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## **A Nurse-Led Staff Education Program to Prevent and Detect Elder Abuse by Caregivers in the Home**

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# Walden University

College of Nursing

This is to certify that the doctoral study by

Nicola Brown-Walters

has been found to be complete and satisfactory in all respects,  
and that any and all revisions required by  
the review committee have been made.

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Walden University  
2026

Executive Summary: Staff Education Project

A Nurse-Led Staff Education Program to Prevent and Detect Elder Abuse by Caregivers  
in the Home

by

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MSN, Walden University, 2020

BSN, University of the West Indies, 2012

Executive Summary Submitted in Partial Fulfillment  
of the Requirements for the Degree of  
Doctor of Nursing Practice

Walden University

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## Summary

This Doctor of Nursing Practice (DNP) project was a nurse-led, evidence-based staff education initiative designed to improve the prevention and detection of elder abuse in the home by caregivers within an outpatient primary care setting. Elder abuse places older adults at risk for physical harm, neglect, medication mismanagement, and violations of autonomy and patient rights. Elder abuse remains a pervasive and underrecognized problem in nursing practice, often resulting from limited staff education, inconsistent screening practices, and uncertainty regarding mandatory reporting requirements.

The practice-focused question examined whether implementing a nurse-led targeted education program guided by the ADDIE instructional design model and incorporating the caregiver stress theory (CST) and the social exchange theory (SET) would improve staff's perception of their knowledge, skills, and confidence to identify and respond to suspected elder abuse.

Using the Johns Hopkins evidence-based practice model, evidence was systematically appraised and translated into practice. Project outcomes were evaluated through pre- and posteducation assessments. Postimplementation findings showed an improvement in perceived knowledge by 20.0%, skills by 30.41%, and confidence by 15.47%. Marked improvements were in awareness of risk factors and private screening; skills in assessment, documentation, and mandated reporting; and confidence in recognizing, reporting, and documenting elder abuse. Overall, results indicate enhanced preparedness to deliver ethical, trauma-informed, and legally compliant care promoting equitable protection of vulnerable older adults, supporting regulatory compliance, and reinforcing the critical advocacy role of nurses in preventing elder abuse.

## **Background**

Elder abuse occurring in the home represents a persistent and largely hidden public health crisis that continues to challenge healthcare systems, policymakers, and clinicians. As the population of older adults grows and reliance on informal caregiving increases, the risk of abuse, particularly by trusted caregivers, has become more pronounced. Abuse in the home frequently remains undetected due to its private nature, complex relational dynamics, and inconsistent screening practices across healthcare settings. Outpatient primary care environments are uniquely positioned to identify early indicators of abuse; however, limited staff education, lack of standardized workflows, and uncertainty regarding reporting requirements contribute to missed opportunities for intervention (Dong, 2015; Lachs & Pillemer, 2023).

The project aim was to explore whether a nurse-led education program improves staff perceptions of the knowledge, skills, and confidence to detect elder abuse by caregivers. The aim was to close gaps in the screening process. Systematic reviews and guidelines showing moderate-to-strong evidence that structured education increased recognition, documentation, and reporting accuracy rates (Dang et al., 2022; Melnyk & Fineout-Overholt, 2023).

DNP-prepared nurses are uniquely positioned to lead systems-level change by translating evidence into practice and addressing quality gaps in care (Melnyk & Fineout-Overholt, 2019; American Association of Colleges of Nursing [AACN], 2006). This executive summary presents a comprehensive overview of a nurse-led staff education project designed to prevent and detect elder abuse in the home by caregivers at an outpatient primary care clinic and center. The summary synthesizes evidence from

project initiation through implementation and evaluation, demonstrating scholarly rigor and alignment with Walden University expectations.

The purpose of this DNP project was to design, implement, and evaluate a nurse-led staff education program to improve prevention and detection of elder abuse in the home by caregivers in an outpatient primary care setting. The aim of this project was to improve staff knowledge, skills (i.e., screening behaviors), and confidence related to elder abuse detection and appropriate referral. The practice-focused question was: In a primary care setting, does implementing a targeted education program guided by the ADDIE instructional design model and incorporating the caregiver stress theory (CST) and the social exchange theory (SET) improve staff's perception of their knowledge, skills, and confidence to identify and respond to suspected elder abuse to identify and respond appropriately to suspected elder abuse?

### **Staff Education Project Development**

Analytical strategies were guided by the Johns Hopkins evidence-based model, guidelines, and tools including the Practice Question, Evidence, and Translation (PET) Process Guide Evidence Based Practice (EBP) Work Plan, which was used as a guiding framework throughout project development, implementation, evaluation, and dissemination. A pre- and posteducation evaluation was developed to determine program effectiveness using Excel and descriptive statistics to analyze the evidence generated during project implementation.

### **Evidence Synthesis Supporting the Practice Change**

A comprehensive literature review was conducted using 11 peer-reviewed sources identified and appraised using the Johns Hopkins evidence-based practice model (Dang et

al., 2022). The synthesis included three Level I systematic reviews (Dong, 2015; Lachs & Pillemer, 2023; White et al., 2024), two Level II randomized controlled trials (Hall et al., 2022; Tolar & Conrad, 2020), two Level III quasi-experimental studies (Johnson et al., 2022; Qureshi & Mehta, 2021), three Level IV observational or qualitative studies (Cohen et al., 2021; Nguyen et al., 2022; Ramsey-Klawnsnik et al., 2020), and one Level V expert guideline (National Center on Elder Abuse [NCEA], 2021). The quality of the evidence was rated as high ( $n = 5$ ), good ( $n = 4$ ), and low ( $n = 2$ ) based on the Johns Hopkins Appendix H criteria. This synthesized evidence directly informed the design of the staff education program by highlighting gaps in elder abuse recognition, documentation, and reporting, as well as effective educational strategies, including trauma-informed approaches and caregiver stress mitigation.

Across studies, consistent findings indicated that healthcare professionals frequently lack formal training in elder abuse recognition and documentation, contributing to systemic under-screening, misrecognition, and delayed reporting (Lachs & Pillemer, 2023). Hall et al. (2022) identified additional barriers including discomfort initiating sensitive conversations, fear of mislabeling situations as abuse, and uncertainty regarding institutional protocols. These factors emphasize the need for structured, evidence-based staff education programs to increase both confidence and competence in abuse detection and intervention.

Structured, interactive education has been shown to improve clinician knowledge and behaviors, particularly when incorporating trauma-informed screening to enhance disclosure and reduce stigma (Dong, 2015; Melnyk & Fineout-Overholt, 2023). Synthesized evidence supported addressing caregiver stress and power dynamics as

precursors to abuse and guided the development of targeted content aligned with the Johns Hopkins evidence-based practice model (Dang et al. 2022; White et al., 2024).

## **Theoretical and Conceptual Frameworks**

### ***ADDIE Instructional Design Model***

The ADDIE model provided a systematic structure for project development:

- **Analysis:** I collaborated with stakeholders to assess workflow gaps and staff readiness while using the TEAMS tool. The SWOT analysis identified strong leadership, and an engaged education team supported the design, while data limitations and staff turnover informed a feasible, priority-aligned intervention.
- **Design:** Content was aligned with evidence and clinic operations, guided by adult learning theory (Knowles, et al., 2015), SET (see Cropanzano & Mitchell, 2005), CST (see Tsai, 2003), and the ADDIE model to support behavior change and system integration. Alignment with SET and CST theories ensures training addresses real-world drivers of elder abuse (see Dong, 2015; George, 2025).
- **Development:** Educational materials, pre/post assessments, and screening guidance were created (see Appendix in this paper for educational materials developed for this project).
- **Implementation:** One 1-hour nurse-led education session was delivered onsite.
- **Evaluation:** An evaluation plan included an outline of outcomes to be measured via pre/post testing. Analysis was completed using Excel to enter data and use descriptive statistics to report the results.

### ***Care Stress Theory***

CST (see Tsai, 2003) informed the project's emphasis on recognizing caregiver burden as a risk factor for abuse (Dong, 2015). Education emphasized early identification of stress indicators and supportive interventions rather than punitive assumptions.

### ***Social Exchange Theory***

SET (see Cropanzano & Mitchell, 2005) provided insight into relational dynamics, highlighting how dependency, power imbalance, and perceived reciprocity may mask abuse. This framework strengthened staff ability to identify subtle relational cues during assessment.

### **Project Implementation**

The education program was delivered during one 1-hour scheduled staff education session and included didactic instruction using PowerPoint, case-based discussion with case studies and a laminated Quick Guide followed by an interactive Q&A. Content addressed abuse definitions, warning signs, private screening strategies, documentation standards, mandatory reporting laws, and Adult Protective Services (APS) referral processes. Staff were encouraged to conduct screening privately, reinforcing patient autonomy and safety. Educational materials were designed for sustainability and integration into routine practice. Each invited participant received a packet of materials with nonidentifiable ID codes; preassessment and postassessment questionnaires were collected during the session. Leadership engagement, preceptor collaboration, and alignment with clinic workflows facilitated implementation.

### **Evaluation Methods and Data Management**

Evaluation utilized a pre- and post-education knowledge, skills, and confidence

assessment administered anonymously to participants at the start of the staff education session and at the end of the session. Data were managed through anonymous collection using number and letter ID with distribution and collection of packets by one of the staff, to support transparency and trend analysis (see Appendix for questionnaires).

## **Results**

### **Knowledge, Skills, and Confidence**

The pre- and post-intervention assessment results demonstrated meaningful improvements in participants' knowledge, skills, and confidence related to identifying and managing elder abuse by caregivers. Following the educational intervention, knowledge scores increased by 20%, with all participants (100%) reporting familiarity with types of elder abuse, warning signs, risk factors, and appropriate private screening practices, compared to lower baseline levels, particularly in screening and risk factor awareness. Skill assessment scores showed a 30.41% increase post-teaching, with 100% of participants indicating competency in assessing abuse, utilizing interventional resources, following prevention strategies, and understanding mandated reporting and APS requirements, compared to pre-intervention skill levels that ranged from 50% to 83.3%. Additionally, confidence levels improved by 15.47% following the educational session, with mean Likert scores increasing to the maximum rating of 5.0 across all confidence domains, including recognizing, reporting, and documenting suspected elder abuse.

Overall, these findings suggest that the nurse-led educational intervention was effective in strengthening staff preparedness and self-efficacy, supporting improved early detection and response to elder abuse in the home setting. Table 1 provides the results of

staff's perceptions of their knowledge of risk factors and screening, skills in identifying and making referrals of elder abuse, and confidence in recognizing, documenting, and referring for elder abuse.

**Table 1**

*Pre- and Posteducation Findings on Perceptions of Knowledge, Skills, and Confidence*

Questions	Pre		Post	
	<i>n</i>	%	<i>n</i>	%
<b>Knowledge</b>				
1. I am familiar with the different types of elder abuse	10	83.3	12	100.0
2. I can identify at least 3 warning signs of possible elder abuse	11	91.7	12	100.0
3. I know what elder abuse by caregivers means	12	100.0	12	100.0
4. I am aware of risk factors that increase the likelihood of elder abuse	9	75.0	12	100.0
5. I know how to screen a patient privately for suspected abuse	8	66.7	12	100.0
<i>M</i>	10	83.3	12	100.0
<b>Skills</b>	<i>N</i>	%	<i>n</i>	%
1. I can assess and identify possible abuse	10	83.3	12	100.0
2. I use interventional resources when abuse is suspected	10	83.3	12	100.0
3. I follow up with strategies to prevent abuse.	10	83.3	12	100.0
4. I know the correct person/department to notify if I suspect elder abuse	8	66.7	12	100.0
5. I know the APS (Adult Protective Services) reporting requirement for mandated reporters	8	66.7	12	100.0
6. In the past 12 months, I have suspected or encountered possible elder abuse	6	50.0	12	100.0
<i>M</i>	8.7	72.2	12	100.0
<b>Confidence<sup>a</sup></b>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
1. I am confident in recognizing elder abuse?	4.25		5.00	
2. I am confident in reporting suspected elder abuse?	4.50		5.00	
3. I am confident in documenting concerns related to abuse?	4.25		5.00	
<i>M</i>	4.33		5.0	

<sup>a</sup>Based on ratings using Likert scale with 1= Not confident → 5= Very confident

## **Barriers and Facilitators**

An open-ended question in the preevaluation questionnaire asked about what barriers existed that prevented reporting. In the preevaluation ( $n = 6$ ), staff reported that they lacked the steps and who to contact and that patients were unwilling to verify or indicate abuse based on fear of retaliation by caregiver. In the postevaluation ( $n = 9$ ) staff answered what they found to be most helpful. They reported that all of the information, resources on how to identify elder abuse, and resources on how to report elder abuse and contact authorities were helpful. Staff expressed themselves as being more easily able to identify abuse.

Qualitative feedback based on discussion following the education program revealed increased staff confidence, improved comfort with sensitive conversations, and greater clarity regarding APS reporting pathways. Staff reported heightened awareness of caregiver stress and relational risk factors. On the four questions on the Training Evaluation, 100% ( $N = 12$ ) rated all items 5 (high), indicating their satisfaction with educational program. Two questions, which were labeled “Outcome Indicators,” were all answered “Yes” postimplementation indicating that staff were “prepared to take action” if they suspected elder abuse and that they understood their “legal obligation as a mandated reporter.”

## **Limitations**

Limitations include single-site implementation, small sample size, and short-term outcome measurement. Behavioral outcomes such as long-term screening consistency and referral rates were not measured within the project timeframe.

### **Implications for Nursing Practice, Education, and Leadership**

This project demonstrates the effectiveness of nurse-led education to increase knowledge and confidence, and thus, their ability to address complex ethical and clinical challenges. DNP-prepared nurses are uniquely positioned to lead such initiatives through evidence translation, interprofessional collaboration, and systems thinking. Integration of elder abuse screening into routine workflows and ongoing education is essential for sustainability. Therefore, emphasis should be put on education to ensure continuity of safe and quality care.

### **Sustainability and Dissemination**

Sustainability strategies include embedding education into onboarding, reinforcing screening prompts, maintaining APS partnerships, and incorporating content into annual competencies. Dissemination will occur through leadership briefings, QI forums, and scholarly presentation.

### **Conclusions**

Elder abuse in the home is a complex and often concealed threat, especially as reliance on informal caregivers grows. This DNP project addressed a critical practice gap through a nurse-led education initiative at a primary care clinic to enhance recognition and reporting of caregiver abuse. Guided by evidence-based frameworks, results supported that the intervention notably increased staff's rating of their knowledge, skills, and confidence, suggesting their readiness to act. Findings underscore nurses' role as frontline advocates capable of detecting subtle signs of abuse in outpatient settings. The integration of the ADDIE model, CST, and SET supported design of education with a sustainable, systems-level approach. While limited by sample size and timeframe, the

project highlights the DNP nurse's leadership in advancing safety, ethical care, and social change for vulnerable elders.

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**Appendix: Education Materials**

**A Staff Education Program to Prevent and  
Address Abuse Against Elders in the Home**

Nicola Brown-Walters, RN, BSN, MSN  
DNP Student and Project Lead  
Walden University

## Introduction

Elder abuse in the home, particularly the diversion of prescribed pain medications by family caregivers, represents a critical and often undetected threat to the health, dignity, and safety of older adults. Within the practice setting, preliminary observations and stakeholder discussions revealed gaps in staff knowledge, inconsistent screening practices, and limited confidence in identifying and reporting suspected caregiver-initiated diversion or other forms of mistreatment. These deficiencies contribute to under recognition of abuse, delayed interventions, and compromised patient outcomes. The purpose of this staff education project is therefore to strengthen clinical vigilance and enhance the capacity of healthcare personnel to detect, document, and report suspected cases of caregiver-related elder abuse, including medication diversion.

Guided by the practice-focused question: *To what extent does a structured staff education program improve knowledge, confidence, and screening/reporting practices related to detecting and preventing caregiver diversion of medications from elderly patients?*

The staff education program emphasizes the integration of evidence-based screening principles, trauma-informed communication strategies, and mandated reporting requirements. The learner population targets an interdisciplinary group of healthcare professionals including nurses, medical assistants, care coordinators, advanced practice providers, and social work collaborators. These learners exhibit diverse levels of clinical expertise, differing familiarity with elder abuse risk indicators, and variable comfort addressing sensitive topics with patients and caregivers.

Educational intervention occurs within a busy ambulatory practice environment in which clinical workflows, high patient volumes, and competing operational priorities present foreseeable constraints. Stakeholders noted that limited protected education time, inconsistent access to private spaces for screening, and competing documentation demands may affect staff availability and learning uptake. Nonetheless, strong managerial support, organizational commitment to patient safety, and staff willingness to enhance elderly safety create a favorable context for implementing the education program. This project seeks to address a critical practice gap by equipping clinical personnel with the competencies necessary to recognize medication diversion and elder mistreatment promptly, thereby promoting early intervention, regulatory compliance, and improved health outcomes for vulnerable older adults.

The overarching goal is to improve staff knowledge and confidence, standardize screening practices, and strengthen protective interventions for older adults. Enhancing provider competency in recognizing elder abuse represents a critical strategy for improving patient safety, promoting early intervention, and advancing quality of care for one of the most vulnerable patient populations.

## A. Learning Objectives

By the end of this education program, participants will be able to:

1. **Define** the major types of elder abuse, including medication diversion, and describe at least three indicators associated with each category.  
(Bloom: Remember/Understand)
2. **Explain** the risk factors that place older adults at increased vulnerability for caregiver-related abuse and **differentiate** between normal aging changes and signs suggestive of mistreatment.  
(Bloom: Understand/Analyze)
3. **Demonstrate** the use of standardized screening questions to privately assess an elderly patient for possible abuse or medication diversion during clinical encounters.  
(Bloom: Apply)
4. **Identify** at least three warning signs of medication diversion and interpret discrepancies in medication use, refill patterns, or caregiver behavior as potential red flags for diversion.  
(Bloom: Analyze)
5. **Document** suspected cases of elder abuse or diversion accurately and objectively using organizational guidelines and required clinical documentation standards.  
(Bloom: Apply/Evaluate)
6. **Summarize** mandated reporting requirements and execute the correct reporting steps when elder abuse or diversion is reasonably suspected, including notification of APS and appropriate internal stakeholders.  
(Bloom: Understand/Apply)
7. **Evaluate** personal confidence and readiness to screen, identify, and report elder abuse using a pre- and post-intervention self-assessment tool with an expected improvement of  $\geq 20\%$  in knowledge or confidence scores.  
(Bloom: Evaluate)

## B. Curricular Plan

<b>Learning Objective</b>	<b>Content</b>	<b>Strategies</b>	<b>Resources</b>
Types of elder abuse	Definitions, examples, prevalence	Lecture, case examples	PowerPoint, APS fact sheet
Risk factors	Caregiver stress, dependency, isolation	Group discussion	Risk factor pocket card
Screening	Screening questions, communication skills	Demonstration + role-play	Script handout
Clinical red flags	Refill patterns, caregiver control	Case vignettes	Mock MAR sheets
Documentation	Objective vs subjective notes	Practice exercise	Documentation template
Reporting	APS laws, internal protocols	Policy review	Reporting flowchart
Evaluation	Knowledge/confidence assessment	Pre/post test	Questionnaires

## **C. Evaluation Strategies**

### **1. Learner Outcomes**

- **Knowledge Assessment:** Pre/post test score improvement of  $\geq 20\%$
- **Confidence Assessment:** Likert scale +0.7 increase
- **Skill demonstration:** Screening and documentation exercises

### **2. Program Effectiveness**

- Satisfaction survey/ Training Evaluation (Goal  $\geq 4/5$ )

# Preventing & Detecting Elder Abuse in the Home

## Pre-Training Evaluation

Tester # \_\_\_\_\_

### **Instructions:**

Please complete this short questionnaire before the education session. Your responses are confidential and are used only to guide staff education needs.

### **Section 1: Knowledge Assessment**

1. I am familiar with the different types of elder abuse  
 Yes    No    Unsure
2. I can identify at least 3 warning signs of possible elder abuse  
 Yes    No    Unsure
3. I know what elder abuse by caregivers means  
 Yes    No    Unsure
4. I am aware of risk factors that increase the likelihood of elder abuse  
 Yes    No    Unsure
5. I know how to screen a patient privately for suspected abuse  
 Yes    No    Unsure

### **Section 2: Confidence Assessment (Likert Scale)**

*Please circle one response per question.*

1. I am confident in recognizing elder abuse?  
1   2   3   4   5  
(Not confident) → (Very confident)
2. I am confident in reporting suspected elder abuse?  
1   2   3   4   5
3. I am confident in documenting concerns related to abuse?  
1   2   3   4   5

**Section 3: Skills Checkoff**

11. I can assess and identify possible abuse  
 Yes  No  Unsure
12. I use interventional resources when abuse is suspected  
 Yes  No  Unsure
13. I follow up with strategies to prevent abuse.  
 Yes  No  Unsure
14. I know the correct person/department to notify if I suspect elder abuse  
 Yes  No  Unsure
15. I know the APS (Adult Protective Services) reporting requirement for mandated reporters  
 Yes  No  Unsure
16. In the past 12 months, I have suspected or encountered possible elder abuse  
 Yes  No  Prefer not to say

**Section 4: Open-Ended Question (optional)**

17. What barriers prevent you from identifying or reporting elder abuse?
-

**Post-Training Evaluation**

Tester # \_\_\_\_\_

**Instructions:**

Please complete this questionnaire after the education session. Your feedback helps evaluate the effectiveness of this training.

**Section 1: Knowledge Gained**

1. I am familiar with the different types of elder abuse  
 Yes    No    Unsure
2. I can identify at least 3 warning signs of possible elder abuse  
 Yes    No    Unsure
3. I know what elder abuse by caregivers means  
 Yes    No    Unsure
4. I am aware of risk factors that increase the likelihood of elder abuse  
 Yes    No    Unsure
5. I know how to screen a patient privately for suspected abuse  
 Yes    No    Unsure

**Section 2: Confidence Assessment (Likert Scale)**

*Please circle one response per question.*

7. I am confident in recognizing elder abuse?  
1   2   3   4   5  
(Not confident) → (Very confident)
8. I am confident in reporting suspected elder abuse?  
1   2   3   4   5
9. I am confident in documenting concerns related to abuse?  
1   2   3   4   5

### Section 3: Skills Checkoff

10. I can assess and identify possible abuse  
 Yes  No  Unsure
11. I use interventional resources when abuse is suspected  
 Yes  No  Unsure
12. I follow up with strategies to prevent abuse.  
 Yes  No  Unsure
13. I know the correct person/department to notify if I suspect elder abuse  
 Yes  No  Unsure
14. I know the APS (Adult Protective Services) reporting requirement for mandated reporters  
 Yes  No  Unsure
15. In the past 12 months, I have suspected or encountered possible elder abuse  
 Yes  No  Prefer not to say

### Section 4: Training Evaluation

16. The training objectives were clearly communicated  
 1 2 3 4 5
17. The content was relevant to my clinical practice  
 1 2 3 4 5
18. The session improved my knowledge of identifying elder abuse  
 1 2 3 4 5
19. The teaching materials (handout, slides, examples) were helpful  
 1 2 3 4 5

### Section 5: Outcome Indicators

20. After this training, I am prepared to take action if I suspect elder abuse  
 Yes  No
21. I understand my legal obligation as a mandated reporter  
 Yes  No

### Section 6: Open-Ended Questions

22. What part of the training was most helpful?

## PowerPoint Slides

### **A Staff Education Program to Prevent and Address Abuse Against Elders in the Home**

Nicola Brown-Walters, RN, BSN, MSN

DNP Student

Walden University

#### **Purpose of This Education**

- Elder abuse in the home, including physical abuse, neglect, emotional mistreatment, and financial exploitation is a growing public health concern. Many cases go unrecognized, placing older adults at risk for injury, untreated illness, psychological harm, medication complications, and death. This education supports staff in identifying, documenting, and reporting suspected abuse to protect vulnerable older adults.

## What Is Elder Abuse?

- Elder abuse is any intentional or unintentional act that harms an adult aged 60 years or older.

## Type of Elder Abuse

### 1. Physical Abuse

Causing physical pain or injury.

**Signs:** bruises, fractures, burns, restraint marks.

### 2. Emotional/Psychological Abuse

Verbal assault, humiliation, intimidation.

**Signs:** fearfulness, withdrawal, anxiety, depressed mood.

### 3. Financial Exploitation

Misuse of funds, property, credit cards, or bank accounts.

**Signs:** unpaid bills, unusual withdrawals, missing belongings.



### 4. Neglect

Failure to provide care, food, hygiene, or medications.

**Signs:** malnutrition, poor hygiene, skin breakdown, medication nonadherence.

## Signs of elder abuse

 **5 MAIN TYPES OF ELDER ABUSE**

 <p><b>01</b> NEGLECT</p> <p>Occurs when a senior isn't receiving the proper care or attention. Sometimes this act is intentional and other times it is not.</p> <p><b>Signs:</b> Unexplained weight loss Malnutrition/dehydration A messy living area Bed sores Dirty clothes or bedding Poor personal hygiene</p>	 <p><b>02</b> PHYSICAL ABUSE</p> <p>Occurs when an elder is experiencing physical pain, injury or impairment due to maltreatment or neglect from a caregiver or person of trust.</p> <p><b>Signs:</b> Unexplained bruises, welts or black eyes Unexplained head, neck or back injuries Chronic pain or soreness Internal injuries or bleeding Being undermedicated or overmedicated</p>	 <p><b>03</b> EMOTIONAL ABUSE</p> <p>An invisible type of abuse that occurs when a senior is experiencing unnecessary emotional pain or suffering from a caregiver or person of trust.</p> <p><b>Caretaker Behavior:</b> Yelling, shouting or screaming Intimidation Insulting, name-calling or making fun of the senior Ignoring the senior Isolation of the senior Restricting access to food, water, the bathroom or other patients</p>	 <p><b>04</b> SEXUAL ABUSE</p> <p>Occurs when a caregiver or other person of trust violates a senior and takes advantage of them sexually.</p> <p><b>Signs:</b> Difficulty in walking or sitting Signs of depression, withdrawal or anxiety Bruises or unexplained marks in genital areas, thighs or breasts Unexplained symptoms of sexually transmitted diseases and urinary tract infections</p>	 <p><b>05</b> FINANCIAL ABUSE</p> <p>Occurs when a senior is exploited financially by a caregiver or person of trust.</p> <p><b>Signs:</b> Missing cash, checks or valuables Inexplicable changes to the senior's bank account or last will and testament Unpaid bills</p>
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## Who is at Risk?

- Older adults with:
- Cognitive impairment (e.g., dementia)
- Mobility limitations
- Dependence on caregiver for ADLs
- Chronic pain or long-term opioid therapy
- Social isolation or limited family support

## Caregivers with:

- High stress or burnout
- Substance use history
- Financial strain
- Poor coping skills

## Signs to Look For



## Warning Signs for Staff to Observe

- Frequent medication shortages
- Patient appears over-sedated or in uncontrolled pain
- Caregiver refusing to leave during assessment
- Delayed medical visits or missed appointments
- Conflicting reports between patient and caregiver
- Visible fear or withdrawal from patient
- Unkempt appearance or unsafe living conditions

## Screening Questions to Ask Patients (Privately)

- “Do you feel safe at home?”
- “Has anyone taken your medications without permission?”
- “Has anyone prevented you from receiving your medications?”
- “Who helps you manage your prescriptions?”
- “Is there anything about your care at home that worries you?”
- **Observe verbal and non-verbal behaviors carefully.**

## Reporting Requirements

All healthcare staff are mandated reporters. You need only reasonable suspicion.

### **Report immediately to:**

- Charge Nurse / Supervisor
- Adult Protective Services (APS)
- Social Worker or Case Manager
- Compliance / Risk Management
- Document thoroughly in the patient chart
- **APS Hotline:** 1-866-552-4464 (Georgia)

## **How do I report concerns about an elderly person?**

To report concerns about an elderly person, contact your local Adult Protective Services (APS) or Area Agency on Aging (AAA) to report suspected abuse, neglect, or exploitation, or call 911 for immediate danger, providing specific details like dates, locations, and observed behaviors such as malnutrition, confusion, or unexplained injuries. For facility issues, contact the Long-Term Care Ombudsman, and gather details like names, health conditions, and the urgency of the risk.

## Georgia statues of law

### Legal Penalties

- **Felony:** Knowingly and willfully exploiting, abusing, or neglecting an elder is a felony, carrying penalties of 1 to 20 years in prison, a fine of up to \$50,000, or both.
- **Misdemeanor:** Intimidating victims or obstructing investigations is a high and aggravated misdemeanor.

### Reporting Elder Abuse in Georgia

- **Immediate Danger:** Call 911.
- **Non-Immediate Danger:** Contact Adult Protective Services (APS) online or by phone to report abuse, neglect, or exploitation of an at-risk adult.
- **Mandated Reporters:** Professionals like doctors, nurses, social workers, and home care providers are legally required to report suspected abuse or face misdemeanor charges.

## Reporting in Georgia

- Georgia Department of Human Services Adult Protective Services: For reporting and information on APS.
- Georgia Attorney General's Consumer Protection Division: Provides information on preventing elder abuse and exploitation.
- **Area Agency on Aging (AAA):** Can connect you to local resources and support services.
- **Long-Term Care Ombudsman:** For concerns about residents in nursing homes or assisted living facilities.

## Elder Abuse in the Home: Quick Guide for Staff

### What Is Elder Abuse?

Elder abuse is any intentional act—or failure to act—by a caregiver or trusted person that causes harm or places an older adult (typically age 60+) at risk of harm. Abuse often occurs in private homes and may involve family members or paid caregivers.

### Types of Elder Abuse

**Physical:** Hitting, pushing, restraining, burns, injuries

**Emotional:** Threats, intimidation, humiliation, isolation

**Financial:** Stealing, misuse of funds, coercion

**Neglect:** Failure to provide food, medications, hygiene, or care

**Sexual:** Any non-consensual sexual contact

**Abandonment:** Leaving an elder without needed support

### Warning Signs

**Physical:** Unexplained bruises, fractures, burns; dehydration or weight loss

**Behavioral:** Fearfulness, withdrawal, anxiety; reluctance to speak freely

**Financial:** Unpaid bills, sudden money issues, caregiver control

**Caregiver Red Flags:** Appears stressed, hostile, or prevents private interaction

### Your Role

Screen routinely and observe carefully

Speak with the patient privately when possible

Document objective findings only

Report concerns promptly—you do not need proof

### Screening Tips

Ask privately:

“Do you feel safe at home?”

Does anyone take your medications?”

“Have you missed doses because someone withheld them?”

Observe interactions.

### Documentation

Write factual, objective, specific information:

What you saw

What the patient or caregiver said

What concerned you

Who you notified

### Reporting Steps

Notify charge nurse or supervisor

Contact APS

Notify social work/case management

Document your actions

### Reporting Elder Abuse -- When in doubt—REPORT

#### Adult Protective Services (APS)

Georgia APS Hotline: **1-866-552-4464** <https://aging.georgia.gov/adult-protective-services>

**Emergency:** Call 911

### Key Reminders

- Elder abuse is often hidden and underreported
- Caregiver stress does not justify abuse
- Early reporting improves safety and outcomes