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Nurses' Self-Efficacy for Managing Elder Abuse

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NURSES' SELF-EFFICACY FOR MANAGING ELDER ABUSE

by

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Abstract

NURSES' SELF-EFFICACY FOR MANAGING ELDER ABUSE

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Elder abuse is a serious issue that negatively affects physical and mental health in those affected. A significant portion of the older population suffers from abuse. Abuse of older adults is often not detected or reported, for various reasons. Health care providers, especially nurses, are often in contact with older victims of abuse and therefore have the potential to play a significant role in detecting, reporting, and intervening in such cases. Nurses are hesitant to intervene due to lack of self-efficacy in their ability to properly manage elder abuse. This quantitative, descriptive study was designed to determine whether educational content on elder abuse, perceived capability, and self-efficacy, affected actions on reporting elder abuse by registered nurses. This study used an online survey to obtain data. Findings from this study indicated there is an interaction of educational content on reporting actions of elder abuse by registered nurses. There is a need to further examine the issue of reporting elder abuse by registered nurses to determine in more detail which factors affect reporting of suspected cases of abuse.

Chapter 1.

Overview of the Research Study

Overall Purpose of the Study

Abuse of older adults is a serious problem that leads to negative health outcomes for those involved. It is an issue that is not detected or reported in most cases, for various reasons. Health care providers have been found to be one of the groups in contact most frequently with older victims of abuse and therefore have the potential to play a significant role in detecting, reporting, and intervening in such cases, potentially decreasing the incidence of the issue. Providers are reluctant to intervene in suspected cases of abuse because they lack of knowledge and confidence. The purpose of this quantitative study is to examine factors which influence registered nurses' reporting of elder abuse, including self-efficacy in managing elder abuse, perceived barriers to intervention, and educational content. Instruments used in this study included Reported Actions, Perceived Intervention Barriers, and Self-Efficacy for Management of Elder Abuse.

Introduction to Articles

This portfolio contains two manuscripts, *The State of the Science on Nurses' Management of Elder Abuse* and *Nurses' Self-Efficacy for Managing Elder Abuse.* The first article consists of a review of literature of nurses' management of elder abuse. This review includes definitions of elder abuse, types of elder abuse, settings in which it occurs, risk factors for the victim and the abuser, reporting statistics, and tools published in literature. In summary, nurses do not adequately report suspected cases of elder abuse and future research should focus on factors which may affect reporting, such as self-

efficacy, knowledge, and education. The second article discusses a quantitative study done which evaluated the interaction between nurses' self-efficacy in management of elder abuse, educational content on elder abuse, perceived intervention barriers in management of elder abuse, and reporting actions on elder abuse. Findings indicate that educational content on elder abuse has the highest correlation with actions in reporting elder abuse.

Chapter 2

The State of the Science on Nurses' Management of Elder Abuse

Abstract

Elder abuse affects a significant portion of the older population and leads to negative health outcomes in those affected. There are five categories of elder abuse identified in literature, which include physical, emotional, sexual, financial, and neglect. Most elder abuse occurs in the home and is committed by a family member of the older adult. Risk factors are identified for both the older adult and the care giver, factors which increase the chance abuse will occur in the situation. Healthcare workers, especially nurses, have the opportunity to improve the situation through reporting suspected cases, but many do not do so. Future research should focus on factors related to nurses reporting suspected cases of elder abuse, such as knowledge, self-efficacy, and education.

Keywords: elder abuse, nurses, reporting

The prevalence of elder abuse falls between two and ten percent of the older population (Anetzberger, 2001; Brownell, 2005; Cooper, Selwood, & Livingston, 2008; Cox, 2008; McCreadie, Bennett, Gilthorpe, Houghton, & Tinker, 2000; Ploeg, Fear, Hutchison, MacMillan, & Bolan, 2009; Wolf, 2000). Elder abuse (EA) leads to increased mortality (Charland, 2006; Cooper, Selwood, & Livingston, 2009; Halphen, Varas, & Sadowsky, 2009; Laumann, Leitsch, & Waite, 2008; Pearsall, 2005; Schofield, Powers, & Loxton, 2013), tripling the likelihood of death within three years (Cox, 2008), increased hospital and physician visits (Charland, 2006; Lachs & Pillemer, 2004) and nursing home placement (Charland, 2006; Cooper et al., 2009). Abuse of older adults also results in depression and emotional distress (Charland, 2006; Cooper et al., 2009; Hirsch et al., 1999; Laumann et al., 2008).

Review of Literature

Definitions

As defined by the National Academy of Science and a report by the National Research Council, Elder abuse includes intentional actions causing harm or creating a serious risk of harm to a vulnerable elder by an individual who stands in a trust relationship to the elder, as well as failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm (Buzgova & Ivanova, 2009; Cohen, Levin, Gagin, & Friedman, 2007; Lachs & Pillemer, 2004; Laumann et al., 2008). Abuse is classified into the five categories of physical, emotional/psychological, sexual, financial, and neglect (Anthony et al., 2009; Cohen et al., 2007; Cooper et al., 2009; Davison, 2007;

Desmarais & Reeves, 2007; Gray-Vickrey, 2005; Griffith & Tengnah, 2006; Lachs & Pillemer, 2004; Nelson, Nygren, McInerny, & Klein, 2004; Starr, 2010).

Physical abuse consists of violent acts causing pain or injury, unintentionally or not, through kicking, pushing, hitting, burning, strangling, etc. (Fitzpatrick & Hamill, 2011; Hirsch et al., 1999; Jayawardena & Liao, 2006; Kleinschmidt, 1997; Lachs & Pillemer, 2004; Pearsall, 2005; Radensky & Parikh, 2008). Physical abuse is generally the most easy to identify due to physical injuries that are visible (Fitzpatrick & Hamill, 2011; Hirsch et al., 1999), which may include bruising, broken bones or fractures, and repeated hospitalizations (Anthony et al., 2009). Sexual abuse is defined as nonconsensual intimate contact, including with older adults who lack the cognitive ability to consent (Jayawardena & Liao, 2006; Pearsall, 2005; Kleinschmidt, 1997; Lachs & Pillemer, 2004).

Emotional abuse includes actions that cause fear, isolation, confusion, or disorientation with the intent to cause emotional pain, anguish or distress (Fitzpatrick & Hamill, 2011; Gorbien & Eisenstein, 2005; Lachs & Pillemer, 2004; Pearsall, 2005). Actions that comprise emotional abuse include "verbal or nonverbal insults, humiliation, infantilization or threats, including institutionalization or abandonment" (Jayawardena & Liao, 2006; Kleinschmidt, 1997; Radensky & Parikh, 2008). Financial abuse and exploitation are seemingly interchangeable terms defined as the improper use of an adult's money or property for another person's gain or profit (Charland, 2006; Fitzpatrick & Hamill, 2011; Gorbien & Eisenstein, 2005; Hirsch et al., 1999; Lachs & Pillemer, 2004). Additionally, coercion or undue influence is included in the definition of financial abuse (Jayawardena & Liao, 2006; Kleinschmidt, 1997).

Components of neglect include inadequate care of any kind to a vulnerable older adult by an individual responsible to provide care. Neglect may include lack of provision of adequate shelter, nutrition, clothing, supervision, protection, attention, personal care, medical necessities, and needed devices such as glasses, dentures, hearing aides, and walkers (Charland, 2006; Fitzpatrick & Hamill, 2011; Fulmer, Paveza, Abraham, & Fairchild, 2000; Halphen et al., 2009; Hirsch et al., 1999; Jayawardena & Liao, 2006; Kleinschmidt, 1997; Lachs & Pillemer, 2004; Pearsall, 2005; Radensky & Parikh, 2008). Indicators of neglect are more difficult to identify (Anthony et al., 2009).

Prevalence and Reporting

The prevalence of elder abuse falls between two and ten percent of older adults (Brownell, 2005; Cox, 2008; Halphen et al., 2009; Lachs & Pillemer, 2004; Pickering & Rempusheski, 2013). These statistics are just the tip of the iceberg, as elder abuse has consistently been found to be a problem that is underreported. According to numerous studies (Brownell, 2005; Gray-Vickrey, 2005; Heath et al., 2005; Pickering & Rempusheski, 2013; Radensky & Parikh, 2008; Sayles-Cross, 1988; Schecter & Dougherty, 2009), for every case of elder abuse reported, there are at least five cases that go unreported.

Settings and Risk Factors

Abuse of older adults occurs in various settings, including the home (67%), hospital (5%), and nursing home (22%) (Agnew, 2006; Davison, 2007; Griffith & Tengnah, 2006; Jayawardena & Liao, 2006; Plitnick, 2008). Most abuse is committed by a family member (Davison, 2007; Jayawardena & Liao, 2006; Plitnick, 2008), with fifty percent of the abusers being an adult child of the older adult and 25 percent of the abusers

being a spouse of the older adult (Agnew, 2006; Desmarais & Reeves, 2007; Jayawardena & Liao, 2006; Wolf, 2000).

Risk factors or characteristics which make the individual more susceptible to abuse, were identified. These risk factors include decreased cognitive and functional status requiring assistance with activities of daily living (Cooper et al., 2009; Cox, 2008; Dong, Simon, & Evans, 2012; Erlingsson, Carlson, & Saveman, 2005; Gorbien & Eisenstein, 2005; Gray-Vickrey, 2005; Jayawardena & Liao, 2006; Lachs & Pillemer, 2004; O'Connor, Hall, & Donnelly, 2009; Plitnick, 2008), older age (Gorbien & Eisenstein, 2005; Gray-Vickrey, 2005; Halphen et al., 2009), female gender (Desmarais & Reeves, 2007; Gorbien & Eisenstein, 2005; Gray-Vickrey, 2005; O'Connor et al., 2009; Plitnick, 2008; Schecter & Dougherty, 2009), social isolation (Erlingsson et al., 2005; Gorbien & Eisenstein, 2005; Halphen et al., 2009; Lachs & Pillemer, 2004; McGarry & Simpson, 2009; Muehlbauer, 2006), low income, minority status, and low education level (Gorbien & Eisenstein, 2005; Halphen et al., 2009; Lachs & Pillemer, 2004), as well as lack of access to resources (Gorbien & Eisenstein, 2005).

Risk factors have been found for those committing the abuse, characteristics which contribute to the caregiver being an abuser. These include drug or alcohol use (Cooney, Howard, & Lawlor, 2006; Gainey & Payne, 2006; Halphen et al., 2009; Jayawardena & Liao, 2006; Lowder, Buzney, & Buzo, 2005; Muehlbauer, 2006; Reay & Browne, 2001; Schecter & Dougherty, 2009), depression or other mental health issues (Cooney et al., 2006; Gainey and Payne, 2006; Halphen et al., 2009; Jayawardena & Liao, 2006; Reay & Browne, 2001; Sayles-Cross, 1988; Schecter & Dougherty, 2009), as well as a previous difficult or violent relationship between the caregiver and older adult

(Gainey & Payne, 2006; Gray-Vickrey, 2005; McGarry & Simpson, 2009; Muehlbauer, 2006). Abuse is also related to dependence of the caregiver on the victim (Gray-Vickrey, 2005; Kleinschmidt, 1997; Lachs & Pillemer, 2004; Muehlbauer, 2006; McGarry & Simpson, 2009) and the abuser is often financially dependent on the victim (Gorbien & Eisenstein, 2005).

Lack of Reporting

Reasons identified for not reporting instances of abuse by the victim include fear, shame, embarrassment (Anthony et al., 2009; Charland, 2006; Cronin, 2007; Gray-Vickrey, 2005; Pearsall, 2005; Yaffe et al., 2008), loyalty, gratitude, inability to recognize abuse, decreased cognition (Desmarais & Reeves, 2007), self-blame, and desire for privacy (Pearsall, 2005; Yaffe, Wolfson, Lithwick, & Weiss, 2008). Other reasons were found to include fear of abandonment, the belief they deserved the abuse, and feeling of having nowhere else to go (Reay & Browne, 2001), as well as hesitancy to see a family member punished or a family to be broken apart (Agnew, 2006; Cronin, 2007; Pearsall, 2005; Yaffe et al., 2008).

The importance of reporting abuse by healthcare workers in order to decrease its occurrence was emphasized (Erlingsson et al., 2005; Gorbien & Eisenstein, 2005; Halphen et al., 2009). Healthcare providers are in a prime position to report EA due to their frequent contact with abused older adults (Cooper et al., 2009; Daly & Coffey, 2010; Fulmer et al., 2004; Radensky & Parikh, 2008). In spite of the optimal opportunity to identify EA, most healthcare workers are not adequately prepared to do so (Erlingsson, Carlson, & Saveman, 2005; Gorbien & Eisenstein, 2005) as they often fail to suspect abuse (Tilden et al., 1994).

Legal Responsibility

Reporting suspected abuse is crucial for healthcare workers as most states require healthcare providers to report suspected cases of abuse (Fulmer et al., 2004; Hirsch et al., 1999; Liao, Jayawardena, Bufalinia, & Wiglesworth, 2009; Muehlbauer, 2006; Shugarman, Fries, Wolf, & Morris, 2003). The American Medical Association recommends screening for elder mistreatment in all older patients (Fulmer et al., 2004). Legal viewpoints have argued that a clinician's failure to detect and report abuse of an elder constitutes negligence and malpractice (Hirsch et al., 1999) and failure to act by the nurse in cases of suspected abuse could be in itself considered abuse (Muehlbauer, 2006).

Reporting Statistics

Reporting of EA varied among healthcare workers. Home care workers reported 27 percent of the cases, physicians and other healthcare professionals eighteen percent of the cases, and family members fifteen percent of the cases (Gorbien & Eisenstein, 2005). More specifically, others (Gorbien & Eisenstein, 2005; Kleinschmidt, 1997) reported that physicians made two percent of the reports, community members 41 percent, non-physician healthcare providers 26 percent, social workers 25 percent, and law enforcement officials five percent of cases. More than 50 percent of nurses, 25 percent of physicians, and most of the dental workers surveyed stated they would not report suspected elder abuse to authorities (Tilden et al., 1994).

Reasons for Not Reporting EA

Numerous reasons healthcare workers did not report EA were located. Reasons included unclear definitions (Fulmer et al., 2004; Liao et al., 2009), lack of awareness regarding mandated reporting laws (Halphen et al., 2009; Liao et al., 2009), fear of

breaching confidentiality (Anetzberger, 2001; Desmarais & Reeves, 2007; Jayawardena & Liao, 2006; Liao et al., 2009; Muehlbauer, 2006), and fear of causing abuse to escalate (Desmarais & Reeves, 2007; Jayawardena & Liao, 2006). Additional barriers to reporting by health care providers include lack of awareness of prevalence (Fulmer et al., 2004; Jayawardena, 2006; Shugarman et al., 2000; Shugarman et al., 2003), lack of knowledge on how to report (Charland, 2006; Fulmer et al., 2004; Halphen et al., 2009; Jayawardena, 2006; Liao et al., 2009; Shugarman et al., 2003; Wagenaar, 2009; Yaffe et al., 2008), and lack of faith in authorities to deal with the issue (Anetzberger, 2001; Jayawardena & Liao, 2006; Tilden et al., 1994).

Additional obstacles to reporting by healthcare providers were located. Healthcare providers found it difficult to recognize EA because signs were subtle or attributed to aging (Anthony et. al., 2009; Liao et al., 2009; Tilden et al., 1994), a lack of universally accepted detection instruments (Erlingsson et al., 2005; Halphen et al., 2009; Kennedy, 2005; Yaffe et al., 2008), lack of time and resources (Halphen et al., 2009; Gorbien & Eisenstein, 2005; Kleinschmidt, 1997; Yaffe et al., 2008), and lack of knowledge regarding signs and risk factors (Agnew, 2006; Almogue et al., 2010; Anetzberger, 2001; Gorbien & Eisenstein, 2005; Halphen et al., 2009; Kennedy, 2005; Neno & Neno, 2010; Starr, 2010; Wagenaar, 2009; Yaffe et al., 2008). The primary themes that appeared repeatedly throughout the literature was a lack of healthcare providers' knowledge regarding types, risk factors, reporting methods, and prevalence of elder abuse, as well as confidence in their ability to appropriately detect and report abuse (Almogue et al., 2010; Muehlbauer, 2006; Schofield & Mishra, 2004; Shugarman et al., 2003; Starr, 2010).

Tools

Validated instruments assist with screening for abuse and risk for abuse. One such tool is the Elder Assessment Instrument, EAI, which provides nurses with a mechanism for screening older individuals for possible abuse (Fulmer, 2008). The screening is achieved via interview and designed to gather information to increase understanding of the situation.

The Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST) consists of 15 items determined to detect one of three categories; overt violation of personal rights or direct abuse, characteristics of the older adult making him/her vulnerable to abuse, or characteristics identifying a situation as potentially abusive (Neale, Hwalek, Scott, Sengstock, & Stahl, 1990). A positive result indicates the need for further assessment, not the actual presence of abuse. The Vulnerability to Abuse-Screening Scale (VASS) was developed to assess for abuse of older women (Schofield & Mishra, 2004). It is a modified form of the H-S/EAST and consists of 12 items on a self-report assessment including the four concepts of vulnerability, dependence, dejection, and coercion.

The Health, Attitudes towards aging, Living arrangements, and Finances Assessment (H.A.L.F.) was developed as a clinician-based tool to identify older adults at risk for abuse in a health service setting (Fulmer et al., 2004). The interviewer answers questions after meeting with both the caretaker and older adult during which the interviewer assesses areas such as the older adult's health status, attitudes of the family towards aging, finances, and living arrangements. The H.A.L.F. is a useful tool because it has been developed for a variety of health service settings, including hospital and home health.

Two instruments require EA-specific training or training to administer the tool. The Indicators of Abuse Screen (IOA) was developed by a multidisciplinary committee consensus panel (Fulmer et al., 2004) to discriminate between abuse and non-abuse. An individual must be trained on its administration and administration takes two to three hours. It was found that the IOA identified between 78% and 84% of abuse of older adults in a health and a social service agency (Fulmer et al., 2004). The tool has not been tested in other settings. The Brief Abuse Screen for the Elderly (BASE) is a screening tool consisting of five brief questions. Anyone administering this tool must be trained on the topic of abuse (Fulmer et al., 2004).

The Elder Abuse Suspicion Index (EASI) was developed for physician use when EA was suspected and possible assessment by protective services required (Yaffe et al., 2008). The EASI contains six questions with yes/no answers and two additional items for the physician as to whether physical findings of abuse were present; the EASI takes approximately two minutes to administer.

The Screen for Various Types of Abuse or Neglect was developed by the American Medical Association (Daly & Jogerst, 2006). The Screen for Various Types of Abuse or Neglect consists of nine general questions to be asked of an older person. A health care professional asks the older adult direct questions. Any questions answered positively should be followed up to determine how and when the mistreatment occurs, who the abuser is, and how the patient feels about and copes with it.

Conclusions and Recommendations

Elder abuse affects a significant portion of older adults and causes increased morbidity and mortality in those affected. Healthcare workers are in a prime position to

intervene in suspected cases of EA. Many often do not act primarily due to lack of knowledge and confidence in how to manage such situations. Risk factors for both the older adult and the abuser, characteristics which increase the chance of abuse were identified. Most abuse is committed in the home by a family member caregiver. Numerous tools have been identified to promote screening and identification of elder abuse, but none are widely tested or used in practice.

The prevalence of elder abuse has been established and future research should focus on decreasing the prevalence and negative impact on older adults. Healthcare providers' knowledge, confidence in reporting, and actual reporting of EA should be assessed. Intervention studies to examine innovative methods of educating current providers as well as healthcare students are needed. Approaches such as online learning modules, low-fidelity, and standardized models are examples of teaching approaches that might be evaluated.

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Chapter 3

Nurses' Self-Efficacy in Management of Elder Abuse

Abstract

Purpose: The purpose of this quantitative study was to examine the effects of educational content, perceived barriers, and self-efficacy in managing elder abuse on reported actions by registered nurses.

Method: This study was guided by Bandura's Theory of Self-Efficacy and used a quantitative cross-sectional survey. One hundred eighty-four participants completed an online survey including Self-Efficacy in Management of EA, Perceived Intervention Barriers, Reported Actions, and demographics. To test the hypotheses on the relationships between the reported actions of EA and its predictors, blockwise multiple regression was conducted. The dependent variable was Actions in Reporting EA. Educational content and the interaction term for Self-efficacy and Educational content were the significant predictors and accounted for the largest changes in *R* square.

Findings: Nurses' education on elder abuse had the highest correlation with reporting of elder abuse.

Conclusion: Future studies to further evaluate educational content and delivery methods in relation to reporting elder abuse by nurses are needed.

Keywords: elder abuse, nurses, self-efficacy, reporting, knowledge

The prevalence of elder abuse (EA) is between two and ten percent of the older population (Anetzberger, 2001; Brownell, 2005; Cooper, Selwood, & Livingston, 2008; Cox, 2008; McCreadie, Bennett, Gilthorpe, Houghton, & Tinker, 2000; Ploeg, Fear, Hutchison, MacMillan, & Bolan, 2009; Wolf, 2000). The number of adults affected in the United States each year is estimated to be close to two million (Gorbien & Eisenstein, 2005; Gray-Vickrey, 2005; Jayawardena & Liao, 2006; Pearsall, 2005; Plitnick, 2008; Schecter & Dougherty, 2009; Wagenaar, Rosenbaum, Herman, & Page, 2009). It is difficult to report the actual numbers due to inadequate reporting.

Abuse of older adults results in a decreased lifespan and begins a downward spiral in their physical and emotional status (Breaux & Hatch, 2003; Charland, 2006; Halphen, Varas, & Sadowsky, 2009; Cooper, Selwood, & Livingston, 2009; Laumann, Leitsch, & Waite, 2008; Pearsall, 2005). Abuse leads to increases in mortality rates, nursing home placement, and physician and hospital visits (Charland, 2006; Lachs & Pillemer, 2004). EA results in depression and emotional distress in many victims (Charland, 2006; Cooper et al., 2009; Laumann et al., 2008), as well as anxiety, depression, or post-traumatic stress disorder (Hirsch et al., 1999). Other negative effects of abuse of older adults include needless distress, pain, injury, and decreased quality of life (Pearsall, 2005).

It is estimated that one in fourteen cases of EA was reported (Acierno et al., 2010; Anetzberger, 2001; Muehlbauer, 2006; Plitnick, 2008). The older adult may have had difficulty reporting abuse for a number of reasons, including shock, sadness, or shame (Cronin, 2007; Pearsall, 2005; Yaffe et al., 2008). Nurses also do not report abuse, for numerous reasons (Fulmer et al., 2004). Healthcare workers, especially nurses, have the potential to make a significant difference in preventing elder abuse through knowledge of

what constitutes abuse, warning signs, and appropriate interventions (Davison, 2007; Plitnick, 2008). Nurses are in an optimal position to detect, manage, and prevent EA as they may be the only outside adult in contact with the victim (Muehlbauer, 2006; Potter, 2004). Additionally, nurses have been trained to perform assessments and collaborate with other disciplines, which are important in managing the issue. Nurses must be confident and knowledgeable in their ability to identify and manage cases of EA (Richardson, Kitchen, & Livingston, 2002).

Literature Review

A review of current literature was conducted using Ovid with the keywords "elder abuse", "prevention,", "elder abuse", "knowledge" and "assessment." When searching with the keyword "elder abuse" only, Medline yielded 2,541 results. When combined with "knowledge," 753 articles were found. Using the keyword "prevention" with "elder abuse" yielded 778 articles and the term "assessment" found 1172 articles. Keywords were used in Google Scholar, with a few additional articles located. Many of the articles were duplicates. The majority of the articles described or briefly mentioned elder abuse; many were letters to the editor, with a smaller portion comprised of studies done on various issues related to elder abuse.

Definitions and Forms of EA

The World Health Organization defined 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" (World Health Organization, n.d.). Abuse has been separated into the five categories of physical, emotional/psychological, sexual, financial, and neglect (Anthony et al., 2009; Cohen et

al., 2007; Cooper et al., 2009; Davison, 2007; Desmarais & Reeves, 2007; Gray-Vickrey, 2005; Griffith & Tengnah, 2006; Lachs & Pillemer, 2004; Nelson, Nygren, McInerny, & Klein, 2004; Starr, 2010). Physical abuse has been defined as violent acts causing pain or injury to an older adult, (Fitzpatrick & Hamill, 2011; Hirsch et al., 1999; Jayawardena & Liao, 2006; Kleinschmidt, 1997; Lachs & Pillemer, 2004; Pearsall, 2005; Radensky & Parikh, 2008).

Definitions were consistent in describing emotional/psychological abuse, and both terms were used interchangeably. Emotional abuse was considered to include actions that caused emotional distress to the older adult, such as fear, isolation, confusion, or disorientation (Fitzpatrick & Hamill, 2011; Gorbien & Eisenstein, 2005; Lachs & Pillemer, 2004; Pearsall, 2005). Financial exploitation is defined as "illegal or unethical exploitation of funds, which includes providing substandard care despite the availability of funds to the elder and cashing checks without permission" (Radensky & Parikh, 2008, p. 254).

Neglect encompassed failure to meet basic needs of the older adult, including shelter, food, clothing, protection from harm, medical needs, personal care, and assistive devices (Charland, 2006; Halphen et al., 2009; Fitzpatrick & Hamill, 2011; Fulmer, Paveza, Abraham, & Fairchild, 2000; Hirsch et al., 1999; Jayawardena & Liao, 2006; Kleinschmidt, 1997; Gorbien & Eisenstein, 2005; Lachs & Pillemer, 2004; Pearsall, 2005; Radensky & Parikh, 2008). Sexual abuse was defined as intimate contact without consent or ability to consent (Jayawardena & Liao, 2006; Pearsall, 2005; Kleinschmidt, 1997; Lachs & Pillemer, 2004).

Barriers to Reporting EA

Elder abuse is underreported. For every case of EA reported, it was estimated that five cases were unreported (Gray-Vickrey, 2005; Schecter & Dougherty, 2009; Brownell, 2005; Heath et al., 2005; Radensky & Parikh, 2008; Sayles-Cross, 1988). An estimated 2.16 million older Americans are abused every year and approximately only one in fourteen cases are reported (Plitnick, 2008).

Health care workers. The majority of the responsibility for detecting and reporting EA has fallen to healthcare and social workers (Daly & Coffey, 2010). Most states require healthcare providers to report suspected cases of abuse (Muehlbauer, 2006; Shugarman, Fries, Wolf, & Morris, 2003; Liao, Jayawardena, Bufalinia, & Wiglesworth, 2009; Fulmer et al., 2004; Hirsch et al., 1999) and nurses are included in those laws (Plitnick, 2008; Quinn, 2002). The American Medical Association recommends screening for elder mistreatment in all older patients (Fulmer et al., 2004). Legal viewpoints have argued that a clinician's failure to detect and report abuse of an elder constitutes negligence and malpractice (Hirsch et al., 1999) and failure to act by the nurse in cases of suspected abuse could be in itself considered abuse (Muehlbauer, 2006). Additionally, national organizations such as the US Department of Health and Human Services, Adult Protective Services, and the Joint Commission of Healthcare Organizations have taken steps to prevent, protect, detect and report, respond to, and educate health care professionals about EA.

Although health care workers have the opportunity and professional responsibility to identify EA, most were not adequately prepared to do so (Erlingsson, Carlson, & Saveman, 2005) and often failed to suspect abuse (Cooper et al., 2009; Tilden et al.,

1994). In fact, over 50 percent of nurses stated they would not report suspected elder abuse to authorities (Cooper et al., 2009; Tilden et al., 1994). Additionally, one-third of nurses would not report abuse unless absolutely positive it had occurred (Cooper et al., 2009).

Specific barriers to reporting EA by nurses included fear of misinterpreting the situation (Agnew, 2006), fear of causing harm to a family (Agnew, 2006), and fear of breaching confidentiality (Muehlbauer, 2006). Lack of knowledge was also a barrier to reporting by nurses, (Starr, 2010; Almogue et al., 2010; Neno & Neno, 2010). Nurses also lacked confidence in their ability to detect abuse accurately (Agnew, 2006; Alford, 2006; Cooper et al., 2009). Identifying elder abuse may be difficult for many reasons. In the form of emotional abuse, there are no physical signs. Other signs of abuse may be vague and might go unrecognized. Identifying elder abuse may also be made more difficult by the presence of medical conditions associated with aging that mask the signs of abuse (Gray-Vickrey, 2005; Anetzberger, 2001; Starr, 2010), such as medications that thin blood making the individual more susceptible to bruising (Desmarais & Reeves, 2007). However, a healthcare provider does not have to confirm abuse to report it, but must merely have a suspicion of abuse (Cronin, 2007).

Lack of knowledge. Fifty-three percent of nurses were unaware of reporting policies and ninety-nine percent would like training on identifying and reporting abuse (Potter, 2004). Two quantitative studies assessed nursing students' preparedness regarding EA. Students reported insufficient knowledge (Policastro & Payne, 2014) or preparation (Lo, Lai, & Tsui, 2009) to manage EA.

Lack of Confidence. Two-thirds of nurses in the U.S. were not confident in their knowledge of state laws protecting them from litigation when reporting EA (Cooper et al., 2009). Perceptions of EA among nurses in long-term care facilities revealed that half of nurses were not confident regarding their ability to detect abuse and seventy-nine percent desired training on abuse of older adults (Daly & Coffey, 2010).

Self-efficacy. Self-efficacy is an individual's beliefs in their ability to manage their own functioning and maintain control over events affecting their lives (Bandura, 1997). Self-efficacy is rooted in the core belief that one is capable of producing desired effects through one's actions (Benight & Bandura, 2004). The stronger an individual's self-efficacy, the more difficult goals the individual sets and the stronger their commitment to achieve them (Bandura, 1993). Bandura (1993) further states that individuals with equal skill level are differentiated based on their perceived self-efficacy; their performance is based on their self-efficacy rather than their actual ability.

Self-efficacy in managing elder abuse, therefore, would refer to belief that one can manage the issue and would affect actual performance. Limited literature was located regarding self-efficacy for managing elder abuse; therefore, the following summarizes providers' experiences with various forms of abuse. Nurses and medical interns exhibited a wide range of self-efficacy regarding their ability to screen victims of intimate partner violence (Chapman, Coleman, & Varner, 2011). As knowledge of services increased, self-efficacy also increased. The second strongest relationship was between self-efficacy and understanding of obstacles (Chapman, Coleman, & Varner, 2011). It has been found that self-efficacy regarding management of domestic, child, and

elder abuse by physicians improves with training (Shefet, Dascal-Weichhendler, Rubin, Pessach, Itzik, Benita, & Ziv, 2007).

Barriers to reporting other forms of abuse. Literature related to barriers in reporting various types of abuse was examined. Barriers to reporting intimate partner violence included nurses' disbelief and blame of the abuse on the victim (Reisenhofer & Seibold, 2012). These attitudes caused victims to distance themselves from and not confide in the nurse. The women felt as if they were being blamed for the abuse by an authority figure, which increased shame, guilt, and worthlessness, and created barriers to seeking and receiving help. Additional barriers to detection of abuse were nurses' discomfort, frustration, lack of skills, embarrassment, inability to find a remedy, fear of losing control, denial, guilt, lack of awareness, beliefs that questioning constitutes an invasion of privacy, feelings of hopelessness and helplessness, and lack of trust in the system (Natan & Rais, 2010). Organizational policies regarding patient questioning affected nurses' decision whether to question battered women. Compliance with questioning diminished when workers knew that management did not support such inquiries and when there was a lack of privacy, the inability to isolate the patient from other patients or from those accompanying her, or if the nurse's schedule was not conducive (Natan & Rais, 2010). Forty-four percent of nurses had not received any training on domestic violence; of those who received training 28.2% had learned about violence through in-service, 19.5% through an advanced course, and only 14.1% through advanced degrees (Natan & Rais, 2010).

Inquiring about and reporting of domestic violence by healthcare providers is lacking. Intimate partner violence is not reported sufficiently in emergency departments

or other healthcare facilities (Reisenhofer & Seibold, 2012). Despite women's wish to be questioned and willingness to talk (Natan & Rais, 2010), only 37.5% of providers agreed that they question patients about violence, 26% slightly agreed, and 36.5% said that they do not question female patients regarding violence. Although physicians are in a unique position to identify and report domestic violence (DV), detection rates are poor (Shefet, Dascal-Weichhendler, Rubin, Pessach, Itzik, Benita, & Ziv, 2007).

Gaps in Literature

Review of the literature on elder abuse yielded several areas requiring further consideration. While the prevalence, types of EA, and risk factors for EA have been established, there is a lack of evidence to support appropriate prevention and intervention measures (Cooney et al., 2006; Lachs & Pillemer, 2004; Schofield & Mishra, 2004). There is a need to understand nurses' knowledge, confidence, and understanding of EA (Almogue et al., 2010; McCreadie et al., 2000). Interventions aimed at providers' ability to detect EA (Cox, 2008) and the efficacy of various educational methods aimed at improving provider reporting is needed.

Theoretical Framework

This study is based on Self-Efficacy Theory within the framework of Social Cognitive Theory (Bandura, 1997). Social Cognitive Theory (Bandura, 1996) is based on the premise that learning occurs in the social context and most learning occurs through observation. Self-efficacy is not concerned with the skills an individual possesses, but rather with what an individual believes he or she can do. An individual's self-efficacy beliefs shape their life course as it influences choices an individual makes (Bandura, 1993). The stronger the perceived self-efficacy of the individual, the higher the goals the

individual sets and the stronger their commitment to them. Therefore, behaviors of individuals with similar knowledge and skills may vary based on the strength of their perceived self-efficacy. Thus, individuals with higher self-efficacy for managing EA are more likely to intervene appropriately in suspected cases.

Person, environment, and behavior are the core concepts of Self-Efficacy Theory. According to Bandura, the concepts of person, environment, and behavior interact and affect human functioning (Pajares, nd.). For the purpose of this study, person is defined as nurses' self-efficacy in management of elder abuse as well as demographic factors. According to Self-efficacy Theory, environment is defined as a succession of transactional life events in which individuals play a role in shaping the course of their personal development (Bandura, 1993). Self-efficacy affects environment; individuals with higher self-efficacy are more likely to exercise control over their environment because they are more likely to undertake difficult activities they feel they are capable of managing (Bandura, 1993). For the purpose of this study, environment is defined as educational content about EA in nursing education and employment, and number of years since previous education on EA. Behavioral processes, according to Self-efficacy Theory, are the choices an individual makes at decisional points. Beliefs of efficacy influence behaviors; the higher the perceived self-efficacy, the higher the goal is set and the stronger the commitment to the goal and more likely the behavior performed (Bandura, 1993). Behavior for this study is defined as reported actions on elder abuse. Theoretical concepts, definitions, and operational definitions appear in Table 1.

Methodology

Research Question

What are the relationships between EA educational experience, perceived intervention barriers, self-efficacy for managing EA, and reported actions for registered nurses?

Hypotheses

The hypotheses for this study included:

1. EA educational experience, perceived intervention barriers, and self-efficacy for managing EA significantly predicts reported actions for registered nurses.
2. There is a significant interaction effect between EA educational experience and self-efficacy for managing EA on reported actions for registered nurses.
3. There is a significant interaction effect between perceived intervention barriers and self-efficacy for managing EA on reported actions for registered nurses.

Design

This study used a quantitative cross-sectional survey design to address the proposed hypotheses.

Sample

The convenience sample consisted of 184 Registered Nurses (RN). RN's were contacted and provided the survey link through alumni lists from Universities and social media such as Facebook and LinkedIn. Inclusion criteria included RN's currently employed as a nurse.

A priori power analysis was performed in G*Power 3.1 before data collection. Assuming a medium effect size (f^2=.15), a power of .80 (Cohen, 1992), and an alpha of

.05, with five predictors including two interaction terms, the results suggested a sample of 138 participants for the proposed study. The use of medium effect size is supported in other studies on elder abuse (Harries, Davies, Gilhooly, Gilhooly, Tomlinson, 2014; Amendola, Slipman, Hamilton & Whitman, 2010)

IRB approval from the University of Texas at Tyler was obtained prior to data collection. Consent was implied through completion of the survey. Participants' identity and responses were kept anonymous.

Setting

Cross sectional data were collected through an online survey using Qualtrics.

Instruments

Demographics. Participants responded to demographic questions and prior EA education (Appendix D), and EA patient experiences. Two instruments, EA Reported Actions (Appendix A), and Perceived EA Intervention Barriers (Appendix B), were originally used in a study on domestic violence. These instruments were modified for this study and used with permission (Appendix E). The Self-Efficacy for Managing EA Scale was designed for this study by the researcher with input from experts in the field.

The Reported Actions Scale contained nine questions designed to evaluate individuals' actions in suspected abuse cases, which was measured on a 4-point Likert scale with 1 representing *never* and 4 *always*. Participants were instructed to choose the response for each question based on actions they take when encountering a case in which they were suspicious of abuse. No prior psychometric evidence was available for this scale.

The Perceived Intervention Barriers scale contained 11 questions which determined participants' perceptions of what prevented them from intervening in cases of suspected abuse. Participants' responses were rated on a 4-point Liker scale with 1 as *will not prevent my intervention at all* and 4 as *will strongly prevent my intervention.* Respondents were instructed to mark the answer which correlated to the extent each of the questions has prevented (or may prevent) intervention in cases of suspected abuse. No psychometric evidence was available for this scale.

The Self-efficacy for Managing EA Scale was developed by the author based on literature findings, Bandura's (1982) suggestions regarding instrument development and expert review. The tool was evaluated by experts and found to be representative of EA management (Appendix C).

On The Self-efficacy for Managing EA Scale, participants responded to eight questions and four open-ended questions. Participants rated their confidence to perform various aspects of managing EA on a 100-point scale. Ratings were presented in 10 unit intervals, the standard method. In this type of scale 0 indicated *Cannot do,* 50 indicated *Moderately certain can do* and 100 indicated *Certain can do*.

Data Collection

Data was collected through an online survey using Qualtrics.

Data Analysis

All analyses were performed in SPSS 21.0 (Field, 2009). First, descriptive statistics were obtained to address demographic information from participants. Then, internal consistency coefficients were calculated to examine the reliability of each scale. After that blockwise multiple regression was conducted to address the research question,

before which assumptions were evaluated. The dependent variable for this study was reported actions for RNs. The independent variables included EA educational experience, perceived intervention barriers, and self-efficacy for managing EA. Assumptions that were checked before performing blockwise multiple regression include variable types, non-zero variance, absence of multicollinearity, independence of values of outcome variables, normal distribution of errors, and homoscedasticity.

Research Findings

Sample

Participants (n = 184) included 9 males (4.9%) and 175 females (95.1%). Ages ranged from 22 years to 71 years with an average age of 41.11 years (SD = 12.16). Participants were made up of 4.9% (9) African Americans, 1.1% (2) American Indians, 1.6% (3) Asian, 2.2% (4) Hispanic, 85.2 % (156) Non-Hispanic white, and 4.9% (9) other. Years since graduation ranged from 0 to 45 years, with an average of 8.12 years (SD = 8.30). When asked how many times the individual had reported suspected elder abuse, numbers ranged from 0 to 36 with an average of 1.02 times (SD = 3.46). Regarding the question if the participant had frequent contact with older adults, 57.4% (109) reported yes and 32.6% (62) reported no with 19 missing responses. Current level of education for participants was 14.7% (28) had an associate's degree, 35.8% (68) had a bachelor's degree, 30% (57) had a master's degree, 9.5% (18) had a doctorate degree, and 19 participants did not respond. When asked if the participant had cared for a patient suspected of abuse, 52.6% (100) said yes, 37.4% (71) said no, and 19 did not provide a response. Participants' employment settings and area of specialty are listed in Table 2 below.

Evaluation of the sample finds that the highest percent (48.4%) of participants work in the hospital setting and 63.7% of participants are in frequent contact with older adults. The factor of educational content on EA indicates 82.5% of participants learned about EA in nursing school, 47.4% learned about EA from media sources, and 16.3% learned about EA from personal experience. Additionally, it was found that 58.5% of participants have cared for a patient who was abused or suspected of being abused.

Self-efficacy for managing EA was evaluated. Participants were most confident in their ability to identify physical abuse (M = 74.84, SD = 18.28) and neglect (M = 76.97, SD = 17.67) and least confident in their ability to identify sexual abuse (M = 47.42, SD = 26.55). Participants were most confident in their ability to notify the correct authority if EA was suspected (M = 82.97, SD = 20.26) and least confident in their ability to identify a caregiver at risk of committing abuse (M = 65.68, SD = 20.86).

Factors which would prevent intervention in suspected cases of EA were examined and the majority of factors were not at all likely to prevent nurses' intervention. The factors which respondents stated would not prevent intervention were "It's a private matter-it's none of my business" (80.1%) and "One can't help in these cases anyway" (84.9%).

When evaluating nurses' Reporting Actions, most participants chose "Always" for most factors included. The factors which had highest numbers for "Always" included "document patients' remarks in the medical chart" (62.8%) and "inform another professional" (64.9%). The factors which did not have ratings of "Always" were "inquire about danger to a family member", with "Almost always" as the highest choice (33.1%),

and “invite aggressor to a meeting”, with “Never” as the option chosen by the most participants (29.7%).

Instruments

To examine the reliability of each scale, internal consistency coefficients were calculated. Each of these scales has good reliability: for the Reported Actions scale, Cronbach’s alpha was .78; for the Self-Efficacy scale, alpha was .91; and for the Barriers scale, alpha was .91. Internal consistency was not calculated for EA Education due to the dichotomous variables on the scale. The scores for each of the scales were calculated as listed below:

The variables (and their abbreviation) included in the analysis were:

1. average of responses to nine questions about reported actions (**Aavg)**,
2. sum of responses to six questions about EA educational experience (**Esum)**,
3. average of responses to eleven questions about perceived intervention barriers (**Bavg)**,
4. average of responses to seven questions to self-efficacy for managing EA (**SEavg)**,
5. interaction term, product of the normalized responses for self-efficacy and EA educational experience **(Z_SE_E)**, and
6. interaction term, product of the normalized responses for perceived intervention barriers and self-efficacy for managing EA (**Z_SE_B).**

Multiple Regression

To test the hypotheses on the relationships between the reported actions of EA and its predictors, blockwise multiple regression was conducted. The dependent variable

was Actions in Reporting EA. Predictors were entered in the following order suggested by evidence from the literature, Self-Efficacy Theory, and practice: Educational content, Barriers to Reporting, and Self-efficacy regarding management of elder abuse, followed by the two interaction terms. The variables are summarized in Table 3. The sample size was reduced from 184 to 146 due to missing data.

Models and Predictors

As shown in Table 4, all models were statistically significant ($p \leq 0.05$). Model 5 with all the predictors entered was the final model: Aavg = 2.999 + 0.117*Esum + 0.076*Bavg + 0.002*SEavg – 0.159*Z_SE_E – 0.109*Z_SE_B. The *R* square and the change in the *R* square as each variable was sequentially entered are also shown. The *R* square in Model 5 indicated that the predictors accounted for 11.1% of Reported Actions. However, because the *R* square is influenced by the number of predictors, the adjusted *R* square was also reported for each model. The adjusted *R* square for Model 5 indicated that all the predictors were able to explain 8.0% of the variance in Reported Actions, which was a small effect ($f^2 > .02$) according to Cohen's (1992) criteria, indicating this was a weak model.

Educational content and the interaction term for Self-efficacy and Educational content were the significant predictors (as shown in Table 4) and accounted for the largest changes in *R* square (0.05 and 0.04, respectively). Only those two variables were significant in all five models. The confidence intervals for each of the coefficients in Model 5 also indicated the relevance of the variables. Those intervals that contain the value 0 (lower bound negative, upper bound positive) indicated that the population coefficient could be 0 which would negate the variable in the equation. The coefficient

for Educational Content (*B*=.12) indicated that for every one unit increase in Educational Content, the Reported Action increased by 0.12. Likewise, for every one unit increase in the interaction term for Self-efficacy and Education, the Reported Action decreased by 0.16.

Model Assessment

Assumptions for multiple regression were evaluated for Model 5. First, independence of values or observations can be assumed because each participants' response was not correlated with anyone else's. Next, variances were calculated for all variables in the model and no zero variance was identified (Table 4). After that, multicollinearity was examined based on the evidence from multiple sources. Collinearity is the significant correlation between predictor variables. Pearson's correlation coefficients (Table 5) indicated the absence of collinearity. Moreover, alternative measures of collinearity, Tolerance and VIF (the reciprocal of Tolerance), also confirmed that there was no collinearity present. All Tolerance values were greater than 0.1 and VIF values less than 10.

Next the model residuals were evaluated. Normal distribution of errors was assumed because the normal probability plot of the error terms (residuals) deviated only slightly from a straight line (Figure 1). The line signifies the amount of variation of data values. A standard deviation close to 0 (the line) indicates that the data points tend to be very close to the mean of the set, while a high standard deviation indicates that the data points are spread out over a wider range of values. However, homescedasticity was not assumed for the common variance for the error terms, which was evaluated by a Residual * Predicted plot (Figure 2). A random pattern would indicate homogeneity of variance.

For Model 5, it was not randomly distributed, i.e., oval shape. The dotted line in the upper part was those who reported N/A on the DV, i.e., EA reported action, approximately 30.

To summarize, the final model significantly (p=0.005) predicted Actions in Reporting EA with two of the five variables being significant predictors, Self-efficacy (p=0.034) and the interaction term Self-efficacy*EA educational experience (p=0.017). The adjusted R-square indicated that only 8.0% of the variability seen in the Actions in Reporting EA average scores for each of the survey respondents can be explained by the two significant predictor variables. Therefore, there was 92% of the variability that was explained by unknown variable(s) and error terms, which was suggested by the violation of homoscedasticity of the residuals in Reporting EA.

Discussion of Findings

This study found that most nurses learned about EA in nursing school and over half cared for a patient who was abused or that was suspected of being abused. Nurses are overall reasonably confident in their ability to manage EA in older adults. They are more confident in their ability to identify physical abuse and neglect and least confident in their ability to identify sexual abuse. This is consistent with previous literature in that physical abuse and neglect are easier to detect due to the physical manifestations present. They are also least confident in their ability to identify caregivers at risk for committing abuse as compared to other factors related to EA management.

Most barriers will not prevent nurses acting when they suspect abuse; however, knowledge and cultural barriers were the most likely to prevent intervention. The lack of knowledge as a barrier has been supported in previous findings in literature (Charland,

2006; Fulmer et al., 2004; Halphen et al., 2009; Jayawardena, 2006; Liao et al., 2009; Shugarman et al., 2003; Wagenaar, 2009; Yaffe et al., 2008). Previous findings also indicated that increased in knowledge will increase self-efficacy. Nurses reported always performing identified steps related to reporting of EA with the exception of inquiring about danger to family, which is less often, and will never invite the aggressor for a meeting. Educational content had the highest correlation with reporting EA by nurses, but the correlation was not very high.

The tools utilized for this study were reliable. However, there was a lack of congruency between items on the Reported Actions scale and the Self-Efficacy for Management of EA scale. Factors which should be added to the Self-Efficacy for Management of EA scale include "Inquire about the danger of violence against other family members" and "Check immediate risk and/or work with the patient on a safety plan" to better capture all factors related to management of EA.

Recommendations

Research is needed to further explore reporting elder abuse by registered nurses. Closer examination of the educational content nurses receive as compared to intent to report could be beneficial for nurse educators. Determining current content would indicate areas in which education is lacking. Best educational practices and delivery methods should be determined.

Recommendations for future studies include determination of whether nurses routinely screen older adults for EA and what screening policies involve. Additionally, evaluation of other factors which affect registered nurses' reporting of suspected cases of elder abuse are needed. For example, lack of time to appropriately evaluate older adults

for suspected abuse might be an important consideration. Identification of additional factors which affect registered nurses' reporting of suspected elder abuse, addressing methods to overcome barriers, and determining whether interventions improve reporting is necessary.

Implications for Practice

Findings from this study indicate that of all the predictors tested, educational content on elder abuse has the highest correlation with actions in reporting elder abuse. This provides important information to nurse educators and employers, in that education does signify a higher chance for registered nurses to report suspected elder abuse. Therefore, educators and employers should develop and implement educational content on the topic of elder abuse for nurses. Institutions should consider implementing a policy that requires screening of all older adults using a short screening tool.

The tools utilized were reliable. No previous reliability was reported on self-efficacy for managing elder abuse, perceiver intervention barriers, or reported actions; therefore, this study contributes to future studies which would evaluate these factors to provide more data. Replication studies are needed to confirm reliability of these instruments.

Limitations

Several limitations are noted. The instruments used in this survey, although previously used in literature, lacked reliability and validity data. However, the instruments were reliable based on this sample's responses. An additional limitation noted was the use of anonymous self-report which may produce recall bias or response

bias. When performing multiple regression, the scores in the instruments were averaged, which could have led to loss of interaction effect of certain components.

Conclusion

Study findings indicate further research must be done in order to further evaluate factors which affect registered nurses' reporting of suspected cases of elder abuse. Educational content does play a role, although a minor one. Further examination of the actual content in nursing curricula as well as delivery method could be useful in determining where improvements can be made.

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Table 1.

Conceptual and Operational Definitions

Bandura's Concepts	Conceptual Definition	Operational Definition
Person	Personal factors in the form of cognition, affect, and biological events (Pajares, nd)	Demographic factors
• Self-efficacy	What an individual believes he or she can do (Bandura, 1993)	Perceived Self-efficacy for Managing EA (Anderson)
Environment	A succession of transactional life events in which individuals play a role in shaping the course of personal development (Bandura, 1993)	EA content: number of hours Education method (lecture, role play, etc.) Number of years since previous education about EA EA Perceived Intervention Barriers questionnaire (Shefet et al., 2007)*
Behavioral processes	Choices an individual makes at important decisional points (Bandura, 1993)	EA Reported Actions questionnaire (Shefet et al, 2007.)

* Items on this scale cover content from both Environment and Person.

Table 2.

Sample Employment Setting/Specialty (more than 1 response possible)

Setting/specialty	Number	Percentage
Hospice/palliative	5	2.6%
Long term care	1	0.5%
Physician office	9	4.7%
Academic setting	54	28.4%
Health department	2	1.1%
Rehabilitation	2	1.1%
Medical-Surgical	14	7.4%
OB/GYN	12	6.3%
Pediatrics	13	6.8%
Surgery/recovery	6	3.2%
Critical care	23	12.1%
Emergency	12	6.3%
Geriatrics	2	1.1%
Mental health	4	2.1%
Administration	8	4.2%
Other	22	11.6%

Table 3.

Descriptive Statistics of the Predictors for Reported Actions of EA

	N	Mean	Std. Deviation	Range
Reported Actions	146	3.74	.79	1.89 - 5.00
EA Education	146	3.57	1.22	2.00 – 7.00
Perceived Intervention Barriers	146	1.64	.61	1.00 – 4.00
Self-efficacy for managing EA	146	74.39	15.63	18.57 – 100.00
Interaction of Self-efficacy and EA education	146	-.17	1.01	-4.96 – 2.25
Interaction of Perceived Barriers and Self-efficacy	146	-.22	1.04	-5.51 – 5.40

Table 4.

Model Summary and Coefficients for Reported Action of Elder Abuse

Models		*B*	*Beta*	95% CI	
1	(Constant)	3.21***			
	Educational content	.15**	.23		
2	(Constant)	3.16***			
	Educational content	.15**	.23		
	Barriers	.03	.02		
3	(Constant)	3.14***			
	Educational content	.15**	.23		
	Barriers	.03	.03		
	Self-efficacy	.00[1]	.01		
4	(Constant)	3.18***			
	Educational content	.11*	.17		
	Barriers	.05	.04		
	Self-efficacy	.00[1]	.02		
	SE*Edu	-.16*	-.21		
5	(Constant)	3.00***		[2.06	3.94]
	Educational content	.12*	.18	[.01	.23]
	Barriers	.08	.06	[-.14	.29]
	Self-efficacy	.00[1]	.04	[-.01	.01]
	SE*Edu	-.16*	-.20	[-.29	-.02]
	SE*Barrier	-.11	-.14	[-.23	.01]

Models	R^2	Adjusted R^2	F	$R^2\,\Delta$
1	.05	.05	7.97**	.05
2	.05	.04	4.00*	.00[1]
3	.05	.03	2.65*	.00[1]
4	.09	.07	3.55**	.04
5	.11	.08	3.51**	.02

*p <.05, **p<.01, ***p<.001. [1] <.01

Table 5.

Variable Statistics

	Reported Action	Barrier	SE	Edu	SE*Edu	SE*Barrier
Variance	.63	.38	244.17	1.49	1.02	1.08

Table 6.

Pearson's Correlation Coefficients (N=146)

	1	2	3	4	5
1. Reported Action	-				
2. Barrier	.03	-			
3. Self-efficacy	-.04	-.23**	-		
4. Educational content	.23**	.04	-.18*	-	
5. SE*Edu	-.25**	.04	.09	-.30**	-
6. SE*Barrier	-.13	.11	.11	.05	.02

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

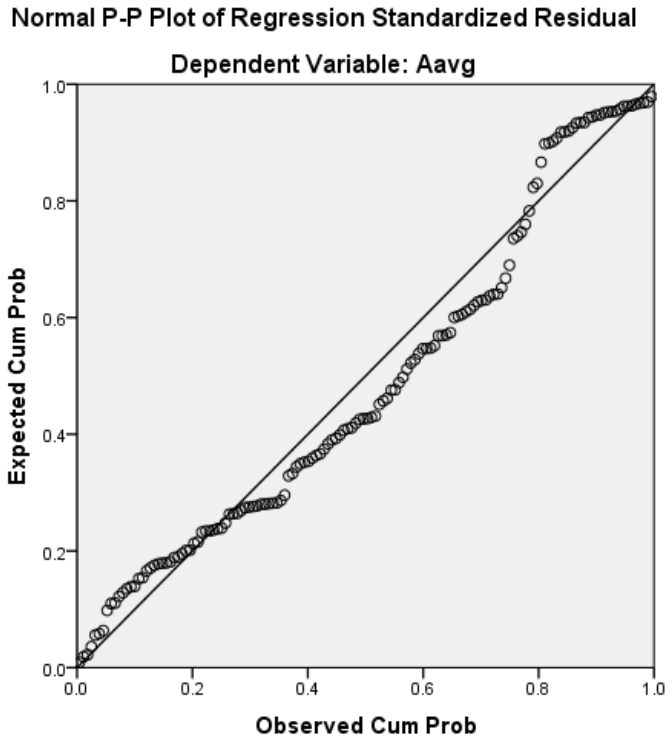

Figure 1. P-Plot of Regression

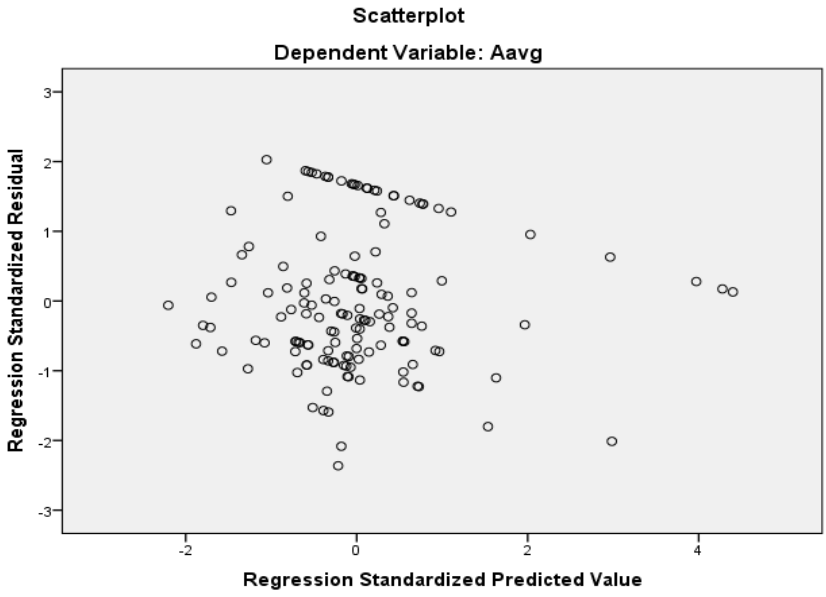

Figure 2. Scatterplot

Chapter 4.

Summary and Conclusion

A significant portion of older adults suffer from abuse at the hands of those entrusted with their care. This abuse causes negative health outcomes leading to increased mortality, nursing home placement, and mental health issues. Elder abuse is not adequately detected or reported. Nurses have an opportunity and responsibility to report suspected abuse, although literature indicates that they do not do so.

This portfolio contains two manuscripts. The first manuscript is *The State of the Science on Nurses' Management of Elder Abuse,* which provides a summary of the numerous factors related to elder abuse, including definitions and types, risk factors for the victim and caregiver, issues affecting nurses' reporting, and tools available in literature. Findings from this review indicated further examination of reasons nurses do not adequately report elder abuse are needed. Literature suggests potential reasons may be related to knowledge (education), self-efficacy, and barriers in practice.

Nurses' Self-Efficacy for Managing Elder Abuse is the second manuscript and it evaluated the interaction between nurses' self-efficacy in managing elder abuse, perceived intervention barriers, and educational content over elder abuse with reporting actions of registered nurses. The framework for this study was Bandura's Self-Efficacy Theory.

This quantitative study used an online survey to gather data. Tools used in this study included Reported Actions, Perceived Intervention Barriers, and Self-Efficacy for Management of Elder Abuse all of which were reliable. It was found that educational

content had the highest interaction effect on reported actions, although this effect was not large. Further evaluation of potential factors influencing reporting of elder abuse by registered nurses is needed.

Appendix A Reported Actions

Instructions: When encountering a case suspicious of elder abuse, do you take the following actions? Please answer on a scale of 1 (never) to 4 (always).

1. Document the patient's remarks in his/her own words in the medical chart.

1 2 3 4

2. Document suspicion of violence even if the patient denies it.

1 2 3 4

3. Explain to the patient that violence against him/her is unjustified.

1 2 3 4

4. Provide information regarding elder abuse (such as prevalence, escalation with time).

1 2 3 4

5. Invite the alleged aggressor for a meeting.

1 2 3 4

6. Inquire about the danger of violence against other family members.

1 2 3 4

7. Check immediate risk and/or work with the patient on a safety plan.

1 2 3 4

8. Offer the patient appropriate help (such as social hospitalization, legal aid, social services). 1 2 3 4

9. Inform another professional (staff member/social agent/legal agent).

Appendix B Perceived Intervention Barriers

Instructions: To what extent has each of the following prevented (or may prevent) your intervention in cases suspicious of elder abuse? Please grade on a scale of 1 (will not prevent my intervention at all) to 4 (will strongly prevent my intervention*)

1. I don't have enough knowledge on the subject. 1 2 3 4

2. I don't have the appropriate conditions (time, privacy). 1 2 3 4

3. I'm afraid to hurt the patient's or his family's feelings if I ask. 1 2 3

4. It's a private matter—it's none of my business. 1 2 3 4

5. One can't help in these cases anyway. 1 2 3 4

6. I don't know where to refer the patient. 1 2 3 4

7. I don't know how to ask about it. 1 2 3 4

8. I'm afraid I'll find it difficult to cope emotionally. 1 2 3 4

9. I'm afraid of violence against me. 1 2 3 4

10. Negative professional experience in this field (previous intervention has led to unwanted results). 1 2 3 4

11. Cultural barriers (language, mentality). 1 2 3 4

12. Do you see other barriers not listed here? Please specify. _____

_____

Appendix C Self-Efficacy for Management of Elder Abuse

Instructions:

We would like to find out how confident you are that you can recognize and manage elder abuse in your nursing practice. Please consider each question carefully and be honest regarding what you think you can do. For each question, think about it carefully and answer according to how confident you are that you can do each item. Rate your degree of confidence from 0 to 100 using the following scale:

0	10	20	30	40	50	60	70	80	90	100
Cannot do				Moderately						Certain
at all				certain can do						can do

Please rate based on what you could do today.

Please rate your confidence for each item from 0 (cannot do at all) to 50 (moderately certain can do) to 100 (certain can do). How confident are you that you can:

1. identify each of the following types of elder abuse?

a) Physical abuse

0	10	20	30	40	50	60	70	80	90	100

b) Sexual abuse

0	10	20	30	40	50	60	70	80	90	100

Appendix C Self-Efficacy for Management of Elder Abuse (continued)

c) Emotional abuse

0 10 20 30 40 50 60 70 80 90 100

d) Financial abuse

0 10 20 30 40 50 60 70 80 90 100

e) Neglect

0 10 20 30 40 50 60 70 80 90 100

2. identify risk factors of elder abuse?

0 10 20 30 40 50 60 70 80 90 100

3. identify older adults at risk for elder abuse?

0 10 20 30 40 50 60 70 80 90 100

4. identify caregivers of older adults at risk for committing abuse?

0 10 20 30 40 50 60 70 80 90 100

5. discuss concerns regarding elder abuse with older adults?

0 10 20 30 40 50 60 70 80 90 100

6. notify the correct authority if elder abuse is suspected?

0 10 20 30 40 50 60 70 80 90 100

7. intervene in a situation where the older adult is in an unsafe environment or at high risk for harm?

0 10 20 30 40 50 60 70 80 90 100

Appendix C Self-Efficacy for Management of Elder Abuse (continued)

8. educate older adults about the various components of elder abuse, including definitions, types, risk factors, etc?

0 10 20 30 40 50 60 70 80 90 100

9. If currently using a screening tool to assess for elder abuse, please identify which tool you are using. _____

10. Share any experience you have had caring for someone you suspected was a victim of EA. _____

11. Please share your comments regarding knowledge, perceptions, or definitions of EA. _____

12. What is your organization's policy regarding how to handle cases of suspected abuse?_____

Appendix D Demographics and Educational Information

Instructions: Please answer the following questions by filling in or checking the appropriate line or box.

1. What is your level of education? Associate degree____ Baccalaureate degree____ Master's degree_____ PhD_____

2. How many years has it been since you graduated from nursing school? _____

3. What is your age? _____

4. What is your gender? Male_____ Female_____

5. What is your ethnicity?

a. African American_____

b. American Indian_____

c. Asian_____

d. Hispanic_____

e. Non-Hispanic White

f. Other_____

6. What is the setting in which you work?

a. Hospital_____

b. Home Health_____

c. Hospice_____

d. Long term care_____

e. Physician Office_____

Appendix D Demographics and Educational Information (continued)

f. Academic setting_____

g. Health Dept. _____

h. Prison_____

i. Rehabilitation Setting

j. Nursing Faculty

k. Other(please state)_____

7. In your employment, do you have frequent contact with older adults?

Yes_____No____

8. What is the specialty area in which you work?

a. Medical Surgical_____

b. Surgery_____

c. Critical care_____

d. Pediatrics_____

e. Obstetrics_____

f. Palliative_____

g. Rehabilitation_____

h. Geriatrics_____

i. Emergency Department

j. Other (please state)_____

Appendix D Demographics and Educational Information (continued)

9. Did you learn about any form of EA (physical, sexual, financial, emotional/psychological, or neglect) during nursing school? Yes ___ No ___

10. Did you learn about any form of EA (physical, sexual, financial, emotional/psychological, or neglect) while at work (continuing education program, during report, etc.)? Yes ___ No ___

11. During your working experience, have you ever cared for a patient who was abused or suspected of being abused? Yes_____ No_____

12. How many times have you reported suspected elder abuse? _____

13. Please share any experiences you had with elder abuse.

Appendix E Permission to Use Scales: Perceived Intervention Barriers and Reported Actions

On Wednesday, August 6, 2014 2:23 AM, "daphnash@clalit.org.il" <daphnash@clalit.org.il> wrote:

Yes, of course (with proper reference and credit).

Good luck!

Daphna

On Tuesday, July 22, 2014 1:22 PM, Alana Anderson <alanakanderson@yahoo.com> wrote:

Dr. Shefet,

I am an Instructor of Nursing at the University of Central Oklahoma in the United States. I am interested in using the scales from your study "Domestic violence: a national simulation-based educational program to improve physicians' knowledge, skills and detection rates". I would be using it in a study on elder abuse education in nursing students. I would provide credit for use of your scale in my study. Please advise at your earliest convenience. If you allow use of the scale, I would appreciate any statistical data on the tool that you may have.

Thank you so much for your time,

Alana K. Anderson, RN, MS

Biosketch

BIOGRAPHICAL SKETCH	
NAME **Alana Anderson**	POSITION TITLE **Instructor**

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE	MM/YY	FIELD OF STUDY
University of Texas at Tyler, Tyler, Texas	Ph.D	05/2015	Nursing
University of Oklahoma HSC, Oklahoma City, OK	MS	12/2007	Nursing
University of Oklahoma HSC, Oklahoma City, OK	BSN	05/2001	Education Nursing

A. Personal Statement

The purpose of this quantitative study was to examine the effects of educational content, perceived barriers, and self-efficacy in managing elder abuse on reported actions by registered nurses. The study provided information to nurse educators and administrators regarding factors which affect reporting of suspected elder abuse by registered nurses. Future research should be directed at further examination of educational content and delivery methods as well as other factors which may limit reporting.

B. Positions and Honors

2006-present University of Central Oklahoma (UCO)
2004-2006 Central Technology Center (CTC)
2000-2006 Homecall Home Health
2001-2003 Mercy Healthcare

<u>Other Experiences and Professional Memberships</u>

2013-present	The National Society of Leadership and Success
2007-present	National League of Nursing
2009-2011	Southern Nursing Research Society
2009-2011	Gerontological Society of America