Long Term Care Social Workers of Iowa

Fall 2020

Elder-to-Elder Abuse

By Lindsey Getz

Mistreatment between residents is an underrecognized problem in long term care settings, with potentially serious consequences.

Most research about elder abuse pertains to abuse by long term care staff or caregivers, but elder-to-elder abuse—or "elder-to-elder mistreatment" as it's also been termed—is an issue that demands more attention. While there's no epidemiological evidence for the incidence of this type of maltreatment—and this issue remains vastly understudied—there's significant indirect evidence that points to it being a serious concern in long term care settings across the nation.

There are various definitions of elder-to-elder abuse, but the phenomenon can be understood most simply as negative behavior between long term care residents (from one resident against another) including, most commonly, physical, sexual, and verbal abuse. This issue can be exceedingly complex, with many factors to consider.

According to Ronan Factora, MD, chair of the Special Interest Group on Elder Abuse and Mistreatment at the American Geriatrics Society and a Cleveland Clinic geriatrician, elder-to-elder abuse can show up in different ways and always takes place in long term care community settings in which residents already are in close contact with one another.

Factora says this abuse could occur between roommates or between residents who have contact with one another in public settings within the long term care facility. It might also take place, he adds, when a resident wanders in and out of another resident's room.

While resident-on-resident abuse frequently happens behind the scenes, with caregivers and health care providers unaware of the behavior, there may be situations in which long term care staff might turn a blind eye. Some indirect evidence seems to point to the fact that elder-to-elder abuse is often accepted to some degree by long term care staff. According to a study published in the ***Journal of Elder Abuse & Neglect*** in 2012, for example, incidents of yelling and verbal insults among residents were not viewed as abuse by nurse aids and so were not reported. Some long term care employees even view this behavior as normal.

Recognition of abuse may be a judgment call based on staff's perception of a problem, says Julie Ellis, PhD, RN, GCNS-BC, of the University of Wisconsin-Milwaukee College of Nursing. Having worked in long term care settings, she's witnessed resident-to-resident abuse and observes that it can take many forms. "It might involve physical contact in the dining room when a resident becomes agitated. It could also involve a resident wandering uninvited to another resident's room and initiating physical contact or perhaps even taking something that doesn't belong to them," Ellis says. "Because you must factor in that it may involve dementia [on part of the perpetrator], there is sometimes no intent associated with the action, so this becomes a very complicated issue."

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Elder-to-elder abuse is an issue that demands more attention

Inside this issue:

Iowa Board of Social Work Emergency Proclamation Guidelines

Governor Kim Reynolds has issued a Proclamation of Emergency Disaster. In this Proclamation, Governor Reynolds temporarily suspended a number of regulatory provisions applicable to various professions. The full text of the Proclamation is available on the Governor's website. The Board issues the following guidance regarding the Proclamation:

License Renewal

The Board office is still processing renewals at this time. Licensees are not required to renew for the duration of the Proclamation. Licensees who wish to renew as scheduled are encouraged to renew using the online system. You will have 60 days after the Proclamation expires to renew your license without penalty.

Continuing Education

Licensees will have until June 30, 2021 to complete the continuing education required for license renewal for licenses set to expire on December 31, 2020. Licensees may renew prior to completing the required continuing education. In order to complete the renewal application, licensees will need to attest to completion of the required continuing education. Licensees should attest to the completion of the required hours if they have completed, or plan to complete, the required continuing education by June 30, 2021.

Licensees are reminded that all of the required continuing education may be obtained online.

Supervision Requirements

Licensees who begin their period of supervised professional practice for licensure at the independent level while the Proclamation is in effect are not required to have their first supervision meeting in person. Licensees are already permitted to have the remaining supervision meetings via electronic means.

Out-of-state Social Workers

For the duration of the Proclamation, individuals who are licensed as social workers in another state, whose license is in good standing, may provide services to Iowans through electronic means without obtaining a license from the Board.

Iowa Department of Public Health

11/10/20

Elder to Elder Abuse ~ Continued

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Risk Factors

Because this aggressive behavior is understudied, it can be difficult to glean specifics about risk factors. However, a 2004 study published in ***JAMA*** found that victims of elder abuse were more likely to have cognitive impairment, moderate functional dependency, and behavioral disturbances (eg, wandering).

According to Factora, there are also risk factors associated with long term care communities themselves that could make elder-to-elder abuse more prevalent, such as understaffing or large populations of residents with cognitive impairment and mobility issues. "If you have residents who are not ambulatory, they may be at an increased risk simply because they cannot get away from the perpetrator," Factora says. "Unfortunately, we lack good data surrounding this issue, but these are points to consider as you evaluate whether your long term care facility might pose increased risks simply due to its population."

Keep in mind, Ellis says, that perpetrators might have been perpetrators in their younger years, as well. If you have men—or women, though Ellis says it's more often men—who have a history of engaging in physical or sexual abuse, that behavior might be part of a lifelong pattern. "However, there are also many instances where the person does not have an abusive history but might be confused and experiencing aggression that they never exhibited before," she adds. "Dementia-related agitation is a legitimate concern."

Red Flags of Elder-to-Elder Abuse

Because it's not always happening overtly—such as in a shared dining area where staff can spot a problem—it's important for long term care clinicians to actively look for warning signs of elder-to-elder abuse. Often there are red flags. "There are different signs and indicators for different types of abuse," says Wenche Malmedal, PhD, MSc, RN, FAAN, an associate professor at Norwegian University of Science and Technology in Trondheim, Norway, a specialist in psychiatric nursing who's written several articles and book chapters on elder abuse and speaks internationally on the topic.

"In terms of physical abuse, you might see bruises, cuts, scratches, fractures, slap marks, kick marks, eye injuries, and burns," Malmedal says. "But for psychological abuse, you might see depression, withdrawal, apathy, feelings of hopelessness, insomnia, appetite change, unexplained paranoia, agitation, tearfulness, excessive fears, and confusion. You must also be aware when a person shows anxiety and fear for a certain person. An important indicator of abuse is if an older person tells you about being abused. Often, they are not believed due to old age and possible cognitive decline; nevertheless, they should be listened to and what they tell should be investigated."

Factora points out that sometimes the red flags can come from the perpetrator rather than the victim. If you notice increased signs of aggression or agitative behavior or observe that a resident is suddenly spending more time around another resident, it would be prudent to be more watchful, he says.

Elder-to-Elder Sexual Abuse

Of course, not all abuse is physical or verbal. Malmedal says that there's also the less talked about but very important issue of sexual abuse, which will have its own set of potential signs. In these cases, the bruises might be located around the breasts, genital area, or inner thigh, and there may be irritation or pain around the anus and genitals, Malmedal says.

"Some older victims of elder sexual abuse may have unexplained genital infections or venereal diseases," she continues. "Their underclothing may be torn, stained, or bloody, and some may have difficulties in walking, standing, or sitting. Shame and embarrassment are even more present, and this reduces the likelihood of disclosure of the abuse. It's important to be familiar with the different forensic markers—these very specific signs and symptoms that indicate elder sexual abuse. It's also important to be responsive to any verbal or nonverbal disclosure from the older person. It might not be that they are using direct language to disclose sexual abuse but may 'beat around the bush.'"

Ellis adds that the issue of sexual abuse becomes increasingly complicated when confusion or dementia is involved. While she describes physical abuse as "cut and dry," sexual abuse involves quite a bit of "gray area."

"Sexuality is encouraged in older adults if they are alert and oriented, but when you start talking about one person having dementia or even just confusion, lines can quickly become blurred," Ellis explains. "Take for instance, a woman who seemingly consents to sexual activity because she believes the person is her husband. Is that abuse? It's a gray area, but in my opinion, consent cannot occur when there is confusion involved. Sexual abuse is a serious issue, and I think when there is any doubt or gray area, the clinicians need to be involved in protecting the resident."

There are also reasons some residents may choose not to come forward, adds Julie Schoen, JD, deputy director at the National Center on Elder Abuse, Keck School of Medicine at the University of Southern California, particularly when they've experienced physical or sexual abuse. This is why it's imperative for long term care providers to remember that signs of abuse may not always be evident.

"I do think a lot of this is occurring behind closed doors, making it

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incredibly important that clinicians are paying close attention," Schoen says. "Oftentimes there is a lot of fear associated with reporting. The resident may be fearful that they'll lose the place where they're living, that there will be retaliation, or even just that they won't be believed."

Societal attitudes toward elder abuse—particularly sexual abuse—have also made it difficult for residents to come forward, Malmedal says. "Societal ignorance and disbelief regarding elder sexual abuse may play an important role in regard to why cases are not detected and that the victims are not getting adequate help," she says. "Sexual abuse of older adults is still not recognized as a social problem in many countries, and along with lack of a mandatory reporting system, this problem is often hidden and not acknowledged among professionals or in society in general. Some countries and states do have mandatory reporting of elder abuse cases, but even where this exists, the health care providers are not always aware of the mandatory reporting laws or how to enforce those."

Implementing Solutions

Attitudes, inadequate education, and lack of protocols for reporting elder-to-elder abuse are significant contributors to the problem. Also, Malmedal says, when long term care communities see elder-to-elder abuse as normal or inevitable, it makes it increasingly difficult to institute change.

"This attitude must change," she insists. "Educational programs are important to raise awareness of this topic. There are also a lot of useful websites, e-learning programs, and YouTube videos that could be used by staff to gain knowledge and spread the word about this issue."

Ellis adds that verbal abuse is often the most likely to be overlooked, but it can be psychologically damaging and should not be ignored. "Verbal abuse can lead to depression and lead residents to withdraw or even to stop eating," she adds. "It's so important to watch for this and not to just dismiss it. It's the staff's responsibility to take care of this issue. Sometimes the resident committing the verbal abuse needs help. Just saying 'don't go near that person' is not a solution. Action needs to be taken."

A study published in the ***Journal of Continuing Education in Nursing*** looked at whether utilizing the SEARCH approach—Support, Evaluate, Act, Report, Care plan, and Help—could be effective in managing elder-to-elder abuse. The SEARCH approach provides clear guidelines for long term care staff to follow in terms of reacting to elder-to-elder abuse. The study applied this approach to three case studies and found it was effective in enhancing knowledge, recognition, and reporting of elder-to-elder abuse.

Education is certainly an important part of the solution, Factora says. Along with that comes the implementation of protocols—including reporting protocols. What should happen after witnessing or hearing a disclosure regarding abuse?

"I think there is a lot of confusion regarding who the appropriate authority to contact is," Factora says. "Some issues may be able to be handled internally, but it often needs to go beyond that. Along with that, there needs to be a clear pathway for concerns to be communicated. It should never be assumed that somebody else already reported or handled an issue—the communication paradigm must be addressed. There should be a protocol in place for any suspicion of abuse."

While external help may be called for, it's also important to recognize that law enforcement often does not know how to deal with or address these issues, Schoen says. They are rarely well versed on how to deal with elder abuse and often view it as an internal issue that the long term care facility needs to handle.

Social workers, on the other hand, are typically well-versed in dealing with elder abuse and should always be brought into the conversation, Ellis adds. They have experience with psychosocial needs and a better understanding of how to approach this issue.

"The family should also become part of this conversation, as they likely may not be aware that any of this is occurring," Factora says. "The last thing that any long term care facility wants is for an abuse concern to come to their attention through other means. Families should always know what's going on so that they have the ability to be involved in any decision making that would naturally follow an abuse allegation."

It's also necessary to inform the family of a perpetrator about incidents of abuse. "The perpetrator's family also likely has decisions to make—including whether they might be better served in a different community," Factora says. "A perpetrator's family has just as much right to know what's going on."

Looking to the Future

Although elder-to-elder abuse remains understudied, there's hope that the future will bring better understanding and improved education. "The more we talk about this issue, the better," Schoen adds. "It's not talked about nearly enough. Even just helping doctors and caregivers in long term care communities to be more cognizant of the issues that can arise will likely play a role in decreasing their prevalence. Long term care communities need to be thinking about the 'what ifs' and how they can prevent them. Education and increased awareness can go a really long way."

— Lindsey Getz is an award-winning freelance writer based in Royersford, Pennsylvania.

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Fall Conference Followup

- **Connectivity Issues?**
  If anyone had connectivity issues during the conference and needs to access certain portions, please contact me for the link

- **Attendance/CEUs Certificates**
  If anyone did not receive their Attendance/CEUs Certificates, please contact me

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COVID Recovery Iowa Services

We hear you. We see you. We are here to help. COVID Recovery Iowa provides free counseling, virtual activities, referrals and help finding resources to any Iowan seeking assistance or a listening ear. Iowans of all ages may join groups online for activities and learn creative strategies for coping with the effects of the pandemic.

Are you an older adult or a caregiver or loved one of an older adult? We have services just for you:

Counseling: We provide emotional support, education, and basic crisis counseling to you and your family and can connect you to community support systems.

Older Adult Support: We offer number of activities to get ahead of the loneliness that may come with social isolation due to the pandemic. Our services which can be adapted from no-tech to high-tech include: **Peer Counseling and Personal Support; Social Check-ins and Coffee Chats; Musical Telegrams; Legacy-Writing; Pen Pals; and Tech and Media Solutions.**

LTC Worker Support: We know that Long Term Care staff are busier than ever, and we want to help. Let us know how we can serve you! Some ideas include: providing workplace diffusion seminars for staff to navigate the stress of the pandemic; providing you with easy and engaging activity packets that residents can enjoy from the safety of their rooms; hosting phone-in and/or virtual group activities to provide fun ways for residents and loved ones to connect with each other.

Contact Us: submit an online request via **www.COVIDrecoveryiowa.org**

Facebook, Instagram, Twitter and YouTube: COVID Recovery Iowa COVID Recovery Iowa information and programs can be interacted with on all major social media platforms.

Iowa Concern: 800-447-1985 Provides confidential access to stress counselors and an attorney for legal education focusing on rural and agricultural issues. Iowa Concern services are available 24 hours a day, seven days per week at no charge. Language interpretation service is available.

Iowa Warm Line: 844-775-WARM (9276) Provides confidential access to peer counseling and can connect people upon request with COVID Recovery Iowa Services. Language interpretation service is available.

Older Adults Programming: Email or call Ash Roberts at 531-800-4450 or aroberts@heartlandfamilyservice.org

We're stronger together, even in these uncertain times!

Fall Conference Q&A: Suicide Risk Assessment & Documentation

Could Dr. Page share with us some bullet points he has staff use when he feels a resident is at risk for suicide.

~ Paula Brinning

Response from Kyle Page

Thanks for your question about documentation Paula. I would preface that each facility certainly may have its own way to assess and document concerns about suicide risk. In my experience, everyone seems clear on how to address acute concerns about risk, such as a resident making direct statements about wanting to kill themselves. But, there is less direction on how to address residents who have an elevated risk for suicide but are not currently at an acute level (imagine someone who does not meet the criteria to be sent to an emergency department or to be admitted to an inpatient psychiatric facility, but you still worry about them when you leave for the day). We want to ensure that our staff are aware that someone can have an elevated risk for suicide but not be actively suicidal at the moment. It is not as cut and dry as "yes" and "no" in many of these complex presentations with our residents. We want to recognize that residents have two risk levels - an acute risk (which may be low, intermediate, or high) and a chronic risk (which also may be low, intermediate, or high).

For those residents who need a bit more coordinated monitoring, but don't need to go to an emergency room at the moment, I will offer specific concerns for nursing staff (or any staff really) to monitor for, and I will try to make these recommendations tailored to the resident as much as I can. In my LTC and SNF settings over the years, we have generally used a tiered screening system. So, if a member of nursing staff notes concerns about someone's suicide risk, they have a screening item from the PHQ-9 (item 9) that the RN will ask (thoughts about being better off dead or of hurting themselves). If that is positive, they then use something like the Columbia Suicide Severity Rating Scale (C-SSRS) to assess for an acute risk (plans, intents, attempts). If that is then positive a licensed medical or mental health provider will conduct a more thorough evaluation. This can help us differentiate between those thinking about death versus those thinking of taking steps to end their lives now.

I've included an example of how I might write this message to staff. It is only a partial example, as I might have more to add about non-suicide specific concerns (our therapy session, other recommendations, plan for other aspects of my treatment), but what I am sharing here is what I would point out to the staff.

Thanks for the question!
Kyle

Note: Example follows on Page 7

Example Message to Staff from Kyle Page

Risk Assessment:

The resident denied current suicidal ideation, plans, and intent, but made vague conditional statements about considering killing himself if his "health got worse." Current risk factors include: advanced age, gender, race/ethnicity, admission to hospital, multiple mental health and physical health diagnoses, previous inpatient psychiatry admissions, history of suicidal ideation/plan/intent, declining functional abilities, pain, cognitive impairment. Current protective factors include: currently future oriented, willing to engage with mental health during this admission, taking psych medications, supportive family member, occasional observation on rehabilitation unit, medications administered by staff.

Acute Risk: Low
Chronic Risk: Intermediate

Summary Statement:

Of concern, he has a history of suicidal ideation, plans, intent, including several hospitalizations for his suicidal ideation. Currently, he denied any concern when directly asked, but made a vague conditional statement. His acute risk for intentional self-harm may be low, but his chronic risk is elevated to an intermediate level given his history. I have alerted the team and staff to his heightened risk, and recommend we monitor of any warning signs or changes in behavior. Re-evaluate as warranted, especially if there are any notable changes to his functional abilities or discharge plans.

Staff Recommendations:

1) Given his history of distress and thoughts of suicide, staff are encouraged to continually monitor for:
   a) Declines in mood (for him may be increased irritability and verbal aggression towards staff)
   b) Several days of declining to participate in rehabilitation care plan
   c) Declines in attention to hygiene and grooming (for him this may be two or more consecutive times of refusing to shower)
   d) Declines in participation in social activities (for him this may be no longer watching the baseball games in the group room)
   e) Increased isolation in room (with lights off and curtains drawn)
   f) Subsequent skipped or declines meals
   g) Any statements about death, dying, and suicide (we will help staff differentiate
   h) between acute concerns and death ideation)

2) Staff are encouraged to continue sharing any observations during shift change reports and documenting in the medical record.
3) If nursing or other staff observe concerns about worsening behavioral presentation, worsening mood, or increasing risk for suicide, please assess the situation using the PHQ i9, and if positive, the C-SSRS.
4) If based on screening measures or professional judgment, there is concern about acute risk for suicide, staff are to immediately assign a 1:1 while the attending physician and/or psychologist is contacted for an full evaluation. If after hours, staff are to call the on-call physician. The 1:1 should remain until cleared by a licensed medical or mental health provider.

Long Term Care Social Workers of Iowa

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LONG TERM CARE
SOCIAL WORKERS OF IOWA

Membership Directory

The LTCSWI Membership Directory for 2020 has been emailed to all members. Updates will be sent periodically as new members join during the year. The email address you listed as a preferred email is included. If you did not receive the directory or if you know of any changes or corrections, please contact me. This directory is a tool for your personal use and is not to be used for solicitation purposes, nor is it to be provided to non-members.

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LTCSWI Fall Conference in Review

We held our first virtual conference this fall on October 22-23. Seventy-five people registered for the conference. Sara Sanders and Stephen Cummings from the University of Iowa presented, *Ethics in Long-term Care: Maintaining Boundaries in the World of Technology and Social Media,* which met the Iowa Board of Social Work Examiners rules for 3.0 hours of continuing education in Ethics. During the second Thursday presentation, Angela Broughton-Romain from Iowa Legal Aid, discussed *Elder Abuse Protective Orders in Iowa: Legal Updates and Strategies for Preventing Elder Abuse.* Kyle Page made two presentations on Friday morning, *Personality Disorders in Long-Term Care & Mood Disorders in Later Life: Is it Really All That Bad?* Our conference concluded with a presentation on *Guardianship, Conservatorship, and Alternatives,* by Jennifer Donovan from the Office of Public Guardian. Attendees made the following comments:

- *Ethics presentation was interesting and flowed very well between the two presenters.*
- *Personality presentation. This presentation had very practical approaches, and insights for day to day application.*
- *All topics were beneficial to LTC and other settings.*
- *Appreciate offering of virtual for CEU's*
- *Thank you for the handouts and resources. Being able to connect with others and obtain a refresher or new ideas is the best part!*
- *I really enjoyed the sections on personality disorders and mood disorders.*
- *The information from Jennifer Donovan (Guardianship/ Conservatorship). I find those topics to be tricky.*
- *It all flowed together so well. The information was useful and appreciated.*
- *Good conference under difficult circumstances. I appreciated this opportunity to get CEU's and more importantly, to get more information from people who really knew their stuff.*