Elder Abuse

CLPNA Self-Study Course
2018
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The material herein contains information and guidance for nursing practice. This information is not legal advice. Abuse or neglect of older adults can have serious consequences. You must understand your professional responsibility and obligation to ensure older adults are provided with the support needed and to report situations as required by law and employer policy.

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Course Introduction

This course has been designed as continuing education for licensed practical nurses (LPNs) who have a vested interest in recognizing, responding to, and preventing instances of elder abuse/mistreatment. The main purpose of this course is to bring further awareness to the issue of elder abuse and to develop strategies that can be used to support older persons in situations where abuse is suspected or a person has disclosed that he or she is being abused.

Elder abuse is a significant public health problem and is therefore everybody’s business. Statistics on elder abuse indicate that between 2 and 10 percent of older adults will experience elder abuse.1 The statistics are likely lower than the reality because older adults are often reluctant to disclose abuse for various reasons. Elder abuse is a patient-safety issue and puts LPNs in a unique position to understand how abuse can be prevented and to support those who have been abused or are experiencing abuse.

Because LPNs are frequently in close contact with clients and families, they are in a position to be entrusted with information about abuse of elders. This course provides opportunities for LPNs to gain the knowledge and skills to prevent and mitigate abuse. This includes building the confidence and capacity to intervene when faced with elder abuse in their practice. This course will provide an array of information regarding elder abuse that includes primary indicators, prevention, assessment, relevant legislation, regulatory requirements, and resources.

This study guide cannot cover every aspect of identifying and intervening in a case of elder abuse because situations are unique. The important message is to be familiar with the issues surrounding elder abuse and have an awareness of resources/services available. The LPN is expected to do something – from asking if support is needed, making a referral or reporting a suspected case of abuse. LPNs should always refer to and follow their organization’s protocols, policies, professional standards and legislation – when determining an appropriate course of action.

There are five modules in this self-study course. Upon completion of this course, LPNs will be able to

- outline legislation that applies to the protection and safe care of older adults;
- articulate the link between elder abuse and professional responsibilities;
- identify forms of elder abuse using possible indicators;
- recognize elder abuse situations in various care settings;
- respond to elder abuse using appropriate strategies;
- identify strategies to prevent elder abuse; and
- explore resources for elder abuse victims and health care professionals.

The course also includes a variety of learning activities to enhance the learners’ understanding of elder abuse. The website hosts quizzes, a final examination and a quick guide to resources.

Note: For the most part, this guide is written for the LPN practicing in Alberta. Key legislation and resources relate to agencies and services provided in the province of Alberta, Canada.
Module 1: Introduction to Elder Abuse

Upon completion of Module 1, LPNs will be able to

- define the terms elder and elder abuse;
- introduce the concept of elder abuse;
- summarize the various theories associated with elder abuse; and
- identify groups more at risk for elder abuse.

Defining Elder Abuse

Elder abuse is a complex topic because abuse can take a variety of forms and is sometimes a combination of those forms. There are many definitions of elder abuse. The Alzheimer Society of Canada (2010) and the World Health Organization (WHO) define elder abuse as “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.” Similarly, Seniors Canada defines elder abuse as any action or deliberate inaction by a person in a position of trust that causes harm or could be reasonably expected to cause harm to an older person. This includes all types of abuse—emotional, physical, sexual, and financial—as well as instances of neglect and violation of rights.

- Physical: causing pain, injury, or harm to health
- Financial: illegal or improper use of funds or assets (e.g. theft, fraud)
- Psychological: infliction of mental anguish and suffering
- Sexual: non-consensual sexual activity or harassing sexual comments

Neglect: refusal or failure to provide services or necessary care

Just as abuse and neglect of seniors can take many forms, the resulting effects of the abuse can have dire impacts on many aspects of seniors’ health and well-being. Elder abuse can occur anywhere: in the community, at home, in the hospital, in a care facility, or in a clinic. Elders can be abused by spouses, friends, caregivers, health professionals, legal guardians, and family. Elder abuse can involve one incident or be a pattern of abuse, and abuse can be intentional or unintentional.

Defining the Term Elder

For the purposes of this course, the term elder refers to all older adults, regardless of culture or affiliation. The terms elder, older adult or older person, and senior are used interchangeably. The term elder should not be mistaken with Elder, which is often used to refer to older members of Aboriginal communities.

The terms elder abuse, elder mistreatment, and abuse of the older adult are used throughout the literature, with elder abuse used most frequently.

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A Social, Political and Legal Issue

Elder abuse was formally identified by the Canadian government in 1989, after the identification of child abuse in the 1960s and spousal abuse in the 1970s. The identification of elder abuse led the provinces to enact legislation for the protection of abused older adults living in facilities. Many federal and provincial laws apply to elder abuse, and each province and territory takes a unique approach. Alberta has key legislation that applies to elder abuse, namely the Protection for Persons in Care Act (PPCA).

PPCA responds to reports of abuse or safety concerns for seniors in publicly funded care facilities including hospitals, seniors’ lodges and nursing homes.

More information about the PPCA will be provided in Modules 3 and 4.

Elder abuse is an epidemic affecting all ethnicities, socioeconomic groups, and genders. Any elder, but particularly those suffering from diminished mental acuity or declining physical wellness, can become a victim.

Statistics

Many older adults suffer in silence; therefore, it is difficult to accurately report rates of abuse because much abuse goes unreported. Various literature states that accurate statistics are difficult to obtain because of differences in definitions and methods used to obtain data. To illustrate the severity of the elder abuse problem, the World Health Organization reports the following facts:

- Around 1 in 10 older adults experience abuse every month.
- Elder abuse can happen just once or repeatedly.
- Elder abuse can lead to serious physical injuries and long-term psychological consequences.
- Elder abuse is predicted to increase because many countries are experiencing rapidly aging populations.

The 2010 report by the Chief Public Health Officer of Canada emphasizes the potential for physical, psychological, sexual, and financial abuse or neglect of seniors. It is difficult to know the extent of this problem in Canada, since the data is extremely limited, outdated, and, due to the nature of the issue, most likely underreported. Research estimates, however, that between 4 and 10 percent of Canadian seniors experience some form of abuse or neglect from someone they trust or rely on.

According to a 2015 study by the National Initiative for Care of the Elderly (NICE), the prevalence for elder abuse is growing. In a survey of nearly 700,000 Canadians, 7.5 percent of older adults had experienced some type of abuse. Not surprisingly, the incidences of elder abuse are expected to increase as the population of older adults rises.

It is difficult to measure the societal, legal, and economic impacts of elder abuse. Economic measures do not consider the human costs of emotional suffering, decreased quality of life, and, in some cases, death.

Just how widespread is elder abuse across Canadian society? According to CARP, (formerly the Canadian Association for Retired Persons) Canada’s largest advocacy association for older Canadians, the issue of elder abuse is getting worse. Some studies suggest that 8 to 10 percent of seniors experience elder abuse (approximately
750,000 seniors in Canada), but this is not at all clear.

Elder abuse is one of the most underreported crimes in Canada. One study estimates that only 20 percent of incidents of elder abuse ever come to the attention of someone who can be of assistance. There are several reasons for this:

- Some victims are dependent upon caregivers who are abusing them and do not have other options. If they report the caregivers, they may no longer be able to live in their own homes.
- Some victims fear retaliation from their abusers.
- Some seniors fear that they will not be believed. Ageism is a form of discrimination that leads to stereotypical assumptions about the reliability of a senior’s memory, for example.
- Some victims experience deep shame and humiliation, often culturally based, which would be exacerbated by reporting the abuse to others.
- Some victims are simply unable to report due to mobility issues or issues speaking.

Elder abuse is perpetuated against Canada’s most vulnerable citizens. When elder abuse occurs, it is likely to be repeated; in fact, in 80 percent of cases, it is not a single incident. It is grossly underreported, and CARP believes the real figures may be much higher than 8 to 10 percent.

**Theories Associated with the Incidence of Abuse**

Theories can be useful in explaining the prevalence of elder abuse. Although they do not account for every situation, theories are helpful in facilitating understanding and intervention. The following theories are brief explanations why elder abuse may occur.12

**Transgenerational/Social Learning Theory:** Abuse is described as a learned behaviour—an individual who witnessed violence at a young age as a method of coping with stressful situations is more likely to use violence in similar situations.

**Situational Theory or Caregiver Stress:** The probability of elder abuse perpetrated by a caregiver is proportional to the perceived burden of caregiving.

**Exchange Theory:** The incidence of abuse is classified in terms of a combination of the reliance of the older adult on a caregiver (increased burden) and a history of ineffective coping methods.

**Political Economic Theory:** Abuse is more likely to occur when an older adult is forced to find a caregiver or other support after a financial loss or a decreased level of independence.

**Risk-Vulnerability Model:** The interplay of risks (external environmental factors) and vulnerabilities (physical, emotional, mental, social, and spiritual) increase the likelihood of abuse incidence.

**Psychopathology of the Caregiver:** The focus for risk of abuse is on the caregiver who has emotional or mental health issues (including addiction), especially in combination with an older adult experiencing cognitive and mental health issues.13

**Isolation Theory:** Abuse may be more likely to occur when there is little or no support from caring family members, friends, or neighbours.14

**Psychopathology of the Abuser:** Mental illness, alcohol use, and drug dependency are considered factors in abuse of older adults. An abuser may also have personality flaws or
characteristics that contribute to abusiveness. If abusers become caregivers, they often do not have the capacity to make appropriate decisions for their elderly parents or the elderly person under their care.\textsuperscript{15}

There is a high degree of complexity associated with elder abuse, and it cannot be explained by any one theory. As well, theories provide an explanation why abuse may occur, but they do not provide a clear theoretical formula to prevent elder abuse.\textsuperscript{16}

Risk Factors

There is no clear reason why elder abuse occurs, but the risks are many. Its causes are both complex and often hidden. However, experience suggests certain factors are related to abuse and that the existence of more than one of these factors places a person at high risk of abuse. Typically, key risk factors for abuse include caregiver stress, family conflict, isolation, medical/psychological problems, and addictive behaviours. The WHO suggests that risks can be divided into four main categories: individual, relationship(s), community, and sociocultural.\textsuperscript{17}

Individual

At the individual level, reduced physical and mental health presents an increased risk for abuse. Perpetrators’ mental disorders and alcohol and substance abuse also increase the risk. In some situations a shared living arrangement may increase the risk for abuse. While older men have the same risk for abuse as older women, widowed females in some cultures may be targets for financial and physical abuse and neglect.

Relationship

Shared living accommodations may be a risk factor for elder abuse. Spouses or adult children may become perpetrators for a variety of reasons. A perpetrator’s dependency on the older person for financial support increases the risk of abuse. A history of poor family relationships may result in caregiver stress and elder abuse when the older adult requires more care. Caring for older relatives requires much time and energy, and this load creates additional stress, particularly on women who are still in the workforce.

Community

Social isolation and lack of social support is a significant risk factor for elder abuse. Many older people are isolated because of diminishing physical and mental capacity or because of the loss of family and friends.

Sociocultural

There are many sociocultural factors that link to elder abuse. Older people’s social statuses combined with ageism have portrayed them as frail, weak, and dependent.\textsuperscript{18} Canada has become a country with many languages and cultures. Over the last decade, about 10 percent of immigrants to Canada have been over the age of 60.\textsuperscript{19} Limited research has made it difficult to show exact statistics, but according to 2006 data, more than 20 percent of immigrants are over 65 years of age.

Older adults who are immigrants have been described as “under enormous stress from isolation due to language barriers, social isolation, financial and emotional dependency, sociocultural factors, dysfunctional family dynamics, caregiver stress…the personal characteristics of the victim and the perpetrator may lead to elder abuse. Abused ethno-cultural older people often do not know about their legal and human rights or about community reserves.”\textsuperscript{20} To add to the complexity, new immigrants may have a general lack of understanding of their rights as residents, causing them to increasingly depend on
others due to sponsorship and language barriers.

Additional cultural or socioeconomic factors that may affect the risk of elder abuse include:

- erosion of the bonds between generations of a family;
- restructuring of the basic support networks for older people; and
- systems of inheritance and land rights affecting the distribution of power and material good within families.

Specific Populations Vulnerable to Elder Abuse

There are several diverse groups who are more vulnerable to elder abuse: older adults with memory impairments; elders in institutions; lesbian, gay, bisexual, transgender, and queer (LGBTQ) older adults; incarcerated seniors; and Indigenous seniors. These populations experience unique challenges that often contribute to increased incidences of elder abuse.

Older Adults with Memory Impairments (Dementia)

When both dementia and abuse are present, challenges such as impaired language, motor abilities, or decision-making capacity, disinhibited behaviour, and underlying depression complicate the detection of and response to elder abuse. Abuse of older adults with dementia is relatively common and often goes underdiagnosed.

Dementia is characterized by a progressive and persistent decline in both cognition and function and applies to a group of signs and symptoms seen in a variety of diseases affecting the brain. Surprising statistics from the Alzheimer Society of Canada show that 564,000 Canadians are currently living with the disease. Even more startling is that 1.1 million Canadians are affected directly or indirectly by dementia.

People with dementia are vulnerable to abuse by people who are close to them as well as by strangers. A person with dementia may also abuse a caregiver either due to lifelong habits or the impact of the disease. Cases of abuse, mistreatment, or neglect may be intentional or unintentional. By understanding the disease and its associated behaviours, strategies can be developed to reduce and even prevent abuse.

Older Persons in Institutions

Older adults must be treated with dignity and respect regardless of the care setting, including facility care (also referred to as institutional or systemic care). Data on the extent of the problem in institutions such as hospitals, nursing homes, and other long-term care facilities is scarce.

A survey of nursing-home staff in the United States suggests rates may be high:

- 36 percent witnessed at least one incident of physical abuse of an elderly client in the previous year;
- 10 percent committed at least one act of physical abuse toward an elderly client; and
- 40 percent admitted to psychologically abusing clients.

Within facilities, there is increased risk for abuse by staff, families, or volunteers when

- standards for health care, welfare services, and care facilities are substandard;
- staff are poorly trained, overworked, and inadequately compensated;
- the physical environment is deficient;
interactions between staff and residents are difficult; and

- policies operate in the interests of the institution rather than the residents.\(^{28}\)

Abusive acts in institutions may include

- physically restraining clients;

- neglecting clients' basic care needs (e.g. food, clothing, health care services);

- depriving them of dignity (e.g. leaving them in soiled clothes) and choices over daily affairs;

- invading clients' privacy (e.g. opening mail or emails, accessing personal information);

- intentionally providing insufficient care (e.g. allowing them to develop pressure sores);

- over- and under medicating and withholding medication from clients;

- emotional neglect and abuse;\(^{29}\)

- sexual abuse (e.g. harassment, inappropriate comments, sexual activity);

- threats of harm (e.g. saying or doing something that causes fear);

- fraudulently gaining access to clients’ money (e.g. theft, stealing banking information);

- preventing clients from engaging in spiritual practices (e.g. refusing to allow clients to attend religious services); and

- causing social isolation (e.g. refusing to allow visitors).

Abuse in facilities can easily be condoned if no actions are taken.

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Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) Older Adults

Our society is moving toward inclusivity, regardless of colour, race, religion, gender, or sexual orientation. According to Simon Fraser University Gerontology Research Centre, LGBTQ older adults are more vulnerable to elder abuse for the following reasons:

- They face prejudice that makes them an “invisible population.”

- They are twice as likely to be single and living alone.

- They are less likely to have children or to find children supportive.

- They are more likely to have experienced trauma and to have drug and alcohol issues.\(^{30}\)

LGBTQ older adults are less likely to report abuse because they do not want to be further criticized and may not wish others to know of their revised gender or sexuality.\(^{31}\)

Abuse of LGBTQ older adults is complex with many different tensions—such as family loyalty, internalized homophobia, control, and gender conformity—and physical and psychological violence intersecting. The Canadian Network for Prevention of Elder Abuse website has many resources available to further explore LGBTQ elder abuse.\(^{32}\)

Incarcerated Seniors

Most elder abuse prevention, detection, and intervention strategies are focused on community-dwelling older adults who are abused, neglected, and exploited in their family homes, neighbourhoods, and long-term care settings; much less attention is given to older adults who are incarcerated.\(^{33}\) Older adults in correctional facilities face the same mistreatment, exploitation, and rights violations that are experienced by older
adults in care facilities or their homes. The United Nations takes a firm position that older prisoners are a special-needs population who require specific, flexible guidelines for their treatment.34

Regardless of older adults’ past criminal histories, they deserve equal rights and protection from elder abuse.35

**Indigenous Older Adults**

According to the National Indigenous Elder Justice Initiative (NIEJI) in North Dakota, most cases of elder abuse are undetected, underreported, and unresolved, resulting in injury, financial decimation, and even death. NIEJI was created to address the lack of culturally appropriate information and community education materials on elder abuse, neglect, and exploitation of Indigenous older adults.36

While statistics on the abuse of elders are scarce for the general Canadian population, even less information is available for the Indigenous elder population with respect to the incidence and prevalence of abuse that may be occurring in Indigenous communities. However, research on the issue of violence and Indigenous peoples indicates higher rates in comparison to the non-Indigenous population in Canada.37 Due to a lower life expectancy of Indigenous peoples in Canada, the older adult population is often not included in studies of elder abuse, as the minimum age for inclusion is typically 65 years of age.38

Indigenous elders are susceptible to being victimized for numerous reasons. In many instances, elders have lost their respected standing in the family and community because of the colonization process and, most notably, the residential school system, which impacted both the function of the Indigenous family and the vital and respected roles of older persons. In addition, Indigenous elders are at higher risk because of the current poor socioeconomic conditions (e.g. lack of education, employment, housing, and culturally specific health and social services) that exist in remote, rural, and urban settings, which could lead to increased family tension and result in violence.39

A research study noted that grandparents often become the primary caregivers of their grandchildren due to social issues facing their adult children, such as domestic abuse or child abuse. As a result, Indigenous grandparents who raise grandchildren are in conflict with their traditional values and caregiving responsibilities in their senior years.40

**Caregivers (Older Adult)**

Many nonprofessional/unpaid Caregivers—spouses, adult children, or other relatives and friends—find taking care of an elder to be satisfying and enriching. But the responsibilities and demands of caregiving, which often escalate as the elder’s condition deteriorates, can also be extremely stressful. The stress of caregiving for an older adult can lead to mental and physical health problems that make caregivers feel burned out, impatient, and more susceptible to abusing the elders in their care.41

Among Caregivers, significant risk factors for elder abuse may include

- inability to cope with stress (lack of resilience);
- depression, which is common among caregivers;
- inadequate support for giving high-quality care;
- heavy physical or emotional costs of being a caregiver;
- lack of respite care;
• financial difficulties;
• the caregiver’s perception that taking care of the elder is burdensome and without psychological reward; and
• substance abuse.

Key Points
• There are a variety of definitions of elder abuse worldwide, but it is generally agreed to be actions and inactions by a trusted person who inflicts harm to an older adult.
• Elder abuse statistics are difficult to report because much abuse is unreported.

Several theories attempt to explain why elder abuse occurs.
Risk factors for elder abuse are at the individual, relationship, community, and sociocultural levels.
Diverse populations such as persons with memory impairments (dementia), those living in institutions, LGBTQ individuals, incarcerated seniors, Indigenous older adults, and Caregivers face unique challenges regarding elder abuse.

Reflective Questions
1. In Module 1, the concept of some older adults being at an increased risk for elder abuse is introduced. Are there other populations not listed that may be at an increased risk for elder abuse? What might some of the additional barriers be for these people with reporting elder abuse, or seeking required support?

2. Consider the implications of caregiver stress mentioned for non-professionals. How does this translate to caregiver stress for service providers (e.g. Health professionals)?
Module 2: Recognizing Elder Abuse

Upon completion of Module 2, LPNs will be able to

- identify forms of elder abuse; and
- recognize the warning signs and symptoms of elder abuse.

Introduction

Next to children, the elderly are the most vulnerable people in society. Many elderly adults are abused in their own homes, in relatives’ homes, and even in facilities responsible for their care. If it is suspected that an elderly person is at risk from a neglectful or overwhelmed caregiver or being preyed upon financially, it is important for LPNs to respond appropriately. Learning about the warning signs of elder abuse, what the risk factors are, and how elder abuse can be prevented and reported is critically important.

It may be difficult to recognize the signs of elder abuse. Signs may appear to be symptoms of dementia or signs of the elderly person’s frailty; caregivers may also explain them as symptoms of the individual’s physical or mental condition. Signs of abuse may also be detected through disclosure by the vulnerable person or observations of such things as the living environment, financial circumstances, family relationships, or the older adult’s communication with others.

Two important questions that are key in helping to recognize possible abuse situations are:

1. Why is this situation causing me concern? (Listen and watch for red flags.)
2. What am I observing? (Get facts; reflect on the situation to see how it fits with the definition of abuse).

Remember, abuse may present as a cluster of physical and behavioural signs. As well, an older adult might experience more than one type of abuse by the same person.

Forms of Elder Abuse

There are several forms of abuse that older adults may experience. Among the most common types of abuse are emotional and financial abuse.

It is important to understand that signs of abuse are often subtle. There may be multiple signs, symptoms, or indicators, which individually may not be “obvious” abuse, but when taken together raise concerns. It is also possible that what may be warning signs for abuse are from other causes such as early signs of dementia, physical or mental illness, sensory deprivation, limited functional ability, poverty, or even grief, to name a few.

Therefore, it is important not to jump to conclusions; however, it is equally important not to ignore or “explain away” the signs and symptoms. The signs and symptoms described below are not an exhaustive list and are intended to describe possible indicators of elder abuse.
Physical Abuse

Physical abuse is defined as the use of physical force that may result in bodily injury, physical pain, or impairment. In other words, physical abuse is any act of violence or rough handling that causes physical discomfort, pain, or physical injury.\textsuperscript{45}

\textit{Signs and Symptoms}

- Reports of physical assault (e.g. aggressive acts such as beating, pushing, shoving, hitting, slapping, poking, pulling hair, biting, pinching, or spitting)
- Inappropriate restraint using medications, belts, or ropes (e.g. cuts, finger marks, or other evidence of physical restraint)
- Unexplained falls and injuries
- Poorly explained, inconsistent, or unexplained injuries (e.g. bruising, burns, fractures, scratches, or lacerations)
- Delays in medical attention or seeking help at a variety of clinics to conceal the “why and how” of the injuries so the abuser is not discovered
- Malnourishment or dehydration without an illness-related cause
- Depression, fear, or paranoia
- Complete silence in the presence of certain people

Often, the alleged abuser will try to keep the abuse hidden. Signs of physical abuse may be subtle or covered by clothing. Statistics show it is often a family member who physically harms the older adult.

Medication Abuse

Both over medication and under medication are medication abuse, and both are harmful. Individuals caring for seniors may use medication to have them go to bed earlier or be more “cooperative” or easier to care for. Alternatively, seniors may also be under medicated due to prescription theft by family members, friends, or caregivers.

\textit{Signs and Symptoms}

- Reduced mental or physical activity
- Depression
- Heightened, reduced, or absent therapeutic response
- Prescriptions being filled too often or not being filled\textsuperscript{46}
- Excessive repeat prescriptions or usage of medications

Psychological or Emotional and Mental Abuse

Economic and Social Development Canada defines this type of abuse as “any action, verbal or non-verbal, that lessens a person’s sense of identity, dignity and self-worth.”\textsuperscript{47}

Emotional abuse attacks a senior’s feelings of self-worth or self-esteem. Use of verbal abuse such as taunts, threats, and put-downs or withdrawal of love and affection or emotional support over a period of time affects how a senior feels and is extremely harmful to his or her well-being.\textsuperscript{48}

\textit{Signs and Symptoms}

- Threatening violence, retaliation, or isolation (e.g. threatening to put the senior in a nursing home if he or she does not cooperate)
- Alienating the senior’s children, grandchildren, or friends (e.g. denying access)
• Withholding affection
• Removing decision-making power while the older adult is cognitively competent
• Not showing respect for belongings or pets
• Associated symptoms such as insomnia, fatigue, fear, withdrawal, depression, anxiety, nervousness, and low self-esteem
• Making jokes about habits, faults, and age disabilities
• Verbal abuse (e.g. name calling, insults)
• Changes in appetite
• Low self-esteem, acting withdrawn or passive
• Acting fearful or anxious
• Feeling guilty without cause
• Difficulty making decisions
• Difficulty sleeping or needing excessive sleep
• Decreased social interactions or being excluded from family gatherings
• Being overly familiar (e.g. the use of dear when that is not the senior’s preferred name)
• Treating senior as a child
• Ignoring wishes (e.g. choice of food, clothing, bathroom habits)
• Lying to the senior
• Silence or shunning
• Expecting senior to look after grandchildren when that task is beyond the senior’s physical and other capabilities
• Adult children moving home and/or living off senior
• Having a nervous breakdown or depression
• Threatened or attempted suicide (abuser); attempted suicide (senior)

Financial Abuse

Financial exploitation is abuse that is defined as “improper conduct done with or without the consent of the older adult which results in monetary gain for the abuser and/or a loss for the older person.”\(^{49}\) The abuser is typically a spouse or partner, family member (often adult child), caregiver, friend, or trusted person in the senior’s life. Financial abuse is often accompanied by other forms of abuse, such as emotional abuse, physical abuse, or denial of rights. Misuse of power of attorney and joint bank accounts are one of the main ways that financial abuse occurs.\(^{50}\)

Studies have shown that financial abuse is the most prevalent type of abuse reported. Often, those that are most likely to financially abuse older adults are relatives, friends, or neighbours, rather than close family members. Older adults found to be financially abused are generally single, somewhat isolated, and have health problems,\(^{51}\) where they increasingly rely on outside assistance.

Three components are typically necessary for financial abuse to happen:\(^{52}\)

1. Need or greed: the abuser is under financial pressure.
2. Opportunity: the abuser has access to funds or property.
3. False sense of entitlement: the abuser believes he or she deserves it or is owed.
**Signs and Symptoms**

- Theft of cash, credit cards, bank cards, or mail
- Cashing in RRSPs without the senior’s permission
- Using the senior’s bank card to withdraw cash (often large sums) without his or her knowledge
- Pressuring senior to give money to relatives or caregivers
- Overcharging the senior for small services
- Changes to a will or other financial documents
- Unpaid loans or repeated borrowing from the senior
- Using trickery or persuasion to get the senior’s money or possessions
- Taking or withholding the senior’s pension or insurance cheques
- Inability of the older adult to meet expenses
- Borrowing or taking the senior’s possessions without permission
- Selling the senior’s property or possessions without permission
- Forcing the senior to change his or her will or give power of attorney
- Misuse of power of attorney
- Refusing to pay the senior’s bills, rent, or mortgage
- Forging the senior’s name or altering a document
- Establishing a joint account and using the senior’s money without his or her knowledge or permission
- Stealing from the senior’s financial accounts
- Forcing the senior to sign over his or her property, such as a car or a house

**Neglect or Abandonment**

Neglect refers to the intentional withholding of care or the necessities of life.53 It can be categorized as intentional or unintentional. Intentional neglect is the deliberate withholding of care or the necessities of life, while unintentional neglect is when a care provider fails to provide proper care due to lack of knowledge, resources, information, experience, or ability. Neglect includes situations where an organization fails to provide services or necessary care for an older adult.

**Signs and Symptoms**

- Inadequate clothing
- Lack of hygiene
- Poorly maintained living environment
- Poor physical appearance (e.g. unkempt, malnourished, dehydrated)
- Lack of access to food
- Withholding nutrition or fluids
- Dehydration, malnutrition
- Untreated medical problems
- Withholding medical services, treatment, or health care needs
- Lack of comforts of living (e.g. radio, television, telephone)
- Insufficient medication
- Lack of necessary supervision (e.g. being left alone for long periods)
- Lack of safety precautions (e.g. railings or ramps)
• Leaving a person in an unsafe place
• Abandonment

**Sexual Abuse**

Sexual abuse is defined as “sexual behavior directed toward another individual without that person’s full knowledge or consent.” Sexual abuse can take place with a confused senior (e.g. with dementia) or confused residents in care facilities who may be approached by other vulnerable residents, a visiting spouse, partner, or friend, or a health care provider. Sexual abuse can also happen to competent seniors by spouses, partners, family members, or trusted people in their lives.

Sexual abuse includes coercing an older person through force, trickery, threats, or other means. Unwanted sexual activity, such as verbal or suggestive behaviour, fondling, or lack of personal privacy, is also sexual abuse.

**Signs and Symptoms**

• Indecent exposure or voyeurism
• Verbal or suggestive behaviour
• Lack of personal privacy
• Physical indicators such as pain, bruising, or bleeding from the genitals
• Disclosures of strange encounters with unknown persons
• Strong reactions to discussing sexual abuse
• The abuser sharing pornography or telling “dirty” stories
• The abuser providing unnecessary help with dressing or hygiene

**Additional Abuse Indicators**

The abused older adult may exhibit any of the following:

• A history of repeated incidents of unexplained accidents or injuries
• A medical history that does not coincide with presenting injuries
• Seeking medical attention from a variety of doctors (i.e. “doctor shopping”)
• Postponing seeking medical attention
• Frequent use of emergency department
• Prolonged delay between time of injury and presentation for treatment

Raising the subject of abuse is not easy, but it is necessary. When alerted to the potential of elder abuse, it is important to follow agency protocols and legislated reporting requirements (discussed further in Module 3). Unless it is known that there is another reason for the observed signs or indicators, abuse must be considered as a possibility.

**Key Points**

• There are various forms of elder abuse identified by possible indicators.
• Each form of abuse has associated signs, symptoms, or indicators.
• The most common types of abuse are emotional and financial.
• LPNs are in a position to be entrusted with information about abuse.
Reflective Questions

1. There are many signs and symptoms of elder abuse. Have you encountered this in your practice? How did you respond? How do you plan to respond if you encounter this?

2. The most common forms of abuse are emotional and financial; therefore, the signs may not always be visible. How might an LPN discover abuse is taking place for a client, given this knowledge? How does this impact the way in which you interact with your clients?
Module 3: Responding to Elder Abuse

Upon completion of Module 3, LPNs will be able to

- describe how the nursing process is used to identify and respond to elder abuse;
- apply accurate documentation when recording elder abuse;
- state how the United Nations Principles for Older Persons apply to elder abuse;
- recognize guiding principles for health professionals responding to elder abuse;
- outline disclosure barriers for health care providers and older adults;
- describe possible strategies that support disclosure of abuse;
- discuss how standardized assessment tools support disclosure;
- explain why a safety plan may be necessary; and
- discuss the role of law enforcement personnel in elder abuse.

Introduction

Module 2 provided information on recognizing the signs and symptoms of elder abuse; Module 3 will focus on responding to elder abuse using the nursing process as a guide. The importance of clear and precise documentation will also be discussed. Older adults often feel hesitant to disclose abuse, so this module discusses appropriate strategies to help support disclosure. Finally, this module covers the development of a safety plan and tips for liaising with law enforcement personnel and other agencies.

Nursing Process

Clients who present with injuries or signs of abuse should be assessed, treated, and appropriately referred. An LPN may find it helpful to use the nursing process as a framework to assess the possibility of abuse and when abuse has been identified. The nursing process is an organized, systematic approach used by nurses worldwide and is integral to nursing. This humanistic process consists of five phases—assessment, diagnosis, planning, implementation, and evaluation—and considers the unique interests, values, and desires of the client,
family, and community. The nursing process is recognized as the foundation for professional nursing practice and provides the professional nurse with a framework for decision making and problem solving in everyday practice and situations. It is a decision-making approach that promotes critical thinking and clinical judgment in nursing.\(^5^8\)

**Assessment**

The signs and symptoms of abuse can be subtle and difficult to identify, as they may be attributed to other causes such as chronic diseases, mental status, or age.\(^5^9\) In the assessment phase, the nurse collects and examines information about the client’s health status and evidence of abnormal function or risk factors that may contribute to health problems. Evidence of client strengths is also assessed.

Fulmer and Cacres state that the assessment process should include collecting information in three areas: violence screening; physical assessment of the client and his or her environment; and risk assessment.\(^6^0\) They believe it is important that these three areas of abuse are explored because this determines potential and actual abuse.

Risk assessment involves identifying the known risks and their magnitudes. Further research infers that an older adult at high risk for abuse is most likely currently experiencing abuse. In addition, the exploration of an older adult’s spirituality and how he or she feels about life in general may reveal some form of abuse.\(^6^1\)

When assessing for violence, direct questions are used to find out about neglect and emotional, physical, and sexual abuse. A physical examination requires a health assessment for unexplained bruises, sores, untreated injuries, and other issues such as substandard hygiene and inadequate nutrition or hydration. Bruising may appear in obvious locations (e.g. face, neck, abdomen, buttocks, and chest), indicating non-accidental injury. The marks and swelling may also display a specific pattern indicating the instrument used (e.g. fist, fingers, knuckles, or multiple straight lines representing a stick).

**Assessment Tools**

Many standardized assessment tools and protocols for screening for elder abuse by health care professionals have been developed. Most have been created for use in hospitals, clinics, or home care. Although all are directed toward identifying elder abuse, they have key differences in the focus, format, structure, and type of data gathered. Physicians play a key role in identifying elder abuse and in promoting awareness. The American Medical Association recommends that all geriatric clients receive elder abuse screening, and multiple researchers have recommended screening to help prevent and detect elder abuse. A universal screening tool for elder abuse does not exist.\(^6^2\) It is important to understand that a positive screen for elder abuse does not automatically mean abuse is occurring, but it does indicate more information should be gathered.

Some examples of Screening Tools include:

- **Elder Abuse Suspicion Index** (EASI) – used mainly by Physicians
- **Elder Assessment Instrument** (EAI) – for use in all clinical settings
- **Indicators of Abuse** (IOA)

If a health care professional is not required to use a standardized assessment tool, there are assessment questions available. For example, Alberta Health has developed a list of possible screening questions:\(^6^3\)

- Is there something you would like to share with me?
- How is everything going for you?
• Is someone making you feel unsafe?
• Is someone asking or forcing you to do things that you do not wish to do?
• Is someone refusing to assist you when you need help?
• Are you afraid of someone?
• Have you been asked to sign documents that you do not understand?
• Has someone hurt you?
• Who makes decisions about your life, such as how or where you will live?
• Would you like some help with __________?
• It must be hard for you to look after __________.

If elder abuse is disclosed, whether by a formal assessment tool or by screening questions, the nurse may be involved with the development of a safety plan. Typically, a multidisciplinary and collaborative approach is used to effectively address incidents of elder abuse and corresponding interventions.

**Nursing Diagnosis (Problem Identification)**

LPNs are required to demonstrate knowledge and ability when applying critical thinking and critical inquiry to generate nursing diagnoses using data from comprehensive holistic assessments.64

- Identify actual and potential concerns/health issues.
- Research and validate components of client issues and concerns.

The data or health information is analyzed to determine actual and potential problems, which form the basis for the plan of care. Noting the client’s strengths is also essential when developing an effective plan. An example of a nursing diagnosis for a client who may be at risk for low self-esteem would read as follows: Client is “vulnerable to developing a negative perception of self-worth in response to a current situation, which may compromise health.”65 The LPN is responsible for documenting the nursing diagnosis, expected outcomes and for communicating the nursing diagnosis with the client, family, and other caregivers as appropriate (keeping in mind privacy and confidentiality considerations).

**Planning**

There are basic steps within the planning phase. Immediate priorities are established for nursing and interdisciplinary problems, including problems that may be delegated. Expected outcomes or goals are then confirmed within specific time frames, and the interventions or nursing actions are assigned to the problems. The individualized plan of care is also recorded for each client. LPNs are responsible for communicating expected outcomes and the plan with the client, family, and others as appropriate.

**Implementation**

The implementation phase involves nursing actions or interventions that are assigned to problems. However, before the plan of care is implemented, there may be new problems that require immediate attention and a change in the plan. The nurse reports and records appropriate nursing actions.

**Evaluation**

Although evaluation often happens covertly throughout the nursing process, it is crucial to determine whether outcomes have been achieved, whether interventions were effective, and whether changes are required for the plan of care in the final phase.66 The nursing process has been compared with the scientific method of solving problems.
The steps are similar in the two approaches because they proceed from identification of the problem to evaluation. One difference, though, is that the scientist first identifies the problem and then collects the data, while the nurse collects the data first and then identifies the problem.67

The nursing process is an effective framework for managing elder abuse. Comprehensive assessment skills, accurate documentation, and careful evaluation of the client is the LPNs professional responsibility.

Screening for elder abuse may take any or all of the following forms:

- Psychiatric concerns/psychiatric assessment
- Cognitive screening
- Physical assessment
- Referrals to appropriate programs, assessments, and services
- Patient and family teaching
- Communications with other health professionals/health teams

Note: If suspected abuse has been identified or you suspect the person is susceptible to more harm, call 911.

**Applying Accurate Documentation Principles**

Documentation allows LPNs to communicate about the care they provide. Proper documentation can lead to the protection of a client. LPNs are required to demonstrate the knowledge and ability to ensure accurate, concise, and complete documentation.68 A client’s health record is a legal document that records health issues and progress.69 Employers have policies and procedures for accurate documentation as part of health care standards. Documentation of elder abuse can be considered an adverse or critical event that requires special care and attention. Documentation has both clinical and legal implications and may be read by police, investigators, and professional regulatory organizations and may be required for court (e.g. cases of criminal charges).

Physical assessment findings should be clearly described using photographs and diagrams if possible.70 The nurse should record direct quotes from the victim and alleged abuser; using quotes and a “facts only” approach avoids judgmental and opinion-based notes and value statements. It is important to include information about notification of supervisors and their responses. Always adhere to agency policy regarding consent and collection of assessment findings.

Referrals and follow-up with community agencies and services should also be documented. Many community partners such as churches and religious organizations play significant roles in supporting an abused older adult. In most situations, consent or permission must be received and documented before acting or disclosing any personal or health information.71 The LPN is responsible for seeking guidance if he or she is unclear about the type of information that can be collected, disclosed and to whom. See Modules 3 and 4 for more information regarding confidentiality and key legislation.

Outcomes of nursing actions are an area that is often not documented. It is important that documentation is completed in a chronological manner with the correct dates, times, and signatures according to employer policies and procedures.72 The LPN is responsible for seeking guidance if there is any question about appropriate actions to take.

The nursing process establishes the plan of care, while accurate documentation keeps a
record of the events involving elder abuse. It is important to remember notes and any documented information, either in writing or electronically, may be considered evidence for admission into court or regulatory proceeding. Clear, concise and accurate documentation is essential. For more information about Documentation, access CLPNA self-study module – Nursing Documentation 101.

The Canadian Centre for Elder Law has created a documentation tool that can be used to document abuse or neglect of an older adult. It can be accessed online at the Canadian Centre for Elder Law by clicking on “Publications.” Counterpoint Charting Sheet

Principles for Interacting with Older Adults

The key to interacting with older adults is acknowledging the dignity of all human beings and their right to live in safety and security while at the same time experiencing a healthy quality of life. The United Nations outlines five principles for working with older adults:

- **Independence**: Older adults should have access to food, water, shelter, clothing, and health care and be able to participate in meaningful work. They should have access to education and training and should be able to live in a safe environment and in their own homes as long as possible.

- **Participation**: Older adults should be able to remain integrated in their society and participate in community service and form associations.

- **Care**: Older adults should be able to benefit from family and community care and social and legal services and should be able to make use of appropriate levels of safe institutional care. They should have others’ full respect for their dignity, beliefs, needs, and privacy and should have the right to make decisions about their care.

- **Self-fulfillment**: Older adults should be able to pursue opportunities for the full development of their potentials and access to the educational, cultural, spiritual, and recreational resources of society.

- **Dignity**: Older adults should be able to live in dignity and security and be free from exploitation and physical or mental abuse. They should be treated fairly, regardless of age, gender, racial or ethnic background, disability, or other status and be valued independently of their economic contribution.

Awareness of the United Nations Principles for Older Persons contains underlying ideologies for anyone who interacts with older persons. These principles facilitate the approach of “person-centered care,” which means that the older adult’s values and preferences are elicited and then used to guide all aspects of his or her health care.
Recognizing and responding effectively to matters involving elder abuse requires ongoing competence. To increase understanding, the Canadian Centre for Elder Law developed guiding principles to help professionals and volunteers understand and effectively respond to the rights of older adults who are abused, neglected, or at risk:

- **Talk to the older adult; ask questions.** Talk to the older person about his or her experience. Help the person identify resources that could be helpful.

- **Respect personal values.** Respect the older adult’s personal values, priorities, goals, and lifestyle choices. Identify support networks and solutions that suit the older adult’s individuality.

- **Recognize the right to make decisions.** Mentally capable older adults have the right to make decisions, including choices others might consider risky or unwise.

- **Seek consent or permission.** In most situations, an older adult’s consent is required before acting.

- **Respect confidentiality and privacy rights.** Get consent before sharing another person’s private information, including confidential personal and health information.

- **Avoid ageism.** Prevent ageist assumptions or discriminatory thinking based on age from affecting your judgment. Avoid stereotypes about older people, and show respect for the inherent dignity of all human beings, regardless of age.

- **Recognize the value of independence and autonomy.** Where this is consistent with the adult’s wishes, assist the adult in identifying the least intrusive way to access support or assistance.

- **Know that abuse and neglect can happen anywhere and by anyone.** Abuse and neglect of older adults can occur in a variety of circumstances from home care to family violence.

- **Respect rights.** An appropriate response to abuse, neglect, or risk of abuse or neglect should respect the legal rights of the older adult while addressing the need for support, assistance, or protection in practical ways.

- **Get informed.** Ignorance of the law is not an excuse for inaction when someone’s safety is at stake. If you work with older adults, you need to educate yourself about elder abuse.

LPNs are often key providers of care to older adults and are in unique positions that allow older adults to disclose information. Through
interactions such as health assessments, dressing changes, and overall communication with older adults, LPNs may detect abuse. LPNs can use these principles to increase their individual competence in dealing with elder abuse or suspicion of elder abuse.

**Barriers to Disclosure**

Both older adults who are experiencing abuse and care providers may be reluctant to disclose elder abuse. There are many reasons why care providers may be hesitant to disclose abuse. The following list provides information on why care providers or clinicians may fail to screen for and/or disclose elder abuse:

- Lack of knowledge about the criminal nature of abuse and how to proceed
- Unfounded legal concerns, including mandatory reporting requirements
- Reluctance to become involved and perhaps to become a potential witness
- A sense of powerlessness in the belief that change is not possible
- Fear of offending the older adult
- Minimization and denial
- Fear of the abuser
- Concerns about time constraints and increased workload
- Concerns about breaching confidentiality
- Concerns about being wrong about the situation
- Concerns about having lack of ample proof to make a report

Ignoring the problem will not only place the older adult in continued jeopardy but will also result in increased time spent on repeated health visits and treatment of the adverse impacts of the abuse.

There are several possible reasons why an older person may not disclose abuse or neglect:

- Does not recognize the situation as abusive
- Does not know where to get help
- Feels humiliated (believes he or she should be able to control or stop the abuse)
- Takes blame for the abuse
- Fears a loss of connection to family or relatives
- Is not cognitively aware
- Denies the abuse is occurring
- Is afraid that by disclosing, the abuse will escalate (e.g. destruction of personal property, injury to pets, or increased physical harm, even death)
- Does not think people will believe him or her
- Pride—wants to maintain autonomy and not admit vulnerability
- Fears dependency and poor care
- Feels shame, embarrassment, and humiliation (especially if sexual abuse is involved or he or she has been a victim of a monetary scam)
- Wants to protect relatives (e.g. adult children) from possible prosecution or public censure
- Has cultural boundaries that prohibit talking about this situation outside the family
• Believes in responsibility and loyalty to family first, not to oneself
• Feels disgraced that children/relatives would treat him or her this way
• Does not want to initiate legal action
• Believes he or she is being “paid back” for earlier behaviour in life
• May believe institutionalization is the only other option and wants to avoid that outcome (i.e. solution to the problem is worse than the problem)
• Is trapped in a cycle of isolation and intimidation—learned helplessness, resignation, hopelessness, depression, psychological decline
• Has grief over loss of physical function and role in family
• Has a sense of worthlessness that he or she is a burden to others and cannot expect any better
• Fears losing any benefits of the relationship with the abuser, especially in situations of financial or physical dependence
• Has a strong ethic of privacy—believes he or she should be able to solve his or her own problems (not “air dirty laundry in public”) 
• Has a history of abuse, and disclosing led to an unpleasant outcome
• Lack of evidence—fears he or she will not be taken seriously or that reporting will be a waste of time
• Is unable to communicate clearly because of a hearing or speech impairment or lack of fluency in English

Did you know? You, as an LPN, are professionally obligated to report concerns of elder abuse
• anytime abuse comes to your attention;
• anytime a senior reports it to you; and
• anytime you observe it
Call 911 if you believe your client has been harmed or at risk of being harmed.

Strategies that Support Disclosure
Although both care providers and older adults may be reluctant to disclose elder abuse, Alberta Health outlines several strategies that support disclosure of elder abuse from older adults:

• Ask the senior questions alone in a safe location.
• Develop a trusting relationship, and be sensitive to the senior’s culture, language, religion, and comfort level when disclosing.
• Ask the senior if you can gather information about his or her situation.
• Let the senior know that the information is confidential, but if he or she is in danger, the appropriate authorities will be contacted.
• Note anything about the senior that may be indications of abuse.
• Identify what information is necessary to assist the older adult or, if necessary, the police.
• Be aware that there is a potential for misuse of power by a health care professional when the senior is in a dependent role.
• Consider the impact, the willingness to change, and the ability to recognize abuse.

• Ensure that the senior is aware that speaking out may incur legal consequences; generally, seniors do not want to see the abuser punished, but rather they want the abusive behaviour to stop or change.

• Note the senior’s ability to understand information and consequences and the ability to follow through on decisions.

• If there is no one the older person trusts, the Alberta Office of the Public Guardian and the Office of the Public Trustee may be able to assist.

Additional strategies for approaching a discussion with an older adult may include the following:

• Choose a comfortable environment.

• Do everything possible so that the conversation will not be overheard or interrupted.

• Be mindful of hearing difficulties, language barriers, and cultural and religious values.

• Maintain a relaxed, nonjudgmental, and supportive environment.

• Talk less and listen more, and allow the older adult to set the pace of the discussion.

• Notice inconsistencies and discrepancies in the older person’s reporting.

• Allow time for responses.

• Avoid comments that minimize or downplay actual or suspected abuse.

• Offer support and discuss options but do not give advice.

Possible Interview Questions

Open-ended questions will allow the older adult to share information, and the following examples can be used as a tool to get the conversation going.

• How is everything going at home?

• Has anyone at home ever hurt you?

• Do you feel safe? Is there something that you would like to share with me?

• Has there been a recent incident that has caused you concern? Tell me about it.

• Has anyone ever tried to take advantage of you?

• Has anyone ever pressured or forced you to do things you did not want to do?

• Do you make decisions for yourself or does someone else make decisions about your life, such as how or where you should live?

• Are you alone a lot? Has anyone ever failed to help you take care of yourself when you needed help?

• Are you afraid of anyone?

• Would you like some help with ________?

• It must be hard for you to look after ________.

Make note of the following points:

• Are there any inconsistencies (e.g. vague explanations)?

• What are the person’s wishes? What do they understand and appreciate about what is happening?
Is any important information missing (e.g. frequency of abuse, duration, urgency, need for physical examination)?

**Important messages for victims of abuse**

It is important for the older adult to receive key messages relating to the abuse they are experiencing to help clarify their thoughts and make decisions about safety.

- Abuse at the hands of another person can happen at any age. It is never acceptable.
- Abuse does not stop on its own. If it is ignored, it will continue, and may even get worse.
- You can take actions on your own and with the help of others – end the abuse.
- You have the right to have control over your life.
- Abusive behaviour is not healthy for your or for the abuser.

**Safety Plans**

Depending on the severity and form of abuse, a safety plan may be necessary. For immediate danger, call 911 or the local police. The older person should have a plan of what to do and a place where he or she can go in an emergency. It is advisable for the older adult to assemble a travel bag that contains identification papers (or copies), medications, a change of clothes, copies of house and vehicle keys, cash, and other important documents. The LPN should encourage the senior who is experiencing abuse to have contact with trusted family and friends. If the older adult is in denial of the abuse, the nurse should keep the lines of communication open and respect the client’s decisions.

Elder Abuse Ontario reinforces the need for safety planning for older adults. They describe a safety plan as “an outline of actions that an older adult can put in place and follow to increase their safety. An older adult may be at risk from one or several different types of abuse from a caregiver or family member. A safety plan includes steps and strategies to help keep an older adult safe if they are in an unhealthy relationship. They can use the plan to prepare in advance for the possibility of (further) violence, as well as during or after a crisis.”

In other words, a safety plan is a plan of action to help someone protect themselves from abuse. It includes steps for improving safety and strategies for responding to or escaping abusive behaviour when it happens. Safety planning is not a guarantee of safety, but it can help the older adult feel more confident and in control and reduce stress and fear.
Approach to Safety Planning

Safety plans need to be practical and realistic, taking into account the person’s strengths as well as his or her need for support. Emotional safety and well-being can be as important as physical safety. When talking to an older person about safety planning, it is important to be supportive.91

- Listen and give assurance that you will maintain confidentiality.
- Provide reassurance that he or she is not at fault and that no one deserves abuse.
- Encourage positive self-esteem and assertiveness.
- Let the older person know he or she is not alone and that help is available, and provide information about how to get it.
- Provide information about help available for the abuser, such as drug and alcohol or mental health services.
- Inform the older person about the support you can offer now and in the future, and follow up as agreed.
- When necessary, refer the older adult to agencies or other health care providers that can encourage and support him or her to work through a plan (or develop his or her own).

In reality, there is an unrelenting need to break down the barriers and continue the conversation about this critical issue, and planning is an important part of the conversation.92

Confidentiality and Reporting

Disclosure of elder abuse is a moral and ethical responsibility. However, the security and confidentiality of information is a sensitive area. According to the Freedom of Information and Protection of Privacy Act, anyone who collects personal information and considers the disclosure or communication of this information to be in the best interests of the person may have to disclose.

The general rule is that disclosure of a person’s confidential information requires the person’s consent. However, there are exceptions to the rule. In Alberta there are several key pieces of legislation that govern confidentiality and reporting of abuse. For example, when it comes to reporting, the Protection of Persons in Care Act (PPCA) states:

Every individual who has reasonable grounds to believe there is or has been abuse involving a client [who receives care or support services from a hospital or lives in a care facility] shall report that abuse:

- (a) to a complaints officer,
- (b) to a police service, or
- (c) to a committee, body or person authorized under another enactment to investigate such abuse.93

Committees, bodies, or persons authorized to investigate abuse include regulatory bodies governing professionals under the Health Professions Act (e.g. CLPNA).

Every service provider or individual employed by or engaged for services by a service provider who provides care or support services to a client has a duty
(a) to take reasonable steps to protect the client from abuse while providing care or support services, and
(b) to maintain a reasonable level of safety for the client.⁹⁴

Reporting abuse is a professional obligation for LPNs.

When an LPN has reasonable grounds to believe there is or has been abuse involving a client, he or she is required to report that abuse as soon as possible.⁹⁵ There are four options for reporting abuse:⁹⁶

- The Protection for Persons in Care office
- The police
- A professional regulatory body, when the incident involves a health professional (e.g. CLPNA, CARNA, CPSA, etc.)
- A mental health patient advocate, if the client is or was under an admission certificate or subject to a community treatment order at the time the alleged abuse occurred

According to PPCA, clients are not required to report abuse they have experienced unless they choose to do so. If a client decides to report abuse, they must make that report no later than two years from the date the alleged abuse occurred.⁹⁷

Employees who notify the appropriate person or organization about concerns of abuse under the Protection for Persons in Care Act (PPCA) are legally protected from adverse action in the workplace.⁹⁸ Employers cannot fire or discipline an employee for notifying the appropriate authority about a reasonable belief of abuse.

PPCA does not cover older adults in every situation. A major limitation of adult protection legislation such as the Protection for Persons in Care Act is that it only addresses incidents of abuse in publicly funded care facilities and does not extend to abuse of older adults in the community or nongovernment-funded facilities. Publicly funded service providers include agencies such as: hospitals, seniors’ lodges, nursing homes, mental health facilities, shelters, group homes, addictions treatment centres, many settings funded by the Persons with Developmental Disabilities program, and other supportive living settings.⁹⁹ For more information, check out this section of the Alberta Health website.

Did you know? Licensed practical nurses are accountable for their practice and responsible for ensuring that their practice and conduct meet both the standards of the profession and legislative requirements.¹⁰⁰

The LPN is expected to take reasonable steps to protect the client from abuse and maintain a reasonable level of safety for the client. As well, the LPN is expected to take all reasonable steps to provide for the immediate safety, security and well-being of all clients when notified that a report of abuse has been made.

For more information about LPN professional accountability and responsibilities, see the Code of Ethics and Standards of Practice for Licensed Practical Nurses in Canada. Also see CLPNA’s Practice Policy – Professional Responsibility and Accountability.

Module 4 identifies several additional key pieces of legislation LPNs should familiarize themselves with. In addition to adhering to applicable legislation, LPNs must always consult employer policies, protocols, and legislative acts. Always seek guidance as needed.
The Role of the Police

At times, it may be necessary to also involve the police for protection of older adults. Abuse of older persons is considered a form of family violence. Police forces across Canada are being educated and trained in elder abuse and are prepared to assist both the abused older adult and the alleged abuser. The National Committee for the Prevention of Elder Abuse (NCPEA) advocates that police, sheriffs, prosecutors, and courts hold perpetrators accountable for their actions.\textsuperscript{101} This sends a clear message that society does not tolerate the victimization of its most vulnerable members. The NCPEA advocates that law enforcement personnel perform the following tasks:

- Arrest, prosecute, and incarcerate abusers
- Enforce restraining orders and perform well-being checks
- Provide assistance to other professionals to investigate and intervene
- Supervise perpetrators and ensure they receive the required services

Some of the abuse may be criminal in nature, and the abuser will be charged according to the law. The judicial process may mandate that an abuser attend programming such as mental health treatment, rehabilitation, or counseling to prevent future occurrences. Prior to this, the police will interview the older person and others who have evidence about the event(s). The alleged abuser may also be interviewed. Even if there are no criminal charges laid, the police may assist in connecting seniors to various community supports.\textsuperscript{102}

To better understand how police services respond to elder abuse, review the document called \textit{Elder Abuse Police Guidelines}.

Reconnecting

When the abuse has stopped or has been curtailed, it is important that, when possible and where appropriate, the nurse continues to support the older person. Once a trusted relationship has been established, the nurse is in a unique position to provide emotional support and information about programs and services that may be available in the elder’s community. There are many resources (see Module 5) that enable nurses and older adults to recognize, respond to, and prevent elder abuse.

Key Points

- The nursing process is a framework for creating a plan of care when responding to elder abuse.
- Accurate documentation of elder abuse requires a “facts only,” or objective, approach.
- Documentation of elder abuse may be reviewed by the police or judicial system, regulatory bodies, or other agencies.
- Both health care professionals and older adults may experience barriers to disclosing abuse.
- LPNs are mandated professionally and under the Protection for Persons in Care Act to report abuse.
- There are many possible strategies that support disclosure of abuse.
- Health care professionals may use standardized assessment tools or screening questions to assist in disclosure of abuse.
- A safety plan may be necessary for an abused older adult and depends on the type and severity of the abuse.
• Law enforcement personnel may be involved in protecting the senior from the abuser.

• Ongoing support and continuing the professional relationship may assist an older adult in coping with past or current abuse.

**Reflective Questions**

1. Module 3 discusses some of a client’s barriers to reporting. If you discovered elder abuse was taking place, what may be some concerns or perceived barriers you have about reporting?

2. Consider all of the options available to you for reporting or seeking support and information related to elder abuse: the police, PPIC, your agency, another agency, a practice supervisor, your regulatory College. Do you have a plan for reporting or consulting regarding elder abuse? What information guides your actions?
Module 4: Preventing Elder Abuse

Upon completion of Module 4, LPNs will be able to:

- identify elder abuse prevention strategies in developed countries;
- state three interdisciplinary sectors that take the lead role for dealing with elder abuse;
- define mental capacity and consent and their relationship to elder abuse;
- identify Alberta legislation related to elder abuse and protection of health and personal information;
- discuss the role of education in prevention of elder abuse; and
- explain how World Elder Abuse Awareness Day assists in awareness and prevention of elder abuse.

Introduction

Prevention of elder abuse begins with awareness. Using the knowledge and strategies from the previous modules, an LPN will be able to advocate for the prevention of elder abuse. This module includes information about how interdisciplinary collaboration among social services, education, and health prevents abuse. Nurses also need to be mindful of legal considerations and understand the role of education in minimizing and preventing abuse.

Strategies for Preventing Elder Abuse

The World Health Organization (WHO) has taken a leading role in identifying a variety of strategies for the prevention of elder abuse in developed countries. Community projects have increased the awareness of abuse and reduced ageism. Health care services have provided education and training for care providers to recognize and respond to elder abuse. Programs and services have also been designed and implemented for the abused older adult and the perpetrator.

The following strategies have been employed to prevent and act on elder abuse:

- Public and professional awareness campaigns
- Screening of potential victims and perpetrators
- School-based intergenerational programs
- Care-provider support programs that include stress management and respite care
- Institutional care policies that define and improve standards of care
- Care-provider education and training on dementia and other gerontological topics
Efforts to respond to and prevent further abuse include interventions such as the following:\textsuperscript{104}

- Mandatory reporting of abuse to authorities
- Self-help groups
- Safe houses and emergency shelters
- Psychological programs for perpetrators
- Help lines to provide information and referrals
- Care-provider support

Evidence for the effectiveness of these interventions is limited at present. However, care-provider support after abuse has occurred reduces the likelihood of its reoccurrence.\textsuperscript{105} School-based intergenerational programs have shown some positive outcomes because they aim to decrease negative societal attitudes and stereotyping of older adults. Care-provider support before abuse occurs and professional awareness of the problem have been shown to have success in preventing abuse.\textsuperscript{106}

Interdisciplinary collaboration among social services, education, and the health sector is aimed at preventing and reducing elder abuse. This is possible through

- the social services sector and the provision of legal, financial, and housing support;
- the education sector using public education and awareness campaigns; and
- the health sector through the detection and treatment of victims by primary health care workers.

In some countries, the health sector has taken a leading role in raising public

Awareness of elder abuse, while in others, the social services sector has taken the lead. Globally, too little is known about elder abuse and how to prevent it, particularly in developing countries. The scope and nature of the problem is only beginning to be explained and the evidence for what works to prevent elder abuse is often limited.\textsuperscript{107} However, in most provinces in Canada, there are legal considerations that assist to prevent and mitigate elder abuse.

**Elder Abuse and the Law**

In Alberta there are several legal considerations that work to prevent and mitigate elder abuse. This section outlines some general information LPNs need to know about laws that apply to elder abuse in Alberta.

**Mental Capacity**

Older persons who both have and lack mental capacity face the potential for abuse. Mental capacity, also called capacity, is an individual’s ability to make decisions that may have legal or other consequences.\textsuperscript{108} Legal definitions may vary; however, *mental capacity* is often defined as the “ability to understand and appreciate the nature and consequences of one’s decisions.”\textsuperscript{109}

All adults (those who are 18 years and older in Alberta) are presumed to have legal capacity unless established otherwise. Non-capacity (sometimes called incapacity) and capacity are established by medical opinions or a judge’s decision.\textsuperscript{110} A lack of capacity could affect a person’s ability to access support or assistance.\textsuperscript{111} Capacity is also relevant to whether a person can provide informed consent to supportive interventions.\textsuperscript{112}
Capacity of an older person may be influenced by the following:\[113\]

- A medical condition such as infection or malnutrition, which may cause memory impairment
- Stress or anxiety in challenging circumstances or events; for example, the death of a close family member or a sudden move to an alternate living arrangement
- Effects of medications, inappropriate use of medications, or refusal to take medications
- Exhaustion and the time of day—seniors who are fatigued, particularly late in the day, may not be able to use appropriate judgment and reasoning when making decisions
- Diabetes and blood glucose levels—fluctuating blood sugar levels can cause an older person to have irrational behaviour and be unable to make appropriate decisions
- Alcohol and recreational drugs—alcohol and drug use impair judgment and memory

LPNs should be alert to signs that an adult is incapable and might benefit from access to additional support or assistance. LPNs assess capacity as part of their nursing practice, even when he or she is not participating in a formal capacity assessment or legal process related to determining capacity.

More information on personal directives in general and capacity assessments specifically is available at the following link: http://www.humanservices.alberta.ca/guardianship-trusteeship/personal-directives-how-it-works.html

Consent

LPNs have a professional obligation to seek consent to contact others. Consent means giving someone permission to do something that impacts you. The adult who is giving consent must have the mental capacity to understand and appreciate the consequences of his or her decision. If an adult is legally incapable, consent must be obtained from the guardian or substitute decision maker. Otherwise, consent is not valid.\[114\]

Consent can be expressed verbally or in writing. It can also be implied in a person’s behaviour.\[115\]

A suggested resource pamphlet can be accessed online through the Canadian Centre for Elder Law: https://www.bcli.org/publication/counterpoint-brochure-mental-capacity-and-consent

Legislation

*This information is not legal advice. The law is always changing, and this is a summary of key legislation only. February 2018.*

There are several laws, both federal and provincial, that apply to elder abuse. The overall options and obligations regarding elder abuse depend on the relationship between the various laws and the specific circumstance of abuse. For example, there are laws for nurses and other health care providers about maintaining the confidentiality of an older adult’s health and personal information, and there are different laws that pertain to reporting abuse. The following acts are some examples that relate to the prevention of elder abuse and protection of an older person’s information.

Powers of Attorney Act

The Power of Attorney (POA) is a legal document that enables one person to give another person the authority to deal with
their property and financial affairs. A person must be mentally competent to grant a POA, recognizing that it does not come into effect until they have lost capacity.

This act makes provision for a legal document that gives another adult (or attorney) the authority to handle an older adult’s financial affairs indefinitely or for a predetermined length of time. The legal document is called an enduring power of attorney (sometimes called durable power of attorney) when it is not terminated by the mental incapacity of the older adult. For example, when one individual has exclusive control of finances, there is always the potential for financial abuse and mismanagement of funds, particularly if the older adult lacks capacity.

**Personal Directives Act (Alberta)**

A Personal Directive is a legal document that provides seniors and older adults with the means to plan for the time when they are incapable of making personal decisions for themselves.

A personal directive is like a living will, which outlines end-of-life wishes, but it is broader. A personal directive can be about all health care decisions: where you live, the activities you take part in, etc. This act, by way of a legal document, permits one or more trusted individuals to make decisions, other than financial, when an older adult is unable to do so because of illness or injury. A personal directive contains decisions on health care and medical treatments, social or recreational choices, and future living arrangements. There is the potential for elder abuse if the decision maker does not follow instructions in the personal directive.

**Mental Health Act (Alberta)**

This legislation was enacted to provide safeguards, supports, and supervision for mentally ill individuals. The Mental Health Act (MHA) allows for involuntary detention and treatment under certain circumstances. For example, if an older adult is being abused by someone who has a mental disorder, the police can remove the senior. There are rights set out under the MHA, such as appealing to a review panel, relating to people who are under the MHA.

**Protection Against Family Violence Act (PAFVA)**

This law is to provide assistance to victims of family violence and provides protection to Alberta’s family members against family violence including threats, stalking, damage to property, not allowing a family member to leave the home, and physical and sexual abuse. This legislation also grants law enforcement personnel the legal tools to obtain protection orders, and identify and assist individuals who may have been victims of family violence. There are two kinds of protective orders that are available under the PAFVA: 1) emergency protective orders; and 2) Queen’s Bench protection orders. These protective orders are used to keep the abuser away. The law prevents contact between an abuser and others (seniors, women, men, and children) who reside together or apart.

**Protection for Persons in Care Act (PPCA)**

The PPCA is Alberta-specific legislation designed to improve protection for adults receiving government-funded care or support services through the prevention of abuse. In addition, the act requires reporting of abuse and independent reviews of reports of abuse. The PPCA requires that every individual who has reasonable grounds to
believe there is or has been abuse involving a client report that abuse as soon as possible.\textsuperscript{125}

\textit{Alberta Guardianship and Trustee Act (AGTA)}

The AGTA contains provisions that offer protection to vulnerable adults who may want assistance or are no long able to make financial or personal decisions. The AGTA provides decision-making options for health care providers, physicians, clients, and their families to ensure that consent for health care is obtained from the appropriate decision maker(s). AGTA decision-making options require the use of regulated forms. The Office of the Public Guardian and Trustee provides services to help all Albertans, including seniors, plan for the future if decision-making support is needed. These provisions prevent unauthorized individuals from making decisions and potentially abusing elders.\textsuperscript{126} For further details around what the AGTA is, please visit the Office of the Public Guardian and Trustee, which administers the AGTA.

\textit{Health Information Act (HIA)}

This act establishes the rules that must be followed for the collection, use, disclosure, and protection of health information in the health sector that is in the custody or under the control of a custodian. Examples of custodians include Alberta Health, Alberta Health Services, Covenant Health, physicians, pharmacists, registered nurses, and dentists. The HIA strikes a balance between the protection of privacy and enabling the appropriate amount of information sharing to provide health services and manage the health system.\textsuperscript{127} The HIA aims to make the process transparent to those involved in the health system, as well as to the public. The rules are intended to protect the privacy of individuals and the confidentiality of their health information, to ensure that health information is shared appropriately, and to ensure that health records are managed and protected properly. The potential for elder abuse may exist if a care provider does not protect confidential information according to HIA guidelines.\textsuperscript{128}

\textit{Personal Information and Protection Act (PIPA)}

PIPA applies to provincial private sector organizations, businesses, and, in some instances, non-profit organizations regarding the protection of personal information and providing a right of access to an individual’s own personal information. Organizations that are subject to PIPA must develop and follow policies that are reasonable to meet their obligations under the act.\textsuperscript{129}

When PIPA refers to anything or any matter as “reasonable,” it means that which a reasonable person would consider appropriate in the circumstances. PIPA sustains the protection of personal information by providing a right of access to an individual’s own personal information.\textsuperscript{130}

\textit{Criminal Code of Canada}

Although there are no specific Canadian Criminal Code provisions to combat elder abuse, the code’s provisions provide protection generally to all Canadians against mistreatment. For example, physical abuse could come under a number of Criminal Code provisions, such as assault; psychological abuse is captured under provisions such as intimidation and uttering threats; financial abuse may come under provisions that deal with theft, forgery, extortion, or fraud; and neglect may be addressed as criminal negligence causing bodily harm or breach of duty to provide necessities of life. Therefore, criminal law deals with the after-effects of elder abuse.\textsuperscript{131}
Role of Education

Education of health care professionals has an extremely important role in recognizing, responding to, and preventing elder abuse. For example, the National Center on Elder Abuse (NCEA) recognizes that successful elder abuse prevention, detection, and intervention relies, in part, on the education of professionals and includes the public. The NCEA is a resource centre that provides awareness flyers, educational fact sheets, and a series of training curricula.132

The Alberta Elder Abuse Awareness Council (AEAAC) also has many tools and resources for health care professionals and awareness flyers for older adults in many languages. The AEAAC also offers conferences for professionals that are specific to the topic of elder abuse. Generally, each city or conglomeration of towns in Alberta either has, or is developing, an elder abuse “community coordinated response” team made up of various stakeholders from each area. With the development of response teams, there may be increased opportunities for training/education.

LPNs and other health care professionals are in an ideal position to identify, intervene in, report, and lead the way in preventing abuse of the elderly. LPNs are required to demonstrate knowledge and ability to identify and manage situations of abuse of older adults.133 This includes seeking support, education, and resources to understand the complexities of elder abuse.

A comprehensive resource section is provided in Module 5.

World Elder Abuse Awareness Day

Many countries worldwide are experiencing a tremendous growth in the number of older adults in their populations; as a result, the incidence of abuse toward older people is predicted to increase.134 Research suggests elder abuse is a social issue that affects the health and human rights of millions of older adults around the world. To bring attention to this international problem, the United Nations General Assembly designated June 15 as World Elder Abuse Awareness Day.135 This day was created so that individuals, organizations, and communities are aware of seniors’ rights. LPNs can play an important role in promoting awareness about this important issue in their workplaces and communities.

Key Points

- Legislation on elder abuse includes legal strategies for older adults and guidelines for care providers who have access to confidential information.
- Mental capacity is the ability to make appropriate decisions and understand the nature and consequences of those decisions.
- Appropriate education and training for health care professionals is important for prevention of elder abuse.
- Elder Abuse Awareness Day (June 15) was created to bring international attention to the mistreatment of older persons.
Reflective Questions

1. Module 4 discusses concerns of capacity. When does an older adult have the right to live at risk? What can you do when an older adult who has capacity chooses to remain in a situation where abuse is taking place?

2. Prevention is every person’s responsibility. What can you do to prevent elder abuse in your home, community, and workplace?
Module 5: Resources

Upon completion of Module 5, LPNs will be able to

- identify community partners and resources that support the prevention of elder abuse; and
- identify additional learning opportunities.

Introduction

Elder abuse is a complex issue, and the dynamics of each case are different, so the response to abuse must be individualized. Governments, community and non-profit organizations, social services agencies, health care providers, police, and concerned citizens work together to prevent and address elder abuse throughout Alberta.

There are many resources available to address and prevent elder abuse and assist individuals impacted by elder abuse. Prevention starts with awareness.

Government and Public Resources

Many older people can make their own decisions when deciding whether to seek resources that support and protect them. Sometimes no formal intervention is required, other than locating information on elder abuse. There are several government and private agencies that can assist older adults who are experiencing abuse, regardless of whether they live in urban or rural communities.

- **Pension sources**: Employment and Social Development Canada—who distribute Canada Pension Plan (CPP), Old Age Security (OAS), and the Guaranteed Income Supplement (GIS)—may be contacted to provide information about pension income, change of address, or stopping payments.[^136]

- **Victim services**: Many communities have community-based and/or police-based victim services that can connect with seniors to provide support and refer them to other services.[^137]

- **Shelters**: Many communities have safe houses for older women leaving abusive relationships, and some communities have safe houses for both men and women. Some health authorities have specific places where abused seniors may be temporarily sheltered, depending on their needs. The Alberta Elder Abuse Awareness Council has contact information and listings of places for abused older adults.

- **Seniors’ organizations**: Local seniors’ organizations have community-based programs with socialization and recreational activities. They also provide the support of peers who can encourage the abused senior.[^138]

- **Provincial or territorial help lines**: These telephone services can provide the support of a “listening ear” and options such as referrals to local agencies.
• **Immigration or language services:** Some communities offer translation or interpretation services that enable a senior to understand his or her situation and the resulting risks. It is not recommended that the abusive person provide interpretation services, as he or she may use deceit to his or her advantage.

• **Nurses and other health care providers:** Nurses generally assess and implement the care services of older adults, whether they live in their own homes or in care facilities. Direct care providers may witness or listen to events of abuse and have a duty to report.139

• **Mental health programs:** Most health authorities have programs that assess an older adult’s functioning and mental capacity.

• **Public Guardian/Trustee:** Most provinces and territories have a department or office that investigates the misuse of an older adult’s finances. If the older adult lacks capacity for finances and personal decision making and has no suitable friend or relative to do so, the government appoints a decision maker, as discussed in Module 4.140

• **Legal services:** Legal support is available in most areas to assist older adults with protecting their assets and creating decision-making documents. In some areas, these services are offered to seniors at no cost or on a sliding scale. Additionally, most communities have lawyers who may retrieve stolen funds; however, these lawyers generally charge for their services.

**Moving Forward**

In this course we have learned that elder abuse is a complex and widespread issue that has not been effectively addressed in the past.141 Worldwide, a rapidly growing aging population will correspond to an increase in the cases of abuse and neglect of seniors.142 Although elder abuse may require community responses and efforts, the nurse or health care provider is in a powerful role to identify, respond to, and prevent elder abuse. Schools of nursing should commit to elder abuse curricula so new graduates can identify and respond appropriately to potential or actual abuse.

It is anticipated that all LPNs and health care professionals will take a leadership role in recognition, response to, and prevention of elder abuse.

**Reflective Questions**

1. Consider the role LPNs play in identifying, responding to, and preventing elder abuse. How does elder abuse fall under the “health care” umbrella?

2. LPNs are not expected to intervene in elder abuse alone. Where does your work “end” with elder abuse? How important is collaboration with the health team when dealing with elder abuse? Are you familiar with the elder abuse resources in your community? If there are none; how can you inspire change to best support older adults in your area?
Additional Resources

The following articles, websites, and telephone numbers may be useful in supporting abused older persons and exploring additional learning.

**Alberta**

**Alberta Elder Abuse Awareness Network**
Phone: 780-392-3267 (Edmonton); 403-206-8311 (Calgary)
Website: [http://www.albertaelderabuse.ca/](http://www.albertaelderabuse.ca/)

**Alberta Family Violence Information Line**
Toll-Free (in Alberta): 310-1818 (24 hours)
Website: [http://www.familyviolence.alberta.ca](http://www.familyviolence.alberta.ca)

**Alberta Health Services Helpline**
Toll Free: 1-877-303-2642

**Alberta Seniors and Housing—Seniors Services—Elder Abuse—Resources**
[http://www.seniors-housing.alberta.ca/seniors/elder-abuse-resources.html](http://www.seniors-housing.alberta.ca/seniors/elder-abuse-resources.html)

**Alberta Seniors Information Line**
Phone: 1-800-642-3853

**Calgary Legal Guidance**
Phone: 403-234-9266
Website: [http://www.clg.ab.ca](http://www.clg.ab.ca)

**Carya (formerly Calgary Family Services)**
Website: [http://caryacalgary.ca/our-programs/older-adults/](http://caryacalgary.ca/our-programs/older-adults/)

**Central Alberta Women’s Emergency Shelter (CAWES)**
Toll-Free: 1-888-346-5643 (24 hours)
Shelter: 403-346-5643
Website: [http://www.cawes.com](http://www.cawes.com)

**Confederation Park 55+ Activity Centre Lawyer Clinic**
Phone: 403-289-4780 (must be a member to book an appointment)
Website: [http://yycseniors.com/](http://yycseniors.com/)

**Distress and Suicide Prevention Line of Southwestern Alberta (CMHA)**
Toll-Free Crisis Line: 1-888-787-2880 (24 hours)
Phone: 403-327-7905
Distress Centre Calgary
Toll-Free Crisis Line: 1-800-SUICIDE (1-800-784-2433) (24 hours)
Senior’s Line: 403-264-7700

Edmonton Seniors Safe Housing
Phone: 780-702-1520 (Edmonton)

Elder Abuse Intervention Team
Phone: 780-477-2929 (Edmonton)

Golden Circle Senior Resource Centre (Red Deer)
Phone: 403-343-6074
Website: http://www.goldencircle.ca/

Government of Alberta—Seniors and Housing
Website: www.seniors.alberta.ca

Greater Forest Lawn 55 Plus Society Lawyer Clinic
Phone: 403-272-4661
Website: http://www.gfls.org

Health Link Alberta
Phone: 1-866-408-5465
Website: www.health.alberta.ca

Kerby Elder Abuse Line
Crisis Line (Calgary): 403-705-3250 (24 hours)

Kerby Centre—Information and Advocacy
Phone: 403-705-3246
Website: https://www.kerbycentre.com/general/supportservices/information-resources/

Mental Health Patient Advocate
Toll-Free (outside Edmonton): 310-0000
Phone: 780-422-1812
Website: www.mhpa.ab.ca/

Oak-Net Legal Resource Centre
Phone: 780-451-8764
Website: http://www.oaknet.ca

Office of the Public Guardian and Trustee
Phone: 1-877-427-4525
Website: http://www.humanservices.alberta.ca/guardianship-trusteeship.html
Older Women’s Long-Term Survival (OWLS)
Phone: 403-253-2912 (Calgary)

Protection for Persons in Care (PPC)
Toll-Free (in Alberta): 1-888-357-9339
Website: http://www.health.alberta.ca/services/protection-persons-care.html

Senior Abuse Help Line
Phone: 780-454-8888 (Edmonton)

Canada

ABCs of Fraud Awareness Program
Website: http://www.abcfraud.ca/

Canadian Anti-Fraud Centre
Telephone: 1-888-495-8501
Fax: 1-888-654-9426
Website: http://www.antifraudcentre-centreantifraude.ca/index-eng.htm

CARP (formerly the Canadian Association for Retired Persons)
Website: http://www.carp.ca/about/#about

Canadian Centre for Elder Law (CCEL)
Phone: 604-822-0633
Website: http://www.bcli.org/ccel

Canadian Frailty Network
Website: www.cfn-nce.ca

Canadian Network for the Prevention of Elder Abuse (CNPEA)
Website: http://www.cnpea.ca

Canadian Nurses Association (CNA) NurseOne.ca—Elder Abuse
Website: https://www.nurseone.ca/knowledge-features/elder-abuse

Elder Abuse Ontario

National Initiative for the Care of the Elderly (NICE) Network
Phone: 416-978-0545
Website: http://www.nicenet.ca
Ombudsman for Banking Services and Investments (OBSI)
Toll Free: 1-888-451-4519
Website: http://www.obsi.ca

Phone Busters: The Canadian Anti-Fraud Call Centre
Toll Free: 1-888-495-8501
Website: http://www.antifraudcentre-centreantifraude.ca/

Public Health Canada, Division of Aging and Seniors (PHAC)
Website: http://www.phac-aspc.gc.ca/seniors-aines/

Vital Signs: Elder Abuse Awareness for Healthcare Professionals
Website: https://www.legalinfo.org/ElderAbuse

Documents (PDF)
“Abuse and Neglect of Older Adults: Community Awareness and Response” by Dianne Kinnon:
https://www.albertaelderabuse.ca/Community_Awareness_and_Response.pdf


“Caregiver Abuse Screen”: http://www.nicenet.ca/files/CASE.pdf

“CCR: Coordinated Community Response to Abuse of Seniors“:
http://www.nicenet.ca/files/Coordinated_Community_Response_-_CCR.pdf

“Clinician’s Role in the Documentation of Elder Mistreatment“:


“Counterpoint Charting Sheet,” Canadian Centre for Elder Law:
https://www.bcli.org/publication/counterpoint-charting-sheet

“Elder Abuse—Assessment: An Intervention Reference Guide“:
http://www.nicenet.ca/files/U_of_T_Nice_176064_Police_Tool.PDF


“Elder Abuse Suspicion Index”: http://www.nicenet.ca/files/U_of_T_Nice_175084_EASI_Revised_5_Panel.PDF

“Five Measures You Can Take to Protect Yourself” by the Registered Nurses Association of Ontario: http://rnao.ca/sites/rnao-ca/files/Elder_Abuse_-_Fact_Sheet_template-Final_English.pdf

“Looking Beyond the Hurt: A Service Providers Guide to Elder Abuse”: http://www.nlnpea.ca/LBH Scroll down to click on links to each section of the guide


Videos

“Elder Abuse in Canada”: https://www.youtube.com/watch?v=pPq3NBswzRM

“Elder Abuse: Learn the Signs and Break the Silence” by YourAlberta: https://www.youtube.com/watch?v=OEGhbbpel30&feature=youtu.be


“Open Your Eyes to Elder Abuse in Your Community” by Comfort Keepers Ireland: https://www.youtube.com/watch?v=t9CFcoJ5-cU

“Recognising and Responding to Elder Abuse in Residential Care Settings (Part 1)” by Comfort Keepers Ireland: https://www.youtube.com/watch?v=YzxTSzaCZMo

“Recognising and Responding to Elder Abuse in Residential Care Settings (Part 2)” by Comfort Keepers Ireland: https://www.youtube.com/watch?v=akyUL9o7mCA
Video Series
Canadian Center for Elder Law’s Counterpoint Project
Module 1: Confidentiality and Privacy
Module 2: Mental Capacity and Risk
Module 3: Social Isolation and Elder Abuse
Module 4: Asking Difficult Questions and Building Relationships of Trust
Module 5: Risk, Vulnerability and Family Dynamics
Module 6: Developing an Interprofessional Practice

Articles
“Care Givers Marrying the Elderly—Elder Abuse?” by HG.org Legal Resources, 2017: https://www.hg.org/article.asp?id=18612


Case Studies – Elder Abuse*

Case Study 1: Home Care Setting

Sonia is an 86-year-old widow who is a retired nurse. She has nine adult children, seven of whom have families of their own and are self-sufficient. Her older home is located a few miles from a small town.

She participates in events at the local seniors’ centre and can drive to pick up mail, do banking, attend health appointments, buy some groceries, and attend a few special events. Two of her children make regular trips to help with lawn care, gardening, and a few heavy-duty household chores. She has two elderly neighbours, aged 89 and 90, who check on her daily, and vice versa.

Although Sonia has several chronic diseases, her health is relatively stable. She had a knee replacement and a cardiac stent in the past three years and is scheduled for another knee replacement. She has had several surgeries including bladder repair, spinal surgery for hemangioma, gallbladder disease, and benign duodenal tumor. Her mobility is impaired because of osteoarthritis of her joints. She takes medications for hypertension, acid reflux, and type 2 diabetes. She also has medications for pain, cardiac function, and incontinence. She sees her physician regularly, and he has told her that she is depressed. Her home is equipped with an emergency call unit, a bath lift, a commode, and a bed pole.

A home care nurse visits every two weeks to monitor Sonia’s cardiac status and her day-to-day function regarding living alone. A home support aide helps with housecleaning and some meal preparation weekly. A health care aide assists with bathing weekly. Foot care is done every six weeks.

Janet, her oldest daughter, is joint owner on her bank account. Sonia’s pensions are more than adequate to cover monthly expenses. Sonia is a well-respected member of her church and community. With help, she enjoys hosting family dinners.

One of Sonia’s daughters, Lee, is 47 years old and a single parent. Lee lives nearby and works full time at a government job with benefits. Lee has been known to consistently ask for money and other financial help. Since her husband passed away, Sonia has been babysitting Lee’s son during summer holidays, on weekends, and at other times when school is out or when Lee “needs a break” or has “social activities.” Sonia states that Lee “can’t afford babysitters and after-school care.” Lee generally visits Sonia when no other family members are present to ask for help.

Sonia harbours much guilt because she believes she is responsible for raising an “emotionally and financially dependent child.” Janet has noted that over $10,000 has been “loaned” to Lee for various reasons. Lee said she needed “money for archery lessons and school fees and had no food in her home.”

Lee has an ageist attitude and has no plans to repay any of the funds. Sonia says that maybe “Lee can give me $25 or $50 each month or whatever she can afford.” When Lee is questioned about her mother’s financial help, she becomes very angry. She has written several derogatory letters to family members and threatens to refuse to visit Sonia with her son. Sonia is afraid of these “blowouts” and outbursts. Lee makes comments such as, “I’m a single parent—you don’t know

*All of the case studies are fictional examples.
what it’s like to live off one income.” Lee was very disappointed when her mother did not sign over her property to her.

When family is visiting, Sonia becomes very withdrawn and anxious if Lee is present or if the conversation drifts to Lee’s activities. Lee phones her mother several times a day to direct her son’s care and to make sure that her orders are followed. She has left demanding notes of “what to do and what not to do” for the day and keeps a large-print calendar by Sonia’s telephone with Lee’s and her son’s activities written on it. Lee expects free child sitting and expects Sonia to cook meals while she is there or to go out to restaurants if there are no meals prepared. Sonia’s social activities have been cancelled when she is child sitting.

Assignment

Please review Module 2 and answer the following questions:

1. Is this an abusive situation?
2. What forms of abuse are present in this case study?
3. What are possible indicators for each type of abuse?
4. What are possible indicators of the abuser?
5. How could Sonia find support and encouragement in her rural community?
Case Study 2: Facility Care Setting

Alexander is 92 years old and has been a resident of a veterans’ care facility (nursing home) for six months. He has not adjusted well to this change of living environment and was given the nickname “grandpa.” He has post-traumatic stress disorder (PTSD) from World War II and awakens at night from nightmares. He usually settles back to sleep after a walk and a snack. He has angry outbursts, paranoia, and other behavioural issues related to his PTSD. He sometimes becomes delusional and combative. He is then placed in a geri-chair with a lap belt.

He is not incontinent, but recently he has started wearing adult incontinence briefs, as the staff say that he cannot toilet himself in time. His other health issues include back pain, mild cognitive impairment, CVA, hypertension, depression, and arthritis. His medications include anti-hypertensives for blood pressure, analgesics, and antipsychotics for behavioural issues. When he refuses medications, they are crushed and hidden in applesauce.

He enjoys listening to the radio, bird watching, and one-on-one visits from family and volunteers. He does not like to watch TV because he says it is a “waste of time.” He resists his weekly tub bath using the mechanical lift. He also will not allow a female care provider to do his personal care. Related to his paranoia, he complains of someone “speaking in languages that he does not understand,” and this causes him anxiety. The staff wears gloves when they feed him in case he coughs, although he can feed himself slowly.

Assignment

Please review Module 2 and list four reasons why unintentional abuse often occurs in facilities. After reading this case study, are you able to detect areas or events that could be considered facility elder abuse? Please prepare a list and compare it to the suggestions below.

- Nicknames such as “Grandpa” and childlike expressions such as “dearie” and “sweetie” are considered ageist or inappropriate.
- Restraints such as recliner chairs and lap belts are often used inappropriately; there must be a physician order and routine monitoring of a client who is restrained. Forcibly restraining an individual when it is not necessary can be a form of elder abuse. There are many other ways to settle an agitated client, such as music, walking, or other distractions.
- Clients who can be toileted should not be placed in incontinence briefs for the convenience of the staff. Toileting should be done in a private manner and location. Older adults deserve to be treated respectfully and with the same consideration as all other clients.
- Antipsychotics should not be used as chemical restraints, unless there is no other alternative. Antipsychotics have serious side effects and may contribute to falls. Medication used improperly is a form of medication abuse.
- Crushing medications and hiding them in applesauce is not permitted unless the physician and the family agree that this is the only safe way for the client to take his or her important medication. Without this direction or the consent of an approved decision maker, this act may be considered medication abuse.
• Mechanical lifts and rough handling do frighten older persons. “Rough handling” is considered a form of physical elder abuse. A care provider should explain the lift, including its sensations, and be fully aware of the stress and anxiety that a client may experience.

• Placing a client who does not like television in front of one is not best practice; causing a client discomfort intentionally would be a form of mistreatment.

• Speaking another language in the presence of a client who is not familiar with that language is rude, and if this is done while discussing the client or their care, would be improper care and mistreatment. Clients have a right to know information related to their care whenever possible and appropriate.

• Wearing gloves for all care events is not necessary and may give clients a feeling that they are dirty and unclean. Care providers should use gloves only when necessary.
Case Study 3 – Assisted Living Facility

Fatima is an 88 year old woman who has recently moved to an assisted living facility, where she can receive for her severe physical limitations and mild cognitive decline. Although Fatima would much rather live at home with her family, they cannot meet her care needs, and she has transitioned into care despite her wishes. There are many medical staff supporting her with tasks such as bathing, eating, toileting, daily activities, etc., and most are empathetic to Fatima’s frustration with the changes to her living situation.

Two of Fatima’s care providers are Anita and Louise; both have been nurses at this care facility for over ten years together, and have developed a long-standing friendship throughout this time. Louise finds Fatima’s frequent requests for fresh water, more blankets, different food, and simply “more time” to be sometimes taxing, but understands that Fatima is still adjusting to being in a new place without her family. Louise has noticed that Anita has seemed increasingly frustrated with Fatima over the past few weeks, in contrast to the compassionate, caring, and empathetic nurse she has always known Anita to be. Louise has noticed Anita finding other tasks to do before responding to Fatima’s calls for assistance, rushing through the care she provides, denying all non-essential requests, being a little “rough” when handling her, and avoiding conversation with her while completing the required tasks. Louise has heard Anita mumbling under her breath when she leaves the room that Fatima should, “just get over it already” and “quit complaining”. Louise has heard rumours that Anita has ignored Fatima’s requests for up to a couple of hours, “passing it off” to the next shift, and that on one occasion, Fatima told Anita that she would “be speaking to someone about this”, to which Anita loudly replied, “good luck with that, I wouldn’t think about trying that if I were you.”

Louise was worried about Anita, and didn’t want to believe the rumours about her friend. She knew that Anita had been behaving unusually lately, but also was aware that Anita was under her own stress as well. Anita had been separated last year, and this had brought financial stress to her and her young son. Financial resources had been stretched further when Anita’s mother grew sick, and she had to hire a private caregiver to help care for her. Anita had been complaining of working long hours trying to make ends meet, and the difficulties of providing care to so many patients at once. Some of the patients Anita had connected with had passed on recently, and Anita was having a more difficult time with this than usual. Louise knew that she should do something, both for Anita and for Fatima, but she didn’t want to get her friend in trouble especially with everything else Anita was going through.

Assignment

Questions to consider:

Imagine you were in Louise’s position; how would you navigate this situation to support your friend, and also protect the patient at risk? What are the possible implications of doing nothing, to avoid “getting anyone in trouble”? What are the implications of speaking up? Does Louise have any obligations to do something, based on what she has seen? Lastly, what may cause a person to change their behavior towards a patient (from typically empathetic to easily frustrated, for example)?
Louise is aware of a patient that is at risk of experiencing abuse. Louise has many options for accessing support; however, these must be informed by her College’s guidelines and in accordance with the Protection for Person’s in Care Act. According to the Act, abuse can include an act that causes serious physical harm, serious emotional harm, or results in failing to provide adequate medical attention. (Section 1(2)). Louise could consult with a trusted supervisor if what had been observed constituted “serious harm”, to determine if this falls under the legislation’s mandatory reporting, or if the concerns can be handled at an agency level. Louise and the supervisor may also consult with PPIC directly to determine the necessary course of action.

Despite Louise’s fears, seeking support with a concern does not necessarily mean a person will automatically be fired, fined, or face charges for abuse. Rather, an investigation may have many outcomes, including protecting a patient at risk, offering intervention to a service provider who may be unwell and in need of support, reviewing ineffective agency standards of care, etc.

There may be many implications to not speaking up. In this situation, Fatima may have been at risk of experiencing serious bodily or emotional harm by: not having her requests for medical care answered in a timely manner, having requests denied, and administering inadequate or improper care. These were examples of possible neglect towards Fatima; furthermore, the “rumors” indicated alleged threat, which were emotional/psychological abuse, and the concern of Anita being “rough” may have been considered physical abuse. Should this have met PPIC’s threshold for “serious harm”, Louise may face financial and professional repercussions by not reporting. Most significantly, Fatima may face greater risk of harm should Anita’s behaviour continue or escalate.

If she chose, Louise could offer many supports to her friend upon noticing the change in her behaviour: simply checking in, recommending the agency’s Human Resources department, connecting her with resources for caregiver burnout, etc. All of these are options in addition to involving the necessary parties, but are not replacements seeking additional support.

Lastly, consider the signs of caregiver burnout; how may Anita’s recent actions been influenced by this? What protective factors in her life that assisted her with managing her work had been compromised, impacting her ability to best care for herself and others? Consider how a person such as Anita may handle this, but also, how you may take action in your life if you were facing caregiver burnout or stress?
Endnotes

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96 Government of Alberta, “Reporting Abuse.”
97 Government of Alberta, “Reporting Abuse.”
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