An elderly with skin bruising

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Case 1

- Ms Tao,
- F/94.
- OAH resident, bedbound and on Ryle tube feeding.
- HBV carrier, Dementia, old right ICH.
- Parathyroid adenoma.

Case 1

- admitted to ortho 18/03/2010 to 19/03/2010 for left upper arm bruising and swelling for three days.
- XR left shoulder and elbow: no fracture seen.

Case 1

- readmitted again to M&G 23/03/2010 for left chest wall bruising for four days .
- Still have left arm bruising.
- Also noted to have bruising over both hands.

Physical exam

- BP 175/85mm Hg, HR 80/min.
- Chest: clear.
- CNS: spontaneous eye opening, aphasic, left upper limb power grade 2/5, right upper limb power grade 3/5, bilateral lower limbs contracture.
- On Ryle tube feeding.

Case 1 (cont')

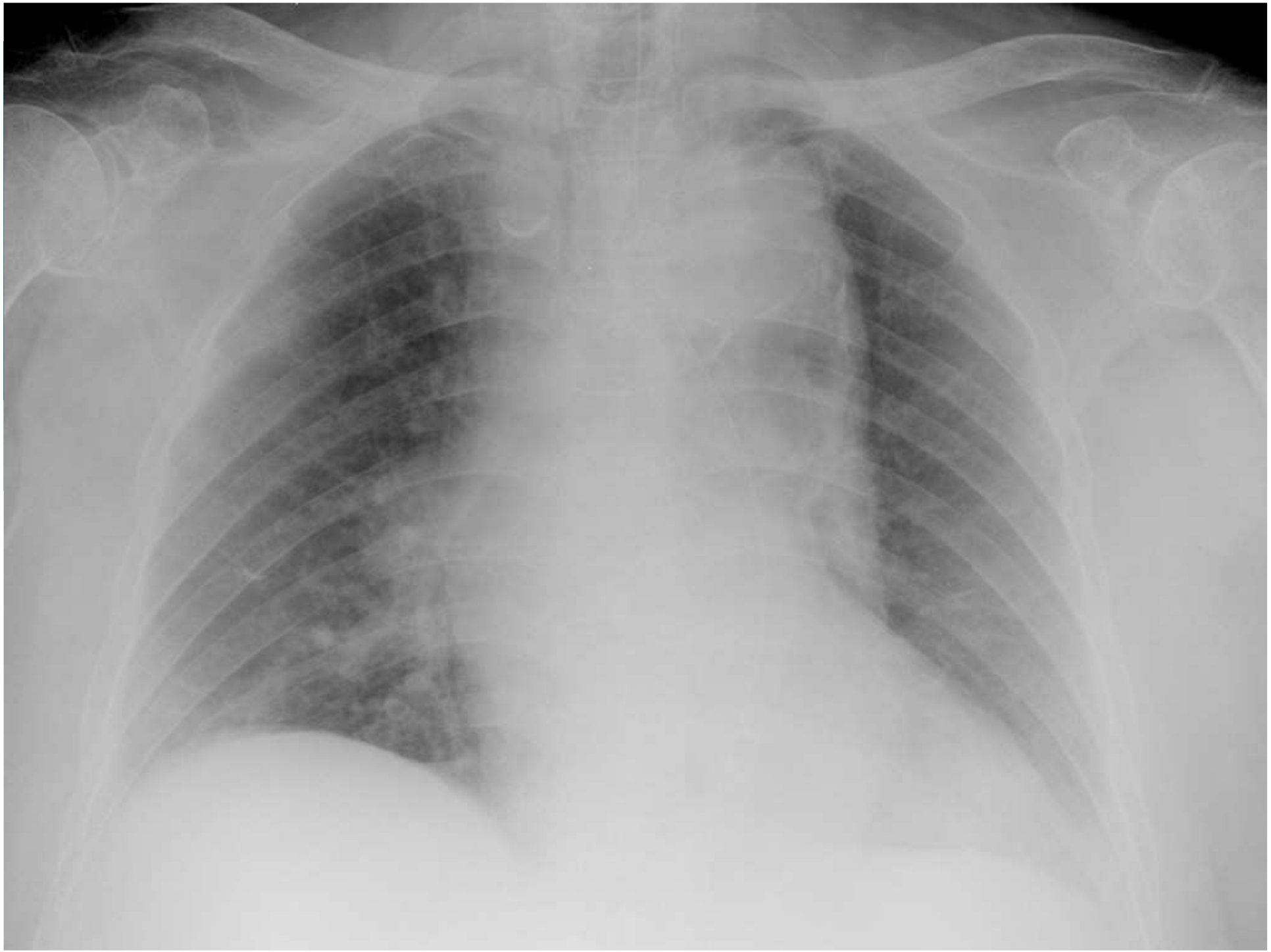
- Bruising over left eyebrow, both hands, left upper arm and left chest wall.
- Multiple skin abrasion over both feet.
- Sacral bedsore, stage II.
- *Mental state: patient is aphasic and not obey commands.*

medication history

- Vitamin C 300mg daily.
- Enervon C plus 10ml daily.
- Ferrous hausmann 6ml daily.
- Adalat 5mg tds.

Investigation

- CXR： lung fields clear, no rib fracture seen.
- XR left shoulder, left humerus, left forearm and left wrist: no fracture seen.
- ECG: AF, T inversion over V2—6.



Investigation

- CBP: Hb: 9.4 MCV 98.9 WBC: 4.5 Plt: 217.
- RFT: urea: 10.2 creat: 80 Na: 134 K: 4.8 calcium: 2.51 Phos: 1.01
- LFT: Bil: 10, ALP: 75 ALT: 21 A/G: 30/48
- CK: 58 LDH: 126
- PT: 9.5, INR: 0.93. APTT: 32.4

Work up for anaemia

- HB: 9.4-9.5 gm/dl MCV 99
- WBC: 5.3 Plt: 229
- TSH: 1.21
- Ferritin:103
- Vitamin B12 level: 342.
- Folate: 45.3

Case 1

- Patient has history of HBV carrier
- reverse A/G = 28/48
- AFP:2.
- Serum protein eletrophoresis: no abnormal band detected.
- Urine for B-J protein: no abnormal band detected

USG abdomen

- Liver echoes appear normal.
- No abnormal SOL seen.
- Spleen normal in size.

Progress

- Patient's daughter suspected patient was abused in the OAH.
- She claimed that patient developed large areas of bruising three episodes in recent one year.
- The OAH staff had been hit patient's forehead to the drawer near bedside when they were doing turning.

Case 1

- In this admission, patient's daughter reported to the police for suspected elderly abuse in OAH.

- Does it cause by elderly abuse?
- Consistent history cannot be obtained from the patient because of old CVA and *dementia.*

Progress

- MSW was referred.
- The case was discussed with liaison doctor.
- Patient was transferred to rehab ward for multidisciplinary assessment and case conference arranged to discuss about patient's future caring plan.
- The relatives planned to arrange another OAH for caring patient.

Case 2

- Miss Tong, F/82.
- Live with daughter, chairbound. cared by maid.
- Has guardian, Miss Lam (MSW). Patient on guardian due to sibling relationship problem.

Past history

- recurrent ischemic CVA with left hemiparesis 2000,2001. CT brain showed multiple cerebral infarct.
- Vascular Dementia, FU Psychiatric clinic.
- hypertension, hyperlipidemia.
- old fracture of left neck of humerus.
- left supracondylar fracture of humerus 11/2000 for conservative treatment.

- Hx of dysphagia with aspirate pneumonia.
- ST: dysphagia, high risk of aspiration for oral feedding.
- VFSS: silent aspiration noted for thin and thick liquid.
- Put on Ryle tube feeding.

Case 2

- Admitted for multiple bruises over trunk and limbs.
- A big hematoma over left upper chest wall.
- Bruising and hematoma appeared while daughter was not at home and cared by maid only.

P/E

- BP 170/90mmhg, HR: 84/min.
- Chest: clear.
- CNS: conscious, aphasic, no verbal communication.
- Bruises over trunk and abdomen.
- Big intramuscular hematoma over left upper chest wall.

Case 2

- Scar over left forearm.
- Non-union over left supracondylar fracture of humerus.
- Left shoulder: loss of normal contour. ?old deformity due to fracture.

Medication history

- Aspirin 150mg daily.
- Multivitamin 10ml daily.
- Caltrate 1500mg daily.
- Nacl 900mg daily.
- Pepcidine 20mg BD.

Investigation

- CBP:Hb:7.5 MCV 101, WBC: 8.2, Plt: 313
- Noted Hb drop from 10 g/dl to 7.5 g/dl
- L/RFT: urea: 6.4, creat: 60, Na: 135, K: 3.7
- Bil: 19, ALP: 67, AST: 23, ALT: 19. A/G:23/43
- INR: 1.0
- USG Chest :a large(10*5*4cm) intramuscular hematoma over left chest wall.

Case 2

- HBsAg: positive
- HBsAb: negative
- AntiHAV IgM: negative

Skeletal survey

- Bones osteopenic.
- Old left supracondylar fracture with displacement.
- Recent fracture distal left ulna with callus formation.
- Deformity in neck of left humerus due to old fracture seen in 2000.

- ?elderly abuse.
- MSW was referred
- Also reported to police
- Police: keep this case in record. No further action was taken

- Patient was on aspirin 150mg daily.
- Patient's daughter stepped up the dosage of aspirin to 300mg daily (patient was on Aspirin 325mg daily in USA before back to HK in 2000).
- Patient's daughter claimed that no one abuse patient.

Management

- patient's relatives were interviewed about the suspected physical elderly abuse. They denied any abuse towards patient.
- They claimed that the bruising may be due to caring problem.
- They preferred continue the caring at home.
- Referred CNS for home visit and supervision.

Management

- Aspirin was withhold during admission as huge hematoma and multiple bruise.
- In view of poor mobility, secondary prevention of CVA may not be benefit for patient. Aspirin was stopped.

Table 3. Participants According to the Size of Their Largest Bruise

Bruise Size (cm)	n (%)	
	Physical Abuse (n=48)	No Abuse* (n=68)
Small (0.1 – 1.0)	0 (0.0)	24 (35.3)
Medium (1.1 – 4.9)	21 (43.7)	39 (57.3)
Large (5.0 – 25.0)	27 (56.2)	5 (7.3)

Pearson chi-square, P<.001.

* Participants in an earlier study of accidental bruising in the geriatric population.[3] Only

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Table 4. Older Adults with Bruising: Comparison of Location Between Abused and Not Abused

Region	Physical Abuse n=48 (%)	No Abuse* n=68 (%)	P-Value†
Head and neck	10 (20.8)	3 (4.4)	.006
Anterior torso	4 (8.3)	5 (7.3)	.85
Posterior torso	7 (14.6)	2 (2.9)	.02
Lateral right arm	12 (25.0)	5 (7.3)	.008
Right arm, not lateral	13 (27.1)	25 (36.8)	.27
Left arm	25 (52.1)	25 (36.8)	.10
Right leg	7 (14.6)	5 (7.3)	.21
Left leg	8 (16.7)	9 (13.2)	.61

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Elder Abuse

- Dates back to ancient times
- Follow the development of child abuse and domestic violence
- Growing worldwide concerns about human rights and gender equality, domestic violence and population ageing
- Initially a social welfare issue and subsequently a problem of ageing, developed into public health and criminal justice concern
- Universal phenomenon

Elder Abuse

- First described in British scientific journals in 1975 under the term “granny battering” (Burston 1975)
- It was the United States Congress that first seized on the problem, followed later by researchers and practitioners
- Since the 1980s, scientific research and government actions has been reported from Australia, Canada, Norway, Sweden and USA, later followed by Argentina, Brazil, Chile, India, Israel, Japan, S Africa, UK and other European countries

Elder abuse in Hong Kong

- Hong Kong Christian Service was commissioned by SWD in Feb 2002 to launch the project on elder abuse research and develop a protocol for handling abuse cases

What is elderly abuse

- The International Network for the Prevention of Elder Abuse adopt the following definition for elderly abuse:
- Elderly abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person.

- Generally speaking, elder abuse refers to the commission or omission of any act that endangers the welfare or safety of an elder.

Categories of elderly abuse

- Domestic
- Institutional
- Self neglect

Domestic elderly abuse

- Any of several forms of maltreatment of an older person(>60) by someone who has a special relationship with elder (e.g.: a spouse, a sibling, a child, a friend, or a caregiver) who is living with the older person.

Institutional abuse

- Any forms of abuse that occur in residential facilities for older persons (e.g. nursing homes, infirmaries, hospitals)
- Perpetrators of institutional abuse usually are persons who are paid caregivers or professionals.

Different forms of elderly abuse

- Physical abuse
- Sexual abuse
- Psychological abuse
- Neglect
- Abandonment
- Financial exploitation

Physical abuse

- The use of physical force that may result in bodily injuries, physical pain, or impairment.
- The inappropriate use of restraint. (chemical or physical)
- Force-feeding.
- Physical punishment.

Sexual abuse

- Non-consensual sexual contact of any kind with an elderly person
- It includes all types of sexual assault and acts such as unwanted touching, coerced nudity, and sexually explicit photographing

Psychological abuse

- The infliction of anguish, pain, or distress through verbal or nonverbal acts
- Treating an elder person like a child
- Threats of institutionalization, abandonment and enforced social isolation are also examples of emotional/psychological abuse

Signs and symptoms of Physical abuse

- Being emotionally upset or agitated
- Being extremely withdrawn and non-communicative or non responsive
- Unusual behaviour usually attributed to dementia (e.g.: sucking, biting, rocking).
- An elder's report of being verbally or emotionally mistreated

Neglect

- Failure to provide care for an elder
- Refusal or failure to provide an elderly person with such life necessities as food, water, clothing, shelter, medicine, comfort, personal hygiene, personal safety etc.

The elder person may present with

- Dehydration, malnutrition
- Untreated bed sores, poor personal hygiene
- Unattended or untreated health problems

abandonment

- Desertion of an elderly person, e.g. at a hospital, a nursing facility, or other similar institution

Financial exploitation

- Illegal or improper use of an elder's funds, property, or assets
- Example include forging an older person's signature, misusing or stealing an older person's money or possessions, coercing or deceiving an older person into signing any document

Screening questions

- Has anyone at home ever hurt you?
- Has anyone ever touched you without your consent?
- Has anyone ever made you do things you didn't want to do?
- Has anyone taken anything that was yours without asking?

Screening questions

- Has anyone ever scolded or threatened you?
- Have you ever signed any documents that you didn't understand?
- Are you afraid of anyone at home?
- Are you alone a lot?
- Has anyone ever failed to help you take care of yourself when needed help?

Indicators of Elder Abuse

- When elders are abused, they often exhibit unusual behaviour, such as:
- apprehension, withdrawal, low mood, depression, becoming passive or
- being absent from activities in which they used to participate without cause

Indicator of elderly abuse

- Multiple injuries at different stages of healing
- Unusual soft tissue injuries, e.g.: bite marks
- Malnutrition or dehydration
- Poor personal hygiene
- Sexually transmitted disease
- Passivity, withdrawal, depression, agitation

Documentation

- Careful documentation of findings is crucial, since the medical record may become part of a legal record
- It is helpful to include detail descriptions of events and drawings or photographs of injuries

Where abuse of elderly happens

- Own home
- Nursing home
- Residential care
- Hospital
- Sheltered housing
- Other locations

Who may be the abusers

- Relatives
- Spouse
- Partners
- Professional care giver
- Doctors, lawyers, bankers, accountants etc.

Risk factors for elder abuse the victim

Women (over 60%).

The oldest old (age 80 or above).

Problematic behaviour, e.g. incontinence, shouting, paranoia

Socially isolated

Increasing care needs because of progression or fluctuation in disease state, e.g. dementia, parkinsonism, stroke

Risk factor for elder abuse the caregiver and family members

- Alcohol or drug abuse
- Mental illness
- Poor impulse control
- Unemployed or dependent on elderly for housing or money
- Physical, functional or cognitive impairment in caregivers
- History of domestic violence
- Forced to take care of elderly
- External stressors, e.g. loss of job, divorce.

Risk factors for elderly abuse social factors

- A lack of respect by the younger generation
- Tension between traditional and new family structures
- Restructuring of the basic support networks for the elderly
- Migration of young couples to new towns, leaving elderly parents in deteriorating residential areas within town centers

Institutional abuse-risk factors

- culture & style of the organization e.g.: custodial orientation, little flexibility in visiting hours, inadequate staffing level, inappropriate management support and supervision
- Staff characteristics: little training & support (illegal immigrants), poor communication skills, low morale, low salary, understaffing, little commitment
- Patient characteristics: dementia (inability to complain)

Prevalence of elderly abuse

- 4-5% of older people have been mistreatment or abuse in UK. (O'keeffe et al 2007).
- A recent summary of international elder abuse prevalence data reported that as many as 4.3% of older adults are physically abused annually. Event higher rates are reported for dependent elderly with caregivers.

- In a study by the HK council of social services and school of social work of HK polytechnic in 1984.
- The estimated prevalence of elderly abuse in the community was around 4.9%.

Type of elderly abuse case (2004)

Physical abuse	201
Psychological abuse	45
Neglect	7
Financial abuse	5
Abandonment	1
Sexual abuse	0
Multiple abuse	70
Total	329

Type of abuse by victim's sex (2004)

Type of abuse	Male		Female		total	
		%		%		%
Physical	62	64.6	139	59.7	201	61.1
Psychological	12	12.5	33	14.2	45	13.7
neglect	0	0	7	3.0	7	2.1
Financial	2	2.1	3	1.3	5	1.5
abandonment	1	1.0	0	0	1	0.3
Sexual abuse	0	0	0	0	0	0
Multiple	19	19.8	51	21.9	70	21.3
total	96	100	233	100	329	100

- The HK SWD recorded a total 528 cases of abuse of elderly people in 2005.
- An increase of 60% over the previous years(329 cases in 2004).
- Elderly abuse is often underreported.

Under-reporting- professionals

- Little awareness.
- Thinks that intervention would not be help.
- Difficulty to confirm a suspicion.
- Do not want to collect evidence.
- Time consuming.
- Lack of formal channels for multidisciplinary action.
- Lack of guidelines.

Handling of suspected cases of elderly abuse

- The Social Welfare Department has promulgated a Protocol for Handling Elderly abuse cases in 2003.
- The protocol adopts a multi-disciplinary approach to the problem of elderly abuse.

management

- The clinician's highest priority is to protect the safety of the elderly person while respecting the person's autonomy.

management

- Implementing a safety plan for the patient who is in immediate danger.
- Providing assistance that addresses that causes of mistreatment.
- Referring patient or family members to appropriate services.

Management in ward

- Easy observed bed.
- Communicate with case doctor.
- Refer MSW.(MSW consider inform police).
- Frontline staff may consider inform police if immediate needs such action.
- Refer Geriatric team of respective hospital for comprehensive assessment.
- Clinical photo.
- Arrange multidisciplinary case conference for discharge planning.

Management for MIP

- Assess mental competence and underlying mental/cognitive impairment.
- Check MIP/Guardianship.
- Refer MSW.
- Consider guardianship application for MIP.
- Consider emergency placement/integrated family centre for community support.

Management for institutional abuse (within HA Hospital)

- A complaint lodged by patient through complaint procedures.
- Potential elderly abuse case noted by staff, to be reported to unit/dept.I/C.
- Liaison doctor of hospital/cluster to be informed by PRO or unit/dept I/C.
- if considered a true elderly abuse case, PRO will notify liaison MSW for record keeping.
- MSW will need to seek consent from client for entry of client data into elder abuse registry.

Prevention elderly abuse

- Avoiding latrogenesis: too many drugs, too many investigations, too many restrictions (restrainer, visiting hours, privacy), too many interventions.
- High quality long term care.
- Care giver training &support.
- Guidance from government.
- Good practice.

Thank you