5.

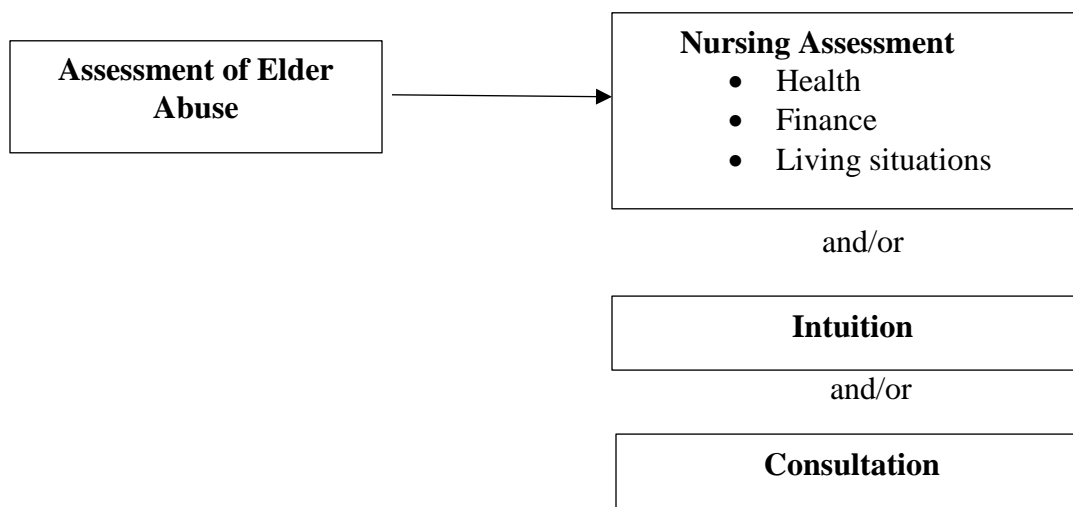


Figure 4. 5 Public Health Nurses' Strategies for Assessing Elder Abuse

Participants' responses signify that elder abuse assessment is still done despite the absence of tools to guide nurses. Assessment strategies identified by participants were, inclusion of elder abuse assessment in routine nursing assessment, use of intuition and consultation with colleagues and experts.

#### 4.3.5. Frequency of elder abuse encounters.

Participants' responses signify that elder abuse encounters are not common. In responding to how often elder abuse was encountered in public health nursing practice, Alfa (proficient) stated she had encountered 4-5 cases bad enough to be classified as elder abuse and where victims had allowed for intervention to take place. For clients that Alfa had deemed as vulnerable individuals, Alfa stated there are lots more that did not press charges or leave the abusive environment. Ben (novice) stated he had not experienced elder abuse in his few months of public health nursing practice. However, he stated it is sometimes hard to decipher actual abuse, if the victim's choice in relation to his own values is conflicting. Ben also stated except there is concrete proof such as money loss or bruising, he feels uncomfortable reporting elder abuse. Chloe (competent) acknowledged encountering elder abuse, but she was unable to

estimate a frequency of abuse. However, she did not think it is rare. Her clientele did not include a lot of elderly population. Chloe stated if she dealt with more elderly population, she might have encountered more incidences of elder abuse. Dan (competent), on the other hand, stated he encountered elder abuse on a monthly basis. Dan further stated the numbers do not show it, however, the rate is high. Dan stated, “so it is frequent, the numbers don’t show it from a larger systems perspective, but when you are working with older adults that are vulnerable in particular, the rate is high.”

Eric (competent) acknowledged encountering elder abuse in the past, but stated he no longer sees it now because most clients he sees in his sexual health practice are young adults. But he hopes he will be able to identify abuse in the elderly if seen. Eric stated,

I wouldn’t see it at all really now, em, because my just of the area that I was working now, but, em, I mean, I would hope that because I work with young people that are in need and having some issues with absolutely abuse and many ways sexual assaults that I will be open to seeing it. I hope that I could see it in seniors if I come across it.

Felix (competent) stated he is certain elder abuse exists, but he does not deal with it directly.

Felix stated there are community health workers that deal with elder abuse. Greg (novice) stated “none” because he is not a frontline staff. I inquired from Greg why he does not consider his job as an intake staff as frontline. Greg responded saying being a frontline staff at the telephone, his communication is with schools and other programs. Greg stated there are not many programs for the elderly in his health department and identified this as a gap. Harper (competent) stated his elder abuse encounters are not much and rated them between 1% - 2%. However, Harper stated he had expected more numbers than was brought to the situation table. Ian (competent) stated in

his experience working with youth and children, elder abuse is rarely encountered. Jerome (novice) stated he has had no elder abuse encounters in his practice.

#### **4.4 Addressing Elder Abuse**

Responses to what actions would and could be taken upon suspecting or confirming elder abuse, or what situation required acting were: further assessments, safety plan, consult with other support agencies, involve law enforcement and education.

##### **4.4.1 Further assessment.**

Alfa (proficient) stated he conducted several unscheduled visits to ascertain how the victim was being treated. Alfa further mentioned he asked questions and trusted his instinct, kind of just prod to see what sort of issues are underlying it and if it makes sense. If they don't make sense, trying to involve other professionals that will continue the search, without actually attempting to make the situation worse.

Alfa mentioned assessing nutrition, appearance and coherence of the elderly. Alfa also stated ascertaining competency; "... if they are competent or if they are borderline competent or incompetent, we will try to have the Office of the Public Guardian and Trustee (OPGT) to do an investigation" In addition, Alfa stated,

if they are competent, and if that is how they want to live, then you, as long as you do your due diligence, and provide the abusee or potential abusee the information they need in case they want to get out of the situation.

Ben (novice) stated a relationship should first be established, then the nurse should explore the knowledge of victim on elder abuse, if they perceive they are in an abusive situation or not.

Chloe (competent) also mentioned ascertaining abuse; "... the most important thing is I need to

like diagnose. Like I try to get point that the person got abused or not”. Felix (competent) identified acting, which includes assessing further. Felix stated,

I will take action...let’s say that I am trying to give injection, and I see a bruise, I always ask like how did this happen, you know that kind of a thing, to find out, em, if the person had a fall or what happened.

Despite saying I don’t know what to do, Greg (novice) on reflecting on previous client relations, talked on further assessment as well, “... I’m looking at those situations, I’m thinking that could be a situation where I could have investigated a little bit more, right. And I could have provided some support, right”.

#### **4.4.2 Safety plan.**

Alfa (proficient) and Ben (novice) both stated foremost intervention would be to create a safety plan. Alfa, having confirmed abuse in her practice, stated when next she encounters elder abuse victims, “... first thing I will do is make sure the client is safe in his or her environment, so do a safety plan, if they actually admit to being abused”. In addition, Alfa stated that attempts should be made not to trigger the abuser or make the situation worse for the victim. Similar to what Alfa said, Dan (competent) started his response by stating that “so with elder abuse I would say this is something that has to be approached really carefully with a lot of wisdom”. Dan stated,

often times when they get to a point where they share there is some kind of elder abuse going on, there is that premise or the condition that they make, please don’t tell anybody because I am afraid of a backlash. If they find out that I have told you this that the abuse is going to get worse. And often times, these are individuals with limited resources so the

idea of having even more limited resources and not having somebody to potentially take care of their groceries and their rent and all that type of stuff is really fear inducing.

Despite having not encountered elder abuse situations, Ben (novice) stated if there is immediate safety risk, immediate response should be taken to address the situation. Jerome (novice) stated if there is danger, attempts should be made to modify the situation or client be moved to alternative place. From Alfa's experience, the victim was completely removed from the abusive situation.

Dan (competent) stated that for suspected abuse cases to help the victim leave the situation, "try to come at this from the perspective of how can we help this individual to get out of this situation and also not lose that relationship potentially with a family member." Jerome also stated moving the victim to an alternative place or modifying the situation.

#### **4.4.3 Consult and involve other support agencies.**

Alfa said to involve other professionals and as many agencies as possible. For instance, Alfa stated "...if they are competent or if they are borderline competent or incompetent, we will try to have the Office of the Public Guardian and Trustee to do an investigation" Ben (novice) said if abuse is suspected he will consult with his team and manager. He will also involve the police and inquire from the OPGT on what types of support could be in place for the victim.

Chloe (competent) said she will also notify her supervisor and get feedback on what resources that can be used, for instance, consulting with the physician and social worker on her team.

Similar to Alfa, Ben and Chloe, Dan (competent) stated that for suspected elder abuse cases, manager and colleagues should be consulted and the OPGT for financial abuse situations. In

addition, Dan stated to connect client with community caregivers for accountability. Eric

(competent) said he consulted a lawyer. Eric also mentioned consulting with one's manager and

team. Felix (competent) mentioned following workplace policy and if there is none, a call out can be done to ascertain what action to take.

#### **4.4.4 Legal intervention/law enforcement.**

Six participants mentioned calling the police. Alfa (proficient) stated, “Em, if there is concern with safety, we will probably call police.” Ben (novice) stated he will call the police and office of the OPGT. Chloe (competent) mentioned reporting to authorities, but she is unaware of an authority addressing elder matters, “...so we try to connect with all the resources available, sometimes, like, inform, like, authority, I don’t know what kind of authority for elder abuse. I still don’t know.” Dan (competent) stated with explicit abuse, physical or sexual, abuser should be reported to the police. Dan also stated the Office of the Public Guardian and Trustee should be involved for financial abuse situations. Eric (competent) stated he spoke to a lawyer when confronted with an elder abuse situation. Both Ian (competent) and Jerome (novice) stated they will call the police.

#### **4.4.5 Education.**

Education was mentioned to fill the knowledge gap for both client and healthcare provider. Alfa (proficient) identified providing information to victims stating,

at the end of the day, if they are competent and if that is how they want to live, then you, as long as you do your due diligence, and provide the abuser or potential abuser, ah, the information that they need, in case they want to get out of the situation.

Ben (novice) mentioned providing client with resources and encouraging them to reach out to the supports. Dan (competent) described education through empowerment and autonomy by stating, “I have printed off pamphlets and given it to them to put the power back into their hands if they wanted to follow up.” Felix (competent) stated awareness should be created, in particular, for



those who conceal abuse; "... creating awareness especially for, em, people who wouldn't openly ..." Felix further stated,

but sometimes too, culturally they might not know it is abuse that they are going through. Right, yeah, but coming to Canada, like we have more awareness, yeah, of what abuse really is. Sometimes, they don't consider, some people think it is all hitting and beating, but verbal is also very damaging. And it can be worse right and so some people might not consider it, they will ask you he hit you, did she beat you? Yeah, but they don't know that verbal, even denying you of stuff that you need is also considered abuse.

Participants' strategies for addressing elder abuse is presented in Figure 4.6.

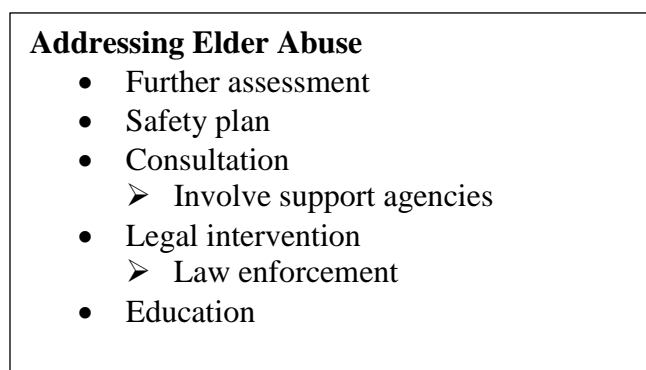


Figure 4. 6 Public Health Nurses' Strategies for Addressing Elder Abuse

#### **4.5 Situations that Requires Taking Action**

In responding to what situations requires taking action, Alfa (proficient) stated if they are incompetent and they are being taken advantage of, the police and the Office of the Public Guardian and Trustee should be involved. Dan (competent) identified physical and sexual abuse as priorities that require prompt action. In addition, when fear and anxiety are expressed, Dan stated action is required. Eric (competent) stated if there is health concern, lack of competency over finance or self-care, dependence on others and someone is taking advantage of them, advocacy is required,

certainly, health like, em, if somebody is ill or they have been abused and if they seem they don't have control over money or somebody is taking advantage of that, em, you know, I guess is more of that and also if they don't have ability to take care of themselves they are not independent any more, em, so they require some advocacy.

Harper (competent) told a story about physical abuse he encountered and reported, and he stated it was a situation that required taking action, which he did by reporting to his supervisor, but no action was taken to address the incident. Instead, Harper said he became a villain for reporting the abuse. Greg (novice) acknowledged that people do call in to make inquiries, and sometimes there is a sense that something is going on, but with no screening tool to assess what is happening, he does not know what to do. However, Greg acknowledged that further investigation is necessary even if it is just intuition warranting it.

#### **4.6 Professional Obligation of Public Health Nurses**

Nine participants stated that the professional obligation of nurses is to report elder abuse. Alfa (proficient) pointed out that neither the College of Nurses Ontario nor the organization she works at had a step by step procedure on how to address elder abuse. However, the professional obligation of nurses is to "... identify whenever possible and to report it". Ben's (novice) response was,

... I know that there is mandatory reporting for child abuse, as far as I know I don't think there is mandatory reporting, em, but yeah, I must say I am not totally clear on that ... I think that as a nurse obviously it's our duty to provide people with health and maximize wellbeing and you know try and like advocate and help people if we see them in pain and suffering. I do feel we have a moral obligation to do something but in terms of what that action actually looks like to me that is not totally clear.

Chloe (competent) stated there is an obligation to act if an individual is not treated well. Chloe stated, “so if somebody is not treated according to the legal system, social system we have in Canada, we have the obligation to act.” Dan (competent) stated,

    this is an interesting question because as a nurse we often talk about reporting for sure if somebody is a harm to themselves or harm to others ... when it comes to irrational thinking adults there is no obligation to report that case. The only caveat, and again not my practice area, is if you are in long term care there would be a duty to report, but as far as I know there isn't a duty to report in the community.

Felix (competent) said, “...as nurses, we advocate for our clients ... we are supposed to take it upon ourselves to make sure that the elderly are not abused.” Harper (competent) stated reporting elder abuse falls under professional nursing obligation.

#### **4.7 Reporting Elder Abuse**

Alfa (proficient) stated despite the lack of a step by step manual on how to address elder abuse, elder abuse should be identified whenever possible and be reported. Alfa further stated that there is professional liability for not acting. Alfa stated, “because if they can't, if they are incompetent, then it's a scary situation and we are more liable.” Chloe (competent), who had mentioned reporting elder abuse said, “I told you I am not sure about where to report outside the system.” Irrespective of this fact, Chloe advocated for reporting in both suspected and confirmed cases of elder abuse. Dan (competent) stated except in long term care where there is a duty to report abuse, there is no duty to report in the community. Dan, however said, “from an ethic or moral perspective I definitively feel there is a duty to report, but there is no professional obligation.”

Eric (competent) stated elder abuse should be followed up from a legal point-view, particularly physical abuse, and it should be reported to the manager and police. Felix (competent) stated nurses are to ensure the elderly are not abused by reporting any case of abuse. Similarly, Greg (novice) stated similar to child abuse, elder abuse must be reported. Harper (competent) stated in reporting, if he observes something, he will follow up to ascertain that something is done to address the incidence (based on the experience of not following up he had before years ago). Harper stated, “I want and make sure it has gone up the system so that there will be something done about it.” Ian (competent) stated to report to the authorities. Jerome (novice) also stated to report it. However, since working with the elderly is not his area of practice, he may call public health, state the situation and ask for direction to the right department. Ben (novice) stated there is mandatory reporting for child abuse but does not think there is for the elderly. Ben stated he feels there is a moral obligation to do something, but he is not totally clear on that. Eric (competent) stated, “I don’t know what they are in terms of for seniors other than that particular legal place, the ACE (Advocacy Centre for the Elderly), but yes, it would have to be followed up from a legal point of view.”

#### **4.8 Elder Abuse Interventions**

On the response to what interventions have been used or what interventions participants are aware of, responses included police/law enforcement, Elder Abuse Ontario, Office of the Public Guardian and Trustee, support services and education. Six participants mentioned involving the police. Four participants mentioned Elder Abuse Network (EAN), hotline or support. Three mentioned OPGT and one mentioned the Advocacy Centre for the Elderly (ACE).

##### **4.8.1 Police/law enforcement.**

Responses included in this category of calling the police are notifying authorities and calling 911. One of the services Alfa (proficient) stated he had utilized was the police. Ben (novice) mentioned connecting victims with the police stating,

in terms of other interventions I guess if it's you know, like, a crime and they want to press charges, then again connecting them with the police and providing them with the number of the police officer who works specifically with elder abuse.

Dan (competent) stated for physical abuse situations, the police should be involved. Eric also mentioned calling the police. Chloe (competent) mentioned informing the authorities but stated, "I don't know what kind of authority for elder abuse. I still don't know." On the other hand, Ian (competent) mentioned notifying authorities as well but then specifically mentioned the police stating, "if it's confirmed then ... it's already confirmed, and you are assuming that authorities have been informed ... like starting with the police." Jerome (novice) stated he does not have a lot of knowledge on interventions but mentioned calling emergency services.

#### **4.8.2 Elder abuse networks or support.**

Participants identified support networks in the community that they had used or will consult with regarding elder abuse incidences. Four participants mentioned Elder Abuse Ontario or support relating to elder abuse network. Ben (novice), having not encountered elder abuse in his practice stated,

I know there are resources through Elder Abuse Ontario, and there is a hotline for the seniors like a safety line and a helpline, so again providing them with those resources and encouraging them to reach out to the supports.

Dan (competent) said,

there is an elder abuse network, but as far as I know, I have never referred a client to them outside of providing them with resources. So, when you see a tentative client, I have printed off pamphlets and given it to them to put the power back into their hands if they wanted to follow up and they could do that and unfortunately with those, you don't actually know what the outcome is.

Felix (competent) stated,

they have an abuse hotline, yeah, they have an abuse hotline so that is another thing, creating awareness especially for em people who wouldn't openly, but you can call anonymously, right, to state. So, I can also, if I find a confirmed one, part of what I will do is also maybe give the person the hotline to call and explain, yeah.

Greg (novice) said he will consult with the elder abuse coordinator in his municipality, "... because she is the only one I know, and if that was the case, I will probably look her up ... and talk to her."

#### **4.8.3 Office of the public guardian and trustee.**

Three participants mentioned the Office of the Public Guardian and Trustee (OPGT) as an intervention in this study, Alfa, Ben and Dan. Alfa (proficient) mentioned the OPGT was an intervention that she had utilized. Ben (novice) mentioned the OPGT as an organization that inquiries could be made from on types of support that could be put in place for victim or would be victims. Dan (competent) stated in cases of financial abuse, victims should be connected to the OPGT and or with trust worthy power of attorney (POA). Dan stated; "... few individuals we had connected with the public guardian and trustees, so their financial situation was a little bit better than family members dealing with them."

#### **4.8.4 Support services.**

Responses on support services in this category include linking victim with a social worker and counselling services. Four participants mentioned connecting victims with support services. Four participants mentioned family resolution. One participant mentioned client education/empowerment. Support services were mentioned by four participants. Alfa (proficient) stated she was able to link victims with support services,

I have tried to get involved where the abusee wants to remain in the home, I tried to get as many services in as possible, so at least there is several organizations in one place that can have the potential to speak out if they suspect that the abuser is abusing the client more than what's currently happening.

In previous responses, Alfa had also made mention of getting as many agencies involved as possible, involving other professionals and seeking shelter/housing support. Similar to Alfa, Dan (competent) stated;

I think the biggest action I can take as a nurse is connecting them to community and other caregivers so that at the end of the day there is accountability with their caregivers as well and I think when other people know what is going on, they are less likely to be abused.

Ben (novice) mentioned counselling services for holistic family resolutions, for maintaining relationships, for safety and comfort. Ben stated; "I feel like ultimately like there needs to be like a holistic like resolution kind of with the family." Dan (competent) also mentioned keeping family relationship by reconnecting victims with family, stating; "... and try to come at this from the perspective of how can we help this individual to get out of this situation and also not lose that relationship potentially with a family member." In addition, Dan stated if it is a situation of emotional abuse, victims should be connected with community social worker and counselling. Harper (competent) stated the situation will be addressed through consultation and

collaboration at the elder abuse situation table in his jurisdiction. Harper also mentioned that sometimes family members are involved to provide support. Felix (competent) stated nurses should advocate for clients, ensure both victims and abusers undergo counselling.

Ian (competent) stated when abuse is confirmed to be perpetrated by family, the victim is isolated, "... so making sure that you build a social circle around the person." Ian stated there are agencies that can be accessed,

I am sure there are seniors' affairs ministry, the ombudsman through the city, you can try even starting with your MP (Member of Parliament) in your local area to figure out what you can do, the councilors to trump up support for that person.

Chloe (competent) stated she has not used any interventions so far and does not know where to report outside the organization. However, she will notify her manager, who can then consult with social worker to collaborate. Felix (competent) also mentioned connecting with professional bodies such as CNO and RNAO as resource, but he has not had the need to do so.

#### **4.8.5 Education/creating awareness.**

Alfa (proficient) identified providing information to victim. Ben (novice) mentioned providing client with resources and encouraging them to reach out to the supports. Dan (competent) described education through empowerment and autonomy. Felix (competent) stated awareness should be created, in particular, for individuals who conceal abuse. Felix further stated,

but sometimes too, culturally they might not know it is abuse that they are going through. Right, but coming to Canada, like we have more awareness, of what abuse really is .... Some people think it is all hitting and beating, but verbal is also very damaging. And it can be worse right, and so, some people might not consider it, they will ask you, did he



hit you? did she beat you? But they don't know that verbal, even denying you of stuff that you need is also considered abuse.

Eric (competent) stated he is not aware of adult protective services. However, Eric believes there is a part of the government that investigates elder abuse matters and that ignoring the issue amounts to negligence.

#### **4.9 Summary of Findings**

The findings showed that with a lack of academic knowledge on elder abuse, most participants acquired knowledge from public awareness campaigns and professional trainings. No one pattern of knowing on its own is sufficient to deal with the complex issue of elder abuse; all patterns are necessary for successful resolution of elder abuse cases (Kingsley, 2002). The various patterns of knowing were interdependent and inter-related for an understanding of the experienced reality of participants (Kingsley, 2002). Despite not having screening tools to aid in the identification of elder abuse, knowing the client aided participants to make judgment about the nature of their clients and the clinical situation and choosing appropriate therapeutic measures (Mantzorou & Mastrogiannis, 2011). Nurses with deep understanding of their clients and their needs advocated to ensure their clients had appropriate interventions. Participants in responding to what they will do if they suspect or confirm a case of elder abuse, mostly stated further assessment, creating a safety plan and removing the victim from the abusive situation, contact support agencies, involve law enforcement and provide education to victims. The professional practice in which participants mostly dealt with elder abuse situations were to assess clients to get factual evidence (empirical) on what is occurring in the abusive situation, personal knowledge (personal) and understanding of the older adult, exploring to know and gain a perception their experience of being abused (aesthetic), and to ascertain how to intervene and

address the abuse (ethics). All of these show the incorporation and inter-play of the various ways of knowing. The Carper's Ways of Knowing, as per Carper (1978), is further explained in the next chapter.

Overall findings from the data is illustrated in Figure 4.7 below. Participants' perceptions of assessing, identifying and addressing elder abuse was determined by their knowledge of elder abuse and the social determinants of health. **Knowledge** of elder abuse comprises of its meaning or definition, constituents (forms), perpetrators, prevalence, risk factors, barriers to identifying and addressing, and the consequences of elder abuse. Perceptions of the risk factors for elder abuse were identified through the lens of the **social determinants of health**. Both knowledge of elder abuse and risk factors identified through the social determinants of health were influenced by **ageism**, which was either implicit or explicit, determined how participants assessed, identified and addressed elder abuse. Ageism was presented in the forms of discounting the elderly, misperceptions about the elderly, negative stereotypes about the elderly, and community/societal indifference and/or complacency about the older adults. Ageism, as an overlying shadow influenced the knowledge of public health nurses' practice relating to elder abuse assessment, identification and interventions. Figure 4.7 is a summary of the findings of public health nurses' perceptions on assessing, identifying, and addressing elder abuse in their practice.

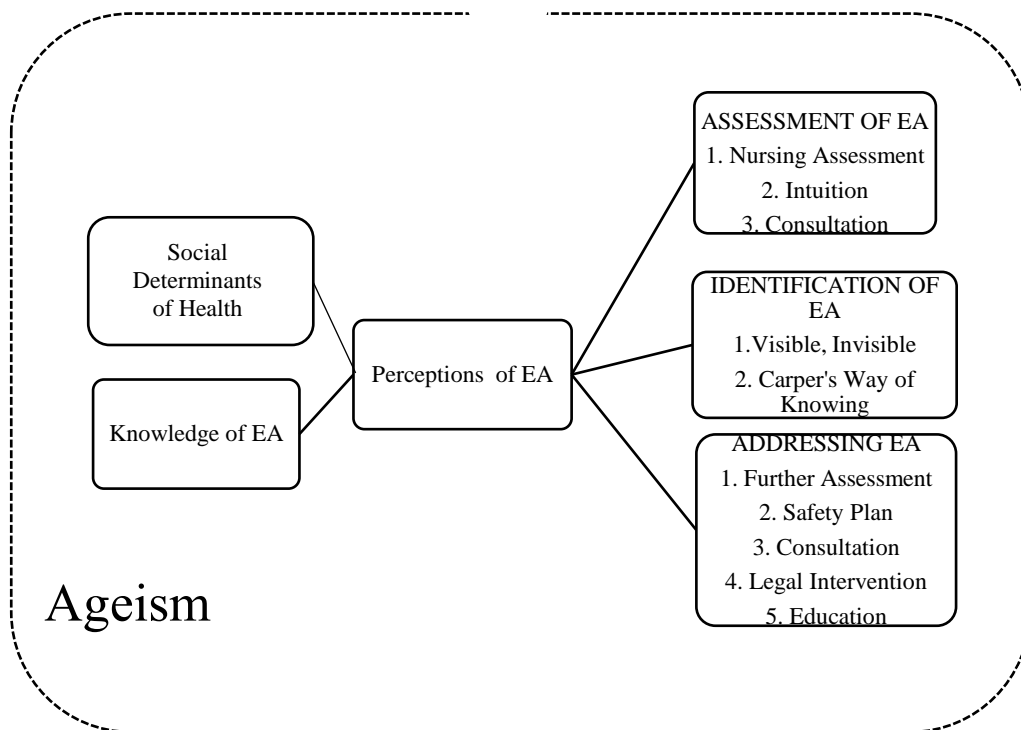


Figure 4. 7 Public Health Nurses' Perceptions of Assessing, Identifying and Addressing Elder Abuse

## Chapter Five: Discussion and Conclusion

The purpose of this study was to examine the perceptions of public health nurses in assessing, identifying and addressing elder abuse. I wanted to explore public health nurses' knowledge on the issue of elder abuse, and how this knowledge affects their perceptions of assessing, identifying and addressing elder abuse. I conducted in-depth interviews to collect qualitative data for a naturalistic inquiry. Participants in the study consisted of 10 public health nurses. Data were coded, analyzed, and organized by research questions, categories and themes from the findings. The research question was, 'What are the perceptions of public health nurses in assessing, identifying and addressing elder abuse in their nursing practices?' The study was based on the following three research objectives; (1) to explore public health nurses' perceptions of elder abuse; (2) to explore how public health nurses assess and identify elder abuse in their nursing practice; and (3) to explore how public health nurses address elder abuse in their nursing practice.

These three objectives were satisfied by the findings presented in chapter 4. The dominant findings in this study revealed that public health nurses had a critical view of elder abuse in stating or implying that there is harm or risk of harm to an older adult. Most (8) participants acquired knowledge of elder abuse through public awareness campaigns and professional development/continuing education, but less than half (4) fully understood elder abuse, what it constitutes and how it relates to public health nursing. Despite having some knowledge of elder abuse, public health nurses perceived that the lack of (standardized) screening of elder abuse in public health nursing practice creates a disconnect in determining and addressing elder abuse. This perceived disconnect between screening and actually identifying and addressing elder abuse was compounded by the fact that nurses perceived that elder abuse is

hidden and difficult to identify, and that assessment of elder abuse is not the focus of their programs. Therefore, despite suspecting abuse, on some occasions, further assessments were not done to determine and address the abuse. As a consequence, public health nurses mostly do not assess elder abuse, and when encountered, there may be an oversight of identifying elder abuse. In addition, there is a general knowledge of the professional obligation to report abuse, but there was limited knowledge on how to actually address elder abuse.

In writing this discussion chapter, I synthesized the findings of the study with the conceptual framework from figure 2.2 on page 41 which was developed from the summary of the literature review. The chapter is organized by the following analytical categories; (1) Public health nurses' perceptions of elder abuse, (2) Public health nurses' assessment and identification of elder abuse, and (3) Public health nurses' addressing of elder abuse. The analytical categories align with each of the study's research objectives. These same analytical categories were used to guide the coding of the data and in presenting the findings in the previous chapter. In the analysis, I sought to primarily connect patterns within the analytical categories and then compared and contrasted them to similar studies. The strengths and limitations of the study are discussed. The implications of the study for practice, policy and future research are also discussed.

### **5.1 Public Health Nurses' Perceptions of Elder Abuse**

The first objective of my study was to determine the perceptions of public health nurse participants on the issue of elder abuse. Four questions were asked in this category; what elder abuse means to the participants, what knowledge participants have about elder abuse, what experience participants have or how elder abuse present in participants' practice, and what risk factors contribute to the elderly becoming vulnerable to elder abuse.

### **5.1.1. The influence of knowledge.**

#### ***5.1.1.1 Demographics on knowledge of elder abuse.***

Participants' source of knowledge of elder abuse showed that there is awareness on the topic. Majority of study participants acquired their knowledge of elder abuse through public awareness campaigns such as infomercials, annual campaigns and events from the World Elder Abuse Awareness Day (WEAAD) and professional development/continuing education at their public health units. The study by Daly and Coffey (2010) showed that 60% of study participants had attended at least one training on elder abuse. On the other hand, in the study by Ahmed et al. (2016), 99% of the doctors and 50% of the nurses reported they have not been trained to diagnose elder abuse and neglect. In my study, half of the public health nurse participants acquired their knowledge of elder abuse informally through self-study and stories on lived experiences of victims. While some (4) participants acquired their knowledge of elder abuse through academia, none was from undergraduate nursing curriculum in Canada. The 2 participants who acquired knowledge of elder abuse, while in undergraduate nursing, actually acquired the knowledge from consolidation practice in the community setting. With a lack of academic knowledge on elder abuse, most participants acquired knowledge from public awareness campaigns and professional trainings. This finding shows an existing gap in nursing curriculum on elder abuse. The finding is similar to that found in the study by Sandmoe and Kirkevold (2011), where elder abuse was not in the Norwegian nursing curriculum, nor was it a mandatory course and only very few universities incorporated elder abuse as a topic in an elective course. Since the nurses were not taught how to identify abuse, their approach to such encounters was based on clinical experiences (Sandmoe & Kirkevold, 2011). In addition, in the study by Leddy et al. (2014), of 120 obstetrician-gynecologists, 64.7% reported training on elder

abuse as nonexistent while receiving medical training or residency. Only 1 person stated they had received adequate and comprehensive training.

In my study, six participants self-rated themselves as competent on knowledge of elder abuse, one participant self-rated as proficient while three participants self-rated as novice. Despite a high percentage of participants acquiring knowledge from public awareness campaigns and any form of professional training or continuing education, less than half (4) expressed full understanding of elder abuse, what it constitutes and how it relates to their public health nursing practice. This finding is similar to the study by Daly and Coffey (2010), where there was a high level of uncertainty on elder abuse and what it constituted despite participants having received at least one training session on elder abuse. In a Malaysian study by Ahmed et al. (2016), both doctors and nurses showed deficiency in their knowledge of elder abuse.

In my study, half of the participants had direct elder abuse experiences. Of those without professional elder abuse encounters, 3 participants reported having limited or no knowledge of elder abuse. Despite participants reporting limited to no knowledge of elder abuse, in the course of responding to questions, they were able to identify and relate their encounters to their knowledge of elder abuse. This finding is similar to the study of Sandmoe and Kirkevold (2011) where community nurses struggled with defining abuse in cases they encountered and were reluctant in considering unintentional neglect as a form of abuse. However, after an outline of the definition of abuse was discussed, the study participants acknowledged having encountered elder abuse.

#### ***5.1.1.2 Defining and describing elder abuse.***

Meanings and definition ascribed to elder abuse varied across participants. However, all participants held a critical view of elder abuse and their responses implied that there was harm or

risk of harm to an older adult. None of the participants defined elder abuse by the international (WHO) or local (any Canadian) definition of topic. Instead, participants described it based their own understanding and as it pertained to their practice. Wang et al. (2015) stated that the concept of elder abuse is not consistently defined across jurisdictions in Canada. However, the definition/description of elder abuse by study participants was similar to the definition by the WHO (2002) and NICE (2012) in implying that there was harm or risk of harm to the elderly.

As earlier mentioned in the thesis' introduction, elder abuse, as a term, encompasses multiple types of abuse; physical, psychological, sexual, financial and neglect. Participants in describing elder abuse had used the different forms of abuse to define elder abuse. For instance, a participant described elder abuse as “when an elder is neglected... it is a form of abuse, when information are not shared properly with an elder ... hiding... details that may be helpful to them”. This description depicts two kinds of abuse; neglect and psychological abuse. In the study by Schmeidel et al. (2012), nurses from the United States described rather than labelled elder abuse, physicians succinctly labelled the types of abuse, while social workers focused on self-neglect. In contrast to the study by Schmeidel et al. (2012), where nurses tended to describe rather than label abuse, half of the participants in my study succinctly mentioned three to four forms of abuse in describing or defining elder abuse while 2 participants described, rather than label the form of abuse. In another study by Daly et al. (2012), critical care nurses described scenarios for emotional abuse, physical abuse, financial exploitation and neglect.

#### ***5.1.1.3 Variations in elder abuse definition.***

There was no consensus on the definition of elder abuse by participants. Participants described elder abuse based on what it constitutes to them and on the type of abuse they have heard of or experienced. The systematic review by Touza Garma (2017) revealed that when



social and health professionals defined abuse, their views could differ from the one reflected in standard definitions which were not generated by them. The variations in the definition and description of elder abuse seem to be influenced by participants' understanding of the issue. The review by Touza Garma (2017) revealed that definitions can be influenced by cultural factors and situational contexts which can increase the probability of the abuse being rationalized. Particular to my study, participants defined and described elder abuse in the context of their experiences and practices. For instance, one participant's encounter with neglect as a form of elder abuse influenced his definition/description of what elder abuse is. The participant focused more on neglect in the description on elder abuse and defined elder abuse as intentional. Is unintentional abuse being rationalized as not constituting abuse? Wang et al. (2015) stated explicitly that abuse includes acts of both commission and omission. In describing what elder abuse is, the participant appeared not to have considered unintentional abuse as abuse. Another participant, in talking further on not having previous knowledge of elder abuse prior to public health experience, stated, "like my idea when we talk about elder abuse I'm thinking about physical, I'm thinking about emotional, but I never really thought about taking advantage of another person and abuse can be that as well." It appeared this participant did not initially relate the act of intentionally taking advantage of another as abuse. In the study by Sandmoe and Kirkevold (2011), community nurses struggled with defining abuse in cases they encountered and were reluctant to consider unintentional neglect as a form of abuse. Another study participant did not define elder abuse nor succinctly state the forms of abuse but rather described his pre-nursing encounter (situational context) on elder abuse by giving a scenario of concealing information and exploitation in explaining neglect, psychological and financial abuse.

This finding of a variance in definitions of elder abuse is similar to the findings in the literature review of the diverse definitions of elder abuse across Canadian jurisdictions, and the variance reflects the differences in agenda and purposes of the various stakeholders (NICE, 2012; Wang et al, 2015). The differences in the definition of elder abuse portrayed a variation in the interpretation of what elder abuse meant to participants and therefore a variation in the way elder abuse is assessed, identified and addressed. Six of the study participants had rated themselves to be competent in their knowledge of elder abuse, while 5 participants have had professional experiences on elder abuse. Three out of the 5 participants of those with professional experience on elder abuse, had roles specifically geared to providing support and/or seeking to address elder abuse, and they appeared to have a better understanding on the subject. This was reflected in their definition and description of what elder abuse was. All other participants encountered the elderly in their practice but none specified that an agenda exists for elder abuse in their public health programs.

#### **5.1.2 Lack of professional elder abuse experience.**

Despite all participants coming in contact with the elderly in the course of their public health nursing practice, only 5 participants reported to have had direct professional elder abuse encounters. In the same vein, participants' responses signified that elder abuse encounters are uncommon. For participants whose practice focused more on the geriatric population, they affirmed encountering and identifying more elder abuse situations compared to other participants with fewer or no older adults in the demographics directly being served. For the participants with limited or no older adult demographics, some did not consider the older adult population as clients requiring assessment even if they saw and interacted with them in the practice environment. Their focus was solely on the services being provided.

The participant who had reported the highest number of elder abuse encounters, mentioned that of the few encounters she experienced, there were many more victims that did not press charges nor leave the abusive environment. The prevalence rate of elder mistreatment in Canada from the literature is 8.2% (McDonald, 2015), and only 1 in 24 cases are reported (Hirst et al., 2016; WHO, 2017). This may account for the low number of elder abuse encounters. However, some participants did acknowledge the possibility of oversight on elder abuse for one reason or the other; sometimes because it is hard to decipher, lack of awareness, poor knowledge and elder abuse not being a focus in their practice.

Some participants considered the older adult clients they served as relatively healthy, independent, active, functioning and well-connected older adults with less vulnerability to abuse. One participant stated the few older clients she has had contact with are well cared for and that if she had had dealings with a higher number of older adults, she might have encountered more incidences of elder abuse. Some health professionals are mostly unaware of the issue of elder mistreatment and of the appropriate course of action to pursue when mistreatment is suspected (Falk et al., 2012; Rudnick & Teaster, 2013; Winterstein, 2012). Two participants reported to have worked directly with older adults in their practice but did not encounter elder abuse cases directly. One of the two participants worked in intake (receives central telephone calls) and reported that he sometimes communicates directly with the elderly over the telephone in the course of his work. Another participant sits on the elder abuse situation network in his jurisdiction where elder abuse cases are discussed and addressed. The intake staff acknowledged that older adults sometimes call because they need someone to speak with or they are calling because of some issue. However, the issue is not assessed further if there is no provision to address it. The second participant, who is part of the elder abuse network in his jurisdiction,

provided services such as Falls Prevention to younger well seniors. However, he said he is rarely around the older senior population. This implies that the participant considers the older senior population as those prone to elder abuse. Elder abuse is not restricted to the older senior population alone. From the literature and government reports, older seniors experienced less abuse compared to younger seniors aged 60-69 years (Frazao et al., 2015; Roberto, 2016; Statistics Canada, 2014). It appears that participants' lack of further assessment to ascertain if any older adult is facing elder abuse is being regarded as a lack of professional elder abuse experience.

### **5.1.3 Masking of elder abuse.**

Despite the absence of a specific question inquiring on reasons for abuse being hidden, participants in this study identified conscious and unconscious barriers in detecting and managing elder abuse situations. Five of the study participants identified elder abuse as hidden or concealed. Phrases such as “very subtle”, “really really hidden”, “not easy to identify”, “they don’t want to speak” were phrases used by study participants to identify the concealing of elder abuse by victims.

The reasons participants identified for the masking of elder abuse were shame and guilt, trust concerns, fear of abuse being repeated or worsening conditions, culture, language barrier, literacy, stigma, lack of funding, and lack of mobility. These reasons are similar to those from the literature. Elder abuse is rarely revealed, and help is rarely sought for by victims for multifactorial reasons and each reason is contextual (Hirst et al., 2016 & Pickering & Rempusheski, 2014). As identified by my study and other studies, victims of abuse share a fear of retaliation (backlash in form of worsening abuse and less support), stigma (shame and guilt), emotional distress (depression) and culture as reasons for not disclosing elder abuse (Andrews,

2017; Ko & Koh, 2012, Perel-Levin, 2008; Pickering & Rempusheski, 2014). Also identified by my study participants was the lack of trust in others.

Visible signs of elder abuse identified by participants were appearance (physical or neglect), finance concerns, and narratives to reveal emotions or verbal outbursts (psychological/emotional/verbal). This finding is in contrast to the report by Horning, Wilkins, Dhanani and Henriques (2013), who stated that visible signs of elder abuse and neglect may be easily identified/recognized by skilled healthcare workers, but psychological and financial abuse may be less transparent. If a victim of abuse does not make the choice of revealing emotional/psychological abuse or financial abuse as a narrative and if a healthcare worker, though skilled, does not make effort to properly assess and inquire from the client about abuse, then psychological and financial abuse will remain masked. Unfortunately, a victim's self-report of the abuse may also be unreliable, further masking abuse. For instance, from the description of an elder abuse situation, one of the participants suspected and recognized the abuse as physical, psychological and financial. Though reported to be eloquent and cognitively intact, the elderly victim was described as "apprehensive" when the perpetrator was present, and therefore avoided making eye contact with the nurse and would claim not to remember anything in order not to disclose being abused. Horning et al. (2013) stated that due to undue influence, older adults may remain at risk for financial exploitation because of the emotional abuse and manipulation being perpetrated on them.

In my study, a participant who initially denied having encountered elder abuse did mention that identifying elder abuse is sometimes not easy. The reason given was that upon further probing, findings might be confidential and therefore the victim might not want to reveal

it. Hirst et al. (2016) stated that sometimes healthcare professionals find elder mistreatment situations complex and difficult to handle.

Some participants acknowledged the possibility of an oversight in their encounters with the elderly. The attitude of uncertainty about occurrence due to lack of knowledge of signs of abuse or clinical findings and fear of misdiagnosis was identified by a couple of participants as reasons for not disclosing elder abuse. The study by Cooper et al. (2009) showed that nurses and physicians cited fear of damaging existing therapeutic relationships as major reasons for not reporting abuse. The attitude of uncertainty about elder abuse occurrence due to a lack of knowledge of signs or clinical findings on abuse will further make elder abuse invisible and remain masked to healthcare providers (Cooper et al., 2009).

#### **5.1.4 Elder abuse in the light of ageism and the social determinants of health**

Ageism and the social determinants of health were identified by some participants as factors to consider while deliberating risk factors for elder abuse. However, the two concepts of ageism and the social determinants of health encompass the responses given by participants regarding risk factors of elder abuse. Ageism and finances were identified at all 3 levels inquired about in the question; individual (micro), community (meso) and systems (macro) levels. Participants identified ageism and finances as very significant risk factors that put older adults at risk of elder abuse. Study participants also talked about community resources (in the light of the social determinants of health); their responses rested mainly on the limited amount of available community resources which was related to funding and funding appropriation.

##### ***5.1.4.1. Ageism.***

Ageist perceptions within healthcare and the society at large overtly and covertly influence how healthcare professionals view the elderly and incidence of elder abuse (Band-

Winterstein, 2015; Phelan, 2010). Band-Winterstein (2015) identified ageism in healthcare on three levels: individual, institutional and societal. At the individual level, ageism was explained from a psychological perspective of terror management, such that, to cope with the emotions of fear of suffering, helplessness and dependency, ageist behaviour is developed by others towards the elderly in order to cope and or manage the fear of dying (Band-Winterstein, 2015). At the institutional level, ageism is displayed through inappropriate care in institutional settings such as lack of accurate medical diagnoses or treating the incompetent older adult as invisible. Band-Winterstein (2015) describes ageism at the societal level as patronization and use of ageist language. The position of being marginalized and disadvantaged, which society gives to older persons is an example (Mysyuk et al., 2016 (b)). Ageism described in this way shows how the older adult is vulnerable to marginalization, which is a key factor to social isolation and exclusion, which in turn have a negative effect on the social determinant of health outcome (Podnieks, 2006).

Ageism, the negative social attitude towards the elderly based on negative beliefs about ageing and assumptions that the elderly are frail, weak and incapable (CCEL, 2011; RNAO, 2014) was identified as contributing to elder abuse. Two participants identified the society as not being age friendly. One had mentioned that there are existing misperceptions about the elderly, and that negative stereotyping of the elderly could play as a risk factor to elder abuse. The same participant stated that having such misperceptions implies the community is not embracing of the elderly and this can lead to abuse. Another participant identified the discounting of the experiences and wisdom of the elderly as a loss to the society. A third participant also stated that the idea of the elder having wisdom is lacking in North Americans culture. Pillemer et al. (2016) stated that stereotypes and negative attitudes towards the elderly, such as perceiving them as

fragile, dependent and a burden, may contribute to societal acceptance of elder abuse and it can make it permissible for younger generations to mistreat them. These kinds of misperceptions and discounting of the elderly can lead to social isolation and exclusion, which can have a negative effect on health determinants (Podnieks, 2006). Furthermore, the normalization of violence in the society may further perpetuate violent behavior toward the elderly (Pillemer et al., 2016). Ageist perceptions have been shown to overtly and covertly influence how public health nurses view the elderly (Phelan, 2010).

#### *5.1.4.2. Social Determinants of Health.*

The social determinants of health are unique and peculiar for every individual. In relating what determines health to the risk of being susceptible to elder abuse, the findings from my study showed that the elderly are vulnerable to abuse at all levels; micro, meso and macro levels. As per PHAC (2010), fifty percent of the health status of any population is attributed to social and economic factors, while the physical environment accounts for 10% and biological and genetic endowment accounts for 15% and the healthcare system accounts for 25%. Therefore, factors such income, education, physical and social environments have more influence on health much more than the availability of healthcare services and resources.

Finances, social isolation, family complexities, medical history, knowledge/awareness of the concept of elder abuse, dependence on perpetrator, were risk factors identified by study participants at the micro level. Community resources, ageism, social determinants of health, legal, culture, differing priorities of the government were identified by study participants as risk factors alternating between the meso and macro levels that cause the elderly to be susceptible to elder abuse. The following findings are some of the many risk factors also identified in the systematic reviews done by Gallione et al. (2017) and Hirst et al. (2016); changing economic and



social structures, isolation, intergenerational conflict, cognitive and functional impairment, shared living environment and inadequate knowledge of laws and services. Other risk factors particular to the macro level include the healthcare system, care delivery models and public policies (RNAO, 2014; Schiamberg et al., 2011).

The longer people live in stressed economic and social conditions, the greater the impact on their health outcomes (PHAC, 2010). The same goes for vulnerability and susceptibility to elder abuse. Finance (income) was the biggest risk factor identified by 8 participants in the study. Finance was covered at all three levels, micro, meso and macro levels but with differing views. One view was that more money means better access to services and less chance of isolation. Another view was that limited financial resource means higher chances of being abused as the elder could be seen as a burden to the family. Yet another view similar to the last one was that with ageing comes reduced income and money can diminish fast with rising cost of living. One participant's statement sheds more light on this when he stated that lots of seniors who are poor before retirement will still remain poor, increasing their vulnerability. One participant, on the other hand, stated that more money can expose the elderly to being taken advantage of. Another participant buttressed this by implying that financial disposition leads to theft, whereby individuals want to take from the elderly, and made references to incidences described in the media. One participant was neither for nor against and stated that having access to income or limited financial means, either ways, increases the chances of the elderly being susceptible to elder abuse.

Finances were also addressed in the funding of health and other community services by the government. At the meso and macro levels, the inequitable distribution of resources based on geographical locations, the inequitable or lack of funding of program slated for the elderly, such

as cut backs on health coverage, dental care and home care service support and the inappropriate disbursement of funds, whereby it does not reach the end users (through lack of promoting awareness/education), are ways finance is a risk factor to the elderly being vulnerable to abuse. One participant described finance in the context of differing priorities for the government and stated that matters pertaining to the elderly are least among government priorities, if they are being deliberated on. Change or no change in economic situations, participants' responses depict that the elderly are still vulnerable to being financially abused by both individuals and the society at large.

Social support network, which is associated with better health, was identified by participants as support from families, friends, and communities. Community and social support play a significant role in the well-being of the older adult. Participants also identified that a breakdown or strain in family relationships, incapacity to care for the elderly, having limited love for parents, children moving away from home to seek better opportunities, social isolation all put the elderly at risk of losing or lacking social connectedness and making the elderly vulnerable to abuse. Low social support was one of two most consistent correlates of elder abuse identified by Acierno et al. (2010), the other being previous traumatic event exposure such as interpersonal and domestic violence.

Findings from the study also revealed the change in the social structure of the individual in the context of family complexities, dependence on perpetrator, social isolation, and community resources as risk factors to elder abuse. A significant factor that increases the risk of elder abuse in domestic settings is having a shared living situation (WHO, 2018). Dependency could be mutual, whereby the older adult becomes more dependent on family member(s) for caregiving due to worsening health or worsening family relationships and resulting in stress. Or

the abuser, who may be living with a mental illness or have a substance abuse problem, is dependent on the older adult for support or resources usually finance (Pillemer et al., 2016, WHO, 2018). Mysyuk et al. (2016) (a) described the dependence between the victim and perpetrator of elder abuse as mutual dependency, whereby loneliness, power and control imbalances and the marginalization of the social position of the elderly contribute to elder abuse.

Culture, another significant part of the determinants of health was addressed in different contexts by participants. Elder abuse in the context of gender could go both ways. Participants' responses did not specify a particular gender in the context of prevalence of forms of elder abuse. Examples of elder abuse incidences given by participants showed that both older male and female adults were victims of elder abuse. In the context of relationships/ intimate partner violence (IPV), one participant identified the female as a perpetrator while a couple of other participants identified the males as the perpetrator of elder abuse.

One participant described his encounter of suspected elder abuse, in particular spousal abuse, but the female victim concealed the abuse. Since the suspected victim did not disclose abuse, the participant did not inquire further nor follow up with the suspected victim. In the study by Brossoie and Roberto (2015), participants reasoned that the lack of awareness of intimate partner violence in late life was largely limited because older women are not asking for help. Some participants in the study by Brossoie and Roberto (2015) had a shared assumption that individuals grow too old to engage in violent relationships. The participant in my study went further to mention that it was the way the husband acted towards the wife that prompted the suspicion of abuse and his fellow public health nurse colleague also confirmed feeling the same way. Study participants in Brossoie and Roberto (2015) identified that it was easy to identify an alleged male perpetrator of intimate partner violence than the victim. Beach et al. (2016) stated

that due to non-reporting and minuscule studies on intimate partner violence in old age, there is minimal education to health care providers for screening and intervention for this group.

One participant stated that elder abuse is rarely talked about in his culture, inquiring if victims of abuse consider the minimizing of elder abuse as a norm. The participant's response identified the benefit of ethnic group members living in close proximity to one another, saying it allowed for checks and balances for the elderly living within the community. But when these individuals live separately, they become isolated and vulnerable to abuse. The participant went further to state that in his own East African ethnicity, individuals who care for their parents are praised, but no one is actually assessing the quality of the care. This participant's observation is in agreement with the comments from the summary of the workshop by the National Research Council (2014); that in the context of African-American families, despite being abused by their children, older adults want their children nearby, and they are often reluctant to report abuse because they do not want to be seen as going against a family member or harming their family's reputation in the community. The same participant in my study mentioned that elder abuse is rarely discussed in his community, and community complacency might make elder abuse hidden and keep the elderly vulnerable and at risk. Findings from the workshop summary on Elder Abuse and its Prevention showed that socially isolated individuals and individuals with a lack of familiar social network are at somewhat higher risk for abuse (Taylor, Institute of Medicine (US), & National Academies Press (US), 2014). Low social support, meaning the lack of social connectedness and connectedness to the community is a risk factor for elder abuse (Taylor et al., 2014). The study by Acierno et al. (2010) showed that addressing low social support with other preventive interventions can have significant public health implications in addressing elder abuse.

### **5.1.5 Consequences of elder abuse.**

No direct question was asked about outcomes of elder abuse. Participants identified physical and psychological outcomes mostly. Most participants identified insufficient finances, social isolation, and inadequate care as outcomes of elder abuse. Also mentioned were psychological outcomes such as fear, anxiety, depression and apprehension of the health care system. Two participants identified bruising. Applying these findings to the literature, consequences of elder abuse were viewed as precarious. Physical injuries from minor scratches, bruising to fractures led to disabilities (Butchart & Mikton, 2014). Insufficient finances led to less or no home care support which meant inadequate care. Inadequate care can further worsen a victims' physiological and psychological health which may exacerbate existing health conditions already affecting the older adult. This outcome will in turn incur economic costs on law enforcement and for health care interventions and overall hasten death (Butchart & Mikton, 2014; Hirst et al., 2016; Wong & Waite, 2017).

### **5.2 Public Health Nurses' Assessment and Identification of Elder Abuse**

The second objective of my study was to explore how public health nurse participants assessed and identified elder abuse. Three questions were asked in this category; have you suspected and/or confirmed at least a case of elder abuse in your practice/ how did you identify elder abuse?; what screening tool(s), if any, do you use to assess elder abuse?; and how often do you encounter elder abuse in your nursing practice? Ability to identify abuse was evaluated by asking participants whether they had suspected or confirmed at least a case of elder abuse in their public health nursing practice, what screening tools were used for the assessment, and how often did they encounter elder abuse in their practice. This assumed that as abuse is more common than reported, participants may have knowingly or unknowingly assessed for elder abuse. The

discussion takes into consideration how they identified the case as elder abuse, meaning identification of the type of abuse.

Seven of the study participants said they do not assess for elder abuse in their practice. Six participants have suspected and or have confirmed elder abuse in their public health nursing practice while the remaining 4 participants reported no evidence of elder abuse in their practice due to oversight, lack of awareness or poor knowledge of elder abuse, and because it was not a focus in their nursing practice. Despite more than half suspecting or confirming elder abuse, only half (3 of 6) of those who have encountered or suspected elder abuse in their practice assessed for it. In the study by O'Brien, Rianin, Collins, Long & O'Neill (2014), 64.5% of general practitioner study participants had encountered elder abuse during home visits, and only 57.6% of those who had encountered the abuse were involved in actual detection of the case. One of my study participants, who had a wide age range of clientele and sometimes work with older adults, considered most of her senior clients well taken care of, and, therefore did not assess for elder abuse, but in the course of the interview acknowledged that she could have done more to assess for elder abuse. The findings from my study and O'Brien et al. (2014) showed that further steps need to be taken when elder abuse is encountered in the community in order to properly assess and identify it. From O'Brien et al. (2014), the most common mechanism of detecting elder abuse is self-detection by the healthcare practitioner followed by family member, neighbor, while the least is the victim.

### **5.2.1 Lack of screening tools for assessing elder abuse.**

Nine of the study participants stated they did not use screening tools to assess for elder abuse in their practice. Seven of the study participants were not aware of the existence of screening tools in elder abuse in their public health nursing practice. One participant who had

identified using a screening tool had referred to a safety planning toolkit. This safety planning toolkit is not a screening tool but rather a pamphlet that provides information about family and partner violence and also provides suggestions and strategies to protect vulnerable older adults who are at risk or danger on how to maintain their security and safety. The same participant mentioned the existence of another screening tool used by his network group but that he had not used any of the screening tools. In the study by Leddy et al. (2014), 95% of obstetrician-gynecologists were unaware of existing validated tools for assessing elder abuse, less than 5% have heard of any screening tools. Also, in the study by Sandmoe and Kirkevold (2011), no nurse participant reported using any tool to detect elder abuse, nor did they identify any tool that could be used confirm or dispel suspected abuse cases.

### **5.2.2 Elder abuse screening strategies.**

Despite lacking screening tools, knowledge about elder abuse screening tools, organizational policy or guidelines on how to assess elder abuse, public health nurses still assessed for elder abuse. How were nurses able to assess for elder abuse despite lacking knowledge of guidelines or screening tools? In stating that by looking for things that do not seem right, relying on gut feeling and then consulting with co-workers, study participants were utilizing the ways of knowing in attempting to ascertain elder abuse. The strategies participants described in assessing elder abuse were general nursing assessment, intuition and consultation.

#### ***5.2.2.1 Carper's patterns of knowing.***

Carper's Fundamental Patterns of Knowing in Nursing was applied to the assessment strategies utilized by nurses in their attempts at ascertaining elder abuse. Carper (1978) identified four fundamental patterns of knowing that form the conceptual and syntactical structure of nursing knowledge, and they include: personal, empirical, ethical, and aesthetic knowing. The

incorporation and interplay of the ways of knowing was used to interpret the responses on how elder abuse was assessed and identified. Responses from participants, with or without direct elder abuse encounters showed there was an interplay of the various ways of knowing in their assessment strategies which promoted the need for further assessment, advocacy and the development of specialized plan of care to address elder abuse situations.

The empirical pattern of knowing is knowledge obtained from research and objective facts. Carper (1978) described it as nursing science; knowledge that is systematically organized into general theories and laws in order to explain, describe, and predict phenomena in nursing. Empirical way of knowing includes facts, organized descriptions, theories and conceptual models which explain and predict relationships (Carper, 1978; Mantzorou & Mastrogiannis, 2011). Scholarly knowledge was shown not to be a major domain of inquiry into the issue of elder abuse for participants, but other forms of empirical knowing. Professional training and continuing education were the major forms of empirical knowing for participants, which aided in the participant's knowledge of the topic. Training and continuing education are representative of facts, organized descriptions, theories and conceptual models that provide knowledge on elder abuse.

General nursing assessments were mentioned by participants as a tool to get evidence and an understanding of their clients and their clients' situations. Participants mentioned integrating routine questions on elder abuse into basic nursing assessment routines. Both actual and anecdotal assessment areas that participants mentioned that aided them in identifying elder abuse included assessing physical appearance, finance, living situations and narratives. One participant stated he asked 2-3 questions to assess for elder abuse. Another participant assessed and explored clients' situations including their finances and living situations. A third participant based his



assessment on the social determinants of health as a guide to assess for abuse. Sandmoe and Kirkevold (2011) stated that when viewed from the perspective of the older adult, providing answers to a handful of open-ended questions can aid the healthcare professional in identifying elder abuse.

As per Phelan (2018), the American Medical Association recommended that questions on elder abuse be integrated into the full assessment of the older adults. Phelan (2018) also stated that the strategy of simply asking questions can prompt a conversation where abuse might not have ordinarily been acknowledged but may now be disclosed due to probing from questions asked. In the study by Cooper et al. (2009), few U.S. physicians routinely asked older people about abuse but those who did were more likely to detect and report it. In the study by Leddy et al. (2014), when elder abuse was suspected, 87.8% of study participants frequently asked their patients if they were being mistreated.

Another strategy identified by participants that had encountered elder abuse was consulting with colleagues, supervisor or other programs in their public health units to ascertain abuse and how to address it. Participants in the study by Sandmoe and Kirkevold (2011) identified consulting with other colleagues within the service for advice, and also consulted with their supervisor and general practitioner. The responses of my study participants showed that the issue of elder abuse was analyzed and understood, as the case may be for some, through the other forms of Carper's ways of knowing aside from empirical, which influenced the way they perceived and dealt with the issue.

Despite being a novice nurse who was yet to encounter his first elder abuse experience, one of the participants explained how he would identify abuse; "... I guess it would ... just kind of understanding somebody, so when we meet somebody, we would do our nursing assessment.

... so just getting a sense of what is going on.” The esthetics way of knowing in nursing is the art of nursing; the caring process in nursing that widens one’s understanding of the world and the core qualities of human links and inter-relations (Carper, 1978; Mantzourou & Mastrogiannis, 2011). Esthetics allows for one to gain experience on the issue of elder abuse. In relation to elder abuse, the esthetics way of knowing includes care that involves perceptive assessment of the client to grasp the unique particulars of the client, and the analysis, understanding and interpretation of the subjective experience of the client as a victim (Kingsley, 2002). Esthetics pattern of knowing requires that the nurse be fully engaged in that experience, interpret the client situation, look beyond to envision other possibilities of what can be, and to act according to what has been envisioned (Mantzourou & Mastrogiannis, 2011).

The process of being engaged in the client’s experience might prompt empathy for the other. Empathy, an important component of the esthetic pattern of knowing, creates room for a nurse to participate in, or vicariously experience the feeling of another, so as to gain knowledge of the other’s situation (Kingsley, 2002). For participants in my study, empathy for the other was depicted in the way nurses spoke. For instance, one participant, in reflecting and talking about his days as a telemarketer selling financial products with minimal explanation to clients, stated, “for me, I felt uncomfortable with that... I can read, I can take time... elder person may not take the time to understand, may not understand what is this about and the money will be withdrawn from the account.”

The third strategy identified from participants’ responses was the use of intuition; gut feeling. Intuition played a significant role in nursing assessment and intervention of elder abuse for 4 participants. Some participants described intuitive feeling as “... just kind of trusting the gut...”; “I guess is putting the pieces together as you build the relationship, it’s just the idea, the

hunch that something is not right so what is it?" In assessing for elder abuse particularly when it was not visible such as inconsistent narratives from the victim's end, the lack of evidence of care, inhibition of service by perpetrator, or when there were attempts to conceal the abuse, study participants specifically mentioned the use of intuition, while others implied it in their responses to suspect or confirm elder abuse. With increased experience, practitioners become expert and intuition will become an important part of their clinical judgment (Kingsley, 2002). With an increased understanding and awareness of a client's way of experiencing their reality, nurses will gain/develop intuitive recognition of creative options and innovative interventions that can be utilized in addressing abuse (Kingsley, 2002).

Expert nurses who have an enormous background of experiences, can have an intuitive grasp of situations and deal with problems holistically, without wasting valuable time (Mantzorou & Mastrogiannis, 2011). For instance, some participants addressed the situation of elder abuse they encountered with experience of having worked with the elderly before and having encountered other elder abuse situations. They knew what to assess for and what action to take, what agencies to call to aid in addressing the situation. One participant who worked in a program where colleagues have encountered and shared elder abuse experiences and have acquired empirical knowledge of the subject now knows what to do hypothetically when he encounters elder abuse situations. Esthetic way of knowing and increased empathy from the lived experience of the victim will prompt one to want to act to address the need of the victim in the abusive situation. Esthetic knowing coupled with empathy can promote advocacy and pursuit of interventions on behalf of the victim

Personal knowing (Carper, 1978) and the therapeutic use of self created a thirst for further assessment from participants. Responses from participants showed the way personal

knowing aided in bringing awareness of the unique perspective of the clients' health experiences, enabled an understanding of the reality of the client, aided in gaining rapport and developing trust from client. Personal pattern of knowing is from the domain of interpersonal interactions and relationships where the practitioner utilizes the therapeutic use of self in encounters with clients (Carper, 1978; Kingsley, 2002). Personal knowing and the therapeutic use of self in the nurse-client relationship will enable nurses to develop rapport and trust with clients, to approach them as equals and to accept them for who they are (Kingsley, 2002). Through personal knowing and use of therapeutic self, the nurse-client relationship enabled a participant's client to develop trust and rapport in him. The participant stated "... it has to be a relationship, they have to trust you and that trust is hard to earn because they already don't trust the person that is abusing them."

Participants' responses in this study showed they all abhorred the thought of anyone harming the elderly. Ethics, the moral component of knowing relates to the obligations, moral questions, choices of right and wrong that have to be made in times of uncertainty and ambiguity (Carper, 1978), where the traditional principles and codes might not offer help and consequences of one's actions are difficult to predict (Kingsley, 2002). Participants reverted to ethics to ascertain right or wrong about elder abuse situations, and this affected their determination of what course of action to take in addressing elder abuse. One of the participants told a story of his experience on elder abuse while working in a nursing home as a support worker prior to being a nurse. He had witnessed and reported on an incidence of violence against a resident in the nursing home. The participant reported that the matter was not addressed properly; the incident was covered up by the charge nurse and the perpetrator was not held accountable for their action. Rather, the participant was treated as a villain by the perpetrator for reporting the incident. The

participant stated that he did not let being called a villain dissuade him. He had wanted the incident documented but did not know the process back then. The participant went further to state "... because of what happened ... years ago, I would follow up now. Who does this go to next? ... I want to make sure it has gone up the system so that there will be something done about it."

### **5.3 Public Health Nurses' Addressing of Elder Abuse**

The third objective of my study was to explore how public health nurses address elder abuse in their practice. Three questions were asked in this category: what have you done, or would you do if and/or when you suspect(ed) and/or confirm(ed) elder abuse? What situations require taking action?; What is the professional obligation of nurses in cases of suspected or confirmed elder abuse? In either case of suspected or confirmed abuse, what interventions are you aware of and have you used for your clients?

#### **5.3.1 Action post detection of elder abuse: elder abuse interventions.**

Kingsley (2002) stated that when nurses are able to perceive and engage with the situation of the older adult and the reality of their experience, then nursing interventions will address the needs and underlying causes of the abuse. For participants whether they have suspected, confirmed or not encountered elder abuse at all, when asked what they will do if they suspect or confirm elder abuse, all responded to assess clients' situations further and directly intervene or refer to others who will intervene or contact their supervisor/manager to source for intervention. No one mentioned ignoring the situation completely. In addressing elder abuse, 8 participants indicated further assessments to gather more information and to get an understanding of the client and his/her situation; 4 participants mentioned assessing for safety risks and developing/creating safety plan; 9 participants mentioned consulting with colleagues, supervisor,

manager, involving other support agencies including the authorities/law enforcement such as the police and OPGT. Very few participants stated they had no knowledge of what to do or what action to take but did mention further assessment should have been done with regards to their previous encounters with the elderly.

The use of multidisciplinary teams which engage multiple professional disciplines and perspectives was identified in most elder abuse interventions in the literature findings (Along & Berg-Warman, 2014; Fearing et al., 2017; Hirst et al., 2016; Ploeg et al., 2009; Roberto, 2016). Nine participants in this study mentioned consultation and involving other support agencies and legal/law enforcement. Participants mentioned linking the clients with support services/ community agencies for social worker, and/or counselling, which can be related to therapeutic intervention as mentioned by Ploeg et al. (2009), in the form of individual counselling, psycho-educational support groups or volunteer victim assistance services. Four participants mentioned family resolution, which involves linking victims with agencies that can provide this service. No specifics were provided on names of community services because participants were uncertain of them. Also mentioned was linking the victim with a lawyer, Advocacy Centre for the Elderly (ACE), Elder Abuse Ontario (EAO), involving the Office of the Public Guardian and Trustee (OPGT) and the police. Some participants mentioned informing the authorities but were uncertain what organizations in particular. Multi-disciplinary interventions identified by Along and Berg-Warman (2014) include individual and group counselling and legal interventions.

Safety assessment and developing a safety plan was mentioned by 4 participants. Three participants mentioned relocating victims or modifying the living situation as safety strategies. Ploeg et al. (2009) stated that relocation may remove victims of abuse from harm's way, but it comes with other costs such as disruption of social relationships, placement in unfamiliar

surroundings and the possibility of reduction or loss of autonomy. Hirst et al. (2016) stated that interventions should be acceptable to the victim, family and/or caregivers. Some participants were in favour of family resolution.

Most interventions in the literature aimed at increasing awareness and knowledge of elder abuse. Education was not extensively addressed by participants in this study. Seven participants claimed competent to proficient knowledge while 3 participants claimed being novice on the topic. However, only 4 showed a good understanding on the topic. Educational requirements mentioned in the study included the need for further assessments, familiarity with laws and professional obligations, and to know what agencies to refer clients to for interventions. Only one participant mentioned educating the client. In the study by Wangmo et al. (2017), continuing education /targeted training was seen as a means to sensitize both the less experienced and qualified personnel on the nuances that afflict elderly clients and the ethical issues involved.

### **5.3.2 Emergency situations requiring action.**

Situations that require taking action identified by participants were imminent safety concerns, capacity concerns, concerns with inability to care for self, lack of competence over finances, confirmed cases of physical or sexual abuse. Four participants identified imminent safety as a priority concern that needed immediate response in elder abuse situations. Assessing for safety was seen as a priority, and therefore prompt interventions were suggested by all participants particularly to address the safety concerns, including developing a safety plan and removing the client from the unsafe environment. The study by Wang et al. (2015) stated that imminent safety of all clients should be assessed and clearly reported to the clients and an emergency safety plan be created. One of the recommendations of RNAO (2014), in

incorporating multiple strategies to preventing or addressing harm to the elderly, was to develop a safety plan.

Another situation identified by participants as requiring taking action was in the case of capacity concerns. Capacity concerns identified by study participants related to client's health, inability to care for self and therefore dependence on others, a lack of competence over finances, and someone taking advantage of them. The two most important factors influencing the response of nurses to elder abuse in the review by Touza Garma (2017) were the gravity of the case and the cognitive ability of the victim. Two participants stated outrightly that the OPGT should be involved to investigate further while another stated that advocacy is required. Wang et al. (2015) stated that the assessment of suspected elder abuse should commence with an assessment of capacity in order to identify if the older adult is able to understand what situation they are in. One participant stated he would explore what the older adult perceives the situation to be and unfortunately if they don't see it as abuse and do not want to do anything about it, he cannot do anything about it either. Similar to this response, another participant stated if the client is competent and want to live that way, due diligence should be done by providing the victim with information they need should they want to get out of the situation. To affirm these responses, if the client is deemed capable, instead of involving outside agencies immediately, Wang et al. (2015) suggested that the care provider should present the concern about the abuse to the client, educate the client about the tendency for an increase in severity and frequency, and link the client with local resources. Dan's (competent) response that the OPGT should take over victims' financial management, in situations where the power of attorney (POA) has taken advantage of the older adult, is similar to Wang's statement. Wang et al. (2015) stated that in cases of incapable older adult experiencing abuse, where the POA is not acting in the best interest of the



client or is the perpetrator of abuse, alternative strategies should be explored such as contacting other family members, liaising with social service agencies, or guardianship should be sought through the OPGT.

The third situation where participants stated that action is required is in confirmed abuse cases. One participant stated that when victims disclose elder abuse, it is an obvious cry for action. Another participant had said sometimes disclosure of elder abuse comes with a clause of confidentiality. Cooper et al. (2009) identified that Canadian professionals had often failed to report abuse because victims did not want them to or because the care provider is fearful of what will happen to the victim. A participant had identified physical and sexual abuse cases as requiring prompt action being taken. Another participant's encounter with elder abuse was not physical but neglect. He did not report the confirmed case of neglect he had encountered in his practice. His rationale was that since it was not physical, there was no need to send the client to the hospital, so emergency services including the police were not contacted, and it was only advocacy that was required instead. Another participant also identified physical abuse as requiring prompt action. He had promptly reported an elder abuse incidence he encountered, but it was pushed under the rug by the nurse in charge.

### **5.3.3 Professional obligation of nurses.**

There was a mixture of certainty, ambivalence and contrast in responses to the question on the professional obligation of nurses regarding elder abuse issues, and if it is mandatory or not to report elder abuse. The certainty was that 9 participants stated that nurses have a professional and or moral obligation to report both potential and or actual elder abuse. A question asked that created ambivalence was "report to whom?" Most participants were unsure. Responses ranged from "... I told you I am not sure about where to report outside the system." to "I do feel that we

have a moral obligation to do something but in terms of what that action actually looks like to me that is not totally clear". Another participant stated that in cases of incompetent adult (capacity concerns), nurses are liable. The same participant stated there is no guideline or step by step manual from the CNO, Ontario's regulatory nursing body, nor her organization about how to report. The systematic review by Hirst et al. (2016) identified that health care providers are not always aware of mandatory reporting laws and policies or how to enforce them. Participants' responses on whom to report to included supervisor, manager, police, authorities, and professionals who will take care of it. In the study by Schmeidel et al. (2012), a majority of doctors and nurses agreed it is expected that they will report cases with symptoms of elder abuse and neglect. In the study by Schmeidel et al. (2012), nurses looked to others to deal with abuse; nurses thought they should just direct any suspicion to the manager or supervisor, and that supervisors and physician are to deal with the abuse. In my study as well, participants stated they will consult with manager or supervisor. The contrast identified with regards to the professional obligation of nurses was that some participants, after stating that the issue be reported, also stated that it is not mandatory to report elder abuse. One stated that there is an ethical or moral duty to report, but no professional obligation to report elder abuse in the community. As earlier mentioned, another nurse had said that nurses have a moral obligation to do something but does not think there is mandatory reporting on elder abuse. Three participants stated that similar to child abuse, it is mandatory for elder abuse to be reported. One participant thought there must be guidelines and policies in place, while another stated he can refer to the CNO and RNAO as resource.

Despite not all participants knowing the professional obligation of nurses relating to elder abuse, participants reverted to ethics to ascertain the right and wrong of the situation to

determine what course of action to take. The moral code or professional obligation pertaining to the elderly entails providing quality service, respecting the rights of the elderly client, and promoting the safety and well-being of the client (Kingsley, 2002). One participant stated despite the absence of an organizational policy, and the lack of a step by step manual from the CNO, elder abuse still needs to be identified and reported. Another participant mentioned he feels that nurses have a moral obligation to do something, but he is not clear on what to do. Like the last participant, another stated he thinks nurses have the obligation to act; first investigate further, and then act. Four participants mentioned that there is mandatory reporting for child abuse. One of the four participants stated he is aware of mandatory reporting of elder abuse in long term care settings but that there is no duty to report elder abuse in the community. However, from an ethical or moral perspective, the participant stated he felt there is a duty to report, but not due to professional obligation. Another one of the four participants that referenced mandatory reporting of child abuse rates elder abuse same as child abuse, and stated it had the same obligation as child abuse, which is to report. All participants were supportive of reporting elder abuse as the professional obligation of nurses; meaning there is willingness to accept responsibility to act when faced with difficult, complex, moral decisions. There was also willingness to explore what to do for most participants.

Nursing is a regulated profession, and the aim of regulation is to protect both the public and the profession (Phelan, 2018). Nursing practice in Ontario is governed and regulated by the College of Nurses of Ontario. The Canadian Nursing Association is the national professional voice of nurses in Canada. The Registered Nurses' Association of Ontario is the professional association representing registered nurses, nurse practitioners and students in Ontario. The guideline by RNAO (2014) aims to prevent and address abuse and neglect of older adults

throughout various health-care institutions and community settings in Canada. Nurses, being in a regulated profession, are guided by codes of professional practice and are mandated to engage in responsible and accountable practice (Phelan, 2018). The elder abuse best practice guideline of the RNAO recommends that nurses respond to suspected or confirmed cases of elder abuse according to legal requirements and organizational policies or procedures (RNAO-BPG, 2014). Despite the majority of study participants outrightly stating that elder abuse matters must be reported, there was a huge knowledge gap in actually specifying to whom to report to, what the legal requirements are and what the policies of their organizations stipulate regarding elder abuse situations. No participant identified that their organization had a policy or step by step guide on dealing with elder abuse situations.

#### **5.3.4 Reporting elder abuse.**

##### ***5.3.4.1. Elder abuse law and moral obligation to act.***

The responses above show a variation in the perceptions of participants on the professional obligation of nurses regarding reporting elder abuse. Similarly, Almogue et al. (2010) identified that healthcare professionals including nurses were unaware of existing laws and medical protocols for identifying and reporting elder abuse. From the study by Cooper et al. (2009), a quarter of nurses thought that their profession provided clear-cut definitions of elder abuse, but the nursing association did not have published guidelines on elder abuse. Nursing practices are regulated by the CNO; hence participants' comments demonstrated the belief that guidelines and policies should exist for a precarious issue like elder abuse. This belief appeared to be why participants identified reporting of elder abuse as a professional obligation for nurses, and why some of the participants were certain there must be policies and guidelines in place for this issue and referred to the CNO and RNAO. The RNAO (2014) recommended that nurses and

health-care professionals must uphold the legal and professional responsibilities in responding to abuse and neglect of the older adult. However, diversity exists in the jurisdictional laws and practice settings in Canada and each province has its own approach to responding to elder abuse, which is acknowledged by the RNAO (2014). This implies that the professional obligation of nurses is limited by the elder abuse laws of the jurisdiction they practice in.

It appeared that participants, who were relating the mandatory requirement of reporting child abuse to that of elder abuse, are linking it with the United States, where there is mandatory reporting of elder abuse and Adult Protective Services in 48 states (Pickering et al., 2016; Roberto, 2016). There is no elder abuse law in Canada and therefore no federal mandatory requirement to report abuse. Lacking national mandatory reporting, Canadian provinces and regions address issues of elder abuse independently. However, various provinces and organizations have their own stipulations and guidelines on responding to elder abuse. In comparison to the United States, Canada does not have a specific elder abuse code provision. Rather, Bill C-36 was amended to incorporate elder abuse as a criminal offence. So, there is no specific crime of elder abuse, rather the criminal code applies to all adults regardless of age of the victims, and charges are laid based on the criminal act (CCEL, 2011). Reporting elder abuse, therefore, might be mandated by work obligation or professional code of ethics. As per the Canadian Nursing Association, the professional obligation of nurses mandates duty of disclosure on matters relating to abuse of the vulnerable elderly (CNA, 2011). However, the College of Nurses of Ontario does not address the issue of elder abuse, rather it makes reference to abuse only. Furthermore, there exists the Canadian Charter of Rights and Freedom (1982), which protects the rights of all Canadians from being forced against their will, for instance, reporting abuse to authority.

### **5.3.5 Barriers to addressing elder abuse.**

A challenge identified by participants was the lack of organizational policy or guidelines in addressing elder abuse. Eight or more of study participants were unaware if there is a standard procedure for addressing confirmed or suspected cases of elder abuse. No nurse identified that his or her organization had a policy to guide in the case of elder abuse situations. There was either a knowledge gap or there were actually no policies in place. No nurse knew of any policy from his/her place of work. Not all organizations have established standard operating procedures, leaving many frontline workers unsure about how to behave and what to do in situations in which abuse might be occurring (Touza Garma, 2017).

### **5.3.6 Knowledge and use of elder abuse interventions in public health nursing.**

Despite not every participant having encountered elder abuse in their public health nursing practice, responses about interventions were similar between nurses who had encountered and those who had not encountered elder abuse. From participants that had encountered elder abuse, responses about interventions they had utilized or are aware of, for actual or suspected elder abuse situations included calling the authorities to report the abuse (police, EAO, OPGT), consulting and connecting victims with support services, creating/developing safety plans (help client get out of the situation), utilizing shelter support, educating/creating awareness, providing information to client, counselling, and setting up of power of attorney.

For participants without direct elder abuse encounters in public health, responses on what interventions they were aware of included counselling, arbitration, elder abuse hotlines, creating awareness, consulting with elder abuse network representative, consulting, collaborating and connecting with elder abuse network members, involving family, and notifying authorities

(police, social service, ombudsman, MP, emergency number- 911). Only one participant did not provide any information on intervention, not even anecdotal.

#### ***5.3.6.1 Calling authorities.***

A majority of participants identified notifying the authorities including the police, social services, ombudsman, and Member of Parliament (MP). Some participants acknowledged they did not know which specific authority to call to address elder abuse matters. Calling the police or any other figure that can address elder abuse may appear as the right action to take in seeking social justice. However, the consent of the victim plays a significant role in deciding if calling the police is right. There are no elder abuse laws in Canada and the Canadian Charter of Rights and Freedoms of (1982) protects the rights of all Canadians including the elderly from being forced to report abuse to the authorities. There is no reporting authority in the province of Ontario, such as the Adult Protective Service (APS) that is available in some provinces and in the USA. Health professionals cannot force their clients to report when abuse occurs. The recommendation from RNAO (2014) is that nurses recognize that reporting of elder abuse is not always mandated particularly if the victim chooses to remain in the abusive relationship. Nurses are professionally and ethically bound to report elder abuse as per the CNA, not the CNO. But to whom do they report? In Ontario, mandatory reporting is only applicable to long term care, retirement homes, older adults living with developmental disabilities, and if reporting is required by an employer, someone's employment duties, a contract for services, or a professional code of ethics (RNAO-BPG, 2014).

#### **5.4. Ageism and Vulnerability in Public Health Nursing**

Older adults are a major population group within adult care nursing and are considered vulnerable. A great threat to older adults in successfully aging is becoming dependent for one

reason or another (Mysyuk et al., 2016)(a), and it predisposes the older adult to being unprotected, undefended, exposed, and sensitive (CARNA, 2005). The idea of old age being seen as a disadvantage, causing disrespect to the older adult, a lack of social responsibility for the older adult, make the older adult vulnerable to any form of abuse, regardless of their independence or autonomy. When society make the older adult appear helpless and seem dependent, instead of looking at the strengths of the elderly in light of their vulnerability gives a negative portrayal of the elderly. Ageism has been shown to be an acceptable and wide form of discrimination against the elderly and contributes to keeping them prone to elder abuse. Responses from participants further support this. From participants' responses, elder abuse risk factors in the social determinants of health in terms of housing, social exclusion, social safety net, and lack of community services put the elderly at a disadvantage. Basically, the social determinants of health influence vulnerability (CARNA, 2005).

Vulnerability reflects personal characteristics that influence a person's ability to adapt to stress (Baker, 2007). The older adult is vulnerable to stressful life changes, such as declining health, declining mobility, and the loss of a spouse. The impact of social isolation compounds this vulnerability. Vulnerable older adults are at risk of, or susceptible to harm, injury, loss, victimization or damage (CARNA, 2005). Nurses come into contact with vulnerable persons, groups, and population in the course of their practice. Vulnerability for the older adult can change from temporary to permanent, but it can be reduced and perhaps prevented. Vulnerability is both a personal and public issue; whereby being vulnerable robs an individual of the ability to enjoy health and well-being, society is left to deal with the consequences in increased health care costs and lost economic productivity (CARNA, 2005).



Neoliberal policies and reforms in the economy introduces the privatization and the reduction of public services, and a reduction of a government's sovereignty in the regulation of economic activities that affect environmental and educational health (Shaffer, Waitzkin, Brenner, & Jasso-Aguilar, 2005). Neoliberal policies and reforms introduced into healthcare to reduce public indebtedness, and to accentuate the role of free markets in social and economic systems (Williams & Maruthappu, 2013) pose a detrimental impact on worsening the vulnerability of the older adult. Allowing the private sector and market-based goals of competitiveness, efficiency, and effectiveness to dominate in healthcare funding and service provision undermines the idea of collective responsibility for societal well-being, and instead justifies and legitimizes inequality as the outcome of personal failure of individual ability to compete (Choiniere, MacDonnell, Campbell, & Smele, 2014). This approach of forcing austerity to the economy contributes to the discrimination and the marginalization of the older adult in society, particularly in terms of finance, healthcare and housing, making them vulnerable to a variety of issues including abuse. From participants' responses, elder abuse existing in healthcare were presented in the form of low levels of funding allocation into providing healthcare and community resources for the older adult, poor quality of care, lack of availability of clinics and programs in the community. Funding cuts to services for the older adult can be seen as ageist, and a form structural violence that disproportionately affects a vulnerable segment of the population. Structural violence is a form of violence where social structures or institutions impedes people from meeting their basic needs (Choiniere et al., 2014). Specific to public health, elder abuse presents as cuts and limited funding for geriatrics services.

Language used to identify the older adult sometimes suggested ageist ways of viewing the older adult. For instance, when a participant's response depicted surprise in a 94 years old

client being well cared for, it suggested that someone that old should appear worse than they had appeared to be. Another language used by a participant was that public health and society were not age-friendly. Are public health units age friendly in the services and programs offered and made available to the elderly? Ageism is perceived to over-ride even in public health, whereby nurses come in contact with the elderly, but since their business is only with the groups they provide service to, the older adult is not given a second view.

To further buttress this point, some of the participants talked about exclusion of the older adult in service provision. For instance, a participant mentioned that older adults call to make inquiries sometimes about family concerns, but stated they are unable to provide the support to the older adult because their programs are mostly geared to children and youth. Treating the complaints of the older person as less serious, particularly when they call in, can be considered abuse with an ageist ideation. Ageism was also identified by participants when public health nurses and programs were available for only well seniors or seniors that are independent. Not all older older (very old) adults reside in long term care setting or retirement homes. The older older adult should not be seen as separate from other 'vital members' of the community because of their age. The exclusion or the limited number of programs in public health units for the older older adult amounts to a lack of representation of the demographic and a purposeful exclusion from public health services.

Despite acquiring knowledge of elder abuse mostly from public awareness campaigns and other avenues, there exist a limitation in identifying elder abuse and a lack of knowledge about elder abuse interventions for one reason or another. This represents a non-prioritization of a precarious geriatric issue despite an increase in the demographics of the older adults. The lack of further assessment to explore suspected abuse, for one reason or the other, or the knowledge

gap on interventions should be considered in the light of ageist perceptions. The lack of elder abuse in nursing curriculum should also be viewed in the light of ageism.

The Canadian approach to elder abuse prevention and intervention can be identified as a soft policy of education and awareness, as opposed to the creation of adult protective service that is available in the USA (EAO, 2018). The approach to elder abuse prevention and intervention should not only be about educating the older adult. Strategies and policies should be put in place on how to protect, empower and support the older adult in the preventing and addressing of elder abuse in public health nursing.

### **5.5 Synthesizing Conceptual Framework and Findings**

In relating the conceptual framework, pages 41 and 112, to the results, the findings from the study showed that participants' perceptions of assessing, identifying and addressing elder abuse was determined by their knowledge of elder abuse and the social determinants of health. Knowledge of elder abuse comprised of its meaning or definition, constituents (forms), perpetrators, prevalence, risk factors, barriers to identifying and addressing, and the consequences of elder abuse. Perceptions of the risk factors for elder abuse were identified through the lens of the social determinants of health. Both knowledge of elder abuse and risk factors identified through the social determinants of health were influenced by ageism, which was either implicit or explicit, and they determined how participants assessed, identified and addressed elder abuse. Ageism was presented in the forms of discounting the elderly, misperceptions about the elderly, negative stereotypes about the elderly, and community/societal indifference and/or complacency about the older adults. Ageism, as an overlying shadow influenced the perceptions of public health nurses' practice relating to elder abuse assessment, identification and interventions.

Participants' knowledge of elder abuse influenced its assessment, it determined the level of awareness of elder abuse, and if assessment will be done. Inadequate knowledge of the definition of elder abuse and what it constituted blurred the recognition of abuse by participants. Ageist views of victims, healthcare provider, health care organizations and society as a whole affected the awareness of elder abuse, what to assess, what signs to look out for, and the need to disclose elder abuse. Rationale given for elder abuse and the knowledge of the risk factors that made the elderly vulnerable to elder abuse when clouded by ageism deterred assessment.

Knowledge of elder abuse and ageism affected the perceptions of participants in the identification of elder abuse. Society frowns on violence of any sort, but prevalence on elder abuse, a subset of violence showed there is lower awareness and support for victims. Therefore, there is an urgent need for society to be proactive with elder abuse matters. Ageist perceptions affected both visible and invisible signs of elder abuse because victims or suspected victims were not asked if they are undergoing any form of abuse. Even when confirmed, there were no further efforts made to probe further in order to support the victims. Lack of knowledge of screening tools hindered recognition and identification. Furthermore, the absence of organizational guidelines, policies and protocols for actual or anticipated elder abuse encounters showed that the elderly were not a priority in public health nursing. This may be considered as discrimination and a form of exclusion based on age.

Knowledge of and ability to recognize elder abuse should prompt the need to want to intervene or address elder abuse. Knowledge gap in awareness of intervention resources, laws and guidelines on actions to address elder abuse, in the cloud of ageism, will make intervention of elder abuse of less importance and completely disregarded. Ageism shrouded the perceptions of addressing elder abuse and was evident when participants showed little or no knowledge for

elder abuse, what action to take, policy or protocols when elder abuse is encountered, or their professional obligation regarding elder abuse. The majority of participants wanted to report elder abuse, but they did not know who to call or how to go about it. Despite understanding that there is a safety risk involved in not reporting, but yet ignoring the incident, showed there was insufficient awareness and a lack of intention to follow through with professional obligations. Also, in addressing elder abuse, there is knowledge gap originating from the CNO, the professional board governing practice of nurses in the province of Ontario; there were no guidelines for elder abuse stipulated by the CNO as at the time of data collection. In addition, participants identified they lacked knowledge on organizational policies and guidelines relating to elder abuse, if they exist. Overall, the perceptions of elder abuse were determined by the influence of ageism on the knowledge of the concept, this shaped how public health nurse participants assessed, identified and addressed elder abuse.

## **5.6 Study Limitations**

In this study, I used a single method of data collection, semi-structured interviewing. Using multiple data collection methods such as focus groups would have produced a more comprehensive result. To enhance trustworthiness of the study, I included participants from various public health units, from different programs and varying demographics. This was to ensure participation from diverse social backgrounds (ethnicity), educational qualification, work experience, gender and age gap. As a result, diverse views and opinions were captured, though not all perspectives may have been covered.

Furthermore, being a study that explored public health nursing practice, limitations existed in amount of information being shared by participants regarding the various public health units they worked for. Information that was collected that might be considered critical of public

health units and their practice in relation to programs/service provision and policies and procedures geared towards the geriatric population and particularly elder abuse were removed by me. However, some of the characteristics of the population (public health nursing) and their practice of nursing might be similar to processes in other health units or settings. Further research is therefore needed to establish the relevance of this study in other contexts.

Nevertheless, this study highlights the need to pay attention to the contextualization of definition, and the perceptions of elder abuse in public health in order to fully understand public health nursing practice in relation to elder abuse matters.

### **5.7 Implications for Nursing Practice and Research**

The implication of the findings of my study for nursing practice indicates the need for healthcare organizations, particularly public health units, to be aware of the huge impact of their service responsibility to the older adults through inclusion or broadening of programs and services and revision of their policies and procedures. Nurses have a major responsibility to address both ageism and elder abuse concurrently. Nurses need to recognize their own stereotypes and prejudices. From a public health perspective, nurses have a responsibility to address ageism by lobbying to improve legislations and policies surrounding the social determinants of health to ensure safety, equity, equality and autonomy of the older adult in relation to finance, housing and health vulnerabilities. While addressing ageism, its influence on elder abuse should be highlighted to aid proper understanding of elder abuse and why it has been present for so long yet appears to still remain in the shadows.

Identifying elder abuse was reported by participants to be a challenge especially because it was concealed by victims and systemic barriers existed particularly the lack/non-awareness of organizational guidelines and policies and the lack/non-awareness of screening tools to assess

and identify elder abuse in public health nursing. It is imperative that nurses seek to understand why the older adult is concealing abuse, develop a therapeutic relationship with the older adult so as to build trust and aid in the disclosure and ultimately intervention in elder abuse.

Furthermore, the cultural norms of healthcare professionals, organizations and society at large should be objectively reviewed to identify inherent challenges. Public health programs and services should be reviewed to ascertain if bias exists relating to age; if programs/service(s) are limited to 'well/independent' seniors alone. Inquiries should be raised to ascertain what public health services are available to older adults who are home bound but still reside in the community. For older adult programs such as Falls Preventions and Healthy Ageing, elder abuse should be incorporated into such programs particularly since the demographics has grown larger compared to previous years, and it has been predicted that the demographic will be larger in the near future. Funding for programs and funding appropriation for services in public health should not be biased against the elderly. However, the neoliberal stance in healthcare administration and cuts to healthcare funding might further jeopardize equitable distribution of programs and services (Shaffer et al., 2005) towards the elderly thereby worsening the vulnerability of the older adult with lower socio-economic status and increased healthcare needs. Neoliberal changes in healthcare should force public health units to closely look at the organization of their programs and services geared towards the older adult so as to ascertain that the older adults are not purposefully being precluded from programs and services. Nurses should advocate for reviews and changes to organizational policies and guidelines that precludes and are discriminatory towards the geriatric population.

Elder abuse is multifaceted, triggering the need for proper screening. There is a need for healthcare organizations including public health units to support their nursing staff in improving

their knowledge to be able to properly screen and handle elder abuse issues in their practice. Screening is still recommended, and it was suggested that elder abuse questions be integrated into routine assessments of the older adult (Gallione et al., 2017, Phelan, 2018). This means that there has to be education on elder abuse so that nurses can carry out adequate assessments, starting from baccalaureate nursing to routine continuing education in healthcare settings. There is a need for the development of operational definitions of elder abuse in public health units particularly geared to public health nurses, to guide the interpretation of elder abuse. Educating nurses should not be limited to screening and identifying alone, but it must include interventions and next line of action to take to prevent elder abuse from continuing. Canadian nurses in particular must be aware of the laws and legislations on elder abuse in their jurisdictions because it varies from provinces to territories. In Ontario, due to the soft policy of education and awareness, nurses must be aware of resources and interventions that will empower and benefit their clients. In addition, nurses encounter victims that do not want action taken even when abuse is confirmed, such clients have the right to their autonomy. Nurses are professionally obligated to support clients. However, this approach of providing education and awareness may be risky for some victims. Also, it may mean passing the buck by transferring the responsibility of the older adult to the older person's social network or the society at large (Winterstein, 2012). Public health nurses need continuous support in the community setting from their organizations, particularly when safety of the older adult is paramount. Nurses must be supported so they can support the client appropriately. The context of the abuse in relation to client's situation must be deliberated on carefully to ascertain the need to involve law enforcements and how prompt interventions must be. Participants also mentioned the need for safety as priority. Public health



nurses must consider a balance between the need to remove the client from the risky environment to the overall wellness of the adult.

Further research on perceptions of elder abuse is needed to reveal a clearer and more complete view of elder abuse in public health practice and community health practice. For instance, research should be conducted on the perceptions of elder abuse among public health nurses in more directorates, in rural public health units and other non-nursing practice areas of public health. Continued research on perceptions can play a role in determining the understanding of health professionals about recognizing elder abuse and raising awareness on the need for assessment, identification and interventions available in various jurisdictions. It will also aid in raising awareness of the educational needs of service providers who help and support the older adult.

Furthermore, research is imperative to examine the incidence of elder abuse subtypes in public health in diverse settings. Of significance is gender and Intimate Partner Violence (IPV) grown old. Studies should focus on elder abuse risk factors in relation to ageism and the social determinants of health. Research is also needed on elder abuse screening, the types of screening tools or assessment strategies in public health practice. Research should also be done on nursing obligation of addressing elder abuse in relation to the soft educational/awareness approach of addressing elder abuse in Ontario. In addition, research is needed to determine the cost/benefits of routine screening and intervention provision in public health as a prevention strategy.

## **5.8 Conclusion**

Findings from this study showed that majority of public health nurse participants were aware of elder abuse, but ambivalence, contrasts and gaps existed on the knowledge about what elder abuse constituted, recognizing and addressing it in public health nursing. Basic information

on elder abuse such as one-time professional development or training course or infrequent public awareness campaigns are insufficient as training source for elder abuse knowledge. Basic information appeared to act as a barrier to assessing and addressing elder abuse in the forms of care giver obliviousness, self-doubt of care giver to confirm and report abuse, fear of misdiagnosing the situation, and, therefore ignoring it, poor knowledge leading to poor nursing judgment, and poor decision making relating to elder abuse matters. The level of knowledge of elder abuse matters and the knowledge of the professional obligation of nurses can act as a facilitator or barrier in assessing, identifying and addressing elder abuse.

In addition, despite lacking screening tools or the lack of knowledge about elder abuse screening, or the lack of organizational policy/guidelines on how to assess for elder abuse, some public health nurses still assessed for elder abuse. The Carper's Patterns of Knowing in nursing, empirical, aesthetic, personal and ethical (Carper, 1978), was applied to how participants were able to assess and identify elder abuse. The incorporation and the interplay of the ways of knowing was used to interpret participants' responses on how elder abuse was assessed and identified. Responses from study participants with or without elder abuse encounters showed that there was an interplay of the various ways of knowing in their assessment strategies which prompted the need for further assessment, advocacy and the development of specialized plan of care to address elder abuse situations. The 'so what' of this study is that training for an adequate knowledge on elder abuse will aid in facilitating the proper assessment, identification and addressing of elder abuse by public health nurses. Elder abuse has been described as a public health issue in literature. Hopefully, the findings from this study contribute to an increased understanding that elder abuse is indeed an issue in public health as a whole, and particularly to the study participant group, public health nurses.

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## Appendices

### Appendix 1: Letter of Inquiry to Gain Access to Recruit Research Participants

To whom it may concern:

I am a graduate nursing student of York University with intent to carry out a study on **Public Health Nurses' Perceptions of Assessing, Identifying and Addressing Elder Abuse: A Descriptive Qualitative Study**. Elder abuse has been deemed a public health problem and a violation of the human rights of the older adult. Being an upstream approach to healthcare, public health nurses, as frontline healthcare professionals can positively contribute to prevention and interventions of elder abuse.

An initiative being focused on by the public health component of the Federal Elder Abuse Initiative is to develop and provide public health practitioners with up-to-date tools, so they are better equipped in elder abuse prevention and intervention. The aim of this study is to relate public health nurses' perceptions of elder abuse to their practice on assessing, identifying, and addressing elder abuse.

Your organization is a desirable avenue to recruit participants across Ontario for this study. I am seeking public health nurses (registered nurses) who have had experiences with elder abuse. The research requires a sample of 10-12 participants, 18years and older. Results of the study may influence changes and reviews to elder abuse policies and practices in professional public health nursing.

If possible, I would like to schedule an appointment with you to discuss the possibility of recruiting participants through your organization.

Sincerely,

Funmilayo Agbi (RN, MScN Candidate)  
York University

**Appendix II: Elder Abuse Flyer**

**Qualitative Study on the Perceptions of Public Health  
Nurses on Elder Abuse**

**Participants Needed**

**If you are a public health nurse who comes in contact with older adults, please  
consider participation**

**Please contact: Funmilayo Agbi  
XXXXX**

**The goal of this research is to explore public health nurses' perceptions of  
elder abuse and assessing, identifying, and addressing elder abuse in nursing  
practice.**

### Appendix III: Informed Consent Form

**Study name:** Public Health Nurses' Perceptions of Assessing, Identifying and Addressing Elder Abuse: A Descriptive Qualitative Study

**Researcher name:** Funmilayo Agbi (Graduate Student)

**Graduate Program:** Nursing

**Email address:** XXXXXX

**Office phone:** XXXXXX

**Purpose of the research:** The objective of the study is to present the findings of a descriptive qualitative study on public health nurses' perceptions of assessing, identifying and reporting elder abuse.

**What you will be asked to do in the research:** You will be asked to participate in a 1-1.30 hour of face-to-face interview, which will be audio recorded, and the tapes will be transcribed. The initial questions will be on demographics. Thereafter, questions will focus on the objective of the study.

During the interview, questions will be asked about your thoughts, knowledge and experiences on elder abuse. The research design is a descriptive qualitative study, it will present a concise description of public health nurses' perceptions of elder abuse and how it influences their practice of assessing, identifying and addressing elder abuse. If clarification is required on some responses, you might be contacted again.

Your personal information will be kept completely confidential, as outlined below

**Risks and discomforts:** There is a minimal risk associated with the study. No physical risks or discomforts are foreseen for participating in the study. However, there might be moral distress from sharing personal experiences or discomfort from recalling negative experiences which might have a potential psychological implication that is worth considering. Information will be provided to nurses to seek assistance or support for debriefing with a counselor through the Employee Assistance Program in their place of work. Researcher will also explore additional resources that will be beneficial to participants. However, if you are having difficulty proceeding with the interview, you may withdraw at any point in time.

**Benefits of the research and benefits to you:** The information collected and the findings will benefit healthcare professionals and caregivers who come in contact with the elderly, agencies and organizations, researchers, and policy makers including the government. Its implication will be to raise awareness of this issue amongst nurses and other healthcare professionals, which hopefully can translate to intervention program proposals and changes in policy making.

**Voluntary participation:** Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer will not influence the relationship you may have with the researcher or the nature of your relationship with York University either now, or in the future.

**Withdrawal from the study:** You can stop participating in the study at any time, for any reason, if you so decide. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researcher, York University, or any other group associated with this project. In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

**Confidentiality**

Confidentiality will be provided to the fullest extent possible by law. All information collected during the study will be held in confidence, and your name will not appear in any report or publication of the study. Data will be collected by the study interviewer using audio recording, the tapes will be transcribed and then destroyed. The collected data will be safely stored in a password protected and encrypted USB key. Only the researcher and the thesis committee members will have access to the information. Data will be stored in this manner for a period of no more than five years and then permanently deleted or destroyed. Participants will be anonymous for the duration of and after the study.

**Questions about the research:** If you have questions about the research in general or about your role in the study, please feel free to contact Funmilayo Agbi (researcher for this project) at xxxxxx or Dr. Nazilla Khanlou (research thesis supervisor) either by telephone at xxxxxx or by email at xxxxxx.

This research has been reviewed and approved by the Human Participants Review Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines.

If you have any questions about this process, or about your rights as a participant in the study, you may contact the Senior Manager and Policy Advisor for the Office of Research Ethics, 5th Floor, York Research Tower, York University, telephone XXXXXX

**Legal rights and signatures:**

I, \_\_\_\_\_, consent to participate in "Public Health Nurses' Perceptions of Assessing, Identifying and Addressing Elder Abuse: A Descriptive Qualitative Study" which is a study being conducted by FUNMILAYO AGBI. I have understood the nature of this project and wish to participate. I am not waiving any legal rights by signing this form. My signature below indicates my consent.

I agree to be audio-recorded during the interview  Yes  No

**Signature**  
\_\_\_\_\_  
**Participant**

**Date**  
\_\_\_\_\_

**Signature**  
\_\_\_\_\_  
**Principal Investigator**

**Date**  
\_\_\_\_\_

**Appendix IV: Demographic Form**

1. What is your country of birth? \_\_\_\_\_
2. What is your ethnicity? \_\_\_\_\_
3. What is your current age range?
  - 20-50
  - 51-Over
4. What gender do you identify with?
  - Male
  - Female
  - Other
5. What is the highest education level you have completed?
  - College/Bachelor's degree
  - Master's or professional degree
  - Other \_\_\_\_\_
6. How many years of nursing experience do you have?
  - 0-5
  - 6 and over
7. How many years of nursing experience in public health do you have?
  - 0-5
  - 6 and over
8. How do you rate yourself on knowledge of elder abuse?
  - Novice
  - Competent
  - Proficient
  - Expert

Please leave a contact number in case we need to reach you \_\_\_\_\_



## **Appendix V: Open-Ended Interview Questions for Study**

**Instructions:** Feel free to answer the questions in as much detail as you feel comfortable. There is no correct or incorrect response. If at any point during the session you feel uncomfortable with the questions, you may choose not to respond.

Remember, during the interview, I will be taping our conversation. Please provide no information that would identify yourself or any of your clients. I am interested in understanding public health nurses' perceptions on assessing, identifying and addressing elder abuse in their professional nursing practice.

### ***Perception of Elder Abuse***

1. What does elder abuse mean for you?
2. What knowledge do you have on elder abuse?
  - Professional training
  - Continuing education
  - Academic curricula (undergraduate, graduate)
  - Public awareness campaign
  - Informal training, personal knowledge, self-study, others
3. How does elder abuse present in your nursing practice? What kind of experience have you had on elder abuse in you practice?
4. In your practice, what risk factors contribute to older adults becoming vulnerable to elder abuse from the perspective of the
  - Individual level
  - Community level
  - Systems level

### ***Assessment and Identification***

5. Have you suspected and/or confirmed at least a case of elder abuse in your practice? How did you identify elder abuse?
6. What screening tool(s), if any, do you use to assess elder abuse?

7. How often do you encounter elder abuse in your nursing practice?

*Addressing Elder Abuse*

8. What have you done or would you do if and/or when you suspect(ed) and/or confirm(ed) elder abuse? What situations require taking action?

9. What is the professional obligation of nurses in cases is of suspected or confirmed elder abuse?

10. In either cases of suspected or confirmed abuse, what interventions are you aware of and have you used for your clients?

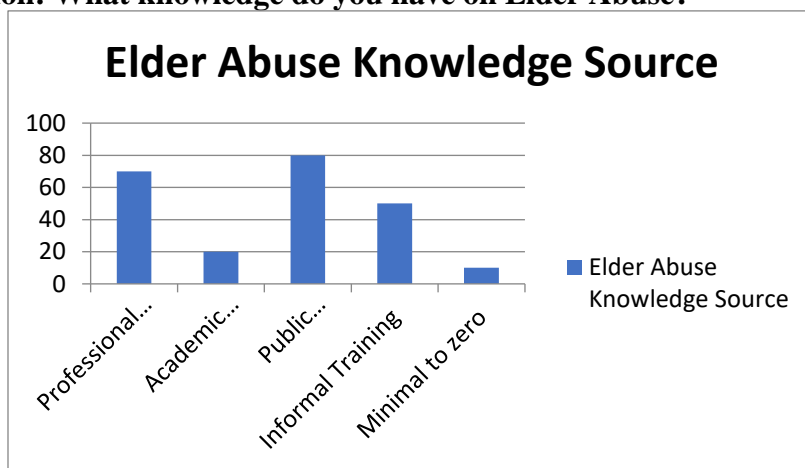
## Appendix VI: Summary of Findings and Interpreted Data

### Perceptions of Elder Abuse

#### Question: What does Elder Abuse mean?

- There was variance in the definitions given on elder abuse. No participant defined elder abuse based on the collective definition by World Health Organization or any other local definitions. Elder abuse was described based on understanding and in the context of public health nurses' experiences and practices.
- The variation in definition was influenced by knowledge on the subject of elder abuse.
- All participants held a critical view of elder abuse and all responses implied that there is harm or risk of harm to an older adult.
- Elder abuse was mostly described in the forms it mostly comes in: financial, physical, and psychological. Neglect and sexual abuse were the least mentioned.
- One participant identified elder abuse as criminal

#### Question: What knowledge do you have on Elder Abuse?



- Knowledge source of elder abuse showed there is awareness on the topic amongst public health nurse participants and they include:
  - Professional training/continuing education – 70% (work related learning outside and or within public health nursing)
  - Academic nursing curricula – 20% (both graduate and undergraduate)
  - Public awareness campaigns – 80% (infomercials, World Elder Abuse Awareness Day campaigns)
  - Informal training – 50% (personal knowledge, self-study, others)
  - Minimal to zero knowledge -10% (zero training, not aware of public awareness campaigns)
- 20% of participants acquired knowledge from academia. No participant acquired elder abuse knowledge directly from Canadian undergraduate curricula.
- 20% of participants had pre-nursing experiences on elder abuse, while other participants had heard about or read elder abuse information and/or experiences

- Despite a high percentage of participants acquiring knowledge from public awareness campaign and any form of professional training or continuing education, less than half expressed full understanding of elder abuse, what it constitutes and actually relates it to their practice experience.

**Question: How does elder abuse present in your practice?**

- Participants in the study have had both direct and indirect professional experience with elder abuse. For those who have had indirect professional experience, they are in contact with the elderly, but older adults is not the focus in their practice, therefore elder abuse is not always considered in their practice.
- Most participants stated that elder abuse is mostly masked (hidden or concealed).
- Reasons identified for the masking were trust concerns, fear of repeating or worsening conditions, and culture.
- Three most common types of elder abuse mentioned or described were financial, physical and psychological. Neglect was mentioned by three participants, and sexual abuse by one

**Question: What risk factors contribute to older adults being vulnerable to elder abuse?**

- **Individual level:** medical/health, finance, knowledge of community resources, isolation, understanding/awareness of elder abuse, family dynamics/complexities, dependency on perpetrator
- **Community level:** ageism, culture, finance, location of community services
- **Systems level:** ageism, social determinant of health, legal system, differing priorities of government versus needs of the older adult

### **Assessment and Identification of Elder Abuse**

**Question: How often do you encounter elder abuse in your nursing practice?**

- Some participants identified elder abuse encounters as uncommon.
- Other participants have their public health nursing practice focused solely on the geriatric demographics. These participants have encountered and identified more elder abuse situations compared to those with fewer or no older adults in the demographics being directly served. Of this group, there was a small number of participants who serve relatively healthy, independent, active, functioning and well connected older adults with less vulnerability to abuse
- For participants whose practice is not limited to the older population alone, a small percentage of them do not consider the older adult population as clients requiring assessment even if they are seen and interacted with in the practice environment. Focus is directly on the service being provided.

**Question: Have you suspected or confirmed elder abuse in your practice?**

- More than half percentage of participants suspected or confirmed at least a case of elder abuse in their public health nursing practice.
- Remaining percentage claimed no evidence of elder abuse in their public health nursing practice. However, they acknowledged the possibility of oversight on the issue due to

lack of awareness or poor knowledge of elder abuse and because elder abuse not a focus in their nursing practice.

**Question: What screening tool(s) do you use to assess elder abuse?**

- 90% of participants do not use screening tools. Of this percentage, some are not aware of the existence of screening tools in assessing elder abuse

**Question: How did you identify elder abuse?**

- Most participants do not assess and therefore do not identify elder abuse in their public health nursing practice
- Few participants throw in routine questions to assess elder abuse during basic assessment routines.
- Questions on elder abuse were integrated into the assessment of the older adult. Both actual and anecdotal assessment areas that aid in identifying elder abuse from the responses include: physical appearance, finance, use of intuition, finance, verbal-psychological/emotional, inconsistent narratives, silence, inhibiting service or service providers, lack of evidence of care
- Some participants are members of Elder Abuse Network that screen for and address elder abuse

**Outcome of elder abuse identified from responses include:**

- physical outcomes: bruising, insufficient funds leading to social isolation and inadequate care
- psychological outcomes: fear, anxiety, depression, apprehension of the healthcare system

**How Perceptions and Assessment of Elder Abuse influence Addressing Elder Abuse**

**Question: what will you do if you suspect or confirm abuse and what situations require taking action?**

- Assess: 80% of participants stated they will conduct further assessments to gather more information and to get an understanding of the client and his/her situation
- Safety: 40% of participants stated they will assess for safety risks and develop safety plan
- Consult: 90% of participants stated they will consult with colleagues, supervisor, manager, support agencies involve authorities (police, Office of the Public Guardian Trustee)
- Very few participants stated they had no knowledge of what to do or what action to take but still mentioned that further assessment should have been done with regards to their previous encounters with the elderly

**Identified situations that require taking actions include:** safety risks, capacity concerns, concern with inability to care for self, lack of competence over finances, confirmed case of physical or sexual abuse.

**Challenges in addressing elder abuse from responses include:** shame and guilt, fear of backlash leading to worsening the situation, lack of trust, culture, obliviousness of care providers, poor knowledge elder abuse by care giver, fear of misdiagnosing the situation, fear of

being a villain for reporting as a care giver, and the conflict of mandatory reporting versus the will of the client

**Question: what is the professional obligation of nurses in cases of suspected or confirmed elder abuse?**

- Ambivalence and contrast exist on the professional obligation of nurses regarding reporting of elder abuse; is it mandatory or not to report elder abuse?
- 90% of participants stated there is professional and/or moral obligation to report both potential and or actual elder abuse
  - Report to whom? Most participants were unsure.
  - Varied responses about whom to report to - report to supervisor, manager, professionals, police, authorities
- 20% of participants stated no obligation for nurses to report elder abuse. Of the 20%, 10% feels there is a moral obligation to act but unclear on how to. The other 10% stated there is no duty to report elder abuse in the community, only in long term care setting
- 30% of participants stated like child abuse, it is mandatory for elder abuse to be reported
- 10% identified the lack of a step by step guideline(s) from Ontario's regulatory nursing body, College of Nurses of Ontario (CNO).
- No participant identified that their organization have a policy or step by step guide on dealing with elder abuse situations
- Though they have not had a reason to search, 10% of participants stated they know they can go to the CNO and RNAO (professional nursing bodies) to find resources on guidelines and nursing obligations

**Question: in the cases of suspected or confirmed elder abuse, what interventions are you aware of and have you used for your clients?**

- Half of participants' responses on encounters of elder abuse in public health nursing ranged from; develop safety plan (help client get out of the situation), utilize shelter system, report the abuse, consult and involve support agencies, involve police, consult with Elder Abuse Ontario, consult with Office of the Public guardian trustee, Elder Abuse Network, educate/create awareness/provide information to client, counselling, set up power of attorney,
- 40% of participants' responses without direct encounters with elder abuse in public health nursing include; counselling, arbitration, elder abuse hotline, create awareness, consult with elder abuse network/representative, consult collaborate and connect with elder abuse network members, involve family, notify authorities (police, social services, ombudsman, MP, call 911).
- 10% of participants have not used any intervention and therefore did not provide any information even anecdotal

### **Interpretations of Findings**

***Influence of Definitions***

- Variations in the definitions of elder abuse means variation in its interpretation and therefore variation in the way elder abuse is assessed, identified and addressed by public health nurses

### ***Knowledge as a Facilitator or Barrier***

- From findings, it appears majority of public health nurses are aware of elder abuse, but ambivalence, contrasts and lots of gaps exist in knowledge about what elder abuse constitutes and how to address it amongst public health nurses
- Basic information on elder abuse such as one time professional training course or infrequent public awareness campaigns are not sufficient training source for elder abuse knowledge. Basic information appears to act as barriers to assessing and addressing elder abuse in the forms of care giver obliviousness, self-doubt of care givers, fear of misdiagnosing the situation therefore ignoring it, poor knowledge leading to poor nursing judgement and poor decision making relating to elder abuse matters
- Level of knowledge on elder abuse matters and knowledge of the professional obligation of nurses can act as a facilitator or barrier in assessing, identifying and addressing elder abuse.

### ***Nursing Assessment of Elder Abuse***

- Despite lacking screening tools or the lack of knowledge about elder abuse screening tools or the lack of organizational policy or guideline or lack of knowledge on organizational policy/guidelines on how to assess elder abuse, public health nurses still assessed elder abuse.
- Carpers patterns of knowing was applied to assessment strategies used by nurses:
  - **Empirical way of knowing:** basic routine nursing assessment to get evidence (physical appearance, verbal, finance, presence or lack of support/help)
  - **Aesthetic way of knowing:** trying to gain understanding of client and the abusive situation, (inconsistent narratives, inhibiting services, lack of evidence of care, silence). Intuition and empathy interplayed in this category.
  - **Personal way of knowing:** personal knowing and the therapeutic use of self created a thirst for further assessment. Responses from participants showed the way personal knowing brought awareness of the unique perspective of the client's health experience, enabled an understanding of the reality of the client, aided in gaining rapport and develop trust (verbal-psychological/emotional) from client.
  - **Ethical way of knowing:** moral component of knowing. Participants reverted to ethics to ascertain right or wrong of elder abuse situation and this affected their determination on what course of action to take in addressing elder abuse.
- The incorporation and interplay of the ways of knowing was used to interpret the responses on how elder abuse was assessed and identified.
  - Responses from participants with and without direct elder abuse encounters showed there was interplay of the various ways of knowing in their assessment strategies which promoted the need for further assessment, advocacy and the development of specialized plan of care to address elder abuse situations.

### ***Training as a Means of Advocacy***

- Adequate knowledge on elder abuse will act as facilitator in properly assessing, identifying and addressing elder abuse in nursing.

- Elder abuse should be incorporated into undergraduate curricular so that assessment and advocacy for a vulnerable group that has been overlooked
- Purposeful effort is required to intentionally train and educate public health nurses about assessing and addressing elder abuse irrespective of working directly or indirectly with the elderly

#### **Gaps Identified from the Study**

- Knowledge gap of elder abuse in undergraduate curricula
- Knowledge gap about regulations and guidelines from professional bodies, CNO, CNA on elder abuse matters
- Knowledge gap of public health nurses about organizational policies on abuse of the older adults as public health consumers, (if organizational policies or guidelines exist on elder abuse)
- Lack of screening of elder abuse in public health nursing
- A need for the development of operational definitions of elder abuse in public health units particularly geared to public health nurses, to guide the interpretation of elder abuse.