




## Case Study

### A Case Study: Is This Elder Abuse?

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## Introduction

The aging population in the U.S. is predicted to grow substantially more than double than in 2000, reaching approximately 80.8 million older individuals by 2040 and increasing to 94.7 million by 2060 (U.S. Department of Health and Human Services Administration for Community Living, 2021). Nurses possess the authority to assess the health, well-being, and potential risk of violence or abuse in individuals of all age groups. However, the identification of elder maltreatment falls behind the identification of child abuse and interpersonal violence (Goldstein & Glass, 2020). Filling the gap in nursing knowledge about elder and vulnerable person maltreatment is essential to build confidence in screening older and vulnerable adults. By identifying their risks, recognizing cardinal signs of physical abuse and neglect, and evaluating past and current experiences of maltreatment, nurses have the potential to improve the lives of older and vulnerable persons. Building knowledge about the elder maltreatment begins with the definition, which is “any action or neglect that harms or poses a risk to an older adult [or vulnerable dependent adult], perpetrated by someone in a position of trust or targeted towards them due to their age or disability. Th[e] mistreatment, also referred to as elder abuse, encompasses a range of forms such as physical abuse, sexual abuse, psychological abuse, financial exploitation, benefits trafficking, and neglect” (Rosen et al., 2020, p. 295).

Despite mandatory reporting protocols, professionals often exhibit hesitancy in reporting cases of abuse. Reasons for a reluctance includes fear of making a mistake, lack of evident physical signs, or concerns that reporting might exacerbate the abuse (Carney, 2020a). Therefore, systems that have specialized *advanced and generalist*<sup>1</sup> forensic nurse experts in elder maltreatment or abuse is essential when abuse is suspected. Seeking immediate consultation is important because not all injuries are the result of maltreatment or abuse. Injuries happen for a wide variety of reasons, and confirming a diagnosis occurs only after the provider rules out all differential diagnoses. To make assumptions about the cause of an injury without identifiable evidence and analysis is a form of bias to avoid.

In the context of a compelling case study, authors highlight the essential consequence of promptly referring elder maltreatment and abuse cases to an expert forensic team in elder abuse. By referring to the experts, nurses have a critical role in safeguarding the well-being and dignity of older adults, ensuring that older and vulnerable persons receive care and protection.

### Case Presentation

In the scenario, a distressing incident involving a 75-year-old woman unfolds. The elderly woman called 911 seeking help to get up from the floor, refusing to be taken to the emergency department. Upon arrival, paramedics discovered her lying on the floor with her rolling walker nearby. Although awake and alert, she complains of discomfort in her left shoulder. A closer examination by the paramedics finds: bruising on her right and left arms, impaired leg movement preventing her from sitting up, bilateral weakness in her grip, and with manipulation, pain in her left arm. The woman shares a brief medical history, including a 4-vessel heart bypass 13 years ago, a right rotator cuff repair 10 years ago, a right hip repair 4 years ago, and a diagnosis of muscular dystrophy in the last year. When questioned about her muscular dystrophy, she refers to her sister as the source of detailed information. When asked about anyone being present before her fall, she mentions living alone since her husband's death eight months ago, but her daughter and granddaughter assist her with placing compression stockings on for lymphedema in the morning and removing them in the evening. After a discussion with the patient, the evidence supported referral for a comprehensive hospital assessment, which is essential as paramedic concerns about the injuries included extension beyond mere joint and limb pain resulting from the fall. The approach to the patient was trauma-informed and compassionate with understanding about her difficult choices. She agreed to transport to take her to the hospital for further evaluation and care.

Upon reaching the emergency department, the triage nurse moved to a private room to screen the patient for maltreatment by asking, “Do you feel safe in your home?” To which the patient says, “Yes.” During the nurse’s assessment, three large areas of bruising on the patient’s arms and smaller bruises on her legs on both sides of her body were in various stages of healing, reporting her pain level as 8/10. She mentions allergies to all pain medications except morphine, and says she is sensitive to morphine’s effects. Imaging reveal fractures to the left humerus and ulna. While waiting for the orthopedic surgeon, the emergency nurse shares her suspicion about abuse with the charge nurse and bases her concern on the injuries and fractures seen. Responding

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<sup>1</sup> The [American Association of Colleges of Nursing \(2021\)](#) define *Level 1* as Entry-Level Professional Nursing Education sub-competencies, e.g., Generalist Forensic Nurse, and *Level 2* as Advanced-Level Nursing Education sub-competencies and specialty role requirements and competencies, e.g., Advanced Forensic Nurse.

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promptly, the charge nurse involved the hospital's team of *forensic nurses*<sup>2</sup> to explore the situation further. The case underscores the importance of skilled assessments with comprehensive interventions when there is suspicion of vulnerable or older person maltreatment. By referring to a specialized team of generalist and advanced forensic nurses, the medical professionals are ensuring comprehensive wrap around services to protect the person's well-being and safety and guarantees an evaluation by forensic nurse experts and the interprofessional team.

### Management and Outcome

The responding advanced forensic nurse thoroughly reviewed the nurse's assessment and their concerns. Using a trauma-informed approach with introductions before proceeding, permission was sought and obtained, specifically to talk about the patient's concerns (Dowdell & Speck, 2022). Seeking permission for informed consent is the first step in creating safety, respecting the person's autonomy, and ensuring transparency, thereby giving voice and choice to the patient (SAMHSA, 2014). Conducting a comprehensive forensic medical exam, the generalist forensic nurse observed and meticulously documented the numerous injuries during the evaluation, following photography guidelines for a visual record. Throughout the permission seeking process, the patient cooperated with the forensic nurse team and provided valuable information regarding the timeline and circumstance of the injury causes. The trauma-informed approach increased her willingness to share details to determine the mechanism of injury to the affected areas. Images serve as important contributions to explanations that demonstrate understanding of the extent and nature of the injuries, whether abusive or unintentional.

For illustrative purposes in Figures 1, 2, and 3, authors selected photographs to showcase injuries often mistaken for abusive injuries but are a result of underlying medical issues.

### Figures 1, 2, 3

#### *Right forearm*



*Photos used with permission © Dr. Meliss Batchen.*

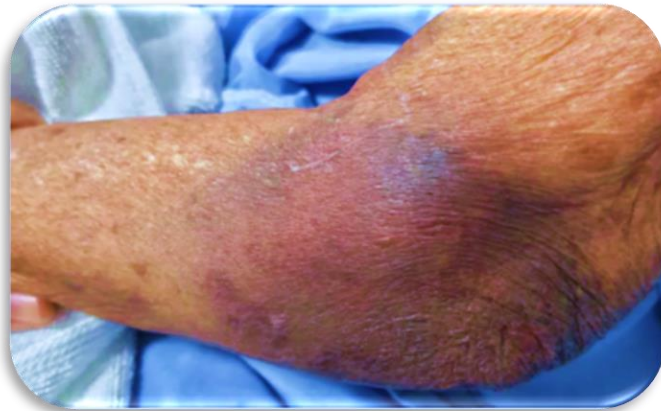
*Description: dorsal aspect of right arm, irregularly shaped, red, and purple discolorations with deep purple areas slightly raised, located two inches above wrist extending to two inches below antecubital space, length 8 inches by width 6 inches, pain 2 out of 10, "I must have bumped my arm when I fell." Photos were captured on a personal cell phone by a family member prior to transport to the hospital.*

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<sup>2</sup> Generalist and Advanced Forensic Nurses in elder maltreatment work in teams, collaborating with risk management, geriatricians, geriatric nurse practitioners, government agencies, and community stakeholders ensuring comprehensive wrap-around services.

**Figure 4**

*Left forearm*



*Photos used with permission ©Dr. Meliss Batchen*

*Description: Dorsal aspect of the left arm with a focus on the left elbow, area of circular redness and purple discoloration, diameter approximately 9 inches, swelling, and pain of 8 out of 10, "I tried to catch myself, but I fell on my left side and my arm and shoulder hurt."*

Respecting the patient's autonomy and demonstrating transparency and mutuality, the advanced forensic nurse, sought, and obtained permission to communicate with the patient's sister. A private consultation room allowed for a compassionate and thorough phone interview with the sister who provided valuable insight into the patient's past medical history, current health status and medical diagnoses, medications, and living conditions. The collaborative efforts of the sister with the forensic nurse resulted in a comprehensive understanding of the patient's situation.

With the sister's information, the patient underwent a thorough evaluation by an orthopedic surgeon, who determined that her fractured humeral head urgently required a shoulder hemiarthroplasty or partial shoulder replacement with a metal implant. In addition, the patient had a minimally displaced proximal ulnar fracture, which required a cast from her fingertips to just below the elbow to control forearm rotation and prevent further displacement. The orthopedic surgeon attributed both fractures to the patient's history of falling. Humeral head fractures in the older population are typically seen in women after a ground-level fall (Attum & Thompson, 2023). The ulnar fracture likely occurred from an axial load applied to the forearm through the hand as an attempt to stop the fall (Sharareh & Riehl, 2021). The surgical staff prepared to take the patient to surgery and the ortho-tech casted the arm in the emergency department, delivering timely interventions. With the entire record, including evaluative findings and the information shared during the patient and sister interviews, the team of forensic nurses met with medical and nursing providers involved in the patient's care to review the evidence. Informed, the team created collaborative decisions, acceptable to the patient and family to foster the patient's well-being.

### **Forensic Medical Legal Evaluation Results**

The consensus conclusion for the patient revealed that the multiple bruises were a result of her instability and frequent bumps into objects, even when using a walker. She explained that occasional thigh and leg bruises occurred when her family assisted her with compression stockings, when the hands slipped because the leg swelling made it difficult to don the socks. Understanding the activity and circumstance helped reveal the cause of bruises, avoiding misinterpretation of intentional injury and abusive maltreatment.

Maintaining a high index of suspicion, based on evidence, for elder and vulnerable person maltreatment and abuse is essential for a healthy population of community dwellers. The

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knowledge necessary considers the impact of the underlying health issues on the overall health and well-being of individuals. As demonstrated in this case, it is difficult to distinguish between intentional physical abuse and the sequelae of unintentional injury due to medical conditions. So, the question to be answered is, do injury patterns of individuals with confirmed elder abuse differ from those of elderly persons with accidental falls? The evidence suggests that there is an association of abuse with traumatic findings. One study compared injuries in 78 cases of confirmed elder abuse and 78 cases of elders with unintentional injuries (Rosen et al., 2020) and the differences are outlined in Table 1.

**Table 1**

*Injuries in Elder Physical Abuse Victims versus Elders with Unintentional Trauma*

<b>Injury Types and Locations</b>	<b>Abuse Victims</b>	<b>Unintentional Trauma</b>
Bruising on maxillofacial, dental, or neck areas	78%	54%
Injuries in maxillofacial, dental, or neck areas	67%	28%
Injuries to the left cheek or zygoma	22%	3%
Injuries on neck	15%	0%
Injuries on ear	6%	0%
Maxillofacial, dental, or neck injuries combined with no upper and lower extremity injuries	50%	8%
Fractures	8%	22%
Lower Extremity Injuries	9%	41%

*(Rosen et al., 2020)*

With the guidance of Rosen et al (2020) research findings, the team of forensic nurses determined that the patient in this case study had fractures and lower extremity injuries consistent with unintentional injuries, confirmed during the interprofessional team case review. However, knowledgeable advanced forensic nurses have a high index of suspicion for intentional injury while considering underlying health issues, especially diagnoses that increase the potential for unintentional injury. Therefore, the interdisciplinary and interprofessional teams, which include the advanced forensic nurse, work collaboratively to comprehensively address the patient's needs. In the case, even though the government's Adult/Elder Protective Services was not notified, the interprofessional team was proactive and consulted social services to ensure the patient received appropriate support. Social services led the community referrals for in-home physical therapy and occupational therapy to assess mobility concerns, evaluate environmental safety, and provide necessary resources, all aimed at enhancing the patient's overall well-being and safety when returning home.

Throughout this process, the collaborative efforts of the forensic nurse, medical professionals, and social services exemplified the person-centered approach espoused in the AACN *Essentials*. The team not only addressed the patient's immediate medical needs but also considered her overall well-being in the context of potential elder maltreatment or abuse concerns. The trauma-informed and compassionate comprehensive approach underscores the need for forensic nurse experts in elder maltreatment and abuse while they advocate for and safeguard vulnerable individuals in the healthcare system.

**Discussion**

The patient has an onset late-onset neuromuscular disease that presents symptoms and mobility issues that are easily perceived as advanced age-related changes. Interpretation includes a possible neurological injury from her fall. The knowledge that many neuromuscular diseases present late-onset symptoms helps healthcare professionals assess and treat older or vulnerable patients accurately without bias. Consideration includes that many older patients are not aware of a decline in safe activities with a neuromuscular disease diagnosis. The information provided to health care staff by the patient’s sister revealed that the patient did not know about her neuromuscular disease until she was genetically tested at age 72, after her sister and first cousin were diagnosed with the same neuromuscular disease! Incorrectly, the patient attributed physical mobility issues to a history of her advancing age and life-long orthopedic health problems.

A broad definition of a neuromuscular disorder encompasses a diverse group of conditions that affect the peripheral nervous system, including all motor and sensory nerves connecting the brain and spinal cord to the body (University of Michigan Health, 2022). The key hallmark is progressive muscle weakness. However, the age of onset, level of mobility impairment, and rate of progression varies significantly across different neuromuscular diseases.

Certain neuromuscular diseases emerge at ages 50, 60, or 70 and are mistakenly attributed to normal aging. The limited healthcare professional knowledge about neuromuscular diseases leads to misdiagnoses, delayed treatments, and subsequent challenges in recognizing and understanding symptomology, usual age of symptom onset, rates of progression, organ and/or bodily system involvement. A variety of common neuromuscular diseases and their corresponding variable age of symptom onset v recognition are in Table 2.

**Table 2**

*Neuromuscular Diseases and Symptom Onset*

<b>Neuromuscular Disease</b>	<b>Age of Symptom Onset</b>
Limb-Girdle Muscular Dystrophy (Over 43 types and subtypes)	Usually in adulthood, but onset can be as early as childhood or as late as ages 50-70 years
Amyotrophic Lateral Sclerosis (ALS)	Usually between 40-70 years
Inclusion Body Myositis	Typically, over 50 years
Polymyositis	Usually between 30-60 years
Guillain-Barré Syndrome	Any age
Myasthenia Gravis	Any age
Facioscapulohumeral Muscular Dystrophy	Teenage years to adulthood
Charcot-Marie-Tooth Disease	Childhood or early adulthood with few types in late adulthood
Becker Muscular Dystrophy	Childhood to early adulthood
Duchenne Muscular Dystrophy	Childhood (2-6 years)
Spinal Muscular Atrophy	Infancy or early childhood

Symptom onset is often earlier than the age at diagnosis because some neuromuscular diseases have subtle early symptoms, becoming more evident over time. Consulting with a variety of healthcare professionals ensures accurate diagnosis and individualized management of neuromuscular diseases. (NYU Langone Health, 2023). By promoting better understanding and knowledge-sharing among healthcare professionals, nurses find opportunity to improve the early detection and accurate diagnosis of neuromuscular diseases, enabling timely interventions and personalized care plans for patients. The primary care physician (PCP), who is familiar with the patient's specific disease, along with other specialized physicians, enhance the coordination of care and facilitate a holistic approach to managing the patient's disease progress. Open communication and collaboration among healthcare providers and the stakeholder community ensures the collaborative effort enhances effective and safe community care for patients with neuromuscular disorders, improving quality of life and outcomes for individuals with neuromuscular disease.

Other nursing considerations in busy healthcare settings require knowledge of or suspicion of the existence of a neuromuscular disease. If limited knowledge, the nurse evaluates the history of frequent falls, and the impact of pain medication on patients who may have difficulty communicating or providing medical information. In this case, nurse is suspicious because the patient had a history of falls, and currently needed pain medication due to the fractures. In a short time, she would undergo anesthesia for the surgical repair of her fractures. The evidence supports that patients who have neuromuscular diseases infrequently experience more significant adverse effects from certain pain medications and anesthetics due to the suppression of neuromuscular function (Katz & Murphy, 2017). A careful preoperative assessment prevents complications of worsening muscle weakness that contributes to postoperative respiratory failure and/or prolonged intubation.

The patient's desire to live independently aligns with research findings that highlight how older individuals often anticipate mobility changes and make adaptive changes accordingly (Moller, Martinsen, Werlauff, & Dreyer, 2021). While maintaining independence is essential for their well-being, safety hazards increase with a patient's limitations and abilities. Nurses prevent poor outcomes, e.g., aspiration, falls, and pressure sore development, with careful monitoring, continual assessment, and implementation of hazard reduction strategies (Clemson, et al., 2019).

### **Implications for Practice**

Acknowledging autonomy in older and vulnerable persons often lead to hesitation in reporting abuse. The hesitation is due to various reasons, such as fear of punishment, loss of independence, or embarrassment (Carney, 2020a). Healthcare organizations are required by The Joint Commission (2022) to have written criteria to identify potential abuse victims and to report such cases to external agencies in compliance with laws and regulations. A scoping review of multiple elder assessment tools highlighted more recently developed tools (Van Royen et al., 2020). In the case presented here, the emergency nurse followed institutional policy by asking about abuse. With suspicion, the charge nurse enlisted the forensic nurse team of elder maltreatment experts for a more robust and structured assessment. With trauma informed care, additional details about the home environment and a neuromuscular disease contributor to unintentional injury emerged. The forensic team of elder maltreatment experts and stakeholders created a comprehensive plan of care that utilized community resources to address the needs of the patient and the family.

## Summary

An elder abuse expert, Dr. Amy Carney (2020b) published, “Not every bruise is abuse, and not every fall is suspicious....it is important to be able to identify disease processes and accidental injury that mimic maltreatment” (p. 24). Healthcare providers who adopt a trauma-informed, person-centered approach adapt their care plans from the very first encounter to the abilities and limitations of the older or vulnerable person. To fill the gap in knowledge, all healthcare professionals ought to receive training to recognize maltreatment of older and vulnerable persons, identify and evaluate conditions that mimic abuse, document objective findings, and report injuries and signs that indicate maltreatment or abuse. Collaborative strategies involving various interprofessional partners, including generalist and advanced forensic nurses, physical and occupational therapists, social services, advocacy organizations, elder protection services, law enforcement, and other community stakeholders, are essential to comprehensively manage the healthcare consequences of disease processes effectively.

The meticulous work and attention to detail demonstrated by the emergency nurses and team of forensic nurses were pivotal in unraveling the truth behind the patient's injuries, contributing to a thorough and impartial assessment, collecting the data to arrive at a diagnostic conclusion. Their dedication and expertise played a pivotal role in protecting all older and vulnerable persons like the patient from intrusive and maligned bias and highlighted the important specialized knowledge of elder maltreatment and abuse possessed by the generalist and advanced forensic nurse in cases of suspected older and vulnerable person maltreatment.

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